**Statement for the Record**
**to the National Committee on Vital and Health Statistics**
**April 28-29, 2009**
**on**
**Meaningful Use of Health IT**

The College of Healthcare Information Management Executives (CHIME), on behalf of our more than 1350 healthcare chief information officers across the U.S., is pleased to submit this statement for the record sharing our views on "meaningful use of health information technology." CHIME serves as a voice of the healthcare IT executive within the U.S., informing and influencing public policy leaders and other officials on the role of information technology in transforming the delivery of healthcare, while providing members with the latest information regarding new HIT legislation, regulations and polices. Founded in 1992, CHIME provides a highly interactive and trusted environment to enable senior professionals and industry leaders to collaborate and exchange best practices.

As healthcare IT executives charged with leading the implementation of electronic medical records (EMRs) and other IT tools to improve the quality and effectiveness of patient care, we are excited about an expanded Federal focus on encouraging the adoption of health IT, and at the same time we are well aware of the enormous challenges in achieving this goal. Under the American Recovery and Reinvestment Act (ARRA) of 2009, hospitals and physician practices beginning in 2011 are eligible for incentive payments under Medicare as well as payments for serving Medicaid patients by demonstrating "meaningful use of health information technology." Failure to do so by 2015 will result in reduced payments for Medicare, specifically. Title IV of ARRA articulates three general criteria as evidence of meaningful use: (1) Quality metric reporting; (2) Connection to exchange data; and (3) Certified systems. CHIME's comments address numbers one and two.

**Quality Reporting and Outcomes**
CMS currently collects 30 quality measures as part of its Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program, which requires most hospitals to submit data for specific quality measures for health conditions common among people with Medicare, and which typically result in hospitalization. ARRA adds to these efforts a direct tie for use of health IT to improve care. The bottom line for these efforts is better health/better outcomes. Using an EMR and other IT tools to accomplish this goal is clearly about outcomes and less about the technology. It is CHIME's view that meaningful use must focus on outcomes and not mandate specific functionalities.

**Phased Approach to Adoption**
Across the U.S., there are approximately 5,000 hospitals. This diverse universe includes community hospitals, large multi-hospital systems, teaching institutions, rural facilities, critical access hospitals and small specialty hospitals, among others. Some of these facilities are experiencing financial hardship, particularly in today's strained economic environment. Loans and a reasonable hardship delay could assist those least able. On the other hand, some hospitals are more financially able to move forward now with health information exchange (HIE), computerized physician order entry (CPOE) and outcomes improvement to earn incentive funds.

As reported in "Use of Electronic Health Records in U.S. Hospitals" (Jha, DesRoches, Blumenthal, et al, NEJM 2009; 360), only 1.5 percent of U.S. hospitals have a comprehensive electronic-records system and an additional 7.6 percent have a basic system. Adoption was

higher among larger institutions, major teaching hospitals, facilities that are part of a larger system or those located in urban areas. Non- adopters cited inadequate capital for purchase, concerns about maintenance and resistance on the part of physicians.

Recognizing this diversity and low adoption rate, CHIME supports phasing in criteria for meaningful use to encourage early adoption without raising the bar too high, too early. During later years, we recommend raising the bar to encourage continued development and progress by those who have adopted EMRs.

**Exchange of Data and HIEs**

According to a nationwide survey conducted by the eHealth Initiative in 2008, 130 respondents identified themselves as health information exchanges (HIEs) with some 42 percent of respondents reporting their status as "operational," that is, transmitting data for use by healthcare stakeholders, although the scope of the exchange is not specified and details are lacking. Among the challenges reported by respondents, 82 percent cited development of a sustainable business model as the most significant hurdle. With the exception of a few HIEs, such as the Indiana Health Exchange and CareSpark in Tennessee, health information exchange connecting major health care providers does not exist in most U.S. communities. In addition to lack of a sustainable business model, other barriers include upfront funding, governance issues, privacy concerns and agreement on standards.

Given this obstacle, immediately requiring connection to an HIE for exchange of data is not reasonable. In the short term, CHIME recommends exploring other ways to exchange health information electronically other than through an HIE. An example of this is the use of a single vendor's product to enable its community/regional customers to electronically exchange health information.

The accepted standard for exchange of clinical information is the HL7 Continuity of Care Document (CCD), recognized by physicians, nurses, technologists and laypersons. At least initially, it may be necessary to explore other acceptable means for exchange of health data. As noted above, smaller hospitals, those in rural areas and others lacking the necessary resources may not have the capability to immediately deploy the CCD. CHIME believes that some flexibility in this regard may be needed for compliance.

**Conclusion**

Regarding the meaningful use of health IT, CHIME supports:

- The use of quality metrics and outcomes regardless of technology in place;
- A phased approach to encourage early adoption without raising the bar too high, too early;
  - raising the bar during later years to encourage continued development and progress by those who have adopted EMRs;
- Explore alternative means to connectivity in the short term and connection to an HIE over time as these entities become fully established by community and region;
- Consideration of alternative means to use of CCD for exchange of health data, at least initially to accommodate hospitals financially and technically unable to comply.

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