



## **EHRA Testimony for HITPC Certified Technology Comparison Task Force Richard Loomis, MD**

On behalf of the Electronic Health Record Association (EHRA) and our member companies, thank you for inviting me to share input on this important topic. Established in 2004, the EHRA brings together companies that develop, market, and support EHRs, to collaborate on issues that impact our businesses and our collective clients – hospitals and ambulatory healthcare professionals that represent the majority of EHR users in the US. In addition to being a member of the EHRA Executive Committee, I am the Chief Medical Officer at Practice Fusion, a cloud-based ambulatory EHR vendor.

- **What specific modules are relevant for the typical ambulatory office, and how do you package those features? Does this packaging change for specialty practices.**

Broadly, the EHRA believes that it is critical for our clients to make informed choices when purchasing health IT products. The products and functionality offered by EHRA member companies is widely varied, reflective of the broad needs of the health IT market, even when considering only the ambulatory setting. A number of factors contribute to the requirements of specific clients in this setting, including the number of physicians and other professionals in a practice, practice specialty or specialties, affiliations with other providers and delivery systems in their community, and participation in accountable care organizations, among others. As a result, developers of EHR and health IT technology offer a breadth of product offerings to meet these wide-ranging needs.

The term “module” may not be the most relevant one for this analysis as the features may not be packaged in separate components, as would be suggested by the term. Rather, I will address this question in terms of what features and functionality are core to the ambulatory practice of medicine. If one takes the approach that CCHIT used successfully, these would be a core set that all physicians (regardless of specialty) would need, with add-on functionality specific to a specialty. Core functionality common to all includes medication management and e-prescribing, lab ordering and resulting, access and/or information on radiology and other images and results, vital signs, clinical note documentation, secure messaging, generation and consumption of a cCDA, referral management, the ability to document problems, past medical history, family history, and social history, and the ability to run reports on the data. Functionality specific to just certain specialties might include growth charts used by pediatricians or the ability to generate a prenatal record for obstetricians.

With the advent of MU and ONC certification, products have had to include functionality that might not be used or prioritized by a software developer’s client base to satisfy regulatory requirements. In an ideal world, an EHR developer would be able to package functionality in a way that was logical for its mix of client specialties, sizes, and needs.

I would note that, although all of the EHR Association’s members offer a core EHR, many of our product offerings extend beyond this common scope in depth or breadth. Additional



functionality relevant to the ambulatory setting includes practice management, revenue cycle management, quality measurement and reporting, population health, care coordination, patient portals, patient engagement tools, and specific interfaces and interoperability approaches, to name a few. Of course, many of these functions are part of the modern EHR as it is offered today and others, like practice management/revenue cycle, may be included in integrated products that combine clinical and non-clinical functions. In many cases, our member companies work with current and prospective clients to determine and customize the combination of modules that will best meet their needs.

With the release of the 2015 Edition Final Rule, the Office of the National Coordinator for Health IT (ONC) recognized the role of health IT extending beyond EHRs by eliminating the notion of a “complete EHR,” with a sole focus on modular certification.

- **What should be the standard features for comparison? Ex. technical methods for deployment (are they hosted, do they depend on local implementation or management, basics of licensing approach)**

As I previously stated, the wide range of health IT products and functionality as well as the broad range of customer requirements in the market make it difficult to identify a specific panel of features for standardized comparison. However, a few broadly applicable areas include:

- **Specialties and settings served**
  - Technical requirements (hosted vs. cloud, server, OS, browser, etc.)
  - Other software requirements needed to achieve expected functionality beyond what is either included in the EHR or provided by the EHR developer
  - Licensing structure - such as per concurrent user, per physician, or per practice.
  - Interoperability approaches and capabilities, including standards and connectivity models supported, interfaces currently in production for lab vendors, immunization interfaces, syndromic surveillance, specialty registries, and cancer registries
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  - Types of devices supported natively (PC, MAC, iPad, other mobile devices, smart phones)
  - Availability of other complementary technologies, functions, and services (analytics, practice management, population health)
- **Does a vendor comparison tool foster competition and innovation?**

The EHR Association and our members welcome transparency. On balance, however, a government-developed/driven comparison tool would be unlikely to foster competition or innovation above what the market already encourages today. There are currently several tools and services that compare and facilitate the rating of EHRs (the American College of Physicians American EHR site, BlackBook, Gartner, KLAS, and HIMSS Analytics), and more are likely to be proffered as the market grows and evolves; the availability of additional data via HHS data sources like the Open CHPL initiative will further support this. We see little evidence, further, that a government-developed version would add additional value to consumers who already



have many opportunities to find information and see feedback about electronic health records and other health information technology.

We further note that, with regulatory requirements pushing vendors to all include the same functionality irrespective of their target market and clients, the grounds for comparison is becoming thinner. The greatest thing regulators could do to foster more innovation would be to reduce certification requirements to only what is absolutely core. This shift would allow vendors to focus on bringing to market new innovations that will meet the needs of their client base and respond to client requests.

- **Should information on the market focus of the developer (i.e. do they have experience with providers like me) be available for comparison? If yes, what would you want the developer to provide?**

As stated, we do not favor a government-sponsored comparison tool. In the context of market comparisons, however, information on the market focus and experience associated with the product and its developer could be helpful. Making the distinction between product and developer is important in that many developers offer multiple products to meet the needs of diverse customer segments. Categories to consider include specialties (dermatology, orthopedics, primary care, etc.) and care settings (ambulatory, ED, urgent care, inpatient, long-term care, etc.) supported. We note that sources of this data may be subjective and should be validated by real-world customer data. We also emphasize that the costs and restrictions around keeping a government comparison tool up to date could be substantial given the increasingly fluid nature of health IT product development and deployment and urge that the fewest critical data elements be used to minimize data collection costs, the risk of stale data, and interference in the ability to make rapid product and market changes.

In closing, the EHRA supports efforts to better inform and protect consumers, but we do not believe that another ONC-maintained resource would be the most efficient or effective approach.

We suggest that there are lessons to be learned from other comparison programs, as we have seen ratings systems such as the Medicare Advantage Star Ratings System and the College Affordability Score Card undergo significant and much needed overhauls in recent years.

Further, the ONC Certified Health IT Product List (CHPL) currently serves as a resource for potential clients of certified health IT products. As outlined in the 2015 Certification Rule, the CHPL will be enhanced with increased structured data on features and functionality provided by respective products. The planned availability of an API to access CHPL data will promote innovative approaches to product evaluation in the private sector. An additional ONC comparison tool would be largely duplicative.

We suggest instead that a more beneficial approach would be to create resources for prospective purchasers of Health IT that would provide guidance on how to determine the requirements of their practice or organization, and how to evaluate the ability of health IT software to meet those requirements. Also, we feel the emergence of new forums for collaboration and information sharing among users of certified health IT technology is going to be accelerating. These approaches are much



more flexible than a new comparison tool, as the needs of clients in the industry will continue to evolve rapidly in the coming years. New programs such as MIPS, APMs, and other value-based payment models, among others, will serve to both expand customer requirements and hasten health IT product changes. Lastly, any comparison tool should be limited to the objective presence or absence of product functionality as opposed to any subjective rating of specific functionality.