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April 30, 2009

Ms. Marjorie S. Greenberg
Executive Secretary
National Committee on Vital and Health Statistics

Dear Ms. Greenberg:

PeriGen (formerly E&C Medical Intelligence) is an Obstetrical risk reduction company, using technology to improve outcomes for mothers and babies. We congratulate the National Committee on Health and Vital Statistics Executive Subcommittee on its productive and informative two-day hearing on Meaningful Use, and welcome this opportunity to contribute our testimony to the Committee's deliberations.

ARRA 2009 makes incentives contingent on "meaningful use" of "certified EHRs". We are confident our customers' use of our products is indeed "meaningful" by all possible measures – in terms of timely and complete documentation by physicians and nurses, in the use of advanced decision support capabilities to reduce error and improve outcomes, and in quantified reporting of multiple measures that capture these elements. Yet we are concerned that current certification frameworks do not address departmental applications such as ours.

The existing CCHIT inpatient certification framework is built around the primary assumption that a single vendor's application or suite of applications is used throughout the hospital. Internal connectivity between the different modules of that single application or suite is the vendor's responsibility, and the system is certified as a whole.

For a hospital pursuing a best-of-breed strategy, the challenge is the opposite: a collection of applications purchased from multiple vendors, each application chosen to address the unique requirements of specific department(s), with a total system assembled from these components. The individual components may or may not be eligible for certification (as currently exists) by themselves, but the assembled system can as a whole perform all necessary functions of a certified product. While there is nothing in the CCHIT process as such that prevents certification of self-developed or self-assembled EHR systems, the certification process as it is currently structured does not easily lend itself to this purpose, and places the financial burden of achieving certification on the hospital, not the various vendors.

We would argue that hospitals pursuing a best-of-breed strategy – and 10% of US hospitals overall (18% of teaching hospitals) are currently adopting this strategy according to a recent study published in the JHIM – are deliberately taking what is in many ways a more difficult route, in order to pursue excellence. A structure needs to be found that does not penalize this pursuit of excellence.

The very fact that each application in the best-of-breed environment has been selected as the "best" suggests that it is not the same as other applications in its class. Certification today requires compliance with a detailed and lengthy list of functional points, but these "best" applications may very well have different and "better" solutions to the clinical and operational

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requirements driving those functional points, but they could potentially fail certification because they are different.

We would recommend changing the existing certification process to better serve the needs of hospitals pursuing a best-of-breed approach. There are a number of possible routes, or combination of elements of these routes, which should be considered:

A. **Creating departmental and ancillary certification tracks**

By establishing a minimum set of departmental system standards, including clearly defined interoperability requirements, a light-weight certification for departmental systems would allow the use of such systems within the confines of the larger, certified enterprise system. Documentation occurring within one departmental system is available to the other systems via standard HITSP-available constructs and interoperability standards.

B. **Certifying installed systems rather than off-the-shelf applications**

Creating a certification framework and inspection mechanism that would be better suited to certify the functionality of a total installed system as actually configured, rather than certifying the individual components that make up that system.

C. **Allowing one certified EHR to act as a "wrapper" for other systems**

Setting the incentive rules in such a way that a hospital would be eligible for incentives by designating one certified EHR as its primary system, with the hospital being responsible for interconnections between that system and any other systems that may be in use.

D. **Lowering the bar for certification and concentrating on meaningful use**

By reducing the list of criteria required for certification, and concentrating on meaningful use, it may be possible to create a framework that addresses the intent of ARRA while better meeting the challenge of certifying multiple different systems. This minimal criteria list could be framed in such a way that individual criteria would be applicable when relevant to the particular departmental or ancillary system, rather attempting to be a "one size fits all" list.

Whichever of these solutions – or other options – is adopted, we would additionally recommend a change to the existing requirement of compliance with 100% of certification criteria. There is a real need to encourage the pursuit of innovative solutions in order to improve HIT and through it benefit US healthcare, and there is a real danger of stifling innovation by adopting a system that requires that all systems use the same solutions.

Respectfully submitted,

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Chairman and CEO