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February 6, 2015

Karen DeSalvo, MD, MPH, MSc

National Coordinator

Office of the National Coordinator for Health IT/Office of the Secretary

Department of Health and Human Services

RE: Federal Health Information Technology (IT) Strategic Plan 2015-2020

Dr. DeSalvo,

On behalf of the over 79,000 members of American College of Surgeons (ACS), I am writing in response to the *Federal Health IT Strategic Plan (2015-2020)*. The ACS is a scientific and educational association of surgeons, founded in 1913, to improve the quality of care for the surgical patient by setting high standards for surgical education and practice.

The *Federal Health IT Strategic Plan* considers feedback from more than 35 federal agencies, offices and partners with an interest in furthering the use of health IT to improve health, health outcomes, and potentially reduce healthcare spending, through streamlined information exchange among relevant stakeholders. Our comments and concerns specific to the identified goals of collecting, sharing and using health IT, along with potential solutions, are discussed below.

Federal Health IT Goals

Expand Adoption of Health IT

With regard to expanding the adoption of health IT, the ACS believes that several changes need to be made specifically to the EHR Incentive Program in order to better enable this goal. For example, EHR technology vendors have had difficulty creating interoperable products and modules tailored for use by surgeons. This has made participation in the program particularly challenging for surgeons. Since the EHR Incentive Program has now moved to a penalty-only phase, we would strongly encourage the Office of the National Coordinator (ONC) for Health IT (and other involved federal government agencies), to work with Congress to continue access to EHR Meaningful Use (MU) bonus payments for those eligible professionals achieving MU for the first time. If it is not possible to make this change, we believe that efforts should be made to provide necessary hardship exceptions to help practices avoid penalties when they are unable to adopt health IT due to technical reasons.

Also, the goal of expanding the adoption of health IT should include an objective that aims to revise the MU program such that it provides more flexibility for specialists. An emphasis should be placed on having eligible professionals report on menu requirements instead core requirements so that providers, particularly in the surgical specialties, can use health IT products in a way that is meaningful to their patients and practices. Additionally, the program should be re-evaluated to eliminate measures

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requiring patient action. We have heard anecdotally from our members about the difficulty of engaging patients to access patient portals due to reasons beyond their control.

Surgeons have also raised concerns about the usability of current EHR products, and the impact of usability on patient safety and quality. As part of the EHR certification criteria, ONC should mandate vendor adherence to usability standards. In addition, accredited testing bodies should conduct human factors usability testing in a multitude of healthcare situations and clinical scenarios, including a variety of surgical environments.

Moreover, the ACS suggests that CMS update the Quality Assessment and Performance Improvement (QAPI) Conditions of Participation to require hospitals and other facilities to include their medical staffs in health IT purchasing decisions and implementation processes, establish a process that would facilitate reporting of patient safety issues associated with EHR use and respond to medical staff concerns about patient safety and other health IT issues during and after implementation, in a timely fashion.

Advance Secure and Interoperable Health Information

EHR vendors have shared that they face financial pressures and only expend resources on software upgrades and program modifications when there is a strong business case. Since the inception of the EHR Incentive Program, the business case has been almost directly linked to the MU and certification criterion. Provider and consumer demand are simply not enough to drive interoperability. With that in mind, ONC and its federal partners must do significantly more to achieve its interoperability goals. In fact, this may be one of the few instances where negotiated rulemaking would be an appropriate course of action. We urge ONC to consider multiple avenues that will bring meaningful health information exchange to patients and providers.

Given the above, we believe that objective 2B “identify, prioritize, and advance technical standards to support secure and interoperable health information” is an essential first-step to achieving objective 2A “enable individuals, providers, and public health entities to securely send, receive, find, and use electronic health information,” and urge ONC to reverse their order.

Furthermore, the ACS recommends an additional objective to be added to this goal: facilitate secure interoperable data exchange for clinical platforms, data registries, and applications.

Strengthen Health Care Delivery

The number of vendors that use telecommunication tools to facilitate patient access to health care services is growing at a rapid pace. These vendors offer a wide range of services to consumers at various prices. Given the variation in services, it begs the

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question: how is telemedicine/telehealth defined? Is telemedicine limited to instances where a provider communicates with a patient using both audio and video communication tools? Or can they simply communicate via email/chat room or by phone? Federal agencies, including the Centers for Medicare and Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ), have generally defined telehealth as two-way, real-time audio-visual communication. However, in thinking about the rapid growth and wide-range of services offered as “telehealth” and their expanding availability to patients in other non-federal health programs, including health insurance exchange plans, it would be helpful to have a more concrete federal definition as to what constitutes telehealth. This is particularly important as we look to appropriately price these services in federal and other health programs. We urge ONC to work with the medical community to define telehealth/telemedicine.

We also support action to facilitate the development and use of telecommunications technology and services. ONC should make the availability of telecommunications technologies a requirement of its certification criteria, which would ensure these tools are available to providers participating in the EHR Incentive Program. We also urge ONC to collaborate with CMS’ Innovation Center to encourage telemedicine demonstrations in specialty areas, such as surgery and surgical subspecialties.

Finally, with regard to the third strategy under objective 3B, ACS agrees that the capacity of electronic information sources to support providers’ ability to accurately and efficiently report and receive health care quality measures should be improved, but we encourage ONC to further develop this strategy by adding that this should be done in real time.

Advance the Health and Well-Being of Individuals and Communities

ACS believes that objective 4A, “empowering individual, family, and caregiver health management and engagement” is unquestionably the role of primary care physicians. The role of the surgical specialist is less clearly defined and focuses more on shared decision making in surgery. As such, ACS feels that there should be more efforts made towards empowering patients and families in surgical care management.

Advance Research, Scientific Knowledge, and Innovation

The ACS believes that the current data ecosystem is highly controlled by EHR vendors. ONC and government agencies should assist in removing barriers vendors create on data standards and clinical cohorts which are important for leveraging HIT for better and more affordable care. To be truly efficient, ACS thinks that data ecosystem should be broadly governed by multiple stakeholders including government, patients, providers, and payers. Additionally, the ACS recommends that there be an ongoing assessment of health IT use and its impact on quality and outcomes.

We appreciate the opportunity to comment on the *Federal Health IT Strategic Plan (2015-2020)*. The ACS looks forward to continuing dialogue on these important

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issues. If you have any questions about our comments, please contact Jill Sage, Quality Affairs Manager in the Division of Advocacy and Health Policy for questions. She may be reached at jsage@facs.org or at (202) 672-1507.

Sincerely,

David B. Hoyt, MD FACS
Executive Director

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