April 30, 2009

Marietta Squire
National Committee on Vital and Health Statistics
Executive Committee, Defining Meaningful Use of HIT

Dear Ms. Squire

Thank you for the opportunity to submit public testimony to the Committee on the "meaningful use of an EHR." As Director of the Office of HIT Adoption in HHS over the past several years, I had the privilege of hearing numerous testimonies from many diverse sectors of the health care industry regarding adoption of electronic health records (EHRS), personal health records (PHRs), technologies that support communication between providers and patients, and technologies that support health information exchange (HIE).

As a current member of the community of Quality Improvement Organizations, I am familiar with the robust experience that these organizations have had through the 8th Scope of Work contracts with the Centers for Medicare and Medicaid Services (CMS) in supporting efficient adoption and effective use of EHRs in close to 5000 small to medium sized primary care oriented physician practices.

Based on this knowledge, I would like to submit for the Committee's consideration two critical recommendations for the CMS incentive programs outlined in Chapter IV of the American Recovery and Reconciliation Act of 2009.

1) **The definition of "meaningful" use of an EHR must be iterative, given the evolving nature of the technology available**. Providers can only be expected to use functionalities that are available in "certified" products and share data that have been "standardized" by the HITSP, tested by the NIST process, and recognized by the Secretary of HHS in time for inclusion into the 2009 certification process for 2011 "meaningful use." As interoperability standards annually expand and are included in the certification criteria, the definition of sharing data for meaningful use can also expand on a cycle to match certification upgrades. As functionalities (such as clinical decision support) become more integrated into technical workflow and as EHRs themselves become more useable, the definition of meaningful use would also be expected to expand.

2) Many of my colleagues have provided important and relevant testimony which focuses on their need to access specific data elements for the purposes of payment, public health, or quality monitoring. First and foremost, however, **EHR use must be "meaningful" for patients with respect to the care experience**. This means that certain elements of the encounter, be it in person or remote, should be electronically integrated into the visit to reach specific goals:

- Viewing of all authorized and available electronic data regarding a patient at the point of care (presented in a well organized format) to provide more comprehensive and coordinated care.
- Educating patients regarding possible diagnoses, options, and treatments so that they can be fully informed and engaged with the decisions necessary to optimize their health status
- Generating care plans for patients with chronic or complicated clinical conditions so that patients and/or their immediate caregivers are clear about steps to be taken under various circumstances
- Communicating with patients when they are no longer physically present in the care setting, to ensure appropriate follow up and adherence

Again, certified technologies are evolving in their ability to perform these functions and meet these objectives, as are payment policies. However, in order to prepare both the vendor community and the provider market for 2011 and beyond, HHS will need to signal now that these important elements of meaningful use will be incorporated into its definition.

I would also like to recognize the current debate between proponents of widespread EHR adoption in the provider community as a first priority and proponents of the development of a widespread network for sharing of health information as a first priority. I suggest that both will take time to come to fruition, and both will need to progress in parallel along thoughtful and realistic timelines. Assuring that all EHRs currently in use are upgraded to include at least 2009 interoperability criteria and that all new EHR installations are of products certified at the 2009 level will support whatever health information exchange structures that are built to these same interoperability standards and specifications. The HIE community will need to mature its governance structures, attune to new privacy policy, and develop more sustainable business models as more and more useable clinical data becomes available from the delivery system. The first priority for both should be use of HIT to support better patient care.

In closing, the CMS provider incentives for EHR adoption are a necessary and critical component for realizing the future potential of interoperable HIT to create a better informed delivery system and to improve the health of the population of the US. Thank you for your efforts in assuring that they are operationalized with better patient care as a first priority.

Sincerely,

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