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February 4, 2015

Karen DeSalvo, MD, MPH, MSc
National Coordinator
Office of the National Coordinator for Health Information Technology
Office of the Secretary
U.S. Department of Health and Human Services
Washington, DC

RE: Federal Health Information Technology (IT) Strategic Plan 2015-2020

Dr. DeSalvo,

On behalf of the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), representing over 4,000 neurosurgeons in the United States, we are writing to provide feedback to the Office of the National Coordinator (ONC) for Health Information Technology regarding the *Federal Health IT Strategic Plan (2015-2020)*. We applaud ONC for collaborating with over 35 different federal entities to develop goals related to the collection, sharing and use of electronic data. While we appreciate that the strategy aims to increase the electronic collection and sharing of health information in an effort to improve health outcomes and reduce healthcare costs. Nevertheless, we are concerned about the prioritization of these goals and potential implementation strategies, which are discussed below.

Advancing Secure and Interoperable Health Information

Our comments focus on the strategic plan's goal of advancing the securement and interoperability of health information. While ONC lists this as goal #2, organized neurosurgery believes that interoperability is the keystone on which all of ONC's other goals rest, including expanded adoption of health information technology (HIT) and using such technology to advance the health of individuals and communities. The current lack of interoperability is the primary impediment to electronic health records (EHR) realizing their full potential, and, in many instances, has actually resulted in less efficient and lower quality care—the exact opposite of what the federal government's intention. At the most basic level, many physician office EHRs still cannot communicate with their hospital. In addition, different versions of the same EHR system are often not able to share information. For example, Stanford Hospital and Lucille Packard Children's Hospital share a building, a university, and a medical staff; they both use EPIC; and yet the two EHRs cannot communicate.

Just as the federal government mandates that healthcare providers comply with minimum quality reporting requirements, the AANS and CNS firmly believe that EHR vendors must be held to a similar standard in regards to interoperability. Without minimum regulatory requirements regarding the free exchange of information between platforms, the field will continue to be dominated by a handful of siloed EHR systems, which has resulted in the balkanization of critical health data. It is important that interoperability standards apply to the exchange of data within a single EHR employed across multiple settings; between different EHR systems; and between EHRs and other data sources, such as clinical

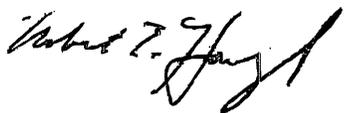
data registries. In fact, interoperability with registries is so critical that we urge ONC to add an objective directly targeting this activity. Furthermore, as a condition of certification, all EHR systems should be required to have the necessary functionality to support federal quality improvement requirements for a range of providers, including surgical specialists. Finally, if the federal government truly wishes to create a system that promotes the seamless exchange of data in the name of higher value healthcare, it is important to keep in mind that enforcement of these standards among EHR vendors is equally important as setting them.

A critical component of interoperability is the development of a standardized, consensus-driven electronic taxonomy. A diagnostic taxonomy is a critical starting point for building the foundation for downstream interpretations related to diseases, treatments, and patients. In a sense, upstream heterogeneity in classification or misclassification of disease states and health conditions is equitable to a lethal frame-shift DNA mutation. No degree of downstream depth and breadth of electronic data capture can make up for invalid or blurry diagnostic patient assignment when attempting meaningful interpretation. Nevertheless, common data sets and taxonomies are also important for patient demographics, procedures, and outcomes assessment tools. Implementation of this work will likely require a phased-approach. Regardless of the strategy, consultation with specialty societies and other appropriate clinical experts is essential.

Finally, the AANS and CNS reiterate the concerns we previously registered about the need for the Centers for Medicare & Medicaid Services (CMS) and ONC, working in collaboration with specialty societies, to gather better data regarding physician use of EHRs and their experiences trying to comply with meaningful use requirements. This is especially critical now that the program has transitioned to penalty-only system. There remains a serious paucity of evidence regarding the feasibility of meaningful use Stage 1 and Stage 2 criteria and the effect of those criteria on physician practice and overall patient care and safety. In addition, there are still widespread gaps in certified EHR technology functionality. Given that investment in an EHR system requires a considerable amount of time and financial resources, it is critical that ONC and CMS carefully evaluate the program prior to the implementation of Stage 3.

Again, the AANS and CNS appreciate the opportunity to provide feedback on ONC's Federal HIT Plan and look forward to a meaningful and ongoing dialogue with ONC on this and related efforts.

Sincerely,



Robert E. Harbaugh, MD, President
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