

**HIT Policy Committee
Certification/Adoption Workgroup
Public Meeting
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Participants

Paul Egerman, Chairman & CEO, eScription
Marc Probst, CIO Intermountain Healthcare
John Glaser, VP & CIO, Partners HealthCare
Steve Downs
Edmund Billings, CMO, Medsphere Systems Corporation
David Kates, SVP Business & Product Strategy, Prematics
Carl Christensen, CTO, Marshfield Clinic

Presentation

Paul Egerman – eScription – Chairman & CEO

Great. Good morning. This is the second day of our public workgroup meeting. And according to the agenda, John Glaser has opening remarks.

Dr. John Glaser – Partners HealthCare – VP & CIO

Thank you. My apologies. Welcome back to all of you. I only had two comments that I wanted to point out before the Chair goes. One is to let you know that Paul Egerman and Marc Probst will be presenting some preliminary recommendations from the workgroup tomorrow at the HIT Policy Committee, so reflecting the conversation of today, yesterday, and some other input that they have received. So you have the opportunity; this is an open public meeting. We'd encourage you to listen in and, you know, hear what they have to say, etc. The others they will announce tomorrow, although I think we're still working on the timetable of a public comment period, so we're open to receiving written comments from the public on the proceedings and the conversation of yesterday, today, and the material that they will present tomorrow. So just to let you and those on the listener line know that we will be posting that in the *Federal Registry* and the ONC Web site such that we look forward to other additional input that we ought to factor into this conversation. And without further ado, I'll let you two gentleman carry on. Thank you.

Paul Egerman – eScription – Chairman & CEO

Thank you, John. And this morning's panel on non-vendor products will be moderated by Steve Downs.

Steve Downs – Moderator

Thank you, Paul. So we're going to have a final public panel this morning, and it's going to involve some different flavors of systems that are candidates for certification. And we're just going to go through in the order that they're listed in the agenda. We have Edmund Billings, who's the Chief Medical Officer from Medsphere Systems Corporation, representing an open-source product; David Kates the Senior Vice President for Business and Product Strategy at Prematics, representing a modular HER; and then Carl Christensen, the Chief Technology Officer from the Marshfield Clinic, representing a home-run system. And they're each going to present, and then after that, we'll have time for discussion. So Edmund, you want to go ahead?

Dr. Edmund Billings – Medsphere Systems – CMO

Thank you very much for having us. I want to give you some perspectives from our experience over the last 3–5 years in regards to taking an open source product into the mainstream health care system marketplace. I'll just give you a quick background on Medsphere. We provide an open-source platform for health systems. We got the Vista system through the Freedom of Information Act and commercialized

that over the last 5 years. We combined it with other open-source components—the Mirth interface engine, the GTM database, the Tolden CDR, and other technologies—to provide an open-source stack. Our major customer and partner is the Indian Health Service, so we advance the Vista core database and product with their help. We're deploying—outside of that customer, we're deploying in small to medium-size community hospitals and State systems, and we don't have a vendor model. And I was pleased by the name of this panel, because we think it's a distinction that when you give the software away for free and the customer pays you for support and services, you have to prove those every day. You don't have dependence on software. And they could—there's an industry around Vista, and those customers are not reliant on us alone. And that makes it quite a meritocracy. And that's what's needed—is to actually partner with this customers and to get them to meaningful results. We have heard over and over again the same product can go into two different settings and have completely different outcomes. It's about the outcomes.

Now, I mean, this is the most glaring problem here—is that we have 1.5 percent adoption of full EMRs in the hospital market. And if you look at the VA and put their hospitals in the mix, it doubles that. If we look at the HIMSS adoption model, we have 0.8 percent at Stage 6, which means even of that 1.5 percent to get full clinical adoption, meaning physicians and nurses fully using the ordering and the documentation, we have even a fraction of a percent.

So we haven't crossed the chasm. If you haven't read the book by Geoffrey Moore, everyone should. I mean, these products that are in the marketplace today were designed when I was in—you know, when I was early in the industry; the same products are the leading products. And the functional data s—the functional set has been the same functional set and growing since the early nineties. The customers that have bought these have been the early adopters; they've had the resources; they've had the physicians and clinicians to put on these projects. And those innovators have helped drive the complexity of these systems up. Early adopters strive for the 100 percent case, and what happens is, those products don't translate to the mainstream; 1.5 percent shows us that.

And the vendor model is a dependence model. It's not in the interest—you know, there's no financial interest to be interoperable. There's actually a financial—there's more financial interest to be less interoperable. You get a lock on the customer; you—they come to you for all your systems. So it's the business model. And the full-blown—and this term was used in a few of these committee meetings—full-blown EMRs is a vision that just hasn't translated to the mainstream. They're—I hear over and over again, "These systems are too much; they too expensive, they're too complex, and we can't afford them on any front to adopt them." When we talk to these mainstream customers, they either go with us or they don't do anything. We have not lost the deal to another vendor, because they can't afford these other vendors.

So disruptive innovation is needed. And I—you know, these—this is exactly spot on by, you know, Clayton Christensen—is basically—a disruptive innovation is a technology that can—that brings a much more affordable product and simpler to use. It opens a whole new population of consumers that can then afford and have the skills to use.

So I'm going to tell you about our customer—an example customer. This is Midland Memorial Hospital, with 320 beds. They had an end-of-life on their health information system, and it was a \$20 million upgrade. They had no capital wherewithal to go with that. They downloaded Vista, looked at it, called Medsphere. They put in the product, and they attained Stage 6, and they then went on and got involved in the Institute for Healthcare Improvement 5 Million Lives project. And we commissioned a study on—a case study with Perot Systems. And they implemented the product in 3 years with a budget of around \$6 million. And these are the other 9—the other 10 hospitals that made that first cut of Stage 6 hospitals as of 2008. There's about 50 now, but this was in 2008. And with guerilla research, we came up with these—this—these estimates.

In terms of time, you can see it's about a third to a half the time and about a third to a half the cost. On a per bed basis, the average was \$66,000 per bed total cost of ownership, and Midland spent \$18,000. You can see the ranges there.

This is their budget. The software was free. They paid us for implementation, consulting, and support. They had the full budget here—you know, the comparable was \$20 million for the software without services; that was the incumbent. But they had enough wherewithal in their budget to be able to then also get a financial system. They bought computers, laptops for all of their physicians; they put in, I think, 400 access points; they knew that physician access was how you drove adoption; they remodeled the nurses station so they could put more computers in place. The point is, if they're not spending it on software licenses, they're spending it on adoption or transformation.

This was the adoption curve of the 200 physicians affiliated. You know, some of them don't order anything. It got up to—over 9 months, got to 150 or—you know, approximately 100 percent of the physicians were using CPOE. And in the 5 Million Lives project, they went after central line bundles—care bundles with 88 percent improvement; they went after ventilator-associated pneumonia, 77 percent improvement; and reconciled medications, 59 percent improvement.

This is the AARA-based ROI estimate, if they attain meaningful use, that it would pay—basically, their ongoing subscription return on investment would be paid for within 48 months—I guess 46 months. And that—the point there being that if they had spent the money on the \$20 million system, they would never get a return on investment from AARA.

So to cross the chasm, we need—the mainstream needs complete solutions, not comprehensive solutions, “complete” meaning they solve and directly address meaningful use, but they don't have to do everything and the kitchen sink. Bells and whistles get in the way of adoption. They need the 80/20 rule, not the 100 percent case; less is more. They—these organizations don't have the resources to buy technology. They need it packaged as services, and they need partners for results. In connecting, first, this whole idea that you should automate your practice, then get connected is backwards. Look at e-prescribing. E-prescribing took off when yet there was a network. Start with the network.

So the recommendations are—do not require certification on comprehensive criteria. So the—you know, the HRC is just—you know, the—between 2007 and 2009, there was 36 percent increase in criteria. And that's not going to stop. It's called “bloatware.” Certified solutions to protect the customer: meaningful use, plug-and-play interoperability, patient safety and privacy, certified modular solutions to support incremental adoption, continuous innovation and customer choice, certified sites on demonstrated meaningful use, and foster an on-the-ground service industry. That's where the rubber meets the road. A product can be usable; the question is, is it being used? Require and incentive for electronic communications, and obviously shift the payment to value and quality and wellness; that will drive the whole model. If the business model's not there, we're just—you know, these standards are mea—you know, standards and certification are meaningless. And then support Vista, RPMS, NHIN-CONNECT—all the national projects as they're all going public domain and open source, and they can be leveraged. And you can see the results in terms of the total cost of ownership. Thank you very much.

Paul Eggerman – eScription – Chairman & CEO

Thank you. David Kates?

David Kates – Prematics – SVP Business & Product Strategy

Thank you, Dr. Glaser and the rest of the community and guests. It's a pleasure to present to the committee here. Just by way of background introduction, I've actually been involved with health IT for—I was actually thinking about it; it's almost 30 years to the day that I was first working on cardiac monitoring

devices in the basement of the Kirstein Building at Beth Israel Hospital as an MIT undergrad and focusing my technical expertise around applying the advantages that technology could bring to health care, initially more focused in the large hospital settings, like Dr. Billings just described. And then over time, I've moved from large academic medical centers to community hospitals to large clinics, like Mr. Christensen will be describing, and ultimately into the small physician practice, which is where most of the focus of Prematics is as well as most of my comments are addressed today.

By way of background as well, I've been—I was a founding board member of HL7 and have served on CCHIT from its conception. So I'm quite familiar with the certification efforts that have been undertaken, driven by ONC, and driven by the industry for quite some time. And I think I want to address my comments as it relates to how those do and don't apply in that small physician practice setting, where adoption rates are very low and the barriers to overcoming adoption of health IT are great, many of which will be addressed by the funding that the incentive stimulus plan provides. But we need to be careful about where we focus our adoption and certification efforts to make sure that the adoption in those settings is targeted and things that are going to provide most meaningful use and most benefit to the cost and quality and efficiency of the care delivery system in the U.S.

[Inaudible] I didn't get training on this. There we go.

So as you all know and we all understand, most physicians in the U.S. do practice in small group settings, and that's where most care is delivered. And you know, as I've mentioned, adoption of technology in general and clinical information technology specifically in those settings is woefully behind even the hospital marketplace because of the myriad of obstacles in terms of funding and in terms of incentives that—as well as in terms of resources and skills in those settings. And the focus of this discussion isn't so much on Prematics, although I'll leverage some of the experiences that Prematics brings to the table, but more around the needs and interests and potential opportunity to improve the delivery of quality and cost-effective care in those settings, informed by the experiences that I personally and that Prematics has had in that marketplace.

An incremental approach to adoption is going to create the most benefit. Again, in those settings, there isn't a widespread use of this technology, and the need to go and provide something that is of value, fits into the workflow, and can be adopted in a meaningful way in those settings that benefits the physician, their office staff, and the patient is crucial to being able to get a significant foothold in those settings. And certification, while very important because of the sophistication and the focus or lack thereof on IT in those settings, is crucial and significant. It needs to be focused in efforts that are appropriate along the lines of the modular EHR certification approach that's being undertaken.

So the numbers behind that statement that most physicians practice in small groups—you know, again, of the ambulatory positions in the U.S.—the, you know, 600,000 or so physicians, more of half of them and 71 percent in total are in 10-doctor-or-less practices; more than half of them are in 1- or 2-doctor practices. So turning that statistic on its side, that's the number of physicians and how they're organized. If you actually look at the number of physical addresses and locations where physicians practice, over 90 percent of physicians are in small physician practices, less than 10 doctors. And just looking at the one specific area, those of you unfamiliar with Prematics think of Prematics as an electronic prescribing company. In fact, it is much like Dr. Billings described: the—a service company that delivers clinical information at the point of care into small physician practices and does it ostensibly around a prescribing process. So today, being able to deliver a workflow automation tool that allows doctors to be able to write a prescription and deliver that safely and efficiently to the pharmacy where it can be fulfilled, mail order or retail, is on the face of it what we do. But what we're really doing is introducing technology in to the doctor in their hand in the exam room while they're interacting with the patient and providing meaningful information, initially in the context of writing a prescription, and informing that by clinical information related to other medications the patient's on and formulary information that might drive the use of lower-

cost or generic alternatives. But the opportunity to deliver other clinical information in that setting driven by an embedded application that's sticky that can go and provide value to the doctor initially around the prescribing process, and ultimately around other processes, is key to what we're talking about.

So in those settings, when we walk in to a doctor's office, our service is free to the physician, and that includes not only the electronic prescribing service but also the handheld device and the wireless network and the like. And we walk in to these doctors offices and, as, you know, we've all experienced, the technology that's in place is unsophisticated, to say the least. You know, they've got PCs in there; I didn't realize there were still DOS machines out in the world, but there are some of those. And you know, to fit into the workflow and be adopted in those settings, the need to be able to go and integrate information around what patients are in that practice, what the schedule is that drives the workflow around e-prescribing—so we're in there providing the full automation. Wireless networks—you know, you might think that the physician practices, which do, by and large, have Internet access, although in certain markets—that's not even true in the more rural markets; where we started in central Pennsylvania, that wasn't the case. But while they do have Internet access, it's typically limited to the doctor's office, where they're going out and looking up information on Medscape, or the front desk, where they're doing eligibility checks. It's not in the exam rooms, and while they may have Wi-Fi, it's really generally because the broadband provider that provided their Internet access has that built into their standard router, but it's not really designed for them to have access online to the Internet and to other resources as they move through the exam and in the practices.

So we're—what we see when we walk in to these settings is, we have to go and build the infrastructure from ground zero. Again, we're in those less-than-10-doctor practices and largely in the 1- and 2-doctor physician practices. IT resources—we all know that song, but that's not their job. The IT staff is the doctor's spouse, the front desk, the doctor's kid that knows something about computers, and it's not anybody's job responsibility in that small setting to manage IT. It really—all the activities in those practices are focused around delivering care and getting reimbursed under the current reimbursement system as best they can for the care that's delivered in those settings. And the notion that—and we all know this, but the notion that physicians are not interested and afraid of technology is not the case at all; it just needs to provide value in those settings. So as we walk into these settings, we're finding an eagerness to adopt the technology; it's just they don't have either the financial or the technical skills in order to be able to take that on themselves.

So what we see both in the context of the services that we provided in the past and just generally based on the collective experience of people in our organization—myself, Kevin Hutchinson, Dave Brailer—that have been in those small physician practices is, they need to be able to adopt this technology in a modular or incremental fashion: a workflow like prescribing where the network's in place and the infrastructure's there to support the entire workflow; having access to clinical and financial information that's relevant in the context of writing a prescription; being able to go and fully automate that process; even, you know, thinking about where the printers need to be located in those practices so that when the patients leave that are used to walking out with a piece of paper or prescription, they have something that reminds them what pharmacy they have to go to pick up their medications or which mail-order pharmacy's going to deliver those; and being able to provide relevant information to the patient to inform them of what the therapies are that have been delivered. So being able to deliver that incrementally is crucial.

Focusing on key workflows—and I think the discussions that I've listened to and participated in around meaningful use have always come back to some key clinical information and key workflows being automated: electronic prescribing, lab order entry and results reporting in the context of a clinical decision support system, being able to manage a problem list, and being able to access information in the context of registries for managing chronic diseases. That's where the big benefits are. You look at the Center for Information Technology and Leadership studies published in *Health Affairs* around the benefits from EHR

and health information exchange, and they all come back pointing to the core processes that are—directly or indirectly relate to this information and being to share that, access that, and manage that effectively.

The comprehensive EHR—the—I forget the terms that Edmund used in his slide, but the complete, comprehensive, full, all-singing, all-dancing EHR in the past traditionally—and I've been in those businesses in prior lives in my career, and a lot of that is geared around creating a comprehensive progress note—a comprehensive soap note. And the reasons for that are many, but it comes back to a business model, in this case for the vendor and for the practice, for them to have a compelling reason to get to the doctor to make the investment in IT. And in that small physicians practice, costs around dictation and transcription run into thousands of dollars a month. And the documentation needs are significant, both because of the litigation that they're trying to prevent and because reimbursement today is tied to the complexity of the visit—the E&M code. And so, being able to go and maximize that is a business case that the EMR vendors need to drive.

So certification and comprehensive certification have really geared around that progress note—the structured, codified, comprehensive progress note, which has great, great benefits in being able to derive useful information and lead up towards comparative effectiveness and all the things that we strive for. But that's the running. That's, you know, the comprehensive thing. I happen to sit on the Technology Committee Operations Subcommittee, and we're dealing with some of the things that come out of the Policy Committee in terms of quality metrics that need to be addressed, whether it's measuring hemoglobin A1c levels on high-risk diabetics or smoking cessation programs. And even with the comprehensive documentation tools that are out there today, those minimal discrete data elements are hard to get from those tools and could be a pain without, you know, the comprehensive, codified notes that are really driving a lot of what's in the EHRC certification.

So in terms of certification, we and those that I work with in the industry absolutely applaud and see an incredible value in certification. It is, as I've expressed, an unsophisticated buyer that needs guidance. And there's externalities that we want to try and drive through this certification in terms of interoperability that may not be of direct benefit today, given the current reimbursement model. Those are all spot-on in terms of the value that certification can provide. The paternalistic aspect of the certification effort, making sure that physicians are investing in a quality product, are well-placed, making sure that they have some of the comprehensive, full-blown—if you will, overblown—capabilities around documentation needs may be putting the cart before the horse. It's there are things that we absolutely want to get to and provide value to the industry, but we need to focus our efforts. Even though the Stimulus Act provides incentive money to overcome the financial barriers that have impeded adoption in the physician's office, we still need to overcome some of the adoption hurdles about their ability to use this technology and have it embedded within their workflow. And the workflow focus and efforts targeted around those core processes—electronic prescribing, lab order entry, access to quality information, registries to manage chronic diseases—is, I think, where the greatest benefit could be derived. And these more comprehensive documentation tools are things that we want to strive towards in the future that we can get in an innovative fashion.

So, you know, as I've touched on, the approach that CCHIT were—I'm heading to Chicago right after this meeting to join and co-chair one of the CCHIT workgroups—this model, which I hope to learn more about, I think, is the appropriate direction. We just need to be careful about what we require and when on the left side around the comprehensive EHR so that we can meet the needs of the small physician practice and the goals that we have as a country and as this committee is striving towards meaningful use and adoption in those settings and getting the quality and cost-effectiveness that we're hoping to attain by providing technology and making this huge investment in IT and in those physician offices for the benefit of the whole.

So, you know, in conclusion, certification's great. It's crucial to the objectives of what we're trying to attain, and it should focus on those areas where we can get the greatest impact, the biggest bang for the buck, and do so in an incremental fashion. Thank you.

Paul Egerman – eScription – Chairman & CEO

Thank you very much. Carl Christensen?

Carl Christensen – Marshfield Clinic – CTO

Good morning. Carl Christensen, Chief Technology Officer for Marshfield Clinic. Actually, I—this talk will reinforce the previous two talks with just a slight different focus, and that being that the—I firmly believe that inhouse development is—having some across the country is key to innovation. A lot of the products that we're using today have their starts in that way. And the point that, you know, the comprehensive certification on broad setup features and functions is a barrier. It is a barrier to us for innovation. And I feel that the right approach, like the previous two speakers, is more focus on meaningful use.

As background, Marshfield Clinic—we're a large, multispecialty group practice serving across the northern half of Wisconsin. Our physician led around 800 physicians, 45 sites. We see about 400,000 unique patients per year, which translates into about 3.5 million encounters or roughly about \$1 billion in revenues. We've been at informatics a long time, actually about five decades, with our first—with—the group I work in formed in the early 1960s. Our first electronic medical record application went live in 1985 and in 1994. You cannot practice medicine at the Marshfield Clinic without interacting with the computer on every encounter. That's when our electronic record became our legal medical record, and the elec—you'd at least have to sign your notes electronically.

The—we're part of the physician group practice (PGP) CMS demonstration project. And I'll talk a little more about that later, but that's real important, I believe, in this discussion. We have certified with CCHIT, both in 2006 and 2008 standards, so we sat last month for the 2008. I believe we were the first in-house-developed, CCHIT-certified system.

We have an HIE of sorts that has all the characteristics of an HIE. These dots represent within there the facilities across the State within the Marshfield Clinic system, as well as outside of the system, that are connected into our network in some way, and we're exchanging, you know, health care information electronically. We have a shared EHR model within the region across multiple organizations. What that means is, the same instance of the electronic medical record is used by multiple organizations as their legal electronic record. We have hosted and sponsored a large immunization network, and we have a large laboratory business that connects to many health care organizations throughout the State and the country.

As I mentioned, we were the first inhouse-developed system that received certification to the '06 standards, ambulatory standards, and we sat last month and passed on the '08 standards. The—we spent about 65,000 hours over and above the '06 tasks to certify on the '08 for—CC for the '08. And for a group of our size, that is significant, to say the least. A significant portion of the work added little or no value, from our definition of value. You know, probably somewhere in the neighborhood of, I would say, 20 percent of what we did for the certification added no value whatsoever. Of the other 80 percent, only half of that was actually roadmapped in the same time frame that we were looking at, and probably, again, half of that we would have done in a different way. And this diverted focus away from what we would say are our other high-value enhancements, away from those to, you know, working through this checking off a comprehensive list of features and functions as we went through further certification.

One example: This—there's a number of them; this one was probably the—caused the most grumbling within our group. I would argue that we have one of the most comprehensive clinical data warehouses in the country. We have coded diagnoses that go back to 1960. Right from the start, we have had a

warehouse for four decades now and have been adding coded information to that and have been doing some pretty significant things from that, and given that it far exceeded the basic reporting capabilities required. However, the logistics of this forced us to rewrite a parallel reporting system, and—which added no value. And the specific things around the logistics were that the testing process required that you be able to report off of your clinical data warehouse immediately. And clinical data warehouses don't work that way in a—other than in a toy vendor-based demonstration. And unless this requirement is changed or we choose not to certify, we will now be re—maintaining this parallel reporting system forever, which adds—which essentially will not be used, because it is inferior—significantly inferior to the—our large CDW.

The few observations—and this is echoing what the previous speakers have said: The biggest benefit, in my opinion, of CCHIT certification is the reduction of buying risk for purchases of HIT. While we purchased our HIT 40 years ago—so in terms of adding that value to Marshfield—was minimal. The physician group practice—the pay-for-performance CMS demonstration project, which we've had—we've done very well on that—had a very positive impact on the quality of the—of our health information technology. It improved the quality of health care; it lowered co—we demonstrated that it had significantly lower cost before we added any of these '08 features or, actually, many of the—some of the '06 features. We have driven down hospitalizations significantly for the care management groups that we are focusing on, with IT being a key enabler.

When we—the—when our board approved back in 2004 that we would be part of this demonstration project, our focus—our entire focus on HIT changed overnight. And it changed to—very much to an outcome-driven “How are we going to meet those quality and cost metrics?” And our focus was on—then translated into that, which was very much doing the right thing. We do not see the same thing—we have not seen the same thing coming from the certification process. And again, echoing the previous two speakers, the quality of the implementation process is far more important than the feature list. And we should be—if we're going to incent, you know, HIT adoption, we should be focusing on that, not checking off the comprehensive feature list.

Recommendations: These incentives should be based on demonstrated improvements in efficiency and effectiveness. Competitive score cards, interoperability, e-prescribing, all are great things to focus on and should not be based on a list of product features. And in summary, if we want HIT to support evidence-based care, I think the features should be evidence-based as well. And I would argue that I don't think we're quit there. I don't think we really know yet which features within the systems actually, certainly in a comprehensive manner, drive the results that we're trying to achieve.

Steve Downs – Moderator

All right. Thank you very much. Now we'll move to Q&A, and I'm going to look to the workgroup for questions. And seeing none immediately, I'll ask one of my own. This is for Carl Christensen. And just—I'm curious of the 65,000 hours spent. Would you be able to estimate the split between how much of that was for developing features to be compliant with CCHIT versus actually the sort of process of going through the certification?

Carl Christensen – Marshfield Clinic – CTO

We did not—on our time accounting, we did not break it out exactly across that way. My estimate would be—is that—is, probably 90 percent was spent on the features, as opposed to—10 percent was spent on process—something along that—those lines.

Steve Downs – Moderator

Thank you. Charles?

Charles

Good morning. When we talk, David—well, really all of you—when we talk about a modular approach for deployment of health IT, can you comment a bit about the resulting data structure that you might see? In other words, as we deploy these solutions, we're hoping to create a foundation for clinical decision support, cognitive decision support, whatever you want to call it. But as you do this modular type of approach, how do we ensure that we're creating a data foundation that will be supportive of decision support algorithms?

David Kates – Prematics – SVP Business & Product Strategy

It's a great question. I think the modular aspect of what CCHIT contemplates and what my comments address were more around the features and the decision support and the workflow automation tools. But I do think, both from an interoperability standpoint and sort of an overriding data model, if you will, what the information is that needs to be shared so that these modular feat—modular components can access that data and—that can support these quality initiatives—that there does need to be some definition and architecture, if you will, around how the data would be structured so that the modular features that access that information and support quality initiatives are driven around a common framework.

Charles

Do you think that should be part of the modular certification practice, or how might that happen?

David Kates – Prematics – SVP Business & Product Strategy

I think the—on the edge of how the information's going to be accessed, it needs to be—the modular certification process needs to enforce that this is how information's going to be exchanged and here's how the data will live, whether it's in the cloud or whether it's in a system that's local within that organization. So it does need to be cognizant of that [inaudible]. You know, there's more definition in terms of how it would define it. But I think the definition should focus on the goes-into's and goes-out-of's—how you're going to get the data in and out of that from an interoperability standpoint, not necessarily where it lives and how you generate reports out of it and some of the things that are more feature driven in that comprehensive model.

Steve Downs – Moderator

Marc?

Marc Probst – Intermountain Healthcare – CIO

Marc Probst. Dr. Billings, so with Vista—and I don't know a tremendous amount about it, but being an open-source product—and I'm not even sure how many clients you have. Is—can you give me an idea?

Dr. Edmund Billings – Medsphere Systems – CMO

Well we have the Indian Health System and their extensive 200-facility network. We work with them on development. And then we have—right now we have the State of West Virginia Public Health Hospitals; there are seven of them. And then we have seven other commercial hospitals. The stimulus package has definitely stimulated the marketplace, and we're seeing a lot—you know, a lot of interest in this type of approach.

Marc Probst – Intermountain Healthcare – CIO

That's what I'm interested in—is the—is there a lot of variability between the sites? And the reason I'm asking is, certification seems like it's a snapshot in time. You know, if you did it in 2006, you're going to do it in 2008, as Carl was talking about. And how—I'm just interested in how much variance there is between your sites, and is that a challenge? Because the concept of open source suggests it changes a lot.

Dr. Edmund Billings – Medsphere Systems – CMO

Well, the open-source concept, you know, scares people. We don't use “open source” when we talk to customers. We talk about “freedom,” and we talk about “not blocked in,” and we talk about “control,”

because, you know, everyone thinks there's some Finnish developers, you know, working on the project somewhere. You know, it's—

Marc Probst – Intermountain Healthcare – CIO

[Laugh] I did.

Dr. Edmund Billings – Medsphere Systems – CMO

I mean, Red Hat has the highest customer satisfaction of any health IT company. What they do is take Linux, which was developed by a bunch of Finnish programmers [laugh], and they package it for deployment in different enterprise systems. And if you have more time than money, you get the Linux yourself and do it; if you have more money than time, you hire Red Hat. So what we're seeing in terms of variability is that the vendor—the previous, you know, vendor model was, you go in with an empty database, and you build the system; each individual hospital's different. Well, that's not the case. I mean, the VA proved that you can go in and deploy, at the 80 percent level, a factory-built system. And you—the best way to get the best practices is to build the best practices into the content and then deploy them and get down the variants. So meaningful use and configuring the system to go after those meaningful use criteria is wonderful in terms of cutting down the variants. And that's what we're talking about in terms of helping our customers—is helping them become efficient. And the system and how you build it is how you get started to do that.

In terms of certifying, you know, as I said earlier, the rubber meets the road at the use of the system. And we've heard it over and over again: Certifying a system protects the customer but doesn't get you any results. The certified system can be used—the same certified system can get completely different results; we've heard that three to four times yesterday. So it's not the certification in and of itself; it's the deployment, the implementation, and the focus on results that gets to those results.

Marc Probst – Intermountain Healthcare – CIO

Okay. And I guess, just to follow up, what I was kind of interested in is, the concern has been, as we talked about, both self-developed and Vista—that these change in a very rapid cycle. They may not be your typical vendor cycle of, you know, every 6 months, a new release, and they may change more often. And I'm wondering what the impact of certification on an environment like that—if you have any thoughts around it.

Dr. Edmund Billings – Medsphere Systems – CMO

Well, I just think, you know, 2-year cycle doesn't match when we come out with service packs every 3 months. The project itself has development going on. The community around Vista is quite large and has development going on all the time. So it's—you know, it's like herding cats, and then you have to publish what do you see as the certified solution that you provide to your customers. And that's what—that's where the—kind of the editing comes in. That's what we have to do, you know; I mean, we have to kind of be the committers of the code that goes into the certified version of the software. And that's—it is more—much more of a quarterly—you know, every—customers can only swallow so much improvements or enhancements or upgrades, but the product—the code itself is advancing much more frequently.

Unidentified

Good. I'll [inaudible] question on—a follow-up question on that. So let's say there are four or five Medspheres out there that are each servicing, essentially, and supporting and offering a version of Vista. Do you see each of those organizations seeking a certification?

Dr. Edmund Billings – Medsphere Systems – CMO

They are right now.

Unidentified

Oh, essentially of that product, then.

Dr. Edmund Billings – Medsphere Systems – CMO

Essentially of the same code.

Unidentified

Yeah.

Dr. Edmund Billings – Medsphere Systems – CMO

We actually have two—we have two versions: we have open Vista, which is commercialized, and we have RPMS. And we have to certify both.

Unidentified

And are you suggesting that there should be one certified version of it?

Dr. Edmund Billings – Medsphere Systems – CMO

Right, yes. And then when you combine that with the comprehensive criteria, it's overwhelming. And you're not building in value; you're building in features and functions. You're not—as I said before, if we're taking people from ground zero, the modular approach to certification is the modular approach to adoption. You can't adopt all these things all at once, because it's not the way technology gets adopted by the mainstream. The mainstream adopts more gradually.

Unidentified

So just practically on that, then, I'm thinking, "Okay, so that one—for lack of a better term, we'll call them 'vendor'—submits a version of Vista for certification. Should the next one that also wishes to sell Vista say, 'Well, Vista has been essentially certified at—you know, because that first vendor—there should be sort of an equivalency recognition.'" Is that—or is there a different model you're imagining, because—since no one really owns Vista?

Dr. Edmund Billings – Medsphere Systems – CMO

Yeah, well, the—it's a—you know, Linux has multiple distributions, and it comes back to the company that deploys it that has to package it and certify it. And so, I think, you know, because it can—you've got—it's a very different—it's a much more difficult equation than if you own all the code yourself.

Unidentified

Right, okay.

David Kates – Prematics – SVP Business & Product Strategy

Paul.

Paul

I've a couple questions. I first of all wanted to say, "Thank you for being here." And I also wanted to say to you, David Kates, I also worked in the Kirstein Building, so I have a great sense of camaraderie with you in terms of that building. But following up some more on the whole issue of open-source certification, if I understood your presentation correctly, you suggested that instead of certifying this comprehensive medical record, there should be sort of a reduced focus meaning—perhaps a focus on meaningful use. So my question is, if we took that approach—if hypothetically we were to take that approach, what would be the impact in terms of certification for open-source software? How would you go about it under those circumstances if you had—?

Dr. Edmund Billings – Medsphere Systems – CMO

If you took the modular approach—focus more on meaningful use?

Unidentified

That's right, and not on a comprehensive medical record.

Dr. Edmund Billings – Medsphere Systems – CMO

Well, obviously, there'll be—the criteria would be much more based on demonstrating that you can get those to those results—to those meaningful use results that we're—if I look at the matrix that came out, it's very much data- and transaction-driven results. And they're much—you know, there was, like, 18 or 19 in 2011, which is a much smaller lift than if you double—you know, if there's 10 functions for each, you're still talking about a fraction of what the comprehensive criteria are. So in terms of the number of criteria that you have to address, it's much more focused on getting to the demonstration. I personally believe that demons—that certifying at the site is where the important aspects are. As I mentioned earlier, interoperability, patient safety—those are the items that you really need to do at the product level, protecting the customer. But to get to the meaningful use results, I think it's a site-specific, implementation-specific validation that's really required.

Unidentified

So I just want to make sure to understand that—what you said correctly. So even if there was a reduced focus on comprehensive medical record and more of a focus on meaningful use for the open-source community, you would advocate for a—some sort of site inspection process.

Dr. Edmund Billings – Medsphere Systems – CMO

I—if you look at the bottom on that, in all three of those cases, at some point, the site has to submit for meaningful use. And you're right that the slide that Dr. Kates showed and that Dr. Leavitt showed yesterday of the three paths—at the bottom of each, the bottom line is that the site has to prove its meaningful use to get the criteria, not just get—submit a code saying that the product is certified.

Unidentified

Last week, I spoke to another member of the open-source community, and I hope I'm saying his name right: Joseph Van Moulin from Windows Vista.

Dr. Edmund Billings – Medsphere Systems – CMO

Yeah.

Unidentified

And I asked him the same question, and he gave me a different answer, though. He said he was very positive about Vista; he described it as a national treasure that we have—very enthusiastic about open source. But he said the open-source community needs to be able to compete with the commercial products straight up on a level playing field, and whatever commercial products have for certification, open source should have for certification.

Dr. Edmund Billings – Medsphere Systems – CMO

I don't disagree with that. I don't disagree with that [inaudible]. Vendor products are open; they shouldn't be competing on comprehensive feature function, either. I mean, we have 1.5 percent adoption. I think the point of my model is not about the open source; it's about competing for service and results, not competing on product and code.

Unidentified

But my question, though, is, I'm very focused on how you certify open-source software. So if you want to compete on a level playing field—commercial products, shouldn't you have the same certification process?

Dr. Edmund Billings – Medsphere Systems – CMO

Yes.

Unidentified

But that's not—

Dr. Edmund Billings – Medsphere Systems – CMO

He doesn't have an open-source product, and he's saying the same thing as I'm saying.

Unidentified

He's saying modular.

Dr. Edmund Billings – Medsphere Systems – CMO

He's saying modular or site specific.

Unidentified

Or site, okay.

Dr. Edmund Billings – Medsphere Systems – CMO

And the devil's in the details. We saw slides; that's as much as we know. The devil will be in the details about what those criteria are under modular, how frequently they're done—he did talk about the version control issue, because obviously, the ownership—the inheritance of a code base that has been certified shouldn't have to go back and get that recertified. I just download it to my own site and implement and compile it myself; I shouldn't have to go back and get that recertified. So there's a number of items that need to be addressed. The open-source community generated a list of improvements to the process that would make it work for open source. We're not looking for a separate certification process. I'm making the case that if I was sitting here with a—I mean, we heard it from Dr. McCauley yesterday; he said the same thing, and he's from Cerner.

So it's—the comprehensive is missing the point. It's over-engineering, and it's cementing in functional that doesn't drive adoption. Modular, if defined correctly and focused, is what we think we could certify our product and—because it's focused and modular. And then secondly, we think the site-specific certification shouldn't just be for homegrown, because when you put open source in, it's not “buy or build”; it's both.

Unidentified

And that's a very good comment, because I also wanted to ask a question of you, Carl, in Marshfield Clinic. And first of all, as I listened to your presentation, I saw, whatever it was, 65,000 hours that was wasted; that was, like, heartbreaking to see. [Inaudible] It's an interesting presentation. And I'm just trying to understand: Are you advocating for a site visit approach for home grown systems? Or how—what should we be doing so that other people don't have to waste 65,000 hours?

Carl Christensen – Marshfield Clinic – CTO

[Inaudible] previous comments that a site-specific certification is certainly the only network for homegrown system focused on meaningful use, or something around there, as opposed to going through the comprehensive, you know, list of certification features. I would also argue that I don't think it's only advice for inhouse-developed systems. The issues that were raised are, either you're going to run a large, monolithic enterprise system that is fully certified, or basically you are an inhouse integrator that is bringing in multiple systems. So—and I'm not great for—I'm blanking on who said this, but the—is that if you get to a certain size of enterprise, you are doing inhouse development. There's—you're just—it may not be to the ex—certainly to the extent that we're doing at Marshfield. So the, you know, site-specific certification, I think, is the only practical way to go forward. It is—not to say that having some, you know,

Good Housekeeping, you know, Seal of Approval or something for buyers of modules or systems is a bad thing, but it should not be what's really—you know, certainly shouldn't be what's driving, you know, the incentives and focus—and forcing organizations to focus on that.

Unidentified

And when you say “a site certification,” I'm going to make sure that I'm hearing you correctly. When I hear that, I'm thinking about the site visit or site inspections; either somebody goes on site or some virtual process, or they somehow look at computers remotely. But is that what you mean?

Carl Christensen – Marshfield Clinic – CTO

That that—yes. That's what we mean. Now, it possibly could be accomplished 100 percent based on, you know, some sort of, you know, meaningful use criteria, you know, looking at other areas, you know, where we've had the certification and accreditation; that's typically not the case. It's somewhat of—akin to saying that you could do your JCAHO inspection by just reading the policy manuals of the—for the organization and not actually going and doing an inspection or doing a cap inspection by only reading the manuals and checking that off. That is not—I don't think that's feasible. So I would advocate that, A, you have some level of onsite, you know, certification, you know, with the focus being on—not on features—being—the focus being on what is being accomplished. Are we accomplishing what we're setting out to do?

Unidentified

Thank you.

Paul Egerman – eScription – Chairman & CEO

Marc?

Marc Probst – Intermountain Healthcare – CIO

I'm Marc Probst. And you're kind of answering it. I guess this is open for all of them, but it comes from a statement you made, Carl. And the 65,000 hours concerned me, but I think what concerned me more was your statement that a significant amount would have been done in a different way. And you gave the example of your reporting. Is there something in the criteria or the requirements that are out there that's making it so inflexible or it's so slanted toward some set of technology that we should be talking about and addressing that?

Carl Christensen – Marshfield Clinic – CTO

The—again, the answer is yes. It—we seem to be heading in on being, you know—to driving into a more and more granular level of—you know, on the certification getting more and more detailed and losing some of the—you know, the flexibility and the ability to—you know, to innovate. So to answer the question, I think we've just got to take it up and just be careful not to drill in too deeply in terms of the certification, you know, criteria. There probably was a dozen areas, you know, with the reporting being the biggest one. I was actually—when we were sitting through the—you know, I sat through some of the test itself. I thought we were going to be in trouble on how we were managing our problems list. And it had—it was coming down to the criteria—how you make a change. And the problem was, we did a dictionary-based approach, and the—and one of the proctors was—his interpretation on that is, a dictionary-based approach is not what we should be doing—is, we should be actually doing it on the actual value, not the attributes of the value. That's getting a little bit, you know, too focused, you know, drilling down a little bit too deeply, you know. The goal should have been, “There is”—can you modify the problem list?

Marc Probst – Intermountain Healthcare – CIO

Did you pass it?

Carl Christensen – Marshfield Clinic – CTO

We passed it. But it was interesting that—

Marc Probst – Intermountain Healthcare – CIO

Okay, you were able to convince the proctor the right way.

Carl Christensen – Marshfield Clinic – CTO

It was int—we ended up passing it, but we did actually have to, you know, go in and change—make some, you know, data dictionary changes on the fly in our—there so that we could then present it in the way that, you know, the proctor was comfortable with. It was fortunate that we had that flexibility. And it was—and we were not anticipating that.

Dr. Edmund Billings – Medsphere Systems – CMO

[Inaudible] go through the criteria, it's a RFP on steroids. I mean, we get RFPs all the time, and the level of requirements from the customer is a level up from this, and meaningful use is a level up from that. So this just completely overspecified—if you go in, they—you know, it's almost to the point of “Push this button; get this list.”

David Kates – Prematics – SVP Business & Product Strategy

And my comment's along the same lines as Carl's and [inaudible] that we've said “modular,” and I've used that term in this context just because it's a term that CCHIT has introduced, but I think we're really talking more about core capabilities and not overblowing the features and functions that are there, you know, oftentimes facilitating workgroup meetings with physicians and vendors that are trying to look out for their brethren—look out for their fellow physicians that may be purchasing a system or whatnot. It becomes a wish list, you know, that RFP-like thing of all the bells and whistles that you might want to get in there. And the workgroup has constantly struggled trying to say, “What is core functionality?” I think core ought to be measured by “What are the ends? What are we trying to accomplish? What are we trying to go and improve in terms of quality and efficiency of care?” And if you go through the litany of things in there, it's the core functionality. “Modular” is a term that's been introduced, but I don't—it is—“modular” means you're going to have piece parts that all come together and create the functionality defined in comprehensive, and I don't think that's—you know, that's not what I'm talking about.

Carl Christensen – Marshfield Clinic – CTO

We have a roadmap with the Indian Health Service. The VA has its own roadmap and puts code out on a regular basis. And we have a roadmap with our customers. And the CCHIT—you know, they're telling us what they need, basically. They're getting the meaningful use you saw me describe, and they're asking for more meaningful use, you know, functionality. So to be distracted by and have to pull up resources and put effort into something that is overengineered or off course or less adoptable—more complex is just a waste of time and energy.

Steve Downs – Moderator

Time for a few more questions. John, and then Larry.

John

I'm sure you've got a Type 1 coming out of that, Carl, even though you passed overall. I think—was interested more in the site visit angle here. So if you imagine that there's a certification process, perhaps focused on meaningful use, perhaps up a couple of thousand feet—but the fundamental intent is to say the product, however obtained, is capable of doing these basic core elements, etc. So that's one form of inspection, for lack of a better word. There's another form of inspection which CMS will have to use—says, “You want your money, you've got to prove to me you're engaged in meaningful use.” And it's got to think through how it wants to do that.

So if we—there's been some discussion of a site inspection with—largely to address the—an aspect of the former, which is, it might look great in the lab, but when you got it into the setting, it was something other than great. And so, to sort of test the field and to make sure that the field experience was—with the lab experiences, etc.—gets a little messy there, because there can at times be—the supplier hoodwinks somebody, or that's the implication. But also, frankly—and I see this in our place—is at times we screwed it up, and so it's got nothing to do with the vendor; we misconfigured the darn thing, whatever it is. So if you have a failing in the seal, whose failing is it? And one is clear: You're going after the supplier. And the other one, on CMS, is clearer: You're going after those who think they ought to get paid.

What would you do in the site inspection, and who's actually being inspected here? Is it the, you know, Marshfield Clinic and their implement—well, I guess that's the wrong answer, but one of your customers and their implementation of it, or is it the vendor? I mean—trying to get the sort of greater clarity on the intent of this site inspection and who's actually being inspected when that's going on.

Carl Christensen – Marshfield Clinic – CTO

I think it's the site. I mean, I think that we're trying to do is empower the site to change and help them change. And it's when they take this tool and use it and treat it like a tool on a platform to improve; that's when they improve. And that's when the governance gets aligned and everything aligns around improvement; that's when it gets meaningful use. If you don't have that, if you don't have that change management, you get the other result, which is, it isn't being meaningfully used.

John

Would that be more towards the CMS side of the inspection to make sure you were—you know, you were good regarding the payment? I mean, is it more in that camp than the product camp?

Carl Christensen – Marshfield Clinic – CTO

And the closer it's tied to getting paid, the closer you're going to get business models—industry forming around the organizations to help them get there.

John

Okay.

David Kates – Prematics – SVP Business & Product Strategy

This is my concern coming from the small doctor's practice setting—is that I don't see how that's scaled. I mean, that makes sense, but okay, just so I want to go on record that, you know, that's got to be—there's got to be surrogate measures or some means by which—you know, not claims but not, you know, self-adaptation but some metric whereby we can infer and identify that they are using it in a meaningful way by virtue of their ability to go and perform certain actions and provide certain information.

Steve Downs – Moderator

We have a couple more questions in the queue and very little time, so just—if I can ask for very crisp questions and very crisp answers. And I've got Larry and then Charles.

Larry

So let's see if I can keep this crisp. [Pause] I'll make it crisp and skip it. [Laugh]

Steve Downs – Moderator

Thank you, Larry. Charles? [Laugh]

Charles

I hope that's not catching. [Laugh] You know, my question is back to the EHRM approach. And I guess the question I have is, looking back at the CCHIT slide that you showed, David, it says “for providers who

prefer to integrated technologies from multiple certified sources.” And yet, if I look at our progress to date, the thing that jumps out at me is the challenges we’ve had around integration, be it—call it interoperability, health information exchange, whatever. That, to me, has been the yellow if not the red flag in all this. How do we manage the risk that we’re not just providing a path for physicians, not to a bridge to a better and better health IT but rather a series of piers? How do we manage that risk?

David Kates – Prematics – SVP Business & Product Strategy

So my first comment is sort of back to my earlier statement that I think modular EHR that—the way CCHIT is defining it does put the burden back on an organization to integrate piece parts to create the EHR comprehensive. And I use that term, but I think what I’m really talking more about is narrowing the focus of the certification effort around some core features and functions. So the modular approach has merit, whether it’s a large organization that has the ability to do that integration and may be able to piece parts or in a smaller practice, the adoption and the ability to integrate that informat—integrate the tools into the workflow and the practice, I’m describing as a modular approach. But in the smaller physician practice and maybe in other settings, it’s not what’s in the caption that’s on that slide that says that organization wants to integrate it on their own; it’s that our certification and adoption focus needs to be on being able to go and take the baby steps towards building functions that support meaningful use and being able to buy technology and adopt technology in a modular fashion, not the integration focus that’s on that slide.

Carl Christensen – Marshfield Clinic – CTO

And I would add that you can think of the modules as these kind of silos, but that’s not going to work. You need a foundation, a platform where the interoperability is a data module, the data liquidity kind of—you know, that support to allow it to flow across the modules. If you have a separate—and we’re running into this today—if you have a separate emergency department system and it integrates to our system, we can’t catch core measures at the point of entry into the system and flow it through to the main record; we have to redo it. So it needs to have that modular longitudinal flow in the platform. And you—when you see the successful models around SugarCRM, Sales Force, where they build modules on top of this common platform, that’s what’s needed in this module.

Charles

Okay, thank you.

Steve Downs – Moderator

So Paul, I’m going to defer to you, because I know you have a question, and we’re also at time, so it’s time to go back to you anyway.

Paul Egerman – eScription – Chairman & CEO

That’s great. So I’ll ask my question, and then I’ll say thank you. [Laugh] So [inaudible] will have to take a little—well, anyway, my question was, in the discussion that you were having Ed with John Glaser about the site visit for open source, I just wonder if that puts open-source software at a disadvantage if you want to compete with commercial vendors, because if—

Dr. Edmund Billings – Medsphere Systems – CMO

I’m not talking in terms of—I would say this is true for any...

Paul Egerman – eScription – Chairman & CEO

Okay, because if I’m the purchaser—the thing is, if I’m a purchaser—if I’m a commercial vendor, I know I’m getting a certified product, but if I buy open source, then I have to go through the site visit thing to find out if I can get certification.

David Kates – Prematics – SVP Business & Product Strategy

I think there needs to be that it creates a risk.

Dr. Edmund Billings – Medsphere Systems – CMO

I think we should change the terminology. I think I agree with David that it should be, we should get comprehensive versus core or complete versus comprehensive: complete to do meaningful use, not necessarily comprehensive to the detail that was described by Carl. And then, that should be what the products get certified on: open source, you know, proprietary vendor, any of them. And it should be done in a way that you could do it in a modular deployment and modular development, remember? And the site should also be—because we've heard from the Leapfrog Group, and we've heard over and over again that the product has—you know, we want product certification for safety for the customer, but we need to validate the usage in the field. And if we build that close to the financial model, you're going to get a whole industry of helping these organizations get there.

Paul Egerman – eScription – Chairman & CEO

That's very helpful. So let me say "Thank you" to you, Steve Downs, for moderating this panel, and thank you to the panelists; we appreciate your effort. And we had a number of questions for you, just because you're saying some very important things, and we're trying to figure out how do we accommodate these processes, so thank you very much.

We are now heading into the part of the process of our agenda called the public comment. And hopefully, if you're watching on the Internet PowerPoint presentation, there's a phone number which you can call. And there's also a microphone here in the room if anybody has any questions. As John Glaser said in his opening comments, the workgroup will be making a recommendation tomorrow, Thursday. I think we're at 2 o'clock on the agenda, if I remember right. And so, if anybody has any public comments, this would be a very important time to be making them.

Chris Weaver

And we'll just mention real quick that if folks are just on the phone, you just need to press star-1 to indicate that you have a question, and the phone lines will be open one at a time.

Paul Egerman – eScription – Chairman & CEO

Okay. And we have somebody here at the microphone. Go ahead, sir.

Jim MacDonald – College of American Pathology

Good morning. I'm Jim MacDonald with the College of American Pathology, and I'd just like to ask a question, please, if I may, to this august committee—is that—has there been a technology platform—been approved yet that we can look at? And if so, who's the point of contact on that, sir?

Carl Christensen – Marshfield Clinic – CTO

And it's a good question. The way the public comments work, actually, is, it's an opportunity for the public to make statements to us. So if you want to make a statement that we should produce a technology platform, that would be appropriate, but we don't actually answer questions.

Jim MacDonald – College of American Pathology

So has there been an approval on the technology platform or a discussion on a singular technology platform for terminology?

Carl Christensen – Marshfield Clinic – CTO

I mean—could you please explain to us—we should be doing that—and what that means to you in terms of a technology platform.

Jim MacDonald – College of American Pathology

I'll rephrase that into more or less the terminology platform. Has there been a great—I understand there's some—been some discussions about the terminology, but is there a—been approved-of terminology system?

Dr. Edmund Billings – Medsphere Systems – CMO

There will be on next week, July 21. The Standards Committee of the—it's been set up as part of the legislation; we'll hear from its three Workgroups on Clinical Operations, Quality, and Privacy and Security. They will be making recommendations regarding standards. Now, these recommendations are related to meaningful use, for which there'll be a presentation tomorrow. So to the degree that platform is defined as sort of recommended standards, be it either data—vocabulary standards or transactions standards or privacy and security standards, you'll have an opportunity, as will the industry as a whole, to hear the recommendations from those workgroups next week. And so, they're still finishing up their work; it's probably premature to do that, although I would invite you to join that conversation next—or listen in on that conversation and hear the first wave of what they're going to recommend.

Jim MacDonald – College of American Pathology

Okay. Thank you for your time.

Steve Downs – Moderator

We have two on the phone, so the first phone caller.

Operator

Our first comment from the phone comes from the line of Anthony Guerra with Healthcare Informatics.

Anthony Guerra – Healthcare Informatics

Hi. I'm used to asking questions, but I guess we'll phrase this in the form of an answer. Basically, I just wanted to sort of echo or build on what John Glaser—the line of questioning he had been going with. It seems to me, as we discuss more about certification, people seem to move into the direction of site visits and actually evaluating use and saying, "That's going to be more valuable." And we do seem to creep close to the line of what CMS is eventually going to be doing in measuring when—that meaningful use. So without knowing exactly what that's going to be and how that—either inspection or submitting clinical data to qualify for that money—how that's going to work, it seems to be you're guessing where that line is, and either you ramp up with the site visit-type approach, or you really scale back and make it a basic functionality-type level. But then that would go against what seems to be the trend of adding on more and more levels of functionality. So that's just my observation, and we'll leave it at that.

Paul Egerman – eScription – Chairman & CEO

Thank you very much, Anthony; a valuable comment. Did you want to make a comment also here in the room?

Unidentified

Yes. [Inaudible] with the American Physical Therapy Association. And first, on behalf of the association, let me just thank the workgroup for all the valuable work that you're doing to move us toward this health information infrastructure. Particularly, our comment, I think, goes very well with what you've been talking about this morning, about certification adoption and making sure that all of those particular criteria are inclusive of all health care providers, because we think that that's a critical link to collaboration and coordination of care. As we look as CCHIT and their certifying criteria that they set forth, it does not allow for that inclusion currently. For instance, it's required that an EHR incorporate e-prescribing capabilities. And while we believe that e-prescribing is an important component of care, physical therapists and other health care providers and professionals are currently limited in their ability to prescribe medications, laboratory tests, imaging procedures in many jurisdictions, which makes the requirement quite burdensome. Thus, the current criteria set forth by organizations like CCHIT prevent products designed

by or used by non-physician practitioners from being certificated. Therefore, we ask that as you go along with your recommendations and you move forward towards the finalization of those recommendations, we strongly urge the workgroup to put forth a recommendation that first represents comprehensive care and also ensures that EHR is utilized by an array of health care providers and specifically designed for the use of the needs of all patients or [inaudible] feasible certification pathways by CCHIT and other certifying bodies. Thank you.

Paul Egerman – eScription – Chairman & CEO

Thank you very much. And we have somebody else on the telephone. We have a number of phone callers, so the next phone call.

Steve Downs – Moderator

Okay. Our next comment comes from the line of Loveeta Baker.

Loveeta Baker – Caption Colorado

Hi. This is Loveeta, and I'm with Caption Colorado. I'm speaking for Brian Ahier, who is on the relay system. I will read you his comments: "How well in electronic health records, particularly Web-based personal health recorders, be made available to those with disabilities? I have not heard anything about accessibility, and I'm concerned that the ADA might be overlooked. Thank you."

And I have some following comments. I can only see one of his touch messages at a time, so bear with me for a moment. "My comment is worded as a question, but it is an area that I would like the committee to explore in the future. And I thank you for your assistance."

Paul Egerman – eScription – Chairman & CEO

Terrific. Thank you very much, Loveeta and Brian; it was very valuable. The next caller?

Steve Downs – Moderator

Our next comment comes from the line of Richard Thorson with SAMHSA. Hold on one second.

Richard Thorson – SAMHSA

[Audio break] listened to the—almost the entire day and a half of discussions and it seems to me that either because of verbal shorthand or a lack of familiarity with it—that it has not been completely clear that CCHIT is not constrained and has not been constrained in the past to use only standards that have been ANSI—become ANSI-approved standards. If you look at the criteria that are used in the certification testing, a goodly number of those have no source other than the volunteer committees, which by itself would be all right, except that the volunteer committee assignments are not an open process. So quite unlike HL7 or X12 or whatever, we have a non-HITSP—we have a non-open process leading to a certification—a set of certification criteria that are not constrained by having gone through standards processes. And for an industry that commands \$2.4, \$2.6 trillion, it seems to me a somewhat shaky approach.

Unidentified

Thank you.

Paul Egerman – eScription – Chairman & CEO

Thank you. Very interesting comment. Thank you. We have another caller.

Steve Downs – Moderator

Yes, but the callers that were in the queue—they got knocked out of the queue. So if you are in line to ask any questions, please press star-1 again. [Pause]

Paul Egerman – eScription – Chairman & CEO

So is anybody—?

Steve Downs – Moderator

We're not receiving any more by phone right now.

Paul Egerman – eScription – Chairman & CEO

Do we have any other—anybody else here who wants to make a comment? [Pause] Okay. So I'll close this day and a half. One of the callers said that they listened to the entire day and a half on the phone, so I think that person probably deserves a medal for dedication. So if they contact Judy Sparrow, we'll get an official HHS medal to anybody who—that did that, and that'll be sent through the U.S. Postal Service. It might take a long time to receive, though [laugh].

Chris Weaver

I'm sorry to interrupt you; we actually have the two people back waiting to make their public comment. Sorry about that. Ryan, if you'd go ahead and open the first line...

Paul Egerman – eScription – Chairman & CEO

[Inaudible, laugh]

Steve Downs – Moderator

Okay. We have Andrea Pennington from Logical Images.

Andrea Pennington – Logical Images

Hi. Thank you for taking my comment and question. This is Dr. Pennington, and I unfortunately have not been on for the full day and a half, so I do apologize in advance if this question is repetitive of other comments and questions.

Would you strongly agree that health IT can certainly address many of the problems of cost and quality in the health care system? And in regards to the proposed modular certification program or EHRs and other technology, I do believe this is a step in direction. And I respectfully suggest that existing clinical decisions support software be included ineligible for this modular certification. And to that end, I'm wondering if you can comment on this new modular certification. Will these additional resources be made eligible for reimbursement incentives through AARA to encourage greater adoption among providers and clinics who already see the value of division support?

Paul Egerman – eScription – Chairman & CEO

And thank you for your comment, Andrea. And so, we really can't comment on the question unless you want to tell us that you advocate that we somehow do that. If you want to make a comment about that, that would be helpful.

Andrea Pennington – Logical Images

Well, certainly, yes. I mean, we'd advocate that, indeed, this happened simply because of some of the other comments are—have suggested there are various providers who either do not need the full interoperable EHRs because of their practice specialty, or they've already adopted, or they see the value for the, quote-unquote, "smart system" that even the National Research Council suggested, you know, there should be greater emphasis placed there. So I would like to get some comments from your workgroup on that.

Paul Egerman – eScription – Chairman & CEO

Okay. Well, the way public comment works, is we consider all the public's comments, and as John Glaser said, we will be announcing a recommendation tomorrow. So thank you very much, Andrea, for your comment.

Andrea Pennington – Logical Images

Thank you.

Paul Egerman – eScripton – Chairman & CEO

Who do we have from the next caller? Do we have another caller?

Operator

Yes. Our next comment comes from the line of Rochelle Spiro with Spiro Consulting.

Rochelle Spiro – Spiro Consulting

Hello. My name is Shelly Spiro, and I am President-Elect of the American Society of Consultant Pharmacists, which is a national pharmacist association that deals with pharmacists in the long-term care or nursing home setting. I'm also very involved in all aspects of the profession of pharmacy, involved with the Pharmacist's Services Technical Advisory Coalition, involved with NCPDP (the National Council for Prescription Drug Program), X12, and HL7. I'm currently chairing the workgroup—the project—work project that's working on the standalone—prescribing standards within HL7, which was on the fast track to become a CCHIT-certified electronic health record functional profile—certified through CCHIT.

So I'm very familiar with the CCHIT process, very familiar with the modular concept, and totally agree with that process to help with the adoption. Pharmacists and the role that pharmacists play in the health care arena typically have been related to the prescription itself. But as pharmacists, we provide many more aspects of pharmacy services as it relates to medication and therapy management and communication of the services to the personal health record, to facilities and long-term care settings, to help with medication reconciliation—all very important processes that have to be considered when we move forward with solutions for adoption.

And it's a very—and if we're going to have electronic health records being used meaningfully, we have to make sure that the pharmacists themselves are able to communicate this information. And that's one of the reasons why I work so hard on making sure that we can keep the pharmacists linked up as it relates to what pharmacists do professionally and clinically with the patients that we serve, instead of just prescription information. Prescription information is just a piece of that portion.

And one of the things that we have been working on with the pharmacist professionals and professional associations—and there are six of them—we are creating a pharmacist—pharmacy provider electronic health record that we will eventually want to go through the CCHIT certification process. My—our group really believes in the CCHIT certification process. We've seen that it has worked and been involved not in the workgroups but work with system vendors who have gone through the certification process. It does work very well and would be one that would agree that it should be—remain in place to move ahead with adoption of electronic health workers.

Paul Egerman – eScripton – Chairman & CEO

Thank you very much Shelley. That was an excellent comment, and it's great to hear from the pharmacist or pharmaceutical industry. I think, if I understand, that's all the calls we have on the telephone. And we finished our public comment period, so I will again say thank you very much. Our workgroup will reconvene and close session in 15 minutes. Thank you.

Public Comments – Certification/Adoption Public Testimony – July 15, 2009

1. Certification becomes a buying criterion. Assumed to mean effective for needs (meaningful use). What is the market protection as market evolves to ICD 10, Accountable care, etc. what about the danger of too low a bar early on - if too low, legacy systems may become ossified in the system, further limiting interoperability recommendation - certify evidence-based criteria as a complete EHR - use the elements in ARRA (e.g. structured data, interoperable for care coordination, decision support and performance reporting).
2. I am not sure why there are questions about certifying open source Linux? Does this mean that there will be a certification process for Microsoft Windows as well???
3. RedHat has the advantage of support, CentOS is a mirror of RedHat but you are on your own for support.