Statement of Mark J. Segal, PhD
Director, Government and Industry Affairs
GE Healthcare IT
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Good afternoon Mr. Reynolds and members of the Committee. I'm Mark Segal, Director of Government and Industry Affairs at GE Healthcare IT. On behalf of GE, I am pleased to have this opportunity to discuss meaningful use of health information technology.

GE Healthcare IT is a division of the General Electric Company and a leading vendor of healthcare information technologies. Our products include health information exchange services, electronic medical records and practice management systems for independent physician practices, integrated enterprise clinical and financial systems, radiology information systems and PACS, enterprise revenue cycle management, electronic data interchange, pharmacy, lab, and perioperative and perinatal systems.

GE has been a strong supporter of the healthcare IT portion of the American Recovery and Reinvestment Act of 2009 (ARRA), the HITECH Act. This comprehensive framework of infrastructure support, incentives, and standards will greatly accelerate adoption and meaningful use of interoperable electronic health records (EHRs) and lay part of the foundation for healthcare reform. Along with leading policy experts, Congress and the Administration, we believe that the outcome will be a great leap in the quality and efficiency of our health care system

Overall Principles

As you know, the requirement that providers be "meaningful users" of certified, qualified EHRs has three main elements: (1) a general category of demonstration of meaningful use, (2) standards-based data connectivity, and (3) quality and performance reporting. Taken together, these will help our nation see a real return from its investment in HIT.

We suggest that the Department consider several key points, reflecting our perspective as an experienced supplier of EHRs to a wide range of provider organizations.

- Policy should be carefully tied to the ARRA legislative language for meaningful use and mindful of the distinction between functionality, driven in part by certification, and meaningful use, which focuses on what the provider does with that functionality.

- Meaningful use and related policies should encourage adoption of comprehensive EHRs, such as those that would meet current CCHIT requirements. Such widespread

adoption is really the critical precursor to meaningful use and its associated benefits.

- Policies on meaningful use and related concepts should be as simple as possible, issued with considerable advance notice, not impose excessive costs on providers, and create a predictable path for providers and their vendors.

- We should avoid the temptation to create too many requirements, especially in the general "meaningful use" provision, and stay focused on the primary goal, to ensure that providers have and are using interoperable, comprehensive EHRs.

- Finally, we need to ensure that clinicians and hospitals can implement EHRs in a deliberate and non-disruptive way.

These principles, as well as our answers to key questions that the Committee has posed to this panel, lead us to some specific policy recommendations.

General Policy Recommendations

First, there must be a careful transition from standards to certification criteria to products and then into initial use and ultimately "meaningful" use. Not every standard, however appropriate as a standard, meets a current market need or vendor or provider capability. For this reason, CCHIT has considered market readiness in decisions on where to place a standard on its roadmap. This focus on market readiness in selecting standards for certification requirements should be retained. Similar staging should occur in determining when meaningful use criteria should be expanded.

The EHRA, of which we are a founding member, has developed an intereroperability roadmap that sets out the key steps for standards adoption:

1. Standards in Development
2. Standards Harmonized
3. Standards Implementable
4. Standards Piloted
5. Standards Adopted

Given these steps, the "time to market" cycle from adoption of standards to inclusion in certification to installation across a large number of customers can be a matter of years, depending on the status of the standard and the size and complexity of the provider.

For example, implementation and upgrade times are generally much longer for hospitals than for medical groups, often ranging up to 18 months or more across our industry. The timing for medical groups, especially smaller groups, is usually 3 to 12 months.

For 2011 and 2012, we urge that meaningful use criteria start at readily achievable levels, while emphasizing robust health information exchange and quality reporting. Early requirements for robust HIE and quality reporting will produce the data needed for informed progress in meaningful use levels.

Consistent with HITECH, we envision a steady increase over time in the breadth and depth of meaningful use requirements. These increases should stair-step upward, with each level in use for 24 months.

Because of the need for providers to have time to integrate functionality into their workflow, and to have careful change management, they should, via certification, be encouraged from the start to adopt comprehensive EHRs with high levels of functionality that anticipate future meaningful use requirements.

In contrast to the likely pace of change in meaningful user requirements, we envision a relatively small rate growth in EHR certification requirements over time from the initial HITECH certification baseline, with a two-year period of stability between each set of new certification requirements.

To speed time to market, we urge as much reliance as possible on the mature standards already harmonized by HITSP and the certification criteria that have been through the CCHIT requirements development process and deployed in certified products.

Vendor Responses to ARRA

The Committee asked us how vendors, such as GE, will adapt our product development and upgrade cycles to synchronize with progress toward increasingly robust requirements for meaningful use, information exchange, and quality reporting. There is certainly no single answer but I will lay out a general approach and then suggest how policy decisions can make this process work more smoothly for all concerned.

As a business, we are focused on helping our customers qualify as meaningful users. Even before the ARRA, we have progressively oriented ourselves around standards roadmaps and the CCHIT certification cycle and roadmap. This effort has been aided by our active involvement in HIT standards organizations, HITSP, CCHIT, and the EHRA.

This focus is not without cost, however, in terms of resources diverted from other customer-sought enhancements, hence we support a two-year period between certification requirement updates. There should be at least six months advance notification of new requirements before the certification process begins for set of new requirements. In addition, product certifications should be valid for at least two years.

Specific Components of Meaningful Use

Other panels have addressed the specific elements of the definitions of a meaningful user, but I would like to provide a few summary recommendations.

Meaningful Use

Clearly, the components of the general meaningful use criterion will vary for hospitals and for healthcare professionals. Some of the potential criteria include: use of the EHR for documentation at a level that can support quality reporting and interoperability, advanced e-prescribing (for professionals) and use of CPOE (for hospitals), and point of

care, work-flow integrated clinical decision support. This general meaningful use criterion should be less stringent in the early years of the incentive period and more stringent in later years.

We also favor non-intrusive reporting mechanisms appropriate to the dimension of meaningful use being reported on, including use of surveys and attestation where appropriate, and support for registry-based measurements of meaningful use, such as is used for PQRI reporting, obviating the need for claims-based reporting.

Information Exchange

GE is a strong proponent of standards-based interoperability and has been an active participant in such standards organizations as HL7, IHE, and HITSP. As part of the pathway to expanded, standards-based intereroperability, we believe that HHS-recognized HITSP harmonized health information exchange (HIE) standards should, from the beginning, be the basis for the requirement to engage in standards-based "electronic exchange of health information to improve the quality of health care". Such standards are available and applicable, whether for document-based information exchange, lab, or imaging results.

Finally, the focus should be on information exchange that can improve quality and not the specific parties to which a provider is connected. Finally, initial requirements should be robust to start data moving from its silos via standards-based HIE.

Quality and Performance Reporting

The area of quality and performance reporting is one in which critical standards are coming together. We urge that measures chosen be drawn from NQF-endorsed measures already being used by professionals and hospitals in their respective Medicare quality reporting programs, focusing on measures that can be derived from data elements within the EHR to the greatest extent possible and that align with national goals.

HITSP harmonized standards, as available, should be used to define how the quality measure information will be submitted. To provide maximum flexibility to providers and vendors, submission should allow either patient-level data or population-level computed measures. Similarly, submission of EHR-derived quality data should be able to be either directly from the EHR, or via a data registry or other intermediary or reporting application. Such submission should be done periodically throughout the reporting year. Also, consistent with the national-level objectives for HITECH, quality reporting should focus on all patients and not just Medicare or Medicaid beneficiaries.

Overall, as with HIE, we believe that quality reporting should begin with a fairly deep level of required usage. In particular, we believe that care delivery organizations should do more than just report externally on quality data; meaningful use in this area should include provider access to and active use of evidence-based quality data and measures to track and improve on priority areas of clinical focus.

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Conclusions

HITECH will transform our industry and the health care system that we serve. We expect, consistent with CBO forecasts, a substantial increase in hospital and professional adoption of comprehensive EHRs, with most of the impact occurring over the next five years. We can also expect changes in both the structure of the industry and in how our industry's products are developed, priced, and deployed.

We are reviewing key aspects of our business to meet this increased demand, including how we develop and deploy software and how we support implementations and upgrades. We are eager to work with the health information technology extension program created by HITECH to assist providers in acquiring and implementing EHRs in a cost-effective manner and are also delighted with the increased funding for HIT-related education that will help meet the expected increased in need for HIT professionals at all levels.

As we work through these transformations, we look forward to working closely and cooperatively with the Department, with this Committee, with Dr. Blumenthal and his colleagues, with CMS, and with the many other agencies that will contribute to development and implementation of policy for HITECH.

Thank you very much.