

**2009 HIMSS Principles on Government Initiatives**  
**Approved March 6, 2009; Updated December 8, 2009**

**SUMMARY**

The members of the Healthcare Information and Management Systems Society (HIMSS) believe 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. Our mission is to lead healthcare transformation through the effective use of healthcare IT.

Since 1961, HIMSS has been the healthcare industry's membership organization exclusively focused on providing global leadership for the optimal use of healthcare IT and management systems for the betterment of healthcare. Today, with offices in Chicago, Ann Arbor, Washington D.C., Brussels, Singapore and other locations across the United States, HIMSS represents more than 20,000 individual members – of which 73% work in provider settings – and over 350 corporate members that collectively represent organizations employing millions of people.

Each year, HIMSS creates principles for all stakeholders to consider for inclusion as provisions in any legislation proposed by the U.S. Congress or state legislatures to transform healthcare or for inclusion in federal and state regulations. For 2009, HIMSS addresses nine separate categories of principles:

1. Funding and Incentives
2. Healthcare Delivery Transformation
3. Standards
4. Privacy and Security
5. Legal
6. Structural
7. Consumer Empowerment
8. Population Health Monitoring
9. Workforce

Most importantly, HIMSS believes that the U.S. has healthcare IT adoption gap. To address the gap, we believe that:

- Funding of healthcare IT needs to tie directly to adoption incentives, and
- Legislation needs to be enacted to promote healthcare IT initiatives by endorsing the integration of IT into the delivery of patient care and the support of health and wellness.

By linking these principles, HIMSS believes our nation can successfully transform healthcare.

44 **1. Funding and Incentives**

45  
46 1.1. Fully fund all federal initiatives to provide critical resources to complete the goals of the  
47 Health Information Technology Executive Order 13335 for most Americans to have an  
48 electronic health record by 2014 or sooner. Initiatives include informing clinical practice,  
49 interconnecting providers, personalizing care, engaging diverse individuals and communities,  
50 empowering consumers with access to electronic health records and telehealth services, and  
51 improving population health.<sup>1</sup>

52  
53 1.2. Reform reimbursement methodologies to: (a) provide incentives and ongoing  
54 reimbursement for higher quality of care, with a focus on preventive medicine, chronic  
55 disease management, remote monitoring, care coordination, patient-centered medical home  
56 activities, and the use of enabling healthcare IT services; (b) enable health improvements  
57 through IT; (c) overcome the broad adoption gap that is growing nationally; (d) encourage  
58 that standard reimbursement be provided to independent licensed practitioners who use  
59 healthcare IT to deliver clinical consultations and direct patient care services. Incentives need  
60 to have end dates and apply a sliding scale of financial incentives so that those who adopt  
61 sooner would receive a higher amount than those who choose to stall the initiative; and (e)  
62 promote a robust healthcare IT infrastructure that promotes the availability of medical results  
63 to the practitioner, leading to less duplication of services (and thereby reducing costs).

64  
65 1.3. Establish clinical performance goals and reimbursement that can be supported to the  
66 largest extent possible by healthcare IT infrastructure.

67  
68 1.4. Provide sustainable funding business models (including grants, loans and redefining  
69 reimbursement structures involving providers, payers, and healthcare information exchange  
70 [HIE] service providers) for the secure exchange of health information to federally  
71 recognized local/regional/state collaborations of providers, health settings, health plans,  
72 consumers, employers and others; and grants and loans for enabling the secure exchange of  
73 health information in accordance with standards and policies as established by the  
74 Department of Health and Human Services (HHS).

75  
76 1.5. Provide funding such as grants and loans, or other incentives such as significant tax  
77 benefits, to healthcare providers, employers, health plans and other health entities for  
78 adoption of IT that meets national interoperability standards and certification criteria for  
79 providing patient care.

80  
81 1.6. Authorize and appropriate funding for grants and other incentives to establish Healthcare  
82 IT Action Zones that demonstrate effective practices for promoting the adoption of healthcare  
83 IT by clinicians who provide care to individuals in vulnerable populations, as well as by lay  
84 and professional providers who care for patients who are medically underserved and are

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<sup>1</sup> Strategies to implement initiatives included in Executive Order 13335: Incentivizing electronic health record (EHR) adoption, reducing the risk of EHR investment, promoting EHR diffusion in rural and underserved areas, fostering regional collaborations, developing a national health information network, coordinating federal health information systems, encouraging use of personal health records (PHRs), enhancing informed consumer choice, promoting use of telehealth systems, unifying public health surveillance architectures, streamlining quality and health status monitoring, and accelerating research and dissemination of evidence.

85 impacted by health and/or digital disparities. Healthcare IT Action Zones should also apply  
86 healthcare IT to foster model clinical practices disease management, address primary  
87 prevention and co-occurring chronic conditions, and target patients with low health literacy.  
88 Grants and other incentives should require the application of Healthcare Information  
89 Technology Standards Panel (HITSP) interoperability specifications and healthcare IT  
90 products certified by the Certification Commission for Health Information Technology  
91 (CCHIT). In addition, the U.S. Congress should require the HHS Secretary, in collaboration  
92 with a senior level federal administrator for healthcare IT, to conduct a study evaluating the  
93 impact of Healthcare IT Action Zones and make recommendations regarding the use of  
94 healthcare IT to improve the health and healthcare of racial and ethnic minority groups.  
95

96 1.7. Require that federal and state government agencies remove barriers to the adoption of  
97 healthcare IT across all healthcare segments and constituents consistent with maintaining  
98 privacy and security standards. Encourage the interoperability of healthcare IT systems  
99 across healthcare segments and constituents and the integration of interoperable data into  
100 existing IT systems to support the workflow of all end users.  
101

102 1.8. Continue to support and expand research funding for healthcare IT in organizations such  
103 as the Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and  
104 Medicaid Services (CMS), Centers for Disease Control and Prevention (CDC), Veterans  
105 Affairs (VA), Department of Defense (DoD), and appropriate state, private, and non-profit  
106 entities.  
107

108 1.9. Support the harmonization of international healthcare IT standards and establish funding  
109 mechanisms for accelerating the processes for standards development/publishing  
110 organizations to offset potential resource shortages.  
111

112 1.10. Implement policies and funding that will ensure a robust healthcare IT workforce in the  
113 future.  
114

115 1.11. Provide public and private incentives that encourage and educate consumer utilization  
116 of electronic health information.  
117

118 1.12. Mandate an end to the use of paper checks for reimbursements among payers and  
119 providers of federally-funded healthcare programs. This action could serve as a tipping point  
120 for all payers and providers throughout the U.S. to use electronic direct deposit which could  
121 save more than \$6 billion in healthcare expenditures.  
122

123 1.13. The U.S. Congress should direct the Secretary of HHS to incentivize all acute care  
124 providers that contract with Medicare and Medicaid or receive federal funding to achieve  
125 EMRAM Stage 4<sup>2</sup> implementation no later December 31, 2014. EMRAM Stage 4 indicates

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<sup>2</sup> HIMSS Analytics' EMRAM identifies the levels of EMR capabilities of the 5,071 non-federal medical/surgical U.S. hospitals. EMRAM levels range from Stage 0 – Stage 7. EMRAM Stage 0 indicates that a hospital has one or two, but not all three ancillary departmental systems to support the laboratory, pharmacy, or radiology. EMRAM Stage 4 indicates that a hospital has a clinical data repository, nursing documentation on at least one unit, remote access to its PACS, and uses computerized practitioner order entry and decision support protocols on at least one unit other than the emergency department, Stage 7 indicates that a hospital has a paperless EMR environment, the ability to share summary clinical and

126 that a hospital has a clinical data repository, nursing documentation on at least one unit,  
127 remote access to its PACS, and uses computerized practitioner order entry and decision  
128 support protocols on at least one unit other than the emergency department. To carry-out this  
129 requirement, the Secretary should provide adequate incentives such as grants, loans, and tax  
130 benefits to providers for the purchase, implementation, change management, and staff  
131 training of electronic medical record (EMR) products that apply HITSP specifications and are  
132 CCHIT-certified.

133

134 1.14. The U.S. Congress should direct the Secretary of HHS to incentivize all ambulatory  
135 care providers that contract with Medicare and Medicaid or receive federal funding to  
136 achieve EMR adoption to accomplish results such as, but not limited to, data repositories,  
137 basic medication management, electronic prescribing, clinical decision support and reliability  
138 no later than December 31, 2014. To carry-out this requirement, the Secretary should  
139 provide adequate incentives such as grants, loans, and tax benefits to providers for the  
140 purchase, implementation, change management, and staff training of EMR products that  
141 apply HITSP interoperability specifications, are CCHIT-certified and are integrated with  
142 practice payment systems.

143

144 1.15. The U.S. Congress should direct the Secretary of Defense and Secretary of Veterans  
145 Affairs to review their healthcare IT programs and institute necessary requirements to  
146 advance EMR adoption by civilian entities that provide care to beneficiaries and their  
147 families.

148

149 1.16. The U.S. Congress should expand the State Children's Health Insurance Program  
150 (SCHIP), Medicaid, and Federal Medical Assistance Percentages (FMAP) by providing  
151 funding to support the adoption of EMRs, PHRs, and payer-based health records (PBHRs)  
152 for Medicaid and SCHIP providers who deliver healthcare to children, with the goal of  
153 expanding the widespread use of payer data and EMRs among providers to exhibit a  
154 minimum level of functionality, to include but not be limited to data repositories, basic  
155 medication management, electronic prescribing, clinical decision support and reliability no  
156 later than December 31, 2014. CMS should be empowered to coordinate activities with other  
157 agencies to ensure Federally Qualified Health Centers (FQHCs) and Community Health  
158 Centers are engaged in the activity. State Medicaid and SCHIP programs would have the  
159 authority to determine how to best allocate the funds among providers and payers, requiring  
160 that funds be used for the application of HITSP interoperability specifications and CCHIT-  
161 certified healthcare IT products to improve the delivery of healthcare.

162

163 1.17. Invest a minimum of \$25 billion on healthcare IT, by investing a minimum of \$5 billion  
164 per year for five years on healthcare IT in non-governmental hospitals and physician  
165 practices that contract with or receive funding from federal sources.

166

167 1.18. Expand the Federal Communication Commission's (FCC) Rural Healthcare Pilot  
168 Project (RHCPP) to incorporate not only rural healthcare providers, but all providers in  
169 underserved communities that require access to telehealth networks. In addition, the U.S.

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administrative information within HIEs, physician clinics or other hospitals, as well as patients, and  
clinical data warehousing and data mining capabilities to analyze their care data to improve protocols and  
patient care.

170 Congress should require a study and report within one year after expansion of the RHCPP, to  
171 evaluate strengths and weaknesses within the program.

172

173 1.19. Direct the Secretary of HHS to require all Medicare and Medicaid contractors or fee-  
174 for-service programs to create and make available PHRs and PBHRs for the beneficiaries of  
175 such programs. In addition, Medicare and Medicaid contractors or fee-for-service programs  
176 should provide incentives to beneficiaries to aid in adoption and utilization of PHRs and  
177 PBHRs.

178

## 179 **2. Healthcare Delivery Transformation**

180

181 2.1. Support a nationwide healthcare IT infrastructure that facilitates the use and maintenance  
182 of a lifelong EHR.

183

184 2.2. Require a senior-level healthcare IT position, within the Administration, such as the  
185 National Coordinator for Health Information Technology, to work with a broad community  
186 of stakeholders,<sup>3</sup> to establish a prioritized health transformation roadmap and timeline that  
187 sets goals and priorities for healthcare improvement, including the creation of a national  
188 roadmap for clinical decision support. The roadmap should be the basis for implementing  
189 other transformation activities including incentives, process and technology improvements,  
190 and legal reform.

191

192 2.3. Encourage quality forums and consensus organizations such the Ambulatory Care  
193 Quality Alliance and Hospital Quality Alliance, the National Quality Forum (NQF), HITSP,  
194 and other nationally recognized entities that provide healthcare-related quality metrics,  
195 protocols and guidance to develop measures that support and implement these priorities  
196 based on electronic sources of data.

197

198 2.4. Require HHS to collaborate with diverse stakeholders to build consensus and endorse  
199 sets of commonly defined quality measures utilizing healthcare IT that could be used to  
200 reward providers that demonstrate performance excellence in providing patient-centric care.

201

202 2.5. Support initiatives that voluntarily apply the processes of incorporating IT to clinician  
203 staffing, supporting such legislation that incorporates elements such as: accommodating  
204 facility and layout features, patient turnover, patient acuity, and staff education and training  
205 when determining proper clinician staffing. Proper integration of management engineering,  
206 process improvement, and information technologies, across the continuum of care, can have  
207 significant impact on personnel efficiency, staffing requirements and high quality patient  
208 outcome. Therefore, support the techniques and technologies to optimize the productivity of  
209 personnel, while adjusting workload based on variations in patient requirements and the local  
210 care-giving environment. Oppose mandating nurse-to-patient ratios that are fixed and  
211 universal.

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<sup>3</sup> Stakeholders include, but are not limited to providers, consultants, consumers, employers, federal and state agencies/coordination bodies, industry alliances, payers/insurance companies, providers (including safety net providers), public health agencies, purchasers, quality organizations, researchers, standard development organizations, think tanks, and vendors. Recommendations from an AMIA developed roadmap (<http://www.amia.org/inside/initiatives/cds/>) should be considered and incorporated where appropriate into any proposed legislation or regulation.

- 212  
213 2.6. Encourage the responsible use of data at the secondary level by those with access to such  
214 data consistent with the American Medical Informatics Association's (AMIA)  
215 Recommendations on Secondary Use of Data, including but not limited to:  
216  
217 2.6.1. Transparent policies and practices for the secondary use of health data;  
218 2.6.2. Focus on data control rather than data ownership per se;  
219 2.6.3. Consensus on privacy policy and security;  
220 2.6.4. Public awareness;  
221 2.6.5. Comprehensive scope (beginning with a taxonomy); and  
222 2.6.6. National leadership.  
223  
224 2.7. Encourage healthcare transparency in all operational aspects of administrative, financial,  
225 and clinical initiatives.  
226  
227 2.8. Encourage and facilitate the portability of electronic health information based upon  
228 interoperability specifications established by HITSP.  
229  
230 2.9. Encourage electronic prescribing as part of a full medication management plan integrated  
231 into an EHR with clinical decision support as a way to save lives, reduce medication errors  
232 and reduce costs.  
233  
234 2.10. Encourage and support the use of healthcare IT to support telemedicine/ telehealth  
235 applications for remote patient monitoring, e-visits, telehomecare services, consultations and  
236 direct patient care using interactive audio/visual systems.

### 237 **3. Standards**

- 238  
239  
240 3.1. Require that private sector organizations doing business with, submitting data to, or  
241 otherwise exchanging health information with federal and state agencies utilize the same  
242 interoperability specifications established by HITSP.  
243  
244 3.2. Support upgrades to modern coding systems on a timely and regular basis and streamline  
245 the healthcare standards' implementation process by working with the industry in its rule-  
246 making process to determine how best to afford flexibility in keeping standards in pace with  
247 the industry through a timely and predicable process.  
248  
249 3.3. Promote development of harmonized standards to support the coding and reporting of  
250 defined quality measures.  
251  
252 3.4. Support the development and use of standardized semantics for data used in health  
253 information exchanges between healthcare enterprises.  
254  
255 3.5. Apply HITSP and CCHIT among all federally funded health programs and require that  
256 any funding appropriated for the purchase or upgrade of new healthcare IT products among  
257 providers and payers of federally funded health programs be allocated only for the use of  
258 healthcare IT products that apply HITSP interoperability specifications and are CCHIT-  
259 certified. This requirement should be enforced only when appropriate standards and certified

260 products are available on the market. In addition, no later than December 31, 2014, all  
261 federally funded health programs and all organizations that directly conduct business with  
262 federally funded health programs must adhere to these same requirements.

263

264 3.6. The U.S. Congress should codify HITSP as the national harmonization body responsible  
265 for collaborating with the public and private sector to achieve a widely accepted and useful  
266 set of standards to enable the widespread interoperability among healthcare software  
267 applications.

268

#### 269 **4. Privacy and Security**

270

271 4.1. Encourage that electronic health information be made available in a private and secure  
272 electronic manner to individuals, except as exempted by law.

273

274 4.2. Promote measures to protect the confidentiality, integrity and availability of personal  
275 health information.

276

277 4.3. Support measures that provide individuals a reasonable opportunity and capability to  
278 make informed decisions about the collection, use and disclosure of their personal health  
279 information, while at the same time preserving the capability for covered entities to collect,  
280 maintain, use, disclose and exchange information for treatment, payment and healthcare  
281 operations.

282

283 4.4. Support measures that enable providers to access an individual's medical records in  
284 order to ensure timely, appropriate and quality healthcare.

285

286 4.5. Support measures that help individuals understand the value of access to health  
287 information and the privacy and health risks associated with access decisions.

288

289 4.6. Ensure the privacy and security of an individual's health information by requiring  
290 compliance with the privacy and security rules of the Health Insurance Portability and  
291 Accountability Act (HIPAA) by entities that collect, store, or exchange health information.

292

293 4.7. Promote the use of IT and telecommunications infrastructures that have been  
294 independently verified to provide the appropriate levels of information security.

295

296 4.8. Support measures that are consistent with the National Committee on Vital and Health  
297 Statistics' (NCVHS) recommendations regarding the privacy and security of health  
298 information.

299

300 4.9. Support existing or proposed legislation that is consistent with (a) HIPAA; (b) HIPAA-  
301 compatible state legislation; and (c) IHE (Integrating the Healthcare Enterprise), HITSP  
302 CCHIT, and HHS regulation.

303

304 4.10. Support workable measures to inform and aid individuals whose personal health  
305 information (PHI) has been inappropriately accessed. Breach notification provisions should  
306 consider or be triggered by the risk of harm that may result from the disclosure, as opposed to

- 307 merely the number of records breached. Ramifications of notifications where there is little  
308 possibility of further harm would only confuse and worry patients.
- 309
- 310 4.11. Support measures to detect and inform individuals of potential fraudulent use of their  
311 medical identity, and enable them to offer amendments to erroneous information contained in  
312 their medical records as a result of such use.
- 313
- 314 4.12. Promote enforcement measures that (1) support compliance with the rules and  
315 standards, and deter non-compliance; and (2) punish those who intentionally access  
316 information without requisite authority or legitimate purpose, or whose reckless or grossly  
317 negligent privacy and security practices lead to inappropriate disclosures.
- 318
- 319 4.13. Recognizing the necessity and value of electronic access and exchange of PHI in  
320 ensuring safe, high quality healthcare, support measures that enable essential and appropriate  
321 access without imposing undue or unreasonable requirements that are technically or  
322 operationally impractical, or otherwise could result in unintended consequences.
- 323
- 324 4.14 Charge the Secretary of HHS to complete a study, within one year, on the current legal  
325 and regulatory environment affecting the uses and disclosures of electronic PHI. This study  
326 should include HIPAA privacy and security rules, state privacy laws, and other applicable  
327 federal and state laws and regulations (e.g., financial, fair information practices, consumer  
328 protection, etc). The study should review the work of the ONC, Health Information Security  
329 and Privacy Collaboration (HISPC), HITSP, and relevant work from other organizations. The  
330 study would result in the timely development of a pragmatic roadmap or framework  
331 concerning the appropriate uses and disclosures of PHI and any policy recommendations  
332 necessary to support the exchange of health information between public and private sectors.  
333 The study should be facilitated by the senior healthcare IT leaders within the Administration  
334 and carried out by a balanced representation of healthcare, patient, and information  
335 technology stakeholders.
- 336
- 337 4.15 Support provisions requiring the accounting of PHI disclosures, limited initially to  
338 disclosures of structured information and moving toward full accountability as supporting  
339 technology is certified and becomes available. Encourage standards and certification  
340 organizations, under the guidance of the Secretary of HHS, to develop a roadmap for  
341 enabling full accounting of disclosures.
- 342
- 343 4.16 Charge the Secretary of HHS to study the issues relating to the sale of PHI.
- 344
- 345 4.17 Support provisions that maintain that federal officials be responsible for the enforcement  
346 of federal laws for the sake of consistency in application. Oppose provisions that give state  
347 attorneys general the authority to bring civil action as a means of enforcing the HIPAA  
348 Privacy Rule. The Department of Justice and the HHS Office for Civil Rights (OCR) already  
349 have substantial authority to pursue criminal and civil enforcement of the HIPAA Privacy  
350 Rule.
- 351
- 352 4.18 Support policies that enable and facilitate the use of health information in  
353 collaborative clinical and translational research, including identification of cohort

354 populations, recruitment of patients and doctors, and comparative effectiveness studies,  
355 while minimizing risk to individual privacy.

356

357 4.19 HIMSS calls for the Secretary of HHS, under the direction of the U.S. Congress, to  
358 establish an informed patient identity solution. As part of this solution, steps need to  
359 include: a) Congressional lifting of the prohibition against HHS studying UI solutions;  
360 b) HHS conducting a study of the cost/benefit and practicality of implementing a UI  
361 solution; and, c) HHS establishing pilot implementations of unique identifiers to  
362 document the challenges and benefits.

363

## 364 **5. Legal**

365

366 5.1. The Secretary of HHS should expand and make permanent the current Stark exemptions  
367 and Anti-kickback safe harbors for EMRs to cover additional healthcare software and related  
368 devices that apply HITSP interoperability specifications, are CCHIT-certified, and allow for  
369 better coordination of care and information sharing among related providers and their  
370 patients. In facilitating this recommendation, the Secretary should implement necessary  
371 measures and requirements to protect against conflict of interest and improper relationships  
372 among providers.

373

374 5.2. Reduce the cost of health information exchange network development and facilitate  
375 adoption by providers by making such networks immune from liability for merely  
376 transmitting information, and by limiting civil liability for those providers that in good faith  
377 rely upon patient data provided through such networks.

378

379 5.3. Promote tort reform that minimizes medical liability that arises from the use of  
380 interoperable healthcare IT systems and clinical decision support tools associated with such  
381 systems.

382

383 5.4. Support clinician liability protection related to electronic health information entered by a  
384 non-clinically licensed entity (such as patients or family members), while ensuring  
385 individual-provided data is presented in the clinician view of the patient record.

386

## 387 **6. Structural**

388

389 6.1. Codify a senior-level health-IT position within the Administration to oversee national  
390 healthcare IT strategy and carry out necessary responsibilities.

391

392 6.2. Support HITSP's public-private standards harmonization process for development of  
393 interoperability specifications including work products (e.g., standards, implementation  
394 guides, integration profiles, technical reports) to meet the critical common health information  
395 exchange needs as identified by HHS. HHS should provide guidelines for CCHIT to use in  
396 developing test scripts and criteria.

397

398 6.3. Promote sustainable organizations that facilitate the free flow exchange of electronic  
399 health information and ensure the protection of individual privacy.

400

401 6.4. Ensure that public and private stakeholders continue to be actively engaged in the  
402 planning and development of healthcare IT initiatives throughout the U.S. Create a  
403 committee on healthcare IT that is based on the experiences of the AHIC successor  
404 organization, and that is developed to advise a senior level healthcare IT leader within the  
405 administration.

406  
407 6.5. Conduct a White House Summit on Healthcare Reform through Information Technology.  
408 The Summit should provide an opportunity for leading healthcare IT stakeholders to develop  
409 consensus and propose solutions to critical, national healthcare IT issues within the context of  
410 the larger national healthcare reform debate. The bipartisan summit should include  
411 representatives from all stakeholders groups, including clinicians and consumers, with a goal  
412 to propose and support immediate legislative and regulatory changes that can transform our  
413 nation's healthcare system.

414  
415 6.6. Remote telehealth visits provided by homecare agencies or related organizations should  
416 be appropriately recognized for the purposes of eligibility and payment by Medicare and  
417 Medicaid similarly to in-home, face-to-face visits.

418  
419 6.7. The Secretary of HHS should evaluate and make recommendations to the U.S. Congress  
420 to broaden Medicare reimbursement of telehealth services.

421

## 422 **7. Consumer Empowerment**

423

424 7.1. Support the use of IT to facilitate individual control of health decisions to ensure patient  
425 privacy; increase patient/provider communications; reduce medical errors; increase patient  
426 safety; improve the transparency of price, cost and quality; and positively impact the health  
427 and quality of life for all individuals residing in the U.S.

428

429 7.2. Facilitate development and ongoing operation of private and secure interoperable  
430 systems that allow patients to view and contribute to their complete clinical record, including  
431 individual controlled personal health technologies, and make determinations regarding how  
432 the information is shared and/or used for secondary purposes.

433

434 7.3. Promote free access to electronic health information by individuals hampered by the  
435 "digital divide" (e.g., using public libraries to promote access to medical records through  
436 Internet access without degrading secure channels).

437

438 7.4. Require measures that are consistent with the AHIMA e-HIMTM work group's Personal  
439 Health Record recommendations,<sup>4</sup> including the definition and attributes of the PHR,  
440 minimum common data elements to be included in a PHR, and consumer education and tools  
441 to promote the PHR.

442

443 7.5. For individual electronic health information, require measures that are consistent with  
444 the HIMSS e-PHR definition and position statement.<sup>5</sup>

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<sup>4</sup> <http://www.myphr.com>

<sup>5</sup> <http://www.hims.org/content/files/PHRDefinition071707.pdf>

446 7.6. Support creating electronic registries for living wills to provide clear direction to  
447 physicians on patients' choices, enable organ donation requests to be clearly delineated, and  
448 ensure that optimal and palliative care is given without necessarily prolonging life without  
449 patient consent/intent.

450

451 7.7. Support the data collection in the PHR, EHR and EMR of patient/consumer's medical  
452 directive, including Advance Care Directives (to direct a person's medical care if he or she  
453 becomes unable to do so), and organ donations with the long-term goal of incorporating real-  
454 time interoperability between PHRs, EHRs and EMRs and the electronic registries for living  
455 wills.

456

457 7.8. Support initiatives to improve efficiency and effectiveness of healthcare and reduce fraud  
458 in order to enable any savings to be used to expand coverage for those individuals with no  
459 healthcare options.

460

461 7.9. Support outreach efforts to promote healthcare IT adoption by acquainting diverse  
462 communities with healthcare IT utilization options, benefits, and privacy safeguard, utilizing  
463 activities and strategies that are culturally appropriate, and engage, to the fullest extent  
464 possible, community stakeholders in the development, execution and evaluation of such  
465 efforts.

466

467 7.10. Allow individuals to electronically transfer their data to third parties.

468

469 7.11. Require measures that acknowledge and support the role of the individual in managing  
470 privacy and health through his/her dynamic control of the collection, use, disclosure, and  
471 exchange of PHI.

472

473 7.12. Require that personalized quality measure alerts and reminders be available to  
474 individuals in their PHRs.

475

476 7.13. Support measures that aid lay caregivers for adults and minors in accessing and using  
477 individual health information electronically for those for whom they provide care when  
478 authorized by law or by consent of the individual receiving lay care.

479

480 7.14. Support the Secretary of HHS, with the direction of the U.S. Congress, to establish a  
481 patient identity solution.

482

## 483 **8. Population Health Monitoring**

484

485 8.1. Encourage the use of electronic health records and secondary use services to enable rapid  
486 detection and on-going characterization and monitoring of public health events for the  
487 purpose of triggering appropriate early response including resource management, facilities'  
488 planning and modeling.

489

490 8.2. Support initiatives that facilitate the flow of reliable health information among  
491 population health and clinical care systems necessary to protect and improve the public's  
492 health while ensuring the patient's privacy.

493

494 8.3. Encourage the development and utilization of healthcare IT-related data collection and  
495 analysis strategies that will inform policymakers regarding the possible disparate impacts on  
496 specific population groups of public health events.

497

## 498 **9. Workforce**

499

500 9.1 Promote a well-trained workforce that understands the benefits of implementing and  
501 using healthcare IT. The educational audience encompasses three perspectives:

502 9.1.1. Healthcare IT Technicians: Increasing numbers of expert staff needed to develop,  
503 install, and support healthcare software and infrastructure. Recommend development  
504 of programs and tuition support for healthcare IT technicians.

505 9.1.2. Clinical Staff: Physicians, nurses and other clinicians need training to become not  
506 only computer-adept but facile in the use of specific software. Recommend required  
507 inclusion of computer literacy and healthcare IT education in medical, nursing and all  
508 clinical discipline academic programs. In addition, provide tuition support and  
509 continuing education credit for such education.

510 9.1.3. Healthcare IT Educators: The educator plays a key role in the delivery of effective  
511 healthcare IT education. Recommend the development of programs concerning the  
512 delivery of healthcare IT curricula and tuition support.

513 9.1.4. Include methods that enhance or provide in-place training.

514

515 9.2 Assistance should be provided to institutions to establish or expand clinical health  
516 informatics education programs and is inclusive of the needs of the medical, nursing, and  
517 other clinical professions.

518

519 9.3 The Secretary of HHS should conduct a study concerning the needs and strategies to  
520 enhance the healthcare IT workforce that includes IT, health information management  
521 (HIM), and biomedical informatics (BMI) studies professionals.

522

523 9.4 The U.S. Congress should authorize and appropriate adequate funding for the Director of  
524 the National Science Foundation (NSF), in consultation with the National Coordinator, to  
525 award competitive grants to institutions of higher education to establish and improve  
526 undergraduate and master's degree healthcare information programs, focused on IT, HIM,  
527 and BMI studies. In consultation with the National Coordinator, the NSF should administer  
528 grants in a systematic manner that will provide training and education for 10,000 individuals  
529 within the healthcare informatics workforce. Grants should be administered to institutions of  
530 higher education based on need, capacity, and demonstrate a plan for applying the grants.  
531 Institutions of higher education can apply the grants to develop and revise curriculum,  
532 establish degree and certificate programs, acquire equipment that is necessary for student  
533 instruction, establish collaboration with academic institutions, establish student internships  
534 within local, state, and federal governments, and other activities approved by the Secretary of  
535 HHS.

536

## 537 **CONCLUSION**

538 HIMSS is prepared to assist and support all stakeholders to ensure that these principles are  
539 enacted into law and regulations to transform our healthcare system. We are prepared to  
540 devote our available resources to help make these principles a reality. Please contact HIMSS  
541 at [advocacy@himss.org](mailto:advocacy@himss.org).