



**Comments on the Preliminary Definition of “Meaningful Use”
Submitted to the Office of the National Coordinator for Health Information Technology
June 25, 2009**

As the nonpartisan, professional society for over 3,600 health services researchers, policy analysts, and practitioners, AcademyHealth welcomes the opportunity to respond to the Health IT Policy Committee’s request for comments on the definition of “meaningful use.” Given the implications of this definition for our mission to support the development of research and data needed to inform health policy and practice, we are pleased to offer the following thoughts for your consideration on behalf of our members, the research community, and the public more broadly.

As you contemplate the key policy, technology, and governance elements required to achieve the vision of a safe, effective, efficient, equitable, and patient-centered health care system, we encourage you to remember that research must be identified at the outset as an essential means to advancing these goals. Just as Health Information Technology (HIT) provides the necessary information infrastructure for improving care, research is what enables the transformation of that information into knowledge.

The National Priorities Partnership’s report presented a set of national priorities and goals, which was then used to create the framework for “meaningful use” of an electronic health record, including: “patient engagement, reduction of racial disparities, improved safety, increased efficiency, coordination of care, and improved population health.” AcademyHealth believes that progress toward these robust goals will not be achieved without research to inform decision-making, nor will the stewards of this historic investment be able to determine whether their goals have been met unless the “meaningful use” of HIT also creates a path forward—from the outset—for research. In your deliberations of what constitutes “meaningful use,” we hope that you will recognize the importance of health services research in achieving this vision, and incorporate research requirements into the definition.

To date, most of the discussion surrounding “meaningful use” has focused on improving clinical care delivery and on quality reporting. These are largely provider domains—the expectation being that providers will increasingly contribute and use information from electronic health records (EHR), and report out metrics for quality benchmarking. We are encouraged that you recognize the importance of including patients in the equation and suggest that much value will be added by recognizing the ability of other key stakeholders to aggregate and analyze clinical data to answer important questions. For example:

- Managers may want to know which staffing strategies work best in which settings

- Public health authorities may want to track the impact of community-based interventions on key diseases
- Policymakers may want to know whether access to high quality care has improved based on health reforms.

Data in silos—either because they are non-standardized or non-normalized, or because they reside within systems that cannot or will not communicate—will not provide the answers to these questions. Decision makers will need facility-wide, intra-facility, and population-based research to complete the picture. We are encouraged, therefore, that the Health IT Policy Committee lays out the expectation for a “fully interoperable health information system,” recognizing that the recommended definition of “meaningful use” will depend on the health care setting in which it is employed. Without standardization of data elements across units, facilities, health systems, and regions, the capacity for appropriate aggregation and analysis is limited. However, experience to date has revealed a series of challenges that require attention before EHRs can be effectively leveraged for research purposes. Examples of these challenges and their importance for furthering research follow:

- *Poorly coordinated data prioritization process.* Different types of data are more or less critical for research at different levels of aggregation. Who decides what data should be collected (e.g., physicians, the corporation that manages the facility, the local community, the Federal government)? Effective mechanisms for involving these essential players (including researchers) in setting data priorities will impact the extent to which data relevant for research purposes are available.
- *Limitations relating to design of the EHR products.* Informaticians who design and manage HIT systems rarely consider research functions. Forging an interdisciplinary approach to design that includes experts in clinical research (e.g., clinical epidemiologists, including experts in registries, other observational designs, and trials), and outcomes/effectiveness researchers could increase the value of products developed, and should be considered as part of the certification process. In the same vein, EHRs should facilitate the identification of patients for registries, and should make it easy to choose patients and measure data elements for clinical research studies, including both observational and randomized studies.
- *Data capture challenges.* Providers still struggle with integrating EHRs into their practice workflows, and frequently, skip or default on data fields, and overly rely on the open text field (which is the quickest way for them to write notes to themselves). The use of a “minimum” set of data elements across systems and practices would facilitate comparisons of different delivery, reimbursement, and care models. Engaging providers in the research enterprise may be one key to expanding their appreciation for data collection efforts. Another possible solution would be to

establish (either at the local, regional or national level, or some hybrid) a set of clinical priorities for which data must be reliably and consistently collected. For example, there could be datasets for specific clinical areas across practices and systems (e.g., one for cardiovascular drugs, one for patients with depression, etc.)

Lastly, when identifying the EHR-generated measures established to monitor key outcomes, we suggest that you consider using standard criteria such as:

- *Reliability*: How consistent is the recorded information from one group to another? How consistently is the data even recorded?
- *Validity*: How does data recorded by group compared to standard measures of the same phenomenon in the same patients?
- *Completeness*: Has a sufficient sample of the salient data collected?

While many of these issues will continue to be addressed in the coming months and years, AcademyHealth believes that including research as an essential component of “meaningful use” is one important mechanism for ensuring that the current investment in HIT pays off.

AcademyHealth is in active conversation with our members and other stakeholders to further operationalize these ideas and would welcome the opportunity to contribute to the implementation of the “meaningful use” concept. On behalf of AcademyHealth’s members, I appreciate this opportunity to contribute and look forward to being helpful as you continue your work.

Sincerely,

A handwritten signature in black ink, appearing to read "W. David Helms", with a long horizontal flourish extending to the right.

W. David Helms, Ph.D.
President and CEO