February 11, 2011

Joshua Seidman, PhD
Acting Director, Meaningful Use
Office of the National Coordinator for Health Information Technology
Department of Health and Human Services
330 C Street SW, Suite 1200
Washington DD, 20201

Subject:	Meaningful Use Workgroup Request for Comments Regarding Meaningful Use Stage 2

Dear Dr. Seidman,

The American Association of Orthopaedic Surgeons (AAOS) appreciates the opportunity to provide comments on the Stage 2 Meaningful Use (MU) Criteria developed by the Department of Health and Human Services (HHS) Health Information Technology Policy Committee (HITPC), and published in the Federal Register on January 12, 2011. The AAOS represents over 23,000 board-certified orthopaedic surgeons and has been a committed partner to HHS in patient safety and quality health care. The AAOS looks forward to providing input as HHS continues development of EHR MU criteria. We invite HHS to call on the AAOS for any additional feedback from our surgical and specialty perspective.

AAOS applauds your efforts to encourage physicians to become meaningful users of Health Information Technology (HIT), specifically Electronic Health Records (EHR). As surgical specialists, AAOS members have unique HIT needs and offer suggestions to improve the MU criteria and subsequent adoption of EHR technology to better reflect the needs of surgical specialists and their patients.

We have two overarching concerns regarding the proposed Stage 2 MU criteria. First, the lack of specialty specific criteria puts orthopaedic surgeons at a disadvantage in meeting the MU criteria. The combination of Stage 1 and Stage 2 criteria require orthopaedic surgeons to undertake tasks that are not typically required in the care of musculoskeletal patients. Is it medically indicated (necessary) for an orthopaedic surgeon to record vital signs (pulse, blood pressure, etc.) in an otherwise healthy 25 year-old during a cast removal appointment for a closed fracture of the wrist? From our perspective, the impact of this will be to increase costs and reduce physician time to see other patients (access) with no concomitant improvement in quality of care. In our previous comments we noted the difficulty orthopaedic surgeons will face in meeting many of the MU criteria designed for internal medicine. We have these same concerns for the proposed Stage 2 criteria.

Second, we are concerned that the HITPC is moving far too quickly to make final decisions on Stage 2 criteria. Stage 1 MU criteria began just 6 weeks ago. Most orthopaedic surgeons, as well as physicians in all specialties, have little, if any, experience implementing the Stage 1 MU criteria. And yet, now the HITPC is seeking comments on Stage 2 criteria 22 months prior to implementation. A one-year delay would provide orthopaedic surgeons' sufficient EHR Stage 1 MU experience to provide more significant comments on Stage 2 MU and the HITPC would have sufficient time to review and consider comments prior to final release of the criteria. We recommend the HITPC delay the review of Stage 2 MU criteria for an additional twelve months in order for physicians across all specialties to gain sufficient experience with the Stage 1 criteria.

With these overarching comments in mind, the AAOS provides the following Stage 2 MU criteria specific comments. We are concerned that the Stage 2 criteria lack clarity, specificity, and applicability to orthopaedic practice and orthopaedic patient care.

Section 1 - Improving Quality, Safety, Efficiency & Reducing Health Disparities

Computerized Physician Order Entry for Medication Orders
The requirement of 60% of patients with medication orders done by CPOE can be challenging in the face of restrictions placed on physicians and EMR companies by the DEA. The majority of prescriptions written by orthopaedic surgeons are for controlled pain medications. There are no EHR/e-prescribing systems presently available in the United States that meet the strict standards of the DEA with regards to electronically prescribing these medications. In fact, AAOS has learned that several large organizations, such as Kaiser Permanente, have had to revert back to paper prescriptions for these medications due to the new DEA requirements. The standard has to reflect intent, and also what is possible, a delicate balance. AAOS recommends the standard read "60% of all patients receiving a prescription that can be done electronically based on present rules and system availability."

e - Prescribing
Upon discharge, from outpatient care or in-hospital care, many orthopaedic patients receive a prescription for a controlled pain medication. Orthopaedic surgeons will find it difficult to meet the 50% threshold for e-prescribing as DEA requirements for prescribing controlled pain medications specify a paper prescription.

Record Vital Signs
The Stage 2 criteria require physicians to record vital signs for 80% of unique patients. This criterion requires additional and unnecessary tests for many orthopaedic patients at each appointment. In a high volume orthopaedic practice the additional time to record vital signs impacts patient access to care. This criterion demonstrates the need for specialty specific MU criteria. We recommend the addition of language making this a requirement "when medically appropriate and necessary at the judgment of the treating physician."

Implement 1 CDS Rule
AAOS believes that clinical decision support rules must be specialty based. AAOS is in the process of developing those rules for orthopaedics. We do not know what the final result will be. We fully support the idea of the use of CDS tools, but the choice of the measures used must be carefully made in collaboration with the AAOS for orthopaedic surgery.

Record Existence of Advanced Directives
We recognize the value of having advanced directives available for any physician or surgeon treating a patient. However, until all Health Information Exchanges (HIEs) are providing accurate secure data transfer, implementation of this criterion may not be practical. Imagine a patient providing a different set of directives to different treating physicians over an extended period of time. Which record does the physician believe? The State Health Information Exchange Cooperative Agreement Program Internet site notes HIEs need to be fully tested and providing services by January 2014, a full year after Stage 2 MU implementation. In lieu of requiring that individual physicians retain this information, AAOS recommends advanced directives should be a MU criteria for hospitals, as this is the site of emergency care.

Electronic EP Note
The HITPC has not provided any guidance on what defines an acceptable electronic note. In fact, the HITPC is currently seeking input to define an electronic note through a set of separate questions posed with the release of Stage 2 MU criteria. From the AAOS viewpoint it is difficult to define an electronic note that is acceptable to all medical and surgical specialties. Our member's experience indicates one physician's note might be insufficient in the eyes of another, even within orthopaedics given multiple subspecialties. Our analysis indicates the 'standard' note generated by EMR systems is insufficient for documenting orthopaedic care. Further, documenting patient care (progress notes) is connected to medical liability and a definition of what comprises a note by the government may put physicians at risk during a lawsuit for an adverse event.

Section 2 – Engage Patients and Families in Their Care

Provide clinical summaries for each office visit (50% of patients) / Provide timely electronic access (10% of patients)
In one criterion, a patient must be able to review and download a report within 24 hours of encounter. In another criterion the patient must have timely electronic access to health information within four days. AAOS recommends a consistent approach of four days for a patient to have access to any EHR-stored health information, after an encounter or upon request. Our members provide care in hospital, in clinic (office), and in other settings. While in the hospital an orthopaedic surgeon may not necessarily have access to the office EHR system to update patient files. Orthopaedic surgeons may not be able to complete surgical case documentation within 24 hours due to a variety of reasons ranging from overall case load to handling orthopaedic trauma. For many orthopaedic surgeons the typical week of practice is divided between hospital and clinic. Requiring documentation ready for review and downloading within 24 hours of a patient encounter is a substantial added burden for physicians given workload.

Online Secure Messaging
The AAOS applauds the HITPC for including this new criterion. We believe medical care can be enhanced through online secure messaging. Improved communication methods have the opportunity to reduce unnecessary patient visits across the entire spectrum of physician care.

Section 3 - Improve Care Coordination

Perform Test of HIE Participation
As noted above we have concerns regarding the readiness of HIEs across the country. While a physician might be ready and able to conduct a test, we wonder if the HIEs in the state or community will be ready sometime during Stage 2. Ideally, any test should be with one or more HIEs that will handle the majority of secure data transfer for a state or community, rather than a test with an HIE across the nation. The HITPC might benefit by providing additional specificity regarding testing as the MU RFC states, "successful HIE will require development and use of infrastructure like entity-level provider directories (ELPD)." HIE readiness across all metropolitan statistical areas is in question for Stage 2.

Summary Care Records
AAOS supports the development of summary care records for each patient. These records should be in a form that can be delivered via email if at all possible so that information can be shared quickly and securely to other physicians treating a patient. As a time requirement, AAOS recommends information is

made available within four days of the patient encounter.

List of Care Team Members
The AAOS applauds the HITPC for including this new criterion. We believe medical care can be enhanced if physicians and surgeons have ready access to such a list.

Longitudinal Care Plan for Patients with High Priority Health Conditions
While it may be possible to create a standard care plan for a patient with diabetes, there is no standard plan for caring for a patient with a hip or pelvic fracture, one of the high priority conditions listed by NQF. In orthopaedics we have classification systems to determine severity and define appropriate treatment protocols. There is no standard medication that might be prescribed for pain management.

Closing Comment
In addition, to our comments regarding the Stage 2 MU criteria, the attached document represents the AAOS response to the Additional Specific Questions for Public Comment requested by the HITPC.

Again, thank you for the opportunity to provide comments on Stage 2 MU criteria. We believe that Health Information Technology is a fundamental component to improving our nation's health care system. While we are encouraged by the direction of the Stage 2 MU proposed criteria, we have significant concerns about practicality. 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. The proposed Stage 2 criteria make it very difficult for orthopaedic surgeons to become meaningful users of HIT, despite our desire to adopt new technology. The amount of time orthopaedic surgeons would spend trying to meet the proposed criteria would ultimately result in less time treating patients, thereby reducing patients' access to care. We support the common goals of improving quality and providing appropriate documentation of patients' medical care, but we are concerned the complete set of standards is overly onerous and more relevant to primary care physicians, while disadvantaging specialty care physicians. As such, we encourage the HITPC, in conjunction with HHS, to create specialty specific MU standards for surgical specialists concurrent with promulgating the MU standards already published for primary care physicians. The AAOS is ready to support HHS and HITPC efforts to create MU criteria specific to surgical specialists, should HHS and HITPC choose to develop them.

Sincerely,

John J. Callaghan, MD
President
AAOS Board of Directors

Thomas Barber, MD
Chair
EMR Project Team

cc: AAOS Board of Directors
AAOS EHR Project Team members

Attachment: Additional Specific Questions for Public Comment

1. How can electronic progress notes be defined in order to have adequate specificity?

ANSWER: Each medical / surgical specialty requires a standard. Different diagnoses/procedures require different specificity in the note. Creating uniformity within or across medical specialties is not possible from the viewpoint of the American Academy of Orthopaedic Surgeons (AAOS). Some physicians prepare extensive notes while others write substantially less, yet both would be seen as acceptable patient documentation. Two sample progress notes for the same patient and diagnosis demonstrate the range of possible documentation and both are acceptable.

Progress Note #1

HISTORY: Elaine Marie Benis is a 58-year-old female who presents for an evaluation of a chief complaint of pain in her left shoulder. It is related to the following injury: none (non-work-related). She has had this problem now for 1 month(s). The pain is located in or near the lateral sub-acromial bursa. It is made worse with overhead use. It occasionally wakes the patient at night. The problem is getting worse. Previous treatment: injections. Previous imaging studies have not been done. Referring physician: none.

EXAMINATION: Constitutional: Patient is well-developed, well-nourished, and in no acute distress. Neurologic: Patient is oriented to person, place, and time. Gait: non-antalgic reciprocating heel-to-toe gait. Generalized Joint Laxity: normal. Normal appearance of the left shoulder girdle. Tenderness to palpation as follows: antero-lateral sub-acromial bursa. Neer impingement sign - positive. Hawkins impingement sign - positive. Active range-of-motion: Elevation - 170°; Internal rotation to the back - lumbo-sacral junction. Passive range-of-motion: Elevation - 170°; External rotation at the side - 70°; External rotation at 90° or maximal abduction - 90°; Internal rotation at 90° or maximal abduction - 70°. Rhythm of elevation: normal gleno-humeral rhythm. Strength testing: Abduction/Elevation - 5/5 painfree; External Rotation - 5/5 painfree; Internal Rotation - 5/5 painfree. Subscapularis testing: not performed. Neurologic status of upper extremity is fully intact. Vascular status of upper extremity is fully intact with normal pulses, color of the hand, and capillary refill.

IMPRESSION: Rotator cuff rupture, left shoulder

ICD Code: 727.61

OFFICE VISIT: 99203 - New Patient Visit, Level III

DISPOSITION: I reviewed the problem with the patient today, going over the diagnosis, prognosis, and treatment options. Options discussed were NSAIDs. After discussion of the problem, the patient elected to treat this with surgery. Return will be scheduled for pre-operative evaluation.

Electronically Signed by: George H. Costanza, M.D.
Date: 29 February 2012; 0931

RADIOGRAPHS: Full radiographic series of the left shoulder was obtained and reviewed today, including a true-AP, outlet Y-lateral, and axillary lateral. These radiographs showed sclerosis and cysts at the greater tuberosity consistent with a rotator cuff tear.

Electronically Signed by: George Costanza, M.D.
Date: 29 February 2012; 0933

Progress Note #2

HISTORY: Elaine Marie Benis is a 58-year-old female who presents for an evaluation of one month of pain in her left shoulder. The problem is getting worse.

EXAMINATION: Normal appearance of the left shoulder girdle. Positive Neer impingement sign. Full active range-of-motion in the left shoulder. Positive drop-arm test left shoulder.

IMPRESSION: Rotator cuff tear, left shoulder

DISPOSITION: The patients radiographs looked pretty good. After discussion of the problem, the patient elected to treat this with surgery. Return will be scheduled for pre-operative evaluation.

Electronically Signed by: Cosmo Kramer, M.D.
Date: 29 February 2012

2. For patient/family access to personal health information, what standards should exist regarding accessibility for people with disabilities (e.g., interoperability with assistive technologies to support those with hearing, visual, speech, or mobile impairments)?

ANSWER: AAOS members treat patients with many different disabilities ranging from mild to severe. AAOS recognizes people with disabilities are at a disadvantage for many routine activities of daily living. Disability will always create some limitations. There should be no restrictions on accessing patient data by a family member, who is the custodian for a severely disabled patient. In these instances the record notes family member responsibility for medical decision making and access to patient information for a disabled patient.

For patients with mild disabilities to access personal health information (PHI), AAOS recommends EHR program developers create programs to allow for online log-in using voice recognition programs, use of a reading pen, and on-screen keyboards, mouse connected to word prediction programs, and other assistive devices.

3. What strategies should be used to ensure that barriers to patient access—whether secondary to limited Internet access, low health literacy and/or disability—are appropriately addressed?

ANSWER: If access to PHI is not possible due to lack of Internet access, literacy, and/or disability, the patient/family should be encouraged to visit the doctor's office. Alternatively, patients may be able to gain access to PHI through computers at public

libraries and public computers in health care facilities can offer a good alternative for patients who do not have Internet access. It is unacceptable to accept a telephone request for PHI as authentication is questionable.

4. What are providers' and hospitals' experiences with incorporating patient-reported data (e.g., data self-entered into PHRs, electronically collected patient survey data, home monitoring of biometric data, patient suggestions of corrections to errors in the record) into EHRs?

   ANSWER: EHR programs should be required to allow for remote data entry in a segregated field by the patient / family in the patient record. Using a specially segregated field ensures data is not incorrectly inserted into physician entered patient information. After reading information in the 'patient – entered data field, the physician can seek any clarifications necessary through online secure messaging or at a future appointment. There should be provision to allow patient reported outcome data to be input into the patient's EHR file.

5. For future stages of meaningful use assessment, should CMS provide an alternative way to achieve meaningful use based on demonstration of high performance on clinical quality measures (e.g., can either satisfy utilization measures for recording allergies, conducting CPOE, drug-drug interaction checking, etc, or demonstrate low rates of adverse drug events)?

   ANSWER: AAOS believes it is important to reduce the burden on physicians and surgeons regarding meeting the criteria for meaningful use. Further we believe meaningful use criteria need to be specialty specific. HITPC has established a set of criteria for meaningful use in three stages. AAOS believes creating alternative pathways will only serve to create confusion and unnecessary burdens on physicians. High performance on clinical quality measures is variable and difficult to measure or standardize.

6. Should Stage 2 allow for a group reporting option to allow group practices to demonstrate meaningful use at the group level for all EPs in that group?

   ANSWER: Yes. Allowing an established corporate entity (PC or LLC) categorized as a group of physicians to report as a group based on the entity name is a worthwhile goal as it reduces paperwork and time required to report on meaningful use. However, criteria would be needed for group reporting, as there are likely differences in use among physicians in a group.

7. In stage 1, as an optional menu objective, the presence of an advance directive should be recorded for over 50 percent of patients 65 years of age or older. We propose making this objective required and to include the results of the advance-directive discussion, if available. We invite public comment on this proposal, or to offer suggestions for alternative criteria in this area.

   ANSWER: AAOS supports the sharing of advanced directives. However, our major concern is how an advanced directive is shared between EPs / EHs when the state HIE is not operational. Further, AAOS believes advanced directives are best stored by eligible hospitals as this is typically the site of emergency or high risk care.

8. What are the reasonable elements that should make up a care plan, clinical summary, and discharge summary?

ANSWER: This information differs for each medical specialty. This item represents another example of the need for specialty specific MU criteria. Further within a specialty care plans differ substantially by diagnosis and treatment. A set of elements for treating high cholesterol will be different from elements for treating a torn anterior cruciate ligament. There is no standard plan for caring for a patient with a hip or pelvic fracture, one of the high priority conditions listed by NQF. In orthopaedics we have classification systems to determine severity and define appropriate treatment protocols. There is no standard medication that might be prescribed for pain management.

9. What additional meaningful use criteria could be applied to stimulate robust information exchange?

ANSWER: AAOS recommends development a specialty specific criteria focusing on imaging studies. This has the potential to reduce /eliminate overuse of imaging and re-imaging (conducting the same imaging study a second time on the same patient) in order to reduce health care costs. Further, sharing of images (radiographs, MR, CT and other imaging studies) should be a part of MU criteria. Dentists have managed to set a standard for sharing of patient diagnostic images. All physicians should be able to do the same. AAOS is ready to work with the HITPC to develop standards for image sharing.

10. There are some new objectives being considered for stage 3 where there is no precursor objective being proposed for stage 2 in the current matrix. We invite suggestions on appropriate stage 2 objectives that would be meaningful stepping-stone criteria for the new stage 3 objectives.

ANSWER: AAOS is concerned that the HITPC is moving far too quickly to make final decisions on Stage 2 criteria. Stage 1 meaningful use criteria began just 6 weeks ago. Most orthopaedic surgeons, as well as physicians in all specialties, have little, if any, experience implementing the Stage 1 meaningful use criteria. This request is another example of the HITPC moving too quickly to advance meaningful use criteria.