AAOS
American Academy of Orthopaedic Surgeons
American Association of Orthopaedic Surgeons

January 28, 2019

The Honorable Alex Azar II
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Submitted electronically

Subject: Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs

Dear Secretary Azar:

On behalf of over 34,000 orthopaedic surgeons and residents represented by the American Association of Orthopaedic Surgeons (AAOS), we appreciate the opportunity to provide comments on the draft Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs (the Strategy), which was published on November 28, 2018.

AAOS welcomes the Department of Health and Human Services (HHS) and the Office for the National Coordinator (ONC) for Health IT's proposal to reduce the administrative and regulatory burden related to the use of Health IT and electronic health records (EHRs). As noted in the proposal, Section 4001 of the 21st Century Cures Act – signed into law on December 13, 2016 – mandates that HHS; establish a goal with respect to the reduction of regulatory or administrative burdens (such as documentation requirements) relating to the use of EHRs; develop a strategy for meeting the goal established; and develop recommendations for meeting this goal.

AAOS appreciates Congress' recognition of this problem. In the United States, there is an increasing burden associated with the administrative and clinical use of EHRs. A 2016 study found that for every hour of direct clinical time with patients, physicians spent two additional hours on EHR and desk work, and an additional one to two hours of after-hours personal time completing documentation and EHR tasks[1]. While EHRs provide a great opportunity to improve patient care, the current additional burden detracts time from the integral doctor-patient relationship and can contribute to poorer health outcomes. Physician well-being is also impacted by their increasing use. An additional 2018 study found that stress from using EHRs among

[1] Hingle S. Electronic Health Records: An Unfulfilled Promise and a Call to Action. Ann Intern Med. ;165:818–819. doi: 10.7326/M16-1757

317 Massachusetts Avenue NE
Suite 100
Washington, D.C. 20002-5701
PHONE 202.546.4430
www.aaos.org/dc

physicians is common and was independently predictive of burnout symptoms.[2] This is a major issue in the physician community that can be curtailed through more efficient, user-friendly EHR systems.

Clinical Data Registries

AAOS regrets that the Strategy did not identify clinical data registries, such as qualified clinical data registries (QCDRs) or qualified registries (QRs), as a useful tool or recommendation for reducing Health IT and EHR burden. Registries are unique in that they can longitudinally track patient care, quality and outcomes without additional burden on the front end for physicians. At the same time, they can highlight variations in care, provide feedback to physicians, and identify best practices based on real-world evidence (RWE) generated and analyzed on the back end.

The strategy specifically mentions that "physicians and hospitals commonly identified the current set of health IT measures to be excessively burdensome relative to the value they provide." Registries can address this issue. In 2018, AAOS joined 20 other medical specialty societies in writing a letter to the Centers for Medicare and Medicaid Services (CMS) Administrator Seema Verma urging HHS to "allow eligible clinicians utilizing a certified electronic health record to participate in a clinician-led qualified clinical data registry (QCDR) to qualify them as fully achieving all points for the Promoting Interoperability category of the Quality Payment Program's Merit Based Incentive Payment System." This change will not only help reduce reporting burdens, improve Merit-based Incentive Program System (MIPS) performance, increase Certified EHR Technology (CEHRT) use, drive interoperability, and improve quality and outcomes, but it will also satisfy the recommendation listed in the Strategy to simplify the scoring model for the Promoting Interoperability performance category. AAOS encourages HHS to adopt this proposal.

Clinical Documentation

Overall, AAOS greatly appreciates the Administration's interest in reducing physician burden associated with clinical documentation. As mentioned in the Strategy, CMS took new steps in the CY 2019 Physician Fee Schedule (PFS) final rule to attempt to reduce documentation requirements for office visit evaluation and management (E/M) codes. AAOS commends CMS' efforts to clarify current policy for history and exam of office/outpatient E/M visits so that unnecessary data and redundant information already present in the medical record does not need to be re-documented.

Additionally, AAOS applauds the recommendation to alleviate the administrative burden on physicians by reducing documentation requirements and advancing best practices. As we

[2] Rebekah L Gardner, Emily Cooper, Jacqueline Haskell, Daniel A Harris, Sara Poplau, Philip J Kroth, Mark Linzer; Physician stress and burnout: the impact of health information technology, Journal of the American Medical Informatics Association, ocy145, https://doi.org/10.1093/jamia/ocy145

continue to focus on value-based care, increase our reliance on technology, and explore the utilization of team-based care, we must reevaluate our methods of documentation. Alternative Payment Model (APM) adoption has remained slow for a variety of reasons, including the lack of specialty-specific Advanced APMs and an inability to satisfy the Qualifying Participant (QP) threshold. Nevertheless, waiving onerous documentation requirements for purposes of testing or administering APMs could help facilitate faster adoption. CMS should also simplify reporting (such as shortening the reporting period to 90 days) and scoring under the Promoting Interoperability category of MIPS.

Finally, AAOS appreciates that the Strategy recognizes that the prior authorization ecosystem is challenging for clinicians, frustrating for patients, and increasingly burdensome. In 2017, AAOS joined more than 25 organizations to set forth a comprehensive list of 21 principles to reduce the burden of prior authorization requirements. One area described how "the use of standardized electronic prior authorization transactions saves patients, providers and utilization review entities significant time and resources and can speed up the care delivery process." AAOS is glad to see that HHS supports automation of prior authorization processes for medical services and equipment through adoption of standardized templates, data elements, and electronic transactions between providers, suppliers, and payers. Proprietary health plan web-based portals do not represent efficient automation or true administrative simplification, since they require health care providers to manage unique logins/passwords for each plan and manually re-enter patient and clinical data into the portal. Further efforts to promote standardization should include input from medical specialty societies and physicians who directly face these existing challenges.

Health IT Usability and The User Experience

AAOS greatly appreciates the Strategy's emphasis to improve clinical decision support usability, clinical documentation functionality, presentation of clinical data within EHRs, and improve user interface design standards specific to health care delivery. When EHR systems are affordable, well designed, and widely available, their use has several advantages. It is well recognized that a poorly designed and implemented EHR system has far less utility than a system that is functional and adaptable. The care delivery process is only as efficient as its most inefficient part. Because of this, national surveys from both end users – providers and patients – are needed to determine why electronic health information may not be widely exchanged. The end user experience is not just the physician; the real end user of this technology is the patient, and they should also be considered when making any improvements to the user experience.

EHR Reporting

One of the recommendations in the Strategy is to recognize industry-approved best practices for data mapping to improve data accuracy and reduce administrative and financial burdens associated with health IT reporting. AAOS supports the effort to reduce this burden on physicians. As one doctor explains, "Imagine as a physician having hundreds of pages of

specific regulations about what you had to say to a patient and do for a patient in each step of their care for each diagnosis. This is the equivalent of what health IT vendors currently contend with." Providing greater regulatory flexibilities for EHR products while emphasizing a greater focus on interoperability can help to mitigate this issue.

Interoperability should not focus simply on the electronic sending, receiving, finding, integrating, and use of data from outside sources. True interoperability must allow the exchange and use of information to be secure, useful, and valuable to the patient and the provider. Much of current medical communication and documentation within an EHR is unstructured free-text (e.g. case summaries, operative report descriptions, and decision explanations, etc.), and provides some of the most vital information for patient care. AAOS supports the Strategy's recommendation to adopt additional data standards that make access to data, extraction of data from health IT systems, integration of data across multiple health IT systems, and analysis of data easier and less costly for physicians and hospitals. Efforts to promote effective, interoperable measures of data exchange should ensure a focus on the value of qualitative data type (such as the ones mentioned above), not just quantitative measures.

Lastly, the Certified Health IT Products List (CHPL) could also be a useful resource for helping physicians identify which EHR best complies or implements such data standards. We reiterate from previous comments to the EHR Reporting Program Request for Information that the information contained in the CHPL should be more consumer friendly, instead of its current developer-centric version. If these improvements are made, the CHPL could be an authoritative and effective tool for physicians to the make the best decisions for their practices, and for market dynamics to reward the most innovative, least burdensome products.

Thank you for your time and consideration of the American Association of Orthopaedic Surgeons' suggestions. We greatly appreciate the opportunity to comment on reducing the regulatory and administration burden related to health IT and EHRs. AAOS applauds CMS on its continued efforts to reduce physician burden and improve the health IT landscape. If you have any questions on our comments, please do not hesitate to contact William Shaffer, MD, AAOS Medical Director, by email at shaffer@aaos.org.

Sincerely,

David A. Halsey, MD
President, AAOS

cc: Kristy L. Weber, MD, First Vice-President, AAOS
Joseph A. Bosco, III, Second Vice-President, AAOS
Thomas E. Arend, Jr., Esq., CAE, CEO, AAOS
William O. Shaffer, MD, Medical Director, AAOS

This letter has received sign-on from the following orthopaedic societies:

American Association of Hip and Knee Surgeons (AAHKS)
American Orthopaedic Foot and Ankle Society (AOFAS)
American Orthopaedic Society for Sports Medicine (AOSSM)
American Shoulder and Elbow Surgeons (ASES)
American Society for Surgery of the Hand (ASSH)
American Spinal Injury Association (ASIA)
Arthroscopy Association of North America (AANA)
Cervical Spine Research Society (CSRS)
Limb Lengthening and Reconstruction Society (LLRS)
Orthopaedic Rehabilitation Association (ORA)
Orthopaedic Trauma Association (OTA)
Pediatric Orthopaedic Society of North America (POSNA)
Ruth Jackson Orthopaedic Society (RJOS)
Scoliosis Research Society (SRS)
Society of Military Orthopaedic Surgeons (SOMOS)
The Hip Society (HIP)

Alabama Orthopaedic Society
Arkansas Orthopaedic Society
California Orthopaedic Association
Connecticut Orthopaedic Society
Delaware Society of Orthopaedic Surgeons
Florida Orthopaedic Society
Georgia Orthopaedic Society
Illinois State Orthopaedic Association
Iowa Orthopaedic Society
Kansas Orthopaedic Society
Louisiana Orthopaedic Association
Maryland Orthopaedic Association
Massachusetts Orthopaedic Association
Michigan Orthopaedic Society
Minnesota Orthopaedic Society
Nevada Orthopaedic Society
New York State Society of Orthopaedic Surgeons
North Carolina Orthopaedic Association
North Dakota Orthopaedic Society
Ohio Orthopaedic Society
Oregon Association of Orthopaedic Surgeons
Pennsylvania Orthopaedic Society
Rhode Island Orthopaedic Society
South Carolina Orthopaedic Association
South Dakota Orthopaedic Society
Tennessee Orthopaedic Society
Virginia Orthopaedic Society
Washington State Orthopaedic Association
West Virginia Orthopaedic Society
Wyoming Orthopaedic Society