

Position Statement

Health Information Technology (Health IT)

This Position Statement was developed as an educational tool based on the opinion of the authors. It is not a product of a systematic review. Readers are encouraged to consider the information presented and reach their own conclusions.

Overview and History

The health information technology (health IT) landscape has changed considerably over the last decade. In 2011, the Centers for Medicare and Medicaid Services (CMS) began paying out the first “Meaningful Use” incentive payments for physicians to adopt and use electronic health record (EHR) technology, as required by the passage of the Health Information Technology for Economic and Clinical Health (HITECH) Act in February, 2009. Since that time, adoption of EHR technology has been pervasive. The Office of the National Coordinator for Health Information Technology (ONC), reported a 57% adoption rate in 2011, compared to an 85.9% adoption rate in 2017, by office-based physicians.¹ Adoption is even higher among acute care hospitals.²

With widespread EHR adoption, efforts have shifted towards interoperability, the access, use and exchange of electronic health information, and efforts to prevent “information blocking” of a patient’s electronic health information across disparate health care settings. Still, significant efficiencies are needed for many existing EHR technologies. A study found that for every hour of direct clinical time with patients, physicians spent *two additional hours* on EHR and desk work, and an additional one to two hours of after-hours personal time completing documentation and EHR tasks.³ Some of the aims of the “Meaningful Use” program in adopting EHR technology was to modernize medical practices, streamline administrative activities and improve care coordination. As the health care landscape moves toward interoperability, efforts to improve EHR usability and the user experience should remain a top priority. Interoperability is only as successful as the health IT systems that underlie the ability for electronic health information to be effectively utilized at the point of care.

The AAOS believes in the following principles with respect to health IT:

- 1. Health IT should reduce administrative burden for health care providers and increase the amount of time spent interacting with patients and providing patient care.**
- 2. Health IT should strengthen the patient-doctor relationship through enhanced care coordination, improved quality of care, greater patient engagement, and shared decision-making.**

¹ Office of the National Coordinator for Health Information Technology. 'Office-based Physician Electronic Health Record Adoption,' Health IT Quick-Stat #50. dashboard.healthit.gov/quickstats/pages/physician-ehr-adoption-trends.php. January 2019.

² Office of the National Coordinator for Health Information Technology. 'Non-federal Acute Care Hospital Electronic Health Record Adoption,' Health IT Quick-Stat #47. dashboard.healthit.gov/quickstats/pages/FIG-Hospital-EHR-Adoption.php. September 2017.

³ Hingle S. Electronic Health Records: An Unfulfilled Promise and a Call to Action. *Ann Intern Med.* 2016;165:818–819. [Epub ahead of print 6 September 2016]. doi: 10.7326/M16-1757

3. **Health IT vendors should consider specific practice workflows and health care provider needs in developing, implementing and maintaining EHR systems.**
4. **Recognition should be given to the cost burden of adopting or changing EHRs, particularly with respect to health care providers in solo or small group practice, and for health care providers in rural areas.**
5. **A comprehensive set of certification standards, including data and interoperability standards for all EHR systems is important to ensure necessary access, use, and exchange of electronic health information.**
6. **In addition to ensuring that interoperability achieves access, use and exchange of information, it should also guarantee that the information is secure, useful and valuable to both patients and health care providers.**

Digital Health Technologies and Telehealth

As the health IT landscape continues to evolve, so do the technologies that are used to increasingly interact with these systems, and with one another. The Food and Drug Administration's (FDA's) Digital Health Program is focused on regulating this new space of products and devices and has classified these digital health technologies in the following categories: Software as a Medical Device (SaMD), Advanced Analytics, Artificial Intelligence, Cloud, Cybersecurity, Interoperability, Medical Device Data System (MDDS), Mobile Medical App (MMA), Wireless, and Novel Digital Health.⁴ Additional clarification, guidance and regulation of these emerging technologies is needed.

The AAOS believes in the following principles with respect to digital health technologies:

1. **Digital health technologies and decision support tools should follow evidence-based clinical practice guidelines, whenever possible, to safeguard patient safety.**
2. **Digital health technologies should enable care coordination and empower patients to be active participants in their care.**
3. **Regulatory agencies should solicit input from health care providers when developing new guidance on digital health technologies.**

Telehealth is another technology that enables providers to communicate remotely with patients and provide clinical consultation, care and recommendations to improve a patient's health outcomes. In essence, this includes any interaction with a patient not in-person, such as secure messaging, phone calls, and video conferencing, among other novel and emerging forms of communication. The Balanced Budget Act of 1997 (BBA) authorized, for the first time, separate Medicare Fee for Service (FFS) payment for telehealth, starting in 1999⁵ and the Bipartisan Budget Act of

⁴ U.S. Food and Drug Administration. Digital Health, *Why Is the FDA Focusing on Digital Health*. Updated Sep. 27, 2019. Accessed at: <https://www.fda.gov/medical-devices/digital-health>

⁵ Kasich J. H.R.2015 - 105th Congress (1997-1998): Balanced Budget Act of 1997. Aug. 5, 1997. Accessed at: <https://www.congress.gov/bill/105th-congress/house-bill/2015>.

2018 further expanded telehealth services across the Medicare program.⁶ These changes are important as telehealth services continue to increase. A recent report found that utilization of telehealth grew 53% from 2016 to 2017, more than any other location of service.⁷

The AAOS believes in the following principles with respect to telehealth:

- 1. Telehealth services should receive comprehensive and robust reimbursement rates to ensure patients can receive timely care where they live, when care is needed, in the setting of the patients choice.**
- 2. Telehealth services should be reimbursed at the same allowable rates as face-to-face visits. Distant health care services should be decided by patient choice and guided by the patient-doctor relationship.**
- 3. Provision of telehealth services should be based on clinical decision making and left to the discretion of the patient-doctor relationship.**
- 4. Health care providers should be the final arbiter of the need and appropriateness of telehealth services with respect to their patients.**

⁶ Larson J. H.R. 1892 – 115th Congress (2017-2018): Bipartisan Budget Act of 2018. Feb. 9, 2018. Accessed at: <https://www.congress.gov/bill/115th-congress/house-bill/1892>

⁷ FairHealth. FH Healthcare Indicators® and FH Medical Price Index® 2019, An Annual View of Place of Service Trends and Medical Pricing. A FAIR Health White Paper, April 2019. Accessed at: <https://s3.amazonaws.com/media2.fairhealth.org/whitepaper/asset/FH%20Healthcare%20Indicators%20and%20FH%20Medical%20Price%20Index%202019%20-%20A%20FAIR%20Health%20White%20Paper.pdf>