1111 North Fairfax Street
Alexandria, VA 22314-1488
703/684-2782
www.apta.org

March 5, 2020

Don Rucker, MD
National Coordinator for Health Information Technology
Office of the National Coordinator for Health Information Technology
Department of Health and Human Services
330 C St SW, Floor 7
Washington, DC 20201

Submitted Electronically

Re: 2020-2025 Federal Health IT Strategic Plan

Dear National Coordinator Rucker,

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) appreciates the opportunity to comment on the Office of the National Coordinator for Health Information Technology's (ONC's) 2020-2025 Federal Health IT Strategic Plan.

APTA is dedicated to building a community that advances the physical therapy profession to improve the health of society. As experts in rehabilitation and habilitation, physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability for individuals across the age span — helping individuals improve their overall health and prevent the need for avoidable health care services. Physical therapists' roles include education, direct intervention, research, advocacy, and collaborative consultation. These roles are essential to the profession's vision of transforming society by optimizing movement to improve the human experience.

Objective 1a: Improve individual access to health information

APTA supports improved individual access to health information. Patients should be allowed to access prior plan information for up to 10 years, and APTA suggests that ONC reflect this in its final strategic plan. This would be in line with the more stringent record-retention requirements of states that require record retention of 10 years.[1] State laws

[1] States that require 10 years of medical record retention are: Colorado, Connecticut, Illinois, Kansas, Louisiana, Mississippi, Missouri, Montana, Nebraska, New Jersey, New Mexico, North Dakota, Oregon, South Carolina,

generally govern how long medical records are to be retained. However, the administrative simplification rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) require a covered entity, such as a physician billing Medicare, to retain required documentation for 6 years from the date of its creation or the date when it last was in effect, whichever is later.[2]

Patients should have increased access to their medical records. However, APTA has concerns that increasing access without also instituting new data protections increases the risk of unwanted disclosure of that health data. **Therefore, we encourage ONC to implement more safeguards to prevent data breaches, and also to educate patients on protecting the privacy of their health data.** This education is both critical and urgent. While we commend the ONC for supporting patient control over their own data, we are concerned that app vendors do not sufficiently understand data security, and that patients are not sufficiently protected from this deficit of knowledge.

Objective 2c: Reduce regulatory and administrative burden on providers

While APTA supports ONC's efforts to harmonize provider data collection and reporting requirements across federal agencies in electronic health records (EHRs), **we recommend that ONC modify quality reporting requirements for all provider types and settings (including physicians and hospitals).** These reporting requirements should include metrics regarding the collection and communication of information required at transitions, as well as timeliness and completeness metrics. These modifications will ensure that ONC is not adding to providers' burden in complying. **We also encourage ONC to base future quality and regulatory reporting on elements in the standardized data set in order to maintain alignment between clinical needs, reporting requirements, and semantic standardization.**

APTA requests, as well, that ONC require standardized submissions for all Medicare subcontractors. Also, APTA suggests that ONC creates a certification process similar to the Consolidated Clinical Document Architecture (C-CDA) scorecard,[3] whereby providers demonstrate ability to submit in Fast Healthcare Interoperability Resources (FHIR) or other Health Level Seven International (HL7) format.

Certified Electronic Health Records Technology (CEHRT). Physicians and hospitals were afforded EHR incentive funding and multiple stages to adopt EHRs and learn how to successfully exchange patient information using CEHRT. On the other hand, physical therapists in private practice, other nonphysician health care professionals, and long-term and postacute care facilities were ineligible to participate in the Meaningful Use EHR Incentive Program (now the Promoting Interoperability category within the Merit-based Incentive Payment System, or MIPS) and have received little to no direction, nor the time and

South Dakota, Tennessee, Texas, Vermont, Washington State, and Washington, DC. North Carolina requires 11 years, and Massachusetts requires 30 years. https://www.healthit.gov/sites/default/files/appa7-1.pdf. Accessed February 11, 2020.

[2] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1022.pdf. Accessed February 11, 2020.

[3] See https://sitenv.org/ccda-smart-scorecard/.

resources, to adopt and implement comprehensive, interoperable EHR systems that promote care coordination and improve patient outcomes. ONC's certification process has established standards and other criteria for structured data that EHRs must use. However, CEHRT requirements are designed for prescribing professionals and do not capture tasks performed by nonphysician professionals using different types of EHRs. Consequently, the vast majority of EHR technology developed for use by physical therapists and other nonphysician providers cannot fully satisfy the technology requirements outlined in 42 CFR 414.1305, therefore hindering these providers' capability to participate in the PI category of MIPS (and eventually MIPS Value Pathways, or MVPs) or Advanced Alternative Payment Models (APMs).

As is a common theme throughout our previous comments submitted to the agency, modifying and building upon the existing technological structure to satisfy future CEHRT requirements requires significant financial investment, is time-consuming, and is disruptive to workflow. To better leverage health IT functionality, as well as to incentivize physical therapist and other nonphysician provider participation in the QPP and other value-based models in the future, it is critical that ONC recognizes that the 2015 Edition Base EHR definition and several 2015 Edition certification criteria may not apply to physical therapist practice. These include:

CEHRT Category	CEHRT Criteria[4]
Clinical Processes	• Computerized provider order entry (CPOE) medications *(prescribing)* • CPOE laboratory • Drug-drug, drug allergy interaction checks for CPOE • Drug-formulary and preferred drug list checks *(CPOE)* • Implantable device list
Care Coordination	• Electronic prescribing* (for medications)
Public Health	• Transmission to immunization registries • Transmission to public health agencies — syndromic surveillance • Transmission to public health agencies — reportable laboratory tests and values/results • Transmission to cancer registries

[4] While recognizing that some certification criteria are not applicable to physical therapists, it is critical that technology used by physical therapists affords them the ability to receive a medication list. Additionally, it is important that physical therapists have technology that enables them to access laboratory and diagnostic imaging values and results, as well as to record, change, and access diagnostic imaging orders.

	• Transmission to public health agencies — electronic case reporting • Transmission to public health agencies — antimicrobial use and resistance reporting • Transmission to public health agencies —health care surveys
*Electronic prescribing may be utilized for referrals and DME	

Only a limited number of EHRs have been certified by ONC and encompass the necessary components for the documentation and transmission of information regarding physical therapy services. **Accordingly, we encourage ONC to acknowledge that appropriate resources and support, including implementation assistance and/or consultant support, must be afforded to physical therapists and other nonphysicians as they adopt and optimize certified EHRs to better enable these providers to participate in new models of care. Alternatively, as stated previously, ONC could create a certification process similar to the C-CDA scorecard and allow for provider certification for the interoperability functionality if the provider attains a score of "A" or "B."**

The repercussions associated with excluding physical therapists from Meaningful Use, leaving them without guidance (or funding) to adopt CEHRT, are mounting. For example, even though physical therapists now are included in MIPS, physicians are less inclined to refer patients to them because they lack CEHRT. Under MIPS, physicians are being scored on the Promoting Interoperability category transition measure, which requires that the referring provider use CEHRT to create a summary-of-care record and electronically transmit it to a receiving health care provider. However, physical therapy EHRs are not equipped to receive such information — requiring physicians to fax the referral, which they prefer not to do, as such practice detracts from their scoring under the Promoting Interoperability category. Physicians and other MIPS-eligible providers expect other eligible providers to have CEHRT and to be participating in all four categories. However, newly eligible MIPS providers, including physical therapists, do not currently have the capability to participate in the Promoting Interoperability category.

The Centers for Medicare and Medicaid Services (CMS) stated in the 2019 Physician Fee Schedule final rule that it believes "that for increased interoperability and health information exchange it is important for all types of MIPS eligible clinicians to use CEHRT."[5] **To move to a more standardized and interoperable environment, promote increased interoperability and care coordination across the continuum, and facilitate nonphysicians' participation in MIPS and Advanced APMs in the future, we urge ONC to recognize the urgent need to issue guidance and provide financial and administrative support to nonphysicians — including physical therapists in both private practice and**

[5] CY 2019 Physician Fee Schedule Final Rule, page 59819. https://www.govinfo.gov/content/pkg/FR-2018-11-23/pdf/2018-24170.pdf. Accessed February 11, 2020.

long-term and post-acute care providers (LTPAC) settings, and their EHR vendors — in order to adopt and implement CEHRT.

We also recommend that ONC direct those providers that received federal health IT incentive funding to share patient information with the next care setting including PTs in private practice in a timely manner (i.e., before the patient arrives at the next care setting rather than closer to 30 days after discharge). To ensure the future health care system is one that is patient-centric and dedicated to improving care quality and increasing patients' access to their information, all relevant parties across the continuum need and deserve financial and administrative support to help them implement CEHRT and adopt measures that give patients the ability to manage their health information. It is critical that patient information can flow between various sectors of the care continuum — including physicians, hospitals, physical therapists in private practice and LTPAC, and other health care providers.

Finally, for the CEHRT adoption process to be equitable and fair for all parties, we recommend that ONC and other federal agencies be cognizant of health IT development cycles. Incorporating newly adopted standards or revised specifications into the development cycle takes time — time to incorporate, test, and verify that the new standard or specification is operating as expected. It also takes time to roll out updates and new products to clients, who will need time to train staff and implement policy changes. **To that end, we request that ONC allow EHR vendors and health care providers a transition period of 3-5 years to develop, adopt, and integrate certified products. We also recommend that ONC educate providers on the certification process in a manner that clearly conveys what providers need to know, what they need to do now and in future years, and the anticipated costs associated with adopting and implementing certified technology.**

Objective 3a: Advance individual and population-level transfer of health data

APTA supports an integrated ecosystem that can support research, clinical decision making, population health management, and individual access to quality and cost information. This goal is facilitated with the promotion of professional registries.

Development of professional registries has been spurred by the need to create meaningful quality measures to assist providers in the shift to value-based payment and models of care. These registries will be critical to the success of innovative payment models in the future, as they are able to deliver real-time data to providers for monitoring, assessing, and responding to new and dynamic models of care delivery. APTA has serious concerns that lack of standardization across electronic infrastructure on the data element, definition, and value-set level has made it difficult to implement health IT within registries. More work needs to be done to encourage the originators of data to adhere to standards to promote bidirectional data exchange.

For example, supporting a widely used, consensus-based standard such as FHIR reduces burden on health IT implementers. U.S. Core Data for Interoperability (USCDI) was not developed with an eye toward public health or registry reporting, and this needs to be kept in

mind as a use case for future development of the USCDI. Having this work originate in a Standards Developing Organization (SDO) would help alleviate this problem. As we move toward outcomes-based payment and advanced quality-reporting structures that will rely heavily on electronic data submission, it is critical that ONC continues to support the development and success of professional registries.

As payment reform moves from process-oriented performance metrics (e.g., checklists) to outcome-oriented performance metrics (e.g., how patients feel and function based on their self-report and on therapist assessment), EHRs need to keep pace. Currently, very few EHRs can collect patient-reported outcome (PRO) questionnaires of how patients feel and function. They also lack meaningful ways to display this information to clinicians and patients (e.g., graphs of symptoms over time). **APTA recommends that ONC require certified EHRs to be interoperable and able to share information with professional societies' registries. We also recommend that ONC require EHRs to transmit movement-related issues to registries, such as falls history, levels of function, and community activities and participation.**

To assess the current state of clinical data interoperability with respect to registries, APTA participated in a project termed "Improving Health Data Interoperability" sponsored by the Pew Charitable Trusts. The hypotheses were that data liquidity had not been achieved in the registry domain, and that native data interoperability shared by both clinical documentation and registry database systems would provide the best pathway to accomplishing data liquidity. The primary conclusion from the project was that the registry community is not aligned with national interoperability initiatives and is not incentivized to contribute to interoperability efforts.

With "swivel chair interoperability" being the primary mechanism for data submission to registries, this misalignment is a national burden costing billions of dollars. The opportunity exists for the registry community to facilitate and catalyze native data interoperability as a key demonstration of health care data interoperability, with many of the clinical concepts already in the USCDI serving as the proving ground.

APTA recommends that ONC:

- Further develop the USCDI to include technical (both clinical application and database developer) specification of common data elements for capture of information as interoperable data. The technical output of the project is a recommended implementation of core common clinical data elements. The technical implementation specification could serve as a model for accomplishing the same across the USCDI. Should all parties conform to the implementation, data liquidity with native data interoperability will be naturally accomplished for the selected clinical concepts.
- Adopt an authoritative process to identify, define, and specify standards for common clinical data elements and an agreed-upon process for its governance. Also necessary is a common data element repository or common clinical data element library to support the technical adoption of standard common data elements. Similarly, common

data elements, model tooling, and terminology repositories for candidate data elements are needed. APTA recommends that one way to accomplish the above would be to expand the CMS Data Element Library.

- Adopt a program focused on registries to define domain-specific core clinical concepts as data elements. While the Pew Charitable Trusts project did not develop domain-specific clinical concepts, it was clear that the key kernel of clinical information needed to assess quality, performance, and outcomes is well-represented by the data requested through registries. The registry community can be leveraged to capture clinically relevant information as data at the point of care to serve the needs of care delivery, outcomes evaluation, quality and performance measurement, and medical product evaluation and surveillance. Doing so increases the availability of data for real-world evidence, knowledge generation, and translation of that knowledge into practice to improve public health.

Objective 3b: Support research and analysis using health IT and data at the individual and population levels

APTA supports research and analysis using health IT and data at the individual and population levels. This goal is facilitated with the promotion of professional registries. Please see our preceding comments in response to Objective 3a.

Objective 4a: Advance the development and use of health IT capabilities

APTA supports ONC's objective to afford health care providers clear and easy ways to keep up with the continually evolving digital health landscape. Specifically, APTA supports ONC's strategy to promote trustworthiness of health IT through rigorous enforcement of information blocking.

Generally, APTA agrees with ONC's mission to address information blocking. However, APTA seeks clarification from ONC regarding the HHS Office of Inspector General's authority to investigate claims of information blocking if conducted by health information exchanges, health information networks, or health care providers. **We also seek clarification from ONC regarding the penalties the agency might impose if an EHR developer prevents a clinical data registry from providing interfaces to clinicians who use the EHR technology and wish to submit data within the EHR to the registry.**

Objective 4b: Establish transparent expectations for data sharing

APTA supports ONC's objective to establish transparent expectations for data sharing. Specifically, APTA supports ONC's strategy to address information blocking. Please see our preceding comments in response to Objective 4a.

APTA also supports a common agreement for nationwide exchange of health information, facilitated with the promotion of professional registries across the continuum of care. Please see our preceding comments in response to Objective 3a. APTA

also stresses the importance of data sharing at the time of transition of care, across the continuum of care.

Objective 4c: Enhance technology and communications infrastructure

APTA appreciates the fact that ONC is working to enhance technology and communications infrastructure. Specifically, APTA appreciates the fact that ONC is working toward improving and expanding affordable broadband access and wireless infrastructure, especially in rural and underserved areas that are less likely to have access to high-speed internet. APTA also appreciates the fact that ONC is seeking to promote adoption of infrastructure needed for telehealth to reach patients outside of traditional care settings. This infrastructure is critical for telerehabilitation services, and APTA continues to advocate for coverage and reimbursement of telerehabilitation services under the Medicare program.

Broadband access. **APTA recommends that ONC not institute any program that increases broadband access or telehealth coverage by increasing consumer costs.** Consumer cost of connected care services, including broadband connectivity, is a major barrier to telehealth adoption. APTA believes patients should not be asked to pay for anything more in order to receive this high quality, individualized care. While we understand the difficulties associated with administering a program that subsidizes patient access, we will oppose any program that increases the burden associated with patients gaining access to telehealth.

Moreover, ONC must ensure that providers are sufficiently incentivized to participate by ensuring that they receive adequate reimbursement rates. Providers in rural settings often operate with razor-thin margins, and a lack of capital hinders their ability to invest in the necessary technology and equipment to furnish telehealth services. If ONC truly wants to spark innovation for the betterment of patients, it must also do something to alleviate the risk that providers face in undertaking a new business model. APTA suggests that ONC use Regional Education Centers (RECs) to provide ongoing education and training on cybersecurity and cyber hygiene services to physical therapists in private practice and other outpatient therapy providers, as well as to long-term care and post-acute care providers. This would help to enhance interoperability and security.

Conclusion

APTA thanks ONC for the opportunity to provide feedback on its 2020-2025 Federal Health IT Strategic Plan. Should you have any questions, please do not hesitate to contact Steve Postal, senior specialist, regulatory affairs, at stevepostal@apta.org or 703/706-3391.

Sincerely,

Sharon L. Dunn, PT, PhD
Board-Certified Orthopaedic Clinical Specialist
President