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June 26, 2009

David Blumenthal, M.D.
National Coordinator for Health Information Technology
Office of the National Coordinator for HIT
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Dear David:

The Network for Regional Healthcare Improvement (NRHI) would like to offer comments and recommendations on the draft definition of "meaningful use" of health information technology systems developed by the HIT Policy Committee, as requested in the June 18 Federal Register Notice (Vol. 74, No. 116, p. 28937).

The Goal Should Be Both Improving Quality and Reducing Cost

The Committee has recommended that "the ultimate goal of meaningful use of an Electronic Health Record is to enable significant and measurable improvements in population health through a transformed health care delivery system," and that "the ultimate vision is one in which all patients are fully engaged in their healthcare, providers have real-time access to all medical information and tools to help ensure the quality and safety of the care provided while also affording improved access and elimination of health care disparities."

We concur that Health Information Technology (HIT) is a means to an end, not an end in itself, and that improved health is a key goal. Moreover, we would emphasize that a principal goal of HIT should be to help physicians, hospitals, and other providers identify what should be done to ensure quality of care *before* the opportunity is missed, rather than merely telling them how they performed after the fact, as is so often the case today. Although use of HIT can certainly be valuable in creating better means of *post hoc* evaluation, its real value will only be realized when it influences decisions and actions before they are made.

In addition, we feel that improving the efficiency of healthcare delivery and reducing healthcare costs is an equally important goal, and should be made more explicit. The nation cannot encourage the use of HIT in a way that improves the health of the public and the quality of care but increases the cost of healthcare delivery.

Consequently, **we recommend rewording the goal to read: "the ultimate goal of meaningful use of an Electronic Health Record is to enable significant and measurable improvements in population health without increasing costs, through a transformed health care delivery system that uses real-time information to enable providers and patients to make good decisions about how to prevent illness and deliver high quality care efficiently."**

Similarly, **we recommend that the vision statement be revised to read: "the ultimate vision is one in which all patients are fully engaged in maintaining their health and selecting high-value healthcare services, providers have real-time access to all medical information and tools to help ensure the quality, ~~and~~ safety, and efficiency of the care provided while also affording improved access, greater affordability, and elimination of health care disparities."**

We also recommend that the definition of "Transformed Healthcare" include the statement "Health care will be more affordable."

Flexibility Should Be Provided for Regional Approaches

We endorse the HIT Policy Committee's strategy of defining uses of HIT that are not only meaningful, but feasible for providers to implement, particularly in the near-term. However, consistent with this, **we recommend that flexibility be provided in the definition of meaningful use to (a) acknowledge the great differences in the capacity and resources of providers in different parts of the country, and (b) support local quality measurement and improvement initiatives that are designed and implemented by Regional Health Improvement Collaboratives.**

There are clearly some advantages to having a uniform national definition of meaningful use, including establishing a level playing field for providers in all parts of the country, and enabling best practices to be identified and shared across the country.

But there are also serious disadvantages to an inflexibly uniform definition:

- In some parts of the country, physicians, hospitals, and other healthcare providers are already pursuing significant quality measurement improvement initiatives involving HIT, and these initiatives may have different objectives or measures than will be included in the national definition of "meaningful use." The practical reality is that healthcare providers can only implement a limited number of quality improvement initiatives while still keeping up with patient care responsibilities, so a conflict between national and regional goals may force them to choose between continuing an important local quality improvement initiative they have worked hard to develop and shifting their resources and attention to efforts to comply with the national definition of meaningful use.
- The size, capacity, and resources of healthcare providers differ dramatically from region to region. The majority of the nation's healthcare providers are not prepared to quickly implement extensive HIT capabilities, particularly primary care practices which are widely acknowledged to be under-resourced through existing healthcare payment systems. Moreover, the challenges involved in improving the health of the population in poor communities will be greater than in wealthier communities, and small physician practices will inherently have more difficulty implementing HIT systems and making progress on

quality and cost goals than will large physician practices. As a result, what is both meaningful *and* feasible will vary significantly from region to region.

The Committee has specifically asked "whether the recommended timeline of requirements is overly aggressive based on the current state of technology and the demands on new provider workflows, or not challenging enough to result in significant transformation." The answer is: "it depends" – the level of readiness and the capacity to make improvements varies widely from state to state, and even between regions within states. Moreover, the speed and success with which providers will be able to implement HIT will depend heavily on the availability of hands-on technical assistance at the local level, and this varies widely across the country.

Therefore, flexibility is needed to allow more rapid progress to be made by providers in those regions which can do so, and to allow more time and provide more support in other regions if their providers need it. As has been recognized in other efforts to encourage quality improvement, such as proposals developed by CMS for value-based purchasing of hospital and physician services, rewards and penalties for providers' HIT use should be based on a combination of not only their absolute performance but their improvement from their own starting points.

Although the phased approach to the definition of meaningful use that has been recommended by the Committee recognizes that progress will need to be made in steps over a period of time, it does not acknowledge that different providers and different regions will be able to move through those steps in *different* timeframes. A one-size fits all approach, even one that has a phase-in, will inherently set the bar too high for some, and too low for others. A mechanism is needed to set different standards and different timetables for different regions based on their unique challenges and capabilities.

Regional Health Improvement Collaboratives provide an ideal mechanism to enable HHS to provide this flexibility in a controlled way. There are now over 50 Regional Health Improvement Collaboratives across the U.S., all working to improve the quality of healthcare services while controlling skyrocketing costs. These Collaboratives have brought together the healthcare providers and other stakeholders who need to be engaged in HIT implementation: clinicians, hospitals, patients and families, employers, and health plans. With the participation and support of these stakeholders, Regional Health Improvement Collaboratives have designed and implemented programs ranging from public reports on the quality and cost of physicians, hospitals, health plans, and other healthcare providers, to projects that reduce hospital readmissions and improve the health of people with chronic diseases. Two dozen of these Collaboratives have been designated as Chartered Value Exchanges (CVEs) by HHS, and fifteen are being supported by the Robert Wood Johnson Foundation through its Aligning Forces for Quality program.

We recommend that the definition of meaningful use include a provision for different timetables in different regions of the country, if those timetables and the associated objectives have been developed and endorsed by all local stakeholders through a Regional Health Improvement Collaborative.

In addition, we believe that in regions where Regional Health Improvement Collaboratives have already established quality improvement goals and initiatives, it is important that the definition of meaningful use supports those goals and initiatives, rather than conflicts with them. As noted earlier, a conflict between national and regional goals could force providers to abandon a local quality improvement initiative in order to shift their resources and attention to efforts to comply with the national definition of meaningful use, when the local initiative could serve every bit as well to demonstrate meaningful use. Consequently, **we would recommend that the definition of meaningful use explicitly allow a provider to be considered as having achieved all or part of the requirements for meaningful use if they (a) are participating in a quality reporting or improvement initiative developed and monitored by a Regional Health Improvement Collaborative and (b) are using HIT capabilities as an integral part of the strategy for quality improvement in that initiative. We recommend that HHS establish a "waiver" process that would enable a Regional Health Improvement Collaborative to apply and have its regional quality measurement or improvement initiative(s) approved so that providers participating in that initiative could receive full or partial credit towards meeting the meaningful use standard.**

This approach has two significant advantages:

- It leverages the relationships and resources of the Regional Health Improvement Collaboratives to provide technical assistance to providers and to provide a more grass-roots accountability mechanism, which will likely improve the probability that HIT systems will be used successfully; and
- It strengthens existing Collaboratives and encourages other regions to form their own Collaboratives by aligning the incentives of the federal HIT implementation initiatives with the goals of the Regional Health Improvement Collaboratives.

This waiver process would only need to be available during the first few years of HIT implementation. Over time, regional objectives and initiatives could be expected to align with the longer-term national objectives. What is needed is the capability for different regions to start in different places on their common march to the desired endpoint.

This approach would be enhanced by designating Regional Health Improvement Collaboratives as Regional HIT Extension Centers, as we have recommended separately in our June 11 letter commenting on the draft description of the Health Information Technology Regional Extension Program in the May 28 Federal Register Notice.

Two Regional Health Improvement Collaboratives – the Louisiana Health Care Quality Forum and the Pittsburgh Regional Health Initiative – have already demonstrated the value of this approach through their work as community partners with HHS/CMS in implementing the Medicare EHR Demonstration project. They are actively helping the physicians in their regions implement and use electronic health records to improve the quality of their patient care. Other Collaboratives can do the same if federal policy provides the opportunity for them to do so.

Thank you for the opportunity to comment. NRHI would be pleased to provide any additional information or assistance that you would find helpful in finalizing and implementing this important definition.

Sincerely,

Harold D. Miller
President and CEO

cc: Charles P. Friedman, Ph.D., Deputy National Coordinator
John Glaser, Office of the National Coordinator
Paul Tang, Co-Chair, Meaningful Use Workgroup
Farzad Mostashari, Co-Chair, Meaningful Use Workgroup
Judith Sparrow, Office of Programs and Coordination