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August 12, 2014

Ron Wyden
Senate Finance Committee Chairman
221 Dirksen Senate Office Building
Washington, D.C., 20510

Chuck Grassley
Senate Finance Committee Member
135 Hart Senate Office Building
Washington, D.C., 20510

Dear Chairman Wyden and Senator Grassley:

On behalf of the Electronic Health Record Association (EHRA), we are pleased to submit the following response to your June 12, 2014 letter requesting comments on the availability and utility of healthcare data, while considering the need to maintain and protect patient privacy. Our almost 40 member companies represent the electronic health record (EHR) technologies serving the majority of hospitals and ambulatory practices using EHRs in the U.S. today. We offer our collective experiences in developing and maintaining EHRs and other health information technology (health IT) to inform your deliberations on this important topic.

As you know, health IT is a powerful tool that can support the transition of our health system toward a value-based model focused on improved health outcomes, while encouraging innovative technologies to enhance care delivery, making it more efficient, effective, and affordable. Fundamentally, digitized health information enables the connection of patients and providers in different physical locations, empowers patients to become and remain active participants in their care, and provides ongoing patient-focused communication and support.

Central to your inquiry and goals is the fact that we have a much more digitized healthcare system in the U.S., largely driven by the very high growth in adoption of interoperable EHRs. Supported by the nation's investment in the EHR "Meaningful Use" Incentive Program, hospital EHR adoption has grown from 72% reporting use of

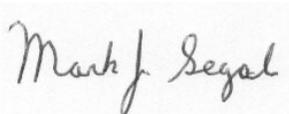
certified electronic health record technology (CEHRT) in 2011 to 94% in 2013.¹ Physician adoption of EHRs, perhaps more significant given financial and technical challenges in that sector, is also growing rapidly, and has reached very high levels, with 78% of physicians having adopted EHRs as of 2013 (according to the National Center for Health Statistics), up from 57% in 2011.²

Clearly, successful and *meaningful* adoption of EHRs is high and growing, and the EHR Incentive Program has played an important role in that growth. Given that Stage 1 of the Incentive Program was focused on accelerating EHR adoption, with the stated intention that Stages 2 and 3 would focus on improved quality and outcomes and increased interoperability, we can be optimistic that the U.S. healthcare system will achieve real return on its investment in health IT and value to Americans as both taxpayers and healthcare consumers.

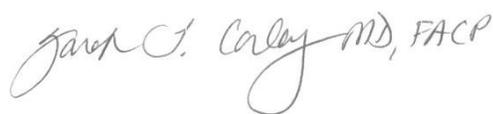
This growth in EHR adoption and associated digitization, including new ecosystems of connected health IT that includes, but extends beyond, EHRs will drive important innovations, including personalized medicine, population health management, data analytics, and advanced payment models. Given the critical role that EHRs will play in enabling these capabilities, we urge Congress and the federal government to engage with EHR developers and the broader health IT community to help prepare for and ensure the best use of technology.

Our detailed responses to your questions are included with this letter as an addendum. We look forward to participating in the ongoing dialog about how healthcare information can be securely shared and used to improve the quality and efficiency of care delivery for all Americans.

Sincerely,



Mark Segal, PhD
Chair, EHR Association
GE Healthcare IT

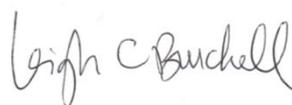


Sarah Corley, MD
Vice Chair, EHR Association
NextGen Healthcare

HIMSS EHR Association Executive Committee



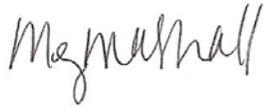
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¹ ONC Data Brief No. 16, May 2014, Adoption of Electronic Health Record Systems among U.S. Non-federal Acute Care Hospitals: 2008-2013, Dustin Charles, MPH; Meghan Gabriel, PhD; Michael F. Furukawa, PhD

² Hsiao C-J, Hing E., Use and characteristics of electronic health record systems among office-based physician practices: United States, 2001-2013. NCHS data brief, no 143. Hyattsville, MD: National Center for Health Statistics, 2014.



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Cerner Corporation



Ginny Meadows, RN
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About HIMSS EHR Association

Established in 2004, the Electronic Health Record (EHR) Association is comprised of nearly 40 companies that supply the vast majority of operational EHRs to physicians' practices and hospitals across the United States. The EHR Association operates on the premise that the rapid, widespread adoption of EHRs will help improve the quality of patient care as well as the productivity and sustainability of the healthcare system as a key enabler of healthcare transformation. The EHR Association and its members 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.

The EHR Association is a partner of HIMSS. For more information, visit www.ehrassociation.org.

Addendum

EHR Association Response to Healthcare Data Sharing Questions

1. What data sources should be made more broadly available?

We recognize that information from sources specific to patients, providers, payers, and communities can be extremely valuable to the improvement of the healthcare system. Uses of data include treatment at the point of care, as well as personalized medicine, clinical research, quality improvement, population health management, etc. Not all of this data is derived from EHRs, with some generated by financial and administrative systems, as well as other ancillary clinically-focused health IT. Thus, data from many sources should be available to authorized recipients for appropriate purposes, including, as feasible, data sets that link data across multiple systems and patients. Uses of all such data must, of course, conform to applicable privacy and security protections. Several categories of data should be considered:

- Patient-generated and/or -captured data: Data that may be captured in personal health records, mobile/wearable medical devices, fitness platforms, and other emerging consumer health devices and web sites.
- Provider-generated and/or -captured data: Data from EHRs and specialty/departmental health IT, generating clinical information, behavioral health information, test results, medications, etc. (i.e., data that is specific to episodes of patient care across providers and care delivery sites).
- Community: Population data such as social determinants, lifestyle factors, and other information that may relate to a patient as a community member.
- Payer data: Quality and outcomes data based on a variety of standardized coding systems and measures, medication and pharmacy data from pharmaceutical companies and pharmacy benefits managers (PBMs), as well as service and cost information from billing and payer systems.

We note that some new and emerging technologies that support secure healthcare data exchange and enable value-based payments and accountable care are part of EHRs while others are not. For example, EHRs provide not only basic reporting on the required quality measures, but can also enhance patient experience and reduce costs with integrated care plans, documented interventions, task management, and outcomes measurement/reporting. With specific focus on accountable care organizations (ACOs), EHRs can be leveraged to promote proactive identification and management of high risk patients, align patients with care teams, help care teams coordinate across delivery sites, coordinate care for multiple problems, support real-time decision-making and population surveillance with evidence-based guidelines, and engage and educate patients to encourage self-care, prescription drug adherence, and lifestyle improvement.

2. How, in what form, and for what purposes should this data be conveyed?

In general, data should follow the patient, with priority given to where the information is needed to provide clinical services. In general, the patient should determine who and for what purposes the data can be used. There is, however, a difference in how to approach identified (i.e., protected health information – PHI) vs. de-identified data (i.e., non-PHI) – the former clearly intended for personal use by the patient, his/her healthcare providers, and others to whom the patient may give permissions; the latter typically for activities supporting the secondary use of large sets of health-related data, such as research, comparative effectiveness studies, public health surveillance, and improving operational efficiency.

Relevant data from health IT and other sources should be made available using standardized mechanisms, including health information exchange (HIE), HIE organizations, and software tools such as application programming interfaces (APIs), which are increasingly standards-based and made available to software developer customers and partners. However, the creation of centralized data stores to be queried and/or enabled via APIs outside the context of an HIE-type organization, an approach that is often over-simplified and recommended by researchers, would not be acceptable to the range of affected stakeholders, including patients and consumers.

3. What reforms would help reduce the unnecessary fragmentation of healthcare data? What reforms would improve the accessibility and usability of healthcare data for consumers, payers, and providers?

We must continue to focus on standardizing common data elements used in health IT to reduce fragmentation in patients' health information and to more effectively support collaborative care delivery and data analytics. This work has been advanced by standards development organizations (SDOs), and encouraged and accelerated in some cases by ONC and CMS in the EHR Meaningful Use Incentive Program and other efforts.

Payment reforms, such as value-based reimbursement, which lead providers to need to exchange clinical data with other providers as well as with payers, will be an important driver to increase accessibility and usability of healthcare data for all stakeholders. The accelerated and meaningful use of EHRs with robust capabilities in clinical quality measure reporting and clinical practice improvement, as well as measurement and attainment of resource use goals, positions these systems to be critical tools in enabling alternative payment models (APMs), all of which are founded on data and the measurement of quality and efficiency.

4. What barriers stand in the way of stakeholders using existing data sources more effectively and what reforms should be made to overcome these barriers?

One of the most critical unresolved issues in the safe and secure electronic exchange of health information is the need for a nationwide patient data matching strategy to ensure the accurate, timely, and efficient matching of patients with their healthcare data across different systems and settings of care. To improve patient safety and data interoperability, a consistent nationwide patient data matching strategy should be a priority. Patient identification that ensures accurate patient record matching across provider sites is a primary concern when aggregating patient information from multiple organizations. Error rates in existing technologies that manage patient identification are sufficiently high to cause concern about medical errors, redundant testing, and inefficiency.

Identification and broad adoption of interoperability transaction and data standards is necessary to mitigate the costs (direct and indirect) of supporting non-standard approaches to data sharing. EHRA continues to support the efforts to build an interoperable healthcare system, and we believe that the consistent implementation of existing health IT data definition and transmission standards not only support the Meaningful Use Incentive Program, but is an essential component of national healthcare reform.

This fundamental shift from a healthcare system that relies on inefficient and incomplete exchange of patient data based on paper flow to a much more interoperable system is well on its way to being realized, but there is more work to be done. Our member companies continue to invest in

interoperability resources in their products and services, as well as in supporting standards development and testing initiatives. We share the belief that transforming the way healthcare is delivered requires effective interoperability among providers, across communities and, eventually, across the nation.

Patient, consumer, and provider concerns with the privacy and security of PHI must also be addressed, including accurate and confidence-building implementation of federal HIPAA provisions as well as the sometimes conflicting provisions of states' laws, which can conflict with HIPAA and each other. Often, this is less an issue for EHRs and other health IT operating within a healthcare organization, and more a consideration among organizations that agree to share healthcare information and therefore must determine governance and ownership policies in compliance with state and federal laws.

Secure HIE that protects patients' privacy rights and honors their wishes and directives is at the core of implementing broad data sharing among providers, payers, patients, and other stakeholders. It is widely recognized that the inconsistencies in various state and federal privacy laws as they pertain to sensitive health information, such as that protected under 42 CFR Part 2 (Confidentiality of Alcohol and Drug Abuse Patient Records), continue to be obstacles to widespread HIE. In addition, varying federal and state laws regarding patient data ownership and consent are also a function of the affiliation and location of organizations seeking to share healthcare information. This variation in applicable laws and regulations is particularly problematic when it comes to behavioral health and substance abuse information. Harmonization of state privacy laws is essential, therefore, in order to deliver a mechanism that provides a nationwide, privacy-focused legal framework for access and disclosure of sensitive PHI based on patient-directed consent.