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2
3 Ms. Marilyn Tavenner
4 Acting Administrator
5 Centers for Medicare and Medicaid Services
6 U.S. Department of Health & Human Services
7 Washington, DC 20201

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9 Dr. Farzad Mostashari, M.D., ScM
10 National Coordinator
11 Office of the National Coordinator for Health IT
12 U.S. Department of Health and Human Services
13 Washington, DC 20201

14
15 Dear Ms. Tavenner and Dr. Mostashari,

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17 On behalf of the [Healthcare Information and Management Systems Society \(HIMSS\)](http://www.himss.org), we are
18 pleased to provide written comments to the Centers for Medicare and Medicaid Services (CMS)
19 and the Office of the National Coordinator for Health IT (ONC) on its [Request for Information](#)
20 [\[CMS-0038-NC\] Advancing Interoperability and Health Information Exchange](#). We appreciate
21 the continued dialogue with CMS and ONC on this critical issue.

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23 HIMSS is a cause-based, not-for-profit organization exclusively focused on leading global
24 endeavors optimizing health engagements and care outcomes through information technology.
25 Founded 52 years ago, HIMSS and its related organizations are headquartered in Chicago with
26 additional offices in the United States, Europe and Asia. HIMSS represents nearly 50,000
27 individual members, of which more than two thirds work in healthcare provider, governmental
28 and not-for-profit organizations. HIMSS also includes over 570 corporate members and more
29 than 225 not-for-profit partner organizations that share our vision of better health through
30 information technology. HIMSS frames and leads healthcare practices and public policy through
31 its content expertise, professional development, research initiatives, and media vehicles designed
32 to promote information and management systems' contributions to improving the quality, safety,
33 access, and cost-effectiveness of patient care.

34
35 HIMSS supports the advancement of interoperable health information systems, including and
36 extending beyond electronic health records (EHRs), to address the functional needs of the full
37 spectrum of healthcare delivery organizations, population and public health agencies, patients,
38 and other healthcare programs.¹ In our [2013-2014 Public Policy Principles](#), we recommend that a
39 forward-looking roadmap should be developed as part of a longer-term national strategy for
40 health IT interoperability –the ability of health information systems to work together within and
41 across organizational boundaries in order to advance the health status of, and the effective

¹ HIMSS 2013-2014 Public Policy Principles: <http://himss.files.cms-plus.com/FileDownloads/HIMSS-Public-Policy-Principles-2013-2014.pdf>

42 delivery of healthcare for, individuals and communities.² We appreciate the efforts of CMS and
43 ONC to identify these potential solutions.

44

45 **RFI Questions**

46

47 *Question 1: What changes in payment policy would have the most impact on the electronic*
48 *exchange of health information, particularly among those organizations that are market*
49 *competitors?*

50

51 HIMSS notes that reforming payment models to improve the delivery of healthcare, control
52 costs, and promote system sustainability can be done by:

53

- 54 • Incorporating value based purchasing (e.g. outcomes-based payment, aggregated risk-
55 shifting and shared savings/risk models, bundled payments, capitation, and ACOs for
56 both public and private payers).
- 57 • Narrowing the IT adoption gap among providers based on their location, size of practice,
58 and available resources.
- 59 • Supporting standard reimbursement regardless of modality and location for independent
60 licensed practitioners who use health IT to deliver clinical consultation and direct patient
61 care services.
- 62 • Promote consumer engagement by making electronic health information more easily
63 accessible to patients

64

65 HIMSS sees evolving care models, such as Accountable Care Organizations and pay for
66 performance policies that reward organizations for care coordination and quality outcomes as
67 essential to promoting the exchange of health information across providers and facilities. These
68 strategies incentivize the exchange of patient information among participants across various
69 provider settings, including long-term post-acute care (LTPAC) and behavioral health. HIMSS
70 strongly supports the development and use of IT that will provide healthcare data required by
71 emerging care delivery and business models and payment structures like ACOs to effectively
72 manage and treat patients across the continuum of care, including outpatient, inpatient, ancillary,
73 emergency, and post- acute care settings.³

74

75 *Question 2: Which of the following programs are having the greatest impact on encouraging*
76 *electronic health information exchange?*

77

- 78 • *hospital readmission payment adjustments*
- 79 • *value-based purchasing*
- 80 • *bundled payments*
- 81 • *ACOs*
- 82 • *Medicare Advantage*
- 83 • *Medicare and Medicaid EHR Incentive Programs (MU)*

² HIMSS *Dictionary of Healthcare Information Technology Terms, Acronyms and Organizations*, 3rd Edition, 2013, p. 75.

³ HIMSS 2013-2014 Public Policy Principles: <http://himss.files.cms-plus.com/FileDownloads/HIMSS-Public-Policy-Principles-2013-2014.pdf>

84 • *medical/health homes*

85

86 *Are there any aspects of the design or implementation of these programs that are limiting their*
87 *potential impact on encouraging care coordination and quality improvement across settings of*
88 *care and among organizations that are market competitors?*

89

90 HIMSS sees market competition as a driving force for information exchange. We note that
91 determining the greatest impact of any of the relatively recent programs listed above may prove
92 difficult, since measuring long-term impacts under existing market conditions can't yet be done.
93 In regard to ACOs, HIMSS observes that there may be several points where CMS could
94 emphasize or encourage HIE as part of this activity. However, as financial incentives have the
95 potential to make information hoarding more profitable, we caution against inadvertently
96 creating new silos that could prohibit information exchange. To mitigate this risk, additional
97 benefits could be granted to the patient-centered medical home or ACO participating
98 organizations that achieve standardized levels of clinical information.

99

100 *Question 3: To what extent do current CMS payment policies encourage or impede electronic*
101 *information exchange across health care provider organizations, particularly those that may be*
102 *market competitors? Furthermore, what CMS and ONC programs and policies would*
103 *specifically address the cultural and economic disincentives for HIE that result in ‘data lock-*
104 *in’ or restricting consumer and provider choice in services and providers? Are there specific*
105 *ways in which providers and vendors could be encouraged to send, receive, and integrate health*
106 *information from other treating providers outside of their practice or system?*

107

108 HIMSS notes that liability concerns are frequently cited as a barrier for adoption, including
109 interstate data sharing, accuracy of the data, completeness of data and integration of patient-
110 supplied data. One barrier to HIE commonly cited is that cyberliability insurance is becoming
111 increasingly expensive. HIMSS supports programs to identify and encourage financially
112 sustainable business models that facilitate the secure exchange of interoperable health
113 information. Payment policies that pose economic disincentives could offset data lock-in, and
114 encourage information flow, could lead to greater exchange. Additionally, a mechanism that
115 could encourage vendors to integrate information from other platforms is greater cost
116 transparency of interfaces, particularly in implementing interfaces required for interoperability.

117

118 *Question 4: What CMS and ONC policies and programs would most impact post-acute, long*
119 *term care providers (institutional and HCBS) and behavioral health providers’ (for example,*
120 *mental health and substance use disorders) exchange of health information, including electronic*
121 *HIE, with other treating providers? How should these programs and policies be developed*
122 *and/or implemented to maximize the impact on care coordination and quality improvement?*

123

124 HIMSS supports incentivizing adoption of health IT that enhances care coordination activities
125 between healthcare providers, especially those requiring LTPAC services. Additionally, we
126 support the continual exploration of performance improvement across all settings including the
127 traditional settings of hospital and clinical offices, rural, long-term, rehabilitation, community-
128 based, home care, behavioral health, ambulatory treatment/surgery centers, physician extenders,
129 pharmacies, and public health based settings in quality improvement initiatives. Anecdotal
130 evidence suggests that some healthcare delivery organizations exclude behavioral health from

131 their centralized EHR or HIE policies, which can hinder comprehensive care for a patient. We
132 suggest that increased education and training around HIPAA and other privacy and security
133 measures could help enable trusted data exchange.

134
135 One suggestion is for the government to mitigate the potential impact of OCR's Final Accounting
136 for Disclosures Privacy Rule. If the government maintains the approach it outlined in the
137 [Accounting of Disclosures Draft Rule](#), it will likely have a significant impact (in terms of cost
138 and burden) on provider adoption of EHR and participation in HIE. This will impact providers,
139 LTPAC, home health and behavioral health. Further, as the efforts of HIEs and ACOs progress,
140 we encourage ONC to monitor the impact in terms of added administrative burden to
141 organizations as well as desired outcomes. Finally, HIMSS acknowledges that there are varying
142 federal and state laws addressing behavioral health information and patient consent. We request
143 guidance and clarity on how consent issues can be addressed, and what viable options exist,
144 within the scope of behavioral health information exchange.

145
146 *Question 5: How could CMS and states use existing authorities to better support electronic and*
147 *interoperable HIE among Medicare and Medicaid providers, including post-acute, long-term*
148 *care and behavioral health providers?*

149
150 We note that existing authorities from CMS and states could include:

- 151
- 152 ▪ CMS grant programs, such as the Innovation grants associated with Medicaid, could be
153 expanded to facilitate HIE deployment and active use.
 - 154 ▪ 45 CFR Part 2 focuses on sharing substance abuse information under federally funded
155 programs. Anecdotal evidence appears to reflect that this is often interpreted too broadly, and
156 we seek clarification and education on proper interpretation so that this information can
157 potentially be folded into an HIE infrastructure.
 - 158 ▪ Inclusion of administrative and payment data, beyond clinical data used in HIE.
 - 159 ▪ Leverage existing federal funding mechanisms to support the provider sector. We note that
160 although the Regional Extension Center funding will expire, the RECs could be used to
161 propel LTPAC, SNFs/NFs, NPs, home health, post-acute and behavioral health providers in
162 adoption and use of health IT and leverage of HIE.
 - 163 ▪ State Medicaid agencies have the authority to set their reimbursement methodology and can
164 accommodate health IT. CMS could provide guidance that validates the ways the states are
165 allowed to utilize this authority.
 - 166 ▪ Levers that could encourage increased alignment with current state requirements that
167 providers are utilizing could boost HIE among entities—these can include state Controlled
168 Substance Databases and immunization registries.

169
170 Anecdotal evidence suggests that CMS provider regions may not be processing claims in a
171 uniform manner. This causes delays to providers using national vendors, and CMS could further
172 enhance the current system with more advanced enterprise data integration (EDI) support. CMS
173 Intermediaries can provide better technical support for the EDI submission of Medicare A and B
174 claims. The intermediaries often deny or suspend claims for formatting errors without
175 appropriate description of the problem to providers. This makes it difficult to fix problems and

176 delays claim processing and payments and is burdensome on providers wishing to advance their
177 system further in HIE adoption.

178
179 HIMSS notes that the Office of the Inspector General (OIG) Anti-Kickback Safe Harbors⁴ and
180 CMS; Physician Self-Referral (Stark) Exceptions⁵ for EHR technology encourages electronic
181 exchanges by removing barriers to stakeholder connectivity and funding for engagement among
182 participants in health information exchange. Permanently codifying these Safe Harbors and
183 Exceptions, which expire at the end of the year, would help protect healthcare organizations and
184 providers of health IT systems and software services from legal action. HIMSS also recommends
185 extending the existing OIG Safe Harbors and CMS Self-Referral Exceptions to other software
186 and devices, especially those supporting HIE.

187
188 Finally, ONC could work with non-profits to support wikis or list-servs to capture the
189 experiences of those that have implemented and used the standards to further refine them to a
190 useful state, as well as providing a repository of experience for subsequent attempts to
191 implement. The feedback loop could inform best practices, as well as areas that need to be
192 modified to achieve intended goals rather than adverse, unintended consequences. ONC could
193 capture best practices for managing mental health/behavioral health information to deliver
194 improved care.

195
196 *Question 6: a) How can CMS leverage regulatory requirements for acceptable quality in the*
197 *operation of health care entities, such as conditions of participation for hospitals or*
198 *requirements for SNFs, NFs, and home health to support and accelerate electronic,*
199 *interoperable health information exchange?*

200
201 HIMSS acknowledges that CMS has already begun the process of tying quality of care to the
202 Quality Indicator Survey (QIS). For LTPAC, this survey process assesses compliance with
203 federal law and state operations regulations, and the QIS survey process could include additional
204 data processing support for providers. Further, states could implement a health IT survey process
205 that could both support consistent quality and assist providers in understanding standards and
206 regulations.

207
208 Currently for LTPAC, CMS uses data submission (MDS 3.0) requirements to leverage payments
209 and gather quality assurance information. The authority to interpret and regulate is delegated to
210 state health agencies through the survey process, and claims submission follows the MDS
211 submission since the MDS supports the claim. This is a data processing intensive process, yet
212 there are currently no incentives for enhancing data analysis and additional data exchange with
213 local acute care and physician organizations. Data requirements (type of information to be
214 exchanged) for transfer from one provider to another are varied. If CMS could create a standard
215 for data requirements that meets the needs of the providers, then providers would have an
216 incentive to comply, thus potentially fostering increased interoperability across the health care
217 enterprise.

⁴ HIMSS 2013 Letter to OIG:

http://www.himss.org/files/HIMSSorg/Content/files/FinalHIMSSCommentsOIG_SafeHarbor_February2013.pdf

⁵ HIMSS 2013 to CMS:

http://www.himss.org/files/HIMSSorg/Content/files/HIMSSLetterCMSStarkExceptions_February2013.pdf

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Related to information technology, CMS could evaluate priorities so that "foundational" IT components of the transformational process are emphasized, incentivized, and implemented first so that subsequent analytics, compliance, and accountability reporting are less problematic and costly to develop in terms of capital and manpower. Specifically, interoperability standards can be put in place that create a basis for efficient information exchange and data sharing, rather than requiring reporting before standardization.

Other points that HIMSS suggests for ONC and CMS are as follows:

- Explore ways to link SNFs, NFs and home health provider Medicare and Medicaid payment to the hospitals. Investigate tying reimbursement requirements to electronic data exchange between hospitals, physicians and SNFs, NFs, and home health.
- Align and harmonize the SNF/NF standard reporting form (MDS) with additional reporting requirements including standardized data elements. This would ensure alignment and would directly impact the quality of reporting.
- Investigate the feasibility of standardizing the quality measures so they could be reported through an HIE organization.
- Continue work to coordinate “data dictionaries” or vocabulary/transmission standards.
- CMS’ ability to require identical data element definitions, structure and syntax for the use of electronic health record data when it’s used for administrative purposes, could be replicated to harmonize the electronic claim attachment standard and the electronic claim of medical data for all administrative purposes.

b) How could requirements for acceptable quality that involve health information exchange be phased in over time? HIMSS suggests that the current work on care transition by the [Standards & Interoperability Framework](#) will help this area. Given the growing number of SNFs/NFs, along with the challenges of monitoring them for quality and compliance, HIMSS sees a need to establish cost effective measures for compliance. Information capture at these sites can be minimal and will have to mature in line with the growing infrastructure of health IT that supports more formal sites of care like hospitals and clinics. The advent of mobile devices and applications offer information gathering portals that can ride on existing infrastructure.

Question 7: How could the EHR Incentives Program advance provider directories that would support exchange of health information between Eligible Professionals participating in the program? For example, could the attestation process capture provider identifiers that could be accessed to enable exchange among participating EPs?

HIMSS supports the example listed of the attestation process capturing provider identifiers that could be accessed to enable exchange among participating eligible professionals. An individual provider identifier (electronic token and multitude of disparate applications) issued by a trusted source allows for this attestation. Similar to the process for procuring SSL certificates, the process for a health identifier should be as or more rigorous.

One approach could be further engaging EPs with incentives, so providers are part of their own credentialing, and then the information would be sent to a Directory. That way, if an entity

264 needed to know if the information was from a credible provider that can support exchange, they
265 could then consult the Directory—California is one state currently utilizing this approach.

266
267 Additional approaches by the government could include:

- 268
- 269 ▪ Identify additional policy levers to provide guidance to providers on directories, with a
270 focus on achieving interoperability with potential identification of a minimum data set to
271 reflect clinical, administrative and payment data efforts.
- 272 ▪ Explore the use of existing tools and NPIs such as the existing UPD (Universal Provider
273 Directory) as one example. Explore ways to use these tools in lieu of creating a new
274 directory. For example, the UPD could be built as a module to support existing efforts
275 rather than creating a new directory.
- 276 ▪ Consider expanding the Direct protocol through the purposes of HIE; directories become
277 valuable even for Direct, when Direct is needed to exchange with an unaffiliated entity.
- 278

279 HIMSS requests clarity around a potential “opt-in” requirement. Additionally, HIMSS notes that
280 the NwHIN Power Team and the ONC Privacy and Security Workgroup noted that “directory”
281 technology generally is embedded in larger services, such as security or transport services. The
282 two current transport standards each have, embedded within it, its own directory technology
283 (DNS for Direct, and UDDI for Exchange, LDAP optional for each). At the recommendations of
284 both the NwHIN Power Team and the Privacy and Security Workgroup, the HIT Standards
285 Committee has recommended against specifying standards for “directory” technology.

286
287 *Question 8: How can the new authorities under the Affordable Care Act for CMS test, evaluate*
288 *and scale innovative payment and service delivery models to best accelerate standards-based*
289 *electronic HIE across treating providers?*

290
291 HIMSS notes that CMS and ONC can further maximize the use of new capabilities through 2014
292 certified EHR technology (CEHRT). We note that CMS can leverage ACA section 1104
293 (standards for electronic claim attachments & supporting operating rules) that focused on
294 movement of data across clinical settings for both Medicare and Medicaid. CMS can also
295 leverage ACA section 10109 to explore opportunities to streamline and potentially consolidate
296 credentialing and enrollment in health plans. This could be extended to include HIE organization
297 participation/enrollment and would leverage technology across initiatives resulting in decreased
298 deployment costs and a reduction in technology silos. Finally, CMS could encourage ways to
299 avoid a federated approach and facilitate exploration of private sector approaches and
300 innovation, such as with a consolidated enrollment process for health plans that leverages the
301 HIE organization and other enrollment processes.

302
303 We suggest that CMS use innovation models to scale and evaluate, and align payments to an
304 outcome of quality in order to incentivize participation. For example, in an ACO, the payment
305 and service delivery models should be based on common best practices for easily measurable
306 models. There must be an HIE infrastructure in place to provide services to an ACO—there are
307 opportunities for HIEs to be an innovative space through this new payment model. There are
308 opportunities for innovation through an economic sustainability model for HIE.

309

310 *Question 9: a) What CMS and ONC policies and programs would most impact patient access*
311 *and use of their electronic health information in the management of their care and health?*

312
313 HIMSS encourages increased clarity on patient-centered and patient-provided data, and clarity
314 for physicians, hospitals and payers on who owns the data or who owns what pieces of the data.
315 We also suggest further education around the new View, Download and Transmit (VDT)
316 capabilities that are part of Meaningful Use Stage 2 and suggest also utilizing the Centers for
317 Medicare and Medicaid Innovation ([CMMI](#)) initiatives and programs where there are financial
318 incentives for patients to utilize that information.

319 The Blue Button program has had a significant impact on patient access and use, but we caution
320 against completion or conflicting between programs like Blue Button and VDT, and instead
321 encourage the use of consistent messaging across these programs. Additionally, we note that one
322 issue in patient engagement is tethered portals and the difficulty of patient navigation across
323 different providers. Finally, we encourage the government to provide educate materials for
324 patients whose primary language is not English. One proposal from HIMSS members is for CMS
325 to encourage vendors to comply with Executive Order 13166, “Improving Access to Services for
326 People with Limited English Proficiency,” as well as compliance with [Section 508 of the](#)
327 [Rehabilitation Act of 1973](#) in order to increase patient engagement in this sector.

328 *b) How should CMS and ONC develop, refine and/or implement policies and program to*
329 *maximize beneficiary access to their health information and engagement in their care?*

330
331 HIMSS notes the following approaches CMS and ONC could take:

- 332
- 333 ▪ Continue to expand and encourage innovation within Blue Button capabilities, extending
334 to auto-loading into a PHR. Also, including patient portal requirements that would
335 include a core set of requirements and address cultural competency approaches.
 - 336 ▪ Explore ways to maximize patient access to information, such as requiring access to
337 historical payer information, even once a beneficiary (patient) has changed payers.
338 Require download capability for both historical and current payer information.
 - 339 ▪ Recognize and target specific populations (e.g., chronic illnesses, family caregivers,
340 pediatrics) for focused activities that would most benefit the targeted population.
 - 341 ▪ Investigate private sector certification of PHR at same level as the current EHR
342 certification where PHRs would meet the same standards (e.g., support interoperability
343 and data aggregation). This should apply to both tethered and untethered PHRs. This type
344 of certification would go beyond basic clinical data use.
 - 345 ▪ Educate and incentivize patients and consumers to utilize these tools by providing breaks
346 on insurance premiums for using PHRs, for example. Provide more patient and
347 consumer education on the benefit and value of patient engagement and access to their
348 data.
 - 349 ▪ To assist in expansion of patient engagement, facilitate development of an agreement on
350 minimum standards of authorizations to disclose in order to allow the patient to designate
351 specific caregivers and to identify their circle of care providers and others who need to
352 access information. This proposed granular level of authorization management could be
353 accomplished with agreed-upon standards and ability to identify unique patients.

- 354 ▪ Consider including CDC and other federal agencies in order to align requirements across
- 355 all federal programs.
- 356 ▪ Consider setting a uniform policy of access for patients and parents, and caregivers, to
- 357 health records.

358
359 Finally, patient monitoring applications via Smartphones and in-home monitoring and sensor
360 technology increase the awareness of both care givers and patients and are increasingly available
361 and affordable through advances made in mobile health. Engaging patients using these emerging
362 technologies could reduce readmissions and the associated costs and penalties to provider
363 hospitals and networks. Providers, patients and families using new, advanced technologies
364 should be educated in their proper use and instructed into the possible risks (e.g. security breach
365 if the Smartphone is lost).

366
367 HIMSS members have noted that many laboratories are using proprietary codes, and increasing
368 the use of LOINC would help increase electronic exchange of laboratory results. Encouraging
369 common practices among technology providers is a first step to allowing consistent exchange
370 between labs and providers. As described in HIMSS' [Good Informatics Practices](#) (GIP), basic
371 infrastructure, security and data management practices pave the way the burden of making data
372 accessible to an EHR. Conversely, having an EHR with appropriate infrastructure and security
373 controls significantly reduces the barrier to interoperability for the provider.

374
375 We suggest that an informed [nationwide patient data matching strategy](#) would enhance
376 laboratory results, and not compromise the privacy and security of patient health information.
377 Such a nationwide patient data matching strategy does not mean a national identity number or
378 card. Technological advances now allow for much more sophisticated solutions to patient
379 identity and privacy controls, including patient consent, voluntary patient identifiers, metadata
380 identification tagging, access credentialing, and sophisticated algorithms. HIMSS strongly
381 supports a nationwide patient data matching strategy. We believe that an informed nationwide
382 patient data matching strategy would enhance, not compromise, the privacy and security of
383 patient health information.

384
385 The current state of patient data matching poses huge patient safety issues. There is no more time
386 for delay; patient data matching needs to be addressed and solved. Federal barriers need to be
387 lowered, enabling those serving in HHS to discuss this important patient safety issue. Such a
388 nationwide patient data matching strategy would not create a national identity number or card. It
389 strengthens rather than reduces participant privacy and security.

390
391 We note that in the absence of a nationwide patient data matching strategy, the states, HIEs,
392 large health plans, various consortiums, and individual electronic health record vendors have had
393 to develop individual patient identity solutions that do not necessarily work well across systems.
394 As our nation moves forward with greater urgency toward system-wide health information
395 exchange, this essential core functionality to ensure the accurate match of a patient with his or
396 her information remains conspicuously absent. The multitude of different solutions and the lack
397 of a national coordinated approach pose major challenges for our health information

398 infrastructure and result in millions of dollars of unnecessary costs. Patient safety, privacy, and
399 security depend on getting this core element right.⁶

400
401 Finally, we note that the ultimate goal would be to achieve delivery of lab results to the provider
402 and the patient at same time. In addition, a suggested set timeframe for reviewing of results
403 between physician and patient could be included to encourage dialogue. We encourage the
404 alignment of state policies with federal regulations. Levers could be identified to encourage
405 states to streamline policy and related changes that include ways to streamline future technology
406 deployment. We suggest furthering education to all providers, including reference labs, on the
407 value of receiving data electronically.

408
409 HIMSS appreciates this opportunity to provide public comment. We look forward to
410 continued dialogue with CMS, and welcome any questions you may have. For more
411 information, please contact [Thomas M. Leary](#), 703.562.8814, Vice President of
412 Government Relations, or [Stephanie Jamison](#), 703.562.8844, Director of Government
413 Services.

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415 Sincerely,

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420 Willa Fields, DNSc, RN, FHIMSS
421 Chair, HIMSS Board of Directors
422 Professor, School of Nursing,
423 San Diego State University



H. Stephen Lieber, CAE
President/CEO
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426 CC: Steve Posnack, Director, Federal Policy Division, Office of the National Coordinator for
427 Health Information Technology
428 Kelly Cronin, Health Care Reform Coordinator; Office of the National Coordinator for
429 Health Information Technology

⁶ HIMSS 2012 Policy Summit Congressional Ask:
http://www.himss.org/files/HIMSSorg/policy/d/2012_Ask1_PatientDataMatchingStrategy.pdf