



2011 – 2012 Public Policy Principles

December 10, 2010

SUMMARY

HIMSS is a cause-based, not-for-profit organization exclusively focused on providing global leadership so that lives can be saved, outcomes of care improved, and costs reduced by transforming the delivery of healthcare through the appropriate use of information technology (IT) and management systems. Founded 50 years ago, HIMSS and its related organizations have offices in Chicago, Washington, DC, Brussels, Singapore, Leipzig, and other locations across the United States. HIMSS represents more than 30,000 individual members, of which two thirds work in healthcare provider, governmental and not-for-profit organizations. HIMSS also includes over 470 corporate members and more than 85 not-for-profit organizations that share our mission of transforming healthcare through the effective use of information technology and management systems. HIMSS frames and leads healthcare practices and public policy through its content expertise, professional development, and research initiatives designed to promote information and management systems' contributions to improving the quality, safety, access, and cost-effectiveness of patient care.

Each year, HIMSS creates policy principles for all stakeholders to consider for inclusion as provisions in legislation proposed by the U.S. Congress or state legislatures, or for inclusion in federal and state regulations, to foster enhanced healthcare using IT. For 2011 - 2012, HIMSS addresses its policy principles in eleven separate categories:

1. Funding and Incentives
2. Quality and Outcomes
3. Organizational Structure
4. Safety, Standards, Infrastructure, and Innovation
5. Privacy and Security
6. Legal
7. Patient Empowerment
8. Equity and Access
9. Population Health
10. Workforce Development
11. Administrative Simplification

The [American Recovery and Reinvestment Act of 2009](#) (ARRA) includes billions of dollars in Medicare and Medicaid incentive payments for the "Meaningful Use" of certified Electronic Health Record (EHR) technology and will help to close the health IT adoption gap in the United States. We agree with Dr. David Blumenthal, of the [Office of](#)

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44 [the National Coordinator for Health IT](#) (ONC), that “these are historic times. The
45 HITECH Act is bringing the power of electronic health records to our healthcare system.”
46 However, these new initiatives should not create a new form of "digital divide" and our
47 goal is to make sure that all constituencies benefit from these efforts.

48
49 By including the policy principles defined below into new federal and/or state legislation
50 or regulations, HIMSS is confident that our nation can successfully transform healthcare
51 using IT.

52 53 **1. Funding and Incentives**

54 ARRA committed unprecedented public funding with the intention of stimulating the
55 economy through methodical purchase, implementation and use of EHRs. Focus is now
56 directed on the administration of these funds in an effective manner, and development of
57 initiatives to assure the durability of these investments. In addition, clinician
58 reimbursement methodologies require updates to reflect the current landscape. Without
59 structural payment reform, such as repeal of the [Sustainable Growth Rate](#) and bringing
60 Medicaid reimbursement to parity with Medicare reimbursement, all health IT initiatives
61 are at risk as providers may choose instead to withdraw from these federal programs.

62
63 1.1 Reform reimbursement methodologies to improve the delivery of healthcare that
64 might:

- 65 (a) Reflect [value based purchasing](#);
- 66 (b) Overcome the broad information technology adoption gap that is
67 growing nationally;
- 68 (c) Encourage that standard reimbursement be provided to independent
69 licensed practitioners who use health IT to deliver clinical consultations and
70 direct patient care services;
- 71 (d) Encourage consumer empowerment by making electronic information
72 available to patients, encouraging discussion with their providers.

73
74 1.2 Continue providing grants and loans, or other incentives such as tax benefits, to
75 healthcare providers to support the adoption, implementation, and meaningful use
76 of health IT that meets nationally approved standards and is certified by one of the
77 federally-recognized certification and testing bodies.

78
79 1.3 Expand the State Children’s Health Insurance Program (SCHIP) Federal Medical
80 Assistance Percentages (FMAP) to support the adoption of EHRs, personal health
81 records (PHRs), and payer-based health records (PBHRs) for Medicaid and
82 SCHIP providers who deliver healthcare to children, with the goal of expanding
83 the use of payer data and EHRs among providers to achieve meaningful use.

84
85 1.4 Incorporate standards-based digital imaging and clinical media exchanges as part
86 of meaningful use, or ONC standards and interoperability framework, to reduce
87 duplicate imaging studies, reduce dose exposure, and increase the effectiveness of
88 clinical care.

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- 90 1.5 Consider expanding the main focus for federally-funded economic incentives
91 from only physicians, hospitals and ambulatory practices as defined by HITECH,
92 to include other healthcare professionals and settings that are not currently
93 eligible for the incentives programs.
94
- 95 1.6 Expand the application of the CMS Certification Number (CCN) in regards to
96 meaningful use incentive payments to include two complementary solutions:
97 either basing incentive payments on distinct physical locations, perhaps limited by
98 a distance criteria, or using a combination of CCN and the facility address to
99 make the determination.
100
- 101 1.7 Encourage federal agencies to incorporate incentives for the meaningful use of
102 certified EHR technology among providers and payers for participation in Health
103 Information Exchange (HIE) efforts and a [Nationwide Health Information](#)
104 [Network](#) (NwHIN). Such HIE and NwHIN activities should incorporate sound
105 business cases and strategic plans that support clinical workflow and data
106 integration across systems. In addition, these activities should be appropriately
107 aligned with other federal initiatives that provide financial assistance for health IT
108 and healthcare transformation so that this nationwide initiative does not become
109 an unfunded mandate for the states.
110
- 111 1.8 Establish funding mechanisms for accelerating and streamlining the processes for
112 targeted standards development and for standards adoption.
113
- 114 1.9 Adequately fund health IT to support the influx of patients into Medicaid
115 programs due to enactment of the [Patient Protection and Affordable Care Act](#)
116 [\(ACA\)](#), H.R. 3590.
117
- 118 1.10 Direct federal programs to incentivize and make available care coordination
119 activities among healthcare providers that serve those patients whose care is the
120 most costly, such as patients suffering from more than one chronic condition, are
121 located in remote locations, receive care from multiple providers, or require long-
122 term care services, and those residing in medically underserved and health
123 professional shortage areas. Care coordination activities should utilize health IT,
124 especially telehealth, to promote best practices and preventative care.
125
- 126 1.11 Fund educational programs that help facilitate compliance with standards and
127 regulations that are underway, including HIPAA modifications, version 5010, and
128 ICD-10 transformation.
129
- 130 1.12 Recommend that HHS issue guidance and funding to the states to begin
131 implementing the state loan program for EHRs as required by HITECH.
132
- 133 1.13 Establish a Small Business Administration loan program for healthcare
134 practitioners and allied professionals who need funding for EHRs and related HIT
135 projects.

136

137 **2. Quality and Outcomes**

138 Quality is the degree to which health services for individuals and populations increase the
139 likelihood of desired health outcomes and are consistent with current professional
140 knowledge. Quality characteristics include appropriateness, availability, continuity,
141 efficacy, effectiveness, efficiency, safety, timeliness, patient satisfaction, stability, health
142 improvement and value. Continuous improvement in the quality of both medical care
143 and the health of the nation's citizens are supported by a scientific approach to the
144 development and reporting of electronic clinical quality measures. Performance
145 improvement results from leveraging health IT to capture data and apply changes to
146 workflow processes to improve efficiencies and quality outcomes.

147

148 2.1 Transform clinical care processes with health information technology as an
149 enabler of quality.

150 2.2 Develop strategies to identify and prevent unintended consequences from EHR
151 functionality and other integrated health IT.

152 2.3 Establish and fund a National Measurement Enterprise that consists of open and
153 transparent measure development, measure endorsement ([National Quality
154 Forum](#)), and measure application ([NQF's Measure Applications Partnership](#)).
155 This National Measurement Enterprise should be connected and linked to clinical
156 decision support (CDS) and to a set of improvement activities in a balanced way.
157 This organization requires transparency in all aspects of the organization and its
158 processes to improve communication and collaboration, enable providers and
159 other stakeholders to help with early planning and implementing new quality
160 measures, and achieving the expected outcomes in the desired timeframe.

161 2.4 Support care coordination through an integrated healthcare community, including
162 the healthcare consumer, where enabling technologies promote usable, efficient,
163 transferable and seamless information flow, including improved safety, quality,
164 and processes of care delivery. As such, support should be given to the efforts of
165 the [National Priorities Partnership](#) (NPP), a multi-stakeholder group convened by
166 the National Quality Forum, which emphasizes the need to coordinate care to
167 drive efficiencies. NPP's eight goal areas focus on the need to eliminate harm,
168 waste, and disparities in the healthcare system:

169 (1) Patient and Family Engagement

170 (2) Safety

171 (3) Care Coordination

172 (4) Palliative and End-of-Life Care

173 (5) Elimination of Overuse

174 (6) Population Health

175 (7) Equitable Access

176 (8) Infrastructure Supports

177

- 178 2.5 Support the continual exploration of performance improvement in settings beyond
179 the traditional settings of hospital and physician office, to include rural, long-
180 term, rehabilitation, community-based, home care, behavioral health, pharmacies
181 and public health based settings, whereby data and information necessary for
182 managing the health of these populations is shared.
- 183 2.6 All quality related efforts should address issues of disparity; including racial and
184 ethnic, urban and rural, gender, and issues of disability.
- 185 2.7 Expand the focus from quality improvement to performance improvement, the
186 latter encompassing not only a quality perspective but also the costs of care
187 delivery and by extrapolation, efficiency considerations.
- 188 2.8 Require CMS and ONC to implement an aggressive, and thorough, quality
189 measures testing program to ensure that measures have been adequately specified
190 and tested before requiring them for meaningful use.
- 191 2.9 Align EHR incentive program quality reporting requirements with other Federal
192 reporting/incentive programs.
- 193
194
- 195 2.10 Develop meaningful use quality criteria which enhance clinical workflow and
196 are defined in a way that will not interfere with provider and practice workflow.
197 Measures and reporting of care should be captured and reported as outcomes care
198 delivery. Patient-centered decision support should be delivered to providers in a
199 manner consistent with optimal workflow.
200

201 **3. Organizational Structure**

202 The administration of the nation's healthcare programs requires efficient and
203 collaborative coordination among government and private sector organizations.
204

- 205 3.1 Fund research to identify financially sustainable business models involving
206 providers, payers, and healthcare information exchange (HIE) service providers to
207 facilitate the secure exchange of health information and make the results of that
208 research widely known.
209
- 210 3.2 Continue support for health IT initiatives and research to transform healthcare
211 within and collaboratively among all federal organizations including the Agency
212 for Healthcare Research and Quality (AHRQ), Centers for Medicare and
213 Medicaid Services (CMS), Centers for Disease Control and Prevention (CDC),
214 Department of Veterans Affairs (VA), Department of Defense (DoD), the
215 National Institute of Standards and Technology (NIST), Health Resources and
216 Services Administration (HRSA), Indian Health Service (IHS), Substance Abuse
217 and Mental Health Services Administration (SAMHSA), National Institutes of
218 Health (NIH), and the Office of Minority Health (OMH) within HHS; provide
219 similar coordination at the state level, and among private, and non-profit entities.
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- 221 3.3 Support the Secretary of Defense and Secretary of Veterans Affairs' efforts to
222 implement a virtual lifetime electronic record (VLER) that is interoperable with
223 civilian entities and that supports care for service members, veterans,
224 beneficiaries, and their families.
225
- 226 3.4 Continue to support the ONC in its efforts to work collaboratively with a broad
227 community of stakeholders to establish a prioritized health transformation
228 roadmap and timeline that sets goals and priorities for healthcare improvement
229 enabled through health IT. This roadmap and timeline should serve as the basis
230 for implementing all transformation activities including incentives, process and
231 technology improvements, and legal reform. It should aim to align various health
232 IT compliance related initiatives, including Meaningful Use, ICD-10, 5010, and
233 many provisions in the ACA. The National Coordinator should facilitate a
234 "clearinghouse" that provides a simple, consolidated communications tool and
235 comprehensive roadmap with supporting information on the many key initiatives
236 that impact the health IT community and the providers they serve.
237
- 238 3.5 Support initiatives that incorporate deep understanding and knowledge of
239 Management Engineering and Process Improvement principles along with
240 information technologies, e.g., oppose legislation mandating staff-to-patient ratios
241 that are fixed and universal without accounting for important related factors like
242 IT systems, facility and layout features, patient turnover, patient acuity, staff
243 education and training and workflow.
244
- 245 3.6 Require Regional Extension Centers (RECs) and other organizations using federal
246 funds that provide educational programs to report on their efforts assisting
247 providers in attaining meaningful use, to take advantage of the tools and resources
248 offered by established non-profits, to share best practices in their efforts, and to
249 offer education and training on required federal quality metrics.
250
- 251 3.7 Ensure that eligibility requirements for meaningful use are clear and realistic.
252 Recommend that HHS publish criteria defining each new meaningful Stage at
253 least 18 months before the beginning of the next stage to allow adequate time for
254 industry to develop its response, certification to occur, if needed, and providers to
255 implement the software and process changes needed. Given some likely
256 challenges with meeting this timing, we urge CMS to consider several approaches
257 that can help mitigate this issue, such as allowing the early adopters (providers
258 that started in FY11) to remain at Stage 1 for FY13, looking to possible
259 congressional action to remove the requirement for Medicare meaningful use
260 years to be successive (as is allowed in the Medicaid program), shifting from 3
261 stages to 2 stages in the timeframe between now and 2015, accelerating the
262 regulatory process, and minimizing the addition of new functionality for Stage 2.
263 Fundamentally, providers and vendors need far more time than has been publicly
264 forecast by ONC and CMS between when meaningful Stage 2 standards and
265 certification criteria are finalized and when the next stage begins.
266

- 267 3.8 Include patient-centered nursing care measures in meaningful Stage 2 as nurses
268 represent the greatest number of potential users of certified EHR technologies,
269 accounting for up to 90% of patient care in hospitals, and consequently, a large
270 portion of the patient care documented in the EHR is completed by nurses. These
271 measures would be developed in conjunction with the nursing community.
272
- 273 3.9 Ensure that CMS establishes processes for providers to understand the basis upon
274 which CMS determined whether the provider qualified as a “meaningful user” so
275 that the provider is able to communicate with CMS regarding grievances and seek
276 redress if it believes that CMS (or its contractors) have made an error or omission.
277
- 278 3.10 Ensure that the certification criteria process is further developed and applied in an
279 open and transparent fashion, with substantial provider and vendor input.
280
- 281 3.11 Encourage the Secretary of HHS to maintain a roadmap reflecting the needs for
282 robust, secure data exchange across multiple levels within the U.S. and across the
283 stages of meaningful use. Such a roadmap should reflect the necessary level of
284 funding and coordination needed to achieve the nationwide exchange of health
285 information.
286
- 287 3.12 Congress should exercise its oversight authority through the following activities:
288 A) Call upon the Government Accountability Office (GAO) to conduct periodic
289 studies to ensure that the healthcare industry is making timely progress in
290 implementing the health IT components of ARRA, and that federal funds are
291 adequately being applied to those components; and B) convene oversight hearings
292 to ensure that ARRA’s health IT components are being carried out in a
293 transparent, accountable, and effective manner if the GAO studies identify any
294 concerns or irregularities.
295
- 296 3.13 Facilitate a competitive market for healthcare information systems, where the
297 development and routine updating of a healthcare information system better meets
298 the needs of patients and society. A strong partnership should be in place between
299 the government and the private sector that will facilitate the implementation and
300 on-going operation of health IT systems through strategic planning, resource
301 management, and both public and private investments. Government should seek
302 all opportunities to benefit from the innovation that comes from the private sector,
303 while the private sector should encourage discoveries and address unmet needs
304 that come from the public sector.
305

306 **4. Safety, Standards, Infrastructure, and Innovation**

307 Progress from isolated to integrated health records requires standardization of
308 technologies and content to allow accurate and timely electronic exchange.
309

- 310 4.1 Support the development of a nationwide health IT infrastructure that facilitates
311 the use and maintenance of a lifelong EHR and PHR across various care settings
312 and activities, such as acute, ambulatory, long-term, community, home care,

- 313 public health, as well as business continuity and disaster preparedness planning
314 activities) through innovative care models, such as patient centered medical
315 homes.
316
- 317 4.2 Encourage the responsible use of data at the secondary level by those with access
318 to such data consistent with the American Medical Informatics Association
319 (AMIA) and the American Health Information Management Association's
320 (AHIMA) [Recommendations on Secondary Use of Data Ownership/Stewardship](#),
321 including but not limited to:
322 (a) Focus on data control and stewardship rather than data ownership;
323 (b) Consensus on privacy policy and security;
324 (c) Public awareness; adoption of policies and procedures which lead to
325 "trust" among the stakeholders;
326 (d) Comprehensive scope (beginning with a taxonomy); and
327 (e) National leadership.
328
- 329 4.3 Encourage and facilitate the portability of electronic health information based
330 upon adopted standards, detailed implementation guides, and profiles that cover
331 message content, terminologies and interpretation of the standards, as well as
332 message transport, security, terminology, authentication and patient identification.
333 These standards should be recognized through an open, consensus based, multi-
334 stakeholder process and should be widely tested and reviewed. Previous work
335 completed by HITSP, IHE, and HHS and should be incorporated into the process.
336 A forward-looking roadmap should be developed that reflects a longer-term
337 national roadmap for health IT interoperability.
338
- 339 4.4 Encourage electronic prescribing (not fax), computerized provider order entry
340 (CPOE), and bar coding administration, all supported by point of care clinical
341 decision support (CDS) as part of a full medication management plan integrated
342 into a complete patient medication list within the EHR. In that these strategies
343 avoid adverse events and near misses, save lives, reduce medication errors and
344 reduce costs.
345
- 346 4.5 Support upgrades to modern coding systems on a timely and regular basis and
347 streamline the healthcare standards implementation process by working with
348 relevant stakeholders in rulemaking processes to determine how best to enable
349 flexibility in keeping standards in place with the industry through a timely and
350 predictable process.
351
- 352 4.6 Promote the public-private development, coordination and use of harmonized
353 standards to support the coding and reporting of defined quality measures,
354 interoperability, public reporting, other components of healthcare, as well as work
355 products such as standards, implementation guides, integration profiles, and
356 technical reports.
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- 358 4.7 Support the harmonization of U.S. and international health IT standards and
359 establish funding mechanisms for accelerating the processes for targeted
360 standards development and for standards adoption to offset potential resource
361 shortages.
362
- 363 4.8 Support the development and use of standardized semantics for data used in HIEs
364 between healthcare enterprises and ambulatory practices.
365
- 366 4.9 Ensure that public funding is only appropriated for the purchase or upgrade of
367 certified EHR systems among providers and payers who participate in federally-
368 funded health programs.
369
- 370 4.10 Ensure that the Drug Enforcement Administration (DEA) completes and releases
371 a final regulation for the e-prescribing of controlled substances that does not
372 reduce the benefits of e-prescribing.
373
- 374 4.11 Support the regular updating of standards, implementation specifications, and
375 operating rules for the electronic exchange and use of health IT for purposes of
376 financial and administrative simplification. It is essential that implementation
377 specification and operating rules are clearly defined for both vendors and
378 providers. Administrative simplification efforts should not undermine the
379 standards development process; they should be transparent and predictable for the
380 healthcare IT community.
381
- 382 4.12 Ensure that ONC continues to rely on an open, transparent, multi-stakeholder
383 standards harmonization process, building on the work of recognized Standards
384 Development Organizations (SDOs), and profiling organizations, in development
385 of health IT standards.
386
- 387 4.13 Promote the development of standards for behavioral health electronic systems
388 and genomics.
389
- 390 4.14 Support the development and use of IT that will provide information required by
391 Accountable Care Organizations (ACO) to effectively manage and treat patients
392 across the continuum of care including Outpatient, Inpatient, Ancillary and Post
393 Acute Care settings.
394
- 395 4.15 Support a patient safety initiatives for health IT that (1) takes into account the
396 importance of innovation through the development and implementation of EHR
397 technology and (2) supports the dissemination and incorporation of lessons
398 learned on unintended consequences (e-iatrogenesis) into education and training
399 of health IT implementation and use, to enable enhanced patient safety and to
400 minimize adverse events.
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- 402 4.16 Support research funding in the field of human factors related to EHRs and related
403 technologies such as ordering, documentation, and decision support. Such
404 research will allow development of evidence-based usability guidelines for EHRs.
405
- 406 4.17 Support the promotion and reporting of improvements in patient safety that are
407 directly attributable from the EHR and associated functionality.
408

409 **5. Privacy and Security**

410 The development of trust requires recognition, management and enforcement of strong
411 security and privacy principles.
412

- 413 5.1 Encourage initiatives for individual electronic health information to be made
414 available to patients in a private and secure electronic manner, except when
415 exempted by law.
416
- 417 5.2 Promote measures to protect the confidentiality, integrity, and the timely
418 availability of essential information and services.
419
- 420 5.3 Recognize the necessity and value of electronic access and exchange of Personal
421 Health Information (PHI) in ensuring safe, high quality healthcare, support
422 measures that enable essential, appropriate, and secure information access and
423 exchange without imposing requirements that are technically or operationally
424 impractical, overly burdensome or that could otherwise result in unintended
425 consequences.
426
- 427 5.4 Support measures that provide consumers with a reasonable opportunity and
428 capability to make informed decisions about the collection, use and disclosure of
429 their personal health information, while at the same time preserving the capability
430 for authorized entities to collect, maintain, use, disclose and exchange information
431 for authorized purposes. These measures should help patients understand the
432 health, safety, and privacy risks associated with their access decisions.
433
- 434 5.5 Promote compliance with the privacy and security provisions of federal and state
435 laws and regulations to protect patients' health information.
436
- 437 5.6 Promote the use of independently validated IT and telecommunications
438 infrastructures to provide the appropriate levels of privacy and information
439 security.
440
- 441 5.7 Support and contribute to the efforts of the National Committee on Vital and
442 Health Statistics (NCVHS), and other federal advisory committees that promote
443 the privacy and security of health information.
444
- 445 5.8 Develop and implement workable measures to inform and assist patients whose
446 PHI has been compromised. Breach notification provisions should consider or be

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- 447 triggered by the risk of harm that may result from their disclosure, as opposed to
448 merely the number of records breached.
449
- 450 5.9 Support measures to detect and inform patients of potential fraudulent use of their
451 medical identities, and to enable them to offer amendments to erroneous
452 information contained in their medical records as a result of such use.
453
- 454 5.10 Promote federal and state enforcement measures that: (1) Support compliance
455 with the privacy and security rules and standards and deter non-compliance; and
456 (2) enforce penalties to those who intentionally access information without
457 requisite authority or legitimate purpose, or whose reckless or grossly negligent
458 privacy and security practices lead to inappropriate disclosures.
459
- 460 5.11 Support the promulgation of an updated, pragmatic and useful privacy and
461 security policy framework, and the consistent use of this framework to govern the
462 appropriate use, disclosure, and exchange of PHI across all federal and state
463 healthcare enterprises.
464
- 465 5.12 Support HHS efforts to arrive at workable provisions requiring the accounting of
466 PHI disclosures, limited initially to disclosures of structured information and
467 moving toward full accountability, as supporting technology is certified by a
468 federally recognized certification body and becomes available. Encourage HHS
469 to develop a roadmap for enabling an accounting of disclosures as a goal.
470
- 471 5.13 Request that the Secretary of HHS study the issues addressing the benefits, harms
472 and definitions relating to the sale of PHI and to report findings and policy
473 options.
474
- 475 5.14 Support policies that enable and facilitate the use of health information in
476 collaborative clinical and translational research, including identification of cohort
477 populations, recruitment of patients and doctors, and comparative effectiveness
478 studies, while minimizing risk to individual privacy and security.
479
- 480 5.15 Support establishment of an informed patient identity solution. Because the U.S.
481 Congress has banned HHS from spending any resources to study a Unique
482 Identifier (UI) solution, recommend that Congress direct the GAO to conduct a
483 study of the technology options of implementing a UI solution. Based on the
484 results of this study, Congress should lift the ban and direct HHS to study the
485 cost/benefit and practicality of implementing a UI solution and to establish pilot
486 implementations of unique identifiers to document the challenges and benefits.
487
- 488 5.16 Support the harmonization of federal and state privacy and security policies.
489
- 490 5.17 Encourage business policies and practices that include annual, formal assessment
491 of privacy and security risk, and that allocate appropriate resources for on-going
492 security operations.

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- 5.18 Support the use of [Fair Information Practices](#) as a basis for establishing sound information laws, policies, and practices to support and promote good data stewardship and foster public trust in the collection, access, use, and disclosure of individually identifiable health information.
- 5.19 Support processes that allow for data base research involving statistical analysis of broad populations on such data bases where there is no publication of personal health information and ensure that neither the structure of the query nor its results might lead to privacy violations or concerns.

6. Legal

EHR systems bring new legal questions and laws must be adapted to the new technology.

- 6.1 Expand and make permanent the current [Stark exemptions and anti-kickback safe harbors](#) for EHRs to cover additional healthcare software, related devices, and implementation activities that apply federally recognized standards and interoperability specifications and are certified by federally recognized certification and testing bodies. This activity should aid in the advancement of meaningful use of certified EHR technology and allow for better coordination of care and information sharing among care or clinical providers (e.g. physicians, nurses, pharmacists, mental health professionals, nurse practitioners, physical therapists, etc.) and their patients. In carrying out this recommendation, the Secretary should implement necessary measures and requirements to protect against conflict of interest and improper relationships among providers.
- 6.2 As national standards are adopted and deployed, promote tort reform that minimizes medical and product liability that arises from the use of interoperable health IT systems and clinical decision support tools and data, including PHRs and PBHRs, associated with such systems. The HIT Policy Committee, NCVHS, or another relevant federally recognized advisory or Congressional committee should hold hearings on aspects of tort reform for the ONC to take into consideration.
- 6.3 Support clinician liability protection related to electronic health information entered by a non-clinically licensed entity (such as patients or family members) or collected from consumer health devices while ensuring individual-provided data are represented in the clinician view of the patient record as such.
- 6.4 Support policies that promote administrative simplification as a way to improve efficiency and compliance while reducing healthcare costs. Further support that covered entities, business associates, and subcontractors use their formal contractual arrangements rather than business associate agreements to (a) explicitly define their permitted uses and disclosures for the business associates to perform their responsibilities, and (b) include a simple statement affirming that

538 business associates as regulated entities agree to comply with the Privacy and
539 Security Rules of HIPAA and HITECH.

540

541 6.5 Recommend elimination of the Business Associate Agreement (BAA)
542 requirement. The direct liability for HIPAA imposed on business associates
543 under HITECH obviates the need for covered entities and business associates to
544 enter BAAs that recite the Rules as a vehicle to manage privacy and security
545 compliance. Maintaining a BAA requirement under HITECH is unduly
546 burdensome and costly for the healthcare industry.

547

548 6.6 Recommend that the Office of Civil Rights (OCR) also further define the term
549 “business associates,” with particular reference to the extent to which the conduit
550 exception applies.

551

552 **7. Patient Empowerment**

553 Putting health information into the hands of patients supports individual responsibility for
554 health care decisions.

555

556 7.1 Provide public and private incentives that encourage and educate patients’ and
557 providers’ utilization of electronic health information with respect for the privacy
558 and security of personal health information and the promotion of health literacy.

559

560 7.2 Require all Medicare and Medicaid contractors or fee-for-service programs to
561 create and make available PHRs and PBHRs for the beneficiaries of such
562 programs. In addition, Medicare and Medicaid contractors or fee-for-service
563 programs should provide incentives to beneficiaries to aid in adoption and
564 utilization of PHRs and PBHRs, including those associated with interoperable
565 provider EHRs.

566

567 7.3 Support the use of health IT, portable technology, and social media to facilitate
568 appropriate and timely consumer awareness and to facilitate and aid decision
569 making in privacy decisions; increase patient/provider communications; reduce
570 medical errors; increase patient safety; manage advance directives; improve the
571 transparency of price, cost and quality; foster trustworthiness among stakeholders;
572 and positively impact the health and quality of life for all individuals residing in
573 the U.S.

574

575 7.4 Develop a strategy which facilitates the innovative development and ongoing
576 operation of private and secure interoperable systems that allow patients to view
577 and appropriately contribute patient notes to their complete clinical record,
578 including individual controlled personal health technologies, and make
579 determinations regarding how the information is shared and/or used for secondary
580 purposes. Such a strategy should align with efforts pertaining to meaningful use.
581 The strategy should include the exploration of what policies and standards are
582 necessary for personal health systems that may become the core of lifetime health
583 record systems in the long-term, and which may be the source of clinical data that

584 is sent to the healthcare providers with the expectation that clinicians will use this
585 information to make clinical decisions.

586

587 7.5 Support policies that aid lay caregivers (i.e. proxies) for adults and minors in
588 accessing and using individual health information electronically for those for
589 whom they provide care when authorized by law or by consent of the consumer
590 receiving lay care.

591

592 **8. Equity and Access**

593 Patients and the healthcare providers who care for them, deserve comparable support for
594 electronic health information technology unaffected by race, ethnicity, gender, geography
595 or health financing.

596

597 8.1 Provide grants and other incentives to establish Health IT Action Zones that
598 demonstrate effective practices for promoting the adoption of health IT by
599 licensed clinicians who provide care to patients in vulnerable populations, as well
600 as by providers who care for patients who are medically underserved, including in
601 rural areas, and are impacted by health and/or digital disparities.

602

603 8.2 Support the robust implementation of a mix of broadband-enabled healthcare
604 technologies to increase access to quality health services for all so that the proper
605 infrastructure is in place to support access to healthcare in rural and underserved
606 communities. Broadband efforts should be coordinated across all relevant federal
607 agencies including: the Federal Communications Commission; National
608 Telecommunications and Information Administration; and the Rural Utilities
609 Service.

610

611 8.3 Encourage private and federal payers to support the use of health IT to utilize
612 telemedicine/telehealth applications for remote patient monitoring, patient-
613 centered medical homes, Accountable Care Organizations, e-visits, telehomecare
614 services, consultations and direct patient care using interactive audio/visual
615 systems.

616

617 8.4 Authorize and appropriate funds for public awareness programs to inform patients
618 about the benefits of health IT (e.g. improvements in the quality, cost, and access
619 to healthcare, as well as patient safety). These programs should be culturally and
620 linguistically focused and appropriate and should be conducted by entities that
621 can demonstrate relevant capacities and experience with respect to the
622 communities of focus. Special focus should also be added to the aging
623 population, to identify and reduce barriers precluding their efficient participation
624 in the healthcare system.

625

626 8.5 Recognize remote telehealth visits provided by homecare agencies or similar
627 organizations, as well as e-visits by physician and nursing providers, especially
628 related to patient-centered medical homes and ACOs for the purposes of
629 eligibility and payment by Medicare, similar to in-home, in-person visits. Such

630 telehealth visits need to be reimbursed by all payers (federal, state, and
631 commercial). HIMSS supports the [American Telemedicine Association's](#)
632 [recommendation](#) that the Secretary of HHS should evaluate and make
633 recommendations to the U.S. Congress to broaden Medicare reimbursement of
634 telehealth and e-health services.

635

636 8.6 Promote free access to electronic health information by patients who may be
637 hampered by the “digital divide” or otherwise unable to gain access.

638

639 8.7 Develop and support assessments and strategy for culturally and linguistically
640 relevant outreach efforts to promote health IT adoption and study the issue of
641 cultural sensitivity as it relates to health IT adoption.

642

643 8.8 Collect provider data by race, ethnicity, gender, geography and other appropriate
644 indicators and at a minimum report on an annual basis the participation of
645 providers serving underserved communities, to include underrepresented minority
646 providers, in order to determine the extent to which these providers, and the
647 patients they serve, are benefiting from meaningful use incentives and other
648 health IT initiatives.

649

650 **9. Population Health**

651 Integrated electronic health records support the need for private and accurate health
652 monitoring and response of disease outbreaks and public emergencies.

653

654 9.1 Encourage the use of health information facilitated by EHRs and HIEs and
655 secondary use services inside and outside of direct healthcare delivery to enable
656 rapid detection and on-going characterization and monitoring of public health
657 events for the purpose of triggering appropriate early response, including
658 syndromic surveillance, resource management, facilities planning and modeling,
659 and improvement of public health, while protecting patient privacy.

660

661 9.2 Support initiatives that facilitate the flow of reliable health information (such as
662 vaccine administration data) among population health and clinical care systems
663 necessary to protect and improve public health while ensuring patient privacy.

664

665 9.3 Develop, in conjunction with innovative care models, the use of information from
666 EHRs to improve healthcare outcomes in public and population health in order to
667 advance future strategies to improve population health outcomes through the
668 development of models, pilots, and innovative strategies.

669

670 9.4 Encourage support for the development and implementation of health IT to
671 prepare for, mitigate, and respond to complex natural and man-made disasters.

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673 **10. Workforce Development**

674 The automation of the nation’s healthcare system requires sufficient numbers of educated
675 and experienced professionals in a variety of roles.

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- 10.1 Promote the development and perpetuation of a well-trained, diverse workforce that understands the knowledge, data and wisdom of technology and informatics and is competent to deliver high quality healthcare using health IT. The educational audience includes:
- (A) Health IT Professionals: Increasing numbers of expert staff are needed to develop, install, and support healthcare software and infrastructure. Recommend continued development of programs, informatics competencies and tuition support for health IT professionals. Since certification ensures standardization of professionals' skills, we recommend the recognition of standardized programs and certifications such as CPHIMS that ensure quality workers.
 - (B) Clinical Staff: Physicians, nurses and other clinicians need training and education to use clinical software effortlessly and effectively. Knowledge of health IT and its use must be a core competency to ensure accurate documentation by healthcare professionals that reflects the patient's story, supports effective clinical decision support that promotes positive outcomes, and yields data that can be used to assess outcomes. The bedside caregivers are instrumental in ensuring this transition. In addition, provide tuition support and continuing education credit for such education. Include methods that can enhance or provide on-site training for clinical staff.
 - (C) Health IT Educators: The educator plays a key role in the delivery of effective health IT education. Recommend the development of programs concerning the delivery of informatics curricula and tuition support. Hold programs accountable for demonstrating incorporation of health IT competencies into training programs with assessment, ongoing optimization, and integration of health IT use in the training environments of healthcare professionals. Recommend required inclusion of basic computer literacy, knowledge assessment and informatics education in undergraduate and graduate medical, nursing and all clinical discipline academic programs, utilizing the recommendations developed by the [TIGER \(Technology Informatics Guiding Education Reform\) Initiative](#) and [CAHME](#) (Commission on Accreditation of Healthcare Management Education).
- 10.2 Provide assistance to institutions to establish or expand clinical health informatics education programs which are inclusive of the needs of the medical, nursing, and other clinical professions.
- 10.3 Encourage the Secretary of HHS, NIH, or any other similar federal entity to conduct a study concerning the needs and strategies to enhance the health IT workforce that includes clinical informatics (nursing, medical, pharmacy and other providers), and health information management (HIM) professionals.

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- 721 10.4 Continue to authorize and appropriate adequate funding for the Director of the
722 National Science Foundation (NSF), in consultation with ONC, to award
723 competitive grants to institutions of higher learning to establish and improve
724 undergraduate and master’s degree health information programs, focused on
725 informatics, IT, and HIM studies. Grants should be administered to institutions of
726 higher learning based on need, capacity, and demonstration of a plan for applying
727 the grants. Institutions of higher learning can apply the grants to develop and
728 revise curricula, establish degree and certificate programs, acquire equipment
729 necessary for student instruction, collaborate with other academic institutions, or
730 establish student internships within local, state, and federal governments, and
731 other activities.
732
- 733 10.5 Support federal, state and private programs that assist providers implement HIT,
734 such as Regional Extension Centers, to train the work force with the selection,
735 implementation, and management of healthcare information systems to improve
736 quality, safety and health outcomes. Encourage scholarship, matching grant
737 funding and loan repayment programs to support this effort.
738
- 739 10.6 Expand or establish new workforce development and training programs that not
740 only provide resources to support health IT curricula, but require the programs to
741 engage in “pipeline” channels (e.g., technically focused middle/high schools,
742 community colleges, AmeriCorps, veterans’ employment and training programs)
743 and support informatics competencies, particularly in underserved communities,
744 through which potential skilled workers can be identified, engage in internships,
745 be recruited and prepared for health IT-related careers.
746

747 **11. Administrative Simplification**

748 Waste of resources can be reduced by the establishment of efficient business practices
749 that take advantage of automation.

- 750
- 751 11.1 Align federal policy in order to facilitate the electronic business processes that can
752 markedly reduce inefficiency in the healthcare financial infrastructure and support
753 real time information management that can impact quality of care.
754
- 755 11.2 As our nation evolves a policy for patient identity integrity, review other
756 industries that have experienced similar issues around evolving systems and
757 information where a person’s identity is critical to operational integrity. In some
758 cases, it may be advisable to leverage existing systems, process and procedures,
759 that are currently funded at a high cost to society.
760
- 761 11.3 All sectors of the health industry, including those outside of HHS and the federal
762 agencies, should use ICD-10 as a foundational element. A clear and concise
763 vendor roadmap is needed to help clinicians meet [version 5010/ICD-10 deadlines](#).
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765

766 **CONCLUSION**

767 HIMSS is prepared to assist and support all stakeholders to ensure that these policy
768 principles are enacted into laws and regulations to transform our healthcare system using
769 IT. We are prepared to devote our available resources to help make these policy
770 principles a reality. Please contact HIMSS at policy@himss.org.