American Society of Anesthesiologists®

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April 22, 2013

Farzad Mostashari, MD, ScM
National Coordinator for Health Information Technology
Department of Health and Human Services
Office of the National Coordinator for Health Information Technology
Hubert H. Humphrey Building, Suite 729D
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-0038-NC Advancing Interoperability and Health Information Exchange

Dear Dr. Mostashari:

On behalf of the over 50,000 members of the American Society of Anesthesiologists (ASA), we appreciate the opportunity to comment on CMS-0038-NC Advancing Interoperability and Health Information Exchange that was published in the Federal Register on March 7, 2013. ASA continues to believe that electronic health records (EHRs) have the capability to improve patient care, particularly in the perioperative setting.

General Comments

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. **We would like to take the opportunity to reiterate to CMS and the Office of the National Coordinator (ONC) for Health Information Technology that this hardship exemption for anesthesiologists and other hospital-based professionals must be maintained through Stage 3 and beyond.**

Question for Public Comment

Which of the following programs are having the greatest impact on encouraging electronic health information exchange: Hospital readmission payment adjustments, value-based purchasing, bundled payments, ACOs, Medicare Advantage, Medicare and Medicaid EHR Incentive Programs (Meaningful Use), or medical/health homes? Are there any aspects of the design or implementation of these programs that are limiting their potential impact on

encouraging care coordination and quality improvement across settings of care and among organizations that are market competitors?

ASA understands the importance of interoperability and agree with ONC and CMS that "gaps and challenges still remain to wide-spread use of interoperable systems and HIE across providers, settings of care, consumers and patients, and payers." We do not believe that the Medicare and Medicaid EHR Incentive Programs have sufficiently encouraged electronic health information exchange. Similarly, we do not believe readmissions, value based purchasing, accountable care organizations or medical homes have encouraged electronic health information exchange among our specialty. As of April 2, 2013, only 1,451 anesthesiologists have attested to meaningful use.[1]

Anesthesiologists continue to face meaningful use criteria that are inapplicable to their practice. **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, CMS and ONC should consider exempting anesthesiologists from burdensome criteria that are inapplicable to the field of anesthesiology.**

For example, in addition to the broad exemption for anesthesiologists, CMS and ONC should consider specifically exempting anesthesiologists from criteria such as providing clinical summaries to patients and providing patients with an electronic copy of their health information. Additionally, anesthesiologists should be exempt from implementing drug to drug and drug to allergy interaction checks. Typically, an anesthesiologist is both ordering and personally administering a drug in response to dynamic and rapidly changing patient conditions. 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's must support data integration and synthesis necessary for development of an anesthetic plan, track intraoperative hemodynamic and other patient data,

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[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.

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 does not interrupt or distract from patient care.

We believe that the ability to share meaningful data and improve interoperability relies on criteria that are relevant to anesthesiologists and we look forward to working with you to that end. Again, we greatly appreciate the opportunity to comment on this Request for Information. 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