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Submitted Electronically

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Hubert H. Humphrey Building, Suite 729D
200 Independence Avenue. S.W.
U.S. Department of Health and Human Services
Washington, DC 20201

*RE: The American Physical Therapy Association's Response to the
Request for Comments: Connecting: Health and Care for the Nation – A
Shared Interoperability Roadmap*

Dear Dr. DeSalvo:

On behalf of our 90,000 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
Office of the National Coordinator for Health Information Technology (ONC)
in response to the request for comments for the "Connecting: Health and Care
for the Nation – A Shared Interoperability Roadmap" (Roadmap). 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, expanding the adoption
of electronic health records (EHR), implementation and enforcement of
privacy and security protections in health IT, interoperability, utilization of
electronic health information to support new payment models such as
accountable care organizations, fostering health information exchange where
it is not currently taking place, strengthening health care delivery through
coordinated patient-centered quality care by utilization of electronic health
information, and advancing the health and well-being of individuals and
communities through research and innovation.

APTA commends the ONC in its vision for and the continued development
and expansion goals of the Roadmap. We would like to take this opportunity
to comment on particular areas of importance to physical therapists (PTs)
within these goals.

General

Physical Therapists and EHRs

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 hospitals, inpatient rehabilitation facilities, home health agencies, skilled nursing facilities and physical therapist owned private practices. The Medicare and Medicaid EHR Programs provide incentive payments to physicians, hospitals and critical access hospitals that demonstrate meaningful use of certified EHR technology through 2016. However, physical therapists in private practice, inpatient rehabilitation facilities, home health agencies, and skilled nursing facilities are not eligible for the incentive payment for adoption of EHRs. As expressed in our comments to the 2011 Strategic Plan, APTA continues to urge the ONC to expand incentives to other non-physician providers, such as physical therapists and providers in other long term and post-acute care (LTPAC) settings, who 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 electronic health devices (EHDs) by all providers.

We further emphasize the need for the ONC to develop an on-going value message for implementing EHRs and communicate to all providers – not just those providers eligible for incentives – the benefits and value of utilizing EHRs beyond receiving a monetary incentive (e.g., robust EHRs enable a provider the ability to deliver true patient-centered care.) In order to expand the adoption of EHRs, EHDs, mHealth, telehealth and other emerging health IT technologies and gain widespread participation in the health information exchange, all providers should be given the tools and information to understand the value in utilizing HIT in their care delivery, particularly if they are providers excluded from receiving incentives. The recent *ONC Health IT Strategic Plan: 2015-2020* (Plan) states that the ONC will encourage the use of health IT among providers practicing in LTPAC settings through federal payment policies, contracts and public and private program funding. APTA is encouraged by this goal as many PTs practice in LTPAC settings and are important providers in care transitions. We look forward to these funding opportunities and federal payment policy initiatives for this group of providers, as well as PTs in private practice and other settings.

However, we do not support the imposition of penalties on physical therapists who were not considered "eligible professionals" under the original meaningful use programs if they become "eligible professionals" in the future. We believe the burden is too high in an environment where technology is changing rapidly, there are too many inconsistencies among vendor products and communication across disparate systems will continue to be an

issue in information exchange even with minimal recommended standards in place[1]. The accuracy of the data exchanged among providers is vital to a patient's health.

Additionally, the Centers for Medicare and Medicaid Services (CMS) experiences frequent data system and programming errors which result in provider payment delays which are administratively and economically burdensome to the provider. Providers in small practices will especially be subjected to cost and administrative burdens if EHRs and accompanying penalties for non-participation and failure to meet meaningful use requirements are imposed. As the cost/benefit analysis to purchase, implement and conduct ongoing training and risk assessment, along with the possibility of penalties, the risks may outweigh the benefits.

APTA has worked diligently to ensure the involvement of physical therapists in quality improvement programs including Medicare Provider Value-based Purchasing initiatives, accountable care organizations and other innovative models. HIT should allow providers and consumers to report and receive feedback on specific quality measures securely. As the discussion on how to encourage health care providers to adopt and use HIT in a meaningful way has progressed, many of the metrics that have been developed to assess progress are exclusive of non-physician specialties, including physical therapy. Physical therapists are involved in the development of quality measures and the consensus-based process for the endorsement of measures. This effort has been recognized through the incorporation of individual measures via the Physicians Quality Reporting System (PQRS) as well as the ability for physical therapists to report functional measures related to musculoskeletal outcomes and group measures related to the treatment of low back pain.

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 huge gap in properly accessing 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. As stated, physical therapists are not currently eligible to receive monetary incentives. We strongly urge ONC to continue to broaden its perspectives and recognize the vital role of other health care professionals across the continuum of care in the development and implementation of HIT.

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[1] See CHIME/AMA Coalition letter to ONC dated January 21, 2015: "Ensuring electronic health information follows patients during transitions of care is one of the most sought after, yet the least successful exchange paradigms in health care today…Yet, EHR vendors who follow the consolidated clinical document architecture (C-CDA) implementation guidance are left with optionality on the methods they use to create C-CDA documents. This variability in C-CDA construction causes a mismatch between the sending and receiving EHRs and limits the usefulness of information that is actually viewed by the physician and other medical professionals at the point of care." Accessed March 2015. Available at http://chimecentral.org/wp-content/uploads/2015/01/EHR-Certification-Letter.pdf.

APTA has made strides over the last 15 years to promote the use of HIT, and we are continually enhancing our services to advance the delivery of physical therapy and to effectively measure patient outcomes. These efforts include HIT educational tools on the APTA website and collaborating with internal and external stakeholders on HIT issues. Recognition of the need to capture rehabilitative services in the EHR has led to substantial growth in the development of EHR systems in the rehabilitation sector. This data is crucial to the development of a robust Physical Therapy Outcomes Registry. APTA's development of clinical guidelines and other important criteria has been the basis for the attributes of many existing HIT systems serving rehabilitative service providers.

Additionally, APTA commends the ONC for increasing opportunities for the usage of telehealth and other mobile health technologies. Research demonstrates success with tele-rehabilitation and we look forward to discussions with the ONC, CMS and other federal agencies regarding innovative models utilizing physical therapy, telehealth and other health IT technologies. APTA would welcome the opportunity to be a participant in providing input as the government develops this technology and related policy and payment solutions. In addition to burden of costs associated with EHRs, 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. As in 2011, providers are concerned that a system purchased today deemed "certified" will not have the wherewithal and compatibility as technology advances to maintain certification or that other technologies will take the place of EHRs. 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 resulting in providers incurring excessive costs of total system replacement in the future.

We commend measures such as the National Institute of Standards and Technology's (NIST) development of a set of objective and standard criteria to evaluate and improve the usability of HIT systems as a method which would help to lessen costs should a system replacement/transition be necessary. Other perspectives and input from a variety of providers is crucial in the development of HIT to encompass true integrated care delivery models.

LTPAC Physical Therapists' Role in Care Transitions

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 vital 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. Their assessment and plan of care for the patient is critical to reducing complications, particularly in the LTPAC community and, therefore, it is important that information from each care team member at the varying settings is captured and exchanged based on the specialist's area of expertise to optimize patient outcomes and reduce miscommunication among the varying providers the patient will see throughout the course of care.

Health Information Exchange across Health Care Settings

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. However, the standards chosen – such as C-CDA in Meaningful Use Stage 2 for document exchange – must be accompanied by additional detailed guidance to ensure the data can be received, free from error and is useable by the receiver. APTA support the AMA/CHIME coalition of health care provider group's recommendation:

> "Further Implementation guidance and less optionality are crucial to ensure true semantic interoperability. It is imperative that ONC works with HL7 to provide sufficient guidance and testing procedures of the C-CDA draft standard and EHR certification incorporates a method to verify C-CDA documents adhere to strict standards of design. Additionally, we urge ONC to not only think about interoperability in the context of EHR to EHR, but to also consider various levels of connectivity and the exchange of information external to an EHR, such as an EHR connecting to a registry."[2]

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. These data must be accurate when received by the provider during care transitions. 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

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[2] AMA/CHIME coalition letter to ONC, dated January 21, 2015. Accessed March 2015. Available at http://chimecentral.org/wp-content/uploads/2015/01/EHR-Certification-Letter.pdf.

information, at best, service duplications may occur and important aspects of the plan of care may be overlooked; at worst, a patient could be harmed by missing or erroneous data.

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 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 are accurate, accessible and transferred with the highest degree of security protocols in place to protect patient privacy.   Additionally, if there is an expansion of federal incentive programs to LTPAC providers and others, mandated common clinical data sets must be carefully considered as not all data sets are applicable or collectable by all providers. Therefore, APTA urges the ONC to carefully consider the following comments and recommendations as it progresses with interoperability regulation and guidance.

Physical therapists are at the forefront of providing health services that reduce preventable hospitalizations. APTA and our members have gained a unique knowledge base through the development of data collection systems that would be valuable to the development of HIT learning health system. APTA is actively involved in other initiatives that warrant appropriate HIT adoption: examples include: Medicare's Physician Quality Reporting System (PQRS) and Provider Value-Based Purchasing (PVBP) projects that have specific components related to EHRs; working with CMS and its contractors on payment reform for therapy services; preparing our members for the transition to ICD-10 and the implementation of the revised Health Insurance Portability and Accountability Act (HIPAA) provisions. There are currently many projects underway that would benefit from a comprehensive and coordinated HIT system that includes physical therapy and rehabilitation. APTA is in a pilot testing phase during the 2015 year for the Physical Therapy Outcomes Registry. The Physical Therapy Outcomes Registry is an organized system for collecting data to evaluate patient function and other clinically relevant measures for the population of patients receiving physical therapist services. The registry will serve to inform payment for physical therapy services, improve practice, fulfill quality reporting requirements, and promote research. The Physical Therapy Outcomes Registry hopes to drive data standardization in the profession and encourage interoperability with EHR products utilized by physical therapists

Current Meaningful Use Incentive Program Requirements:

Disability Status

HHS has asked stakeholders in past proposed rulemaking related to EHR technology certification whether there is an existing standard appropriate for recording 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*. 4 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.

Therefore, 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.

The goal 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.

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 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 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 provide 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. 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. Although the CARE tool has demonstrated good reliability and validity in the Part A post-acute care settings, testing of the CARE tool in the part B setting did not demonstrate such success.

Notably, methods of classifying/representing disability status are "assessment instruments," for which the HIT Standards Committee has recommended LOINC as the vocabulary standard. 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.

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 data set similar to the CARE tool and believes patients should be placed into the appropriate setting to meet their needs based on their clinical characteristics.

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 (e.g., a nurse may view a patient's ability or disability during functional status as the patient having a "slow, steady gait" moving from one point to another, whereas a physical therapist sees a patient stumble, holding on to various items in the room to maintain balance.)

Physical therapists practice in a number of health care settings, are integral members of the health care community, and offer a wealth of expertise that could be valuable to the ONC as they work to create an interoperable national health information network. Therefore, we support the rapid advancement of interoperability standards to reduce fragmentation and inconsistencies in system development. In the development of criteria in relation to the usability of HIT systems, APTA suggests developing a pilot study with alternative, non-

eligible providers, such as physical therapists, for testing and improvement of the usability of EHRs and EHDs.

To further improve quality of care, providers across different health care settings and different clinical specialties will need to share information with each other from their EHRs and coordinate their efforts to eliminate duplication of services and increase efficiency, which is a re-emphasis of the need for certain standards uniformity and system interoperability. 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 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. Health information technology should facilitate both process and care measurement to improve patient safety, improve patient health outcomes, and reduce costs. Secure and private interoperability has the potential to greatly streamline care transitions and improve quality of care.

Priority Interoperability Use Cases

The ONC has requested stakeholder feedback on priority use cases for the ONC's development of technical standards, policies and implementation specifications. APTA emphasizes that – until standards and guidance are in place that ensure that data exchanged is error free and useable between EHR/EHD systems, some of the priority use cases may be ahead of what the variability of disparate HIT systems will allow. Therefore, APTA recommends the testing of EHR systems in multiple health care settings, particularly during care transitions, as a part of the certification process. This would provide important information as to whether the data can be properly and accurately exchanged and determine whether it is of value on the front-lines of care delivery. Until the research and testing demonstrates a high degree of data accuracy during the information exchange process, several of the priority use cases may be premature.

Once patient safety is secured through a high level of data exchange accuracy among EHDs, APTA supports the following interoperability use cases as priority:

- The status of transitions of care should be available to sending and receiving providers to enable effective transitions and closure of all referral loops.
- Hospitals automatically send an electronic notification and care summary to primary care providers when their patients are discharged
- All providers in a care team will have unique access, authorization and auditing functionality from health IT systems necessary to fulfill their role on the care team.

- Patients have access to and can conveniently manage all relevant consents to access or use their data.
- Benefits communication needs to be standardized and made available on all plans through HIT to providers and patients as they make health and healthcare decisions, in a workflow convenient to the decision-making process.
- Patients have the ability to access their holistic longitudinal health record when and where needed.
- Patients, families and caregivers are able to use their personal devices such as smartphones, home BP cuffs, glucometers and scales to routinely contribute data to their longitudinal health records and use it or make it available to providers to support decision-making.

- Narrative components of the medical record are preserved for provider and patient use and augmented with metadata to enable effective storage, routing and searching for these documents.
- Clinical settings and public health are connected through bi-directional interfaces that enable seamless reporting to public health departments and seamless feedback and decision support from public health to clinical providers.
- CEHRT should be required to provide standardized data export and import capabilities to enable providers to change software vendors.
- All health IT should provide access and support for disabled users including patients and providers.
- Patients receive alerts and reminders for preventive screenings, care and medication regimens in a manner convenient to and configurable by the patient

Additionally, as data security and usability problems are improved, clinical decision-making support should be a critical component of HIT to improve care and reduce costs. HIT should enable providers to access a patient's medical history as well as information regarding current interventions and treatments to avoid duplication of efforts, ensure patient safety, and determine - based on evidenced-based practice - the most appropriate interventions specific to the patient's presentation. This could include electronic documentation of items such as daily treatment or encounter notes, progress reports, and discharge summaries. Additionally, tools that remind the provider of important information and that generate reports about needed upcoming care (such as immunizations) help foster the patient/provider relationship. Information on evidenced-based practice, coverage limitations, specific patient information, and patient care reminders help providers make appropriate clinical decisions regarding patient care. Some EHR systems currently being utilized in the rehabilitation market include these critical aspects of clinical decision-making.

APTA supports the incorporation of electronic quality improvement tools and measurements through EHRs to improve and strengthen health care delivery. Capturing the variety of clinical information relevant to both individual patient and health care setting optimizes

safety and quality of care. APTA emphasizes that continuity of care and strengthened health care delivery is accomplished through collaboration of all healthcare providers through HIT that ensures accurate, efficient, secure and protected communication. In addition to facilitating continuity of care, APTA believes that HIT should allow health care providers, including physical therapists, to report and receive feedback on quality measures and report and receive relevant health data to assist in disease monitoring and tracking. Inclusion of all providers in the HIT care delivery process is imperative to improving complete patient care, outcomes and reducing costs. However, tool and measurement data should be minimally exchanged until data accuracy, safety and accessibility can be ensured during the exchange process. For example, closed systems using the same EHD systems (such as some ACOs) will be more readily able to exchange such data. By contrast, a large majority of providers with disparate systems will have difficult with data exchange and guaranteeing readability and accuracy.

APTA supports the overall outline of the Roadmap. We continue to encourage the ONC to include a variety of clinical specialties that may be involved in a patient's care, which is a critical link in the collaboration and coordination of care, particularly with the chronically ill. In the development of interoperability recommendations, specifications and standards, we encourage the ONC to consider that to truly gather data and information for true "meaningful use" in its vision to expand health IT adoption, systems must be first, able to exchange data, and flexible enough to accommodate all providers across the continuum of care without the burden of unnecessary options, standards and costs. Therefore, as the ONC moves forward, we want to emphasize that prioritizing use cases must include identifying the needs of patients as they receive care from an array of health care professionals. These data are also important to track for safety, outcomes and costs reduction in the delivery of care. Failure to track and measure these data now leave a large data gap of information that is important in measuring quality outcomes.

APTA strongly recommends that physical therapists collaborate with ONC to develop the goals, objectives and measures tools most appropriate for rehabilitation providers within the HIT realm. As soon as reasonably possible, the ONC and other government agencies should provide additional incentives – without penalties - to aid all healthcare providers in HIT implementation. Non-physician providers, such as physical therapists, who also play an important role in improving the quality of care would greatly benefit from incentives. APTA encourages the ONC to also consider safeguards for those providers who cannot afford to adopt EHDs for several years to allow them to effectively participate and survive in the provider market.

Additionally, APTA recognizes the vital importance of patient involvement in their care. Physical therapists evaluate the patient to determine the patient's goals for treatment and community factors, such as the assistance of family and/or friends and home environment, to design appropriate interventions. To foster trust, cooperation, and appropriate decision-making on the part of the patient, the consumer should have the ability to learn how personal health information is being utilized and disclosed.

11

APTA believes that HIT, specifically EHRs/EHDs if interoperable, will allow for improved patient and public health outcomes by providing access to real-time health information. For example, an EHR would allow a provider to determine what medications the patient is taking. In the instance of physical therapy, this information could aid the therapist in determining the best method of treatment for the patient or understanding changes in the patient's condition that will affect their progress towards their defined goals as indicated in the plan of care. Some medications may affect balance and, therefore, impact the physical therapist's plan of care. In other instances, knowing that a patient is on blood pressure medication(s) would require the physical therapist to monitor the patient's blood pressure and select interventions that minimize/prevent an elevated heart rate.

Furthermore, it may be possible to conduct disease tracking through HIT that could lead to early interventions to prevent or slowdown the spread of disease. Patient advocates have demonstrated the detrimental effect on health that the delay in sharing this information can have on the patient. Patients should be able to contribute to their medical histories and exchange information with their health care providers. One such example would be the exchange from the EHR to the patient health record information relating to lab results, discharge instructions, and other relevant information. Providing this information has the potential to improve health outcomes for patients. For instance, the ability to provide the patient discharge instructions could improve patient compliance and reduce hospital admissions. Therefore, APTA supports increased consumer access to accurate care information. However, we recommend that mechanisms be in place to ensure that "real time" information is not released to a patient before the provider has the opportunity to review and fully explain the information being released.

However, for interoperability to be successful, the patient must be an active participant in accessing their information online. Currently, a minority of patients access their health information, if available.[3] As consumers' ability to access their health information increases, increased education mechanisms for the consumer and provider must occur. In educating consumers and providers on utilizing personal health information (PHI) and EHRs, an educational strategy that takes into consideration the varying degrees of familiarity with this health information is necessary. Current use by health care providers should be clearly established so that time and resources are effectively spent in developing appropriate educational material and strategies to help providers understand what is being asked of them. Health information access and understanding empowers the individual, allows them more

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[3] A retrospective design study involving over 3 million adult patients in a Kaiser Permanente facility (published in the *American Journal of Managed Care)* measured the number of times the patient portal was accessed from December 2010 through December 2014 and found that nonwhite patients and patients who spoke Spanish as a primary language tended to access their personal health records less frequently than white, English-speaking patients. Available at http://www.beckershospitalreview.com/healthcare-information-technology/poor-minority-patients-access-patient-portals-less-frequently.html. Accessed April 1, 2015.

control in their health care decisions, and is instrumental in minimizing disability and in achieving optimum functional outcomes.

Supportive Business, Cultural, Clinical and Regulatory

APTA supports promulgation of appropriate and enforceable federal policies to protect the privacy and security of health information. We urge the ONC to conduct an analysis of overlapping privacy and security regulations among state and federal laws as well as among government agencies which may impose differing criteria than HIPAA followed by educating stakeholders. Inconsistencies or lack of clarification among regulations can result in impediments in accessing health care. This impedes access to appropriate care because of varying regulatory requirements, increases administrative costs and leads to frustration for the beneficiary, their family members and providers of these essential health care services. Although guidance materials have been issued pertaining to HIPAA, additional outreach, education, revision and clarification is needed. APTA supports the development of an interoperable infrastructure to securely exchange health information among providers, patients and public health agencies with appropriate safeguards. We recommend the establishment of a process to align security and privacy requirements and regulations between federal and state agencies.

APTA members and patients have experienced the adverse effects, such as decreased access to care, resulting from disparate federal, state and local policies which hinder accurate and robust health information exchange. Therefore, we support rigorous standards to support interoperability so that data can be securely exchanged and utilized for multiple purposes. However, before this process can move forward in an effective and efficient manner, there must be a mechanism for assurance that policies do not conflict with existing state and federal regulations and there must be an on-going monitoring of the system to identify and immediately check any failures or inconsistencies within the systems. For example, under 42 CFR Part 1007, § 405.370 through § 405.379, the Secretary of the Department of Health and Human Services (HHS) in consultation with the HHS Office of Inspector General (OIG) has authority to suspend payments to providers in instances "based upon possession of reliable information that an overpayment or fraud or willful misrepresentation exists **or that the payments to be made may not be correct**," although additional evidence may be needed for a determination. APTA fully supports the eradication of fraud and abuse in the delivery of health care services. However, the threshold of payment suspension has been lowered to a "credible allegation." Conceivably, this could occur due to system errors which incorrectly reject proper payments. If a system for rapid correction and deployment is not in place, the provider could suffer a substantial loss and perhaps be forced out of business as a result of the length of time involved in resolving the case. In turn, the patients would experience the stress and adverse impacts of having to find another provider.

Safety, Privacy and Security Protections for Health Information

On March 31, 2015, The Joint Commission issued a Sentinel Event Alert on the safe use of health IT and provided examples of incorrect or miscommunicated data being entered into EHR systems demonstrating the risks inherent in health IT data transport.[4] Its first recommendation under process improvement is "make health IT hardware and software safe and free from malfunctions." As emphasized in these comments, until these malfunctions are corrected, interoperability poses safety risks for patients.

APTA commends the ONC's emphasis on stricter standards for privacy and security in health information exchange and encourages federal agencies to be vigilant in recognizing the differences in implementation of protocols in an integrated, closed health system such as the VA - where information can be shared freely and monitored closely - versus the disparities in the private market with multiple HIT systems, varying internal policies and procedures, proprietary information, etc.

APTA agrees that attention to the privacy and security of any and all personal information is of paramount importance. Stakeholders have expressed the detrimental impact inappropriate disclosure of this information could have on the level of trust and quality of relationship between the patient - whose personal health information is disclosed - and health care providers. Inappropriate disclosures of health information, such as mental illness or HIV status, could have negative consequences, including discriminatory impact, for the patient.

Conclusion

In conclusion, once safe and accurate data transport is realized among providers and health care settings, then more robust and useful information can be exchanged. As the ONC works toward the goal of interoperability, it is vitally important that strategies to expand adoption of HIT and interoperability is approached comprehensively. This means that HIT data analysis and capture should include valid patient assessment tools, clearly identified health outcomes, interventions based on sound science and evidence, and recognition that individuals with the same condition often present differently. Too often discussions about HIT and EHR/EHD expansion are centered on physicians and hospitals only. HIT development needs to focus on better performance by the health care provider and improved health outcomes to the consumer. We strongly urge the ONC to include all health care providers involved throughout the full continuum of care to be participants in the interoperability process. Improving the quality of care, while decreasing costs, will require participation through the use of EHDs by all providers and consumers. We look forward to working with the ONC as it looks for opportunities to assist health care providers in the expansion of health IT. Thank you for your consideration of our comments. If you have any questions, please contact Deborah Crandall, J.D., Senior Regulatory Affairs Specialist, at 703-706-3177 or deborahcrandall@apta.org.

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[4] http://www.jointcommission.org/assets/1/18/SEA_54.pdf. Accessed April 1, 2015.

Sincerely,

Paul Rockar, Jr. PT, DPT, MS
President

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