VCU Medical Center
Virginia Commonwealth University
MCV Hospitals and Physicians

Introduction

Madam Chair and Members of the Committee, thank you for allowing me to participate today. My name is Colin Banas, and I am here in two capacities: one, as physician and believer in the advantages of health technology, and two, as the CMIO for Virginia Commonwealth University Medical Center in Richmond, Virginia, with responsibility for a large EHR serving over 1,000 providers and learners (residents and students in all arenas of healthcare) in both the ambulatory and hospital setting with over 800 beds. VCU takes great pride in the thoughtful application of technology at the point of patient care and has a rich history of electronic medical records usage spanning over three decades. We are no stranger to the benefits of digitization of medical records and processes.

Let me first start by saying that I am thankful for the framework that the Meaningful Use program has brought to the landscape of healthcare and by proxy, thankful for the oversight and contributions of the ONC in said landscape. I do however have opinions on how to make it more facile, flexible, and less burdensome for patients, providers, and vendors.

To be fair, my experience with the certification program has been limited. Most of the knowledge and interpretation is often painted through the eyes of our vendor. We have indeed has contemplated participation in self-certification multiple times in the past but did not pursue. The reasons: number one, we've incurred great expense already in our current vendor based solution. VCU is most likely not alone in this practice, we rely so heavily on the vendor's certification and processes that it often locks us into a non-value added requirement simply to satisfy a report that demonstrates compliance with an attestation measure. The second reason for not seeking self-certification is that our research revealed a prohibitive expense in dollars and man-hours (combined to exceed hundreds of thousands), a timeline of months (on an already compressed schedule), and an excessive test burden to achieve certification. In short, it appears that it is something best left to the vendors and large custom institutions. It does not *appear* to be a friendly process for users who may need to have single modular measure certification performed for unique solutions or workflows to meet some measures. Whether these are legitimate reasons to avoid participation remains to be seen – perhaps we can learn as much from leaders and expertise in this room as the committee hopes to learn from VCU here.

It is important to note – that whether these suppositions are true or not, it is the perception of my colleagues that this is so. If nothing else, I would suggest that greater clarity and education around

the certification process be a priority, specifically in the instance of certifying for the "one-off" phenomenon as described above. It is also my belief that there is a continued confusion regarding the blurred lines between certified technology and how one uses it to achieve attestation. In examples in my written testimony one can see how certification drives the manner of adoption for attestation in an unintended way.

The biggest challenge with the current certification program include that there is virtually no guarantee that a certified EHR product will result in a clinician's ability to meet MU requirements, especially veteran users of this technology with years of pre-existing customization and concrete workflows. As the adage goes, "If you've seen one EHR install, you've seen one EHR install." I also want to point out that very often meeting the measures outlined in MU can require data and input from non-certified systems such as disparate billing, registration, and scheduling systems. The certification process does not (and most likely cannot) take into account all of these variables. Providers often feel stuck or obligated to rip and replace these ancillary systems at great cost simply to plug into the workflow which was certified against by their vendor. To quote Dr. DeSalvo, EHRs are like "giant battleships" with a variety of functions and customization that have been layered on over years of use; a one size fits all approach simply cannot work for every clinician that shares a particular vendor-based EHR in this country. It is difficult to turn a battleship on a dime. I believe this very truism is why the certification program exists. I just wish it were more simple, timely, and inexpensive from a time commitment. Perhaps having more accredited testing and certification bodies might help by spreading the demand for testing across more entities.

VCU has numerous examples of instances where our health system already meets the intent of the measure, but our CEHRT was certified for said function in a different manner. Not knowing any differently, our EHR vendor tells us that we will need to do it the way in which they certified in order to reliably meet MU requirements. It would be impossible to estimate the amount of research and development hours devoted to readjusting clinical workflows and code in order to be able to satisfy a report which was achieved in the vendor certified workflow and technology, even though we are clearly satisfying the clinical intent of the measure. I cannot stress this enough – it is fear that drives this process for clients – fear of audit, fear of penalty, and fear of vendor abandonment should a client choose to forge a different path. The tenor of the MU program has started to shift; the exuberance over the prospect of new technology to benefit our patients is slowly eroding toward a state of fear; fear of being penalized for failure to comply.

A simple look at the collaborative bulletin board web-space that our EHR vendor's clients share reveals that we are not alone in our frustration and in fact a new phenomenon has emerged as a byproduct of MU and certification which I title "code chasing". Clinicians and hospitals are forced to load and test code at an unprecedented pace and even the best intentioned code can often introduce a different problem elsewhere in the system, forcing the client to choose between the "lesser of two evils". I'm not sure it is fair to place blame on the vendors in instances like this. I believe it is a direct correlation with the rapidity of certification requirements changes and the litany of "aha moments" that occur as real users attempt to use these technologies. So the ask here: slow down and permit focus and improvement on the existing criteria.

The way to improve this process is of course to garner even more end-user input in the testing and certification process. In my reading, it appears that the ONC will be conducting "open test procedure development" in a more collaborative process with subject matter experts. I believe this to be a strong step in the right direction and would personally be happy to participate. Put us all in the same room. I believe that increasing involvement from clinicians during these critical certification and measurement development stages is the key towards simplifying what has become a dizzying chaos of rules and regulations. It is the clinicians who often best understand what is and is not feasible and reasonable in the realm of technology, by engaging as many use case scenarios as possible we could start to avoid the "check the box" phenomenon that is suffocating our clinicians and steer the direction of EHRs back towards a focus on usability.

Conclusions

In bulleted format I will distill my thoughts related to suggestions for the future of the certification program:

- Slow down! These things take time, especially given all of the discoveries that occur as technologies and processes get implemented. Chasing code is dangerous to our patients.
- Self-certification seems unduly burdensome, which is why many choose not to pursue it. At a minimum, the certification process should be better advertised and communicated. Ideally it could be made easier, honestly, I would gladly host a site-visit or remote desktop sharing to demonstrate how some of the measures are accomplished outside of how our vendor certified their solution.

- Reliance on vendor interpretation and workflows which achieved certification is painting clinicians into a corner that often does not reflect appropriate usability and workflow. This can leave clients feeling obligated to purchase additional products or technology simply to satisfy a report that was achieved through a certified product rather than the clinical intent of attestation.
- There is an opportunity to introduce more flexibility in the measures (perhaps this not the forum) but in this stage of laying infrastructure, especially in the realm of interoperability, “yes/no” attestations would be welcome.
- Increase the collaboration related to the creation of certification and attestation criteria. Put us all in the “same room”. It appears great strides in this direction are already occurring, this is to be applauded.