May 5, 2011

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National Coordinator of Health Information Technology
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Dr. Mostashari:

Thank you for the opportunity to comment on the Federal Health Information Technology Strategic Plan. The American Osteopathic Association (AOA), which represents more than 70,000 osteopathic physicians (DOs) nationwide, and the American Association of Colleges of Osteopathic Medicine (AACOM), which represents the administrations, faculty, and students of the nation's 26 colleges of osteopathic medicine and four branch campuses that offer the doctor of osteopathic medicine degree, support the adoption of health information technology.

The AOA and AACOM support 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.

The AOA and AACOM also recognize that making the decision to go forward with an EHR system requires a considerable amount of time for a physician's practice. The adoption, implementation, and upgrading on an EHR system is a major and costly undertaking. Success depends on a multitude of factors, including decisions on system, evaluation, selection, contracting, configuration, implementation, training, management, and oversight.

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 electronic health records and the impact those challenges will have on patient care. Adoption of HIT should not create an additional burden for physicians and practices.

Osteopathic physicians fill a critical need by practicing in rural and underserved areas. A majority of DOs have small practices specializing in primary care areas of family practice, internal medicine, obstetrics and gynecology, and pediatrics. The biggest stumbling block to EHR implementation for many of our physician group practices is financing. In 2007, a study that was prepared for the AOA by the Medical Group Management Association Center for Research found that the primary barrier to EHR implementation was lack of capital resources to invest in an EHR system. Without the initial capital to purchase certified EHRs, many physicians in solo and smaller practices are unable to invest in HIT and will not be able to benefit from financial incentives offered under EHR incentive programs. The AOA and AACOM support federal legislation that would provide funds for loans and grants to be used to assist physicians and institutions of medical education with upfront purchase and implementation costs of HIT.

As future federal HIT requirements are put forth, consideration needs to be given to the issue that physician practices cannot continually take on additional unfunded mandated requirements. In addition to the upfront costs of implementation of an HIT system, ongoing costs are incurred by physician practices to implement HIT. Physician practices are being required to make large financial investments in EHR systems and forced to reduce their patient workload during HIT implementation. This comes at a time as the nation faces an uncertain federal and state political and fiscal climate, a physician shortage, a flawed Sustainable Growth Rate formula, and unstable economy.

Goal I

Strategy I.A.2: Provide implementation support to health care providers to help them adopt, implement, and use certified EHR technology.
The AOA and AACOM commend and support efforts to help practices adopt EHR technology. The success of EHR adoption and implementation hinges on a sound infrastructure and interoperability that involves many players outside the physicians' practice. Any lack of readiness or lack of adequate technical support creates significant problems and financial strains on the physicians practice.

Strategy I.A.6: Communicate the value of EHRs and the benefits of achieving meaningful use.
In the draft plan, HHS states they will conduct an outreach effort to providers and that primary care providers will be a primary audience for this strategy. The osteopathic professions have taken an active role in educating our membership on HIT and will continue to do so. Outreach to the physician community should include issuance of FAQs, MLN Matters Articles, a toll-free hotline, open door forums, and town hall meetings for the physician community.

Strategy I.A.7: Align federal programs and services with the adoption and meaningful use of certified EHR technology.
It is important to note that meaningful use requirements are not the only regulatory requirements that physicians and other health professionals will be required to meet in future years. Other mandated requirements such as HIPAA Electronic Transaction Version 5010 and ICD-10 coding will occur within the next few years as well. In order for health professionals to achieve the goals under meaningful use, meaningful use criteria must be compatible and in alignment with other forthcoming mandated requirements.

Strategy I.A.8: Work with private sector payers and provider groups to encourage providers to achieve meaningful use.
E HR adoption would be greatly enhanced if third party payers also provided their own, ongoing financial incentives to meaningful users. Many physicians are still concerned with the long-term, ongoing costs of maintaining an EMR system after the ARRA incentives have paid for the original implementation. Permanent, recurrent bonuses would help offset the ongoing costs associated with an EHR. Since the providers would be using the EHR in a meaningful way, the third party payers benefit from the decreased hospitalizations, and increased efficiency of care that HIT provides.

Strategy I.A.9: Encourage and facilitate improved usability of EHR technology.
Strategy I.B.3: Ensure that health information exchange takes place across individual exchange models, and advance health systems and data interoperability.
In order to have a truly universal EHR system across the nation, strong, comprehensive standards of EHR design and architecture must be established ASAP to allow seamless interfacing and integration of different

EHR's with each other. Vendors have built proprietary systems that do not interface with other systems. The current proprietary nature of the industry (sometimes even among different products of the same vendor) is a major deterrent in EHR adoption. EHR vendors promise compatibility with a physician's hospital's system, but then charge large interface fees.

Strategy I.B.2: Monitor health information exchange options and fill the gaps for providers that do not have viable options.
CMS acknowledged in the final rule for Stage 1 meaningful use that "many areas of the country currently lack the infrastructure to support the electronic exchange of information". In addition, in previous testimony to ONC, several individuals indicated they don't have the ability to exchange information in their area. Health information exchange capability needs to include physicians in a wide variety of practice settings, including physicians in small and rural practices. We understand that the FCC's Rural Healthcare Program, the USDA's Broadband Technologies Opportunities Program (BTOP) and the Department of Commerce's Broadband Initiatives Program (BIP) stand to greatly "even the playing field" for rural physicians who may be inclined to adopt EHR's but cannot because of the unavailability or excessive cost of broadband internet access required to demonstrate meaningful use.

Strategy I.C.1: Ensure public health agencies are able to receive and share information with providers using certified E HR technology.
While we understand the importance of this strategy, we urge ONC to consider current capabilities of health information exchange before finalizing requirements in this area. We understand that many public health departments do not currently have the capability for bi-directional health information exchange, which greatly impacts capability to send and receive information from EHRs.

Goal II

Strategy II.A.1: Identify and implement best practices that use EHRs and other health IT to improve care, efficiency, and population health.
While the AOA and AACOM support the use of tools that can help physicians at the point of care, we caution that the EHR tools should not interfere with the physician's clinical judgment and decision making. The development and implementation of health information technology should enhance, not hinder the physician-patient relationship. Furthermore, in order to enhance physicians' competency in EHR usability, we strongly support the integration of E HR training in the early stages of medical education. In addition, EHRs help establish a culture of continuity of quality care and enhances the continued process of learning among young physicians.

Strategy II.A.2: Create administrative efficiencies to reduce cost and burden for providers, payers, and government health programs.
The Strategic plan cites regulations that are aimed at simplifying the administrative processes, such as transitioning to ICD-10 and streamlining enrollment processes. The AOA and AACOM are concerned that efforts to date have not alleviated the administrative burdens on physician practices. The burdens have been exacerbated by unfunded federal mandates which created numerous implementation challenges within the federal agencies. In addition, transitioning to new systems is a costly endeavor for physician practices which

they cannot afford. For example, during the E HR adoption process, physician practices often decrease their patient workload by up to 25% for a period of three to four months, which is followed by at least six months of unplanned decreased productivity. We have seen little evidence so far that would indicate a reduction in cost and burden on the physician's practice.

Strategy II.B.2: Establish standards, specifications, and certification criteria for collecting and reporting measures through certified E HR technology.

HHS states in this strategy that they "will establish standards, specifications, and certification criteria for E HRs that facilitates the collection and reporting of e-measures". We are supportive of this approach. As additional measures are considered, those measures that have electronic specifications should be given first consideration. It is extremely difficult for providers, particularly those in smaller practices, to complete the necessary calculations for measures that have not been electronically specified. The AOA and AACOM believe that all physician quality measures should be developed by physicians and physician organizations. We strongly support the Physician Consortium for Performance Improvement (PCPI) as the principle organization in the development of physician quality measures.

Goal IV

Strategy IV.A.1: Listen to individuals and implement health IT policies and programs to meet their interests.

Strategy IV.A.2: Communicate with individuals openly and spread messages through existing communication networks and dialogues.

It would be greatly advantageous to ask the general public what their concerns and needs are with HIT; as this would greatly enhance their acceptance of EMR's in their health care and may also help encourage their providers to adopt EMR's.

Strategy IV.B.1: Through Medicare and Medicaid EHR Incentive Programs, encourage providers to give patients access to their information in an electronic format.

The strategic plan cites that there has been little financial incentive for providers to proactively share a copy of the medical record with the patient or to minimize the burden for the patient to obtain a copy. The challenges to sharing medical records go beyond financial incentives. Physicians need time to review patient information before releasing it to the patient. In addition, HIPAA stipulates the grounds on which a physician may deny access to that information. The AOA and AACOM are concerned that patients may pressure physicians to alter the medical record because the patient may not agree with the physician's judgment or assessment. Also electronic copies of health information include diagnostic test results, problem list, medication lists, allergies, etc. The E HR can have so many pieces of data that transferring every data element can create a large document. What constitutes electronic copies of health information needs to be clarified. While the AOA and AACOM believe patients have a right to access their medical records, we also believe physicians and patients are in the best position to decide what type of summary would be most useful to the patient.

Strategy IV.C.1: Support the development of standards and tools that make EHR technology capable of interacting with consumer health IT and build these requirements for the use of standards and tools into EHR certification.
Strategy IV.C.2: Solicit and integrate patient-generated health information into EHRs and quality measurements.
Strategy IV.C.3: Encourage the use of consumer health IT to move toward patient-centered care.
If consumer health IT sources of medical information such as digital glucometers / blood pressure machines / personal health records could provide structured data that certified EMR's could capture and store in patients' health records, there would be a synergistic effect on the ability of HIT to have a positive impact on the management of chronic diseases and decrease morbidity/mortality.

Sincerely,

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