

May 7, 2012

Submitted Electronically

Ms. Marilyn Tavenner
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-0044-P; Proposed Rule: *Medicare and Medicaid Programs; Electronic Health Record Incentive Program – Stage 2*

Dear Ms. Tavenner:

On behalf of our 82,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) appreciates the opportunity to submit comments to the Centers for Medicare and Medicaid Services (CMS), in response to the proposed rule published in the *Federal Register* on March 7, 2012, for the “*Medicare and Medicaid Programs; Electronic Health Record (EHR) Incentive Program – Stage 2.*” APTA is committed to advancing the safety and quality of healthcare through health information technology (HIT) innovation and we are eager to work with HHS and its agencies on health information technology’s evolving role in promoting health and health care reform.

APTA’s commitment includes, but is not limited to, the adoption of electronic health records (EHR), implementation and enforcement of privacy and security protections, and utilization of electronic health information to support new payment models such as accountable care organizations, as well as fostering health information exchange where it is not currently taking place, supporting coordinated patient-centered quality care through utilization of electronic health information, and being an active participant in the evolution of an interconnected electronic health system. APTA has many member physical therapists who have implemented electronic health record systems in their

practices, despite not being defined as “eligible providers” (EPs) to receive meaningful use incentives under the Medicare and Medicaid programs.

Physical therapists play a critical role in a patient’s continuity of care as the patient transitions from one health care setting to another. Physical therapy services are provided in a variety of settings, including home care, hospitals, outpatient clinics or offices; inpatient rehabilitation facilities; skilled nursing, extended care, sub-acute facilities; Intermediate Care Facilities for People with Mental Retardation (ICF/MR); patients’ education or research centers, hospices and schools. Physical therapy efficiently aids a beneficiary in gaining the best possible function within the context of their medical condition. These services ensure the diagnosis of, interventions for, and prevention of impairments, functional limitations, and disabilities related to movement, function, and health. Often, physical therapy is an effective and less costly option than alternative treatments, such as surgery.¹ Costs associated with hospital readmissions after surgical procedures can often be reduced by utilizing physical therapy, where appropriate. Physical therapists are critical to ensuring patients attain an optimal level of mobility and safety in their environment and they are uniquely qualified to provide functional training and educate the patient and caregivers on important factors such as prevention of further injury, illness and/or decline in functional status and the resulting effects of immobility. In addition, physical therapists are able to recognize subtle changes in a person’s status that may require further evaluation or referral to other healthcare providers before the problems are exacerbated and require readmission. With this expertise, physical therapists are essential participants in health care integration.

To further improve quality of care, providers across different health care settings and different clinical specialties will need to share information through EHR technology and coordinate efforts with other providers to eliminate duplication of services and increase efficiency. The need for standards of uniformity and system interoperability are vital. For example, the information gathered by the acute care hospital during a patient’s stay and at discharge is critical in determining the appropriate level and focus of care once the patient is released to a post-acute care setting, such as a skilled nursing facility, inpatient rehabilitation facility, home health agency, or an outpatient therapy setting. Practitioners need an understanding of the patient’s goals, baseline functional status, medical and behavioral health problems, medication, family and support services, and durable medical equipment, prosthetics and orthotics needs. Standardized core content that can be shared through EHRs to inform care delivery is critical and will aid in ensuring effective care transitions. Without this information, service duplications may occur and important aspects of the plan of care may be overlooked.

As patients transition from one care environment to another, APTA is concerned that the flow of data is maintained and that data integrity is ensured. Because long term and post-acute care facilities, as well as physical therapists in office based settings are not eligible for meaningful use incentives, many of the electronic health record systems currently in use by these providers may not be compatible with other EHR systems during the health information exchange process from a hospital to a post-acute care setting (e.g., skilled

¹ *Spine* (Phila Pa 1976). 2008 Jul 15;33(16):1800-5.

nursing facility, inpatient rehabilitation hospital) or outpatient physical therapy clinic. It is important that input from these providers is considered in the evolution of meaningful use requirements so that patient data is accurate, accessible and transferred with the highest degree of security protocols in place to protect patient privacy. Therefore, APTA urges CMS to carefully consider the following comments and recommendations.

Change to Stage 1 Criteria: Revision of “Capability to Exchange Key Clinical Information” Objective

We agree with CMS that the Stage 1 objective: “capability to exchange key clinical information” is too broad and may be difficult for providers to ascertain and – due to that uncertainty - the burden of compliance would be high. We support the modification of this objective to CMS’ proposed fourth option of transferring one actual patient summary of care electronically either to another provider of care at a transition/referral phase or to a patient authorized entity. This would reduce the complexity of the burden on providers. APTA also suggests requiring one or two additional electronic summary of care transfers to different care settings to determine the compatibility and accuracy of the data when exchanged with a variety of health care settings. We believe this would promote increased interactivity among eligible hospitals and providers with health care providers and settings that are ineligible for incentives thereby reducing impediments in transitioning patients to these environments.

Stage 2 Objective: Demographic Data Collection – Including Disability Status

In the proposed rule, CMS seeks public comments on the burden and ability of including disability status for patients as part of data collection. In addition, CMS requests comment on how to define the concept of “disability status” and whether the option to collect disability status should be captured under the objective to record demographics or another objective. Physical therapists provide health services to individuals with disabilities and therefore would be involved in the collection of data and determination of disability status. Physical therapy services encompass the diagnosis of, interventions for, and prevention of impairments, activity limitations, and participation restrictions related to movement, function and health. (Guide to physical therapist practice, second edition. *Phys Ther.* 2001;81(1):9-746.) They are licensed health care professionals who diagnose and manage movement dysfunction and enhance physical and functional status in all age populations.

APTA recognizes that recording of disability status in EHRs could contribute to improving care coordination. However, the definition of disability is ambiguous as recognized by CMS in this notice of proposed rulemaking. An entire framework and vocabulary standard referred to as the International Classification of Functioning, Health, and Disability (ICF) was developed by the World Health Organization to capture and record disability status. The ICF framework organizes three levels of human functioning: the body, the whole person, and the whole person in their complete environment. ICF labels these levels as (1) Body Functions and Structures; (2) Activities, and (3) Participation. The term disability is used in a general sense to indicate a decrease at each

of these levels, (i.e., a body function or structure impairment, an activity limitation, or a participation restriction). As a classification, ICF systematically groups different domains for a person in a given health condition (e.g., what a person with a disease or disorder does do or can do). The components classified in ICF (Body Functions and Structures, Activities and Participation, and Environmental Factors) are quantified using the same generic ordinal scale ranging from no problem to complete problem. It is important to use common language when referring to disability.

One of the challenges with requiring the use of ICF to record disability status in EHRs is that providers are not using ICF to identify problems today in practice. While ICF codes could be useful, it would take considerable time, resources, and education in order for ICF to be widely used by providers in EHRs. We believe that converging on a recommended short, common “instrument” for measuring function for a particular purpose (e.g., transition of care) would be very helpful. However, it should be advanced through the disability research community because the existing assessment tools vary widely and are burdensome. Through continued research, we encourage the development of a more basic, reliable and valid tool with minimal elements which can be aligned across health care settings. This tool should be developed by rehabilitation professionals (i.e., physical therapists, occupational therapists, etc.) should who allow practitioners to input individualized patient assessment information.

Additionally, with patient privacy and security issues being a priority, including the term “disability” in patient data could have unintended consequences, such as legal impacts in connection with health benefit approvals and denials, as well as other discriminatory impacts.

Given the current challenges, APTA recommends that rather than including “disability status” as information that is exchanged among providers, the patient’s “functional status” could be included as exchanged information. However, including “disability” or “functional status” in the demographic data collection may not be the appropriate inclusion category. APTA encourages CMS to consider adding “functional status” in the summary of care information exchange.

Functional status information is important when exchanging information about a patient who is transitioning from one care setting to another. The Continuity Assessment Record and Evaluation (CARE) tool, which was developed under the Post-Acute Care Payment Reform Demonstration as mandated by the Deficit Reduction Act of 2005, includes standardization of functional status. Data pertaining to functional status provides useful details as patients transition to post-acute care settings enabling providers to assess the patient’s status and develop a comprehensive care plan appropriate to their unique needs. Often, patients will transition between health care facilities and home health and utilization of a standardized format for functional status similar to the work that was conducted with the CARE tool could streamline data exchange among patient care settings. However, APTA does not believe that the CARE tool in its current form accurately documents medical severity, functional status and other factors affecting outcomes. Further development is necessary to develop such a tool.

Stage 2 Objective: Provide Summary Care Record for Care Transitions or Referrals

The Medicare and Medicaid beneficiary populations, especially dual eligible beneficiaries, may have serious physical condition(s) or severe disabilities. Proper assessment and communication of functional status in the summary of care is crucial to optimize care. As discussed above, we support the exchange of a summary care record in place of the Stage 1 requirement of “the exchange of key clinical information” to support communication among providers seeing the same patient. To assist the exchange of information a standardized format should be utilized which includes medical, functional, cognitive and social/environmental domains, similar to but more developed than the CARE tool. Such a tool could be used to evaluate a patient’s clinical condition for selecting the most appropriate type of post-acute care. Currently, CMS demonstrations utilize the CARE tool to 1) standardize program information on Medicare beneficiaries’ acuity at discharge from acute hospitals; 2) document medical severity, functional status and other factors related to outcomes and resource utilization at admission, discharge and interim times during post-acute treatment; and 3) understand the relationship between severity of illness, functional status, social support factors and resource utilization. Standardized information could be used to exchange summary record information among providers during patient transitions so that subsequent health providers can evaluate a patient’s clinical condition for selecting the most appropriate type of post-acute care utilizing standard formats. This standardized data exchange would enhance care coordination, minimize errors in data exchange and decrease burdens in data collection.

APTA supports the concept of having a uniform assessment tool similar to the CARE tool and believes patients should be placed into the appropriate setting to meet their needs based on their clinical characteristics. However, we do not believe that the CARE tool in its current form will accurately document medical severity, functional status and other factors related to outcomes. The questions lack sensitivity and, therefore, the type of information about the patient needed to measure outcomes and severity is not being collected by this instrument.

APTA has concerns that the accuracy of the data will differ depending on the individual who completes the uniform assessment tool. Although a nurse may be able to complete a majority of the tool, the Functional Status section should be completed by rehabilitation professionals from the appropriate discipline. An individual who is not specifically educated and trained as a physical therapist would probably include different answers to the functional assessment items than a therapist.

APTA also supports the requirement to include a care plan record which, at a minimum, includes the clinical problem, the outcome goal and provider instructions. We also support the inclusion of a “problem list” of current and active diagnoses as part of the summary of care documents. Although functional and cognitive statuses are important to evaluate and communicate across transitions in care, we do not feel that they should be included on the traditional problem list as there are inherent problems with their inclusion on this list. First, not every patient with cognitive and/or functional deficits will be

evaluated by physical or occupational therapists and therefore, the standardization of these assessments will be difficult to ensure across settings. Second, as the goal of rehabilitation is to improve the functional and/or cognitive deficits of patients, the list will need to be continually updated as the patient improves throughout the course of care. For these reasons we feel that it is more appropriate to include functional and/or cognitive deficits in the care plan.

Additionally, since the development of pressure ulcers can complicate care, lead to infection and increase costs, skin issues should be included in the problem list so it is brought to the attention of subsequent providers and incorporated in the plan of care.

Certified EHR Technology Providers

As providers that are not eligible for meaningful use incentives, yet active in providing care from eligible provider referrals and eligible hospitals, physical therapists caution CMS on imposing numerical parameters which may not be achievable in certain areas of the country. It is conceivable that an eligible provider (EP) may not be able to achieve the proposed 10% minimum threshold for transmitting the summary of care records to recipients with no organizational affiliation, but use different certified EHR technology. Many providers are using EHR systems that are not certified. This requirement could have the unintended consequence of impeding patient choice because the EP will encourage the patient to go to a provider based on the EHR technology the provider has instead of the quality of the provider or the patient's preference. Although 10% may seem like a low threshold, many rural area EPs and eligible hospitals may have difficulty meeting this threshold.

Conclusion

APTA is committed to educating and encouraging its membership to adopt EHRs. However, the cost of implementation and maintenance of EHRs is a barrier to adoption, particularly for small practices. APTA's members practice in a variety of settings, including physical therapist-owned private practices. We urge HHS to expand incentives to other non-physician providers, such as physical therapists and other post-acute care settings, that significantly impact patient care on a daily basis. Improving quality of care across the full health care delivery spectrum while also decreasing costs will require participation through the use of EHRs by all providers.

In addition to cost burdens associated with EHR acquisition and implementation, an impediment to EHR adoption is provider confusion in selecting an EHR system. The current threshold for certification has allowed hundreds of systems to gain certification. Providers are concerned that a system purchased today deemed "certified" will not have the wherewithal and compatibility as technology advances to maintain certification. Providers are also concerned about bad actors in the vendor industry, for example, there are questions as to whether vendors will survive over the long term which could result in excessive costs to the provider of total system replacement in the future.

Gathering input and perspectives from various providers is crucial in the development of HIT to encompass true integrated care delivery models and interoperable health information exchange. Physical therapists are integral members of the health care community and offer a wealth of expertise that can be valuable to the Department of Health and Human Services (HHS) and its agencies as they work to create an interoperable national health information network. Additionally, in an integrated care model of health care delivery, physical therapy and rehabilitation services are commonly a medically necessary service. Exclusion of quality measures related to rehabilitation leaves a large gap in properly delivering true quality of care on the dynamic health care continuum. As more providers acquire EHR systems, including many non-physician providers, their necessary contribution to patient care should not be absent from the analysis.

Too often discussions about HIT and EHR expansion are centered on physicians and hospitals only. HIT development, including meaningful use requirements, should focus on better performance by the health care provider and improved health outcomes to the consumer. We strongly urge the inclusion of all health care providers throughout the full spectrum of care to optimize the quality of care. Improving the quality of care while decreasing costs will require participation through the use of EHRs by all providers and consumers. We look forward to working with HHS, CMS and the ONC as it looks for opportunities to assist health care providers in patient care improvement and nationwide adoption of EHRs. Thank you for your consideration of our comments. If you have any questions regarding our comments, please contact Deborah Crandall, Senior Regulatory Affairs Specialist - Health Finance & Quality, at 703-706-3177 or deborahcrandall@apta.org.

Sincerely,

A handwritten signature in black ink, appearing to read "R. Scott Ward". The signature is fluid and cursive, with a large initial "R" and "W".

R. Scott Ward, PT, PhD
President