CCHIT

Certification Commission
for Healthcare
Information Technology

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June 26, 2009

Office of the National Coordinator
Attn: HIT Policy Committee Meaningful Use Comments
200 Independence Ave, SW, Suite 729D
Washington, DC 20201
(via electronic mail)

Re: Meaningful Use Comments

Members of the Committee:

The Certification Commission (CCHIT) appreciates this opportunity to comment on the recommendations presented by the Meaningful Use Workgroup to the HIT Policy Committee on June 16, 2009.

As the organization contractually empowered by ONC to develop certification criteria and inspection processes for electronic health records from 2005-2009, CCHIT has frequently faced the challenge now confronting the Policy and Standards Committees: balancing the policy goal of advancing EHR adoption against the practical realities of current technology and provider readiness. We congratulate you on the excellent work evidenced by the material published for comment. The Preamble document is a concise, clear statement of the problem, with which we fully agree. The Meaningful Use matrix also represents an excellent body of work, but drawing on our understanding of the EHR marketplace and experience with EHR certification, we offer our comments on the details of that document.

Comments on the Meaningful Use Objectives

Attached to our email, along with this cover letter, is an annotated copy of the meaningful use matrix. The **meaningful use objectives for 2011** have been carefully reviewed and compared to **CCHIT's certification criteria for 08**. Each meaningful use objective has been color coded as follows:

- Green highlighting denotes 2011 (and a few 2013) meaningful use objectives that are already **fully supported** by EHR systems with the most recent (08) CCHIT certification. Approximately 75 EHR products have achieved this standard, with products available for Ambulatory, Inpatient, and Emergency Department settings.
- Yellow highlighting denotes objectives with **minor gaps** beyond the most recent (08) certification requirements, but still achievable in time for the 2011-2012 ARRA incentive window in the Commission's opinion. In some cases the additional capabilities were already anticipated by our newest (09) criteria.
- Red highlighting indicates objectives that represent **major gaps**. They may be on the Commission's "roadmap" for future years, but are not felt to be realistically achievable by the EHR market in time for the 2011-2012 ARRA incentive window. They may be achievable for the 2013-2014 window or later.

Of the **22** meaningful use objectives proposed for 2011, **14** were fully supported by current certification (although some had minor gaps in either Ambulatory [OP] or Inpatient [IP] settings), **5** represented minor gaps that are still achievable, and only **3** were judged to have major gaps. Even those gaps represent an issue of timing and not a lack of ultimate achievability.

We would also like to point out that 7 of the 19 meaningful use objectives proposed for 2013 are already supported by currently certified EHRs. Overall, **we believe that with some adjustments, the 2011 meaningful use objectives could present a realistic and achievable target relative to current EHR technology.**

Comments on the Meaningful Use Measures

The question of whether this EHR technology can be adopted and put into meaningful use in a timely way to meet the 2011-2012 incentives window is more difficult. The lag between a decision to invest in EHR technology and its full, meaningful use in a provider organization is 1 to 2 years at best, and more typically, 3 to 5 years. For this reason, we believe **most of the measures proposed for 2011 would be difficult to achieve by providers who have not already begun EHR implementations**. Given current adoption levels, the incentives would only be available to a small percentage of providers, potentially provoking disillusionment and frustration with the ARRA incentive program. Another issue is that the proposed measures -- while understandably focusing on the highest cost disease areas – are only relevant for a subset of healthcare providers and practices. Among the lessons learned by CCHIT is this: it is essential that a new program take into account the wide diversity of specialties and settings through which health care is delivered. CCHIT recommends that **meaningful use measures be either simplified for 2011, or postponed until 2013.** The intervening time may be used to develop consensus-based measures tailored to as many health care specialties and settings as possible.

Once again, the Commission thanks you for this opportunity to comment. From our perspective as an independent, nonprofit organization with the mission of accelerating the adoption of robust, interoperable EHRs, we look forward to contributing to the success of your efforts.

Respectfully yours,

Mark Leavitt, MD, PhD
Chair, CCHIT

Alisa Ray
Executive Director, CCHIT

Also see attachment: CCHIT Comments on Meaningful Use - Annotated Matrix