

Meaningful Use - Specialists

1. In the context of the policy priorities, care goals and objectives that are part of the definition of *meaningful use*, what is the best way for specialists to be integrated into that framework?

Specialists, like primary care healthcare professionals, strive to ensure that patients are receiving optimal care and reducing death and disability. This is certainly the case with cardiologists, who are at the forefront of treating the number one killer of Americans, cardiovascular disease.

Care goals and objectives for cardiologists are aligned with those already set forth in the *meaningful use* objectives. For example, many of the proposed requirements for *meaningful use* are already being leveraged in cardiology, specifically in cardiovascular based health IT solutions. These include:

- ePrescribing
- Drug to drug, drug to allergy and drug formulary checking
- Up to date problem lists
- Providing patient specific educational resources
- Clinical decision support
- Interoperability functionality

The treatment of cardiovascular disease requires cardiologists to consider the five *meaningful use* goals on a daily basis: Improving quality, safety, efficiency and reducing health disparities; engaging patients and families; improving care coordination; improving population and public health; and ensuring adequate privacy and security protections for personal health information.

In many communities, it is the specialists who are providing primary and secondary care services and actively managing problems related to coronary artery disease, hypertension, heart failure, and lipid disorders. This might be in the context of an integrated delivery network but more often involves independent groups of physicians who are, on a local basis, providing high quality services. It will be important for *meaningful use* measures to recognize this variability in care delivery.

2. Are there relevant national registries in your specialty? Would participation in those registries be a good measure of meaningful use for the HIT incentive?

There are a rich number of national registries in cardiology that can serve as a good measure for meaningful use and should be used.

The **American Heart Association (AHA)** has invested in and built on scientific knowledge to develop treatment guidelines, decision support, and quality improvement tools. AHA's *Get With The Guidelines* program, with its registry, quality improvement and decision-support functions, has proven to be particularly effective in helping to translate advances made in cardiovascular disease and

stroke research into improved patient care at the bedside. In the inpatient setting, *Get With The Guidelines* includes an online, interactive assessment and reporting system, that provides patient-specific guideline information and tracks hospitals' performance for coronary artery disease, heart failure and stroke. About 1,600 hospitals participate in *Get With The Guidelines*.

In November, the AHA/ASA will launch their tools for the ambulatory setting. *Get With The Guidelines - Outpatient* (www.americanheart.org/outpatient), which will leverage the EHRs adopted by family medicine, internal medicine, cardiology and neurology practices to support efforts in providing the highest quality of care to patients.

The NCDR[®], an initiative of the American College of Cardiology (ACC) Foundation[®], began in 1997 to help health care provider groups and institutions respond to increasing requirements to document their processes and outcomes of care in the cath lab setting. Today, the NCDR is a comprehensive, outcomes-based quality improvement program, encompassing both hospital-based registries and a practice-based program. As a trusted, patient-centered resource, the NCDR is uniquely positioned to help participating facilities and other medical professionals identify and close gaps in quality of care; reduce wasteful and inefficient care variations; and implement effective, continuous quality improvement processes. Registries include:

1. Action Registry[®]; for acute coronary syndrome
2. CathPCI Registry[®]: for diagnostic cardiac catheterizations and coronary interventions
3. Impact Registry[®]: for improving pediatric and adult congenital treatment
4. Care Registry[®]: for carotid artery revascularization and endarterectomy procedures
5. ICD Registry[®]: for implantable cardioverter defibrillators
6. IC3 Program: for improving outpatient continuous cardiac care

Participation in these registries could be a good measure of *meaningful use* for the HIT incentive in cardiology.

3. How can specialists and the societies that represent them help accelerate the development of HIT-enabled quality measures that are appropriate for the definition of meaningful use?

Based on scientific guidelines and statements. The key performance measures in cardiology are developed and derived from American College of Cardiology/American Heart Association scientific guidelines and statements. The AMA-convened Physician Consortium for Performance Improvement[®] (PCPI), whose membership includes the AHA and ACC, then develop corresponding measures that are submitted to the National Quality Forum (NQF). Additional measures, not included in the PCPI, may be developed by the AHA or ACC if corresponding scientific guidelines have already been established. Adherence to this well-tested methodology will greatly accelerate the use of quality measures.

EHR specifications. Adapting scientifically valid quality measures to EHRs will be complex. Although it may be tempting to change measure definitions to accommodate reporting through EHRs, it is critical that automation not undermine the scientific basis of performance measures. For example, there are well-defined performance measures for heart failure that have been tested and analyzed extensively, as well as reported in the peer reviewed clinical literature. If revisions to these existing measures are made, there will need to be additional studies of these new measures and clinical expert input into the construction of these EHR-derived data elements and performance measures. The scientific underpinnings of the performance measures are crucial to the validity and reliability of measurement reporting systems. There may need to be pilots to test and demonstrate the validity of measures of meaningful use in different types of settings.

The AMA's Cardio-HIT project is one such example where PCPI/ACC/AHA measures for coronary artery disease and heart failure were HIT-enabled and tested in five different EHR products in different practice settings (single, multi-specialty, university setting and community practices). A cornerstone to this project was the standardization of the measures EHR specifications. The subsequent implementation could then be adjusted for the various EHRs and practice settings.

The PCPI/ACC/AHA is in the process of providing EHR specifications for all of its performance measures.

Clinically relevant measures. It is important that the measurement process flows from routine patient care and not be an additional data burden with each encounter. Once again, pilot testing and feedback will be necessary to determine, per specialty, what measures satisfy this requirement and are important to measure. The professional societies should be able to accomplish this through their registries.

Flexibility. A realistic and flexible timeframe to accommodate practices with varying degrees of IT adoption and expertise. It is important to recognize that for an average practice to move from initial adoption to more robust use will take at least 12-18 months. The measures a practice can incorporate will also vary and flexibility should be allowed. For example allowing practices to choose from a list of measures (e.g. PQRI) rather than expecting a uniform reporting capability.

Best practices and workflow design. EHR implementation and incorporation of performance measures and reporting is primarily a challenge of process redesign. Pilots, such as Cardio-HIT, resulted in a shared learning environment and best practices for workflow redesign. The professional societies have traditionally served a role in practice optimization that would be important in accelerating HIT-enabled quality measure implementation.

Clinical decision support. Beginning with scientific guidelines and statements to HIT-enabled performance measures and the development of disease registries, professional societies such as the AMA/ACC/AHA can then help determine the scientific background and real-time data for clinical decision support tools.

4. What other measures would you propose be considered to assess the meaningful use of EHRs by specialists? Are there any cross cutting measures that could be added to the MU definition today?

Listed are the appropriate resources for the AHA and ACC registries and the PCPI/ACC/AHA measurement sets. These form the basis of the measurement sets derived from scientific guidelines and statements in cardiovascular disease.

Ambulatory:

AMA PCPI/ACC/AHA (CSCAD 2005) - Chronic Stable Coronary Disease

<http://www.ama-assn.org/ama1/pub/upload/mm/370/cadminisetjune06.pdf>

AMA PCPI/ACC/AHA (HF 2005) - Heart Failure

<http://www.ama-assn.org/ama1/pub/upload/mm/370/hfset-12-5.pdf>

AMA PCPI/ACC/AHA (2005) - Hypertension

<http://www.ama-assn.org/ama1/pub/upload/mm/370/hypertension-8-05.pdf>

ACC IC3 Registry

<https://www.improvingcardiaccare.org/Pages/Elements.aspx>

Inpatient:

Get With The Guidelines - CAD Performance Measures -

<http://www.americanheart.org/downloadable/heart/1247859527251sfactsheet1-CAD-web.pdf>

Get With The Guidelines - HF Performance Measures -

<http://www.americanheart.org/downloadable/heart/1251477226167factsheet-HF-02.pdf>

Get With The Guidelines - Stroke Performance Measures -

<http://www.americanheart.org/downloadable/heart/1255117220661Factsheet-S-web.pdf>

Post Discharge:

Get With The Guidelines - 30 day measures (HF and CAD) -

<http://www.americanheart.org/downloadable/heart/1248113023270factsheet-HFCAD-4.pdf>

Get With The Guidelines - 30 day measures (Stroke) -

<http://www.americanheart.org/downloadable/heart/1248113859456factsheet-S-4.pdf>

5. Which measures could be incorporated in the definition of meaningful use that would help drive more communication and coordination between specialists and primary care?

Optimally, leveraging national interoperability standards and creating measures around the use of such standards is a necessity, no matter what the specialty. Interoperability also applies to measure definitions and the EHR specifications. It is important to use NQF-endorsed measures derived from ACC/AHA scientific

guidelines and statements such as the PCPI/ACC/AHA measures, avoiding measures that are “derived from” these measures for computational efficiencies.

Ultimately, the goal is that the primary and secondary care be delivered. It may be difficult for process measures around care communication and coordination to account for the varied processes that may be involved. That said, the PCPI recently published six measures around care transition (<http://www.ama-assn.org/ama1/pub/upload/mm/370/care-transitions-ms.pdf>) concentrating in inpatient and emergency department discharges. These include:

1. Reconciled Medication List Received by Discharged Patients
2. Transition Record with Specified Elements Received by Discharged Patients
3. Timely Transmission of Transition Record
4. Transition Record with Specified Elements Received by Discharged Patients
5. Discharge Planning/Post-Discharge Support for Heart Failure Patients
6. Patient Understanding of Post-Discharge Care Needed

In cardiology, care coordination around heart failure discharges would be a clinically important measure. Potential process measures concerning EHR *meaningful use* could include the inpatient to outpatient electronic transmission of medication reconciliation documentation and discharge summaries.

Care coordination and communication between specialists and primary care physicians could also be achieved and measured through a Continuity of Care Record.