

PRE-PUBLICATION DRAFT

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A Primer on Electronic Health Record License Agreements

By Daniel F. Shay

Alice G. Gosfield and Associates, P.C.
2309 Delancey Place
Philadelphia, PA 19103
215-735-2384
215-735-4778
agosfield@gosfield.com
www.gosfield.com

“Accepted for publication in the Health Law Handbook, 2006 Edition.
Alice G. Gosfield, Editor, (c) West, A Thomson Company.
A complete copy of the Health Law Handbook is available from West by calling
1-800-382-9252 or online at www.west.thomson.com.”

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1 Introduction

Electronic health records (EHRs) and electronic medical records (EMRs) are part of one of the hottest trends in the practice of medicine today: the integration of information technology into healthcare. The United States healthcare industry has arguably reached the “tipping point” for EHR adoption. The recent growth of interest in EHRs and EMRs has been spurred by several factors, including government interest in both the regulation and funding of such technology, the advancement of supporting technology to a point where EHRs actually function in useful ways, and increased media attention regarding the benefits of using EHRs.

1.1 Government Initiatives

In his State of the Union address on January 20, 2004, President Bush brought EHRs into the common lexicon.¹ Shortly thereafter, he issued Executive Order 13335,² creating the Office of National Coordinator for Health Information Technology. Since his appointment to the position on May 6, 2004, David J. Brailer, M.D., Ph.D. has been an outspoken proponent of EHR adoption and the advancement of implementation of health information technology in the United States healthcare industry. During the keynote address at the 77th Convention and Exhibit of the American Health Information Management Association, Dr. Brailer stated “ ‘We will look back at [October] as the point when we moved out of the formative stage—about 85% of what I’ve talked about doing is getting started this month.’ ”³ “Getting started” at the federal level includes initiatives to develop certification criteria for EHRs, establish the infrastructure necessary to create a national health information network (NHIN), and proposed changes to the Stark rule which would permit hospitals to help physician practices adopt information technology.⁴

The overarching goal of the federal government is to implement an NHIN, across which patient information may be shared. Towards that end, most government initiatives are driven by a desire for interoperability and higher adoption rate for technology. However, to spur both, the government believes standards for EHR software must be adopted. Dr. Brailer has likened the current state of health information technology (HIT) to the state of the nation’s railroad network prior to the standardization of railroad gauges, and has pointed to success stories such as the wi-

¹ “By computerizing health records, we can avoid dangerous medical mistakes, reduce costs, and improve care.” State of the Union address, January 20, 2004. www.whitehouse.gov/news/releases/2004/01/20040120-7.html.

² Executive Order 13335, April 27, 2004. See, www.whitehouse.gov/news/releases/2004/04/20040427-4.html.

³ “Brailer: We’re at the Tipping Point,” *Health Data Management*, October 18, 2005. www.healthdatamanagement.com/html/PortalStory.cfm?type=gov&DID=13153.

⁴ In fact, the proposed changes to the Stark rule were published in the Federal Register on October 11, 2005. See, 70 FR 59182.

fi industry as examples that the HIT industry must follow. “The wi-fi industry took off because the three different standards that were out there caused people to step back, not only because they didn’t know whether a product they bought could connect to somebody else’s hub. The bigger question was that they didn’t know which one would prevail in the end, so they just waited it out. The wireless industry came together and cleared a single standard for wi-fi because they knew that would grow the market substantially.”⁵ Thus, if a central standard is developed, the federal government expects the industry to more readily adopt the technology required to establish an NHIN.

As part of this same initiative, the government has developed the VistA-Office EHR software – a platform based on EHR software used at Veterans’ Association hospitals for the past twenty years.⁶ The government intends to distribute this software as a low-cost EHR for smaller physician offices. While there are hurdles that physician practices will have to overcome in implementing VistA-Office software, such as costs incurred during installation and implementation, and determining whether the feature set offered by VistA-Office is worthwhile, the VistA-Office program represents a significant step by the government in the development of EHRs on a national scale. Unfortunately, as of this writing, the full release of VistA-Office has been delayed and the program has moved to “beta” testing, where it will be released to selected physician offices.⁷

State and local initiatives are also underway. For example, Governor Mark Warner of Virginia has advocated the creation of standard electronic records which can be shared by providers when necessary. He has estimated that switching to electronic records will save the state’s healthcare programs between 8 and 15 percent.⁸ In Massachusetts, the Massachusetts eHealth Collaborative, an organization existing as an offshoot of the Massachusetts Health Data Consortium, has developed a pilot program in which participants must develop operational and financial models to assist the statewide adoption of EHRs. The Collaborative is funded by entities such as Blue Cross Blue Shield of Massachusetts, and one of the project’s leaders is the Governor himself.⁹

1.1.2 Technological Advances and Media Attention

None of the government initiatives would have been attractive without the technological advances of the past decade. For example, the concept of an NHIN is far more viable with the development of a faster internet infrastructure, thanks to the widespread availability of

⁵ Cunningham, “Action Through Collaboration: A Conversation with David Brailer,” Health Affairs, 1150-1157, at 1151 (September/October 2005).

⁶ See, www.vista-office.org.

⁷ Tennant and Schneck, “CMS delays full release of much-publicized VistA-Office EHR”, MGMA Connexion, 29-30 (November/December).

⁸ Kantor, “State Sees Technology as Avenue to Savings,” Roanoke Times, September 20, 2005. www.roanoke.com/business/wb/32994.

⁹ Frisse, “State and Community-Based Efforts to Foster Interoperability,” Health Affairs, 1191-1196 (September/October 2005).

broadband internet connections. Electronic claims submission, computerized scheduling, and the insinuation of technology into the clinical aspects of the practice of medicine have further conditioned practitioners to become more comfortable with technology, and thus more receptive to the idea of EHRs. Computers have also grown faster and more user-friendly in the past decade, allowing for the development of more robust and sophisticated programming. Finally, the cost for technology has continued to drop. Where a basic black-and-white scanner alone might have cost several hundred dollars in 1995, in 2005 you can purchase a printer, scanner, copier, and fax machine all in one single desktop unit for under \$300.

Technological advances alone, however, would be insufficient to spur adoption and interest to its current level. The final piece in the puzzle is the recent intense media focus on EHRs and IT. Articles touting the benefits of EHRs, discussing why now is a good time to purchase an EHR, or discussing physician satisfaction or adoption rates for EHRs have flooded the industry media, pointing out, among other things, how EHRs lead to higher profits and greater efficiency.

In the midst of the increased attention on EHRs, many physician practices may be considering adopting an EHR. EHRs are attractive across the spectrum of healthcare provider types, from large hospital networks to small physician practices and those in between. EHRs offer enhanced practice management abilities, the potential for error reduction, improvement in the quality of services, and most importantly increased efficiency and potential profits. However, smaller physician practices have different needs and concerns from larger entities. In a practice's desire to find software which is affordable, meets the practice's needs, and can most effectively be implemented, the practice may not pay attention to the license agreement which will accompany the software. The focus of this chapter will be on the concerns of the smaller physician practice, rather than larger organizations.

..2 EHR Overview

..2.1 EHR Definition & Functions

For a meaningful discussion of EHRs one might think there must be a clear understanding of what exactly an EHR is, and how it differs from an EMR. Both terms, however, are used interchangeably in the marketplace and in the press, which may lead to confusion. One definition characterizes EMRs as “an application environment composed of the clinical data repository, clinical decision support system, controlled medical vocabulary, computerized provider order entry (CPOE), [and] pharmacy and clinical documentation applications,” whereas an EHR is “a subset of each [hospital or physician office's] EMR, presently assumed to include summaries, such as ASTM's Continuity of Care Record and HL7's Care Record summary.”¹⁰ The definition further states “the data in the EMR is the legal record of what happened to the patient during encounters at the [hospital or physician's office],” whereas the EHR is designed to be the system which allows the patient to move their health

¹⁰ Garets and Davis, “EMRs and EHRs”, Healthcare Informatics, October 2005. www.healthcare-informatics.com/issues/2005/10_05/garets.htm.

information across the proposed National Health Information Network (NHIN).¹¹ Under this definition, an EHR is essentially the summary of information contained in the EMR, which is designed to be portable across the NHIN.

The federal government appears to have taken a different approach to defining EHRs. In its recently proposed revisions to the Stark regulations, the Department of Health and Human Services (HHS) is considering creating an exception to Stark which would permit hospitals and group practices to donate EHR software to physicians. As part of the proposed regulations, HHS is considering developing a definition for EHRs.¹² However, even without such a definition, HHS seems to take a different view of what an EHR should do from the first definition. For example, an EHR under the proposed regulations would require that the software include a CPOE component, as well as an e-prescribing component.

At the same time, press releases and product names blur the lines between EMRs and EHRs. One product may describe several common components of the Garetts & Davis definition, without making any reference to interoperability or summarizing capabilities. Another product description may discuss how the software operates as part of a Regional Health Information Organization (RHIO), but makes no mention of CPOE capabilities. Faced with imprecise usage of the terms “EHR” and “EMR”, physicians may become confused, or may simply use the terms interchangeably themselves. For the purposes of this chapter, the term “EHR” and “EMR” will be considered interchangeable; and both will refer to software which combines both an electronic record of the patient’s medical history and additional components such as computerized physician order entry (CPOE), clinical diagnosis tools, or other practice management software (such as billing and scheduling components).

Most EHR software includes the ability to enter information into a patient’s chart, and many offer some practice management features (such as an included billing system, or the ability to interface with existing billing systems and scheduling functions). Charts are typically maintained via electronic templates, into which the physician may input specific information. Some use “auto fills” to automatically input commonly used notes into the patient’s chart. Others provide the ability to generate custom form letters by placing information from the patient chart into a letter template in Microsoft Word. EHRs may also be designed for certain specialties such as medical or radiation oncology, or cardiovascular practices.

Although EHR software is often configured to work in a local area network, among computers connected in an office setting (or in a wide area network, between several connected offices), EHRs may also be used on web-based systems, where data is stored off-site. This will necessarily raise additional practical and legal considerations, since the practice may have less control over the data.

..2.2 Pros & Cons of an EHR

¹¹ Id.

¹² See note 4, *supra*.

Currently, EHR adoption is on the rise, and has been for several years. In 2004, the American Academy of Family Physicians published a report indicating that the market appeared to be maturing.¹³ From the 2001 to 2003 period, adoption rates showed that the smaller the group, the less likely it was to adopt an EHR. During this period, only 13% of solo practitioners had adopted, as compared with 38.9% of groups of 20 or more having adopted.¹⁴ Two years later, the 2005 figures were similar, although some increase in adoption rates had been shown.¹⁵ One reason for the increase is the attraction of EHRs as bolstered by positive stories.

Practices report significant returns on investment (ROI), improved efficiency, increased profits, all of which give the impression that an EHR is the potential silver bullet for any number of problems. “Pull a patient chart within seconds, rather than minutes...Track pending orders for lab tests and diagnostic imaging...Fax prescriptions from your computer to the pharmacy instead of handing them to patients who might lose or alter them...Review a summary of the patient’s health information at a glance instead of flipping through pages,”¹⁶ touts one article. Commentaries discuss how practices increase their efficiency (even securing higher payment rates from insurers)¹⁷, or note increased profits resulting from EHR adoption.¹⁸ “In virtually every specialty, the practices that spend the most on IT (more than \$20,000 per [full-time equivalent] physician) have the most profit. For multispecialty groups with primary and specialty care, the profit was 42 percent greater than the practices that spent less than \$7,000 on IT.”¹⁹ With all of the potential features and benefits of an EHR, what would stand in the way of any practice adopting such a system?

The most common stumbling block for most practices is the high cost of EHR adoption – and the cost of the software alone is not the only expense associated with switching from a paper-based system to an electronic system. A simple questionnaire distributed to medical group practices by the Medical Group Management Association (with support from the Agency for Healthcare Research and Quality) found that the number one reason for not adopting an EHR was not the cost of the program, but rather the cost of implementation.²⁰ Even for a practice that

¹³ Edsall, “Are Electronic Records Catching On?”, Family Practice Management, 13 (March 2004); <http://www.aafp.org/fpm/20040300/13area.html>.

¹⁴ Burt and Sisk, “Which Physicians and Practices are Using Electronic Medical Records?”, Health Affairs 1334-1343 (September/October 2005). The article also notes adoption rates of 16.2% for groups of 2-4, 19.9% of groups of 5-9, and 28.% for groups of 10-19.

¹⁵ *Id.*, p. 1326.

¹⁶ Lowes, “50 Reasons to get an EHR,” Medical Economics, 52-53 (September 16, 2005).

¹⁷ Colwell, “A small practice juggles EHR’s high costs and big payoffs,” ACP Observer, (September 2005); www.acponline.org/journalsnews/sepo5/ehr.htm.

¹⁸ “Does Technology Pay? (Yes),” MGMA Connexion, 22-24, Vol. 5 No. 6, (July 2005).

¹⁹ *Id.*

²⁰ 25% of respondents cited cost as the number one reason. Other reasons included lack of physician support (15%); insufficient time to select, contract, install and implement (10%); insufficient return on investment (9%); and inability to easily input historical medical record data into the system (8%). Vuletich, “EHR use varies widely by

successfully makes the switch from paper to an EHR, the cost can be considerable. For example, a two-physician internal medicine practice in northern Virginia listed total startup costs alone of nearly \$80,000, with maintenance costs amounting to over \$10,000 per year.²¹

In addition to the cost for the license itself, practices may have to purchase additional hardware, adapt existing technology to the new software, train personnel in the use of the software and/or hire additional personnel. During this time, the practice may lose productivity, creating an additional economic burden. In light of these issues, this chapter will discuss typical clauses in EHR license agreements, paying special attention to the implementation and practical concerns facing physician practices in the process of EHR adoption which arise from the legal issues in the agreements.

3 License Agreement Clauses

Although physicians are understandably excited about adopting an EHR, there are practical hurdles that must be surpassed before a practice may reap the benefits of an EHR. Before even getting to implementation, there is the license agreement. Most software will include some form of license agreement, from a basic “click to proceed” agreement, to a more elaborate written agreement. The license agreement will control the relationship between the practice and the vendor. It will describe the obligations of each party, the duration of the relationship, and the rights the practice has to the software. This chapter will examine three general areas of license agreements: the scope of the license, warranty and liability provisions, and support and other miscellaneous provisions. These three areas of concern cover the building blocks of the relationship between the practice and vendor, and thus are essential in understanding the practice’s position in the transaction. The goal of this chapter, therefore, is to provide guidance on common clauses in EHR license agreements and their significance. With a better understanding of the importance of the specific language in these clauses, an attorney can help make the EHR implementation process that much easier for his or her client.

3.1 Scope of License

The scope of a license specifies what is being transferred from the vendor to the practice. The scope of a license for software typically will fall under the aegis of the Copyright Act, although depending on the nature of the agreement, it may also be subject to the Patent Act.²² Under copyright law, a rights holder is entitled to certain statutory rights, which include use,

practice; No. 1 reason for not using it varies little,” MGMA e-Connexion, Issue 66, November 2004. <http://www3.mgma.com/articles/index.cfm?fuseaction=detail.main&articleID=13125&qryRowStart=26&nextPageSetStart=1>.

²¹ See, Colwell, note 16, *supra*. Startup costs included a user license for each physician, training, practice management software, consultation fees for implementation and training, hardware costs, and website costs; the costs were spread out over time. Maintenance includes ongoing maintenance and EHR support fees, an annual support fee to maintain links to outside radiology groups and other consultants, information technology consultant fees, and ongoing website maintenance fees.

²² 17 U.S.C.A. § 101, *et seq.*; 35 U.S.C.A. § 101, *et seq.*, respectively.

distribution, reproduction, and the right to make derivative works of the underlying copyrighted work.²³ Licensors can restrict these rights on virtually any basis. For example, a license might only permit a practice to use the software on a single computer (or might charge an additional fee for multiple installations); might restrict the type of users to only specifically trained users; or might restrict the number of users that can simultaneously log into the system. It is crucial that the practice understands the scope of the license, as that scope pertains to the specific needs of that particular practice.

Conceivably, a license could grant a perpetual, non-exclusive right to use the software only at a specific address, on a single machine, by a specific list of users established in advance. However, as a practical matter, the scope of a license will not be anywhere as restrictive, since such a license would be extremely unattractive to potential users. It is more common to restrict licenses based on the number of users and/or computers, or by the type of user. Consider the following example:

Example A: “Under this Agreement, You are purchasing, and Company grants solely to You, a nonexclusive, non-transferable, limited use license for the term set forth below, to: (i) install the Software on a server at Your Designated Location and workstation(s) within Your facilities; and (ii) for You and Your Affiliated Practices to use and execute the Software solely within the Territory. The total number of workstations accessing the Software shall not exceed five times the number of Provider Licenses purchased by You.”

As is the case in all of the agreements reviewed for this chapter, the license is non-exclusive. This permits the vendor to license the use of the software to other parties as well. If the license were exclusive, the software would essentially be “one of a kind.” While some health systems and practices may purchase custom EHR software, if a license is exclusive the price for the software will likely rise considerably.

This scope of license clause is useful in that it permits a practice to install on multiple workstations for the cost of a single Provider License. Rather than limit the practice to installation on a single workstation, or in a single location, this agreement focuses solely on the number of workstations or number of users. For a group practice with multiple physicians working at multiple office locations, this type of license is ideal. In addition, the practice is not required to purchase additional licenses for multiple users, so physicians, non-physician practitioners, and office staff alike may all use the software wherever it is installed.

By comparison, Example B only permits the user to install on designated computers. Example B: “Subject to the provisions of this Agreement, [Company] hereby grants to Customer, and Customer hereby accepts from [Company], a nonexclusive, nontransferable, nonassignable limited license to use the [Company] Product on the Designated Equipment for internal purposes only in accordance with this agreement during the term specified [herein]. Customer acknowledges and agrees that the [Company] Product is the proprietary information and a trade secret of [Company] and

²³ 17 U.S.C.A. § 104.

that this Agreement grants Customer no title or rights of ownership in the [Company] Product. Customer agrees not to market, sublicense, distribute, permit timeshare, or allow any other access to the [Company] Product other than Customer's own internal use as permitted hereby. The data files and patient data stored in the software are and shall remain the exclusive property of Customer.”

Because this license focuses on designated equipment, it will be more beneficial for a practice with relatively few computers. In the case of software which is priced on a per-computer basis, a practice with twelve potential users but only three computers on which the software will be installed will benefit far more from language like that of Example B than a practice with seven computers and only two potential users.

A per-computer license will also raise an additional concern: namely, how “installed” is defined. If the practice intends to use software on multiple computers, but those computers are simply workstations which link to a central server which will house the software itself, has the practice actually “installed” the software on the workstations? While this issue may be precluded by the nature of the software itself and the structure of the practice's computer network, the agreement should specify what constitutes installation and whether a practice must purchase additional licenses for each workstation.

As an alternative, an agreement which focuses on users rather than the number of computers would benefit a practice which has only a few users, but multiple computers. For example, a practice with only two physicians, one non-physician practitioner, and one staff member who will use the software, but which keeps computers at a front desk and in six exam rooms may find it more practical to purchase an EHR which controls its scope solely based on the number of users rather than the number of computers, as in the language of Example C below.

Example C: “Permitted Users and Facilities may have access to the Application Services for Client's internal use only and solely for purposes of viewing and processing data resulting from or related to clinical procedures or financial transactions performed at the Permitted Facility or for Client in a manner consistent with this Agreement and for which the [Company] Software was designed.”

The mention of Permitted Facilities raises an additional issue – the facility or site license. In the case of site licenses, the practice obtains a license for the physical location where the software will be installed, rather than for a specific number of users or computers. Site licenses are most beneficial to larger practices operating in a single building, or a smaller practice with a large number of computers. By contrast, a license based on the number of locations may be inappropriate for a practice with a relatively small number of computers and users who provide services in multiple locations.

Some licenses, however, may not even have explicit scope of license language in the body of the agreement. Pricing may be controlled by a separate document which the scope of the license does not address.

Example D: “[Company] hereby grants to Customer a nonexclusive, nontransferable license, during the term of this Agreement, to use the [Company] developed technology solely for purposes of using the Service(s). Customer shall have no right to use such technology for any purpose other than using the Services(s).”

In this case, the license focuses primarily on the purpose of the software’s use, rather than on the number of computers, users, or physical locations. Language elsewhere in the body of the agreement from which Example D comes addresses the specific work order which will control pricing.

Each of the above examples may be useful for a practice with one set of needs, and less useful for a practice with different needs. By understanding the practice’s infrastructure and how it intends to use the software, an attorney may more effectively advise the practice on the implications of the scope of the license.

3.2 Warranties and Liability Disclaimers

In general contracting law, warranties function as assurances from seller to buyer about the goods being sold. EHR software licenses typically will touch on several types of warranties, including the warranty of merchantability, warranty of noninfringement, and warranty of fitness for a particular purpose. The warranty of merchantability indicates that a product will perform as well as most other products of the same type.²⁴ By comparison, the warranty of fitness for a particular purpose exists when the seller knows the buyer will use the goods for a particular purpose, and is an assurance that the goods will function for that specific purpose.²⁵ The warranty of noninfringement is simply a guarantee that the seller can legally transfer title under the contract free from third party claims of infringement.²⁶ These warranties are typically implied in the regular course of sales, but may be (and universally are in EHR software licenses) disclaimed within the contract. By disclaiming these warranties, the seller avoids potential liability.

Similarly, EHR vendors typically include language which disclaims or otherwise limits liability for damages. These clauses are usually very broad in scope, and include exemplary damages, consequential damages, or other more specific damages. In combination with an effective warranty disclaimer and absent a claim of fraud, a liability disclaimer will leave the buyer with little by way of legal options should the software fail to perform or if the software somehow causes damages to the buyer or a third party whom the buyer serves.

This type of language is crucial for software vendors, especially in the medical field. Consider the potential harm that an EHR system could cause, both to a practice’s business and to

²⁴ Hunter, Modern Law of Contracts, Sec. 9.5, West Publishing Group, ©2004.

²⁵ Id.

²⁶ U.C.C. § 2-312(3).

its patients. An EHR with clinical features which fails to function properly could contribute to misdiagnosis of a patient. An EHR with practice management features that fail could lead to considerable loss of revenue and/or data. In both cases, without a warranty or liability disclaimer, the vendor is left exposed to potential liability. Moreover, although vendors may work with practices to adapt the software to a practice's existing hardware, given the potential variety of hardware and software interactions, it may be impossible for the vendor to ensure that the software will always function as intended. There are simply too many variables for a vendor to address. It should therefore come as no surprise that these disclaimer clauses appear in every EHR software license.

Consider the following example:

“Warranty Disclaimer: [Company] EXPRESSLY DISCLAIMS ALL IMPLIED WARRANTIES, WITHOUT LIMITATION, WARRANTIES OF MERCHANTABILITY, NONINFRINGEMENT, AND FITNESS FOR A PARTICULAR PURPOSE. NO ORAL OR WRITTEN INFORMATION OR ADVICE GIVEN BY [COMPANY], ITS EMPLOYEES, DISTRIBUTORS, DEALERS OR AGENTS SHALL CREATE ANY WARRANTIES. THE PATIENT DATA, PRACTICE DATA, SERVICES AND [COMPANY] TECHNOLOGY ARE PROVIDED ON AN “AS-IS” BASIS.

“LIMITATION OF LIABILITY: UNDER NO CIRCUMSTANCES AND UNDER NO LEGAL THEORY, TORT (INCLUDING NEGLIGENCE), CONTRACT, STRICT LIABILITY OR OTHERWISE, SHALL [COMPANY] OR ITS SUPPLIERS OR AGENTS, OFFICERS, EMPLOYEES, PRINCIPALS, DIRECTORS OR SUBSIDIARIES BE LIABLE TO CUSTOMER OR ANY OTHER PERSON FOR ANY DAMAGES OF ANY KIND ARISING OUT OF [COMPANY]’S DELIVERY OF OR FAILURE TO DELIVER THE SERVICES, THE USE OR INABILITY TO USE THE SOFTWARE, [COMPANY] TECHNOLOGY OR SERVICES OR ANY DATA SUPPLIED THEREWITH, OR FOR THEFT OR UNAUTHORIZED ACCESS TO PATIENT DATA, OR OTHERWISE OUT OF THIS AGREEMENT, REGARDLESS OF WHETHER THEY ARE DIRECT, INDIRECT, SPECIAL, INCIDENTAL, OR CONSEQUENTIAL DAMAGES OF ANY KIND, INCLUDING WITHOUT LIMITATION, DAMAGES FOR LOSS OF GOODWILL, WORK STOPPAGE, COMPUTER FAILURE OR MALFUNCTION, INTERNET INACCESSIBILITY OR ANY OTHER AND ALL OTHER COMMERCIAL DAMAGES OR LOSSES, EVEN IF [COMPANY] SHALL HAVE BEEN INFORMED OF THE POSSIBILITY OF SUCH DAMAGES, OR FOR ANY CLAIM BY ANY THURD PARTY. THIS LIMITATION OF LIABILITY SHALL APPLY TO LIABILITY FOR DEATH OR PERSONAL INJURY.”

In all of the agreements reviewed for this article, the language of the disclaimers is nearly identical for the warranty disclaimer.

The inform commercial code UCC permits parties to disclaim express warranties otherwise stated in the agreement, so long as doing so is not unreasonable.²⁷ With respect to implied warranties, an implied warranty of merchantability may be disclaimed if the agreement mentions disclaimer of merchantability and is conspicuous.²⁸ To disclaim an implied warranty of fitness, the agreement language must be conspicuous.²⁹ To simply disclaim all implied warranties, the agreement need merely state something to the effect of “There are no warranties which extend beyond the description on the face hereof.”³⁰

Problems which can arise here are numerous. For example, in Evolution, Inc. v. Suntrust Bank, 342 F. Supp. 2d. 964 (D. Kansas 2004), the District Court for the District of Kansas addressed a case in which a software developer sued a licensee for copyright infringement. The licensee counterclaimed for breach of contract, fraud and misrepresentation. In the motions for summary judgment, the licensee claimed that the developer’s limitation of damages clause amounted to an impermissible attempt to disclaim an express warranty. The court stated, “Under Kansas law, an express warranty is created by any affirmation of fact or promise made by the seller to the buyer which relates to the goods and becomes part of the basis for the bargain,” however the court noted that words or conduct which created such a warranty would be construed consistently with words or conduct which sought to negate such a warranty whenever reasonable.³¹ The court did not address whether an express warranty had been created in the case, however, and left that decision to the jury.³²

The more important disclaimer for a medical practice will be the disclaimer of liability. The practical effect in most cases will be that, in the event of a failure of the software for any reason, the practice will only be able to sue the vendor for the cost of the software. If a patient is killed or otherwise harmed by a faulty EHR, if the software causes the entire practice local network to crash and lose months of billing and patient data, the practice will still only be able to sue for the cost of the software.

_.3.3 Support Clauses

Often, EHR software licenses will include support services with the initial software; in these cases, the practice is buying not only the software, but also the ongoing support provided by the company. Support clauses are important in that they typically provide support when problems arise, and may also include updates to the software. Given the impending development of EHR standards by the Federal government, support clauses will take on greater importance.

²⁷ U.C.C. § 2-316(1).

²⁸ U.C.C. § 2-316(2).

²⁹ Id.

³⁰ Id.

³¹ Evolution, at 969.

³² Id., at 971.

Both the Office of Inspector General and the Centers for Medicare and Medicaid Services have proposed exceptions to the Federal anti-kickback statute and the Stark statute for EHR software.³³ In addition, competing standards for EHRs are developing in the private sector.³⁴ Because standards are not fully developed yet and may in fact prove conflicting to some degree, practices will need to know that support will include more than simple bug fixes and enhanced features. The license must therefore anticipate updated requirements for EHRs imposed by new regulations and the eventual development of industry-wide standards for EHRs.

The scope and conditions of support vary from agreement to agreement. Support services may be included in the costs for the EHR license, or may be available as an option for purchase by the practice. Support services may include a variety of specific services, such as on-site support (support provided at the practice's office), and off-site support (such as e-mail, telephone, or web support). A support clause may also distinguish between hardware and software support, and may condition support on various customer actions.

Example A: The customer is charged for services, although support fees may be altered after a two year period by either a 10% increase or an increase of 3% of the Consumer Price Index. Maintenance fees will double if "at any time [Customer] fail[s] to have a [contact person on site, trained by the Company in operation of software] for more than a three-month period". Doubled fees will continue until a new practice member or employee is trained in the operation of the software.

Example A's requirement that the practice designate an individual who serves as the on-site point of contact, or face doubled support fees is significant. A practice may not want to rely on a single point of contact through which all support communications must run. If that individual leaves the practice for any reason, the practice will be forced to find a new contact person who has been appropriately trained by the Company within three months or pay the doubled fees. Similarly, spending the time to train the person may place an additional strain on the practice as it may impact productivity during the training process. On the other hand, the practice may benefit from the single point of contact and may find that, after the initial training costs are surpassed, this method may provide a more streamlined approach to software support.

By contrast, the following example allows the practice a more open-ended approach to interaction with the vendor with respect to software support.

Example B: The customer is charged for support services, but the charges are waived for first year. After this initial period, the customer is charged for support. The practice must perform routine maintenance as required by the software documentation for products, maintain certain environmental conditions required by the products, install new updates as

³³ The proposed exceptions have appeared at 70 FR 59015 and 70 FR 59182, respectively. The OIG's exception for EHR software, however, has not appeared as an additional safe harbor in 42 CFR § 1001.952.

³⁴ For example, both Health Level 7 and The Certification Commission for Healthcare Information Technology are developing standards for functionality of EHR software. See www.hl7.org and www.cchit.org, respectively.

requested by [Company], install recommended communication software (including an industry standard modem and dedicated communication line or provide the company with access for remote diagnostics according to the Company's system requirements), grant supervisor security rights to the Company on the hardware where installed, schedule time for on-site installation and training, and perform other routine maintenance as requested.

Example B permits the practice to rely primarily on the company itself for specific software support, although it does require the practice to maintain its site within the limits specified by the software documentation. The practice must also take time to train its staff on-site, and perform routine maintenance, which will impact productivity to some degree. As a positive, however, because the support is free during the first year, the practice will receive free support during installation and in the months that follow, when it is more likely to run into difficulties with the software. Presumably, by the end of the first year, the practice would be more comfortable with the software and its operation, and require less support services.

Example C: There is no specific charge for support services. However, the practice pays a monthly fee for the EHR services itself. Thus, the cost of support is likely factored into the monthly fee. Support is "Provided to a single point of contact established at the Client site." The agreement also requires that the practice "(i) maintain a support staff capable of performing problem determination prior to engaging [COMPANY]'s support services, (ii) provide access to world wide web support resources for its internal support organization, (iii) provide e-mail capabilities to support personnel, and (iv) perform an annual support self-assessment."

Like Example A, Example C requires a single point of contact. However, because there is no additional support fee imposed, the practice may face a lower economic burden than if it uses a different EHR which requires support fees. Regardless, no matter what a practice does to address support issues, adding to the duties of existing personnel or hiring additional personnel to perform these tasks, the bottom line is that it will cost the practice to meet the requirements of each of these agreements. If the practice adds to existing personnel's duties, it runs the risk of lost productivity. If the practice hires additional personnel, it will place additional costs on the practice. Because one choice may be more economical than another, depending on how the practice operates, recognizing the specific requirements of a support clause in light of a practice's usual operation will help an attorney to guide to the practice in assessing the license agreement.

Moreover, not all agreements will specify that support is even provided. If an agreement does not specify this, the practice should at least inquire as to whether the company offers support services separately. Support services can include version updates (used to fix bugs in the software and bring the software into compliance with regulatory changes), and technical support for troubleshooting. It is therefore in a practice's best interests to purchase an EHR that either includes support services, or which offers them as an additional service.

3.4 Data Ownership Clauses

Another significant issue for practices will be data ownership, depending on the nature of the EHR itself. If the vendor never has access to the practice's data – such as in the case of an EHR that operates only at the practice's office(s) – data ownership may not be as great a concern.³⁵ However, if the practice uses a web-based EHR, or if the practice communicates data to a vendor's server, data ownership will be a more important issue. Data itself is valuable in multiple ways. It can be used as a tool for quality improvement, sold to third parties in de-identified form, or used as the basis of advertising. Given the value of data, a practice will want to keep as much data as possible.

In EHR software licenses, typically the vendor either owns or licenses whatever intellectual property it has brought to the transaction, and retains this information as its own both during and after the term of the agreement (except insofar as it licenses the use of its information to the practice). The practice usually will retain whatever information it inputs into the system, such as patient data. However, in some cases, an agreement may have the practice transfer de-identified data to the vendor.

Example A: “[COMPANY] shall have access to the activity data of Client processed with the [CORE SOFTWARE] so long as such data do not allow the identification of an individual person (such data hereinafter referred to as “blinded data”) and only to the extent permitted by law and by Client’s agreements with third parties. Client hereby grants to [Core company] and [Company] an irrevocable, nonexclusive, transferable, perpetual license to use the blinded data for any purpose permitted by law, including, without limitation, comparative data analysis and the development, marketing and distribution of other products or services. In exchange for its participation in this process, Client may subscribe to [Company]’s subscription services for value-added comparative data and other related services and products.”³⁶

In the first example, the practice turns over de-identified data to the vendor. Although the clause does not specify the intended use for the data, it strongly suggests that the data will be used in comparative analysis and marketing, as well as the development of additional products and services. The practice, however, is given access to comparative data in exchange for the transfer. By comparison, in Example B, the vendor makes no ownership claim to the data.

Example B: “All business data obtained by the Customer is the property of the customer. This includes patient clinical, financial and insurance related information. How the data is presented (i.e. the forms and software programming that presents the data) is the function and property of [Company].” This clause also grants the company a license to enter the database (where the practice's data is stored) at any time for debugging and improvement of the company's software.

³⁵ Shay, “Commerce in Provider Data: What, Why and Provider Contractual Controls”, in Gosfield ed., HEALTH LAW HANDBOOK, 2005 Ed., p. 285.

³⁶ In this example, the software is provided by a vendor, but is developed by another company. Thus, [Company] represents the vendor and the developer of the core software is referred to as [Core Company].

In addition, note that the license is non-exclusive. Thus, the practice may still use this data itself, or transfer it to another entity. However, the license is also irrevocable and perpetual, which means that the practice can never terminate the vendor's right to use the data, and such right will never expire on its own. Practically speaking, the value of the data to subsequent users may be reduced, since another party already has access to it.

Depending on the nature of the practice, the optimal data ownership relationship may vary. For example, a hematology/oncology group making extensive use of cancer treatment drugs might want to maintain control over its data, so that it could sell the de-identified information to a third party, such as IMS. For such a practice, Example B would be far more attractive. On the other hand, a small family practice which has no intention of using the data for anything but its own internal practice improvement and patient treatment might be perfectly content with Example A, especially since they gain access to additional data and services in exchange. Whatever the specific concerns of the practice may be, it is still important to be aware of who will have control and ownership of, as well as access to the data.

3.5 Sub-Licensing

Although many EHRs are developed and licensed to a practice by the same company, some EHRs arrive at a practice's doorstep having been created by a party other than the actual vendor. In these situations, the vendor is sub-licensing the software to the practice. This raises issues which are not a concern when a practice buys its EHR software directly from the developer. For example, one agreement reviewed for this chapter was for a software system licensed from another company, to which additional modifications had been made by the vendor. Although this was explicit in the terms of the license agreement, sub-licensed software will highlight issues such as support clauses. If the practice cannot turn to the developer because of a lack of privity of contract, it will want to make sure that the vendor offers sufficient support services.

This style of "downstreaming", where the practice receives the software from an entity other than the developer, may become increasingly more popular, depending on how the final Stark rule on EHRs develops. Currently, HHS has proposed an exception to the Stark prohibition against self referrals which would permit a hospital to provide EHR software to physician members of its medical staff. In the proposed regulation at 42 CFR § 411.357(w), a hospital would be permitted to supply EHR software to a physician member of the hospital's medical staff (or by a group practice to a member of the group), provided the physician took no action to limit or unnecessarily restrict the use or compatibility of the software with other EHRs.³⁷ In addition, neither the physician nor the physician's practice may condition doing business with the hospital on the basis of receipt of EHR software.³⁸ The eligibility of the physician and the nature of the EHR software must be determined in a manner which does not take into account the volume or value of referrals generated between the parties, and the arrangement must be set out in writing, specify the items or services being provided, and contain

³⁷ 70 FR 59197.

³⁸ Id.

a certification by the physician that the items and services are not technically nor functionally equivalent to items or services that the physician already possesses.³⁹ However, recipients of this software must provide written certification that the software they receive is not equivalent in function to software they already possess, and that donors may not recklessly disregard knowledge of a recipient's technology being equivalent to the donated software.⁴⁰ Recipients cannot condition their business with the donor on the receipt of the software, and cannot only offer services to certain recipients.⁴¹

The regulations covering “pre-interopability” EHR software are more restrictive than “post-interopability” EHR software which meets the functional standards for “post-interopability”.⁴² The likely effect of this will be that, as hospitals and group practices with greater purchasing power seek to take advantage of the Stark exception, we will begin to see a move towards the federal standards to be espoused by the regulations. Currently, the standards as such are fairly broad and unspecific, but this is likely to change as HHS collects comments on the proposed rules and formulates a final rule. Most likely, HHS will adopt regulations which mimic the style of the Health Information Portability and Accessibility Act of 1996 (HIPAA) regulations, which are broad and adaptive. The effect of all of this on physicians who fall within the exception as recipients will be that, as the Stark exception gains popularity, the physicians will be placed in the position of a downstream sub-licensee. In other words, the hospital will purchase the software from a vendor or developer with whom it has a license, and may then execute a sub-license with the physician.

Typically, as a sub-licensee, a practice will only be able to bring its concerns to the sub-licensor, rather than to the vendor, due to privity of contract. If the sub-licensor can provide adequate support for the software, then this may not be a problem. Similarly, the sub-licensor will likely disclaim the same warranties and liability that vendors do. If the practice is purchasing sub-licensed software, it may want to inquire, however, as to what modifications if any the sub-licensor has made to the underlying software. The sub-licensor may have done something as simple as rebranded the software by placing its own trademark on it. Alternatively, the sub-licensor may be selling its own product, which comes packaged with another vendor's product, or which integrates components from another vendor. In such situations, at the very least, the practice should know which other vendor's products are involved.

Alternatively, as the Stark EHR exception develops, in addition to concerns regarding liability and privity of contract, physicians will have to comply with the requirements of the Stark exception, including providing written certification that the software they receive is not functionally equivalent to their existing software system. Towards this end, practices and

³⁹ Id.

⁴⁰ Id.

⁴¹ Id.

⁴² For example, for non-certified EHR software, the donated software may not include any billing, scheduling, or other office management or administration functions. The regulations for certified EHRs do not include this restriction. 70 FR 59197-59198.

attorneys will need an understanding of the functionality of the current software, the donated software, and how both relate to the Stark exception final rule once it is proposed.

3.6 Delivery/Timeframes/Installation Clauses

EHR license agreements may also include provisions which control the delivery and/or installation of the software itself, placing requirements on one or both of the parties, such as required preparations prior to installation. A delivery clause may also absolve the vendor of liability in the event of a failure to deliver on time. Such clauses may be either explicit or vague, elaborate or brief. As a practical matter, delivery/installation clauses are important to the smaller physician practice because they may contain “hidden costs.”

One common factor across agreements is that delivery/installation clauses typically disclaim liability for the vendor’s failure to deliver on time. These clauses also usually require the customer to prepare their site for installation. Preparation of the site often refers to having all necessary hardware (computers where the software will be installed, inter-office networks, online communication capabilities, etc.) in place by the time the company arrives to install the software.

Where EHR license agreements may differ, however, is in how they bind the vendor, how flexible delivery dates are, and whether additional costs are imposed on the customer for delivery or associated services. For example, a customer may be required to pay for lodging and transportation for vendor employees engaged in on-site customer training in the software. Likewise, an agreement may require a customer to pay any costs associated with a customer-caused delay in installation. This is especially noteworthy, given that most agreements have the company disclaiming any liability for damages caused by its own delay in implementation.

A physician practice will benefit most from a definite statement that the company will deliver on time (even if accompanied by a disclaimer of any damages caused by late delivery/installation) than it will from a clause which offers only vague assurances that “both parties agree to cooperate to create a mutually agreed to implementation plan and to use commercially reasonable efforts to implement the Software in accordance with such plan.” While such language sounds very accommodating, it offers little by way of real obligations. While a vendor may disclaim damages for failure to implement on time, if it sets definite dates for delivery rather than a general “implementation plan”, a customer may still sue for breach of contract if the vendor fails to deliver on time even if the customer may not obtain additional damages for the breach.

3.7 Modification

Although not every agreement will have a separate clause regarding modifications to the EHR software, most agreements do address this issue and prohibit such modification or at least require prior written authorization. While such language is generally not a concern, if the physician practice intends to modify the software in any way, the practice should be made aware of the legal effect of such modification. This may range from voiding the software’s warranties,

to termination of all vendor obligations, including disabling the software itself. Modification may be permitted with a written approval by the vendor, or may be prohibited altogether.

The significance of language preventing modification depends on two factors: the need for the practice to modify the software, and what modification specifically means. A practice may have no need to modify the software in the first place. It may simply install the software and adjust all other systems, in terms of both hardware and software, around the new EHR. Alternatively, the practice may need to adapt the EHR itself to mesh with existing systems. If this is the case, having a clear understanding of what “modification” means will be important.

Unfortunately, most agreements do not provide a clear definition for “modification” within the text of the agreement. While modification obviously includes actions such as altering the underlying code of the software and how it performs, other less obvious actions might fall within the scope of modification language. For example, how will compatibility with the practice’s existing software be accomplished? If the new EHR does not interface with other software that the practice needs, is the practice allowed to modify the EHR program to accomplish this end? Moreover, if the vendor’s understanding of “modification” and the practice’s understanding do not match, the practice may unintentionally “modify” the software.

Ideally, the practice should have no need to modify the software itself, and to the extent such modification is necessary, should only do so having previously obtained written permission from the vendor. Ideally, the practice will have done its homework prior to purchasing the EHR, and determined whether the EHR can function with the practice’s existing systems. To the extent that the EHR isn’t immediately compatible, the practice should negotiate for the vendor to adapt the software to the practice’s system.

However, in the event that the practice still needs to somehow change how the EHR functions (which may include how it interacts with other software), the practice will want a clear understanding of what “modification” means. To the extent possible, it is therefore worthwhile to ask the vendor to include at least an inclusive, if not an all-encompassing definition, of “modification” within the body of the agreement itself, or in an exhibit to the agreement. Alternatively, an exhibit with permissible modifications listed may also be useful.

3.8 Assignment

The ability to assign contract duties generally means that a party can transfer its rights and obligations under the contract to a new party. The assigning party is then removed from the entire equation and the new party stands in its place. With EHR licenses, assignment clauses require close scrutiny. In general, to the extent that such issues are addressed, the customer will be unable to assign the agreement. This is less of an issue for practices, however, since they likely want to continue to receive the benefit of the EHR. Except in situations of merger or practice sales, most practices will have no reason to want to assign the agreement. If there is any expectation, though, that merger or sale could occur, assignability should be addressed. Still, the fact that most agreements either entirely prohibit or require written authorization for customer assignment is less of an issue for the practice.

By contrast, the vendor is often either explicitly allowed to assign the agreement, or is implicitly permitted to assign. Implicit ability to assign usually takes the form of a prohibition on assignment by the customer with no similar prohibition placed on the vendor. For example, “This agreement is not assignable without the prior written consent of [Company]. Any attempt to assign any of the rights, duties, or obligations of this Agreement without such consent is void. Subject to the foregoing, this Agreement shall be binding upon and inure to the benefit of the parties and their respective successors and assigns.” Because any assignment requires the company’s prior written consent, presumably, the company itself is free to assign.

Prohibitions on customer assignment which implicitly allow vendor assignment may also appear in “Binding Effect” clauses. Such clauses usually appear as: “This Agreement shall be binding upon and inure to the benefit of the parties and their respective successors. However, Client may not assign this Agreement without the express written consent of [Company].” In these clauses, the company generally states that any successor (such as a company which buys the practice but wishes to continue using the EHR) may assume the rights and duties of the agreement. However, because the company requires written consent before any other assignment is possible, it again implies that the company itself is free to assign.

A company’s assignment of an EHR license may or may not be problematic for the practice, depending on who takes over the license. In a worst-case scenario, the practice may be subjected to a new company which does not meet the practice’s needs with respect to ongoing support for the EHR. In a best-case scenario, the new company may provide better service than the previous company. However, it is more likely that the company which developed the software initially will be best suited to provide support and updates to the software with a minimum of bugs (this assumes that the company with whom the practice is contracting is the actual developer of the EHR software). Accordingly, practices should be made aware of the company’s ability to assign , and the potential problems that can arise from such an assignment.

In some agreements, the company may also be permitted to delegate to third parties. The legal implication of this is that the company remains in the position of receiving the benefit of the agreement (payment, in the company’s case), but has a third party performing its obligations under the agreement. As a practical matter for the practice itself, this is only a slightly better situation than if the agreement is assigned. In this situation, the practice may still complain to the original vendor if it is dissatisfied with the third party’s performance. Thus, if an agreement only allows the vendor to delegate, this is actually a better position for the practice than wholesale assignment.

3.9 Choice of Law and Venue

Most agreements include some form of choice of law, and/or venue (also known as forum selection) clause. Language of such a clause will typically read something like,

“This Agreement is made under, and in all respects shall be interpreted, construed and governed by, and in accordance with the laws of the State of California. Any cause of action arising out of or related to this Agreement may only be brought in

the local court of applicable jurisdiction in the State of California, Orange County, and [Customer] hereby submit[s] to the jurisdiction and venue of such court.”

In this example, both choice of law and venue are addressed. However, some agreements may only address choice of law, and not discuss venue.

In general, both choice of law and forum selection clauses will be considered enforceable. For example, in addressing choice of law provisions, the UCC states that “when a transaction bears reasonable relation to this state and also to another state or nation the parties may agree that the law of either this state or of such other state or nation shall govern their rights and duties. Failing such agreement, this Act applies to transactions bearing an appropriate relation to this state.”⁴³ Likewise, the Second Restatement of Conflicts of Laws states generally that an agreement may select the jurisdiction of law to apply to contractual disputes, unless: (a) the chosen state has no material connection to the transaction, or (b) the enforcement of the clause would run counter to the fundamental policy of the other state, and such other state has a materially greater interest than the state named in the contract.⁴⁴

States may also have a subtly different approach to the application of both types of clauses. Although there is a dearth of caselaw regarding EHR licenses, tangentially related caselaw may provide insight into what a practice may expect in addressing such clauses. For example, in NMP Corp. v. Parametric Technology Corp., 958 F.Supp. 1536 (N.D.Ok. 1997), the enforceability of a choice of law clause in a software license required a closely scrutinized balancing test between Oklahoma law and Massachusetts law. Here, an Oklahoma purchaser sued a Massachusetts software developer for breach of contract as well as claims of fraud and misrepresentation. The District Court for the Northern District of Oklahoma was asked to enforce a choice of law clause which placed the contract under Massachusetts law. On the breach of contract claims, the defense centered on two contractual clauses: (1) a warranty that the product would function as stated for ninety days following installation, and (2) a contractual limitation of liabilities. Although the plaintiffs claimed that Oklahoma public policy prohibited contractual limitation periods for contracts falling outside the scope of Article 2 of the UCC, the court found that Oklahoma public policy was not violated by the application of Massachusetts law. Accordingly, because Massachusetts law permitted contractual one-year limitation periods, and because the Massachusetts UCC permitted parties to limit damages as long as the limitation would not be unconscionable, the contractual terms were valid, despite the plaintiff’s claims of a conflict with Oklahoma law.

In the case of an EHR license, the analysis would be the same: state law selected by the contract would govern unless public policy was violated in some way. While not every issue on which state law may differ can be predicted, the practice should at least be aware of the implications of a choice of law clause. For example, a practice in Pennsylvania purchasing an EHR from a California vendor, whose license applies California law, should understand that where state law differs in interpreting contracts, California law will likely control.

⁴³ UCC § 1-105(1).

⁴⁴ Restatement 2nd of Conflicts of Laws § 187(2).

Likewise, caselaw generally upholds forum selection clauses, so long as they are not unfair or obtained by fraud or overreaching, and are reasonably related to the forum chosen. For example, in CQL Original Products Inc. v. NHL Players' Association, 46 Cal Rptr.2d. 412 (Ca. App. 1995), the California Appeals Court held that a forum selection clause was valid, even though it hailed one party from California to Ontario, Canada. There, a California corporation which had licensed the rights to produce merchandise bearing the likeness of NHL players and the NHL Players' Association logo allegedly breached its contractual requirements in the production of such likenesses and logos. The court stated that so long as the clause was not unreasonable and the choice of forum had a rational basis in light of the facts underlying the transaction, the clause would be enforceable.⁴⁵

Even though in the above case, the license involved trademarks and logos, the analysis would be similar if the substantive clauses of the agreement were largely the same and the parties were instead an EHR vendor and a physician practice. In either situation, the potential impact of a forum selection clause is significant. The practice should explicitly understand that if it accepts this specific term, it consents to appear in the selected forum for all disputes arising from the agreement. As a practical matter, this is a major concern, since medical practice representatives themselves will not only have to travel to the forum in question, but will likely also have to pay for travel expenses for any of the practice's witnesses.

_3.10 Termination

Finally, how a contract terminates is equally as important as how it functions during the life of the contract. Termination and related provisions are important for two reasons: first, they determine how parties may exit the agreement; second, they determine what the parties' rights are following termination. In this respect, EHR license agreements are no exception. However, agreements vary in the form of termination and the effects of termination. Termination may occur for any reason upon notice, for breach, or in some cases via a buyout of the remainder of the term. Termination clauses may also differ in terms of the grounds for termination available to each party.

For example, a contract may permit both the practice and the vendor to terminate the agreement upon written notice in the event of a breach. The agreement may include a window within which the breaching party may attempt to cure the breach. By contrast, an agreement may not even include a specific termination clause containing grounds for termination, and may only provide such grounds in the rest of the agreement (such as in clauses which state that their breach constitutes a default).

In any relationship where the practice is receiving ongoing services from the vendor, it will want to know how that relationship can end, and especially how the practice itself may end the relationship. Ongoing relationships should be terminable for more than simply breach of the terms; the practice should be able to terminate the agreement if it becomes dissatisfied with the services it is receiving, even if there has been no breach. For example, if a practice is receiving

⁴⁵ CQL Productions, at 415.

maintenance and support, but the support staff are slow to respond to the practice's requests, or if the EHR software does not function as effectively as the practice had hoped, but these issues do not rise to the level of a breach, the practice may want to terminate its relationship with the vendor. Specific performance measures (e.g. timeframes, specific deliverables such as customizations) are critical to these provisions. If there is no mechanism by which this may occur aside from termination for breach, the practice will be placed in a difficult position – either continue accepting services which do not meet its needs, or attempt to terminate for breach and risk a lawsuit or arbitration. Thus, it is in a practice's best interests to request that a clause for termination for any reason with a notice period. While the vendor may not agree to such terms (at least not without the terms applying to both parties), it can still be useful to ask for such provisions. At the very least, the practice should understand the implications surrounding how the contract terminates.

Of equal importance, however, is what happens upon termination. Usually, any ongoing services will terminate with the contract (such as support and updates). In some cases, however, termination may require that the practice return all copies of software and manuals to the company. For example,

“Termination of this Agreement also terminates [Customer's] Software License... Upon termination of this Agreement, [Customer is] required to return or destroy, as requested by Company, all copies of the Software in [Customer's] possession (whether modified or unmodified), and all other materials (including but not limited to User Materials) pertaining to the software, including all copies thereof.”⁴⁶

Where this becomes a concern for practices is in the potential scope of the destruction or return requirements. Most likely, the agreement will not require the practice to destroy its existing electronic records in the process of removing the software. However, the practice should request that the vendor explicitly state in the agreement that it will not require destruction of existing records.

An additional concern, however, will be the practical issue of whether the practice can use the records in another system. If the electronic records that the practice created using the vendor's software are stored in a format only readable by the licensed software, the practice will need to transfer these records to another system (assuming the practice does not switch back to paper-only records). When purchasing the software, the practice may want to inquire about the compatibility of the record format with other systems, and the ability to save the information in a format which can be read by multiple systems. If the information cannot be read by multiple systems, the practice may either want to obtain software that can convert the records, or print out the information prior to termination of the agreement. Who bears these costs could be conditioned on the reason for the termination. Specifying the limits on the costs to be borne by either party (e.g. if Customer terminates without cause, it shall be solely responsible for the costs of converting data to a new format. If Company fails to cure an alleged breach and Customer

⁴⁶ “User Materials” are defined essentially as manuals and documentation supplied to the user along with the software itself. The definition in the agreement does not include records or other user-created materials.

terminates, Company shall in the event be liable for any cost above \$_____ for Company to convert its data to a new format.)

.4 Conclusion

EHRs are a hot topic in healthcare today, and even at the smaller practice level, interest is likely to rise. As adoption rates for EHRs rise, practices will need to have a clear understanding of both the functional features of the software, and their legal rights and obligations under the license agreements which will accompany that software. An understanding of both the practical needs of small practices and the functionality of the software being licensed will benefit attorneys in providing useful guidance on these contracts. By understanding a practice's needs, the attorney can better explain the implications of the various clauses of a license agreement. Rather than simply laying out what the various agreement sections mean in general, an understanding both of what is typical in software license agreements as well as his or her specific client's needs will allow the attorney to pinpoint crucial issues in the agreement.