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August 1, 2012

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HIT Policy Committee Members
c/o MacKenzie Robertson
Office of the National Coordinator
The Department of Health and Human Services
355 E Street S.W.
Washington, DC 20201

**Subject: Transitions of Care and Meaningful Use Requirements Development
– Physical Therapist long term and post-acute care (LTPAC) Comments**

To the Members of the HIT Policy Committee:

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 relating to health information exchange and transitions of care with long term and post-acute care (LTPAC) in considering Stage 3 requirements for the Medicare and Medicaid Meaningful Use Incentive Program requirements. APTA submitted comments in response to both the Centers for Medicare and Medicaid Services (CMS), 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*” and the Department of Health and Human Services (HHS), Office of the National Coordinator for Health Information Technology (ONC), 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 Office of the National Coordinator for Health Information Technology (ONC) and other governmental agencies on health information technology’s evolving role in promoting health and health care reform. However, in developing requirements for meaningful use requirements, it is important to obtain input from the LTPAC community because of the constant transition of Medicare and Medicaid patients from primary care and hospital settings to LTPAC and, often, back to the hospital.

APTA is committed 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

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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.

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.

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 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. Therefore, APTA urges the HIT Policy committee to carefully consider the following comments and recommendations in formulating Meaningful Use requirements.

Specific Areas Related to Meaningful Use Requirements:

Disability Status

In the recent Meaningful Use Stage 2 proposed rule referenced above, HHS requested 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 Continuity Assessment Record and Evaluation (CARE) tool as potential tools for recording and reporting disability status. We believe those comments should be reiterated for consideration by this HIT Policy Committee.

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.

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 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.

CARE Tool – An Assessment Tool with Limited Capability

We commend the agency’s desire to develop an assessment tool that can be utilized across settings. However, neither the population health survey questions nor the items from the CARE tool are in widespread clinical use. The tool has not been proven to be effective for adequate assessment across the entire LTPAC provider community. Additionally, if a tool is mandated, then competency of staff must be emphasized in utilizing the tool.

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. 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.

Notably, 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 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 care 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, the questions contained within the CARE tool 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 (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.)

Care Plan

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. The care plan should be more patient-centric, allow for interventions and have the necessary data to support care transitions among providers. At the same time, goal setting is varied based on the care stage and setting and this should be specified. 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 status 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.

The care plan should be dated and time-stamped each time it is updated, with an alert function when changes are made and detail of the changes should be incorporated in the plan. The care plan should be shareable among all providers, preferably electronically, and paper/facsimile should be a last resort, although we realize a large number of providers do not have secure e-communication abilities.

Comments Related to Stage 3 Subgroup Meaningful Use Work Group Care Coordination Recommendations (12/24/2012):

SGRP 303

Stage 3 Care Coordination Objective (Revised Summary of Care)

A common issue in the LTPAC provider community during care transitions in receiving summary discharge information is that data are missing or inaccurate (e.g., missing weight-bearing orders, consults, lab tests). To ensure the validity and quality of data exchanged, there should be the institution of a type of validation check prior to discharge in which all data fields must be addressed before the summary can be exchanged. This validation check should be one in which the administrative burden is minimal.

EP/ EH / CAH Objective: EP/EH/CAH who transitions their patient to another setting of care or refers their patient to another provider of care

Setting Specific Goals

We recommend clarifying whether these are goals which the referring provider had in place or recommendations for the receiving setting. Receiving providers find the previous provider goals informative. However, the LTPAC setting is most concerned with recent treatments, tests and consults. The data exchanged should be of highest value to the patient and receiving provider.

Instructions of care during transition and for 48 hours afterwards

We recommend that different information be provided based on whether the patient is going home versus transitioning to another provider. Care instructions could be mandatory for patients going home, however, the LTPAC providers need information about what occurred during the last 48 or 72 hours of a patient's stay for proper patient evaluation and care planning. Additionally, prior to care setting transition, the patient may experience a gap longer than 72 hours in which s/he has not seen a provider. In such cases, any and all relevant data from the most recent patient/provider(s) encounters should be included.

Utilization of the DECAF Family Caregiver Tool

We support obtaining this type of family contact, communication and role delineation information.

SGRP 304

Stage 3 Care Coordination Objective (New, but Core – Care Plan)

EP/ EH / CAH Objective: EP/ EH/CAH who transitions their patient to another setting of care or refers their patient to another provider of care

- *For each transition of care, provide a care plan with the following elements:*
 - *Concise narrative in support of care transitions (free text, to include key points from summary of care, including setting-specific goals and instructions for care during transition and for 48 hours afterwards)*

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As we previously stated, if this is information from the original setting provided to a patient going home then care instruction should be provided. If the patient is transitioning to another health provider setting, then what has occurred during the last 48 to 72 hours is of most value.

- *Medical diagnoses and stages (if stages are applicable)*
- *Functional status, including ADLs**

This will be variable based on which care provider measures function and what criteria is used to measure function.

- *Relevant social and financial information (free text)*
- *Relevant environmental factors impacting patient's health (free text)*
- *Most likely course of illness or condition, in broad terms (free text)*
- *Cross-setting care team member list, including the primary contact from each active provider setting, including primary care, relevant specialists, and caregiver*

This is important information in transitions of care, which is often unavailable.

- *The patient's long-term goal(s) for care, including time frame (not specific to setting) and initial steps toward meeting these goals*

Currently, this field is often filled in as "to be determined" or "family uncertain." For these data to be meaningful, greater specificity should be required.

- *Specific advance care plan (POLST) and the care setting in which it was executed, if applicable.*
 - *For each referral, provide a care plan if one exists*
 - *Measure: The EP, eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care provides a complete set of electronic care plan information for 10% of transitions of care to receiving provider and patient/caregiver.*
- *= aligned with PE View/Download/Transmit and Report objective.*

We suggest clarifying what is meant by the "Care Plan" in this measure. The term can have different meanings in different settings.

*SGRP 305
Stage 3 Care Coordination Objective
(New, Menu – Collaborative Care)*

EP / EH / CAH Objective (new): Acknowledgment of sending and receipt of external care management information. Must include (but not limited to):

- *Referral Orders and Consult reports*

These reports could be long if all consultant reports are expected. We support this as specialist reports are often difficult to obtain.

- *Lab results received after transition/referral*

We support this as discharges and transfers can be delayed due to medical reasons that the receiving provider is not fully informed about (e.g., Doppler tests to rule out DVT).

- *Summary of care*

Measure: 2 Part measure:

- *Provider acknowledges sending consult reports, lab results received after transition/referral and summary of care for 10% of patients referred or transitioned during the reporting period. (automation is OK; to be sent to origin of referral and patient/caregiver)*
- *Provider acknowledges receipt of consult reports, lab results and summary of care received after transition/referral for 10% of patients referred or transitioned during the reporting period. (automation not OK)*

We support this but question how it is verifiable if the information is given to the patient. Will it be acceptable to state that discharge instructions were provided? Will this impact measurement?

Other Areas of Concern:

- We understand that the exchange of data entails minimum data element requirements at this stage, however, if the goal is for interoperability of valuable information among providers, then how will the EHR integrate the existing variances in state laws and provider practice acts? For example, there are different requirements among states for daily documentation, standards for co-signatures and/or supervision documentation requirements. Additionally, some states have additional documentation requirements based on state and federal case law decisions, some of which require manual completion of documentation.
- Terms used in the Meaningful Use rules should be defined or renamed to reduce confusion among health care settings and to enhance the federal government's efforts of regulatory alignment. For example, in the proposed rule the "Care Plan" seems to be a repository of information to be passed from setting to setting. "The "Care Plan" in the LTPAC community such as the SNF setting is defined differently. Perhaps "Care Pathway" or "Care Overview" could be alternate terms.
- "Problems" as used in the Meaningful Use Stage 2 Requirements proposed rule may not be the optimum terminology. Alternative suggestions are "'Medical condition(s)," which include current or any relevant diagnoses, physical concerns

- (other chronic conditions that may impact outcome, such as mental conditions and functional impairments that prevent the patient from progressing).
- Consider using “Intervention(s)” rather than “Instructions,” with subheadings for training and education.
 - Is there conflict with what is meant to be the “Summary” document under Meaningful Use requirements and summary documents in the LTPAC community? How will the data captured on the “summary” document impact CMS compliance documentation requirements for providers? For example, on the ONC transitions of care Wiki, there is a description of contents in the Discharge Summary. Will this summary allow revisions from each provider who treats the patient (e.g., could a therapist summarize the details of skilled interventions provided to the patient as well as the progress made by the patient toward goals during each episode of care?) so that compliance documentation requirements are met.
 - What is the anticipated method for incorporating new CMS requirements into the EHR framework in order to prevent a disruption of information exchange across settings? For example, CMS just recently released the CY 2013 proposed rule Medicare Physician Fee Schedule which introduces the use of G codes and associated severity modifiers on claims to report functional limitations. If Stage 3 meaningful use evolves to incorporate a patient’s functional abilities (ADLs) from the LT/PAC setting, the stage may possibly be set for conflicting data as the outpatient setting will be reporting on levels of disability.

Conclusion

APTA plans to submit additional comments regarding care transitions relating to the LTPAC provider community. APTA remains 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 the LTPAC community, and they are committed to improving quality of care across the full health care delivery spectrum. 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 that reads "Paul Rockar Jr." in a cursive script.

Paul Rockar, Jr. PT, DPT, MS
President

PR/dc