AMERICAN OSTEOPATHIC ASSOCIATION

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The Honorable Lamar Alexander
United States Senate
455 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Michael Enzi
United States Senate
379A Russell Senate Office Building
Washington, DC 20510

The Honorable Richard Burr
United States Senate
217 Russell Senate Office Building
Washington, DC 20510

The Honorable Pat Roberts
United States Senate
109 Hart Senate Office Building
Washington, DC 20510

The Honorable Tom Coburn
United States Senate
172 Russell Senate Office Building
Washington, DC 20510

The Honorable John Thune
United States Senate
511 Dirksen Senate Office Building
Washington, DC 20510

Dear Senators Alexander, Burr, Coburn, Enzi, Roberts, and Thune:

Thank you for the opportunity to comment on "REBOOT: Re-examining the Strategies Needed to Successfully Adopt Health IT." The American Osteopathic Association (AOA), which represents more than 100,000 osteopathic physicians (DOs) and osteopathic medical students nationwide, supports the adoption of cost-effective and interoperable health information technology by physicians and the entire health care community. As part of this effort, the AOA has strategically partnered with HealthFusion, resulting in greater adoption of electronic health records (EHRs) amongst our members.

The AOA supports efforts to ensure that all patient populations, especially those in rural and underserved communities, benefit from HIT. We are proactive in our quest to improve medical standards and the quality of patient care. Our goals for higher standards include: Deliver patient-centered care, practice evidence-based medicine, focus on quality improvement activities, adequately train the future physician workforce, and use information technology appropriately.

To help physician practices make a successful transition to a fully functioning EHR, HIT requirements must address the specific challenges physician practices face in adopting and implementing EHRs and the impact those challenges will have on patient care. The AOA supports the Medicare and Medicaid EHR Incentive Program created under the HITECH Act, but we believe adoption of HIT should not create an additional burden for physicians and practices. While we

were pleased to see the program's Stage III Meaningful Use suspended until further notice, we do not believe the program should be discontinued altogether.

Many physicians have already invested significant time and money into implementing EHRs in order to qualify for the program's incentives and partially offset the systems' significant cost, and to completely discontinue the program devalues their efforts. The lack of stability and predictability in the current health care system has been a hindrance to physicians' full investment in practice transformations and innovations needed to improve the future of healthcare delivery, and should not be further exacerbated.

Lack of Interoperability

The AOA shares the concerns described in the white paper on the lack of standards to support interoperability, or a long-term plan by the Office of the National Coordinator for Health Information Technology (ONC) to address this issue. There continues to be great reluctance among physicians to make a significant investment in HIT systems that are not equipped to communicate or exchange information with other entities. We understand the need to increase requirements for the exchange of health information in future stages of meaningful use. However, the success of EHR adoption and its meaningful implementation hinge on a sound infrastructure and on interoperability with clinical information systems outside of the physician's practice.

In his testimony before the House Committee on Science, Space and Technology, Subcommittee on Technology and Innovation, Marc Probst, Chief Information Officer (CIO) and Vice President of Information Systems, Intermountain Healthcare and member of the federal HIT Policy Committee (HITPC), shared this concern:

> *"We need national standards to ensure, as the [Institutes of Medicine] recommends, 'that the digital infrastructure captures and delivers the core data elements and interoperability needed.' The federal government has made a major investment in electronic medical records, having committed $20 billion from the stimulus bill to it. We must now ensure that, as the capacities of many individual providers grow, they evolve into an efficient and effective national network.*

The AOA continues to support efforts to set a clear road map towards creating a robust health information exchange (HIE) infrastructure, along with the development and adoption of interoperability standards that support HIE.

In addition, the AOA strongly recommends that CMS, along with ONC, conduct a broad survey of physician, patient, and vendor experience to date regarding HIT implementation before going forward with increasing requirements for future stages of meaningful use and certification. As part of such an effort, physicians should be queried on the relevancy of meaningful use criteria and requirements that pose the greatest challenges to their practices, both administratively and clinically. This could be accomplished by modifying the existing Electronic Health Records Survey that is part of the National Ambulatory Medical Care Survey put out annually by the Centers for Disease Control to capture this additional information, or by working closely with the physician community to develop a new, validated survey instrument. We would suggest complementing any survey with focus groups in order to learn more from providers and their staffs about specific challenges practices face when attempting to meet existing meaningful use criteria, as well as learning what additional criteria would be more meaningful to their practices and patient population.

Increased Costs

According to the white paper, the use of EHRs may be driving up costs via a phenomenon referred to as "code creep." It should be noted that:

- Data show that severity in illness has increased over the decade, i.e. patients are living longer but with a greater disease burden. Eighty percent of Medicare patients have at least one chronic illness.
- Data show there is greater emergency department usage, i.e. 30 million ED visits.
- Coding goes up for legitimate reasons. EHR systems capture data that were not captured before. More accurate and well-documented coding of claims should not be grounds for criticism or suspicion.
- There are significant challenges with EHR systems, particularly in the area of documentation. Templates and macros can lead to misapplications, and inaccurate information entering an EHR system.

Greater understanding of these challenges is necessary rather than being overly critical of those physicians using EHR systems.

Risks to Patient Privacy and Safety

We agree with the white paper's premise that "being proactive in addressing privacy and security concerns while minimizing the additional burden on providers is a critical part of ensuring the long-term success of EHRs. Further, problems with data entry, computer programming errors, and other unforeseen complications can affect the security of patient data and have the potential to jeopardize patient care."

Regarding patient safety, the AOA agrees with ONC's *Proposed HIT Patient Safety Action and Surveillance Plan* that the nation could improve the safety of HIT systems by:

- Collecting more and better data about HIT-related risks.
- Targeting resources and corrective actions to improve HIT safety.
- Promoting a culture of HIT safety at the federal and state levels.

We also believe that vendors should be held accountable for the safety and security of their products, programs, and software since many HIT-related safety issues are the result of the technology itself, and not key-stroke or other human errors.

In a December 2012 questionnaire of AOA members on barriers to meaningful HIT adoption and use, a total of 708 osteopathic physicians responded. When asked if their EHR contributed to any patient safety or adverse events, respondents identified a range of concerns:

- Medication errors have been attributed to the systems. Some computer-generated prescriptions have the incorrect dose, strength, or form due to defaults in the system, pick lists, "canned directions," and limited editing ability on the part of the user; dose calculators can be problematic; medication/lab data is often missing and non-retrievable; and, orders are sometimes duplicated or unrecognizable.
- Pop-ups for drug allergies and adverse reactions are distracting and displayed in an awkward manner. Too many irrelevant notices may cause user overload, which results in critical interactions being missed.

- Templates result in incorrect/inaccurate data input. Due to software limitations, there is sometimes no ability to adjust orders or insert specialized information, especially related to medications. Finding the right keywords to search is also frustrating and can lead to incorrect and omitted testing.

Program Sustainability – Regulatory Landscape

According to the white paper, "multiple overlapping reporting and regulatory burdens will make it difficult for providers to stay abreast of developments and direct the majority of their time to patient care." The AOA agrees.

In a recent comment letter to the Centers for Medicare & Medicaid Services (CMS) on regulatory reform, the AOA pointed out the following burdens that need to be addressed:

Quality Improvement Initiatives - There are still inconsistencies between CMS quality reporting programs. There are multiple federal quality improvement initiatives—such as the Physician Quality Reporting System (PQRS), the Electronic Health Record (EHR) Incentive Program, and the Value-Based Payment Modifier (VBM)— that were enacted under separate laws and have resulted in overlapping documentation requirements and misaligned incentives, creating extraordinary financial and administrative burdens for physicians. Most of these programs include penalties for non- or insufficient participation. While penalties must start on a certain date as required in statute, CMS has flexibility to determine the application start date, and in many instances, has decided to base penalties on data collected a year or two before the date specified by statute. This gives physicians little time to prepare for meeting program requirements.

These programs also rely on measures that are inadequately risk-adjusted, inaccurately attributed, have little demonstrated link to improved outcomes, and lack sufficient flexibility to be meaningful to certain physicians and patients. As such, these programs create confusion and frustration among physicians, who must divert significant resources away from direct patient care to comply with mounting regulatory requirements of questionable value. Better alignment of both public and private sector programs will reduce physician confusion and encourage participation. Physicians also should be incentivized to test and adopt new clinical workflows and technologies that support high-quality, efficient patient care, rather than be penalized for sometimes arbitrary indicators of performance.

Program Integrity/Fraud and Abuse - Physicians are expected to take on a range of duties aimed at protecting the Medicare and Medicaid programs from potential fraud by other providers. Multiple program integrity contractors make it confusing for physicians to know who each one is, what they are responsible for, and what they are allowed to ask for. Some of these contractors, like the Recovery Audit Contractors (RACs), have a history of using outdated information (such as expired local coverage decisions) as the basis for audits. The RAC program continues to be extremely burdensome, prompting physicians and their staff to spend an inordinate amount of time responding to RAC requests, and even more time if an appeal is necessary. Physicians need clarity on what RACs and other program integrity contractors are allowed to use for the basis of audits in advance of the audit. To that end, we recommend that CMS require contractors to use current, published Medicare rules and regulations as the basis for program integrity audits.

Physicians also need more information and education on common billing and coding mistakes that could be corrected easily, and better guidance on how to avoid audits, which would minimize hassles for both physicians and CMS. To that end, we recommend that CMS collect and make publicly available data on common billing and coding errors. CMS should make aggregate statistics on the common coding and billing errors available on a local (MAC) level, and national level. We also recommend that CMS educate providers on these errors through its existing education channels, such as National Provider Calls, MedLearn Matters articles, and through the monthly and quarterly bulletins published by the various Part B MACs. Furthermore, we recommend the development of a dedicated website for publishing the aforementioned information, as well as an associated CMS email listserv to disseminate new information as it is posted to the website. Finally, we encourage CMS to provide technical assistance for physician practices, primarily those with a high volume of coding and billing errors, on how to avoid these errors. This could be accomplished through an expanded scope of work for Medicare's quality improvement organizations (QIOs).

ICD-10 Implementation - Many remain concerned that the one-year delay in implementing ICD-10 is insufficient. The implementation of ICD-10 will create significant burdens on the practice of medicine with no direct benefit to individual patient care, and will compete with other costly transitions associated with quality and HIT reporting programs. Implementation will require physicians and their office staff to contend with 68,000 codes - a five-fold increase from the current set of 13,000 codes. Removing regulatory burdens on physicians and ensuring that small physician practices are able to keep their doors open is critical. We encourage CMS to provide assistance to physicians leading up to and during the transition to ICD-10 in 2014.

Physician Value-Based Payment Modifier - HHS is required to apply a separate, budget-neutral payment modifier to the Medicare physician fee schedule. CMS has previously announced plans to start applying the modifier to large group practices beginning in 2015 despite earlier concerns that it is unprepared to implement such a complicated policy and needs additional time to evaluate demonstration projects. One such project is the physician resource use feedback program, which to date has demonstrated multiple serious challenges related to accurately measuring physician resource use. The AOA urges CMS to ensure that payment policies targeting quality and efficiency are carefully evaluated among a variety of practice types and patient populations to ensure the use of accurate methodologies and meaningful measures before widespread implementation. It is also critical that CMS provide physicians with clear performance feedback on a timely basis, and that the agency provides physicians with the opportunity to make improvements in care based on that feedback prior to the application of payment adjustments.

EHR System Vendors

There are challenges that need to be addressed with regard to EHR system vendors, including complexities of the systems, cost factors, lack of IT support, and system inefficiencies and incompatibility. In addition, vendors appear overwhelmed in trying to meet the EHR Incentive Program criteria. Meanwhile, practices are being forced to adapt to the system requirements instead of the system adapting to the practice's needs, which takes away from individualized patient encounters and care.

In our recent EHR questionnaire, a number of responses commented on interoperability challenges:

- "IT holds all rights to edit or construct templates which are segmented and restricted to various parts of the chart. Difficult to assure that letters are generated for referring physicians."
- "The redundancies involved with attempting to get relevant information (reports etc.) is overwhelming. Attempting to communicate with nursing through the EHR system is abysmal. They do not see the same fields as the physicians do."
- Physicians also raised concerns about bad templates, error propagation, and poor follow-up by the vendor.

Program Delay

We agree that there should be a re-examination of current procedures to safeguard and ensure meaningful use. We applaud CMS and ONC for delaying any further action concerning Stage 3 rulemaking so that existing challenges can be adequately addressed.

While we support the concept of a delay, the AOA does not believe physicians who are meeting the current requirements of the EHR Incentive program should be penalized in the process through any suspension of incentive payments. The capital and time invested to purchase and fully implement an EHR system is a huge undertaking for physicians and should not be discounted.

The formal rule-making process allows for outstanding issues to be addressed, and interoperability (including between EHR systems from the same vendor) must be addressed before physicians are assessed penalties beginning in 2015 under the EHR Incentive Programs. In an October 2012 study by the Bipartisan Policy Center entitled *Clinician Perspectives on Electronic Health Information Sharing for Transitions of Care,* more than 70 percent of clinicians surveyed identified the lack of interoperability, lack of an information infrastructure, and the cost of setting up and maintaining interfaces and exchanges as major barriers preventing clinicians from exchanging information with others.

Other items in the EHR Incentive Program that remain to be addressed include the need for standardized interfaces in areas such as labs and drug formularies. In some specialty areas (e.g., radiology), interfaces can be proprietary and expensive. As well, functionality must be included in EHR systems to assist with maintenance of problem lists, medication lists, and medication allergy lists.

It is important to note that implementation of HIT has been challenging for many physicians. While the AOA supports the adoption and advancement of HIT, we are concerned many of the goals for the EHR Incentive Program and other programs may be too ambitious for small practices. System variability can create large obstacles to interfacing with the office-based EHR system. Gathering patient information from across multiple providers and integrating that data into the office chart can pose significant difficulties for a small practice to overcome when labs, hospitals, urgent care facilities, etc., use different EHR systems. We understand there are also instances in which hospitals send huge amounts of unnecessary information to a practice's EHR system, which overwhelms both the physician and his/her system. The inability for these systems to easily communicate with each other can exponentially increase the cost and decrease the desire to invest in and use EHRs effectively. Interoperability remains a major challenge and barrier to implementing EHR systems.

Conclusion

The osteopathic medical profession will continue to be engaged and provide constructive feedback to the Administration and to Congress toward our shared goal of improving the health care delivery system. Given these ongoing challenges, the AOA has established an EHR Super User Network comprised of osteopathic physicians and staff. The purpose of the Super User Network is to create a conduit between AOA members and CMS, as well as ONC, in an effort to address the challenges physician practices face in adopting and transitioning to an EHR System. Areas of collaboration include collecting data on physician experiences, creating flexibility in the EHR incentive program structure, and addressing challenges related to interoperability and usability.

The Network has raised concerns about the fast pace of the EHR Incentive Program's forward movement without any collection or examination of physicians' experiences with Stages 1 and 2 of meaningful use to date. The Network recommended to CMS that the program rely more heavily on menu options rather than core measures so that physicians have the flexibility to choose metrics that are most relevant to their practice and patient population. The Network hopes to provide CMS further feedback on challenges with specific measures.

The AOA also looks forward to inviting CMS to a webinar for AOA members on the EHR Incentive Program, and providing educational material for distribution through our web site and various publications. As well, the Network plans to provide input to CMS and ONC to help "plug the holes" in any educational material and toolkits offered by the agency.

The AOA and our members appreciate your attention to this issue, and for the opportunity to share these thoughts, views, and recommendations.

Sincerely,

Ray E. Stowers, DO
President