May 7, 2012

Submitted Electronically

Secretary Kathleen Sebelius
Department of Health and Human Services
Office of the National Coordinator for Health Information Technology
Hubert H. Humphrey Building, Suite 729D
200 Independence Avenue, S.W.
Washington, DC 20201

Re: RIN 0991-AB82; Proposed Rule: Health Information Technology: Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology, 2014 Edition; Revisions to the Permanent Certification Program for Health Information Technology

Dear Secretary Sebelius:

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 Department of Health and Human Services (HHS), Office of the National Coordinator for Health Information Technology (ONC), in response to the proposed rule published in the Federal Register on March 7, 2012, for the “Health Information Technology: Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology, 2014 Edition; Revisions to the Permanent Certification Program for Health Information Technology.” APTA is committed to advancing the safety and quality of healthcare through health information technology (HIT) innovation and we are eager to work with the ONC 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. 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.

APTA supports the proposal of requiring an EHR technology developer to document how its EHR technology development processes align with or deviate from the quality management principles and processes that are stated in the ONC guidance document. Because of the expansive list of EHR systems currently certified, providers experience difficulty in choosing a system. Due to the significant investment of an EHR system, any information that would clarify the capabilities of a vendor’s system would be useful in guiding practitioners in choosing a system that best suits their needs.

V. Request for Additional Comments – A. Certification and Certification Criteria for Other Health Care Settings

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 outpatient 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 or long term care facility 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 the ONC to carefully consider the following comments and recommendations.

APTA supports private sector certification bodies for HIT and EHR technology that serve health care settings and other health care providers who are not eligible for incentives. We believe that private bodies have the advantage of being more nimble to revise and develop criteria and standards based on the fast pace of technological development. The Joint Commission serves as an example of a private accreditation body which has been successful and also incorporates federal requirements in its criteria for accreditation.

Disability Status

In the proposed rule, HHS requests input regarding whether EHR technology certified to the 2014 Edition EHR certification criteria should be capable of recording the functional, behavioral, cognitive, and/or disability status of patients (collectively referred to as “disability status.”) Specifically, they ask whether there is an existing standard appropriate for recording disability status and reference the ICF and the CARE tool as potential tools for recording and reporting disability status.

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.)
They are licensed health care professionals who diagnose and manage movement dysfunction and enhance physical and functional status in all age populations.

Rather than including “disability status” as information that is exchanged among providers, APTA recommends including a patient’s “functional status” as exchanged information; however, including it in the demographic data collection may not be the appropriate inclusion category. We believe that functional/disability status is far too complex a construct to be contained in demographics. Just like there is a relationship between measuring blood pressure and recording the “problem” of hypertension as an entry in the problem list, there is a relationship between assessing disability (which can be done in a variety of ways - patient reported, clinician reported, performance based measures, etc) and recording associated problems (e.g., “difficulty walking short distances”) or practical workflow issues related to a patient’s disabilities (e.g., “wheelchair assist”). APTA encourages including “functional status” information in the summary of care information exchange.

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.

The goals of recording functional status (as opposed to using the term “disability status”) in EHRs is important and complex, but has enormous potential for improving care coordination and patient-centeredness. As the Institute of Medicine’s IOM report, (April 2007) indicates, an entire framework and vocabulary standard developed by the World Health Organization, the International Classification of Functioning, Health and Disability (ICF), exists to capture and record functional and disability status. Organizing content around the ICF domain categories would be highly desirable and consistent with the IOM recommendations.

**CARE Tool – An Assessment Tool with Limited Capability**

Neither the population health survey questions nor the items from CARE are in widespread clinical use. The majority of detailed assessment of disability is performed by rehabilitation professionals (e.g., physical therapists, occupational therapists, etc.) who are not currently eligible providers. As the IOM report indicated, a comprehensive disability tracking instrument should include core measures of impairments in body structures and functions, activity limitations, participation restrictions, and key features of the environment as well as personal factors. 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.) and should allow practitioners to input individualized patient assessment information.

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 detail 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.

Of note is that all of these methods of classifying/representing disability status are “assessment instruments,” for which the HIT Standards Committee has recommended LOINC as the vocabulary standard. The CARE and PROMIS items are already represented in LOINC, and the HHS survey questions have already been created and approved for inclusion in the public release of LOINC (scheduled for June 2012). However, we again caution the ONC and other agencies on the utilization of elements in the CARE tool across health care settings due to the significant limitations of the CARE tool and the detrimental potential impacts of its utilization across settings. For example, the items being assessed in the CARE tool may not be as sensitive to the functional ability of patients in various settings (i.e., a patient in a skilled nursing facility may be rated as independent in ambulation with a walker because the CARE tool indicates “independent, with or without assistive devices”) but the goal is for independence without an assistive device. Therefore, one may see the patient as independent in ambulation, yet this is not the level of potential or the level of previous function prior to the illness, injury, or condition.

**Include “Functional Status” versus “Disability Status” in Summary Care Record**

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. We support the exchange of a summary care record to support communication among providers seeing the same patient in care transitions. Communicating functional status at transitions and in summaries of care will help facilitate better care coordination, which in turn may reduce avoidable dependency, lowered quality of life, increased stress on individuals and families, and lost productivity. To assist the exchange of information a standardized format should be utilized which includes medical, functional, cognitive and social/environmental domains. Such a tool could be used to evaluate a patient’s clinical condition for selecting the most appropriate
type of post-acute care. This standard data exchange would minimize errors in data exchange and decrease burdens in data collection while also enhancing coordination.

In the post-acute care demonstration project, CMS developed and utilized 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. 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.

**EHR Technology Price Transparency**

APTA supports the proposal of requiring EHR technology vendors to publish clear pricing of the full cost of certified Complete EHR and/or certified EHR modules. Many
providers who are not eligible for incentives consider purchasing certified EHR technologies in hopes of optimizing health information exchange and reducing barriers to meaningful use achievement should they be included in incentive programs in the future. The publishing of EHR system pricing would be beneficial information to have in the costly EHR purchase process.

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 which are typically small businesses. Improving quality of care across the full health care delivery spectrum 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, rehabilitation services are often medically necessary. Exclusion of input related to rehabilitation, particularly in transitions of care, leaves a large gap in the ability to properly deliver 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. We look forward to working with HHS 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,

[Signature]

R. Scott Ward, PT, PhD
President

RSW/dlc