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Health Information Technology Policy Committee
Implementation and Usability of Meaningful Use Public Hearing
The Dupont Circle Hotel
1500 New Hampshire Avenue, NW
Washington, DC 20036

Dear Committee Members:

The American Association of Orthopaedic Surgeons (AAOS) appreciates this opportunity to address the Health Information Technology Policy Committee's Implementation and Usability Hearing to provide information and comments to electronic health record (EHR) adoption for Stage 2 Meaningful Use and Stage 3 Meaningful Use measures. Thank you for the invitation to participate on this panel to provide information and comments from our surgical and specialty perspective.

The AAOS represents over 18,000 board-certified orthopedic surgeons and shares with the Centers for Medicare & Medicaid Services (CMS) the goals of enhanced patient safety, improved patient outcomes, and readily accessible and affordable quality care. In partnership, hospitals, eligible physician providers, and payers must unite around the goals of health information exchange and health information technology to improve efficiency and effectiveness of care for all participants. The AAOS supports ONC (Office of the National Coordinator for Health Information Technology) and CMS (see attached AAOS public comment letters dated January 14, 2013 and April 22, 2013) health information technology initiatives, such as electronic health record adoption for meaningful use.

In support of meaningful use implementation, the AAOS identifies three major challenges in the path of achieving the desired outcomes. My name is John Bowman, MD, and I am the Chief Medical Officer (CMO) for OrthoVirginia based in Richmond, VA, a metropolitan city of about one million persons and a member of the AAOS.

The first challenge, particularly in the areas of patient engagement and provider to provider health information exchange, is the issue of interoperability. There are three major providers of acute-care facilities in the Richmond metropolitan area - Hospital Corporation of America, Bon Secours, and the medical center at Virginia Commonwealth University. Each share about a third of the market. Meditech, Epic, and Cerner are the electronic medical records of these three institutions, respectively.

As of July 2013, there is no meaningful exchange of health information data. At best, I can access PACS (Picture Archiving and Communication System) images electronically from two of the three sources when providing in-office patient care. Emergency room patient referrals being seen the next day continue to require repeat x-rays to allow physicians to provide standard of care treatment. This is an obvious source of added cost per episode of care. From the patient's perspective, the 15 to 20 minutes spent registering the patient in the emergency room on Sunday is repeated in my office, at the expense of duplication of effort and cost.

Continuing from the patient's point of reference, the same clipboard of data that they provided in the ER during registration is duplicated a day later. For my practice, OrthoVirginia has pursued meaningful use by purchasing a portal. In fact, OrthoVirginia has purchased two portals. The vendor of the first portal has withdrawn from the portal market after about $75,000 in expenses to OrthoVirginia. The second portal is now being installed at the cost of $4000 per year per physician multiplied by the 43 physicians in the group. Included in this contract will be outcomes research capabilities, secure email communication for patients, implant registries, document exchange capability with numerous other institutions, and the ability to assess patient satisfaction scores for each encounter regarding each individual physician.

Most patients, perhaps as high as 75 to 80% in some markets, will embrace this technology and be pleased to use it to register for all OrthoVirginia visits. However, when they need to input the same data into a different portal for their internist, their gynecologist, the dermatologist and the ophthalmologist - all with a different brand of portal - how will cost and frustration be reduced and how will patient engagement rise? EZ Pass, Visa, and ATM cards have solved this issue for travel and banking convenience. We in the medical community must solve this problem by full-scale collaboration on interoperability on the part of acute and ambulatory care EHR vendors.

A possible solution to address the interoperability issue is to create incentives for a common portal standard for the basics of patient registration. Over time, this common shared patient specific data set could then be incorporated with Meaningful Use 1 and Meaningful Use 2 elements such as smoking status, immunization status and recent vital signs. This would enable specialists to provide specialty care rather than re-recording a common dataset that patients must give to every healthcare provider. Meaningful Use 3 should also reward all providers of

radiology services for developing the ability to make imaging studies available electronically to any physician chosen by the patient for follow up care.

For example, instead of measuring immunization compliance or recalling specific patient groups, the latter is something that can readily be done by searching for CPT or ICD code parameters. We suggest incentivizing behaviors that relate specifically to orthopedic care. For example, a very rapid provider to provider image transfer will promote a system that makes repeat x-ray charges unnecessary. Meaningful Use regulations that require lab result electronic reporting are already in place. Require a common standard. The Kansas HIE (Health Information Exchange) requires a uniform labeling of results for all laboratories or they cannot participate.

The second major challenge for EHR adoption for orthopaedic surgeons is the lack of appropriate and applicable quality measures for orthopaedic practices. There are too few orthopaedic specific quality measures in the present set of NQF measures. The two measures focus on back pain and osteoporosis. The AAOS is ready to work with the ONC and NQF to establish several orthopaedic specialty specific measures focusing on total joint replacement for hip, knee, shoulder, elbow, and ankle. We propose development of quality measures on treating high incidence fractures, especially those in the wrist, shoulder, and leg. The AAOS will recruit orthopaedic surgeons to establish panels to work with the ONC and NQF on these and other orthopaedic specific diagnoses.

The third challenge for implementing and developing usable standards for HIT is created by the increasing complexity and capabilities of the electronic medical record itself. Can Meaningful Use 3 measures be developed to leverage and promote all of the research and outcome assessment capabilities of what is now being developed for the EMR? To cite one example, consider that many of the large orthopedic groups around the country are increasingly enrolling in OBERD (outcome based electronic research database). This ever increasing list of orthopedic groups includes OrthoVirginia, OrthoCarolina, the Rothman Institute, OrthoIndy, Midwest Orthopedics at Rush, Sanford Health, Tennessee Orthopedic Clinic, MedSTAR Health, and the University of Rochester. OBERD will provide outcomes by subspecialty in orthopedics including hand, total joint replacement, shoulder, elbow, knee, and foot and ankle. It will also provide joint registries.

Additionally, the AAOS has developed clinical practice guidelines, appropriate use criteria, and pre-operative, peri-operative and post-operative checklists for EMR order sets. The AAOS recommends that the ONC and CMS look specifically at “team training” and thus “team reward” possibilities of any incentive plan. I am pleased to report that my Association has made a substantial commitment to the AHRQ TeamSTEPPS project to improve the teamwork and leadership skills for orthopaedic surgeons. Twenty of my colleagues from across the country have been trained as TeamSTEPPS master trainers and they are voluntarily conducting

interdisciplinary workshops in hospitals and ambulatory surgery centers, fully subsidized by AAOS, to improve safety and teamwork in the OR. In addition to OBERD, this writer, as CMO of OrthoVirginia, has at his disposal Press Ganey, HCAHPS, Premier (Bon Secours), and Crimson (HCA) data for each orthopedist within this clinical group. These widely used programs allow dashboard creations to monitor of a host of clinical and financial measures. Analytic software for the clinical side of care is growing in popularity and functionality. Outliers are more readily defined and identified outliers often fall back toward the mean merely through being identified as an outlier. Why not encourage the creation of specialty specific parameters discovered by the use of analytics software as developed in financially capable groups? Then through further Meaningful Use incentives, enable smaller, financially more challenged groups to enhance their own clinical self-assessment and improvement?

AAOS believes that meaningful use regulations should not emphasize only individual performance. Quality measures that promote system and cross-system data sharing, communication and the achieving of mutually beneficial outcomes for patients, physicians, and hospitals are necessary. As the CMO at OrthoVirginia, I am currently helping to develop a total joint replacement preoperative, peri-operative, and post-operative protocol that will be integrated into the patient's electronic medical record in the Epic system. Through use of these protocols, SCIP (surgical care infection prevention), DVT (deep venous thrombosis) prophylaxis, PT (physical therapy) and post discharge care planning will be enhanced. This will promote better outcomes, fewer complications, and a smaller number of readmissions. Inadvertent overlooking of small but important steps along the clinical care pathway will be minimized if not eliminated.

Many other subspecialty groups have their own set of protocols, for example, the cardiothoracic surgeons utilize a checklist prior to open heart procedures. Incentivize development and utilization of such measures but allow some flexibility to reflect local culture until proven differences in outcomes can be generated. The AAOS is engaged in another program to improve patient safety. Our 2012 Patient Safety Summit led to the establishment of several working groups that are focused on such issues as improving safety in the area of opioid misuse and procedure specific checklists.

For additional specific comments on the HITPC Draft Recommendations for Stage 3 of Meaningful Use, please see the AAOS January 13, 2013 letter addressed to Dr. Farzad Mostashari and the HITPC.

Conclusion

Thank you for the opportunity to provide these comments. Health information technology will ultimately improve every physician's ability to provide better healthcare to the communities in which they serve. We applaud the efforts being made by your committee, the ONC and CMS to

provide a standard platform of health information exchange. The required changes are monumental and can only be adopted by the myriad of rural and smaller groups of physicians if continued guidance and financial incentives are applied strategically to overcome challenges along the way. We support your efforts to illuminate the way, hoping that your vision will allow tailoring meaningful use objectives with enough flexibility and accommodation so that the needs of multiple subspecialty groups can be met.

On behalf of the American Association of Orthopaedic Surgeons and my partners at OrthoVirginia,

Sincerely,

//signed//

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