

EHR System Certification May Be Out This Summer

BY MARY ELLEN SCHNEIDER
Senior Writer

PHILADELPHIA — Physicians purchasing an electronic health record will be able to consult a list of certified products as early as this summer, according to Dr. Mark Leavitt, chair of the Certification Commission for Healthcare Information Technology.

The certification commission planned to begin accepting applications from electronic health record (EHR) vendors in late April or early May and to publish a list of certified products and their developers in late June or early July.

The list, featuring the first batch of products with the certification commission's seal of approval, will be published on its Web site (www.cchit.org).

The process of certification is voluntary and its success is dependent on acceptance in the marketplace, Dr. Leavitt said at the annual meeting of the American College of Physicians. "We're not setting the bar above everyone's heads so that no products meet it," he said. "But it is not trivial to have a product that meets the criteria."

The certification commission was formed in 2004 by the American Health Information Management Association, the Healthcare Information and Management Systems Society, and the National Alliance for Health Information Technology. In September 2005, the group received a 3-year contract from the Department of Health and Human Services to

work on certification criteria for EHRs.

The certification commission is focusing first on certifying products for the ambulatory setting. In phase II, the commission will work on evaluating EHR products for the inpatient setting, and in phase III it will evaluate the infrastructure or network components for EHR interoperability.

Vendors will apply for certification and pay a testing fee. To keep costs down, the testing will be done virtually through an Internet browser. A three-person panel, including at least one practicing physician, will judge the demonstration of the product during a process that could take several hours to a day, Dr. Leavitt said.

It's unclear how many products will be certified in the first round, he added.

EHR products will be evaluated based on more than 250 functional requirements. But the commission is not in the business of designing EHRs, said Dr. Sarah T. Corley, cochair of the certification commission's functionality workgroup, and there will be some variability in the market.

The standards developed by the commission will set a baseline for what every physician needs in an EHR, but some subspecialists may need to work with vendors to add more functionality, she said.

But the commission's work should be valuable to physicians in all specialties because it will help to narrow the field, Dr. Leavitt noted. "You still need to do your homework," he said, but certification will allow physicians to hone in on the advanced level of functionality they need. ■

Measuring Quality of Care Could Reduce Racial Disparities

BY MARY ELLEN SCHNEIDER
Senior Writer

PHILADELPHIA — Performance measurement is one way to help eliminate racial disparities in health care, Dr. John Z. Ayanian said at the annual meeting of the American College of Physicians.

Public and private payers must also do their part by maintaining accurate and complete data on race and ethnicity to help monitor disparities, said Dr. Ayanian, associate professor of medicine and health care policy at Harvard Medical School in Boston.

There has been some success in narrowing the racial care gap in areas where measurement is widespread. For example, a study published last year found both overall quality improvement in the use of β -blockers after acute myocardial infarction among Medicare managed-care beneficiaries and a significant narrowing of the racial gap in treatment. The treatment gap between black and white beneficiaries had been 12% in 1997 and fell to 0.4% in 2002 (N. Engl. J. Med. 2005;353:692-700).

But there is still work to do, he said. For example, the same study shows although overall quality improved in cholesterol control for coronary artery disease, the racial disparity is increasing in that measure. It showed that the gap for cholesterol control, defined as LDL cholesterol below 130 mg/dL after discharge, between black and white patients was 13% in 1999, and the gap widened to 16% in 2002.

Lack of communication and trust be-

tween minority patients and physicians also are factors in care disparities, Dr. Ayanian said. Many physicians don't recognize the legacy of discrimination in health care, such as the Tuskegee syphilis study, that still fuels mistrust of the health care system among minorities, he said.

A cooperative national study by Dr. Ayanian and his colleagues looked at new patient preferences for renal transplantation in end-stage renal disease patients ages 18 to 54 in Michigan, Alabama, Southern California, and the Washington metropolitan area in 1996-1997. They found small differences in the patient preferences for the transplant but larger differences in the referral for evaluation. For example, 86% of white men favored transplantation, and 82% were referred for evaluation. However, 81% of black men favored transplantation but only 58% were referred for evaluation (N. Engl. J. Med. 1999;341:1661-9).

Most patients in the study said they agreed with and trusted their physician. But white patients were more likely to trust and agree with physicians than were black patients, and black patients received less information about transplantation.

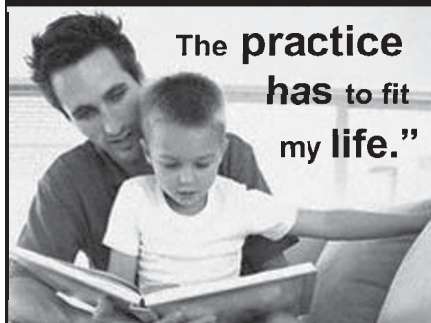
Physicians, researchers, and policy makers need to work together to help eliminate disparities, Dr. Ayanian said. Expanded research funding is needed to better evaluate the causes of disparities and financial incentives from payers can be used to reward "equitable and high-quality" care, he said, adding that there needs to be a broader focus on Hispanic, Asian, and Native American patients. ■

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