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June 26, 2009

David Blumenthal, M.D., M.P.P.
National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
Office of the National Coordinator for Health Information Technology
200 Independence Ave, SW
Suite 729D
Washington, DC 20201

RE: HIT Policy Committee Meaningful Use Comments

Dear Dr. Blumenthal,

Thank you for the opportunity to provide comments on the materials presented by the Meaningful Use Workgroup of the Health Information Technology Policy Committee on June 16, 2009. We welcome the Workgroup's strong vision of how meaningful use of electronic health records (EHRs) can support the transformation of health care so that patients receive better coordinated, high quality care. We are committed to working with you to develop specific criteria that accommodate the unique needs of cancer patients and lead to widespread adoption of EHRs by oncologists.

As you may know, cancer is the second most common cause of death in the United States after heart disease. EHRs can play a key role in improving cancer care and advancing clinical research. We submit these comments on behalf of more than 27,000 oncology practitioners who belong to the American Society of Clinical Oncology (ASCO). Our members represent all oncology disciplines (medical, radiation, and surgical oncology) and subspecialties, and include physicians and health-care professionals participating in approved oncology training programs, oncology nurses, and other practitioners with a predominant interest in oncology. ASCO's members set the standard for patient care worldwide and lead the way in carrying out clinical research aimed at improving the prevention, diagnosis, and treatment of cancer.

ASCO appreciates the overall approach taken by the Workgroup, which emphasizes the use of EHRs to improve quality and efficiency of care, rather than simple acquisition of a product. We also agree wholeheartedly with the five goals the Meaningful Use Workgroup used to frame its initial discussion of criteria that can be used to assess whether providers are using their EHRs to improve care.

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Making a world of difference in cancer care

We are committed to widespread adoption of EHRs by the oncology community and have been working with our members and others to facilitate that process. ASCO has published a comprehensive Field Guide to assist oncologists in the evaluation, selection and implementation of EHRs with oncology specific functionality and ASCO will host its second EHR Symposium this October to disseminate the most recent developments in HIT technology and public policy as these impact the future delivery of cancer care in our nation. These and other efforts have already led to a growing number of oncology practices with installed EHRs.

We are concerned, however, that the specific objectives and measures included in the meaningful use matrix prepared by the Workgroup present an overly challenging timetable given current market conditions. In addition, many of the specific measures have limited relevance to the oncology community. We request flexibility in developing the final criteria and pledge to work with you to identify measures that will lead to widespread use of EHRs by oncologists to improve care for cancer patients.

Current market conditions

To achieve the best outcomes, medical specialties, including oncology, require EHRs that meet their needs. Currently, however, oncologists who are hospital based or work in multidisciplinary healthcare environments are challenged by the limited availability of products tailored to support their unique needs. For example, oncologists must document the type and stage of cancer, use computer physician order entry (CPOE) systems designed to support complex chemotherapy order sets that include supportive care drugs, have access to oncology-specific flow-sheets, and document chemotherapy treatments that often involve highly toxic medications. The relatively small size of oncology within a large institution's functional needs, which include medical-surgical departments, pediatrics, emergency departments and operating rooms, limits vendor interest in developing oncology-specific products.

Furthermore, of the handful of niche EHR vendors that have oncology-specific products (identified at www.asco.org/ehr), none are currently certified by CCHIT. Many of the vendors that tailor products to the oncology specialty are small and have concluded that the current CCHIT process is not appropriate for them. Recently, CCHIT has proposed a modular certification process to address the need for a certification path for medical HIT subspecialty systems. It is crucial that certification requirements and processes accommodate vendors providing systems that support specialty care, as they are filling an important gap in the market.

Despite these difficulties, EHR systems that already meet the spirit and intent of the proposed 2011 targets are in place in many oncology practices. These early adopters should not be excluded from benefiting from the ARRA incentives for meaningful use merely because the certification process has not yet been defined and rendered functional. For example, oncology-specific EHR products now on the market already improve quality, safety, and efficiency of chemotherapy administration through advanced CPOE systems that provide drug-drug interaction checks, automated dosing calculation that prevent doses exceeding safe levels, and lifetime total accumulative drug dose limits for such drugs as doxorubicin.

ASCO has worked diligently and will continue to promote development of products that support oncology practice. For the past three years, ASCO has invited EHR vendors to participate in an EHR Vendor Laboratory to showcase their oncology-specific functionality. Currently, ASCO is working with the National Cancer Institute on a Clinical Oncology Requirements for the EHR (CORE) project. The CORE project will provide a clear understanding of the EHR functions needed to support an oncologist in clinical practice, paving the way for development of oncology-specific products. The CORE project is ongoing and we anticipate that a white paper and technical specifications will be released in October 2009. In addition, the oncology community successfully petitioned CCHIT to place oncology EHRs on its roadmap for certification. That certification, however, will not launch until July 2011.

Until the CORE project is completed and CCHIT or another body has begun certifying oncology-specific products, oncologists have limited access to appropriate technology. We recommend that in the absence of certified, oncology-specific products, the timeline for meeting the meaningful use criteria be extended. Alternatively, the certification process could be modified to accommodate specialty-specific products in a timely manner by acknowledging that some oncology targeted products already have advanced level functionality in core areas of interest that exceeds the requirements applicable to primary care and that other areas, such as improvement in population and public health, may be less relevant to cancer patients.

Timeline

The 2011 objectives laid out in the matrix require sophisticated use of EHRs and sharing of clinical data that will be difficult for those recently adopting EHRs to meet. As you know, implementing an EHR takes time and involves considerable re-working of workflows and practice patterns to achieve the best results for patients. The necessary behavior changes by physicians and office staff often require extensive support and training. Requiring new adopters to climb the adoption curve too quickly could result in poor or failed implementations, or even dissuade physicians from adopting EHRs at all. We recommend providing more time for new users to learn how to use these higher order functions. Initial metrics should focus on entering structured data into the EHR consistently to generate problem lists, medication lists, and allergy lists. Requirements can and should increase over time, but must be achievable in order to provide a true incentive for adoption.

Relevance to oncology

In designing requirements for meaningful use, ONC and CMS should strive to include measures that are relevant to each specialty. While challenging, this approach will encourage the best possible use of EHRs in each clinical domain and avoid the disincentive that arises when you ask providers to report data that they do not believe improves care for their patients.

Below, we identify issues with the measures presented in the matrix in the following domains: e-prescribing, quality measurement, and health information exchange. We also make suggestions for alternative measures and/or timeframes for including them.

e-Prescribing. One of the 2011 objectives includes generating and transmitting permissible prescriptions electronically. Oncology practice involves the administration of numerous expensive, sophisticated, and potentially toxic oncology drugs, including agents to minimize their consequences (such as anti-emetics, steroids, and pain medications). Most of these medications are controlled substances that legally require secure paper prescriptions. While some oncologists may adapt to a work-flow that involves both electronically transmitted and paper prescriptions, others may prefer to continue generating only paper prescriptions for their patients.

Over time, increased use of computerized physician order entry and e-prescribing with decision-support tools for oncologists has the potential to avoid drug interactions and identify significant savings on pharmaceuticals. These safety features are key motivators for adoption of EHRs. Most recently, ASCO has developed a set of guidelines for safe administration of chemotherapy and begun developing the requirements for how EHRs can support them. As the technology improves over time to support these functions, and policies change to support e-prescribing of controlled substances, we recommend including measures of e-prescribing and the use of decision-support in chemotherapy administration in future meaningful use criteria. For oncology, however, they are difficult to achieve in 2011.

Quality reporting. The quality measures included for meaningful use should be relevant to specialty groups and emphasize participation in quality improvement efforts. Currently, most EHRs have a limited ability to generate measures of quality of care that are relevant to specialty practices, including oncology. Consequently, the quality and other meaningful use measures included in the matrix apply primarily to general practice physicians. While we wholeheartedly endorse improvements on these measures, they are generally not good measures of the care provided by oncologists. Examples of measures that are not particularly germane to oncology include:

- % of patients with LDL under control
- % of patients at high-risk for cardiac events on aspirin prophylaxis
- % of eligible patients who receive flu vaccine

Like many medical specialty societies, ASCO has developed quality metrics and quality improvement mechanisms specific to the care its members provide. ASCO has also developed the Quality Oncology Practice Initiative (QOPI), a voluntary office-based quality improvement program that assesses practice performance for a series of evidence- and consensus-based process measures.

We would be happy to work with you to identify a subset of oncology quality measures for inclusion in the meaningful use criteria and identify a realistic timeframe for including them. In addition, until EHRs provide the functionality to electronically report these quality measures, we recommend that oncologists be recognized as meeting the meaningful use criteria by participating in QOPI or other quality improvement activities using existing web-based tools.

Health information exchange. Health information exchange should focus on sharing relevant information to support clinical care. The information that oncologists share include some data common to all providers, such as lab values, but many other elements that are specific to the specialty. Given these realities, health information exchange requirements should focus on sharing relevant clinical information among a patient’s care team, such as providing a chemotherapy treatment summary to a patient and his or her primary care physician.

As part of the CORE project, ASCO and NCI are working to define the data elements that would be needed to generate both a chemotherapy treatment plan and a treatment summary. Once that work is completed and integrated into oncology-specific EHRs, generating and sharing these documents could potentially qualify as appropriate future information exchange measures. Additionally, many oncologists contribute data to cancer registries that are used to improve the quality of care and conduct research. As EHRs mature and accommodate automated reporting into registries, participating in those registries could also be an appropriate future measure of meaningful use. We recommend that, in the meantime, requirements for health information exchange be minimal.

In closing, we thank you for the opportunity to provide our perspectives on how best to describe and measure meaningful use of EHRs. In addition to these comments, ASCO has also co-signed the comment letter submitted by a coalition of physician groups. If you have any questions about these comments or need further information, please do not hesitate to contact Nickol Todd at nickol.todd@asco.org or 571-483-1655.

Sincerely,

A handwritten signature in black ink, appearing to read "Peter Paul Yu". The signature is fluid and cursive, with a long, sweeping tail on the final letter.

Peter Paul Yu, M.D.
Chair, ASCO EHR Workgroup
Member, ASCO Board of Directors