American Society of Anesthesiologists®

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May 16, 2013

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

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

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

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

The Honorable Mike Enzi
379A Russell Senate Office Building
Washington, DC 20510

The Honorable Pat Roberts
109 Hart Senate Office Building
Washington, DC 20510-1605

Dear Senators:

On behalf of the over 50,000 members of the American Society of Anesthesiologists, I appreciate the opportunity to comment on "REBOOT: Re-examining the Strategies Needed to Successfully Adopt Health IT." ASA believes that electronic health records have the ability to improve patient care, especially in the perioperative setting. However, more needs to be done to improve the Medicare and Medicaid Electronic Health Records (EHR) Incentive Program and the white paper highlights some very important issues related to implementation.

We agree that "interoperability is the key to achieving efficiency in care with health IT; however, interoperability has to date proven difficult to establish." We believe that, for surgical care, the ability to share meaningful data and improve interoperability relies on criteria that are relevant to anesthesiologists. Anesthesiologists continue to face meaningful use criteria that are inapplicable to our practice. As of April 2, 2013, only 1,451 eligible professionals with the specialty designation of anesthesiology have attested to meaningful use.[1]

The Centers for Medicare and Medicaid Services (CMS) created an important hardship exemption for anesthesiologists that we believe must be maintained. **However, additional modifications to the meaningful use criteria are needed to ensure that anesthesiologists can reasonably achieve meaningful use and share meaningful data**. **In addition to the hardship exemption for anesthesiologists, Congress should consider exempting anesthesiologists from burdensome criteria that are inapplicable to the field of anesthesiology.**

[1] Centers for Medicare & Medicaid Services "CMS Medicare and Medicaid EHR Incentive Program, electronic health record products used for attestation" http://www.healthit.gov/sites/default/files/mu_report.xlsx. April 2, 2013.

To that end, ASA strongly supports Representative Diane Black's legislation, the Electronic Health Records Improvement Act (H.R. 1331). This legislation would exempt anesthesiologists from criteria that are inapplicable to the unique hyper-acute operating room setting. For example, the measures of 1) providing clinical summaries to patients, 2) providing patients with an electronic copy of their health information and 3) implementing drug to drug and drug to allergy interaction checks do not apply to electronic health record or care process of anesthesiologists. First, patients do not typically request a copy of their anesthesia EHR in isolation, so clinical summaries and electronic copy of the health information is obtained through the hospital or surgery center, not the anesthesiologist. Next, an anesthesiologist is both ordering and personally administering a drug in response to dynamic and rapidly changing patient conditions. The drug-drug and drug-allergy checking measures are designed for the outpatient setting, where hours or days may pass between a prescription and a medication administration. In the operating room, patient care comes first and charting often takes place post administration, negating the value of the checks mandated under current meaningful use rules. Until such time that technology is widely available to perform these checks without impairing timely care of patients under anesthesia, this objective only adds an additional regulatory burden without demonstrable benefit. We do note that the drug-drug and drug-allergy objectives were designed under the assumption that the ordering physician is not the same person as the professional who administers the drug. Under these circumstances, the objective does have value for many physicians, just not for anesthesiologists.

Anesthesiologists are members of a team of professionals who care for patients in a complex, high-risk environment. Successful, high quality peri-procedural care requires excellent collaboration and communication between surgeon, anesthesiologist, patient, nurses and other members of the team. Patient condition and the nature of the surgical intervention drive anesthetic and surgical outcomes. This foundation must be understood in order for electronic health records to be used in a way that is meaningful to anesthesiologists and other members of the surgical team.

Specifically for anesthesiologists, EHR systems must support data integration and synthesis necessary for development of an anesthetic plan, track intraoperative hemodynamic and other patient data, record anesthetic interventions, support evidence-informed practices, augment early recognition of potential adverse events, offer decision support where relevant, summarize relevant data at the end of the anesthetic for others who will care for the patient, and do all of this in a manner that neither interrupts nor distracts from patient care.

Again, we appreciate the opportunity to comment on "REBOOT: Re-examining the Strategies Needed to Successfully Adopt Health IT." If you have any questions please feel free to contact Grant Couch (g.couch@asawash.org), Federal Affairs Associate at (202) 289-2222.

Sincerely,

John M. Zerwas, M.D.
President
American Society of Anesthesiologists