

## Summary of Comments: Non-Physician Providers and Specialist Physician Providers

June 22, 23 and 26, 2009

June 22, 2009

### Participating Organizations

- American College of Surgeons (ACS)
- American College of Obstetricians and Gynecologists (ACOG)
- American Podiatric Medical Association (APMA)
- American College of Nurse Practitioners (ACNP)
- ONC
- CMS

Representatives of obstetricians and gynecologists, podiatrist, and surgeons thought that given the tie of meaningful use to CCHIT certification, the meaningful use timeline is too aggressive. Representatives of surgeons and ObGyn indicated that there are in the “queue” to work with CCHIT on an appropriate certified product but not for 2011. Representatives of podiatry also expressed concerns about registries since none are currently available to podiatrists. They advocated for the development of registries in a very short timeframe if their constituents are going to be expected to meeting he 2011 objective.

A representative of ACOG observed that few of the meaningful use measures are specific to women. He also questioned the use of PQRI since these measures can be reported using paper and don't require an EHRs. Requirements specific to ObGyn are typically not addressed by EHR vendors. The OB specific EHRs that are currently available are not interoperable with other EHRs. Fetal heart rate is an example of a data element they need on their dash board that is not offer in a general OB EHR. Given the rate of CCHIT activities, they don't think they will have a functional, user-friendly EHR available to them in 2011, 2012 or 2013. The ObGyn representative specifically made the point that obstetrics is not only different from general primary care but also from general surgery. The American College of Obstetricians and Gynecologists presented a white paper to CCHIT outlining some of the ObGyn requirements.

A representative of podiatrists echoed the concern that the objectives and measures are primary care focused saying that PQRI measures are for the most part directed at primary care physicians. He cited a recommendation of the HIT Policy Committee relative to transforming health care that talked about preventing hundreds of thousands of unnecessary amputations and premature deaths. The meaningful use measures selected do not include the two or three diabetic foot care measures currently in existence that are directed at preventing amputations. A representative of nurse practitioners agreed that the measures are too primary care focused.

A representative of surgeons suggested using the NQF measures. A representative of ObGyn agreed indicating they too are working actively with NQF and the Physician Consortium for Performance Improvement to develop criteria and measures. He didn't know if any ObGyn measures are part of the Health Information Technology Expert Panel (HITEP) measure set.

A representative of nurse practitioner had specific suggestions relative to the objectives:

- Record clinical documentation in EHR should be moved from 2013 to 2011.
- Incorporate clinical lab test results into an EHR (2011) can be difficult for rural providers who may not want to pay for links with multiple labs (\$5,000 - \$7,000/lab) and, as a result, have to scan in lab results manually. He didn't think scanning documents into the system met the intent of the objective.

He felt that in general the objectives and measures are fine for primary care.

A representative of surgeons wondered if the definition of “meaningful use” could be uncoupled from certification. Based on the premise that it will be possible, she thought meaningful use means requiring the kinds of data elements that are part of data registries that are used for quality improvement and quality measurements. The surgeons are working with a broad coalition of surgical specialty societies to develop a cross surgical data registry that will contain a core of outcome data elements that cross a variety of surgical specialties. They are in the beginning stages of this effort.

When asked about a core set of measures suitable for general practices and specialty practices, a representative from ObGyn indicated that it is hard to know since they are each aware of the measures unique to their discipline. In terms of actual implementation, given the status of platforms and the lack of interoperability, the idea seems “a bit daunting.” The general consensus is that the objectives and measures as a whole are not a good fit for non-physician providers and specialties. Representatives from ObGyn and surgery thought they could identify those measures that will be applicable to both primary care and their specialty. A representative of surgery is concerned that even if they collected the data that it won’t be relevant to surgical outcomes. If it isn’t relevant to surgical outcomes she thought there will be considerable resistance. She didn’t think that surgeons routinely collected all the data currently in the meaningful use matrix.

Many surgeons have not invested in EHRs because there are none with the characteristics and qualities they find relevant to their surgical processes. They need the ability to capture images and the nomenclature is not appropriate for the procedures they do and the anatomy they need to describe. She is concerned about accelerating adoption in a manner that will require surgeons to purchase CCHIT certified products, for the purpose of reporting measures that aren’t relevant to their practice, that require extensive modifications to be relevant to their practice. Given the upcoming penalties, she thought surgeons will feel stuck between a rock and a hard place (e.g., they can collect blood pressure and enter it into an EHR but if it isn’t relevant to their surgical practice and it doesn’t help them in other ways to improve surgical outcomes and improve their practice, they are not going to comply).

A representative for surgeons thought there are some non-CCHIT certified products that meet the needs of certain surgical specialties (e.g., otolaryngology). The representative of podiatry and ObGyn thought there are some CCHIT certified products that worked for their constituents. A representative from nurse practitioners thought that there are, at a minimum, CCHIT certified products that work for family practice but specialty practices have the same problems as expressed by others. When asked if the situation will be improved by changing the criteria for a certified EHR to match the definition of meaningful use, there is still concern that vendors cannot meet the goals within the timeline. In addition there is concern about providers duplicating effort (e.g., all the providers treating a patient could ask if he/she had received the current Pneumovax, but one of the goals of EHRs is to reduce duplication of effort).

All persons participating on the phone call concluded that the meaningful use measures should be provider/specialty specific. The group thought it might be difficult enough to suggest to physicians that there are sufficient incentives for them to expend monies necessary to obtain and maintain an EHR and the current aggressive timeline for objectives and measures will create still another barrier. They thought casting a broad net with a lower standard will be more effective. They also felt that this approach will give the industry time to catch up. A representative of surgery thought that adoption will be a function of the providers’ interaction with their vendors. They need to be able to purchase a system that enhances their practices, works into their workflow, and gives them access to information when they need it. A representative from ObGyn emphasized the need to get guidance from ONC about platform standardization. There is a problem with providers investing \$40,000 - \$60,000+ for a system that is not interoperable. Equally important are good clinical support tools - they felt that the specialists are the best people to advise on an appropriate design.

An unidentified person on the call asked about HIOs and how providers will know if they have a compatible EHR. He asked who is responsible for developing these HIOs. ONC discussed the HITECH state grants and the requirement for interoperability.

**June 23, 2009**

**Participant Organizations**

- National Cancer Institute Center for Bioinformatics and Information Technology
- National Cancer Institute Center for Imaging
- St. Joseph Orange Hospital Cancer Center in Orange, CA
- Oncology Electronic Health Record Workgroup, American Society of Clinical Oncology
- American Psychiatric Association
- American College of Nurse-Midwives
- American Academy of Pediatrics
- Council on Clinical Information Technology, American Academy of Pediatrics
- American Dental Association
- Office of Ophthalmology, DC
- Academy Medical Information Technology Committee, American Academy of Ophthalmology
- American Academy of Ophthalmology
- American Academy of Physician Assistants
- American College of Cardiology
- CMS
- ONC

Two provider groups specifically applauded the meaningful use vision statement and all the provider groups represented expressed a desire to work with the Federal government on appropriate objectives and measures for their constituents. All agreed that achieving interoperability should be the primary goal because, without interoperability standards, proprietary products will continue to be a barrier to interoperability. A representative of cardiology expressed a desire to see coalitions of interested parties to work with the federal government to develop interoperability standards for public programs like Medicare and Medicaid in order to facilitate interoperability with practices, hospitals, etc. He mentioned RHIOs and exchange centers as one possibility of the future but thought that robust interoperability standards might “jump over some of that” and interoperability will happen in a manner similar to the way it happens with search engines where it will be much broader in the applications.

Representatives of Oncology stressed the need for structured data, including formal semantics so that data understandable and reusable. They also expressed the opinion that the specialty component of an EHR is as important as the ambulatory component especially in oncology due to the often lengthy timeline of treatment. Another issue for oncology is the ability of the EHR to communicate with registries since they are required to report to a number of registries.

Currently, most certified EHRs do not have the capacity to support specialty or non-physician practices. For example, psychiatry has particular privacy issues around the need to document psychotherapy sessions but they feel it is inappropriate to make that information available to other providers. Other specialties that also have confidentiality and privacy issues include infectious disease, reproductive medicine, endocrinology, and pediatrics. There is no consensus among providers on the best approach to the confidentiality and privacy issues. Those representing psychiatry indicated that there are good systems for parts of their practice but most psychiatrist use EHRs are a combination of existing systems. Some patients refuse to see psychiatrists once they have adopted EHRs.

Another issue raised is the size of non-physician and specialty practices size.

A high percentage of psychiatrists and nurse midwives have solo practices. Given the economy, some of the providers in solo or small practices are “trying to keep afloat and not go out of business.”

Cardiologists with significantly large practices have EHRs that include CDS. These providers are adhering to guidelines and performance measures in spite of being penalized in terms of reimbursement. They have added appropriate use criteria and are beginning to apply those to improve the appropriateness of images taken and to select the best therapy to choose between surgery, angioplasty, or optimal medical therapy based on science. In spite of this, they felt that the timing for implementing objectives and measures is too aggressive. They are concerned about finding the appropriate balance between encouraging cardiologists to move forward as fast as possible and discouraging them from investing in the ARRA opportunity because they don't feel that they can actually keep up.

A representative of oncology thought that an approach might be to pace components rather than a subset of functionality (e.g., e-prescribing being required after CPOE). A representative of physician assistants thought that more P.A.s are e-prescribing than using EHRs. He stressed the need for flexibility while moving forward because, not only are there different specialties, but also different settings and different capabilities. This approach will entail more specialty specific measures and allowing providers to choose the most applicable measures. It will also involve some flexibility in pacing. He thought that there are some existing objectives that are cross-cutting such as the use of high risk medications in the elderly (cardiology, dentistry, ophthalmology, etc.).

Given the state of EHR certification, a representative of oncology thought that some sort of temporary certification might be reasonable for qualifying for incentives while the community is migrating toward more certifying more specification. A representative of ophthalmology agreed that certification has been a barrier for them. They have invested a fair amount of energy into the certification process to accelerate it for their vendor community but CCHIT's capacity is very limited. A representative of dentistry indicated that they also had worked with CCHIT to develop criteria but that there is an idiosyncratic type of provider base that technology that may not interact directly with that model. Currently, they are trying to work toward a functional profile that could fit in with a functional specification for an EHR. He felt that approach might work across the different specialty groups but within the prescribed timeline.

John Glaser suggested an approach that targets certification at a foundational core set of capabilities that are as close to provider invariant as possible in 2011 and introduce specialty specific measures in 2013. Representatives from ophthalmology, cardiology, psychiatry, physician assistants, oncology, and dentistry verbally agreed to this approach (given difficulties with the number of telephone lines, the other representatives may or may not have been on the call at this time).

June 26, 2009

#### Participating Organizations

- American Academy of Pediatrics
- ONC

A special session with representatives of the American Academy of Pediatrics was arranged due to technical difficulties with their participation on the June 23<sup>rd</sup> call. Data collection for children are different than other age groups (e.g., height and weight [BMI] to calculate immunization levels; hypertension is sensitive to height and age; new born, metabolic, hearing, and lead screening). The representatives emphasized that this is not about the pediatrics specialty but

about children and EHRs that aren't designed for treating children make workflow very difficult (e.g., hunting for information. JCAHO accreditation specifically requires the inclusion of weight on children's prescriptions until a certain age.

A large number of pediatricians work in small practices where purchasing EHRs is very expensive.

EHRs need to be designed to support pediatric care (e.g., immunizations need to be in a repository instead of each record and there should be functionality for bi-directional queries). There is also an assumption that EHRs calculate accurately, which is not true (2/15 miscalculate). Web services or plug-ins might work better because rules can be written once and accessed. They feel the concept should be longitudinal medical records with a standardized set of fields that expand as the patient ages.

Demographics in EHRs are usually designed for adults. For example, children's records need:

- Patient name
- Guardian/Foster parent
- Name of person(s) with whom the child lives (e.g., shared custody)
- Telephone numbers and alternate telephone numbers

CPOE is more complex for children. Therefore it might be realistic to expect EHRs to accommodate children's records in 2011 and begin reporting in 2012. Pediatric records need to communicate with Medicaid and other state agencies. SCHIP is moving toward a model health record format (growth data, newborn screening, medical home, immunization).

Care coordination has a great impact on children. It is important to know the denominator with newborns. A good measure might be the % of patients that visit with their medical home after an emergency department visit. The identity of the medical home will be an important feature of an EHR. It will also be important to identify other providers.

Chronic care is also important. The EHR will need to track supplies (e.g., tracheotomy size, brand names, cleaning instructions, leg braces, feeding tubes, incontinence equipment), durable medical supplies (e.g., wheelchair, nebulizer).

There are special issues with adolescents around privacy and confidentiality that are specific to state law including age of emancipation.