

**Meaningful Use Workgroup
Specialist Subgroup
Draft Transcript
October 18, 2011**

Operator

All lines are bridged Ms. Deering.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Thank you very much. Good morning. This is a meeting of the HIT Policy Committee's Meaningful Use Workgroup, Subgroup on Specialist. I am Mary Jo Deering with the Office of the National Coordinator. We will just take the roll. Michael Barr?

Michael Barr – American College of Physicians

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Eva Powell?

Eva Powell – National Partnership for Women & Families

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Neil Calman? Not yet. Others on the phone, David Hunt?

David R. Hunt, MD, FACS – Medical Director – Office of Provider Adoption & Support Office of the National Coordinator for Health Information Technology

Yes. Hi.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Allen Traylor?

Allen Traylor – Office of the National Coordinator – Meaningful Use Policy Analyst

Hi.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Okay. All right. I would like to note for anyone listening in that we do hope to adjourn this meeting early, possibly by 11:15ish so I wanted to make that note. I'll turn it over to perhaps Michael or David to take the lead. Thank you.

Michael Barr – American College of Physicians

David do you want to do introductions or any opening comments?

David R. Hunt, MD, FACS – Medical Director – Office of Provider Adoption & Support Office of the National Coordinator for Health Information Technology

No actually I'm more of a fly on the wall here. I note that here Josh and the whole Meaningful Use Team have been very interested in what we can do to make sure we can help facilitate and optimize specialist becoming meaningful users, but other than that I'm sort of a fly on the wall.

Michael Barr – American College of Physicians

Very good well thanks for being a great fly on the wall for us.

David R. Hunt, MD, FACS – Medical Director – Office of Provider Adoption & Support Office of the National Coordinator for Health Information Technology

Well thank you.

Michael Barr – American College of Physicians

Let me just say, hi everybody this is Michael Barr I'm a member of the Health IT Policy Committee Meaningful Use Workgroup and now hoping to move us forward on the specialty issues. This is an outgrowth of a meeting that the hearing that was held on October 5th with a committee group continuing to meet on the 6th of October at which time several comments were made about the difficulty for specialists and subspecialist who may not be using electronic health records or may not be able to attest to specific Meaningful Use criteria feeling sort of left out. So Paul Tang who chairs the Workgroup asked to put together a small Workgroup. Eva Powell, myself, and Neil Calman hopefully will be able to join us, but I'm not sure he will be able to. We're assigned the task of trying to come up with some ideas to bring back to the next Meaningful Use Workgroup Committee. Eva, do you have any additional comments or background you'd like to offer.

Eva Powell – National Partnership for Women & Families

I don't think so. I think that was a good summary of kind of why we're here and just some ideas to discuss spring boarding off of our last meeting.

Michael Barr – American College of Physicians

Okay. Thanks Eva. So, you know, in listening to the comments and looking at some of the things people have written there are I think at least two critical issues or issues. One is that some of, for example hospital based physicians, we'll use an example of pathologists to start with, typically are not using electronic health records. They're critical members of the healthcare team of course. They have a unique skills ability and they use laboratory information systems as an example and don't use what we would typically call certified EHR technology. So right from the start that's one class of health care professionals and eligible professionals who can't get in the door in terms of Meaningful Use.

The second issue, which sort of relates to that as well, if they are not able to use certified technology because it's not part of what they normally do, is there a way to have them use the current technology to become part of Meaningful Use in some other way. And I guess as a third one, what would we measure? What would the measures be to determine whether those professionals who are not using certified technology or who are using certified technology but don't have appropriate measures for their clinical scope of practice to specifically clinical quality measures, what can we do for them? So those are sort of the general issues. I'll open it up to Eva or David or Mary Jo in terms of we heard at the hearing if I've missed anything that we'd like to put on the table at this point.

David R. Hunt, MD, FACS – Medical Director – Office of Provider Adoption & Support Office of the National Coordinator for Health Information Technology

No Michael I think that's a great synthesis and the categories fit very well because along with pathologists I think we could probably include other folks like radiologists.

Michael Barr – American College of Physicians

Exactly.

David R. Hunt, MD, FACS – Medical Director – Office of Provider Adoption & Support Office of the National Coordinator for Health Information Technology

I think they sort of fit right in that same category of folks and one of the reasons that I think is incumbent on us, to bring them into the fold if you will, is because they actually touch virtually every other aspect, every other specialty. We're always consulting them. We're always speaking with them. They're very, very computer savvy, both of those groups, pathologist and radiologist. They're all using their own sort of

special domain but they all have also tremendous influence in a lot of the decisions that are going on within the hospital. I don't know a hospital executive board that doesn't have either a radiologist and/or a pathologists on, you know, a critical committee. So I think it's really incumbent on us to find a way to make sure that we can definitely include that category and as you mentioned there are others also.

Michael Barr – American College of Physicians

Great. Any other comments before we kind of take a next, go at the different issues?

Eva Powell – National Partnership for Women & Families

Well this is Eva. I guess, well I'm not sure how to put this in a concise form, but I think what David said is right because the specialists that we so often hear from in the context of Meaningful Use are pathologists and radiologists and so obviously we need to, and given what he just said, we need to figure how to bring them into the fold. At the same time I feel like they also are to some degree outliers in the specialist's category.

David R. Hunt, MD, FACS – Medical Director – Office of Provider Adoption & Support Office of the National Coordinator for Health Information Technology

Yeah.

Eva Powell – National Partnership for Women & Families

In the sense that most specialists can do a lot of the things that in terms of the current criteria for Meaningful Use or it would feasibly fit in their scope of practice say as opposed to pathology and radiology who tend not to have direct contact with patients. So what I wouldn't want us to do is to plan an approach to policy geared toward the outliers.

David R. Hunt, MD, FACS – Medical Director – Office of Provider Adoption & Support Office of the National Coordinator for Health Information Technology

Oh no, I agree.

Eva Powell – National Partnership for Women & Families

Obviously to find a way to bring them into the fold is really important and we do need to do that, but our overall strategy should, I feel like, play to the majority of folks out there for whom much of Meaningful Use I think could apply if we implemented it in a way that it resonated with how they practice. And also just to kind of really explore some of the ways that specialists don't feel included. I guess part of what I have a hard time with coming from the consumer perspective is with the issue of care coordination and communication and that every specialist should have a role there. I can't imagine why you would be in medicine and see yourself not having a role there. Now obviously that's the ideal and that's not the way our system works, and so, and that's not the fault of the specialists, so we need to figure out a way to get there that also deals with realities their dealing with now.

Michael Barr – American College of Physicians

Yeah. Eva, this is Michael I agree with you and I think we're thinking about is similarly but, you know, let me express a little bit of what I'm thinking a little bit more directly. Yes, we shouldn't create policy for outliers. On the other hand we might be able to create policy or recommendations I should say that address more than just pathologists and radiologist and provide other value added options for eligible professionals and eligible hospitals within the Meaningful Use program that would get it right, just what you're describing, so it would enhance care coordination, data sharing and those kinds of things that would leverage the systems that people have put into place that wouldn't be characterized as certified EHR technology.

Eva Powell – National Partnership for Women & Families

Right.

Michael Barr – American College of Physicians

But hold them accountable for actually transmitting into information, sharing information, contributing to registries, etcetera that would help the whole endeavor to improve quality, reduce costs and provide

better care coordination and so on. So, but there's one thing I think, and David please chime in here, I think that we have to acknowledge is that they can't get in the door right now, let's now be more particular to those who don't use EHRs typically pathologist, radiologist, without some sort of opening to allow that technology to interplay with certified EHR technology when in and of itself would not have gone through an ONC, ATCB process.

David R. Hunt, MD, FACS – Medical Director – Office of Provider Adoption & Support Office of the National Coordinator for Health Information Technology

Yeah no I agree and I'm sorry if I mischaracterized things. I definitely agree that the bulk of the specialists are your run-of-the-mill, not run-of-the-mill, but you know, your GI guys, your surgeons, your cardiologists thing like that and that's where we should, that's sort of the sweet spot. I just did latch onto the fact that those two hospital based groups I think are key in terms of, not only in terms of bringing them into the fold and care coordination, but also in terms of influencing how we'll move forward. But with that said, I think that one thing I hope we can also see is that while many of these specialists, and I think the entire spectrum would qualify as this, including pathologists and radiologists, while many of them may not use the certified EHR or don't see a tremendous value in input patient information input, a lot of them, if not all of them would find tremendous value in at least being end users or consumers of the information and that is to say the radiologists will definitely need to see information regarding patients past history and things of that nature. The cardiologists would definitely be able to use so much of the information that is in the EHR. So while, you know, while we figure out ways to bring them in, we really have to emphasize and acknowledge that they really want to be consumers of this information.

Michael Barr – American College of Physicians

So, David implied by your comment is sort of what we're saying that if they have a noncertified technology it has to speak to certified technology and it has to be bidirectional to allow what you just described. So, whereas the system that a pathologist, a radiologist uses wouldn't go through an ONC ATCB process correct? That it should have some functions and features that allow it to communicate and exchange information with a certified EHR technology.

David R. Hunt, MD, FACS – Medical Director – Office of Provider Adoption & Support Office of the National Coordinator for Health Information Technology

Yes. I think we would have to, but also I think that we will be able to find a way to bring in the bulk of specialists with some form of certified EHR technology and bring them in thinking, maybe thinking creatively around some of the other objectives also.

Michael Barr – American College of Physicians

Okay. So you're open to the concept or idea that the current definition of a certified EHR technology might be broadened to allow for some of these other systems, let's put it that way, to be identified as having specific features, functions that connect to EHR technology that has been certified and thereby themselves be part of the whole puzzle.

David R. Hunt, MD, FACS – Medical Director – Office of Provider Adoption & Support Office of the National Coordinator for Health Information Technology

I think we might be able to, but again I think that the bulk of the specialists is broader than that.

Michael Barr – American College of Physicians

Yeah, absolutely...

David R. Hunt, MD, FACS – Medical Director – Office of Provider Adoption & Support Office of the National Coordinator for Health Information Technology

Yeah would be able to fit right in, yeah.

Michael Barr – American College of Physicians

Yeah, yeah we're talking about, I'm sorry we're actually, I agree with you, so you know, cardiology, GI, specific medical subspecialties within the house of for example internal medicine and that kind of thing, I mean we're not necessarily talking about those folks we're talking about the people or professionals who

are like pathologist, radiologist who it doesn't make sense for them to purchase, you know, an ambulatory EHR that is certified for their day to day practice.

David R. Hunt, MD, FACS – Medical Director – Office of Provider Adoption & Support Office of the National Coordinator for Health Information Technology

Yes.

Michael Barr – American College of Physicians

Okay. The other thing that I think that we heard at the testimony was considerable positive comments about the concept of clinical quality measures but some concern about the actual implementation and specification of the CQMs and there was also concern that weren't CQMs for specific specialties without getting into detail. I think that's another whole area where we can again try and bring other specialties into the whole concept of Meaningful Use by focusing on CQMs that are appropriate for them.

Eva Powell – National Partnership for Women & Families

Yeah that makes sense to me. And a question about that because I'm not terribly knowledgeable about CQMs for the specialties, how widespread is it that a particular specialty would not have any CQMs that pertain to it? This is just intuitive to me. I don't really have actual knowledge, but it would seem that as long as we've been focusing on CQM and as long as we've been focused on measurement, and we've been now reporting data, at least at the hospital level for 10+ years, how is it that there's not a specialty that's completely, how is that there are any specialties out there that really haven't taken this on or is it just a matter of the length of time it takes to come up with good measures? What are really the issues there?

Michael Barr – American College of Physicians

Eva, I think one of the things we lack on the current call, other than David, are some specialties, specialist who might better to this. I am a general internist personally and not practicing as much as I used to. So I think it's important for us to get some feedback as part of this process from specialists who might have different perspectives. I think there are probably plenty of measures the question have they been specified adequately to be included in the kind of process that Meaningful Use requires.

David R. Hunt, MD, FACS – Medical Director – Office of Provider Adoption & Support Office of the National Coordinator for Health Information Technology

I think that is absolutely the issue. When you go across the whole broad spectrum because the discussion in terms of quality measures started you know really in the start of this last decade when CMS started to make the push for quality measures at so many different levels. So I think pretty broadly that we can, with relative confidence, say that there are quality measures out there. It's just, there's such a heavy lift in terms of having a robust portfolio for every single specialty, that's going to be some of the tough work. And as Michael said because so many are not eSpecified.

Eva Powell – National Partnership for Women & Families

Right. Right. Okay.

Allen Traylor – Office of the National Coordinator – Meaningful Use Policy Analyst

So this is Allen at the ONC I wanted to make sure that everybody was aware of the work being done not only here at the ONC but CMS around this specific issue. We do have multiple contracts out both again with CMS and ONC and one contract with...to identify measures that can be eSpecified. Our goal is that there aren't any measures in Stage 2 that aren't eSpecified and in doing this we're working to identify measures that can address multiple specialists areas. And again this includes behavioral health, CHIPRA associated measures, so Peds, and so that work is being done. And the Quality Measures Workgroup from the Policy Committee helped us to identify areas in which we should focus. So a lot of that work is currently being done, but again, there always is room for more effort.

Eva Powell – National Partnership for Women & Families

Right.

Michael Barr – American College of Physicians

That is great. Thanks Allen.

Eva Powell – National Partnership for Women & Families

Sorry can I ask a quick follow up question to that? I just want not to assume something, I guess what sometimes concerns me again, not knowing more than I do about the in-depth nitty-gritty details of measure development is just because a measure is an eMeasure does not mean it's valuable and so Allen is there an attempt to work with some of the specialists to identify which of the measures that they have are actually valuable, that actually offer, regardless of the format it's in, offer valuable information for improving care and then to take the step to an eMeasure or is it more of an effort kind of like we took in the beginning with the NQF effort to kind of progress to eMeasures, which is understandable, because we need to get some experience under our belt, but it just seems, I worry that we focus a lot on making measures into eMeasures without regard to how useful the measure actually is regardless of the format.

Allen Traylor – Office of the National Coordinator – Meaningful Use Policy Analyst

Sure. I think that's a good question. There are two ways in which we, a couple of ways in which we approach the measures and the first is the continuous feedback we've been receiving since Stage 1 from the specialists groups. In addition to their feedback we have also, in these contracts have subcontracted out to folks like the AMA and Dartmouth Institute to help provide a lot of that feedback in identifying measures that we should prioritize. And then the other side is there are some measures that simply cannot, the way in which they were spec'd from the authors, cannot be eSpecified. So we can't really get much done between now and Stage 2.

Eva Powell – National Partnership for Women & Families

Right.

David R. Hunt, MD, FACS – Medical Director – Office of Provider Adoption & Support Office of the National Coordinator for Health Information Technology

Yeah.

Allen Traylor – Office of the National Coordinator – Meaningful Use Policy Analyst

So then we tried to focus on the measures that we can eSpecify because again, we want to get as many of these into Stage 2 as possible, we don't want to cause any sort of burden for providers in trying to collect data that's outside of the EHR. So we need to get these eSpecified. So the ones that we can do that are specialist focused we really are putting a lot of attention to. Again, received a lot of feedback from, and we're currently receiving a lot of help from AMA and Dartmouth, Mathematica, NCQA that have received feedback from specialist groups and again we're using the Quality Measures Workgroup information to help drive that as well because they did have some interviews or testimonies rather and so again, there are two ways in which we've been approaching this.

Eva Powell – National Partnership for Women & Families

Great. Okay thanks that's helpful.

Allen Traylor – Office of the National Coordinator – Meaningful Use Policy Analyst

Yeah.

Michael Barr – American College of Physicians

I have to chuckle I'm watching the transcription and the transcriber wrote "eat specified" which is pretty funny.

Allen Traylor – Office of the National Coordinator – Meaningful Use Policy Analyst

Auto spell correct always gets me on that one.

Michael Barr – American College of Physicians

Oh that's great. This is, so there's a whole line of development of CQMs that hopefully will fill in the gaps and then hopefully also address some of the issues that were raised in the testimony early in October

about the implementation guidance and real specifications. I'm glad to hear about all that work. If I could shift just slightly. I mean, could there be other types of expectations of the professionals, EPs that we've been talking about with their non-currently certified systems and system expectations. So for example, that they can exchange patient reports as structured documents, that that would, according to David I think you said they would both like to share and also receive information from certified EHR technology. So could that be an expectation and/or that they can contribute data in structured format to a specialty specific registry. Again, trying to get to the point where data becomes information and that it's shared appropriately and used for quality improvement.

David R. Hunt, MD, FACS – Medical Director – Office of Provider Adoption & Support Office of the National Coordinator for Health Information Technology

I think that last point has a lot of value because so many, I can't think of a specialty again that doesn't have at least some formation of a specialty specific registry that almost all of its members would be able to submit measures too or submit patients too. So I think that has a tremendous amount of value.

Michael Barr – American College of Physicians

And what about the requirements of being able to share structure, I mean patient information in structured format from these LIS systems or otherwise so they can be incorporated into health information exchange but also the EHRs that might be out in the community that small practices are purchasing to meet Meaningful Use.

David R. Hunt, MD, FACS – Medical Director – Office of Provider Adoption & Support Office of the National Coordinator for Health Information Technology

Yeah. I think that'll be important in terms of when we start to get into how will we really be able to exchange, you know, getting the specialists into more of the exchange currency of, you know, of medical information. I think that will be important. The one thing that I'm wary of, I don't want to create too much of a special or individualized track for one particular group or another, I am hoping that we'll be able to find formulas that will be able to include as many as possible of the certified systems that we have and for those few that really can't fit into that, then I think we should move to, you know, sort of a special track.

Michael Barr – American College of Physicians

Yeah, actually I was thinking that these kinds of functions could be part of Stage 2, I mean recommend them for Stage 2 or Stage 3 for certified technology but that they also should have broadly applicable to lots of different specialties as options for meeting Meaningful Use but that in particular the current systems that pathologist, radiologist use could come in the door through those two types of functions.

David R. Hunt, MD, FACS – Medical Director – Office of Provider Adoption & Support Office of the National Coordinator for Health Information Technology

Yes.

Michael Barr – American College of Physicians

Registry base reporting as well as sharing information in structured format on patient information. So it could be accommodated in certified technology. So not just a channel just for those but actually they become options or features for any EP or EHR.

David R. Hunt, MD, FACS – Medical Director – Office of Provider Adoption & Support Office of the National Coordinator for Health Information Technology

Yeah and the rank and file, I think the rank and file specialty groups, you know, all of the specialists in the domain of internal medicine and in the surgical specialty, like I say I think having working on robust portfolio of registries that they can submit to, to help them meet some of the Meaningful Use objectives, I think that has a lot of value.

Michael Barr – American College of Physicians

Okay.

Eva Powell – National Partnership for Women & Families

Yes and this is Eva. Michael would the, I'm just looking at the current criteria just to kind of see is there, are there some that really do apply, but may need to be tweaked so to speak, which is I think what you're kind of saying is not make separate criteria but just make an alternative where it's necessary in order to pull those folks in who aren't actually using EHRs, but CPOE would seem to be one of the those that even though, is there not a way to for an EHR to talk to an LIS or to whatever system that pathologist and radiologists do use it would seem like CPOE would be one of those areas where they need to connect somehow.

Michael Barr – American College of Physicians

I think that's a good process to go through with people who are more knowledgeable about those systems and what capabilities are then probably those of us on the phone on this meeting. So that could be another step where we talk about exactly what you described Eva. So what within the Meaningful Use criteria now if it was broadened or modified somewhat could be accommodated by these other systems after it was defined or specified a little differently. So again you try and bring them in, as David said, without creating a whole new system. Does that make sense to you David?

David R. Hunt, MD, FACS – Medical Director – Office of Provider Adoption & Support Office of the National Coordinator for Health Information Technology

Yeah.

Eva Powell – National Partnership for Women & Families

So and I know that Neil had made the suggestion at the last meeting about, that really is at least bringing specialist from a value standpoint far and away the best value, at least from his point of view, was getting them involved in the exchange and I think we've, in our conversation so far we've really hit on that. So I don't know, is that something we need to build out more specifically or are there other, I mean, I think I would agree with that, but I think there are other things that we lose by only focusing on that, such as some of the, like I said care coordination stuff, although it can be considered that exchange is part of coordination. So, I mean are we hoping today to get kind of a list of.

Michael Barr – American College of Physicians

Yeah. I don't know how far we can go without experts in these areas.

Eva Powell – National Partnership for Women & Families

Yeah.

Michael Barr – American College of Physicians

I agree entirely that was exactly what Neil suggested and I think there was general agreement around the Workgroup table that that was the high value. I think we need to be able to talk about what the functions and features are and then talk about how those apply to the exchange of information and care coordination. One of the other things that came up was the types of reports and the robustness of those reports with respect to recommendations and if you think about not just quality, which is paramount, but also the cost implications as some of the way reports are shared right now that could also be something that people discuss in terms of additional measures of improvement. So, are the reports meeting special certifications and not leading to additional tests unnecessarily, that kind of stuff.

I don't know how we would put that into measure or how that would be assessed but a lot of cost is driven by reports from radiologists, pathologists who may or may not have all the clinical information they need to make more firm recommendations. So to David's point, it might be really interesting if the two-way exchange of information. So they have access to the clinical record when they're looking at a pathology slide and putting the clinical picture along with the pathological picture to make a recommendation.

David R. Hunt, MD, FACS – Medical Director – Office of Provider Adoption & Support Office of the National Coordinator for Health Information Technology

I think that'll be key and I think that'll really add value, you know, when you speak to colleagues, particularly and I can think of off the cuff of pathologists and radiologists who really consume, who really, really need, and sometimes deep dives of information into a patient's history, medications, and other

clinical features to really give you a good consultation. I agree. I think getting them exposure to this information is critical in overall care coordination and increasing the value of the consultation and their services.

Eva Powell – National Partnership for Women & Families

Right. Well and I'm wondering, forgive me for thinking out loud here, but just trying to think about like the patient engagement component of this and I think that can become a sticky wicket, particularly for pathology and radiology because often times they are not face-to-face with the patient and yet they have, as David said, critical information to the whole care of that person, and we've already worked into Meaningful Use the notion of availability of information and updating information going directly to the patient. Is there a way to make that part of what we just talked about in terms of this two-way exchange of information to make sure that, obviously between the primary care and specialist or whatever member of the professional care team and the specialist, but that at some point in there the patient needs to be informed of results.

David R. Hunt, MD, FACS – Medical Director – Office of Provider Adoption & Support Office of the National Coordinator for Health Information Technology

Yeah, you know, I think that there's probably a way to do that. For the rank and file specialists who do have face-to-face contact with patients. I think they should be fully engaged with the patients and their families and I think all of the standards with regard to providing patients with information of their results and their studies and their recommendations. I don't see where that would be very much different from the primary care physicians. But I think for those who don't have face-to-face contact, there should be some expectation that they can at very least provide to the referring physician, some information that would be useful when combined with the regular consultation or visit, a summary that might be useful for the patient. So, you know, if someone had a lab or a Pap result then they go back to their primary care physician to find out the results, perhaps there could be an expectation that information from the pathology information system would be added into, you know, the clinical summary that can help in terms of patient education.

Eva Powell – National Partnership for Women & Families

Right. Right. Well and the other thing that I am thinking of here, and I don't know exactly how to link it, but the other thing that we heard from some of the testimony was that while we on the Policy Committee were hoping that whatever we put together it was clear that people would be able to meet those criteria in a number of different ways, and if there was say one document or whatever, particularly on the patient information side that they could come up with and meet say four or five of those criteria at once and that was great, but we heard that, at least in one case, that the provider was already doing this in terms of making the information available at discharge and then when labs came back they already had a process for updating things, but the way that we structured things in Meaningful Use kind of made them redo their process. And I don't know, I mean, we would have to, I think find out more specifics to understand whether that was just a misunderstanding of the intent or if there really was unintentional rework that wasn't of any value there.

But I guess that's part of kind of what I'm thinking is just really what's important and critical from the patient's side is just to make sure that they've got all the information they need and that if they know they've been for a test or know that they've had a sample sent for testing or whatever, that some result ultimately gets back to them in a timely manner. And ideally, yes that would come through the primary care or through the specialist as that who they've had face-to-face contact with, but what happens if the specialist never makes that available and I don't know, I mean I guess it's exactly what you just said, but I'm just trying to think of a way to bring them into the fold in this capacity in terms of making sure that everyone is accountable for both sending and receiving information and taking action accordingly.

David R. Hunt, MD, FACS – Medical Director – Office of Provider Adoption & Support Office of the National Coordinator for Health Information Technology

Yeah.

Michael Barr – American College of Physicians

That's great Eva I think that's sort of where we're hoping to get and I'm wondering whether something like a...or specialist or subspecialist to make sure that information can be passed to something to consider as sort of one of the alternatives for certification. In other words that they can actually do what you described.

David R. Hunt, MD, FACS – Medical Director – Office of Provider Adoption & Support Office of the National Coordinator for Health Information Technology

And send information back. I think so, but I think the expectation is in general that they would be able to do that, you know, with the systems that they have now. So yeah, I think that would be valuable.

Michael Barr – American College of Physicians

Yeah, I'm thinking about currently certified EHR technology that's what we would like them to have, it may very well be specified. I'm talking about the non, again back to the special case scenarios of the LIS and the laboratory information systems. I mean maybe just that one feature function would be so important. So let me just kind of summarize where I think we are at this point in the conversation so we don't keep going without knowing where we were. It sounds like we're all in agreement this is an important issue, obviously, that we want to bring folks into the process and not create any special tracks unnecessarily. And we want to leverage what's already in place so back to Eva's point about the CQMs and current Meaningful Use specifications, could they be altered slightly or somewhat, or added to accommodate some of these other situations by keeping within the Meaningful Use structure.

We talked about registry-based reporting and potentially to specialty specific registries as being an important part of specialist roles. We've identified that the vast majority of specialists, David you said this, you know, already can go through the Meaningful Use. We're talking about specific EPs and hospitals such as pathologist and radiologists that may have to have a slightly different pathway, but again trying to bring them into the overall pathway that everybody else is following. That exchange of information is critical and that providing views of clinical information, for example to radiologist and pathologist to help them with their evaluation of what they are doing. And then exchanging their impressions with the referring physicians or clinicians to make sure that the referral or the consultation is as robust and as meaningful as possible. Did I miss anything in terms of just where we are at this point?

David R. Hunt, MD, FACS – Medical Director – Office of Provider Adoption & Support Office of the National Coordinator for Health Information Technology

No I think that's good and I think that it's possible that, you know, as we look down, I'm looking at the Meaningful Use Stage 2 and Stage 3 recommendations from the Policy Committee and I think we could almost go down row by row and see whether or not something is at least within the domain, the ballpark of most specialists in which case which specialist it wouldn't fit into. I think that might be possible. I'm not suggesting we do that on this call but that is some work that really could be done and it wouldn't be that difficult.

Michael Barr – American College of Physicians

Great. Actually there's one thing, I agree with you David, I think Eva you said something in your last comment that I wanted to make sure we captured too. You were referring to potentially the testimony that talked about the unintended consequences of Meaningful Use and perhaps misinterpretation of some of the specifications, so perhaps we should also talk about reviewing the unintended consequences and making sure there's a good educational process to make sure that they're not misinterpreted and thereby cause unintended consequences.

Eva Powell – National Partnership for Women & Families

Right. Right and it would seem that the specialty societies could play a big role in that at least for whatever differences there needs to be made for specialists at least.

Michael Barr – American College of Physicians

Great. And then Allen you mentioned that there are currently multiple contracts to develop and identify measures to be eSpecified. I think the earliest possible time, I mean, as early as possible what's happening probably needs to be shared with the Workgroup. So in the context of reviewing what's

applicable to specialists we have a better understanding and thereby our recommendations follow appropriately.

Allen Traylor – Office of the National Coordinator – Meaningful Use Policy Analyst

Certainly and in addition I think speaking with David Lansky and Paul Tang when they, you know, in creating this Workgroup here, we'd like to have those two on the technical expert panels for the contracts and then they can then feed the information back to the committee.

Michael Barr – American College of Physicians

Okay. And then I don't know the answer to this, but what's the process for getting more specialty input to these discussions as we move forward.

Allen Traylor – Office of the National Coordinator – Meaningful Use Policy Analyst

Into this Workgroup here?

Michael Barr – American College of Physicians

Well either to the subgroup or to the larger group. I would think perhaps the subgroup if we continue to do this it would be up to Paul and George of course as to whether we continue with the subgroup or not after we turn in some of these early recommendations.

Allen Traylor – Office of the National Coordinator – Meaningful Use Policy Analyst

Sure, I think it would be fine for this group to invite any sort of comment, public comment or feedback from specialist groups in terms of giving them what you had outlined as examples and boundaries if you will and within those boundaries ask them to provide comment. I think that's a possible route.

Michael Barr – American College of Physicians

Okay. So we can potentially bring that to the larger group as a recommendation and make sure we're not opening a new process that would better be done elsewhere with the overall group.

Allen Traylor – Office of the National Coordinator – Meaningful Use Policy Analyst

Exactly. Certainly.

Eva Powell – National Partnership for Women & Families

Well and the other thing. This is not something we're going to resolve on this call today and it may be more of a specific agenda item for what you just mentioned about seeking input from specialist at various point in time, but it would almost to me seem to be a very specific task that people would need to kind of work on and then bring back, which would be this issue of care planning, I mean because it's such a huge issue that has so many pieces and parts and people have kind of their own understanding of what it is, but we've not yet clearly defined it, although there has been a lot of work done on that, and I think we've got a good start in the context of Meaningful Use, but in terms of moving toward the ideal of a longitude shared care plan that we are not really close to obtaining.

I'm trying to think what groundwork needs to be done in order to move towards that. And since we know that care planning, at least in this point in time, by many folks is viewed as something that's only in the primary care realm. But I think those of us who kind of have a broader view and understand that there needs to be a more holistic approach and coordinated approach among specialists, among primary care between hospitalization and transitions back to the community or to another care setting, we need to figure how to do that, and specialists I think have a critical role to play in helping us figure that out. So is there a piece of this that we can kind of task them with or engage them in. I can't decide if it's a better approach to have them kind of come up from their own perspective with a, you know, how they see themselves fitting into care planning and then everyone coming together and bringing their own pieces or what, but that to me seems like a critical point in part that we need to do at some point that would be related to this conversation. But we're not going to solve today.

Michael Barr – American College of Physicians

Well I agree. I think the whole idea of how the specialty primary care interface works is a very important part of what we're trying to achieve with health information technology. So exploring it as part of this Workgroup, subgroup or as part of the larger one certainly should be, at least in my opinion, is an important conversation to have and then how that translates into Meaningful Use expectations will come out of that discussion.

Eva Powell – National Partnership for Women & Families

Right. Right. Yeah and I think, I mean it's certainly an interface, but I think of that as being more than what we we're talking about earlier in terms of the bidirectional communications. I guess in my mind I tend to think of that as around the very specific point in time. Whereas a care plan would be more across time kind of thing which would be very important from particularly obviously for those with chronic illnesses who are seeing specialists.

Michael Barr – American College of Physicians

I think what we need to, I mean facilitate is sort of the technology solutions to a cultural issue.

Eva Powell – National Partnership for Women & Families

Yeah.

David R. Hunt, MD, FACS – Medical Director – Office of Provider Adoption & Support Office of the National Coordinator for Health Information Technology

Yeah.

Michael Barr – American College of Physicians

In other words, you know, so we only go so far with the technology and then we have to figure out how to help professionals do what we like to do which is talk to each other and help our patients.

David R. Hunt, MD, FACS – Medical Director – Office of Provider Adoption & Support Office of the National Coordinator for Health Information Technology

Yes.

Michael Barr – American College of Physicians

And that is a larger question and probably beyond the scope of what Meaningful Use can actually implement. It has to come from patients, advocates, consumers, and health professionals of all types and actually make that happen. But the technology has to be facilitated so it becomes easier than it is right now.

Eva Powell – National Partnership for Women & Families

Yeah. Yeah and it's almost like there would be some benefit somewhere along the line of a conversation similar to what we had at our last Meaningful Use meeting, which was kind of a strategic long-range thinking kind of discussion, but it was around the whole Meaningful Use with kind of everyone around the table and it almost feels like, and maybe people are doing this and I'm just not aware of it, but each element of our fragmented system needs to figure out, okay we're working in an imperfect system now and we all wish it was this way, well what is the this way from my perspective say as a cardiologist. And then somehow bring all of those together. Maybe again, the specialty societies are doing some of that and maybe it is coming together in places that I've just not seen, but that seems to be a step that then can inform, okay well we've now kind of coalesced around this more cohesive and specific new system that we're after and we've gotten enough specifics that now we can again talk about the technology.

Michael Barr – American College of Physicians

Right. Actually without sounding too parochial, I'll just, I mean the American College of Physicians Council of Subspecialty Societies put forth a patient centered medical home neighbor concept trying to speak to the very issues that you just raised and I mean now we're in the process of trying to operationalize that and get folks to use it and we're not the only ones, but I think you're speaking right to the heart of how we need to improve healthcare.

David R. Hunt, MD, FACS – Medical Director – Office of Provider Adoption & Support Office of the National Coordinator for Health Information Technology

Yeah.

Eva Powell – National Partnership for Women & Families

Yeah. Well and actually I'm glad you mentioned that because I did actually read that a few weeks ago and I really liked it. Is there a way to leverage that in some of the work that we're doing?

Michael Barr – American College of Physicians

Well I think one of the things to do is to look at some of the expectations that the societies, I think there are 22 or 23 internal medicine subspecialties, so it wasn't, well actually family medicine and pediatrics I think were involved, sorry I don't know if the surgeons were involved, David, but I think to broaden the conversation and say okay this is how we as professionals with patient input, I think that's also something that needs to have happen, want the system to work. What of this is a technology solution and needs to be embedded in certified products and tested through Meaningful Use. And what is incumbent upon the professionals and our patients, and their families to actually put into place from a cultural perspective.

They're the same issue but two very different approaches that have to be done in sequence and in the right way so we don't harm anybody. But that's important. I think that the technology solution is what we need to talk about in the Meaningful Use Workgroup. And then the cultural professional issues need to be talked about at the society and organizational levels.

Eva Powell – National Partnership for Women & Families

Yeah. Yeah definitely.

Michael Barr – American College of Physicians

So where are we? Are we at a place where we think we have enough in terms of recommendations or ideas to bring back to the larger group, Eva, David?

Eva Powell – National Partnership for Women & Families

I think so. I can't think of anything.

David R. Hunt, MD, FACS – Medical Director – Office of Provider Adoption & Support Office of the National Coordinator for Health Information Technology

Yeah I think this, at very least a good start. There's a lot that obviously we couldn't take a real bite at, but I think the things that we have right now, I think that's a pretty good chunk.

Michael Barr – American College of Physicians

Allen are you comfortable?

Allen Traylor – Office of the National Coordinator – Meaningful Use Policy Analyst

I am yes.

Michael Barr – American College of Physicians

Okay. All right, well then.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Okay this is Mary Jo then if you are done I think for the formality of it I would ask the operator to open the lines and see if there are any public comments. If indeed we've reached that point?

Michael Barr – American College of Physicians

I think we have, so go ahead.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Okay, operator would you see if there is anyone on the line who would like to make a public comment?

Caitlin Collins – Altarum Institute

Yes. If you are on the phone and would like to make a public comment please press *1 at this time. If you are listening via your computer speakers you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. And we do have public comment.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Thank you, introduce yourself and limit your remarks to 3 minutes.

Operator

Kelsey your line is live.

Kelsey Kurth - American Academy of Ophthalmology

Good morning my name is Kelsey Kurth and I'm staff for the American Academy of Ophthalmology. The academy is pleased that the Meaningful Use Workgroup has formed this team to address the needs of specialists. At the same time we feel this discussion is long overdue and that we can't wait until Stage 3 to make Meaningful Use meaningful to the specialists. Ophthalmologists are trying to meet the existing Stage 1 requirements but they are frustrated that so many objectives such as recording vital signs and reporting to public health agencies bear no relevance to their scope of practice. They don't understand why they should report on measures such as weight screening and follow up that lies so far out of day-to-day ophthalmology practice. We have serious concerns about ophthalmologist abilities to meet the Meaningful Use Stage 2 requirements which include still more objectives with no relevance to the specialty. The Academy's medical information technology committee has already articulated a vision for more meaningful objectives for ophthalmologists such as information exchange with in office equipment and registry participation. We have the specific expertise necessary to articulate more valid objectives for specialists and we strongly urge you to include the Academy and other societies as this discussion moves forward. Thank you.

Michael Barr – American College of Physicians

Thank you. Thank you very much.

David R. Hunt, MD, FACS – Medical Director – Office of Provider Adoption & Support Office of the National Coordinator for Health Information Technology

Yes. Thank you.

Operator

We have another comment from Julie, please go ahead.

Julie Cantor-Weinberg – College of American Pathologists

Hi this is Julie Cantor-Weinberg with the College of American Pathologists and we're very appreciative of all the discussion of pathologist. I think there was a discussion of clinical quality measures. We currently have two measures in the PQRS system and three that are working through the process to be approved for the Medicare fee schedule final rule. Even if we end up having five measures, they'll still be large areas of subspecialists within pathology that have no measures, despite, in our current measure set we began to work on in 2006 and 2007, so the process is just very long. The other thing is it's not true that all specialties have registries. We have...probes and...tracks and credit many, many labs and others quality solutions, but they are not in fact registries, and we'd be happy to contribute and engage the Workgroup in any other way. And the AMA if you might recall, went through the Meaningful Use 1 and 2 objectives and matched it to each specialty. So you should already have that tool at your fingertips. Thank you.

Michael Barr – American College of Physicians

Thanks Julie.

Operator

Michael Peters your line is live.

Michael Peters – American College of Radiology

Hi this is Mike Peters with the American College of Radiology. Thanks a lot for this discussion. There's a lot of rich discussion. I can't possibly address everything that you said at this moment but I will say that a lot of what you said has mimicked, you know, the same themes that we've submitted in the comment periods over the past three years. One thing that we have suggested in the past is not looking so much at just radiologist, per se, but looking at things in terms of imaging creators and imaging consumers. When you look at requirements of Meaningful Use, you know, if you look at it from a global image creator perspective, you not only pull in radiology relevant requirements but also things applicable to dentistry, ophthalmology, orthopedic surgery, cardiology etcetera. So it's more global than what it first appears to be.

The other thing that I will say is that in terms of certified EHR technology, what we're seeing in our field is a lot of our vendors are submitting the radiology information systems for certification, some modular, some actually have achieved complete EHR certification by adding functionalities that aren't particularly useful to radiologists that use those systems, but in order to meet the requirements, and actually, you know, merge came out with their...was complete certified, one of the major mammography...vendors had complete certification. So, you know, one of things that we'd like to see is maybe the regulatory definition of certified EHR technology to be more flexible so that these vendors don't have to do this and that we can use, you know, certified...systems that have the functionalities that we do use. So that's all I had right now, but we'll be happy to work with you guys and if you need, you know, physician input to this particular subgroup just let me. Thank you.

Michael Barr – American College of Physicians

Thank you very much.

David R. Hunt, MD, FACS – Medical Director – Office of Provider Adoption & Support Office of the National Coordinator for Health Information Technology

Thank you.

Operator

We have another comment from Mari Johnson.

Mari Johnson – American Medical Association

Hi this is Mari with AMA. I just wanted to let you folks know you should have this in your hands, Julie mentioned it, there's an excel spreadsheet that one of the tabs at the bottom has all the contact names for all the specialties that we submitted comments on, so if you're looking for certain points of contact they're all there and of course you can always reach out to me.

Michael Barr – American College of Physicians

Thanks Mari.

Mari Johnson – American Medical Associations

Sure.

Operator

We have no more comments.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

All right. Thank you. Does the group have anything else it wants to wrap up with?

David R. Hunt, MD, FACS – Medical Director – Office of Provider Adoption & Support Office of the National Coordinator for Health Information Technology

I think those were great comments and I'm glad that they added them in, that was fantastic. That was super.

Michael Barr – American College of Physicians

I appreciate it and hopefully this is the start of a really good conversation to go forth. We'll bring some of the recommendations, both the ones that we generated and the ones that were stated in the comments, and we'll see where this goes, but hopefully we'll continue to get some good solid recommendations to go forward on.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Thank you all I guess the meeting is adjourned then.

Michael Barr – American College of Physicians

Thank you everybody.

David R. Hunt, MD, FACS – Medical Director – Office of Provider Adoption & Support Office of the National Coordinator for Health Information Technology

Thanks.

M

Bye-bye.

David R. Hunt, MD, FACS – Medical Director – Office of Provider Adoption & Support Office of the National Coordinator for Health Information Technology

Bye-bye.

Public Comment Received During the Meeting

1. Pathologists have only 2 approved PQRS measures; there are 3 more in the pipeline that are likely to appear in the final physician fee schedule rule. However, even so we will not cover all of pathology given subspecialty.
2. Pathology has no registries.
3. AMA has already gone through the list of objectives and determined applicability to each specialty.
4. The AMA has submitted a lengthy document to Dr. Tang which contains the points of contact for each specialty - this is in the Excel spreadsheet we sent around.