



## ***21<sup>st</sup> Century Cures Act: Interoperability, Information Blocking, and the Impacts on Healthcare*** June 25-26, 2019

### **Event Summary**

The EHR Association was honored to host two Congressional briefings in June—one for staff in the U.S. Senate and one for those in the U.S. House of Representatives—to share with policymakers the Association’s perspective on two recent proposals from the Office of the National Coordinator for Health Information Technology (ONC), both stemming from the 21<sup>st</sup> Century Cures Act (Cures Act):



- The Proposed Rule to define reasonable exceptions to information blocking and associated changes to certification requirements.
- The second draft of the voluntary Trusted Exchange Framework and Common Agreement to further enable information exchange.

EHR Association members have concerns in several areas, including where the proposals do not appear to align with the intent of the Cures Act. The Congressional briefings included discussions of the following:

- The risks associated with the proposed price controls and licensing of intellectual property that will override market forces and inhibit innovation.
- The overly broad definitions that go beyond Congressional intent and could add to the healthcare industry’s regulatory burdens.
- Specific references to ambiguous language used in the proposals, which makes compliance difficult.
- Recommendations for a more realistic, achievable scope of work within the proposed timeline.

### **ONC Proposed Rule on Information Blocking**

**The breadth of the proposals go far beyond the intent of Congress when it passed the Cures Act.**

ONC’s proposed regulation fails to clearly define many terms; therefore, it has the potential to include healthcare ecosystem participants not envisioned by Congress as being covered by the legislation, such as banks and credit card processors. As drafted, the far-reaching and all-encompassing nature of overly broad definitions such as “interoperability elements” (“any means by which EHI can be accessed, exchanged, or used”) and “Electronic Health Information” (EHI) will inflict new burdens on healthcare organizations in a compressed time window, while stifling innovation in other areas where providers seek HIT support.

**ONC has stated that its goal is to be “clear, predictable and administrable.”**

Unfortunately, ambiguous and subjective language such as “reasonable” and “near real-time” remain open to interpretation and thus difficult to act upon with confidence. How would a developer code “as soon as possible” into software? Because the penalty for information-blocking is so significant (up to \$1 million), it is crucial that ONC and the HHS Office of Inspector General (OIG) provides *specific* guidance on what is and is not permissible.

**The proposed rule identifies promotion of innovation as a key goal, yet includes far-reaching licensing of intellectual property (IP), severe restrictions on cost recovery, and expands certification requirements – all of which will have negative impacts on innovation.**

Historically, Congress has very rarely implemented compulsory sharing of IP and did not indicate that intent in Cures. However as drafted, ONC's proposed rule would compel health IT developers to license their IP on "reasonable and non-discriminatory" (RAND) terms to essentially anyone who asks for any underlying IP that enables interoperability. Additionally, the proposed requirement to limit companies' ability to charge fees beyond cost recovery devalues the work of software developers and penalizes innovation and efficiency by overriding market forces and profit-driven motivations for investments in new technology.

Those investments in new technology are focused on enhancements sought by health IT customers. By limiting innovation and expanding certification requirements beyond standards-based interoperability, ONC is moving beyond its role as a regulator into that of a product manager, directing the resources of health IT companies away from client requests and toward compliance with government mandates.

Health IT developers regularly share IP and screenshots on a voluntary basis as part of a variety of initiatives, including patient safety organizations, HL7, ONC/CMS/CMMI projects, and among industry partners. Exposure of IP should remain voluntary.

**The proposed scope of work is unrealistic in the proposed 24 month timeline.**

As part of the comment process, the EHR Association surveyed its member companies to estimate development for proposed requirements. The results (see attached infographic and spreadsheet) show that the proposed scope of work is not achievable with high quality delivery in the proposed timeline. In fact, EHR Association member companies' estimates were much higher than ONC's estimates. For example:

- One of the proposed updates to certification criteria—EHI export—was scoped as likely to take an estimated 60,000 development hours per product.
- USCDI implementation was estimated by developers as taking three times as long as ONC's estimate.

Rushed implementation leads to less than desirable functionality and usability. Development and implementation of software updates includes design, coding, quality-testing, feedback, roll-out, customization, onsite testing, and training. Short-changing any element can lead to frustration and higher risk of bugs and non-compliance.

**Privacy issues must be addressed.**

Information-blocking rules introduces a paradigm shift from HIPAA—from a system that requires justification for sharing EHI in order to avoid a penalty—to one where failing to share EHI is penalized. Already today, healthcare providers often make well-intended but ill-informed decisions about information exchange in attempts to comply with HIPAA. Explicit guidance will be needed from ONC, OCR, and SAMHSA to clarify interactions between HIPAA, 42 CFR Part 2, and Information Blocking rules as well as state-by-state laws and regulations.

**Interoperability is a key component of price transparency initiatives.**

Sharing and exchanging data in a standardized way via APIs represents an important opportunity to make information available to patients and their caregivers. Emerging opportunities to put health data to its best use are dependent on protecting the innovation ecosystem that exists in health information technology, however, that would be threatened should the proposed rule be finalized as written.

### **EHR Association Recommendations:**

- Given widespread concerns and questions about how information-blocking will be identified and enforced, OIG should delay enforcement of any financial penalties as the industry adjusts to new information sharing requirements (similar to the rollout of HIPAA). While monitoring and enforcing compliance, OIG could publish corrective action plans and other educational materials to aid healthcare organizations in understanding what is and is not permissible.
- Narrow the focus and scope of requirements for the 24 month timeline to USCDI APIs and documents —which already has industry support and alignment—as well as ePrescribing, which would promote alignment with CMS rules.
- ONC should identify additional opportunities to solicit and incorporate public feedback and shared learnings in order to more effectively meet the goals of the Cures Act. An Interim Final Rule or Supplemental NPRM prior to release of any Final Rule is one such path. Stakeholders need more clarity on definitions and expectations as well as more education and time to successfully adjust.

### **Trusted Exchange Framework and Common Agreement (TEFCA)**

#### **EHR Association members strongly support the intent and goals of the Cures Act to expand interoperability across networks at a national level.**

Existing private-sector exchange efforts such as Carequality, CommonWell, and eHealth Exchange have come a long way since passage of the Cures Act, moving from how to exchange data to which types of data to exchange. The EHR Association believes that building on established networks and processes like these is preferable to developing what would essentially be a duplicate framework, as proposed in Draft 2 of TEFCA.

#### **The Cures Act directed ONC to develop or support a framework to exchange data across networks and ensure a set of contractual agreements to support that exchange.**

The TEFCA was intended to be a voluntary, non-prescriptive approach to addressing governance and trust; but, this draft, in combination with suggestions within ONC's Information Blocking and Certification and CMS' Patient Access and Interoperability proposed rules, introduces essentially mandatory participation, thus requiring transition from participation in existing trusted exchange frameworks into the TEFCA-based trusted exchange framework.

### **EHR Association Recommendation:**

- ONC should build upon existing data exchange efforts by working with the existing trusted exchange frameworks to address potential gaps and foster cross-network integration rather than creating a new, quasi-mandatory and parallel effort that would introduce uncertainty and delay progress on current efforts.



# 21ST CENTURY CURES ACT

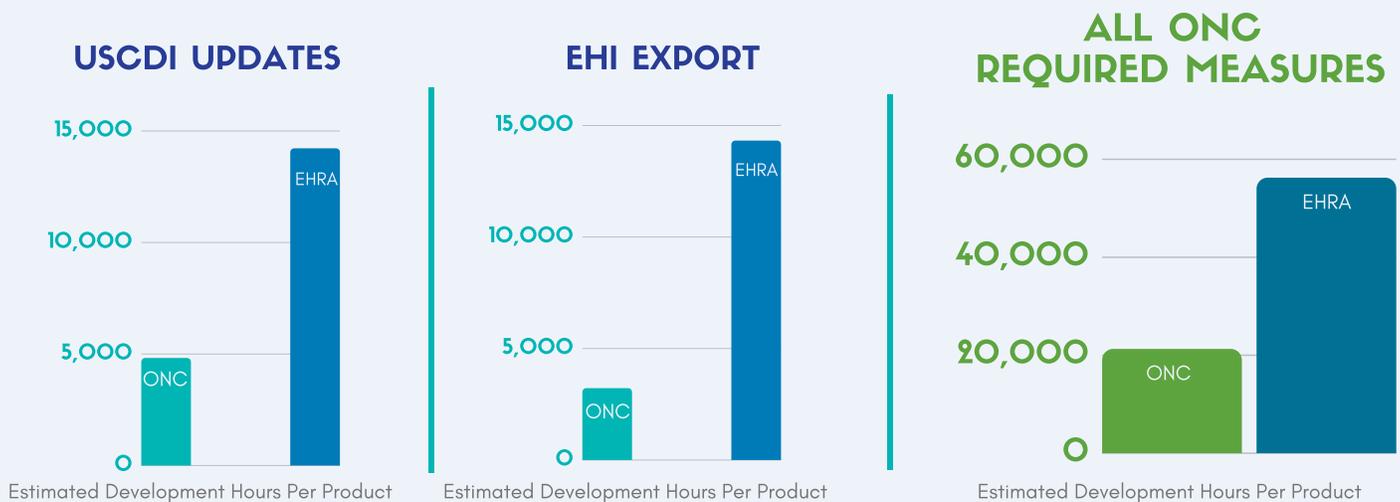
## ONC NPRM VS EHR DEVELOPER ESTIMATED DEVELOPMENT TIMELINES



The EHR Association supports the goals of the 21st Century Cures Act. EHR developers want to do their part to facilitate data exchange in support of improved patient care, but regulatory guidance must be clear, predictable, administrable, and realistic.

Unfortunately, the proposed rule severely underestimates the time required for completion of the new certification requirements. Development and implementation of EHR software updates includes designing workflows, writing code, and performing extensive quality testing, as well as time spent by healthcare organizations installing, customizing, testing, and training providers on new workflows and expectations.

A survey of EHR Association members identified the actual average projected development time for each project in the NPRM. Some examples:



### EHR ASSOCIATION PROPOSAL

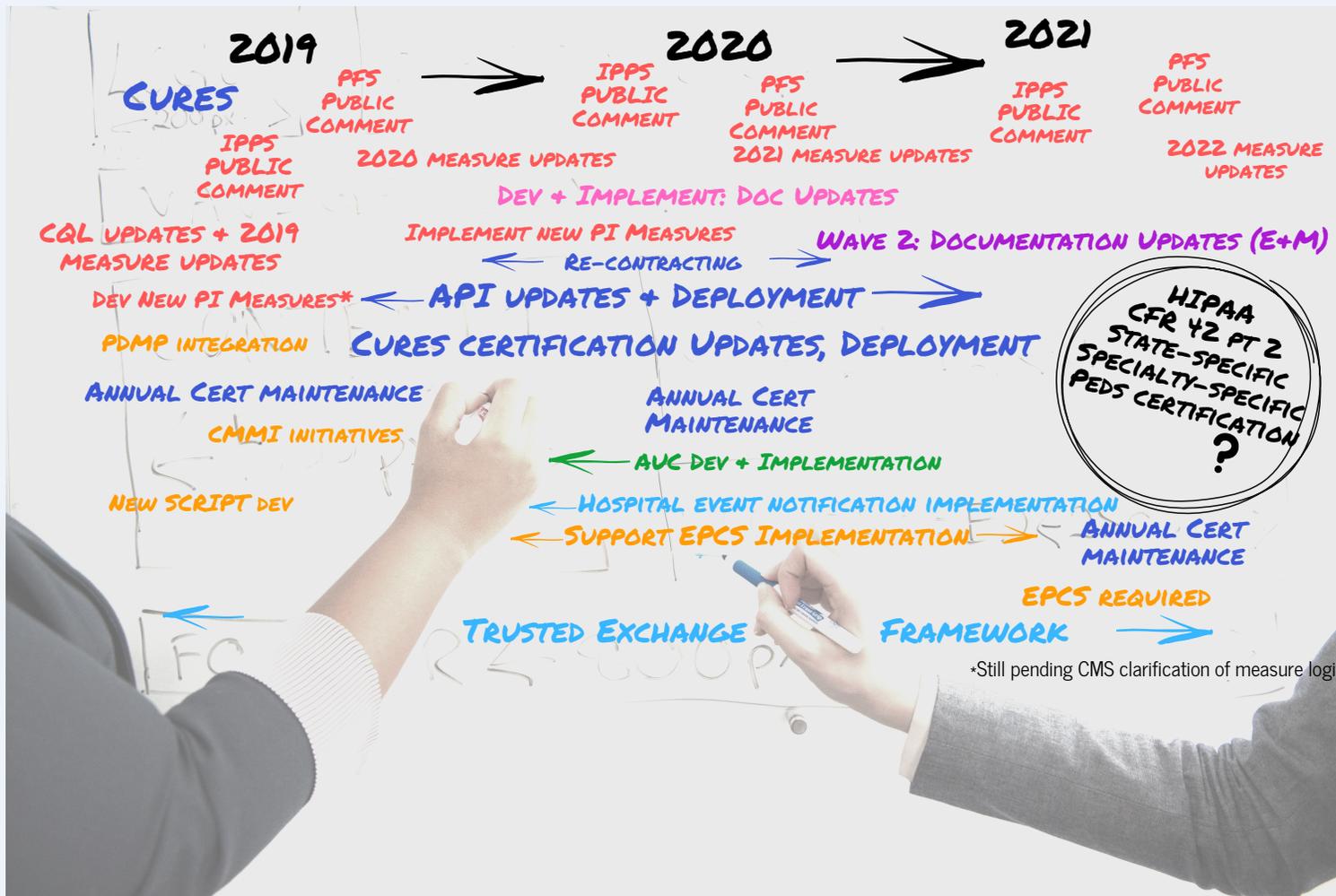
The EHR Association recognizes the desire to progress quickly. We don't believe it is necessary to postpone all development proposed in the rule.

We propose a more measured scope: two proposed criteria--updates to **ePrescribing** and **USCDI APIs**--to be accomplished within the proposed 24 months. A focused, national effort on these areas will achieve Congress' goal to enable a patient's clinical data to be shared freely and in a standardized, clear, and predictable way.

The other proposed criteria should be re-prioritized for subsequent deployment, in collaboration with industry stakeholders.

# The Healthcare Industry's Growing Regulatory To-Do List

In the past decade, EHR design has been affected as much by the requirements of the ONC certification program and other regulatory documentation requirements as by what providers ask for. In addition to the development work proposed in the recent rule, EHR developers and healthcare providers have ongoing commitments to implement a long list of often-overlapping federal and state requirements.



## 21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program (2019-02224)

Excerpts from more than 2,000 Comments on the NPRM

### ONC's proposed regulations are unduly burdensome to the industry

**American Academy of Family Physicians:** "The AAFP has deep concern that this [privacy] exception will add significant burden to health care providers in that they must be the arbiters between state and federal (and among federal) laws." (HHS-ONC-2019-0002-1652)

**American College of Emergency Physicians:** "We are very concerned about the additional burden being placed on providers, from investing in and adopting new technology to understanding all of the new definitions and exceptions around information blocking." (HHS-ONC-2019-0002-1433)

**American College of Surgeons:** "The ACS is concerned that this proposed definition of EHI is too vague, subjective, and potentially expansive for purposes of information blocking enforcement... To limit confusion and regulatory burden, we recommend that the information blocking restrictions in this rule only apply to the data classes in the USCDI." (HHS-ONC-2019-0002-1854)

**American Medical Association:** "The AMA is concerned about the potential increase of administrative burden the proposed rule places on the practice of medicine... The increase in administrative tasks is unsustainable, diverts time and focus away from patient care, and leads to additional stress and burnout among physicians." (HHS-ONC-2019-0002-1914)

**Medical Group Management Association:** "The approach proposed by ONC is far too complex. It would significantly increase administrative burden for physician practices, cause industry confusion regarding what data can be disclosed and when, and increase the risk for sensitive health information to be shared inappropriately or not shared when needed." (HHS-ONC-2019-0002-1297)

### ONC has broadly interpreted congressional intent and overstepped its statutory authority

**Allscripts:** "Patents, copyrights, trade secrets and other intellectual property are property, property that cannot be taken without due process. **Compulsory licensing has happened in the past in very specific situations, but always via an act of Congress. Congress, in drafting the 21st Century Cures Act, did not choose to take that extreme step, and we believe this proposal is antithetical to the fundamental principles of IP in this country.**" (HHS-ONC-2019-0002-1754)

**American Hospital Association:** "In addition, we are opposed to the agency's interpretation of what may be included in the definition of electronic health information, specifically regarding price information. **It goes well beyond what Congress intended and would seriously harm patients, hospitals and other health care providers.**" (HHS-ONC-2019-0002-1814)

**College of Health Information Management Executives (CHIME):** "We are very worried that **the EHI definition proposed by ONC is overly broad, exceeds what was intended by Congress, and would be administratively complex to meet.**" (HHS-ONC-2019-0002-0674)

**Electronic Health Record Association:** "When you consider that "interoperability elements," as defined in the NPRM, refers to "any means by which EHI can be accessed, exchanged, or used", this amounts to virtually any piece of technology that engages EHI on some level. Conversely, the "purpose" for which a competitor may wish to access those "elements" is not reined in at all. This is imbalanced and unfair. The natural result of these proposals moving forward would be lawsuits contesting the validity and arguing the **overreach** of the regulation." (HHS-ONC-2019-0002-1468)

**Federal Trade Commission staff:** "Our goal in providing technical assistance has been to **help ensure that the final rule does not inadvertently distort competition or inhibit conduct that is affirmatively procompetitive and consumer friendly.** We set out below some additional areas where the information-blocking rule and accompanying exceptions could be further refined to help minimize unintended consequences." (HHS-ONC-2019-0002-1923)

**Health Innovation Alliance:** "**These proposed rules extend beyond the scope and Congressional intent of the Cures Act.** The ONC proposed rule envisions a significant expansion of the National Coordinator's regulatory purview and fashions the agency as a regulator instead of a coordinator. If the ONC proposed rule was finalized as written, ONC would have **broad new authority** to regulate health IT manufacturers inside and outside of the Promoting Interoperability program." (HHS-ONC-2019-0002-1731)

**IBM:** "The proposal to extend ONC's regulatory reach to any of a certified developer's noncertified products would also create an unlevel playing field among health IT developers and discourage innovation investment." (HHS-ONC-2019-0002-1723)

### ONC should not interfere with market-based pricing

**Electronic Healthcare Network Accreditation Commission:** "EHNAC believes that the health competition which currently results in the development of an excellent rate of health data processes and products will be thwarted, if the development companies cannot make some sort of profit." (HHS-ONC-2019-0002-1776)

**Federal Trade Commission staff:** "Consider (a) clarifying when market pricing is not deemed information blocking, and (b) providing additional leeway for market pricing and certain ordinary refusals (or failures) to deal under the 'recovering costs reasonably incurred,' 'responding to requests that are infeasible,' and the 'licensing of interoperability elements on fair and reasonable terms' safe harbors." (HHS-ONC-2019-0002-1923)

**Health IT Advisory Committee:** "[T]he HITAC believes the net force of the proposed rule will be to raise prices (by raising compliance burdens, such as accounting controls, pricing controls, and other pricing compliance activities) and limit the supply for value-added interoperability services." (HHS-ONC-2019-0002-1614)

**Indiana Health Information Exchange (IHIE):** “Such prohibition disincentivizes actors from improving security, functionality, and finding solutions to non-standardized implementations beyond the minimum necessary.” (HHS-ONC-2019-0002-1783)

**Integrating the Healthcare Enterprise USA:** “...the proposed fee structure may engender complexities that lead to less innovation, increased administrative burden, and a focus on cost recovery rather than creation of improved ways to improve data access.” (HHS-ONC-2019-0002-1513)

**Partners Healthcare:** “It is important for health IT developers, healthcare providers and/or data providers to innovate. We believe profit spurs innovation and competition and is an important factor in the advancement of health IT.” (HHS-ONC-2019-0002-1691)

**The Sequoia Project:** “We are concerned that requirements for very granular costs and fee accounting will significantly increase the cost of doing business and of data exchange.” (HHS-ONC-2019-0002-0428)

## ONC should revise the Conditions of Certification to respect intellectual property law and investments

**Change Healthcare:** “HIT vendors can create unique, creative, and aesthetic user interfaces based on user-studies at great expense and allowing unfettered access to such screens can stifle innovation and allow malicious actors to compromise the security of systems by providing these malicious actors easy access to the UI organization blueprint.” (HHS-ONC-2019-0002-1552)

**Healthcare Information and Management Systems Society (HIMSS):** “It is also important to note the possibility exists of “bad actors” receiving screen shots and then using that information to develop malware or other harmful IT that could be incorporated into the healthcare ecosystem.” (HHS-ONC-2019-0002-1842)

**Healthcare Leadership Council:** “[ONC] must allow developers of certified health IT to protect legitimate intellectual property interests.” (HHS-ONC-2019-0002-1806)

## ONC should publish a second information blocking NPRM or an IFR

**American Academy of Allergy Asthma and Immunology:** “These proposals do not tackle challenges that providers have raised about health information technologies for several years, and in fact, create a whole new host of challenges that will have significant, unintended consequences for patients and providers. To that end, we strongly urge the Administration to delay these proposed requirements, or at a minimum, issue the provisions as interim final and continue to accept comments from the public.” (HHS-ONC-2019-0002-1591)

**American College of Obstetricians and Gynecologists:** “ACOG also recommends that ONC consider issuing a Supplemental Notice of Proposed Rulemaking to seek further comments on the information blocking provisions in the proposed rule.” (HHS-ONC-2019-0002-1349)

**American Medical Association (AMA):** “The AMA also recommends that ONC consider issuing a Supplemental Notice of Proposed Rulemaking (SNPRM) to seek further comments on the information blocking provisions the proposed rule.” (HHS-ONC-2019-0002-1914)

**American Psychiatric Association (APA):** “The APA requests that the timeline be extended to a 36-month period, and that an interim final rule be released in advance of the final rule. The scope of this Rule is vast and touches every patient and provider in the United States. An interim final rule, with comment period, as well as additional implementation time after the final rule is released, would provide developers, patients, and physicians the opportunity to acclimate to the new regulation.” (HHS-ONC-2019-0002-1768)

**Baylor Scott & White Health:** “To that end, the Proposed Rule should be implemented as an interim final rule, so stakeholders can continue to provide feedback to ONC.” (HHS-ONC-2019-0002-1635)

## ONC and OIG should defer information blocking enforcement and provide a grace period with focus on clarity of guidance and education

**American Academy of Family Physicians:** “The AAFP strongly recommends HHS phase in penalties for information blocking through the implementation of a temporary safe harbor for a consecutive 24-month period after the rule is in effect.” (HHS-ONC-2019-0002-1652)

**Direct Trust:** “Given the broad nature of the definition of information blocking and the narrowness of many of ONC’s proposed exceptions, DirectTrust anticipates that the nuances regarding information blocking practices will come out through subsequent enforcement actions. There is a real risk of entities making spurious complaints and data holders expending significant resources to defend against these complaints.” (HHS-ONC-2019-0002-1512)

**Electronic Health Records Association:** “A time period of enforcement discretion should be established for this necessary guidance to be propagated and for claims to be investigated in an educational manner, without financial penalties.” (HHS-ONC-2019-0002-1468)

**Florida Hospital Assn:** “Given the vast array of actors (the definition of health care provider alone is very expansive) and differing needs for understanding expectations as they exchange EHI among themselves, patients and other parties in compliance with the information blocking rule, FHA believes that a significant period of non-enforcement is required to ensure adequate time for all regulated actors to adapt to and understand what is required for compliance with this new framework.” (HHS-ONC-2019-0002-1627)

**Johns Hopkins Medicine:** “ONC should institute a significant grace period during which it offers guidance and educational assistance to those accused of information blocking. Such an approach would avoid unnecessary and costly litigation and allow for a better understanding of the types of activities that may constitute information blocking and what documentation is required to defend against such an allegation.” (HHS-ONC-2019-0002-1760)

# EHRA RESPONSE TO TEFCA DRAFT 2

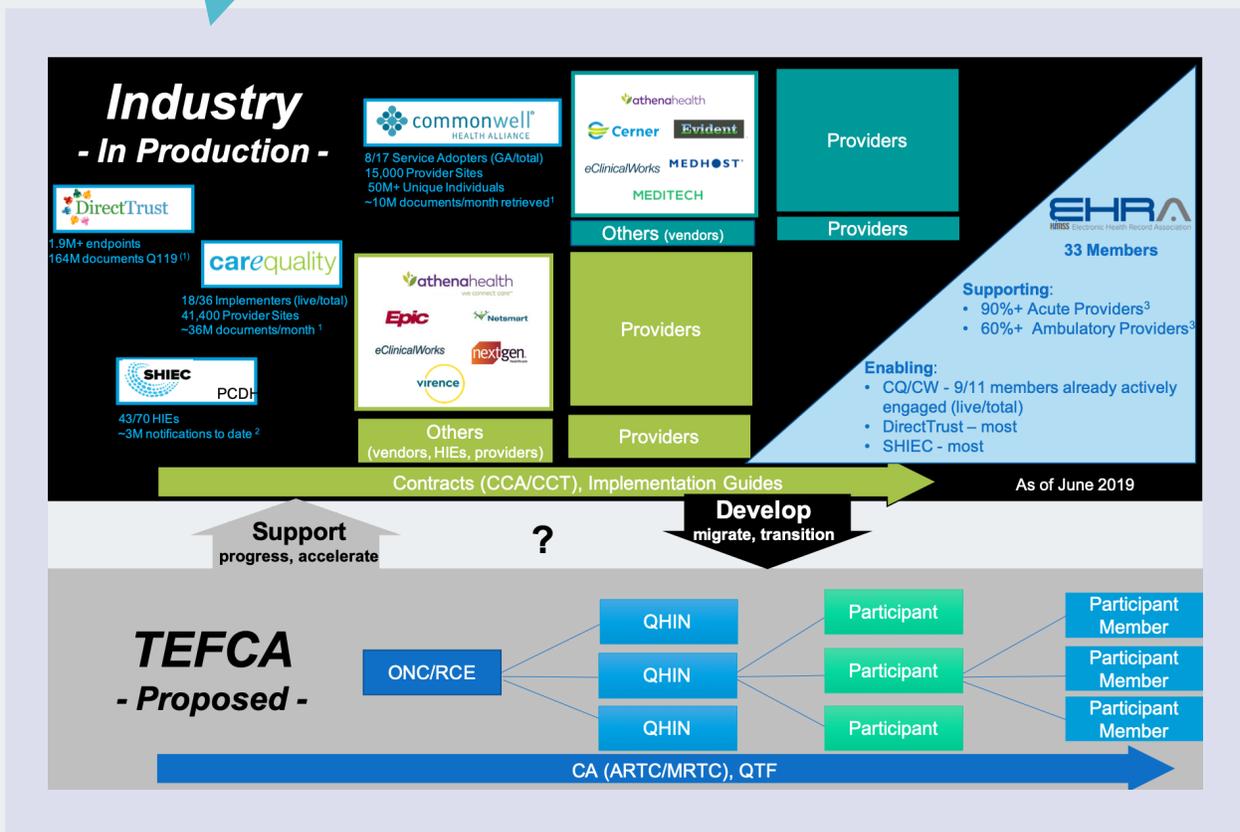
The EHR Association continues to strongly support the intent and goals of the 21st Century Cures Act to enable nationwide data access and exchange in order to more effectively coordinate patient care. EHR developer support is evident from EHR Association members' participation in a wide range of initiatives that have substantially progressed since the Cures Act was enacted in 2016, enabling our healthcare customers to connect:

- To Health Information Networks (HIN), including regional HIEs & national networks such as eHealthExchange & CommonWell
- Across HINs that are part of the Carequality framework
- Directly with other providers in or outside any of these networks using the Direct Protocol

Millions of documents are queried using various query types (broadcast or targeted, brokered or directed), and are also sent to specific providers. Initiatives now in progress go beyond document exchange and will enable scaling of HL7® FHIR®-based API access to national network levels.

The 21st Century Cures Act states:

*"The National Coordinator shall, in collaboration with the National Institute of Standards and Technology and other relevant agencies within the Department of Health and Human Services, for the purpose of ensuring full network-to-network exchange of health information, convene public-private and public-public partnerships to build consensus and **develop** or **support** a trusted exchange framework, including a common agreement among health information networks nationally."*



## If DEVELOP:

- The minimum required terms and conditions (MRTC) as proposed would need to be adopted as-is, in-full
- The technical framework (QTF) as proposed suggests a one-size-fits-all approach
- Creation of such a parallel framework raises questions on duplicative efforts to develop, transition/migration process and co-existence/interoperability across frameworks

## If SUPPORT:

- Opportunity to enhance existing frameworks building on what is already evolving rapidly
- Focus on gaps with TEFCA and collaborate with ONC to fill them (more purposes, more data holders)

## Acronyms

CO - Carequality

- CCA - Carequality Connected Agreement
- CCT - Carequality Connection Terms

CW - CommonWell

TEFCA

- ARTC - Additional Required Terms & Conditions
- CA - Common Agreement
- MRTC - Minimum Required Terms & Conditions
- QHIN - Qualified Health Information network
- QTF - QHIN Technical Framework
- RCE - Recognized Coordinating Entity

GA - Generally Available

SHIIEC - Strategic Health Information Exchange Collaborative

- PCDH - Patient Centered Data Home

## Endnotes

1. Measures have different definitions of what documents are included.

2. The number of documents subsequently exchanged is not yet reported.

3. Sources: KLAS and SK&A, a Cegedim Company | 2018 Hospital EMR Market Share, May 2018. ©2018 KLAS Enterprises, LLC. All rights reserved. [www.KLASresearch.com](http://www.KLASresearch.com) | Physician Office Usage of EHR Software" | SK&A. May 2018."

## Interoperability, Information Blocking, and the Impacts on Healthcare

### Panelist Biographies

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**Hans Buitendijk, M.Sc., FHL7**

*Director, Interoperability Strategy  
Cerner Corporation*

For more than 35 years, Hans Buitendijk has been involved in the development of health IT solutions, client consulting on strategic IT planning, healthcare application development and implementations, large scale business process re-engineering and systems integration, and complex project management, bridging the gap between business process optimization and IT support.

As Director of Interoperability Strategy at Cerner, Buitendijk primarily focuses on establishing and promoting industry standards to enable interoperability across the diverse systems prevalent in health IT. In that role he represents Cerner to a variety of organizations in various leadership roles, including the EHR Association, where he is the incoming Vice Chair, member of the Executive Committee, Chair of the Standards & Interoperability Workgroup, and EHRA's representative on the CARIN Board. He also serves with:

- The Sequoia Project® — The Sequoia Project Board Member, Carequality Board Treasurer, Carequality Steering Committee Member, Carequality FHIR Technical Workgroup Co-Chair
- HL7® — Co-Chair Orders & Observations, FHIR® Management Group Member, V2 Tooling Project Lead, V2-to-FHIR Mapping Project Lead
- Da Vinci Initiative — Vice-Chair Steering Committee
- Argonaut Project — Steering Committee Member
- FAST — Steering Committee Member



**Leigh Burchell**

*VP, Strategic Health Policy & Industry Affairs  
Allscripts*

Leigh Burchell leads the Policy & Government Affairs function for Allscripts, including legislative advocacy and regulatory response. Her role includes speaking on behalf of the company's more than 70,000 ambulatory practices and 2,400 hospitals to ensure that new legislation and administrative policies are supportive of the most efficient paths towards healthcare improvement. A

particular focus is the best way to maximize the volumes of newfound data captured in health IT today, including topics such as interoperability, chronic care management, population health, patient data ownership, and precision medicine. She has been with Allscripts since 2000.

Burchell is active in many collaborative industry organizations, including serving as:

- A Recent Chair of the Electronic Health Record Association (EHRA), current Chair of the Association's Public Policy Leadership Workgroup and Opioid Crisis Task Force, and ex officio member of the Executive Committee

- Steering Committee member for the AHRQ-funded Patient-Centered Clinical Decision Support Learning Network and the AHRQ evidence-based Care Transformation Support (ACTS) workgroup;
- a current Member of the Leadership Council and Chair Emeritus of the Policy Steering Committee for the eHealth Initiative
- Lead on Allscripts' participation within the Global Alliance for Genomics and Health.

Burchell graduated from Wesleyan University in Middletown, Connecticut, with a Bachelor of Arts in Constitutional History (American Studies).



**Emily Richmond, MPH**

*Senior Director, Regulatory Strategy  
Practice Fusion, Inc., a subsidiary of Allscripts*

Emily Richmond has extensive experience working in physician quality improvement, health policy and the field of health information technology. In her current role, she works closely with teams across the Allscripts portfolio of EHRs, directing engineers and designers in the software development work required for ONC EHR certification and other regulatory-based programs. She also uses her experience working with physicians participating in value-based care programs to help ensure that EHR systems are designed to be a beneficial tool that helps physicians move their practices from volume to value.

Richmond gained early experience in the field of healthcare quality as a research consultant at The Lewin Group and RTI International, contributing on several CMS project teams that supported quality measure development and physician participation in the Physician Quality Reporting System (PQRS) and the Medicare Shared Savings ACO Program.

She currently serves as a member of the EHR Association Executive Committee, as Chair of the Association's Clinician Experience workgroup, and as Vice Chair of the Delivery Systems Reform workgroup.

Richmond received her Masters in Public Health in Health Policy and Management from Emory University and a Bachelor of Arts degree from Washington University in St. Louis.



**Sasha TerMaat**

*Director  
Epic*

Sasha TerMaat is a Director at Epic, a health care software company based in Verona, Wisconsin, where she oversees regulatory and quality reporting activities, including implementation of technical standards and software certification.

TerMaat serves as Vice Chair of EHR Association Executive Committee. She is also a member of the Federal Health IT Advisory Committee.

She received a Bachelor of Arts degree from St. Olaf College.



## About EHRA

The Electronic Health Record Association (EHRA) brings together companies that develop, market, and support electronic health records (EHRs), to collaborate on issues that impact our businesses and our collective customers — hospitals and providers that represent the majority of EHR users in the US. EHRA operates on the premise that the rapid, widespread adoption of EHRs is essential to improve the quality of patient care, as well as the productivity and sustainability of the healthcare system as a key enabler of healthcare transformation. We are committed to supporting safe healthcare delivery, fostering continued innovation, and operating with high integrity in the market for our users and their patients and families.

Our core objectives focus on collaborative efforts to accelerate health information and technology (IT) adoption, advance interoperability, and improve the quality and efficiency of care through the use of these important technologies. We strive to engage the EHR software developer community and other stakeholders regarding EHR and health IT standards development, EHR certification processes and criteria, interoperability, patient safety, EHR usability, privacy and security, electronic performance and quality measures (eCQMs), health IT-focused public policy, and other EHR-related issues that are the subject of increasing government, payer, and provider focus.

The Association routinely provides testimony, comments, and education to legislators and policymakers, and has been called on increasingly to do so since its inception in 2004. We strive to represent our customers' perspectives, based on our collective experiences in successfully implementing EHRs in organizations of virtually all sizes and specialties and are pleased to be able to provide valuable input to regulators to bring this balanced perspective to the rule-making process, with the objective that resulting regulations are practical and meet legislative goals to achieve meaningful use of EHRs to improve access, quality, and efficiency of healthcare delivery for all Americans.

## EHR Developer Code of Conduct

EHRA member companies recognize the importance to all stakeholders of promoting a set of transparent industry principles that reflect our continued commitment to support safe healthcare delivery and the value that EHRs have for patients and families, foster continued innovation, and operate with high integrity in the market. With a long tradition of working with their customers to improve care, increase efficiencies, enhance patient safety, and provide better outcomes, EHRA introduced the EHR Developer Code of Conduct in 2013, releasing Version 2 in 2016.

Mindful of the laws and regulations that affect our clients, as well as the important role of health IT in their environments, the Code is intended to complement related government actions, not supersede or duplicate them. EHRs have become essential to the delivery of quality patient care and, ultimately, the transformation of our healthcare system. We encourage all EHR developers, regardless of membership in the EHR Association, to adopt the Code. View the EHR Developer Code of Conduct at [www.ehra.org](http://www.ehra.org).