

Defining Meaningful Use Criteria For Electronic Health Records: An Early Adopter's Wish List

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The Obama administration is committed to transforming healthcare on many levels. The underlying assumption is that implementing electronic health records (EHRs) will result in improved quality of care and cost savings. To that end, starting in 2011 a sliding scale of financial rewards will be available for oncology practices, among others, that demonstrate “meaningful use” of “certified” electronic health records. But before we spend any of that promised money, we need to give some serious consideration to just what exactly is meaningful use, and what will a certified electronic health record look like?

It does make sense to make meaningful use a requirement for the government to give us money, since buying an EHR and leaving it in the box is not what the government intends to pay for. Using a sched-

uling and billing system is also not sufficient. The people writing the checks have specific goals in mind when defining meaningful use and want to ensure that the carrots they offer result in the actions they desire. The intent is to have the EHRs that meet meaningful use criteria—as defined by the Office of the National Coordinator for Health Information Technology (ONCHIT)—be certified. However, the full certification process is long and cumbersome and some of the requirements may not add value for oncology-specific EHR systems.

My meaningful use criteria wish list includes:

1. Decision Support

Ideally, EHRs will improve quality of care because they offer important information to the doctor at the time of patient contact. This is referred to as “decision support” and it is one of the criteria being used by ONCHIT to aid in its definition of meaningful use. Decision support can be done well or it can be done badly. For example, if every time a physician orders Coumadin and a large box

pops up listing all its known interactions, many of them will click past it without reading it. If you order a lot of Coumadin, you will see this box so often that you may develop “alert fatigue”. Therefore, each physician needs to determine what decision support items he will actually find useful.

Surely, an interaction with the known drugs that a patient is taking would be very useful, but it must be done in a way that is not obtrusive and does not slow down patient care. For example, now that we have multiple chemotherapy drugs that prolong the QT interval, it would be very helpful to have the EHR alert us to the other drugs a patient may also be taking that prolongs the QT interval so we do not inadvertently cause a patient to have a bad reaction.

A component of decision support that I believe we will all need in the future is genetic profiling of diseases and patients; at least, I personally am not able to memorize which gene profile goes with which disease, and with which response to treatment. I would love to have the ability to have that information at my fingertips real-time when I am discussing therapy

with a patient. However, I only want the oncology profiles. I do not want my electronic record to make me purchase the genetic decision support for multiple sclerosis or other non-oncologic diseases.

Problem lists of ICD-9 codes are another meaningful use criterion. I work with problem lists as I think they are valuable tools. However, the list is not valuable if it consists of ICD-9 codes that read like this: 174.9. Malignancy of the breast, female, site unspecified. What I would rather have is an ICD-9 code attached to more information, e.g., 174.9. Breast cancer, T1, N1, M0, stage II, one of six nodes positive, ER/PR positive, HER negative, status post AC x four and tamoxifen. In other words, doctors must be able to modify the problem list so that it actually is a meaningful clinical tool. Very soon, ICD-10 codes will be established and while its implementation will be an enormous challenge, this may be an excellent opportunity to create more sophisticated and customizable problem lists.

2. Quality Measures

It comes as no surprise that the people paying for healthcare would like to know that they are getting quality care. It, therefore, makes complete sense that quality measures should be incorporated into an EHR, but those measures should be entered automatically and G codes generated without wasting physicians' time doing data entry.

Unfortunately, specific measures have become part of the meaningful use criteria. For example, one quality measure is a hemoglobin A1c. Since

I must meet that quality measure, I will certainly draw a hemoglobin A1c on all my patients, but since I do not manage their diabetes, it will just add unnecessary expense and no valuable information.

In my opinion, it would have been better for oncology to have ASCO's Quality Oncology Practice Initiative generate quality measures that are meaningful for our own practice improvement. Furthermore, EHR vendors should give us the ability to delete the measures when they are completed and to add new ones when indicated, without billing us for more expensive software.

3. Health Maintenance

Reporting on health maintenance is a great function of an EHR. It would be useful to have flags that come up when people need various screenings and vaccinations. However, each specialty should be able to adapt their screenings for their appropriate patient population. For example, a reminder of when a patient's five-year colorectal screening with colonoscopy is due will be useful for me, but probably not for pediatricians. We also need to have the ability to run reports on that data so that we can challenge insurance companies that downgrade us based on incorrect data.

4. Treatment Summaries

Patient groups have lobbied for treatment summaries as meaningful use criteria. Unfortunately, the meaningful use criteria require a summary after every encounter. Ideally, the physician should decide what information goes into the patient summary

and be able to customize the electronic record so that it auto-populates that summary. Patients definitely need the information, but an abbreviated summary pertinent to each encounter—for example, changes in medications, and then a more complete summary at the end of treatment (or an "episode of care")—would better serve their needs.

Order entry is going to be a criterion of the Certification Commission for Health Information Technology (CCHIT). It will have to have diagnosis codes and there will be e-prescribing. Immunizations and referral management is part of the process.

5. Information Exchange

Currently, every time a physician wants to import data from another laboratory, another x-ray facility, or other offices, she will either end up with scanned documents that are not searchable, or she'll have to spend a lot of money with her vendor creating an interface. (I have learned that interface is truly a four-letter word and generally costs \$20,000.) Or the physician will need to log into a separate portal without being able to import the data, greatly limiting its usefulness.

I think there will be considerable cost savings for the healthcare system without sacrificing quality in the sharing of lab and x-rays. [cont. on pg 10 >>](#)

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