AAOS
American Academy of Orthopaedic Surgeons
American Association of Orthopaedic Surgeons

May 29, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244–1850
Via Regulations.gov

Subject: CMS-3310-P Medicare and Medicaid Programs; Electronic Health Record Incentive Program – Stage 3.

Dear Acting Administrator Slavitt:

The American Association of Orthopaedic Surgeons (AAOS) and orthopaedic specialty societies appreciate the opportunity to provide comments on the meaningful use criteria developed by the Centers for Medicare and Medicaid Services (CMS), and published in the Federal Register on March 30, 2015. We applaud CMS in your efforts to encourage physicians to become meaningful users of Health Information Technology (HIT), specifically Electronic Health Records (EHR). Further we recognize CMS for simplifying Stage 3 with a single set of 8 objectives rather than separate core and menu objectives as embodied in Stages 1 and 2.

The AAOS represents over 18,000 board-certified orthopaedic surgeons and has been a committed partner to CMS in the adoption of electronic health records and the meaningful use program. The AAOS looks forward to providing input as CMS continues the meaningful use program and we invite CMS to call on the AAOS for any additional feedback from our surgical and specialty perspective. Thank you for this opportunity to comment on the Stage 3 meaningful use proposed rule.

As surgical specialists, we have unique HIT needs and offer some suggestions to improve the meaningful use criteria and subsequent adoption to better reflect the needs of our surgical specialists and their patients. As noted in previous communication, the AAOS is ready to work with CMS in establishing specialty specific meaningful use standards and performance measures for all orthopaedic treatment domains. Since our last communication on the meaningful use program, AAOS has begun a program designed to create orthopaedic-specific performance measures. We look forward to the opportunity to share our results with CMS.

As to Stage 3 meaningful use, in general, we are concerned that some requirements may not be achievable given technology limitations outside of physician control, while other measures may be set at unrealizable levels as detailed in this letter. Our members and other eligible professionals continue to experience problems gaining timely updates of CEHRT software from their EHR vendors in order to meet meaningful use requirements. This is evident in physicians' Stage 2 experience and the CMS adjustments in reporting requirements. The

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AAOS is concerned that new Stage 3 requirements will not be supported by CEHRT software vendors in a timely manner, creating difficulty for physicians in meeting the prerequisites enumerated by CMS.

In order to implement all of the standards, orthopaedic surgeons would spend an excessive amount of time with direct input of certain patient data into their EHR systems that are not essential to the diagnosis and treatment of musculoskeletal conditions or injuries. We feel that orthopaedic surgeons should concentrate their time and effort in recording data that are germane to the musculoskeletal issues for which the patient seeks his or her care. For example, when evaluating and treating a 56 year-old female patient with a wrist or hip fracture, the orthopaedic surgeon should document additional patient-specific information on osteoporosis. However, when treating a patient for hip arthritis, conducting tests and documenting information on hypertension at each appointment is not likely to yield meaningful improvement in blood pressure management. An appropriate frequency of measurement criterion and referral to another physician to treat the comorbidity is necessary, otherwise there is an inappropriate burden placed on the specialist community. These examples demonstrate appropriate action for value-based documentation of comorbidities in terms of identification, evaluation, and management.

The AAOS recommends reconsideration of the length of the reporting period for Stage 3 meaningful use. We note that CMS chose to expand the reporting period to a 365 consecutive day cycle for Stage 2 and then changed the rule back to 90 day reporting when there was a substantial shortfall in expected reporting by eligible physicians and hospitals. The AAOS reaffirms our recommendation from previous communication to CMS, to institute a graduated period reporting plan, requiring 180 days for Stage 3, 270 days for Stage 4, and 365 days for Stage 5. Rather than an all or nothing approach characterized by a 365 day requirement for Stage 3, an incremental approach ensures physicians can sustain their meaningful use for a longer period of time.

We offer the following additional comments on specific Stage 3 meaningful use objectives.

1. "Protect Patient Health Information."

The AAOS strongly believes that physicians and their staff have a fundamental responsibility to protect patient health information. We support this criterion and AAOS is producing a security and risk assessment manual and training program to help our members meet this requirement. CMS can help all eligible professionals and hospitals meet this goal by publishing a specific checklist delineating minimum standards for what constitutes a security risk analysis.

2. "Electronic Prescribing."

The AAOS strongly believes that electronic prescribing of medications promotes patient safety. We agree with the criteria established for this objective. The AAOS applauds the intent of this provision and believes this is a vital component to a comprehensive Electronic Health Record (EHR) and meaningful use. We repeat our concern for the prescribing of opioids. Orthopaedic surgeons prescribe narcotic medication at discharge for many patients and our members know the inherent dangers. Yet, electronic prescribing of opioids is not permissible in all states. Further, the study by Harle, CA, et.al., (PMID: 25300237) reported in the Journal of

Medical Systems found "higher levels of opioid prescribing among physicians with EHRs compared to those without. These results highlight the need to better understand how using EHR systems may influence physician prescribing behavior so that EHRs can be designed to reliably guide physicians toward high quality care." The AAOS recommends CMS requires CEHRT vendors to include education and guidelines for prescribing opioids in EHR programs. The measure exclusions should include opioid prescribing using a traditional paper prescription form.

3. "Clinical Decision Support."

Similar to our comments for Stage 2, we strongly believe that physicians need to have clinical decision support tools at the ready. We recommend EHR vendors provide physicians quick and easy access to specialty-specific clinical guidelines and appropriate use criteria developed by national professional organizations such as AAOS. We renew our offer to work with CMS, NCQA, or other agencies to establish orthopaedic-specific clinical decision support tools (clinical quality measures and performance measures) and urge CMS to work with other medical professional organizations to expand specialty-specific quality measures and improvement goals for patient and population health.

The AAOS is engaged in developing performance measures on osteoarthritis pain and on the functional assessment and management of hip fractures in the elderly. Our process for developing these performance measures includes a review of existing AAOS Clinical Practice Guidelines and a systematic literature review. The performance measures link to patient reported outcomes and clinical quality, and make a powerful clinical decision support tool for orthopaedic surgeons. Future performance measure development will focus on the management of anterior cruciate ligament injuries, management of rotator cuff injuries, and shoulder arthroplasty. These efforts represent a unique collaboration opportunity and the AAOS is ready to work with CMS to embed these performance measures into the meaningful use program to provide specialty-specific quality measures.

4. "Computerized Provider Order Entry (CPOE)."

CPOE is now the standard for medication, laboratory, and diagnostic imaging order entry. The AAOS supports the requirements noted in the proposed measures. Our support comes with two caveats focusing on improving patient safety as there are inherent risks when using an EMR system. Studies have documented mixed results in EHRs' ability to detect and prevent an error. The AAOS recommends CMS require CEHRT systems to include patient safety checks when a physician or other provider is entering orders for tests or treatment. Using reflective listening in verbal communication is known to ensure the message is received. The AAOS believes CEHRT systems need to include patient safety order checks to ensure accuracy. The Joint Commission has noted the potential for medical error when using an EHR system. Further, the Joint Commission noted some EHRs have demonstrated the ability to reduce adverse events, particularly EHRs with clinical data repository, clinical decision support, computerized provider order entry (CPOE) and provider documentation functionalities. CEHRT systems need to include these features.

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In addition, the AAOS recommends CMS place new requirements on CEHRT systems to improve order entry for in-office radiology and physical therapy services. Many of today's EHR system designs do not accurately reflect the requirements orthopaedic surgeons have when ordering imaging or physical therapy services. Our members report they are stymied by the order entry program as it defaults to a generic radiology order when the doctor is seeking a more comprehensive imaging study or when they order a more detailed physical therapy program for patients. As a result the doctor receives an incomplete imaging study. A second order is then written on paper in order to complete the needed imaging. For physical therapy, the same is true. EHR programs default to what is "programmed" rather than what the doctor orders. Improving this EHR programming across all systems reduces waste, lost time, and improves patient safety.

5. Patient Electronic Access to Health Information.

During the past 18 months, EHR vendors have made excellent progress in developing the tools necessary for physicians to implement a portal for patients to access health information. More and more medical practices are adopting this technology as soon as vendors can complete the necessary software installations. While we support this requirement, the AAOS is concerned with the proposed measure that 80 percent of all unique patients are provided access to view online, download, and transmit their health information within 24-hours of its availability to the provider. Stage 2 called for 20% of all unique patients to have access to health information within 24 hours. Further, many physicians struggled to meet the Stage 2 requirement not from failure to provide the information, but because patients failed to access portals or available online health information. The AAOS supports gradually increasing thresholds, and we do not want some physicians to struggle to meet a measure only to see CMS later backtrack on the requirements.

The AAOS recommends modifying the percentage of patients from 80 percent to 50 percent. Our view is that incremental growth can be sustained for a longer period of time and lead to additional increases in Stage 4 and Stage 5 meaningful use. Further, we recommend adding the phrase, *"with respect to system capabilities"* to allow practices to develop and enhance this capability in conjunction with the capabilities of their EHR systems as vendors deliver and install new, updated software.

6. "Coordination of Care through Patient Engagement."

The AAOS recognizes the importance of secure communication from the patient to physician offices, between the offices of physicians and other providers, physician offices to hospitals, and physician offices to patients, if we are to achieve this objective. Effective coordination of care through patient engagement requires that each patient participates in his or her care decisions. The patient is the central player and must understand the medical/health information provided by the care team regardless of its delivery method.

The patient must navigate a complex health care system along the entire continuum of care. If the technology is in place, viewing, downloading, and transmitting information to a third party does not represent a significant challenge for patients. The challenge will revolve around the lack of uniform presentation of this information to patients, the need for those with multiple medical problems to manage a similar number of "portals", and the inevitable time-lag that such a broad change in the behaviors of patients and the public will require.

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Data shows coordination of care breaks down at certain key points such as handoffs or patient adherence to treatment due to communication problems. In these situations, the patient must be ready to participate in care decisions.

Measure 1

If the technology is in place, viewing and downloading patient information does not represent a significant challenge and more and more physicians can send and receive secure messages to patients and other providers. Often the technology is not even available, yet alone installed.

Proposed measure 1 places the physician at risk for not meeting the objective for the patient transmitting information to a third party. There are no methods specified in the objective for documenting that the patient has, in fact, transmitted a file to a third party. Physician offices will have difficulty documenting that the patient sent a file to an appropriate third party. The AAOS would rather have the physician be responsible for sending information to an appropriate third party to ensure information gets to the responsible party and is HIPAA-compliant, if necessary. Interoperability between physicians and other providers is preferred over patients sending information. With Stage 2, physicians experienced compliance challenges when patients failed to access information or portals, even when available. Physicians should not be held accountable for a measure that requires action by the patient.

The second option for measure 1 is an ONC-approved API. At this time there are no known ONC-approved APIs and we do not know when or if one will ever be approved.

Measure 2

The AAOS recommends expansion of this proposed measure to include other communication modalities, programs, and applications that provide physicians with use of a secure, mobile network for the transmission of HIPAA-compliant patient information. Limiting the transmission origination from only the CEHRT does not recognize our increasingly mobile world. Using a cellphone or tablet technology and a secure application, physicians are now able to send and receive HIPAA-compliant messages and transfer patient information to downstream caregivers such as physical therapists.

Measure 3

The proposed measure 3 for this objective requires patient generated health data or data from a non-clinical setting is incorporated into the EHR. The AAOS sees potential problems with patient supplied data including accuracy, timeliness to impact treatment, and the quality or value of the information as it pertains to treatment of the patient's problem. These problems may lead to errors in patient care. For these reasons, the AAOS recommends that CMS delete proposed measure 3 for this objective.

The AAOS recommends CMS rethink this critically important Stage 3 objective. While the physician can fulfill this requirement by meeting 2 of 3 measures, the AAOS is concerned that only 1 measure is achievable by physicians. In linking patient responsibility to the physician for both measurements 1 and 3, the likelihood of satisfying this objective is very limited as experience in Stage 2 demonstrates.

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7. "Health Information Exchange."

The AAOS recognizes the high value of accurate and timely health information exchange. Health IT is just beginning to show success in the exchange of health information, but clarity, standards, and practical solutions remain as the major issues standing in the way of interoperability. At the recent HIMSS Annual Meeting ONC National Coordinator for HIT Karen DeSalvo, MD noted these major issues require resolution, if the nation's health care system is to succeed in health information exchange. The unknown is a date certain as to when the technology will be in place to meet the objective. Open questions abound focusing on standards, application program interface, data security during transmission, and costs. The cost of using a local or statewide HIE is not reimbursed and this places an unfair financial burden on physician practices.

Work on health information exchange protocols and technology may have begun too late to meet this objective. Essentially, the timeline to achieve the nationwide capability for health information exchange is very short, just 18 months. The AAOS strongly recommends reducing the proposed measures to a lower threshold of 20 percent for ALL 3 proposed measures in this objective, and to include a caveat that allows the eligible professional to exclude this objective if the technology is not installed and tested by January 1, 2017 or January 1, 2018, depending on when meaningful use attestation is done. Starting with the lower measurement will allow CMS to increase the threshold for Stage 4 and Stage 5 in a similar manner to our suggestion for increasing thresholds for the reporting period for Stage 3 objective 5 noted above.

8. "Public Health and Clinical Data Registry Reporting."

For orthopaedic surgeons, there are few clinical data registry reporting options, and the largest Registry now in operation, The American Joint Replacement Registry is organized to collect data from hospitals rather than orthopaedic surgeon practices. There are no qualified clinical data registries tracking patient outcomes for other orthopaedic procedures that involve implanting a device. This is especially true in orthopaedic trauma, where implanting plates and screws are usual and customary for treating open fractures or in spine care for scoliosis, for example. As a result, most orthopaedic surgeons will report exclusion for this measurement option. The AAOS recommends the engagement options and proposed measures by CMS include the stipulation that the orthopaedic surgeon is given credit for meeting this measurement if the admitting hospital is submitting data on the orthopaedic surgeon's patient cases to a qualified clinical data registry at any time during the reporting period.

In our Stage 2 comments, we noted the importance of differences in medical practices as a factor in public health access. Surgical specialties like orthopaedic surgery have limited indications for administering an immunization and there is no exclusion criteria noted in the proposed rule. In orthopaedic surgery, tetanus immunization used in select trauma cases is the only direct immunization that might be reported to a registry by an orthopaedic surgeon. The AAOS recommends CMS draft a set of exclusions for this measurement similar to the exclusions for other measures for Objective 8.

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For syndromic surveillance, the AAOS recommends that CMS establish clear criteria defining syndromes that would be reportable. A medical syndromes web site list indicates more than 130 different syndromes. There are many orthopaedic problems that are noted as syndromes, but the AAOS questions if it is the intent of CMS to collect data on syndromes such as cubital tunnel syndrome or carpal tunnel syndrome, as compared to those typically reported by primary care physicians, pediatricians, and family physicians such as irritable bowel syndrome, Down syndrome, or toxic shock syndrome.

In closing, we thank you for the opportunity to provide comments on the proposed Stage 3 meaningful use criteria. We believe that Health Information Technology is a fundamental core competency on the road to improving our nation's health care system. While we are encouraged by the direction of the proposed Stage 3 rule, 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. Challenges remain despite our desire to adopt EHR technology. The amount of time orthopaedic surgeons would spend trying to meet the proposed Stage 3 objectives 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 objectives remains more relevant to primary care physicians, while disadvantaging specialty care physicians. As such, we encourage CMS, in conjunction with the Office of the National Coordinator and the HIT Policy and Standards Committee, to create specialty-specific meaningful use standards for surgical specialists concurrent with promulgating the meaningful use standards already published for primary care physicians. The AAOS is ready to support CMS efforts to create meaningful use criteria specific to surgical specialists, should CMS choose that direction.

Sincerely,

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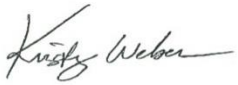

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