AAOS American Academy of Orthopaedic Surgeons
American Association of Orthopaedic Surgeons

Position Statement

Electronic Health Records (EHRs)

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.

Access to and correct usage of patient Electronic Health Records (EHRs)/Electronic Medical Records (EMRs) provide major benefits to patients and physicians alike. When properly designed and utilized, Electronic Health Records can improve patient safety, increase clinical efficiency, reduce costs,[1] allow seamless transfer of vital patient information,[2] and allow physicians to better use their time and expertise treating patients.

The AAOS believes:

1. ***Health Information Technology (HIT) should strive to improve quality care, and not detract time and attention from the care of patients.***
2. ***An electronic medical record in a physician's office offers great potential to be beneficial for patient care, patient safety, quality care, and measurement of outcomes.***

The American Academy of Orthopaedic Surgeons (AAOS) encourages all members to adopt Electronic Health Records that are affordable, well designed, and widely available. The AAOS strongly supports the development of interoperability standards for all EHRs. The AAOS also supports the development of appropriate standards for meaningful use of electronic health records by Government agencies and private carriers which balance the needs of patients and their families, physicians and their staffs, and regulators. Finally, the AAOS believes these standards should be collaboratively developed by physicians through their professional organizations in cooperation with government agencies. The process should emphasize the requirements for the highest level of quality patient care while recognizing the limits and clinical specialty focus of physicians who use the systems.

Overview and History

Electronic Health Records refers to the storage of patient information and records in computer systems rather than on paper forms. When EHR systems are affordable, well designed, and widely available, their use has several advantages, including the ability of physicians to instantly access a patient's complete medical history. The use of EHRs can also reduce medical errors[3] and unnecessary testing[4] and thus, potentially save lives. EHR systems also greatly facilitate the search for specific information within the patient's stored information. Correctly implemented, it can save the health care team time and money, which in turn frees physicians and their staffs to treat patients more effectively. However, challenges in implementation are great. A poorly designed and implemented EHR system will be of far less utility than a system that is functional and adaptable.

Widespread adoption of EHRs has the potential to facilitate advances in medical research. Researchers could have access to incredibly rich sources of data across practitioners and patient populations, and our profession may be able to harness this information into valuable discoveries of the relationships between patient care modalities and patient outcomes.

EHR System Concerns and Goals

In recent years, the development of EHR systems has exploded, with dozens of vendors offering variations on "turnkey" systems. In practice, however, many systems have turned out to be unwieldy and require a large, in some cases excessive, investment of time and resources to implement and operate. Poorly designed systems can affect access to care as a reduction in the number of patient appointments occurs. Many systems are geared toward primary care medical practice which can limit the utility of EHRs for specialty surgical practice.

The AAOS believes vendors should consider the specific practice workflows and needs of orthopaedic surgeons in developing, implementing and maintaining EHR systems.

Regulatory Concerns and Goals

In 2011, Federal agencies such as the Centers for Medicare and Medicaid Services (CMS) began to pay incentives to physicians for the adoption and meaningful use of EHR systems. Grants totaling up to $44,000 will be made over five years to any physician that can demonstrate adoption and "meaningful use" of EHRs. Beginning in 2015, CMS is imposing payment penalties on Medicare participants who have not adopted EHRs for their practices.

The AAOS believes the following standards are essential for the successful development of meaningful use standards and EHR systems certification:

- ***Establish EHR standards by the collective wisdom of physicians actively caring for patients***
- ***Establish a comprehensive set of certification standards, including data and interoperability standards for all EHR systems***
- ***Establish implementation thresholds rather than requiring implementation of all meaningful use criteria as an all-or-nothing requirement that will serve to discourage, not encourage, adoption of EHRs.***
- ***Recognize the different needs and uses of EHRs by disparate medical specialties, especially the differences between surgical specialties and primary care specialties***
- ***Create meaningful use criteria that are HIPAA compliant, protect patients' privacy, and provide safe harbors so as not to expose physicians and other health care professionals to penalties for unintended HIPAA violations.***
- ***Recognize that many aspects of EHRs such as interaction with government, private payers, labs, patients, pharmacies and physicians are still in development and therefore, criteria requiring interoperability for the sharing of data may not be attainable for reasons beyond the control of physicians***
- ***Recognize the cost burden of adoption of EHRs, particularly for small private practitioners, and for practitioners in rural areas.***

The AAOS endorses efforts to encourage the adoption of Electronic Health Records by physicians and patients. However, the AAOS believes that unless the standards are appropriate and realistic, CMS will end up imposing an untenable and counterproductive burden on physicians that may

disrupt the patient-physician relationship and access to care. Therefore, it is essential that physicians from many specialties and clinical practices be involved in the discussions and deliberations; otherwise, the appropriate and laudable goal of universal EHR adoption will be thwarted.

Summary

The AAOS believes the potential benefits of EHR adoption are vast, and we believe widespread usage of well-designed EHRs will benefit our patients and the practice of medicine. We recognize, however, the cost of implementation may appear prohibitive to many practices. We encourage physicians to weigh the benefits versus the risks and costs and also take into account the fact that, in the near future, payers will likely make EHRs a requirement in order to participate in their networks. The AAOS recommends the adoption of well-designed EHRs; however, physicians should take the time to find the system most appropriate in terms of functionality and cost for their own practice. The AAOS also recommends that payers and government agencies recognize variations in system capabilities in setting standards, incentives, and penalties.

References:

1. One of the most common cost savings tool in EHRs is the ability to check for a drug's formulary status, drug-drug interactions, and allergy checks. Each of these checks improves the reliability of prescription writing, eliminates wastage of medications, and improves patient safety.
2. For example, patient information can be transferred via secure connection from a patient's primary care physician to a surgical specialist seeing the patient for a specific condition or injury. This can occur not just within the same hospital but across providers in different cities all together.
3. Most EHRs put in place a system of careful medicine reconciliation. This process reduces medication errors significantly, and improves the ability of physicians to be sure that patients are kept on important medications they were on prior to admission.
4. For example, you can easily review the patient's previous charts and see when the patient has had a recent CT that answers the question you are trying to answer and thus you are not required to conduct a second CT scan. Time and money is saved, and quality is improved.

EHRs are allowing instant translation of ICD9 to ICD10 codes

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