33 W. Monroe, Suite 1700
Chicago, IL 60603
Phone: 312-915-9526
Fax: 312-915-9511
E-mail:
himssEHRA@himss.org

February 4, 2013

Farzad Mostashari, MD, ScM
Department of Health and Human Services
Office of the National Coordinator for Health Information Technology
Attention: Governance RFI
Hubert H. Humphrey Building, Suite 729D
200 Independence Ave. SW
Washington, DC 20201

Dear Dr. Mostashari:

On behalf of the members of the EHR Association, we are pleased to submit our response to the Office of the National Coordinator for Health IT's (ONC) *Health Information Technology Patient Safety Action & Surveillance Plan for Public Comment* (the Plan), published in December 2012.

We applaud the ONC and the Plan for recognizing and reaffirming the inherent patient safety advantages of electronic health records (EHRs) over paper. We also concur with ONC that all EHR stakeholders must remain vigilant to assure that development and implementation of EHRs does not introduce unacceptable patient safety risk.

We support the language in the Plan that ascribes to both ONC and the Institute of Medicine (IOM) the important concept that patient safety is a "shared responsibility" of providers, developers, regulators, researchers, advocacy communities, patients, and other stakeholders. The EHR Association is committed to working with ONC, the Agency for Health Research and Quality (AHRQ), and other industry stakeholders on the continuous journey to improve patient safety throughout the healthcare system. We believe that this ONC Plan for patient safety reporting and analysis can be leveraged to help increase overall awareness of patient safety reporting to providers and developers throughout the healthcare delivery and IT development systems.

We note the Plan's citation of the IOM report that "[d]espite a growing body of research on patient safety, the IOM found 'little published evidence' quantifying the magnitude of risks associated with health IT." This is an important point to keep in mind. We know that EHR technologies can be very effective in reducing certain types of patient safety events, like medication errors, that are extremely prevalent in paper record systems and described in the Plan's reference to the Pennsylvania reporting. But there is a lot that we have yet to learn about other aspects of EHR safety. To that point, we believe that the ONC Plan should build on what is known, while refraining from regulatory construction of solutions to problems that have yet to be studied and well defined. Similarly, future action by the ONC should aim to achieve the Office's objectives without jeopardizing the healthcare industry's collective ability to innovate toward better safety and usability solutions.

The EHR Association notes that this ONC Plan should not be framed as the long term solution to patient safety issues, but should represent a bridge between the current state and a long term framework to be developed based on the outcomes of the Food and Drug Administration (FDA) 18-month study, combined with lessons learned from further research into patient safety.

In general, the Association agrees with and supports the following components of the Plan:

- Instilling awareness that patient safety is everyone's responsibility
- Ensuring that health IT-related patient safety is approached as a seamless component within the overall patient safety ecosystem, rather than a stand-alone system
- Developing the concept and then building a nationwide, non-punitive safety data reporting, analysis, and learning system
- Leveraging the Patient Safety Act and the Patient Safety Organizations created under that Act
- Leveraging enhanced versions of the AHRQ Common Formats that will incorporate health IT-related data sets into existing reporting processes, and aggregation and analysis processes for both inpatient and ambulatory settings
- Conducting and publishing research
- Providing coordination of patient safety monitoring programs across diverse industry programs, e.g., the Center for Medicaid and Medicare Services (CMS) Conditions of Participation, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and others
- Providing for participation of patient safety stakeholders (certainly including EHR developers) in the dialogue for development of the 18-month study on a risk-based regulatory framework as authorized by the FDA Safety and Innovation Act of 2012 (FDASIA)

In general, we disagree with these components of the Plan and do not support:

- Using the ONC and CMS meaningful use regulations and certification to embed intrusive requirements into EHR design that are not the product of the learning system as envisioned by the Plan.,
- Expanding the ONC Authorized Certification Bodies' (ACBs') role into patient safety evaluation and enforcement, which is not within their core competencies
- ONC potentially dictating both the elements and enforcement of an industry code of conduct that would diminish the value and operation of such a code, which should operate in a truly voluntary and effective manner by virtue of being organizationally grounded in the industry and its organizations
- Equating usability with patient safety. While some usability issues can contribute to safety, in general we do not agree that comparing users' experiences can determine safety among EHRs. We suggest that it is more appropriate to implement usability evaluation processes such as reporting, analyzing and learning to determine the impacts of health IT on patient safety, before devising a regulatory framework.

Besides the above general comments, we submit the following comments on detailed sections of the Plan.

Pages 3 - 4, **Introduction**
The introduction was very well-thought out and articulated.

Pages 5 – 6, **HIT Patient Safety Goal**
Inspire Confidence and Trust in Health IT and Health Information Exchange

The EHR Association concurs with ONC on the goal that there must be trust and confidence in the safety of EHRs – both by EHR users and by patients. We recognize that this is a journey for the reasons the ONC draft Plan points to: the IOM finding that there is little published research; and that national (meaningful) use of EHRs is just starting to reach significant levels of adoption. Thus, patient safety knowledge and actions must evolve and grow with the system. Approaches to safety must be forward-looking and appropriate for the stage of development of this emerging industry. Vigilance must be constant and safety must not be compromised. At the same time, interventions and oversight should foster growth and learning, not undermine the learning system with rigid constraints formulated on yesterday's inexperience.

Overall, goals must be clear. Interventions should be made only after thorough understanding of the issues, thorough testing and demonstrated replicability of the solution and empirical experience that ensures no unintended adverse consequences of the intervention. Confidence and trust will be a matter of growth, not an overnight accomplishment of a regulatory plan. Health IT-focused interventions and solutions must also be evaluated for how they fit or do not fit with the overall patient safety systems, including both health IT and non-health IT aspects.

We agree with the four bullet point examples of how EHR technologies can contribute to patient safety and recognizing that these examples have emerged from the meaningful use policy development process, urge that the ONC Patient Safety Plan follow its stated intention to leverage existing processes and not set up a parallel and redundant mechanism for addressing such features of EHRs.

Page 7, **Health IT Patient Safety Objectives**
The Association supports the two stated objectives and the necessity of mobilizing a broad spectrum of stakeholders in a mode of "shared responsibility". We also agree with the ONC Plan that "safer care" and "safer health IT products" are two distinct yet very interrelated concepts.

Pages 7 - 8, **Use health IT to make care safer**
The EHR Association supports this objective. We agree with the ONC that the goals and objectives of related initiatives should be harmonized—e.g., the National Quality Strategy, the Partnership for Patients, CMS actions around safety, state efforts, Joint Commission, regional PSOs, and the emerging initiative of the Health IT Regulatory Framework report around patient safety legislated by Congress. ONC should collaborate with the other federal agencies, the White House and Congress, in harmonizing these other initiatives. In addition the Bipartisan Policy Center (BPC) soon will issue its recommendations on a health IT oversight framework around patient safety and we urge serious consideration of this document and its principles and recommendations.

We also agree with the potential of health IT to enhance patient safety, as exemplified in the VTE prophylaxis and CDS/drug-drug interaction scenarios. At the same time, we caution that the federal oversight role should be flexible and not prescriptive, but rather one that creates an overarching framework that guides and encourages such solutions. ONC should focus on creating a framework that

can embrace new solutions as they emerge from research and experience, but not dictate the specifics of solutions for each and every safety risk that is currently identified based on yesterday's knowledge and priorities.

Pages 8 - 9, **Continuously improve the safety of health IT**
We support the concept of "continuously improve the safety of health IT." But we point out that the role of government here is still evolving. Insufficient studies exist to determine which paths would impact market forces positively and which might result in adverse outcomes that diminish rather than advance patient safety. Federal agencies and regulators should be partners among the engaged stakeholders. Narrow or over-reaching mandates should be avoided. We repeat our belief that the current role of the ONC should be helping to build a framework and initial plan, while deferring to the insight of the 18-month FDA study to identify the longer term role of the federal government.

Page 9 - 10

1. **Make it easier for clinicians to report patient safety events and risks using EHR technology.**
   We agree that it would be useful to explore how EHR technologies can be used to enhance reporting of safety events and risks in general. At the same time, we caution that it is essential to consider appropriate EHR and reporting workflows for provider communities.

   Given that most patient safety reporting will not be done by a single EHR user, and will occur within intra-organizational workflows and review processes, it critical to consider how EHRs can help collect the data needed by healthcare organizations as they review safety issues internally and potentially report externally.

   We also caution against a focus on a "magic button" that could be used by providers to report on safety issues and also suggest consideration of the electronic data entry methods used by PSOs already. In the context of potential new requirements to certification, as proposed, we assume that consideration of such new certification criteria would be for Stage 3 and urge full consultation with software developers and providers. We urge ONC to avoid dictating a single approach to use of EHRs to facilitate internal and external reporting, particularly in the ambulatory environment where patient safety documentation and reporting is less mature.

   The EHR Association supports the use of the AHRQ Common Formats for event and risk reporting. The AHRQ Common Formats need to be enhanced and updated beyond version 1.2, however, to include a health IT component such as the data set proposed by our Association which focuses on data that is useful for analytics. The AHRQ Common Formats also need to be expanded beyond hospital-based reporting into ambulatory reporting as well.

   We support the reporting and aggregation of reports via the AHRQ Patient Safety Organization framework. Again, it will be essential to avoid burdening and disrupting providers' EHR workflow and performance. It will also be important to consider liability implications of adding additional patient safety relevant information into the legal medical record as opposed to the protected environment that PSOs provide.

   Finally, we also urge that ONC, in the final Plan, recognize the critical importance of direct provider reporting to and consulting with their EHR developer when conducting root cause investigations.

Page 11 - 12

2. **Engage health IT developers to embrace their shared responsibility for patient safety and promote reporting of patient safety events and risks.**

The Association appreciates the Plan's reference to our member companies' commitment to patient safety and a learning health care system.

We believe that industry "codes of conduct" (which may ultimately bear another title) can be useful, and we are aware of several within the healthcare technology industry. The Association is actively engaged in consideration of such a document for EHR developers. At the same time, we believe strongly that such "codes" must be developed and maintained by the affected industries and their organizations. They should also be voluntary and not dictated by the federal government. In this regard, although it could be helpful for ONC to identify potential topics for consideration, we do not agree that ONC should specify the minimum content of such a "code" or to assume responsibility for enforcement of compliance. We certainly do not believe that adherence to such a code should be the subject of the certification process.

The EHR Association appreciates ONC's thoughtful input to this industry initiative for a set of agreed upon guidelines for certain activities. We agree that safe design policies and practices should be in place for every vendor. We also agree in concept with the Plan's third and fourth bullets ("… provider reporting of safety events." and "… compare user experience across different systems ….."), but note that these concepts must be executed so as to attain their objectives without violating the U.S. legal and commercial system principles that protect intellectual property rights and product reputation. We believe such a balance can be achieved and appreciates the ONC's acknowledgment of these principles in its Plan.

We reiterate the point the ONC makes in the Plan's third bullet — health IT patient safety reporting should fit seamlessly into all patient safety reporting. We agree that it would be useful for health IT developers to work with PSOs on a voluntary basis, and we agree with ONC that PSOs could play a very positive role in the health IT safety arena. At the same time, we also underscore the points made by ONC that there are likely to be necessary clarifications and regulatory changes to mitigate various risks for PSOs, providers and developers and to make such vendor engagement with PSOs feasible and effective.

Furthermore, we believe that voluntary provider reporting to PSOs on safety issues should be the primary focus for reporting to PSOs, given that safety events generally happen in a provider context, and that health IT is likely to only be one element of any safety event. We also believe that aggregate data on safety reports should not identify specific developers or product brands but rather focus on patterns and types of health IT functionality involved since many reports are unlikely to undergo full root cause analysis, especially with reporting expected to extend beyond instances of death and serious injury.

More generally, we agree with the ONC that provider reporting of safety events is essential and should be encouraged. The ONC draft Plan references "contractual non-disclosure clauses" as barriers to safety reporting. To date, we have not seen convincing evidence that vendor-provider contracts, including essential provisions to protect intellectual property, pose barriers to the kind of patient safety reporting systems envisioned.

The ONC Plan's reference to emerging tools for comparing user experience across different EHR systems is well taken, but such tools should be one of many market-driven choices available to providers for comparing products. Such new tools, when available, should not be mandated by regulation.

Page 12 - 13

3. **Provide support to Patient Safety Organizations (PSOs) to identify, aggregate, and analyze health IT safety event and hazard reports.**

The EHR Association supports leveraging of the PSO system for aggregation and high level analysis of safety reports. We appreciate the ONC Plan's recognition of the complex issues around the legal protection framework of the PSO system in the Patient Safety Act and the general sensitivity of all parties to legal ramifications around patient privacy, legal medical records and court processes for discovery of electronic documents. We note the belief by some stakeholders that incorporation of developers into the PSO process can be effected in the context of the Patient Safety Act's protections of providers and PSOs. Certainly, we would prefer a guidance or regulatory approach to enabling software developer participation in the PSO process. Should legislative action be found necessary or advisable, the ONC Plan should include support for needed legislative changes and industry stakeholder engagement in that process.

Finally, as stated above, to fully realize a non-punitive learning environment and to increase the accuracy of safety signal detection, it is essential to address the potential negative impact of the collection of incomplete or misleading data. Aggregated reports should be de-identified by provider, developer, and specific product (as opposed to product type) and focus on trends and patterns to encourage robust, widespread, and consistent reporting.

Page 13

4. **Incorporate health IT safety in post-market surveillance of certified EHR technology through ONC-Authorized Certification Bodies (ONC-ACBs).**
   Although the Association does not oppose the concept of a well-structured post-market surveillance process, we do not believe that the ONC ACBs are appropriate entities to implement such a system, and suggest that the role for ONC ACBs proposed in the draft Plan is inappropriate and duplicative. The ACBs have neither the financial structure nor the requisite expertise for either safety-related surveillance or "taking appropriate action with respect to complaints" in patient safety and hazard matters. We suggest that the ONC Plan rely on the outcome of the aforementioned 18-month FDA study of risk-based regulatory approaches.

   If ONC chooses to include ONC-ACBs in its safety strategy, the ONC guidance discussed in the Plan is critical. ONC must ensure ONC-ACBs' competency and qualifications to perform such roles. We also believe that ONC should focus on uniform approaches by ONC-ACBs, and to the greatest extent possible, both ONC and ONC-ACBs should focus on the question of whether certified EHRs are operating consistent with their certifications and not introduce additional considerations in their surveillance or review.

Page 13 - 14

Align CMS health and safety standards with the safety of health IT, and train surveyors.
The EHR Association supports ONC efforts to align safety monitoring with CMS via the Medicare Conditions of Participation and other means. We caution, however, that the ONC Plan should squarely address the educational and harmonization efforts necessary to incorporate the CMS initiative. Furthermore, CMS should qualify (or certify) the surveyors for competency and qualifications to perform such roles. We note recent CMS Medicare Program Integrity Transmittal (438), in which CMS audit processes around electronic notes seemed to be at odds with meaningful use efforts to simplify provider workflows and enhance EHR usability. Should such conflicting guidance across regulators occur, the adverse consequences could be much more severe and could certainly lead to serious risk to patient safety and achievement of Plan goals.

Page 14 - 15

5. **Collect data on health IT safety events through the Quality & Safety Review System (QSRS).**
   We welcome the opportunity to work with AHRQ, providers, and all other stakeholders to create an

effective and efficient system. The EHR Association cautions that the Medicare Patient Safety Monitoring System (MPSMS) and the QSRS must be able to identify duplicate reports in order for the information to be accurate and not misleading to the public. Furthermore, as long as PSO reporting remains voluntary for healthcare facilities and providers, it is difficult to determine the true frequency of events that are reported using the Common Formats due to lack of denominator data.

Page 15

6. **Monitor health IT adverse event reports to the Manufacturer and User Facility Device Experience (MAUDE) database.**

Although we have no concerns with ONC monitoring MAUDE reports, we point out that much health IT, which is not regulated by the FDA, would not be reported in MAUDE, and we urge ONC not to create any expectation that it would be. In addition, it is essential that ONC and other HHS units avoid any duplicative reporting requirements or processes.

Pages 16 - 19, **Health IT Patient Safety Strategies and Actions**

1. **Use Meaningful Use of EHR technology to improve patient safety.**
   The EHR Association has provided comments to the HIT Policy Committee on the potential meaningful use Stage 3 requirements.

   We concur with the ONC draft Plan that health IT is a very significant enabler of patient safety, and the existence of the meaningful use program underscores the federal policy commitment to that end. Our comments to the HIT Policy Committee calling for a more focused approach to Stage 3 notwithstanding, we support the approach used to-date by CMS and ONC of prioritizing for meaningful use those capabilities for which patient safety improvement is a central feature, such as CPOE and medication and allergy list functionality.

Any meaningful use requirements should be minimally prescriptive, with the overarching meaningful use patient safety coming more out of the quality management system requirements and the aforementioned FDA 18-month study. In particular, we note that, by Stage 3, most eligible hospitals (EHs) and eligible providers (EPs) will have collected all their incentive payments and will no longer be receiving any incentive payments. Providers will have much on their plates, including meaningful use, ICD-10, nascent accountable care organizations (ACOs), and the advent of the impacts of the Patient Protection and Affordable Care Act. The Association suggests the Stage 3 requirements be less intrusive than the Stage 1 and Stage 2 requirements, and begin to reflect more maintenance and truly meaningful use of the implemented standards than new functionalities. Similarly, we believe that any Stage 3 requirements around patient safety must not be prescriptive, but should remain very high level and be well integrated into work flows and responsibilities that are already incumbent on providers and developers, rather than creating new demands to ensure high adoption and compliance. In our comments to the Policy Committee, we did suggest that it is premature to add a safety risk assessment to providers' meaningful use requirements.

Incorporate safety into certification criteria for health IT products.

Overall, ONC took a generally measured approach to including safety concerns in Stage 2 meaningful use certification criteria. We applaud the care that was taken. We urge similar care for Stage 3 to avoid approaches to process areas, such as usability and quality management systems, that are overly prescriptive, impede technical innovation, and would not be well suited for certification by ONC-ACBs, which are more product-oriented rather than process-focused. In particular, we do not believe that it is desirable for ONC to use the certification process to mandate usability or quality management processes. *We do, however, believe that alignment of the health IT industry with existing and new*

international standards that address quality management systems (QMS) which include risk-based approaches focused on patient safety and quality is appropriate.

2. **Support research and development of testing, user tools, and best practices related to health IT safety and its safe use.**
   The EHR Association supports the development of knowledge and tools, such as SHARP-C, by ONC, AHRQ, CMS, the National Library of Medicine (NLM) and others. However, we caution that such tools must be well tested and mature before they are ready for general industry adoption. We believe good tools will be quickly and voluntarily adopted by industry and that ONC should exercise caution before considering requirements to force premature adoption.

   We commend ONC for recognizing the critical importance of patient matching in the new world of interoperable patient records and health information exchanges.

3. **Incorporate health IT safety into medical education and training for all health care providers.**
   As referenced earlier, the Association agrees that patient safety is a shared responsibility. We support ONC efforts toward education of all stakeholders in the healthcare system, including patient engagement.

4. **Investigate and take corrective action, when necessary, to address serious adverse events or unsafe conditions involving EHR technology.**
   We recognize the importance of potential government action in the face of serious adverse events or unsafe conditions involving EHR technology that are not addressed through other mechanisms, including timely and appropriate provider or developer action. We also agree with ONC that a National Transportation Safety Board (NTSB)-like agency, as recommended in the IOM report, would not be the most effective means to achieve the patient safety goals. We agree that a national learning system that is non-punitive and which leverages the strengths of the AHRQ PSO system is the best approach. Such a system best fulfills the national learning system objective yet it does not thwart holding stakeholders accountable for patient safety. Medical education and training should be developed by a multi-stakeholder team and published for review.

   We do have some concerns about ONC's stated intention to work with developers toward voluntary corrective actions and to publish notices of "serious adverse events or unsafe conditions involving EHR technology". We certainly support ONC working with developers and providers, as applicable, and believe that voluntary corrective action plans and even notices could be appropriate, but strongly urge ONC to approach such efforts through development of a detailed formal plan, and formal processes and procedures, each of which has gone through a public notification and comment process. We also urge ONC to be selective in the areas where it seeks to engage in such a manner, focusing on high and immediate risk areas, and to avoid processes that may be duplicative or have a dilutive impact on other federal efforts.

   The EHR Association is especially concerned with the vagueness of the paragraph that mentions the Department of Health and Human Services (HHS) publishing public notices of "serious adverse events or unsafe conditions." Although we understand the impetus to quickly alert providers to major safety risks, we do not understand how ONC would be equipped to perform an analysis and be able to determine whether the safety risk is intrinsic to the product across all users or a fault introduced by a site-specific configuration affecting one and only one customer installation of the product. In all likelihood, HHS-level alerts will be too late and too generic to be meaningful or effective. In the best case, it would accomplish little more than alert fatigue. In the worst case, it could deter many unaffected providers from using their EHR systems, dropping out of the

meaningful use program, and reverting to paper in whole or in part.

We agree that safety awareness and accountability should be leveraged across CMS, state, and private accreditors within their scope. But as we pointed out above, the ONC Plan must ensure ongoing harmonization across those surveillance and accrediting entities, and duplication of reporting and duplication within the aggregated data. Without robust harmonization, conflicting directives will result in increased rather than diminished risk.

Pages 20 – 22, **Health IT Patient Safety Strategies and Actions**

1. **Develop health IT safety priority areas, measures, and targets.**
   The Association concurs that multiple stakeholders must be engaged in the patient safety dialogue and plan execution. Not all stakeholders have accountability for their recommendations; therefore, the ONC process must recognize that some ideas that sound very good may not fit into the national system being built.

2. **Publish a report on a strategy and recommendations for an appropriate, risk-based regulatory framework for health IT.**
   We again call out that the ONC Plan should bridge the gap until the FDA 18-month study produces a longer term set of solutions for risk-based approaches to patient safety. We strongly support ONC's stated intention for the FDA 18-month study to include extensive stakeholder input. We also want to emphasize the critical need for a risk-based approach, one that enhances the innovation that is so essential for our healthcare system, and one that recognizes that traditional regulatory approaches are not well suited to EHRs.

3. **Establish an ONC Safety Program to coordinate the implementation the Health IT Safety Plan.**
   The EHR Association believes that an ONC Safety Program is an appropriate component of the Office of the National Coordinator, with a recognition that this program could need to shift in approach following the completion of the more comprehensive study referenced above.

4. **Encourage state governments to incorporate health IT into their patient safety oversight programs.**
   As previously stated, the Association agrees that many stakeholders must be involved. That includes state government. But, as we have also already stated, coordination of vision across the fifty states, the District of Columbia, and the territories is a herculean challenge. Collisions among state program activities, meaningful use, PSO, JCAHO, and other federal initiatives are almost inevitable.

   To enable the state oversight in harmonized fashion, we suggest establishment of a national framework of formats and standards so as to minimize potential for local/national conflicts.

5. **Encourage private sector leadership and shared responsibility for health IT patient safety. (IOM Report, Chapter 6, "Shared Responsibility for Improving Health IT Safety")**
   We agree with this part of the plan and, in our leadership role in the health IT industry, will meet our responsibilities to advance the safety of our industry's products, and the ability of health IT to advance patient safety.

Finally, the EHR Association would like to point out several important concepts that are missing from the draft Plan:

- Irrespective of the patient safety reporting and analysis system that is eventually put into place, it is absolutely critical to patient safety that such a system not distance providers from their EHR

developers. When a patient safety event occurs, it is imperative that the affected provider be able to report the issue directly and immediately to their vendor allowing the developer to address the event, investigate it, inform any other affected clients if necessary and resolve it. Any national reporting or analysis system should work in parallel with the vendor-client relationship, not in lieu of that relationship. To do otherwise would delay and confuse the response to the safety event.

- For most analytical purposes, no patient, provider, nor developer/brand should be identified in the national learning system.

- Within the national learning system, developers need to be able to access data anywhere in the system that involves their own product.

- We believe there is a significant gap in the maturity of patient safety analysis and reporting processes between large, integrated organizations and small ambulatory practices. We suggest that the ONC final Plan address education programs to remediate that gap.

- Without adequate lead time to develop, test, and implement new functionality required by the meaningful use incentive program, there is the potential to create usability issues as well as risks to patient safety. As was stressed by vendor CEOs during our meeting with ONC in November 2012, it is important to consider the pace of new development requirements to ensure the success of the program. The EHR Association would like to reiterate our request for 18 months between Stages 2 and 3 in order to avoid potential issues for developers, providers, and patients that might not only introduce risk, but also undermine the objectives of the program and compromise the benefits that EHRs can deliver.

Again, on behalf of our members, we want to voice our support for this initiative and we look forward to working with ONC on implementing the final Plan which will serve the best interests of our customers and their patients. In the ONC's review of comments received by the EHR Association, our members, and other stakeholders, we also urge that you give careful attention to the forthcoming report by the Bipartisan Policy Center on "Assuring Safety, Quality and Innovation in Health IT."

Sincerely,

Michele McGlynn
Chair, EHR Association
Siemens

Leigh Burchell
Vice Chair, EHR Association
Allscripts

HIMSS EHR Association Executive Committee

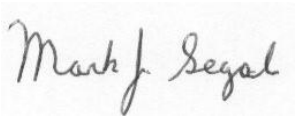
Jason Colquitt
Greenway Medical Technologies

Lauren Fifield
Practice Fusion, Inc.

Charlie Jarvis
NextGen Healthcare

Meg Marshall
Cerner Corporation

Ginny Meadows



Mark Segal

About HIMSS EHR Association

HIMSS EHR Association is a trade association of Electronic Health Record (EHR) companies that join together to lead the health information technology industry in the accelerated adoption of EHRs in hospital and ambulatory care settings in the US. Representing a substantial portion of the installed EHR systems in the US, the association provides a forum for the EHR community to speak with a unified voice relative to standards development, the EHR certification process, interoperability, performance and quality measures, and other EHR issues as they become subject to increasing government, insurance and provider driven initiatives and requests. Membership is open to HIMSS corporate members with legally formed companies designing, developing and marketing their own commercially available EHRs with installations in the US. The association, comprised of more than 40 member companies, is a partner of the Healthcare Information and Management Systems Society (HIMSS) and operates as an organizational unit within HIMSS. For more information, visit http://www.himssehra.org.

cc: Steve Lieber, President and CEO, HIMSS
John Daniels, Vice President, Healthcare Organizational Services
David Muntz, MBA, Principal Deputy National Coordinator, ONC
Gail Arnett, Senior Director, HIMSS Corporate Relations and EHR Association