



230 E. Ohio Street  
Suite 500  
Chicago, IL 60611

Phone: 734-973-6116 x 115  
Fax: 734-973-6996  
E-mail: himssehrva@himss.org

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August 10, 2005

Dr. Mark Leavitt, MD, Ph.D.  
Medical Director and CCHIT Chair  
HIMSS  
18407 NW Keller Road  
North Plains, OR 97133

Dear Dr. Leavitt:

On behalf of the HIMSS EHR Vendors Association (EHRVA) 34 member firms, we want to commend you, the Certification Commission for Healthcare Information Technology (CCHIT) and the CCHIT Workgroups, on your progress toward fair and balanced EHR certification criteria as evidenced in the Phase II work products.

The responses provided by the EHRVA represent the consensus of its members who have collaborated to provide feedback that reflects the unified perspective of EHR vendors who serve the vast majority of provider organizations in the US. The following commentary summarizes key points.

**Interoperability:** Many healthcare entities require communications to/from EHR systems (including immunization registries, pharmacies, hospitals, labs, public health organizations, clinical research facilities, among others). Communicating directly with each of these entities in a piecemeal fashion is impractical and unduly burdens EHR users, vendors and organizations using the EHR for information exchange. As described in the EHRVA response to the ONCHIT RFI for NHIN infrastructure, we continue to support the idea of a standard RHIO-like infrastructure to facilitate communication among disparate systems so that authenticated entities can extract the information required to perform their roles in healthcare delivery and management.

**Functionality:** We commend the Functionality Work Group for the clarity of the Phase II draft. From the clinical perspective, the categories and criteria are clear. From the vendor perspective, the test cases, criteria and comments provide appropriate guidance to achieve the certification milestones.

EHRVA supports CCHIT's attempt to define many of the criteria by identifying the central clinical need, providing examples of solutions and allowing the market to dictate how each need will be addressed. In our specific feedback, we ask for further clarification and definition so that we can accurately assess the availability of functionality to meet each identified need.

While the categories are well-grouped and comprehensive, we encourage the Functionality Workgroup to focus on greater consistency across sections since there is a disparity resulting from similar criteria being defined differently from one instance to the next. For example, for data such as problem lists, medication lists, and patient history, we would expect that all three would include similarly defined criteria regarding the ability to add and delete entries and to record audit trail information.

**Security and Reliability:** EHRVA recommends that the security and reliability requirements should be accompanied by objective measurement criteria to better support

objectivity in the certification process. In particular, objective measurement criteria for reliability requirements should be considered.

We also note that the audit and access requirements (especially granularity and date formats) may not be practical for small and medium practices and are not as immediately available as the workgroup seems to indicate.

For those security and reliability requirements that will leave certain minimum values or ranges for items such as passwords to be established by local or national Standards and Policy Entities, EHRVA recommends that the Security/Reliability Workgroup identify the "best-practice" or "typical" recommended values for high security/privacy environments. This will ensure that minimum thresholds are well understood and anticipated by EHR system suppliers or the suppliers of affected components to the EHR supplier.

We have concerns regarding granularity and modularity. Although small-scale (ambulatory) EHR systems may be turn-key, larger EHR systems are more likely to be composites of multiple vendors' products, with new and existing systems, and infrastructure controlled by no single vendor. In such cases, the certifiable components are difficult to identify and to evaluate in isolation. EHRVA recommends that CCHIT accommodate this modularity by not placing out-of-scope certification burdens on the vendors who supply portions of the overall EHR system. The security and reliability expectations for these components must be communicated appropriately to the buyers of CCHIT-certified products.

As authentication capabilities expand beyond traditional password methods to include capabilities such as biometric authentication, EHRVA would like feedback from the CCHIT as to when it might be expected that these capabilities will appear on the EHR certification roadmap.

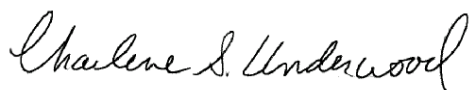
EHRVA suggested in its Phase I feedback that the Security/Reliability Workgroup establish practical use cases that address security implementations, especially for small physician office environments. We reiterate our request that this be addressed as part of Phase II and follow-on CCHIT deliverables.

**General:** EHRVA encourages continued efforts to make criteria and certification requirements consistent among Workgroups. For example, the electronic submission of prescriptions is included by both the Functionality and Interoperability Workgroups with certification dates of 2007 and 2005, respectively. Likewise, both the Functionality and Security/Reliability Workgroups address auditing requirements. We suggest that topics like this be centralized as much as possible in order to reduce inconsistency and redundancy among the groups.

While the terms "EMR" and "EHR" are used interchangeably, and there is little confusion about meaning, we recommend that the CCHIT workgroups use "EHR" consistently and differentiate ambulatory EHRs from acute care EHRs where that distinction is necessary.

EHRVA believes that the widespread adoption of electronic health records is critical to improving healthcare delivery in the United States, and we support CCHIT's efforts to create mechanisms that reduce the barriers to EHR adoption. We will continue to work closely with CCHIT to ensure that certification requirements reflect both the needs of our customers and the realities of our market-driven environment. We welcome any opportunity to engage in direct dialog with CCHIT Commissioners and Workgroup members to continue this important work.

Sincerely,



Charlene Underwood, MBA  
Director, Government and Industry Affairs  
Siemens Medical Solutions  
HIMSS EHRVA Chair

Andy Ury, MD  
President and CEO  
PMSI  
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