**Statement by Mary R. Grealy, President, Healthcare Leadership Council on the National Committee on Vital and Health Statistics Executive Subcommittee Hearing on "Meaningful Use" of Health Information Technology**

**Tuesday, April 28 – Wednesday, April 29, 2009**

I want to thank you on behalf of the members of the Healthcare Leadership Council for the opportunity to provide a written statement for the record on this hearing to discuss a proper definition of "meaningful use" for the purpose of interpreting health information technology (HIT) provisions of the American Recovery and Reinvestment Act (ARRA, P.L. 111-5).

The Healthcare Leadership Council (HLC), a coalition of chief executives from all disciplines within the health care system, strongly supports HIT and its ability to increase the efficiency and safety of care. Improving the accessibility, affordability, and quality of American health care is the goal uniting HLC members -- hospitals, health plans, pharmaceutical companies, medical device manufacturers, biotech firms, health product distributors, pharmacies and academic health centers. HLC members have a unique understanding and successful history in implementing HIT. Our members are some of the earliest adopters of HIT systems and have seen firsthand the many benefits of electronic health records and other HIT tools to improve health care quality, outcomes and patient safety.

Within the ARRA statute, Congress has already identified three broad parameters for the basic functionality of electronic health records, including:

- utilizing certified technology (including e-prescribing);
- conducting electronic exchange of information with others (such as, care coordination); and
- reporting on clinical quality measures.

These are goals that we all share for the promise of improving quality and efficiency through HIT. Many early adopters of HIT systems are now realizing a return on their investment in HIT. For example, North Shore University has seen dramatic reductions in hospital infection rates as a result of incorporating HIT into their practice of medicine, including a 70 percent reduction in Methicillin resistant *Staphylococcus aureus* (MRSA) infections. Another example is the Marshfield Clinic, who, without their sophisticated HIT system, would not have been capable of participating in the CMS Physician Group

Practice demonstration which has improved the care their patients' receive while also saving money for the Medicare program.

These and other HIT success stories are based on different HIT solutions in different settings – there should not be a one-size-fits-all approach to HIT. This forms the basis of our first recommendation for this subcommittee: that the initial definition of "meaningful use" be simple and flexible to ensure that a variety of interoperable HIT products and solutions are available to qualifying providers. Keeping the definition of "meaningful use" simple will maximize provider uptake in the short-term. However we define "meaningful use," the focus should always be on the end goal, which is achieving better health outcomes for all patients. To the extent possible, the definition of "meaningful use" should be simple and achievable. The Department of Health and Human Services (HHS) has been given broad authority over what may constitute "meaningful use." We therefore suggest beginning with a less stringent definition that can be refined over time as lessons in the field are learned.

Second, coming to a timely and clear agreement as to the definition of "meaningful use" will be the best way to demonstrate to providers the parameters necessary to qualify for incentive payments. Ironically, the HIT marketplace has frozen following passage of ARRA. Health care providers are waiting to purchase new technologies until they can be assured that: 1) they will qualify for bonus payments to help defray the cost; and 2) they are assured that the products they purchase will be recognized as meeting government standards.

It is, to be certain, a delicate balance between making the definition of "meaningful use" flexible enough to allow providers to practice the art of medicine in a way that improves outcomes and creates efficiencies yet also makes it stringent enough to ensure that Medicare dollars are being spent wisely. In order to realize the desired effect of ARRA and pave the way for improvements in our health care system, policy makers will need to clearly communicate the requirements of "meaningful use" to the appropriate stakeholders in a timely manner in as simple terms as possible so that providers are given predictable expectations.

Third and finally, HLC would like to reiterate and give our support to the notion, offered continuously by panelists throughout the hearing process, that HIT tools need to be useful to care providers and patients. A goal of HIT adoption, of course, is to enable providers to positively impact health at the point of care; so I urge HHS to incorporate actionable, point of care improvement into the definition of "meaningful use."

I appreciate the opportunity to submit this written statement on behalf of the members of the Healthcare Leadership Council. Any questions about this statement or these issues can be addressed to me or to Ms. Tina Grande, Senior Vice President for Policy, Healthcare Leadership Council (telephone 202-452-8700, e-mail tgrande@hlc.org).