AAOS
American Academy of Orthopaedic Surgeons
American Association of Orthopaedic Surgeons

December 15, 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: Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 3 and Modifications to Meaningful Use in 2015 through 2017

Dear Acting Administrator Slavitt:

The American Association of Orthopaedic Surgeons (AAOS) and orthopaedic specialty societies, representing over 18,000 board-certified orthopaedic surgeons, 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 October 16, 2015. The AAOS has been committed to working with CMS in the adoption of electronic health records and the meaningful use program.

As surgical specialists, we have unique Health Information Technology (HIT) needs and respectfully offer some suggestions to improve the meaningful use criteria for stage 3 to better reflect the needs of our surgical specialists and their patients and accelerate HIT adoption in the future by orthopaedic surgeons. As noted in previous communications, the AAOS is ready to work with CMS in establishing specialty specific meaningful use standards and performance measures for all orthopaedic treatment domains. AAOS is actively engaged in the development of orthopaedic performance measures. We look forward to the opportunity to share our results with CMS.

The AAOS appreciates the modifications made to Meaningful Use Stage 2 in order to align with Stage 3 criteria. However, we are concerned with the lack of interoperability in data exchange across care settings. In addition, the modest improvements with some new requirements may still cause physicians to fail. Due to the shortcomings in Stage 2, we urge a delay in implementation of Stage 3.

As to Stage 3 meaningful use, we are concerned that the requirements will not be achievable by January 1, 2018, the date given by CMS, given technology limitations outside of physician control. In addition, 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 Certified Electronic Health Records Technology (CEHRT) software from their EHR vendors in order to meet meaningful use requirements. The recent study by Ratwani, RM, et. al. (PMID: 26348757) revealed a lack of adherence to ONC certification requirements and usability testing standards among several widely used EHR products. The 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.

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

1. Protect Electronic 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 has produced a security and risk assessment manual 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 always take into account the inherent risks of abuse. Yet, electronic prescribing of opioids is not permissible in all states. A nation-wide tracking system would allow surgeons and pharmacists to see all prescriptions filled by a given patient. Opioid use is best coordinated through a single prescribing physician/surgeon/practice, especially when treating patients who have ongoing/chronic pain issues. Doctors in emergency departments or other consulting physicians can then contact that prescribing physician/surgeon/practice to determine if an exception is warranted. Referral for alternative pain management strategies should be considered for atraumatic musculoskeletal pain. Evidence is available that ongoing pain after injury or surgery is most often associated with symptoms of depression, posttraumatic stress disorder, and ineffective coping strategies—all of which are responsive to cognitive behavioral therapy.

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.

3. Clinical Decision Support

We strongly believe that physicians need to have clinical decision support tools available. 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.

Currently, AAOS has two work groups focused on developing orthopaedic measure sets for osteoarthritis and management of hip fractures in the elderly. We use an evidence-based measure development process that is aligned with the National Quality Strategy (NQS) and focus on measure concepts that are supported by strong evidence within evidence-based clinical practice guidelines and systematic reviews. 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 final measures. Our support comes with two caveats focusing on improving patient safety as there are inherent risks when using an EHR 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. AAOS recommends requiring all CEHRT systems include these features.

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

EHR vendors have made significant 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 final measure that 80 percent of all unique patients are provided access to view, download, transmit and access their health information within 48 hours of its availability to the provider. We appreciate the longer time frame from 24 hours to 48 hours, however many physicians are struggling to meet the Stage 2 requirement, which calls for 20 percent of all unique patients to have to have access to health information within 24 hours, not due to a failure to provide the information, but because patients failed to access portals or available online health information.

The AAOS recommends modifying the percentage of patients from 80 percent to 50 percent. 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.

For similar reasons, we support the use of clinically relevant information to identify patient-specific educational resources and provide electronic access to these materials. AAOS recommends reducing the 35 percent of patient requirements, because patients frequently fail to take action to access portals or available online health information. Our view is that the information should be made available and any level of access by patients would show the materials are made available. We recommend modifying the percentage of patients from 35 percent to 10 percent.

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.

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.

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.

Measure 2

The AAOS recommends expansion of this 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

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 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.

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. Work on health information exchange protocols and technology may have begun too late to meet this objective. The AAOS strongly recommends reducing the measures to a lower threshold of 20 percent for ALL 3 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.

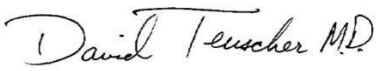
8. Public Health and Clinical Data Registry Reporting

The AAOS appreciates the modifications made to the Public Health and Clinical Data Registry Reporting measure, in particular reducing the requirement to successfully attest to any combination of two measures. For orthopaedic surgeons, there are few clinical data registry reporting options, and the largest registry now in operation, The American Joint Replacement Registry (AJRR) is organized to collect data from hospitals rather than orthopaedic surgeon practices and as such we appreciate the inclusion credit for specialty developed clinical data registries. In addition, the exclusions for this objective, for those who do not diagnose or directly treat any disease or condition associated with a registry in their jurisdiction during the EHR reporting period, or operate in a jurisdiction for which no registry is capable of accepting electronic registry transitions, will relieve subspecialty physicians who are faced with limited options when it comes to registries.

We thank you for the opportunity to provide comments on the final 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 final 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 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,



David Teuscher, MD
American Association of Orthopaedic Surgeons President

Additional signatories on AAOS' comments on the CMS Electronic Health Record Incentive Program – Stage 3 and Modifications to Meaningful Use in 2015 through 2017 include the following organizations:

American Shoulder and Elbow Surgeons
Orthopaedic Trauma Association
American Orthopaedic Foot and Ankle Society
American Association for Hand Surgery'
Cervical Spine Research Society
American Orthopaedic Society for Sports Medicine
American Association of Hip and Knee Surgeons
Arthroscopy Association of North America
American Society for Surgery of the Hand
Orthopaedic Rehabilitation Association
Scoliosis Research Society
Ruth Jackson Orthopaedic Society
J. Robert Gladden Orthopaedic Society
Musculoskeletal Tumor Society
Pediatric Orthopaedic Society of North America