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April 30, 2009

**Meaningful Use Testimony** – Submitted by Intermountain Healthcare, Salt Lake City, Utah
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Intermountain Healthcare is an integrated system of nonprofit hospitals, clinics and related services based in Salt Lake City, Utah. Intermountain's team includes more than 30,000 employees, providing care in 6 million patient visits every year at 21 hospitals and more than 130 clinics. SelectHealth, a nonprofit insurance company, is also owned by Intermountain and provides benefits for close to 500,000 people.

As a guiding principle, Meaningful Use of Electronic Health Records (EHR) should include a detailed **vision for the future** and a series of steps to achieve that vision. **Federal Leadership** should assure that this detailed vision is created, understood and puts the United States in a position to sustain and enhance healthcare delivery to the populations of the country. *The issue of meaningful use is not simply 'federal funding' rather it should be federal leadership supported by appropriate funding.*

Significant research and development has been achieved over the last 40 years in healthcare information systems. The increased focus on medical informatics has brought major advances in using information to improve care processes that increase the quality/effectiveness of care delivery and in several instances lower costs. Practical examples exist of technology supporting best practice care. Intermountain Healthcare has achieved very notable results from the appropriate application of information systems to the clinical process. These results are *sustainable*, will further increase over time, are *extendable* across the country and *scalable* to large integrated delivery organizations, smaller clinics and individual practice settings.

Status quo Clinical Information Systems have solved many problems associated with modern medicine. Indeed, the creativity and skill of professionals across the industry has been amazing. However, on a broad scale, the currently available systems have not proven effective in systematically solving the healthcare problems of the United States. Facilitating the ineffective implementation of systems that are themselves also ineffective, without placing focus on fundamental infrastructure improvements to these systems, is likely to only further automate the chaos which healthcare is experiencing.

General principles

1. **Meaningful use suggests that the use of the EHR makes a positive difference in the cost and quality of health care**. To the extent possible incentives should focus on measuring outcomes and surrogates for outcomes, rather than functionality of the EHR systems. We should pay for achieving measureable outcomes that we want, not for process steps such as simply buying and installing a system. For example; What percent of BMI's (a HEDIS measure), heights, weights, are stored as coded values in the EHR? Ideally, incentives should be provided for: decreasing drug-drug interactions, decreasing adverse drug events, decreasing duplicate orders, decreasing length of stay, decreasing medication administration errors, increasing the accuracy of surveillance data sent in standard messages to public health organizations, increasing the quality

and timeliness of data sent to disease registries, lower HgbA1c levels in diabetics, lower blood pressures in hypertensive patients, discharge with proper medications after MI, etc.

2. **Incentives should be incremental**, not all or nothing so that small or medium steps in specific areas provide motivation for improvement. For example, rather than all or nothing incentives for POE, systems should be rewarded for taking individual steps such as online ordering, allergy checking, barcode medication administration, etc.
3. **Weight should be given to the level of adoption within an institution**. Incentives should depend on the degree of use of the desirable system functions. What matters is that the cost saving or quality improvement capabilities in the system are in widespread everyday use (and presumably having an impact on patient care) not just that the functionality exists in the software. A system that administers all inpatient medications with bedside barcode checks should be rewarded more than a system where barcoding capability exists but is only used for a small percentage of the patients.
4. **Incentives should depend on measures that can be easily and objectively verified and quantified**. It should be easy for an independent observer or auditor to see that an incentive milestone is being met and by what proportion of the system users.
5. **Decreasing costs does not need incentives**; it is its own reward, as long as the savings accrue to the organization that saves the money (e.g. a provider) and not to another group (e.g. a payer) that was not responsible for saving the money. We should try to eliminate any currently misaligned incentives. It ***would*** be appropriate to provide incentives to providers that decreased charges to payers.
6. **Meaningful use should avoid increased operating costs or burden**. Incentive funds should facilitate adoption, not justify new costs or regulatory burdens. For example, changes to privacy requirements (e.g., expanded accounting of disclosures) must be coordinated with incentives and consider impact, as well as risk, and not undermine adoption or the benefit of incentives.

Specific areas where incentives could/should be created:

1. Order entry
    a. Electronic recording and checking of drug and food allergies
    b. Electronic checking for drug-drug interactions
    c. Electronic order entry (non physician entry)
    d. Bar code administration of inpatient medications
    e. Use of evidence based order sets for common diagnoses and procedures
    f. Direct physician entry of orders
2. Appropriate discharge medications after acute MI.
3. Decreases in preventable errors
    a. Drug-Drug interactions
    b. Adverse drug interactions
    c. Decreased rate of ventilator disconnects
    d. Decrease in infusion pump rate errors
4. Improvements in chronic disease/condition management
    a. Decreasing HgbA1c levels in diabetics (and lipids, foot ulcers, microalbuminuria)
    b. Decreasing blood pressures in hypertensives
    c. Decreased morbidity in congestive heart failure
    d. Decrease in kernicterus in newborns
    e. Decreased bleeding complications in chronic anticoagulation
5. Decreased rates of MRSA infections
6. Decrease in NICU admissions and complications in normal pregnancy
7. Provision of data to disease registries, and public health and quality assurance organizations
    a. Use of standards for coding and structuring the data sent
    b. Timeliness
    c. Completeness and accuracy of the data sent
8. Decrease in duplicate and redundant tests performed