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January 14, 2013

Farzad Mostashari, MD, ScM
Chair, Health Information Technology Policy Committee
Office of the National Coordinator
Department of Health and Human Services
200 Independence Avenue, S.W., Suite 729-D
Washington D.C., 20201

RE: Health Information Technology Policy Committee; Request for Comment Regarding the Stage 3 Definition of Meaningful Use of Electronic Health Records

Dear Dr. Mostashari:

The American Association of Orthopaedic Surgeons (AAOS) appreciates the opportunity to provide comments in response to the Request for Comment, published in the Federal Register on November 26, 2012, on Stage 3 "meaningful use" (MU) draft recommendations issued by the Health Information Technology Policy Committee (HITPC) of the Office of the National Coordinator of Health Information Technology (ONC). The AAOS represents over 18,000 board-certified orthopaedic surgeons and has been a committed partner to the Centers for Medicare & Medicaid Services (CMS) in patient safety and the provision of high quality, affordable health care. The AAOS appreciates the role of the HITPC as it develops its final recommendations to ONC and CMS on the definition of MU for Stage 3 of electronic health records (EHR) implementation mandated under the Health Information Technology for Economic and Clinical Health (HITECH) Act, as part of the American Recovery and Reinvestment Act of 2009. We invite the ONC to call on the AAOS for any additional information from our surgical and specialty perspective.

The AAOS shares your goal of having all physicians use Health Information Technology (HIT) in a meaningful way. We have not only encouraged our membership to adopt HIT, but we have provided tools for them to become meaningful users of EHR. We want to partner with ONC and CMS in helping our membership understand and implement programs that will lead to better use of HIT. We are committed to working with you in

further refinement of the MU criteria. As we move onto Stage 3, there are some areas that need immediate attention from all of us:

- Development of specific quality measures for orthopaedic surgery that can be utilized in the MU definitions; and

- Refinement of the meaningful use criteria to better reflect the unique characteristics of surgical specialty practices.

Most orthopaedic surgeons adopted electronic medical records even before the meaningful use regulations were adopted. Yet, according to CMS data, only about 20% have qualified for meaningful use incentive payments as of October 2012. The present lump sum payments have not been sufficient inducement to pursue meaningful use given the lack of orthopaedic surgery quality measures, and the lack of meaningful use requirements appropriate for surgical specialties.

As we move towards 2015 and the onset of financial penalties under the HITECH Act, as detailed in the MU regulations, it is urgent that we work together towards the goal of bringing along those surgeons who have been unable or unwilling to qualify for MU of EHR. It is most critical to maintain access of Medicare patients to orthopaedic surgical services, and to further the goals of the ONC and CMS to allow better interconnectivity and improved quality of care.

In response to the Request for Comments, the AAOS provides below general comments and suggestions for EHR implementation based on our experience with MU, and specific comments to individual draft recommendations, identified by number. The specific suggestions help us get to our goal of working together with ONC and CMS to improve the quality of care for our patients, improve access for Medicare patients, improve our evidence base, and improve our interconnectivity through HIT.

## *I. General Comments and Suggestions Based on Continuing Efforts to Meet Meaningful Use of EHR for Orthopaedic Surgeons*

Since enactment of the HITECH Act, the AAOS has engaged in a continuing campaign to educate orthopaedic surgeons on the value and benefits of using EHR technology. In addition to educational programs and published articles on various aspects of implementing EHR technology, the AAOS provides a MU Toolkit free to members to help them achieve the criteria for each core objective and menu objective measure. As a result, orthopaedic surgeons are adopting EHR technology at very high levels, with the exception of those in small or solo and rural practices, where there are limited resources and limited service from certified EHR vendors. However, our members are reporting impediments impacting their ability to achieve the MU program goals.

Orthopaedic surgeons have focused on the use and deployment of both Picture Archiving and Communications Systems (PACS) and EHR systems. The PACS are often more critical for everyday practice than are the EHR systems. Presently, those PACS systems are not included in the MU regulations. Therefore, the complexity of implementation of EHR systems in the orthopaedic office is greater and often more costly due to integration expenses than in other medical practices.

The primary reason for lack of adoption of EHR for MU by our members has been the lack of requirements that are appropriate for specialty physician practices. For instance, there are only two approved clinical quality measures that fall in orthopaedic surgery – osteoporosis and back pain. Most orthopaedic surgeons have a specialty interest in areas such as adult reconstruction, sports medicine, foot and ankle, or upper extremity care such that osteoporosis and back pain are not a part of everyday practice.

AAOS has been working on developing quality measures that reflect the needs of orthopaedic patients in various stages of consideration and implementation supported by:

1. Evidence-based clinical practice guidelines (CPGs);
2. Appropriate use criteria (AUCs) for orthopaedic procedures and treatments; and
3. Clinical safety checklists for pre-surgery and post-surgery order sets.

We also recommend that ONC and CMS look specifically at developing measures that encourage team-based care. We know that team training can significantly improve medical error reduction, especially in the operating room. The AAOS now offers the TeamSTEPPS program, an evidence-based Agency for Healthcare Research and Quality (AHRQ) program to improve communication and teamwork skills among healthcare professionals, to help teams of orthopaedic surgeons, anesthesiologists, nurses, and other operating room personnel work together in a safer and more productive environment for patients.

The measures developed to date under existing MU regulations emphasize individual provider performance on the use of HIT. However, there should be measures at the practice level, or at the hospital level that will encourage communication, and working together. One example would be the inclusion of criteria for the sharing of imaging studies from the office to the hospital or to other physician offices. Another example would be the use of video conferencing between specialists to encourage a multi-specialty approach to tumor care.

We are committed to assisting CMS in developing measures such as the ones described above. In addition, AAOS can assist by organizing panels of orthopaedic surgeons to define quality measures for treating arthritis of the shoulder, elbow, hip, knee, and ankle, as well as

other high value musculoskeletal conditions, or other high cost/high morbidity orthopaedic conditions including hip fractures in older adults. We believe the inclusion of quality measures such as these that would meet MU requirements would facilitate EHR adoption among orthopaedic surgeons and encourage participation in the Medicare program, and thereby increase patient access to orthopaedic care.

## *II. Specific Comments on the HITPC Draft Recommendations for Stage 3 of Meaningful Use*

**SGRP 105 – Certification Criteria: EHR Systems should provide functionality to help maintain up-to-date, accurate problem list**

The AAOS strongly believes that physicians should have a correct and timely list of issues occurring with their patients. We appreciate that a problem list is defined as "a list of current and active diagnoses as well as past diagnoses relevant to the current care of the patient." The inclusion of the term "relevant" allows physicians to collect relevant information specific to a patient's particular course of treatment as opposed to information that might not be necessary to a specialist. For example, orthopaedic surgeons would record key problems such as obesity and fracture, but not record the problem of amenorrhea which may not be relevant to the patient's musculoskeletal care. We believe the key to advancing patient care is encouraging orthopaedic surgeons to provide comprehensive care relevant to their patients' musculoskeletal treatment(s).

**SGRP 108 – Retire measure to record and chart changes in vital signs because it is topped out (achieved 80% threshold).**

We concur with the decision to retire this measure to record and chart changes in vital signs.

**SGRP 113 – Objective: Use clinical decision support to improve performance on high priority health conditions.**

EHR technology creates an opportunity to distribute nationally reviewed clinical decision support tools. AAOS has made a substantial commitment to improving patient safety and reducing medical errors. Our commitment dates back more than 15 years when we introduced a "sign your site" program to reduce wrong site surgery. Recently, we conducted a Patient Safety Summit in Orthopaedics. We are creating checklists and order sets for orthopaedic procedures. CMS can help us in accelerating EHR adoption with distribution of this and other patient safety material by requiring certified EHR vendors to include nationally reviewed safety material in future software releases.

**SGRP 114 – Objective: Incorporate clinical lab-test results into EHR as structured data**

Typically, clinical laboratory test data come from external organizations and integrating reports into EHR require additional cost and programming. There are no standards for clinical laboratories compelling these companies to meet MU criteria. However, physicians are required to incorporate data from these sources, which creates an added expense for physicians.

**SGRP 115 – Objective: Generate lists of patients for multiple specific conditions and present near real-time (vs. retrospective reporting) patient-oriented dashboards to use for quality improvement, reduction of disparities, research, or outreach reports.**

The requirement to use "near real-time" is not objective. This needs more specificity if the physician is to judge their performance for MU criteria. This also raises the question of how CMS will make the determination of "real-time".

**SGRP 116 – Objective: Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care**

AAOS concurs with the exclusion for specialists to meet this requirement to send prevention reminders to their patients as specialist care is more condition specific.

**SGRP 118 – Core Objective: Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through Certified EHR Technology.**

This core objective can be strengthened. Orthopaedic surgeons have made significant investments in Picture Archiving and Communications Systems (PACS). PACS have become invaluable for imaging. However, few PACS are integrated into EHRs now in use. To achieve this objective, AAOS suggests development of a requirement for certified EHR vendors to work with PACS vendors and medical/surgical practices to integrate existing imaging systems (PACS) into the EHR. This approach will help eligible professionals across many specialties to integrate imaging studies/results into the EHR.

**SGRP 119 – Core Objective: Record high priority family history data.**

This criterion for family needs to be defined more precisely. Is it limited to primary family relationships (e.g., mother/father or siblings) or more broadly?

**SGRP 122 – Objective: The EHR is able to assist with follow-up on test results.**

This criterion would be costly to achieve as it requires special programming by certified EHR vendors, however, physicians bear the burden of ensuring implementation to meet MU requirements.

**SGRP 130 – Objective: Use computerized provider order entry for referrals/transition of care orders directly entered by any licensed health care professional who can enter orders into the medical record per State, local and professional guidelines to create the first record of the order.**

AAOS supports this criterion.

**SGRP 205 – Objective: Provide clinical summaries for patients for each office visit. The clinical summary should be pertinent to the office visit, not just an abstract from the medical record.**

The AAOS supports the rewording of this standard as we believe offices and patients who prefer to not use paper printouts should have that option within an EHR system. We applaud CMS's endorsement of access via a Personal Health Record (PHR) patient portal on the medical practice website or secure e-mail.

**SGRP 401A – Objective: Capability to receive a patient's immunization history supplied by an immunization registry or immunization information system, and to enable health care professionals to use structured historical immunization events in the clinical workflow, except where prohibited, and in accordance with applicable law and practice.**

While the AAOS recognizes that patient immunization data is an important component of their medical history, it is not as important for quality of care for some specialties and subspecialties. For example, this information may be vital for an orthopaedic surgeon with a practice focus in pediatric orthopaedics, but not as relevant for an orthopaedic surgeon with a practice focus in adult sports medicine. In recognizing these differences, we suggest this standard be changed to read "Capability to receive electronic data from immunization registries or immunization system, when relevant to patient diagnosis and treatment."

**MU01 – Specific Questions from HITPC: Currently, providers have to meet all MU criteria to receive incentives. Is there flexibility in achieving a close percentage of the objectives, but not quite achieving all of them? What is the downside of providing this additional flexibility?**

We believe providing this additional flexibility would assist providers who have been able to meet some but not all of the MU criteria and accelerate full adoption of EHR among

eligible providers. In addition, we suggest flexibility in postponing payment adjustments for providers who are able to achieve a close percentage of the objectives, but not quite all.

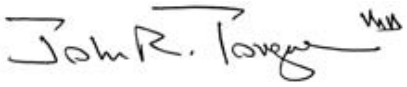
**Conclusion**

Thank you for the opportunity to provide comments on Stage 3 MU criteria in response to the HITPC Request for Comments. We believe that HIT is a fundamental component to improving our nation's health care system. AAOS has been working to increase EHR adoption among its members and we are committed to partnering with ONC and CMS to develop MU measures, including specialty specific quality measures that reflect the needs of orthopaedic surgery practices and improve access for orthopaedic patients.

As specialty physicians, we face unique technology challenges, ranging from certification issues to collection of appropriate data, as well as the larger issues impacting all physicians such as interoperability and cost. We appreciate the role that ONC has had in leading HIT efforts and in providing resources to the health care community to implement EHR and we urge the HITPC to consider including in its final recommendations, the suggestions we have provided above to encourage the adoption of HIT to benefit the patients for which orthopaedic surgeons are dedicated to providing high quality and affordable health care.

We are ready to work with ONC and CMS and we look forward to partnering with you. If you have any questions on the AAOS comments, please contact our Medical Director, William R. Martin, III, MD, at (202) 546-4430 or martin@aaos.org.

Sincerely,



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