American Society of Anesthesiologists

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January 14, 2013

MacKenzie Robertson
Office of the National Coordinator
Patriots Plaza III
355 E Street, S.W.
Washington, DC 20201

Dear Ms. Robertson:

On behalf of the over 48,000 members of the American Society of Anesthesiologists (ASA), we appreciate the opportunity to comment on the Health Information Technology (Health IT) Policy Committee's request for comments regarding the Stage 3 Definition of Meaningful Use of Electronic Health Records (EHRs). ASA continues to believe that electronic health records (EHRs) have the capability to improve patient care, particularly in the perioperative setting. However, modifications are needed to ensure that anesthesiologists can reasonably achieve meaningful use.

Anesthesiologists Hardship Exemption

As you may know, anesthesiologists face barriers to demonstrating meaningful use. The Centers for Medicare and Medicaid Services (CMS) acknowledged this fact, when they created a hardship exemption for anesthesiologists in the EHR Incentive Program Stage 2 Final Rule (CMS –0044-F). CMS stated, "we agree with commenters that the specialties of anesthesiology, radiology, and pathology lack face-to-face interactions and need to follow up with patients with sufficient frequency to warrant granting an exception to each EP with one of these primary specialties. We note that anesthesiologists do interact with patients, but not in a manner that is conducive to collecting the information needed for many aspects of meaningful use" (CMS 0044-F). ASA strongly supports this hardship exemption. While this hardship exemption may be beyond the scope of the Health IT Policy Committee's Stage 3 proposal, **we would like to take the opportunity to reiterate to the Committee, CMS and the Office of the National Coordinator (ONC) that this hardship exemption for anesthesiologists and other hospital-based professionals must be maintained through Stage 3 and beyond.**

Current Exclusions from Criteria

Much of the criteria to demonstrate meaningful use do not apply to anesthesiologists. As it relates to the Stage 3 Proposal, there are a number of exclusions proposed. ASA supports the Health IT Policy Committee's proposal to exclude specialists from prevention reminders (SGRP 116). In addition, ASA supports excluding eligible professionals who do not administer immunizations from the immunization objectives (SGRP 401A and SGRP 401B).

Prevention reminders may be applicable to primary care; however they are inapplicable to most specialists, including anesthesiologists. We appreciate that the Health IT Policy Committee is considering an exclusion for specialists from prevention reminders. Additionally, documenting immunizations is not part of an anesthesia service, and we appreciate that if a physician administers no immunizations they would be excluded from this objective. **ASA requests that the exclusion from prevention reminders and immunizations be maintained in Stage 3 and beyond.** However, to ensure that the EHR Incentive Program works for anesthesiologists and their patients, we believe additional exclusions are warranted.

Additional Exclusions to Consider

The Health IT Policy Committee should consider excluding anesthesiologists from the following objectives including: providing clinical summaries to patients (SGRP 205), syndromic surveillance, certification criteria (SGRP 403), e-communication with patients (SGRP 207), and computerized order entry for transfers of care (SGRP 130).

The objective to provide clinical summaries to patients (SGRP 205) is inapplicable to anesthesiologists because the clinical summary is handled through report generation from the primary procedure. Clinical summaries for the diagnostic and therapeutic procedure include relevant anesthesia material when appropriate. Separate reporting of clinical summaries for anesthesia care is burdensome, possibly confusing to the patient and does not improve quality of care.

As it relates to the syndromic surveillance objective (SGRP 403), we recommend that anesthesiologists be exempt from this objective, since it is currently for communicable diseases. Despite the anesthesiologists experience with syndromic surveillance of the fungal meningitis outbreak, that was not (and will not be) detected by the current syndromic surveillance objective.

Anesthesiologists should also be excluded from the e-communication objective (SGRP 207). While there may be rare circumstances where an anesthesiologist would electronically communicate with their patients, it is generally inapplicable to their practice.

The computerized order entry for transfers of care objective (SGRP 130) should provide an exception for emergent requests for services. For example, in cases of emergency airway consults or emergency dialysis the physician may not have the time to enter the data into the computer. An exception may be needed in these and other emergency cases, so as not to impede workflow.

SGRP 204B

We believe the menu objective to provide 10% of patients with the ability to submit patient-generated health information should be delayed until there is a consistent way to verify the data being submitted by the patient. **Should this objective not be delayed and included in Stage 3, it should remain a menu objective as proposed by the Health IT Policy Committee.**

SGRP 405

We support SGRP 405 as a menu objective. Multi-center registries of anesthesia care are now available to all anesthesiologists in the United States, enabling participants to compare their own outcomes to national and peer group benchmarks. ASA believes that participation in such a registry is an important component of ongoing quality improvement in anesthesiology. Additionally, we would recommend that physicians be allowed to use this as a core objective if they were unable to meet a core objective due to workflow or other issues beyond their control.

Retired Objectives

The Health IT Policy Committee is proposing to retire several objectives in Stage 3. We support the proposals to retire these objectives. **As it relates to the vital signs objective (SGRP 108), we support retiring this objective.** However, if this objective is to be maintained it should not require anesthesiologists to plot and display pediatric growth charts. Alternatively, if this objective is maintained, instead of requiring anesthesiologists to plot and display growth charts, the Health IT Policy Committee could consider encouraging anesthesiologists to record a pain score as a vital sign. The Department of Veterans Affairs provides a toolkit for recording pain as a vital sign. [1]

#MU01

In addition, the Health IT Policy Committee in question #MU01 asks if there should be "flexibility in achieving a close percentage of the objectives, but not quite achieving all of them? What is the downside of providing this additional flexibility? How will it impact providers who are achieving all of the MU criteria? If there is additional flexibility of this type, what are the

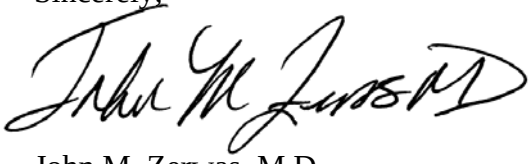
[1] Veterans Health Administration, Department of Veterans Affairs. *Pain as the 5th Vital Sign Toolkit*. 2000: http://www.va.gov/PAINMANAGEMENT/docs/TOOLKIT.pdf

ways this can be constructed so that it is not harmful to the goals of the program and advantageous to others?" **We believe that there should be additional flexibility for eligible professionals who achieve a close percentage of the objectives.** Currently, there are many core objectives that are inapplicable to anesthesiologists. We believe this "close percentage" should be low enough to ensure that anesthesiologists would not have to report on objectives that are inapplicable to their practice.

We do not believe this additional flexibility would negatively impact physicians who are already achieving meaningful use. The EHR Incentive Program is structured so that physicians would receive the same incentive regardless of whether other physicians are participating. In fact, it may even be beneficial for the physicians that are already demonstrating meaningful use. Many physicians are not attempting to become meaningful users because they do not believe they would be able to meet all the objectives, even if they made an attempt. Allowing physicians to become meaningful users if they achieve a close percentage of the objectives would improve interoperability because more physicians would be encouraged to adopt certified health information technology.

Again, we greatly appreciate your consideration of our comments. If you have any questions, please do not hesitate to contact Grant Couch, Federal Affairs Associate at (202) 289-2222 or by email at g.couch@asawash.org.

Sincerely,



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