

Overview:

Our charge is to focus on specialists broadly rather than on a single group.

The primary goal is to improve health care, so the question is both how can MU help specialists contribute to that goal, and how to do it in such a way that it is feasible for specialists and broadly beneficial. Much of MU should be appropriate for specialists, including sending and receiving data, local decision support, local quality improvement, care coordination including teams and plans, and engaging patients.

Areas of focus for possible change:

- 1) *Patient engagement:* What do we need to do for specialists who do not see patients? Focus should be on what specialist providers do for patients, and not what providers should do for MU. For those who do not have direct patient contact, the obligation would be to get the patient data back to the referring doctor.
 - a. Add referrals (consultation results) to View and Download and to Care Summary. Procedures and tests performed by the specialist should normally be presented to the patient by the specialist, except for specialists who do not contact the patient, in which case it would be the referring provider.
 - i. For View and Download, we need to re-check the list and make sure that sub-specialty stuff is included.
- 2) *Care team coordination:* needs to make sure all stakeholders have all information needed.
 - a. Need to expand the summary of care record to send a summary of the consultation back to the referring provider and to the patient (bidirectional data transfer).
 - i. Notification should be sent to referring provider to notify that information is available – send to SC to include. (act of completing referral would close the loop)
 - ii. The summary should be timely.

Areas not currently in MU:

- 3) *Registries:* Consider registries as an alternative way for specialists to meet QM requirements. There is time to address issues around registries before stage 3, but it is not clear whether or not this is within the policy committee's scope.
 - a. It would be optional, thus avoiding requiring paying for registries.
 - i. It encourages the development of specialty-specific measures.

- b. To get data into a registry, we would need the registry and EHR have the capability to transport and exchange data, thus requiring standards input.
 - i. It should be bidirectional, supporting both quality improvement and potentially care management information.
 - c. Option for using these registries for CQM reporting will be taken to CQM sub-workgroup.
- 4) *Imaging*: Ask HITSC, as part of their Feb 16 hearing, to suggest a next step for imaging beyond standards that is still feasible.
- a. Consider one-click access to the PACS system (only relevant for large integrated systems)
- 5) *Exemptions*:
- a. No blanket exemption, rather make the specialists determine if one applies

Options for accommodating specialists: Further exploration needed

- 1) *Use of CEHRT*: Different specialists use different types of systems and are not classified as an EHR.
 - a. Allow an EP to just maintain modules that meet their specialty specific objectives
 - i. This language was already recommended by SC
 - b. Neil: their medical record systems do something completely different than EHRs
 - c. George: This is really a CMS issue and we need to focus more on the clinically relevant core objectives to increase quality.

ONC Action Items:

- 1) ONC/CMS: should go through entire AMA spreadsheet and provide comments: do exemptions apply? Did they mis-interpret the objective?

Possible WG Action Items:

- 1) We may make a statement to CMS that specialists who do not see patients should be addressed directly by CMS (including what to do about systems like LISs and RISs).
- 2) Ask HITSC, as part of their Feb 16 hearing, to suggest a next step for imaging beyond standards that is still feasible.
- 3) Notification should be sent to referring provider to notify that information is available – send to SC to include. (act of completing referral would close the loop)