Statement to the National Committee on Vital and Health Statistics

"Meaningful Use"
of Health Information Exchange under ARRA

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Thank you for the opportunity to testify today. You are coming to the end of a long two days so I'll be brief and then be available for questions.

My name is Steve Findlay and I am here today representing Consumers Union and the consumer-patient perspective on this issue. In full disclosure, I am a registered federal lobbyist. I have no investments in any HIT companies outside of mutual funds accounts. I'm a board member of the National e-Health Collaborative, the AHIC successor entity.

Certification has played an important role in the advance of HIT so far. And Mark just updated you on CCHIT. It was reasonable in 2004, when CCHIT was launched, and it is reasonable now – as specified under ARRA – to look to certification as one foundational pillar of promoting an HIT marketplace which meets certain standards and needs.

In compelling certification in ARRA, Congress aimed to build on work over the past five years. That's good. However, it is now time to pause and reflect on the future role of certification in the context of the changes ARRA calls for ….but also in light of the plain fact that EHR certification has <u>not</u> been particularly successful to date at driving rapid adoption.

But I won't waste time here on the past. Your mission is to help envision the future use of HIT and the best and fastest way to get there. So, cutting to the chase, and being responsive to the formal questions posed to this panel:

First and foremost, certification of EHRs and PHRs should be redirected and adjusted to explicitly promote better quality and safer care, more efficient care, and new models of care that – over time – will save money. That's the "meaningful use" you have been hearing about for two days. *Technology for technology's sake is not the point.*

But, we also believe that meaningful use of HIT should enhance consumer and patient engagement in care and make consumers' access to ACCURATE medical information and data about themselves and their care easy to *obtain, understand, use, and act on.*

Thus, meaningful use for consumers will require some mechanism to present things like lab, blood, and imaging results, diagnosis and clinical status, medication history, and all other relevant information….to consumers in a way they can *evaluate and understand, and that permits them to track changes over time.*

We believe this kind of patient-centered meaningful use should indeed be a criteria of certification – for EHRs as well as for PHRs. Obviously, this is a given for PHRs. But it has not been for EHRs. So we are talking about an evolution in certification that would reward EHR systems that "translate" and "contextualize" part of the content of an EHR for the consumer/patient.

In this regard, some experts – including committee member Paul Tang – have talked about PHRs that are integrated with EHRs. That is one way to go…and is already being deployed in various settings. And we agree it's an attractive model.

But we also believe that EHR data and information should be easily transferable to a secure stand-alone PHR – or other e-tool – set up by a consumer. Of course that is in large part the model of the PHR vendors today.

Either way (integrated or stand-alone), it's critical that data integrity and accuracy be a key component of both EHR and PHR certification. *There*

can be no meaningful use of medical information that is WRONG. And clearly billing data won't do.

That is why we think EHRs simply must be open to patient input, and certification around the ease of that is essential. A patient's input can come in a variety of ways. It may come from a PHR, or it may simply come from a patient asking to see their EHR and reviewing it.

There are two reasons for such patient input. The first is accuracy. As everyone knows, medical records are hardly infallible as a source of truth. And there's been a flurry of discussion recently about the "garbage in-garbage out" problem stemming from a patient's detailed account on a Web blog (and in the *Boston Globe*) of finding errors and misleading information when their data was transferred from an EHR into their PHR.

The second reason EHRs need patient input is that, as we all know, most of the stuff that impacts our health – and may influence the treatments we are prescribed – happens outside the clinical setting. The self-care revolution is alive and well, and a growing number of people are actively engaged in using e-tools, web sites and creative software to track their "medical lives" – whether that be their weight, their symptoms, the OTC medicines they take, the course of their chronic illness, or their treatments.

We think that organized notes from a patient can be every bit as valuable as notes from the doctor. We think every EHR should accommodate patient notes if the patient so chooses.

So, certification around meaningful use must promote two goals: transfer of information from an EHR to the consumer and transfer from the consumer into an EHR. It's a two way street. This has vast potential to improve a lot of things, not the least of which is the doctor-patient relationship.

Again, to repeat, most of us now think of this integration – this two way street – in terms of PHRs and EHRs. But it's not hard these days to imagine new platforms for such information to flow into the consumers' hands. Is an iPhone or other PDA "app" that allows you to organize your top-line registry, insurance, and medical information far away? I doubt it. Should that be certified? I don't know.

Indeed, guidance on "meaningful use" being released tomorrow by the Markle Foundation notes that the definition of certified or qualified EHR technology should not be narrowly construed within the confines of EHRs and HIEs. Such tools, the report will point out, are not the only way to get to meaningful use – for doctors or patients.

Rather, a broad view of HIT, and certification of HIT tools, would and should seed innovation and not lock in today's technology. Certification must evolve and be adaptive.

Two final quick points:

ARRA has propelled us into a new world when it comes to the privacy and confidentiality of medical information. I'm confident vendors and CCHIT know that stricter standards must evolve, abetted by new technology. But I would still urge this committee, which has deliberated on this issue in the past, to develop clear guidelines on privacy in the context of the ARRA legislation. For example, audit trails must now clearly be a larger part of certification.

Finally, you posed a question about additional EHR certifiers recognized formally by the HHS Secretary. In a word, Yes. We think that would be advisable.