Section	Act Language Overview (Key Points for HIM)	Kelly's Analysis
TITLE VIII	**Departments of Labor, Health and Human Services and Education and Related Agencies**	
Sections 1013 & 804	**Comparative Effectiveness Research (CER)** Section 1013 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 - HHS and NIH are allocated funds ($700,000,000) and regulations in this section. Agency for Healthcare Research and Quality are allocated funds and regulations in this section. Comparative Effectiveness Research (CER). ARRA provides $1.1 billion for CER, divided into $300 million to the Agency for Healthcare Research and Quality (AHRQ), $400 million to the Office of the Director of NIH, and $400 million to the Secretary of HHS. Funds are to conduct, support or synthesize research that comparing clinical outcomes, effectiveness and appropriateness of items, services and procedures used to prevent, diagnose, or treat diseases, disorders and other health conditions. Also to encourage the development and use of clinical registries, clinical data networks, and other forms of electronic health data that can be used to generate or obtain outcomes data. The funding shall be used to conduct or support research to evaluate and compare the clinical outcomes, effectiveness, risks, and benefits of two or more medical treatments and services that address a particular medical condition.	CER is potentially controversial as physicians complain that it will facilitate government meddling and mandates for treatments and care protocols, so called 'cook book medicine. The prevailing theory that is driving ARRA is that CER is crucial for cost management and is probably one of the controlling factors that will be brought to bear as the government exerts increased controls in order to keep costs from double digit rises each year. For many years the Government, mostly through Medicare, has collected data, but with the advent of EHRs a much larger universe of specific data will be available for mining. Hopefully this will not lead to reluctance by providers of care to implement EHRs, rather that the payment of incentives and patient safety benefits will outweigh the controversial elements of ARRA. The Allscripts FAQ suggests there is a separate FAQ document released by the Senate in 2009 that specifically prohibits the government from making any coverage decisions based on CER.

Title XIII	Health Information Technology (the HITECH Act)	
Section 3000	**Definitions** (1)The term *certified EHR technology* in this section speak to being certified pursuant to Section 3001(c)(5) and meeting standards adopted under Section 3004 that serve Ambulatory and Hospital venues of care. (13) The 'qualified EHR' definition can be further expanded in other parts of the Act to include demographic , medical history, problem lists, and has the capacity to support clinical decision support, physician order entry, capture and query information relevant to health care quality, to exchange electronic health information with, and integrate such information from other sources. (2) 'Enterprise Integration' is defined as the electronic linkage of healthcare providers, health plans, the government and other interested parties, to enable electronic interchange and use of health information among all components in the healthcare infrastructure along with related protocols and standards. **DEFINITIONS (of providers, mostly hospitals and other facilities, but some mention of ambulatory).** In this title: `(1) CERTIFIED EHR TECHNOLOGY- The term `certified EHR technology' means a qualified electronic health record that is certified pursuant to section 3001(c)(5) as meeting standards adopted under section 3004 that are applicable to the type of record involved (as determined by the Secretary, such as an ambulatory electronic health record for office-based physicians or an inpatient hospital electronic health record for hospitals). `(2) ENTERPRISE INTEGRATION- The term `enterprise integration'	The terms 'certified' and 'qualified' EHR both need further definition through the issuance of Standards. CCHIT has been working on both ambulatory and hospital based records, with little progress to date creating certification scripts for HIM type functionalities. Remember, CCHIT (which may be the certification body for ARRA, but that is not yet determined) is really the floor of the functionalities that are needed to perform the record management and workflow processes needed. HITSP and HL-7 are the standards generating bodies so far. All 3 have not really pushed HIM requirements as much as I'd like to see. Going forward there needs to be more volunteerism from AHIMA and the HIM community. CCHIT has 3 options now for certification of different systems, deep, lighter for home grown, open source orientation, etc. ARRA is loaded with language reflecting the importance of national data interchange (part of the (2) 'Enterprise Integration' model defined in this Section. This is a much tougher problem that would be imagined. Not only are RHIO and HIE data models (by the way ARRA does not fund these enterprises) not widely adopted, there are fundamental issues

	means the electronic linkage of health care providers, health plans, the government, and other interested parties, to enable the electronic exchange and use of health information among all the components in the health care infrastructure in accordance with applicable law, and such term includes related application protocols and other related standards. `(3) HEALTH CARE PROVIDER- The term `health care provider' includes a hospital, skilled nursing facility, nursing facility, home health entity or other long term care facility, health care clinic, community mental health center (as defined in section 1913(b)(1)), renal dialysis facility, blood center, ambulatory surgical center described in section 1833(i) of the Social Security Act, emergency medical services provider, Federally qualified health center, group practice, a pharmacist, a pharmacy, a laboratory, a physician (as defined in section 1861(r) of the Social Security Act), a practitioner (as described in section 1842(b)(18)(C) of the Social Security Act), a provider operated by, or under contract with, the Indian Health Service or by an Indian tribe (as defined in the Indian Self-Determination and Education Assistance Act), tribal organization, or urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act), a rural health clinic, a covered entity under section 340B, an ambulatory surgical center described in section 1833(i) of the Social Security Act, a therapist (as defined in section 1848(k)(3)(B)(iii) of the Social Security Act), and any other category of health care facility, entity, practitioner, or clinician determined appropriate by the Secretary.	with patient identification, release and administration of received information that will need to be addressed by combinations of new technology solutions and their associated manual processes. Failure to have a national patient identifier actually makes patient identification much harder. For example, if a matching algorithm is utilized there has to be a human component somewhere in the mix. Question: Do you send a record to an ED physician that is a 70% or 80% likely match? These kinds of questions will have to be resolved, but are sure to impact the volume of operations in HIM. See definitions of providers on left column for good lists of types of providers covered by incentives.
Subtitle A	**Promotion of Health Information Technology**	
Section 3001	**Office of the National Coordinator for Health Information Technology ONC** (a)(b)Creates the Office of the National Coordinator (ONC) and gives	The Office of the National Coordinator is someone

	the National Coordinator the task of performing various duties related to 'development of a nationwide health information technology infrastructure' that allows for electronic use and exchange of information that is: (1) health information is protected (2) improves quality of healthcare, reduces medical errors (3) reduces healthcare costs from inefficiency, medical errors, inappropriate care duplicative care & incomplete information (4)medical decision support (5)meaningful public input into infrastructure (6) improves coordination of care and information in hospitals, labs, physicians' offices… (7)improves public health activities and facilitates early identification and rapid response to public health threats (8) facilities health, clinical research and health care quality (9) promotes early detection, prevention and management of chronic disease processes (10) promotes a more effective marketplace, greater competition, greater system analysis, increased consumer choice and improved outcomes in healthcare services (11) improves efforts to reduced health disparities (c) ONC duties: (1)(A) Standards - Review and endorse standards (B) make determinations to the Secretary of HHS (2) (A) HIT Policy Coordination - Coordinate Health IT with other relevant executive branches (B) Leading member in establishment and operation of HIP Policy and HIT Standards Committee (3) (A)Strategic Plan Update Federal Health IT Plan and work with other federal agencies to include specific objectives, milestones regarding listed in the Act including, electronic exchange and use of	who AHIMA needs to get as close to as possible. So many decisions rest with that Office that it is imperative to have the ability to influence the decisions that are made going forward to always take HIMs role and requirements into account. There are areas of ARRA that call for caution against undue administrative burdens. HIM is one of the key stakeholders in insuring those burdens are mitigated through the use of standards based technology and that there is recognition of the processes necessary to implement the workflows necessary to address the new HIPAA, data exchange and EHR requirements. The future state of HIM is important to address, but so is the current and near term states which span from paper to hybrid to electronic and have their own defined requirements which must always be considered for efficiencies and burdensomeness. In my opinion, HIM is being called out here to step up and get more talent in the system. Masters and even PhDs are crucial to getting the attention necessary to create Policy and Standards, advanced degrees are simply a necessity, but under all circumstances more talent is better for the entire HIM profession. AHIMA's educators need to get the grants and upgrade the number of students matriculating. Another carve out for HIM to influence, the Chief Privacy Officer. This should become an AHIMA

	health information, utilization of a EHR for each person in the US by 2014, the incorporation of privacy and security… (5) (A) Certification – The National Coordinator in conjunction with the Director of the National Institute of Standards and technology (NIST) shall keep or recognize a program or programs for voluntary certification of health information technology. (B) Certification criteria described – 'certification criteria' means, with respect to standards and implementation specifications for health information technology criteria to establish that the technology meets such standards and implementation specifications. (6)(E) Resource Requirements - ONC is to estimate resources needed to reach the goal of EHR availability by 2014, including resources needed to establish a health information technology workforce sufficient to support this effort including education programs in *medical informatics and health information management*. (8) Governance for Nationwide Health Information Network - OCN shall establish a governance mechanism for a nationwide health information network. (3)(e) Chief Privacy Officer of the Office of the National Coordinator Establishes the position of Chief Privacy Officer within ONC, to advise the Coordinator on privacy, security and data stewardship issues.	strategic objective to capture this position with one of our credentialed members.
Section 3002	**HIT Policy Committee** (a) Establishment - The HIT Policy Committee is established to make Policy recommendations to the National Coordinator relating to the implementation of a nationwide health information technology infrastructure, including implementation of a strategic plan. (b)(1) Duties – The HIT Policy Committee shall recommend a policy	Committee has been formed. Paul Egerman from eScription and Judy Faulkner from Epic are members of this Committee. HITSP seems to be front and center.

	framework for national technology infrastructure that permits the electronic exchange and use of health information as consistent with the strategic plan. (2)(a) In General – recommend areas in which standards, implementation specifications and certification criteria are needed for the electronic exchange and use of health information and shall recommend an order of priority for development, harmonization and recognition of such standards, specifications and certification criteria… (b)(2)(B) (i) Areas Required for Consideration – Technology to promote privacy and promote security in a *qualified* EHR, including the segmentation and protection from disclosure of specific and sensitive individually identifiable health information…the use of *limited data sets*… (ii) Nationwide health information technology infrastructure for electronic use and accurate exchange of health information (iii) The utilization of a certified EHR by each person in the US by 2014 (iv) Technologies that as a part of a *qualified* EHR allow for Accounting of Disclosures (AOD) for Treatment, Payment and Operations (TPO). (v)Use of *certified* EHRs to improve quality of healthcare by promoting coordination of care and improving continuity of care among healthcare providers, reducing medical errors… (vi) Technologies that allow individually identifiable health information to be rendered unusable, unreadable or indecipherable to unauthorized individuals when such information is transmitted in the nationwide network or physically transported outside the secured, physical perimeter of a healthcare provider, health plan or healthcare clearinghouse. (2)(C)(3) Forum – The HIT Policy Committee shall serve as a forum for broad stakeholder input with specific expertise in policies relating to	HIMSS hopes that the National Coordinator will recognize HITSP. The Healthcare Information Technology Standards Panel (HITSP) is a cooperative partnership between the public and private sectors to develop standards which are guided by policy from the HIT Policy Committee. AHIMA and HIM cannot reasonably expect to guide this Committee but membership would be a good thing. More representation on HITSP and HL-7 is needed. HIMSS members and MD / clinician informatiscists dominate these groups, we need HIM balance. Limited data set is an interesting concept, but *management* of the release and appropriate routing through health information exchanges (HIE) will be a challenge. HIM expertise is required, especially the operational aspects of daily management. AOD is a key strength of HIM. AHIMA and the HIM profession need to carefully watch for further standards and regulatory guidance. This is much harder than it would appear to accomplish operationally. Imagine copies of records given to patients to take home or sent from the floor to a nursing home, with no HIM involvement, these TPO disclosures, of which there is a huge number must all be tracked by software which today is not ready for that activity and by staff (nurses and HUC's) that are not as tuned into the necessity of diligence on

	matters described in… (c) (2) Membership - HIT Policy Committee members shall be composed of member as detailed in an included list… (3) Participation – The members of the HIT Policy Committee should represent a balance among various sectors of healthcare system so that no single sector unduly influences the recommendations of the Policy Committee	this front. Not only are software and processes needed but extensive and continuous training. HIM needs to be leaders in this area. Key wording 'broad stakeholder input' and 'balance among various sectors AHIMA take note and be included. No group watches for our areas of expertise like we do, so we must be involved. Vendors are actively stating their position as members and in the public comment forums. EDM (electronic document management) and HIM oriented Vendors need to take active roles, not just core clinical Vendors or divisions within large corporations. Policy Committee meeting June 16 included 22 'meaningful use' functionalities and statements that the bar will be low to start with and raised over time. Go to website to see meeting minutes, agendas, PowerPoint's, etc.
Section 3003	**HIT Standards Committee** (a) Establishment - Establishes an HIT Standards Committee to recommend to the National Coordinator standards, implementation specifications and certification criteria for the exchange and use of health information consistent with the strategic plan. (b)(1)(A) In General – HIT Standards Committee shall recommend to the National Coordinator standards, et al, that have been developed, harmonized or recognized by the HIT Standards Committee. (B) Harmonization – The HIT Standards Committee recognize harmonized or updated standards from entity or entities for the purposes of updating or harmonizing standards and implementation	This Committee has now been formed. Dr, Jonathan Perlin is the Committee Chair. Dr. John Halamka, CIO Harvard Medical School is the Vice Chairman of standards Committee and Chairman of HITSP. ONC funded HITSP and has already completed much standards work. Is establishing 3 workgroups for clinical operations,

Section 3004	specifications in order to achieve uniform and consistent implementation specifications. (C) – Provide for testing (2) Forum – The HIT Standards Committee also calls for a broad range of stakeholders to provide input on harmonization, recognition of standards, implementation specifications and certification criteria necessary for development and adoption of a nationwide health information technology infrastructure that allows for the use and exchange of health information. (4) provides for public input (c) (2) Membership is defined of at least reflect providers, ancillary healthcare workers, consumers, purchasers, health plans, technology vendors, researchers, relevant federal agencies and individuals with technical expertise on health care quality, privacy, security and on the electronic exchange and use of health information. (3) & (5) Participation & Balance Among Sectors – Again calls for a balance of stakeholders in the membership so that no sector dominates. (4) Outside Involvement – The HIT Policy (should that be *Standards?)* Committee shall ensure an opportunity for participation in activities with expertise in development of standards for the electronic exchange and use of health information, including areas of health information privacy and security. **Process for adoption of endorsed standards and certification criteria** (b)(1)In General - No later than December 31, 2009, the Secretary shall, through the rule making process, adopt an initial set of standards and implementation specifications required for consideration under 302(b)(2)(B). The National Coordinator may recognize an entity or entities for the purpose of harmonizing or updating standards and implementation specifications in order to achieve uniform and consistent implementation of the standards and implementation	clinical quality and Privacy & Security. Again, this Committee needs to be balanced; AHIMA and Vendors should be involved heavily to counter balance IT and Clinician influence. 'Ancillary health workers', again a call out for HIM. Implementation requirements are absolutely key. Two systems sold to different customers can turn out radically different based upon implementation. Again, this is where operationalization comes into play and the workers that deal daily with the EHR systems and supporting processes should provide plenty of input.

	specification. (2) Application of Current Standards, Implementation Specification and Certification Criteria – The standards, implementation specifications and certification criteria adopted before the date of this enactment through the process existing through the Office of the National Coordinator for Health Information Technology (OCHIT) may be applied towards meeting the requirement of paragraph (1)	Hopefully CCHIT, HITSP and HL-7 will be recognized as standards and certification groups to build upon the work they have accomplished already.
Section 3006	**Voluntary Use** (1)(2) Nothing in the Act requires a private entity to adopt or comply with a standard or implementation specification adopted under Section 3004. Or to provide a Federal agency authority (other than under other provisions of law) to require a private entity to comply with such a standard or implementation specification.	
Section 3007	**Federal Health Information Technology** (a) In General - National Coordinator shall support routine updating of qualified electronic health record technology (as defined in **Section 3000**) unless Secretary determines through an assessment that the needs and demands of the providers are being met though the marketplace.	
Part 2	**Application and Use of Adopted Health Information Technology Standards; Reports**	
Section 13202	**Research and Development programs** (1) General - NIST, NSF and other Federal agencies shall establish a program of assistance to institutions of higher education (or consortia thereof that may include non-profit entities and Federal Government laboratories) to establish multi-disciplinary Centers for Health Care Information Enterprise Integration.	HIM and Healthcare Informatics programs apply for these grants and to become Centers for Health Care Information Enterprise Integration. 'Health Information Enterprise Management', curricula should be developed to address the broad spectrum of HIM and Informatics across the entire

	(3)Purpose – The purposes of the centers shall be: (A) generate innovative approaches to healthcare enterprise integration by conducting cutting edge multidisciplinary research on the system challenges to healthcare delivery (B) the development of health information technologies and related fields (4) Research Areas include: (A) interfaces between human information and communications technology systems (B) voice recognition systems (C) software that improves interoperability and connectivity among health information systems (D)software dependability in systems critical to healthcare delivery (E) measurement of impact of information technologies on quality and productivity in healthcare (F*) health information enterprise management* (G) health information technology security and integrity (H) relevant health information technology to reduce medical errors	enterprise model ARRA envisions. The technology is being worked out at present, but the operationalization, policies, procedures and daily requirements will be harder to manage, informed leadership is required.
Subtitle C	**Grants and Loan Funding**	
Section 13301	**Grant, Loan and Demonstration programs** Title XXX of the Public Health Service Act, as added by Section 13301 is amended by adding the end a new subtitle (see below subtitle B)	
Subtitle B	**Incentives for the Use of Health Information Technology**	
Section 3011	**Immediate Funding to Strengthen the Health Information technology Infrastructure** (a) In General - Invest in infrastructure necessary to allow for and	Best Practices is a carve out for HIM.

	promote electronic exchange and use of health information for each individual in the US consistent with the goals outlined in the strategic plan and developed by the National Coordinator. Promotion of technologies and best practices that enhance the protection of health information by all holders of individually identifiable health information.	
Section 3012	**Health Information Technology Assistance** (a)To assist healthcare providers adopt, implement and effectively use *certified* EHR technology that allows for electronic exchange and use of health information, the Secretary acting through ONC shall establish a health information technology extension program to provide health information assistance services to be carried out by HHS. (b)(1) The Secretary shall create a **Health Information Technology Research Center** to provide technical assistance and develop or recognize best practices to support and accelerate efforts to adopt, implement and effectively utilize health information technology that allows for the use of information in compliance with standards, implementation specifications and certification criteria adopted under Section 3004. (A)(B)(C)(D)(E)(F) Purposes – identified purposes for this HITRC i.e. assemble, analyze and widely disseminate evidence and experience relating to the adoption, implementation and experience related to the effective use of health information technology that allows for electronic exchange and use of health information (c) **Health Information Regional Extension Centers** (1) In General - The Secretary shall provide assistance for the creation and support of regional centers to provide technical assistance and disseminate best practices and other information learned from the Center, certification and standards compliance, information exchange etc. (2) Affiliation – Regional Centers shall be affiliate with any US based	HITRC, should universities with HIM and Informatics curricula apply for these roles? May 28 Federal Register gave definitions and asked for comments. **Health Information Technology Extension Program, National Health Information Technology research Center, Regional Extension Centers –** $1 - $30M in grant monies ($598 million total), preference to sites that have funds matching. Primary focus to help providers select and implement certified EHR's and meaningful use. Goals listed: • Encourage EHR adoption by clinicians and hospitals • Assist clinicians and hospitals become meaningful users of EHR • Increase probability that adopters will become meaningful users Criteria for determining Qualified Applicants are detailed. Not requiring matching funds in 2010, funding for 2 year awards in 2010. Initial awards early 2010 continuing throughout the year. Target timeframe for FY for hospitals and calendar

	non-profit institution or organization that applies for and is awarded financial assistance under this Section (awarded on merit). (3) Objectives – see the list (A) – (F) for the typical objectives of information use and exchange… (4) Regional Assistance – Each regional center shall aim to provide assistance and education to all providers in a region but shall prioritize direct assistance first to the following: (A) Public or not for profit hospitals or critical access hospitals (B) – (D) different sites listed (5) Financial Support – Provides up to 50% of operating expense unless waived due to downturned economic circumstances and time. Grants announced for $598 million for Regional (Extension) Centers on February 20, 2009. Grant info available on www.grants.gov.	year for physicians 2011 and 2012 when potential Medicare incentives are greatest.
Section 3013	**State Grants to Promote HIT** (a)(b)(c)Secretary through ONC may award planning and implementation grants to state or qualified state designated entity (1) either designed by State as eligible or (2) not for profit entity with broad stakeholder representation. Includes schedule of state matching funds required. (d) Use of funds, typical uses for ARRA (g) in carrying out sections (b) and (c) shall consult with and consider recommendations of, follows a list of typical of ARRA stakeholders, including (4) *health information technology vendors* (h)(i) required matching State funds detailed	Best monitored by HIM CSA's (component state associations) within each state, for sure HIMSS members are involved. In Florida we've had a chronic under achieving of volunteerism with local RNHIO's and HIE's. HIM professional need to recognize and be recognized by these health information exchanges within their states, it's such a large mandate from ARRA that involvement is mandatory.
Section 3014	**Competitive Grants to States and Indian Tribes for the Development of Loan Programs to Facilitate the Widespread Adoption of Certified EHR Technology** (a) In General – the NC may award competitive grants to eligible entities for establishment of programs for loans to healthcare	Does the HIM profession have any Indian Tribe members to be involved?

	providers to conduct activities in subsection (e); purchase certified EHR, enhance utilization, train personnel, improve the secure electronic exchange of information	
Section 3015	**Demonstration Program to Integrate Information Technology Into Clinical Education** (a) In General -Secretary may award grants under this section to carry out demonstration projects to develop academic curricula integrating certified EHR technology into clinical education of health professionals. (b) (3) to be eligible to receive a grant must be; med school, *other graduate health professions school*, etc	Graduate programs for HIM and Informatics can be eligible.
Section 3016	**Information Technology Professionals in Healthcare** (a) General – Secretary in consultation with NSF, shall provide assistance to institutions of higher education (or a consortia thereof) to establish or expand medical health informatics education programs, including certification undergraduate and masters degree programs for both *healthcare and information technology students* to ensure rapid and effective utilization and development of health information technologies (in the US healthcare infrastructure). (b) Activities include; (1) develop and revise curricula (2) Recruiting and retaining students (3)Acquiring equipment necessary for student instruction in these programs (4) Establishing or enhancing bridge programs in the health informatics field between community colleges and universities	Again, it's very important for HIM to develop more and better graduate programs.
Subtitle D	**Privacy (and Security)**	
Section 13400	**Definitions** (1)(A) **Breach** – unauthorized acquisition, access, use, or disclosure of' PHI which compromises the security or privacy of such information, except where an unauthorized person to whom such information is	According to the ONC Implementation plan CMS and OCR will be funded to carry out mandated audits and to make modifications in their case and document management systems and to train State

	disclosed would not reasonably have been able to retain such information. (B) Exceptions – breach does not include (i) any unintentional acquisition, access or use of PHI by an employee or individual acting under the authority of a CE or BA (I)such acquisition was made under good faith and within the course and normal scope of employment or professional relationship…with CE or BA (II) such information is not further acquired, accessed or used (ii) any inadvertent disclosure for an individual who is otherwise authorized to access PHI at a facility operated by a CE or BA… (iii) any such information received as a result of such disclosure is not further acquired, accessed, etc. (5)An **EHR** (electronic health record) is created, gathered, managed, and consulted by authorized health care clinicians and staff. (11) A **PHR** (personal health record) is managed, shared, and controlled by or primarily for the individual. (12**) Protected Health Information** (PHI) meaning in Section 160.103 of Title 45, Code of Federal Regulations. More details on Breach from the Interim Final Rule for HHS and Final Rule from FTC include: • Encryption and destruction are not the only means of compliance with the HIPAA Security Rule; however they are key to understanding if Breach of 'Unsecured' PHI has occurred. Therefore, data encryption in any of its states is highly desired to prevent Breach Notification from being necessary. • Access controls alone are not enough, they alone still require Breach reporting.	Attorney Generals in their new enforcement role. ARRA represents a very large number of changes to the existing HIPAA regulatory structure. HIM involvement in EHR selection, insuring adequate audit logging and reporting (not all audit logs are created equally) will be needed to detect and prevent breaches. Third party access audit applications are a good vehicle for compliance. If a unit clerk accidently, but inappropriately looks at their neighbors EHR based record, but there is not any other disclosure, is that a breach? No. If a PC is stolen containing PHI that is encrypted a Breach? No. PHR's open entire universes of issues and complications that HIM will need to help sort out as it is likely they will be charged with management of PHR based information. **Overview of Privacy & Security provisions;** • Expanded enforcement provisions • Privacy/security breach notification requirements • Extension HIPAA Privacy & Security to BA's • Limitations on marketing communications when CE or BA receive compensation

	• Paper redaction does not exempt breach but can be used to render PHI non-PHI. • Encryption keys should be kept on separate devices from data. • The Breach notification applies to breaches that occur 30 days after this rule (September 23, 2009, although no enforcement until approximately February 23, 2010). • BA's must report breaches to CE. Either party can notice the individual, this should be determined within the BAA. • CE's needs to make 'harm threshold' analysis to determine if Breach needed. This must be documented. The assessment uses the following definition; 'Does the compromised Security or Privacy of PHI pose a significant risk of financial, reputational or other hard to the individual'. ○ CE has the burden to determine no hard, all must be documented. • 18 identifiers comprise de-identification. • The final rule has cost models and # of facilities potentially impacted. • Snooping is definitely a breach, example outlined on page 31 of the interim final rule. • EOB mistakenly sent to wrong addresses is a breach. • Breach discovery remains when CE or BA knows or should have known it to exist. Proactive audits and controls are mandatory to be in compliance with this part of the rule. In no case (except exceptions like for law enforcement purposes) breaches must be reported in no more than 60 days and even 60 days can be too long, so faster is better.	• Restrictions on sale of health information • Minimum necessary obligations • Revisions to individual rights i.e. right to request restrictions on disclosure • New requirements effective on Feb 17, 2010 unless otherwise specified • Civil and Criminal penalties increased and expanded • State Attorney Generals now in the mix • Increased enforcement coming **HHS Guidance on encryption** • Federal Register April 27, 2009 (74 Fed Reg 19006) PHI is deemed unusable if it has been encrypted by use of a algorithmic process to transform the data into a form in which there is a low probability of assigning meaning, without a key • Valid encryption for data at rest are consistent with NIST Special Publication 800-111 • Valid encryption for data in motion are those complying with Federal Information processing Standards (FIPS) 140-2 • Valid destruction Paper destroyed so it cannot be read, electronic media been cleaned, purged or destroyed complying with NIDST Publication 800-88.

	○ CE's & BA's must have breach detection, in place • Breach notification must be in plain, reasonable language. • Notice of breaches must be sent to next of kin. • Don't sent breach notices from both CE and BA, no multiple notices. Same is true for HIPAA and FTC notices for PHR's. • CE's and BA's must develop and document Polices and Procedures, train workforce members, have sanctions for failure to comply, require CE to refrain from intimidation or retaliatory acts. **FTC Final Rule** The FTC final Rule for breach notification for PHR's is very similar to HHS's HIPAA rules, they have been harmonized to a large degree. The following points are key: • Also takes effect September 18, 2009 but enforcement begins February 2010. • PHR defined as medical information from multiple sources and which is controlled by the patient • If a physician's office offers a PHR, they are not covered under the FTC rules, HHS rules will apply. • Breach notice in a case of both FTC and HHS rules should come from the most direct contact to the individual, there must not be multiple notices for the same breach. • Applies to foreign entities with US customers. • Page 20; rebuttable presumption that access leads to unauthorized acquisition unless can otherwise be proven. • Time period for posting notice on a website changed to	

	90 days.	
Part 1	**Improved Privacy Provisions and Security Provisions**	
Section 13401	**Application of Security Provisions and Penalties to Business Associates of Covered Entities; Annual Guidance on Security Provisions** (a) Provides that business associates (BAs) of covered entities will now be directly subject to provisions of the Security Rule in the same way that Covered Entities are, and that recognition of the administrative, technical and physical safeguards, and other applicable security procedures, must be incorporated in the BA agreement between the BA and the CE. Application of Security Provisions – Sections 164.308, 164.310, 164.312, 164.316 of Title 45 Code of Federal Regulations shall apply to business associates of a covered entity shall apply in the same manner that such sections apply to the covered entity. ○	Need to incorporate new ARRA provisions into BAA's. Application of Civil and Criminal Penalties – now also apply to the BA. BAA's need to incorporate HITECH security provisions.
Section 13402	**Notification In Case of Breach** (a) In GE that accesses, maintains, retains, modifies, records, stores, destroys or otherwise holds, uses or discloses unsecured health information (as defined in subsection (h)(1)) shall, in case of breach of such information that is discovered by the CE notify each individual who unsecured protected health information has been or is reasonably believed by the covered entity to have been accessed, acquired or disclosed as the result of such breach. (b) BA's same language they are to notify Covered Entity. (c) Breaches Treated as Discovered - when they are known or should have been known. (d) Timeliness of notification – all notifications made without	Breaches related to unsecured PHI (see April 17 Federal Register for means to secure PHI, think encryption). As Breaches are 'Discovered' (they become known or should have been known) they trigger notification from CE or BA (or both). Many times HIM will likely also have to deal with notifications of breaches; therefore it is imperative to fully define the processes to operationalize. More regulatory guidance is looked for. **Methods of**

	unreasonable delay and in no case later than 60 days after discovery of the breach (d)(2)Burden of Proof – the Covered Entity involved (or the BA) shall have the burden of demonstrating all notifications were made as required under this part, including notification including the necessity of any delays (e)(1) Methods of Notice - Individual Notice – Notice shall be provided to an individual, with respect to the breach, shall be provided promptly and in the listed forms. (e)(2) Media notice, notice provided to prominent media outlets serving a State or jurisdiction following discovery of a breach if more than 500 residents of a state or jurisdiction. (e)(3) Notice to Secretary – Must Notice Secretary of HHS of breaches annually in a log or immediately if over 500. (e)(4) Posting on a Public Website – Secretary will post on public website where >500 persons breaches occurred. (f) Content of Notification - Content of notification includes: Brief description of what happened, including the date if known. A description of types of information involved in breach. The steps the individual should take to protect themselves from potential harm from the breach. A brief description of what the CE is doing to investigate the breach, mitigate losses and protect against further breaches. Contact procedures for individuals for the CE. (g) Law Enforcement can delay notification if they have cause. (h) Unsecured Protected Health Information (PHI)(A)The term 'unsecured protected health information' means PHI that is not secured through the use of a technology or methodology specified by the Secretary in guidance issued under paragraph (2). (B)Exception if timely guidance not issued developed and endorsed by a ANSI body.	**notification include:** • First class mail to last known address • Or e-mail if preferred by patient • Provide for substitute notice if insufficient or unknown contact information • In the case of a Breach with 10 or more patients with unknown contact info post general info in media, site website and have a toll free number to call **Contents of Breach Notification:** • Dates of Breach and Discovery • Brief description of what happened • Description of types of information involved • Steps individuals should take to protect themselves • Brief description of CE (or BA) remediation actions • Contact information for individuals to learn more **Timing of notification:** Without unreasonable delay, not longer than 60 days after discovery Note the public postings, if breaches involve over 500 individuals, the stakes are very high and impact legal health record activities. No facility wants to be noticed for breaches, as it will invite further law suits and speculation from patients about the privacy and security of their information. Careful diligence on what is unsecured PHI is

		needed, clarification is necessary to implement and HIM professionals should input into standards and policy committees and development groups on all areas related to privacy.
Section 1403	**Education on Health Information and Privacy** (a) Secretary shall designate an individual in each regional Office of HHS to offer guidance and education to CE, BA and individuals on their rights and responsibilities related to federal privacy and security requirements. (b) Not later than 12 months after enactment OCR shall develop a national, multi-faceted education campaign to enhance public transparency regarding uses of PHI, etc.	
Section 13404	**Application of Privacy Provisions and Penalties to BA of CE** (a)(b)(c) Applies provisions of the HIPAA Privacy Rule directly to BAs and stipulates that these requirements must be included in the BAA (agreement); the bill also applies the Privacy Rule's civil and criminal penalty provisions directly to BAs.	Civil and criminal penalties now can be levied to BA's which changes the rules significantly. CE's must require BA's to ***contractually*** limit use / disclosure of PHI. HIPAA amended to require key provisions of security rule apply to BA's directly (administrative, technical and physical safeguards, CFR 164.308-312 & 316 (e-PHI). BA requirements of privacy rule apply directly to BA's CFR 164.504 (e)). Privacy rule requires CE's to take certain actions if they know of a pattern or practice by BA Breaching its obligations and also the BA if they know of CE actions or patterns.
	Restrictions on Certain Disclosures and Sales of Health Information;	There can be an issue that there could be missing

Section 13405	**Accounting of Certain Protected Health Information Disclosures; Access to Certain Information in Electronic Format** (a) Covered Entity must restrict disclosure of PHI to a health plan for purposes of payment or health care operations (and is not for the purposes of carrying out treatment at the request of the patient, if the patient has self-paid for a service. (b) Requires CEs (or BA's) to use a *limited data set* to the extent practicable or, if necessary, the *minimum necessary* when making a use or disclosure; the Secretary is to issue guidance on *minimum necessary* within 18 months. The practical import of this provision, a limited data set cannot include direct identifiers such as name, social security number, email address, medical record number, account number, etc. (2) Determination of *minimum necessary* – the CE or BA shall determine what constitutes *minimum necessary* to accomplish the intended purposes of the disclosure. (4) This subsection does not apply to de-identified data (c) **Accounting of Certain protected Health Information Disclosures Required if CE Uses EHR (AOD)** (1)(B) CE must account for disclosures of PHI for a period of 3 years, if the PHI is maintained in an EHR; (2) Regulations The Secretary shall promulgate regulations on what information shall be collected about each disclosure not later than 6 months after the date on which the Secretary adopts standards on AOD. Such regulations require such information be collected through an EHR in a *manner that takes into account the interests of the individual in learning the circumstances under which their PHI is being disclosed and takes into account the administrative burden of such an AOD.* (3)(A)(B)In providing an accounting to individuals who request such, covered entities may describe disclosures to business associates or	treatment reports or data in a database maintained by a health plan / provider through data interchange for such purposes as quality assurance activities, care coordination, provider credentialing, underwriting, fraud and abuse monitoring, customer service if an individual restricts disclosure of their PHI that they have paid out of packet for. There also could be issues with HIE's and RHIO's in compliance with these requests. More details to be worked out in daily operations. I am pessimistic that core clinical systems will quickly be able to provide this functionality, but even if they do, the actual processes surrounding the releases are at issue, who manages the staff and processes that actually release the information that now has to be disclosed? ***Minimum necessary*** should be defined in Policy for routine requests and a system of guidance criteria to evaluate non-routine requests and what comprises their minimum necessary is needed for sites to develop. **05/22/09 AOD** Expanded AOD is for EHR based records, disclosures from 3 years. ARRA also requires AOD from their BA's or require them to make AOD available. HHS is charged with determining what information the patients may request and CE / BA must provide by August 2009. CE using EHR currently have until 2014 to comply to allow for introduction of AOD software, if not using EHR by

	provide a list of all business associates, which then must provide an accounting of disclosures on request. (4)(A)if the EHR is in place as of January 2009, the effective date for this requirement is 2014. (4)(B)If the EHR is implemented after January 2009, the effective date is either January 2011 or the date when the EHR system is acquired. **Prohibition on Sale of Electronic Health Records of PHI** (d) Prohibits the sale of electronic health records or PHI obtained from EHRs absent an authorization by the individual; and neither a CE nor a BA can directly or indirectly receive remuneration in exchange for any PHI; with exceptions for public health activities and research, but any fees exchanged related to research would be limited to only the cost of preparation and transmittal of data. (e) provides individuals the right to obtain from a CE using an EHR a copy of their information in electronic format, with charges for providing such copies limited to the entity's labor costs. The individual may designate a 3rd party, such as a PHR, to receive this copy.	Jan 2009 then must start January 1, 2011. HIM and IT need to be evaluating expanded AOD now! HHS Secretary can delay effective dates but in no case later than 2013 or 2016. In their analysis HIMSS makes good points about what is an EHR in this section and identifying a disclosure. AHIMA will need to input on these concerns. Section 1405 (c)(2) *Key area of concern*- Secretary shall promulgate regulations on what information shall be collected about each disclosure not more than 6 months after the Secretary adopts standards for AOD, here is the good part for HIM…though an EHR in a manner that takes into account the interests of individuals in learning the circumstances in which their PHI is being disclosed and takes into **account the administrative burden of accounting for such disclosures.** HIM should be leaders in defining and promoting what is an administrative burden and what is not with AOD. (If CE or BA receives direct or indirect remuneration for making a communication encouraging the purchase of an item or service there are new ***marketing*** guidelines for the use of PHI. AOD is to be made by CE's, including their BA's or for themselves and by providing a list of BA's which can from which the individual can request a AOD.

		Make note of the AOD timeframe, if the EHR is acquired before January 1, 2009 the timeframe for AOD is January 2014, if after that date it's 2011. This is to facilitate re-engineering of systems already in place whereas it is assumed that newer EHR versions will come with the expanded AOD functionality. Getting the EHR vendors to provide this functionality could be very complex in reality. Under HIPAA a CE did not have to agree to restrict disclosure, with ARRA the ability of individuals to request and be granted disclosure restrictions is strengthened. Individuals have the right to ***opt out*** of written fundraising communications. Also individual may opt out of disclosure of PHI to a health plan for purposes of payment for healthcare operations if all bills have been paid already out of pocket for a particular item(s). – This has a potentially large HIM impact with ROI and Billing Office needing to work together.
Section 13406	**Conditions on Certain Contacts as part of Health Care Operations** (b) Modifies the fundraising exception to marketing, which defines fundraising by non-profits as a health care operation, provides that individuals must be offered the choice of opting out of any fundraising communication.	

Section 13407	**Temporary Breach Notification Requirement for Vendors of PHR and other Non-HIPAA CE's.** (a) & (b) Vendors of PHRs have breach notification obligations, including notification of individuals and of the Federal Trade Commission; and 'third party service providers' that provide services to PHR vendors must notify the PHR vendor if there is a breach, (similar to the requirement that BAs notify CEs); the FTC must notify the Secretary of breaches it is informed of; and there is again a 'safe harbor' for encrypted information.	Again, PHR's are all over the place in structure, governance, ownership, patient input, etc. HIM is leading best practices for PHR's and needs to continue to help the public understand and integrate their usage into daily operations. Questions such as 'will PHR data be automatically added into provider records and what kind of administration processes will be required'? must be addressed.
Section 13408	**BA Contracts Required For Certain Entities** BA agreements between CEs and HIEs, RHIOs, ePrescribing Gateway or any vendor that contracts with a CE to offer a PHR to patients as part of the CE's EHR need BA agreements. BA are subject to the administrative, physical and technical safeguard security requirements of the HIPAA Security Rule, as well as the requirements to maintain policies, procedures and documentation of security activities. They have the same penalties as well.	
Section 13409	**Clarification of Application of Wrongful Disclosure Criminal Penalties** Clarifies that HIPAA's criminal penalties apply not only to CEs but to *individual employees of CEs and other individuals. Individuals* are now covered, for the purposes of criminal provisions a person will be considered to have obtained or disclosed individually identifiable health information in violation of HIPAA (from a CE or BA).	Individuals may now be subject to criminal enforcement under HIPAA for wrongfully obtaining or disclosing PHI

Section 13410	**Improved Enforcement** (a) In general HIPAA enforcement is strengthened, increases the amount of civil monetary penalties under the HIPAA rules, and clarifies that State Attorney Generals can bring civil actions in Federal Court on behalf of the residents in their state. (c) Non-Compliance Due to Willful Neglect requires het Secretary to impose a penalty under Subsection (a)(1). Penalties began immediately, damages include: (c) **Distribution of Certain Civil Monetary Penalties Collected** (1) Monies collected as penalties will go to the Office of Civil Rights for enforcement. (2) GAO report – Within 18 months and then 3 years from enactment a person damaged by a violation can receive a % of the penalties. **(3) Tiers of penalties described** (A) (Offender did not know and by exercising reasonable diligence would not have known that they violated the law) $100 for each violation, for identical requirements violations up to $25,000 in a calendar year. (B) (Violation due to reasonable cause and not willful neglect) $1,000 each / identical issues limited to $100,000 calendar year. (C) (Violation due to willful neglect but was corrected) $10,000 / $250,000 (D) (Violation due to willful neglect and was not corrected) $50,000 / $1,500,000 (d) **Enforcement by State Attorney Generals** (1) Civil Action can be brought by State AG's on behalf of State residents. (A) to enjoin further violations or (B) to obtain damages (2) **Statutory Damages**	Once monetary penalties can be collected by the public for harm derived from privacy violations more scrutiny than ever will be placed upon HIM and all record custodians and providers. Huge penalties can be at stake for Privacy violations. Willful neglect reporting is mandatory and is the worst kind of violation that will be most heavily enforced against. Providers need to work on issues that may contribute to willful neglect soon. No excuses for not addressing potential risk areas. Be very aware that once State AG's can be involved enforcement may increase dramatically. Especially as patient's begin to understand their rights and eventual access to Civil Monetary penalties.

	$100 per violation up to $25,000 in a calendar year for identical violations… (4) **Notice to Secretary** The State shall serve prior notice to the Secretary and a copy of it's complaint…	
Section 13410	**Audits.** HHS Secretary shall provide for periodic audits for CE and BA that are subject to the requirements of this subtitle and subparts C & E of part 164 of Title 45.	These audits may begin on Feb 17, 2010 or Feb. 17, 2011 dependent upon when the regulations supporting them are promulgated. Prudence says be ready for in audits of the new rules by Feb 17, 2010. *Audits may not have been very prevalent in the past but they will be in the future.*
Part 2	**Relationship to Other Laws; Regulatory References; Effective data Reports**	
Section 13421	**(a) Application of HIPAA State Preemption** HIPAA remains the floor, State preemption remains intact (b) HIPAA remains in effect except where changed in ARRA	As has been the case, States are key, still a patchwork of State laws that will be hard to regulate around and understand how Federal and state requirements mesh. CSA's again need to step up and act locally to assist in interpretation and implementation.
Section 13423	**Effective Date** Except as otherwise specifically provided the provisions of part I shall take effect 12 months from enactment,	Not very long to prepare, further regulatory guidance will be coming on proscribed schedules, HIM professionals need to watch for these clarifications.
Section 13424	**(a) Studies, reports, Guidance** Mandates studies and reports, including one by the Secretary, in consultation with the FTC, on the application of privacy and security requirements to non-HIPAA covered entities, including PHR vendors and others	

Title IV	**Medicare and Medicaid Health Information Technology; Miscellaneous Medicare Provisions**	
Section 4001	**Table of Contents of this Title**	
Subtitle A	**Medicare Incentives**	
Section 4101	**Incentives for Eligible Professionals** (a) Incentive Payments Section 1848 of the Social Security Act is amended by adding the following subsection (o) Incentives for Adoption and meaningful Use of Certain EHR Technology (1)(A)(i) In General – An eligible professional is a meaningful user (as determined under paragraph (2) shall be eligible for reimbursement (ii) no incentive payments after 2016 (B)(ii) For physicians Medicare incentive payments can be as much as: $18,000 in year 1, $12,000 in year 2, $8,000 in year 3, $4,000 in year 4 and $2,000 in year 5 – making a total of as much as $44,000 in incentive payments over 5 years for physicians who are meaningful users as of 2011 or 2012; for physicians who become meaningful EHR users in 2013 the year 1 payment is $15,000 instead of $18,000; and for physicians who become meaningful EHR users after 2014 (presumably 2015 and beyond) there are no incentive payments at all – the first 'payment year' will be no earlier than 2011. (iv) Increase for certain eligible professionals – physician shortage areas or others designated by the Secretary can receive up to 10% more reimbursement.(C)(ii) Hospital based professionals (i.e.	Providers can opt for incentives under either Medicare or Medicaid provisions, not both. Approximately $17.2 billion for HIT funding will be distributed through Medicare and Medicaid payment incentives to "meaningful EHR users" HIMSS addressed uniform standards in Enabling Healthcare Reform Using Information Technology. In Stage 2 Document Management may be linked in. These incentives are the 'carrots' for EHR adoption. Up to $44K for ambulatory and $3,500,000 – $8,000,000+ for inpatient hospitals over 4-5 years. The keys are 'certified EHR' which does not directly include electronic document management (EDM). But EDM and HIM technologies (such as deficiency management and release of information is crucial (especially given the poor state of record management capabilities within core clinical

	pathologists or ED physicians who primarily use hospital based systems) are not eligible. (D)(i) Form of payment may be lump sum or periodic installments (2) **Meaningful EHR User** (i) Meaningful Use of certified EHR Technology - Meaningful EHR user includes e-prescribing, electronic exchange of information and to improve the quality of care, such as *promoting care coordination*. (iii) Reporting on measures Using EHR – Using certified EHR technology eligible professional must submit to the Secretary clinical quality and other measures as selected by the Secretary (5)(C) Eligible Professional – defined as 'a physician, as defined in Section 1861(r). (C) **Demonstration of meaningful Use of certified EHR Technology and information Exchange** (i) In general a professional may satisfy the demonstration requirement clauses through means specified by the Secretary which may include: (I)Attestation (II) Submission of claims with appropriate coding (such as a code indicating that a patient encounter was documented using a certified EHR technology) (III) Survey response (IV) reporting under (A)(iii) (V) Or other manner as specified by the Secretary. (D) Posting on a website of the eligible professionals who are meaningful EHR users. (4) Certified EHR technology defined – as in earlier sections (7) Incentives for Meaningful Use of Certified EHR technology (ii) reductions in Medicare reimbursements if not a meaningful user beginning in 2015 @99%, 2016 98%, 2017 and beyond 97%	systems) to overall daily operation of EHR systems. Therefore not only must standards be influenced for their inclusion but Vendors need to develop their sales pitches to take advantage of the incentive funding to support arguments that the EHR is not a single core clinical systems, but a combination of systems that work together to address not only patient care but the administrative processes surrounding the care. **Per HIT Policy Committee Matrix 2011 Goals** **July 16 - July 20, 2009** – HIT Policy Committee (and Standards Committee, but Policy Committee's work more accessible at this point, although still a draft recommendation) outlined their thoughts and a matrix on. See PowerPoint and Matrix for more details. • 2009 Data Capture and Sharing • 2011 Advanced Clinical Processes • 2015 Improved Outcomes • Key Comment: Demonstrating the capability of reporting on MU measures and continuously improving its score would provide evidence of the organization's ability to use HIT to achieve goals of a transformed health system

	(iii) Authority to Decrease Applicable Percentage for 2018 and Subsequent years - If the Secretary finds less than 75% meaningful EHR users additional Percentages of reimbursement can be deducted, but not less than 95%.	**Providers (Hospital and Ambulatory):** • CPOE for all orders 10 % directly entered (Hospitals) by providers 9e.g. MD, DO, RN, PA, NP). 100% orders directly entered for Ambulatory (no external interfaces required). • Institute Drug to Drug – Drug Allergy and Drug Formulary checks • Record advanced directives • Up to date problem list maintained of current and active diagnosis based on ICD-9 or SNOMED • ePrescribing (Ambulatory) • Maintain active medication list • Maintain active allergy list • Record demographics, allergies, vital signs (height, weight, blood pressure, BMI) • Smoking status • Structured labs incorporated into record • Generate lists of patients with specific conditions for quality use (some differences between Ambulatory and Hospitals) • Report ambulatory quality measures to CMS • Send reminders to patients per patient preference for follow-up, preventive care

		• Implement one clinical decision support rule (Ambulatory) • Document a progress note for each encounter (Ambulatory) • Check insurance eligibility from public and private payers where possible • Submit claims electronically for public and private payers • Provide patients with electronic copies of their information (labs, problem list, medication lists, allergies) *upon request* • Provide patients with timely electronic access to their health information (labs, problem lists, medication lists, allergies) • Provide clinical summaries for each encounter (Ambulatory) • Provide access to patient specific education resources • Able to provide key pieces of patient care info (meds, allergies, discharge summary, procedures, problem lists) to healthcare providers and patient authorized entities electronically (slight Ambulatory and Hospital differences) • Provide medication reconciliation at relevant encounters and care transitions • Capability to submit electronic immunization info to registries where possible

		• Capability to provide syndromic surveillance information where possible
		• Compliance with HIPAA Privacy and Security rules
		• Compliance with Fair Data Sharing practices set forth in nationwide Privacy and Security Framework
		
		2011 Quality Measures (same for Hospitals)
		
		• Report Quality measures to CMS including:
		  • % diabetics with A1C under control
		  • Hypertensive patients with BP under control
		  • % of patients with LDL under control
		  • % of smokers offered cessation counseling
		  • % patients with BMI recorded
		  • % eligible patients who receive VTE prophylaxis
		  • % orders entered directly by providers through CPOE
		  • Use of high risk medication (Beers criteria) in the elderly
		  • % patients over 50 with colorectal screening

		• % females over 50 receiving mammogram screening • % patients at high risk for cardiac events on aspirin prophylaxis • % patients who received flu vaccine • % lab results entered into EHR in structured format • Stratify reports by gender, race, insurance type, language, etc • % of medications entered as generic when generic exists • % of orders for high cost imaging with structured indications ordered • % claims sent electronically to all payors • % patient encounters with insurance eligibility confirmed • % of all patients with access to personal health information electronically • % patients with access to patient specific educational resources • % of encounters where electronic clinical summaries were provided • Report 30 day readmission rate • % of encounters where med reconciliation was performed

		• Implemented ability to exchange clinical information electronically with external clinical entity • % of transitions of care for which summary is provided • Report up to date status for childhood immunizations • % reportable lab results submitted electronically • Full Compliance with HIPAA Privacy and Security • Conduct or update a HIPAA Security assessment and implement a security upgrades as necessary **2013 Objectives** • CPOE for all orders (Ambulatory (all order types (Hospital) • Use evidence based order sets • Record clinical documentation in EHR (hospitals) • Generate and transmit permissible discharge prescriptions electronically (Hospital) • Manage chronic conditions using patient lists and decision support • Provide clinical decision support at the point of care (e.g. reminders, alerts)

		• Specialists report to relevant external disease registries • Conduct closed loop medication management including eMAR and computer assisted administration (Hospitals) • Access for all patients to PHR populated in real time with patient health data • Offer secure patient – provider messaging (Ambulatory) • Provide access to patient specific educational resources in common primary languages • Record patient preferences • Documentation of family medical history, in compliance with GINA • Upload data from home monitoring device (Ambulatory) • Retrieve and act on electronic prescription fill data • Produce and share an electronic summary for each transition of are (place of service, consults, discharge) • Perform medication reconciliation at each care transition • Receive immunization histories and recommendations from immunization registries • Receive health alerts for public health agencies

		• Provide sufficiently anonymized electronic syndrome surveillance to public health agencies with capacity to link personal identifiers • Use summarized or de-identified data when reporting data for health purposes (Ambulatory) Nationwide Privacy and Security Framework, released in December 2008. The HIT Policy Committee will make the final recommendations on meaningful use definitions to the Department of Health and Human Services and the Centers for Medicare and Medicaid Services. HHS is mandated to publish an interim final rule for standards, implementation specifications and certification criteria of EHRs that qualify for financial incentives by the end of 2009. CMS will develop the formal definition of meaningful use to support the incentive programs. CMS will go through the full administrative rules process with a proposed rule, public comment period and a final rule. A timetable was not given. The recommendations from the meaningful use workgroup include a matrix of objectives for 2011, plus enhanced objectives for 2013

		and 2015. The workgroup will refine the initial recommendations for 2011 and 2013 within three months. Per Health law update; Bass, Berry & Sims dated Feb 9, 2009: The Act states that the incentive payments are paid to the eligible professional using EHR, "or to an employer or facility in the cases described in clause (A) of section 1842(b)(6)" of the Social Security Act. The referenced clause of the Social Security Act states that no payment may be made under Medicare Part B to anyone other than the physician who provided the service, except that a payment may be made "to the employer of such physician or other person if such physician or other person is required as a condition of his employment to turn over his fee for such service to his employer, or where the service was provided under a contractual arrangement between such physician or other person and an entity" if, under the contractual arrangement, the entity bills for the service under Medicare Part B. Note that the definition of 'eligible professional' in the HITECH Act literally encompasses only individual physicians and not physician groups as entities.

Section 1402	**Incentives for Hospitals** (n) Incentives for Adoption and Meaningful Use of Certified EHR Technology (B) Base amount $2,000,000, however total amounts per hospital can range from $3,500,000 to $8,000,000+ over 4 – 5 years. (C) Discharge Related Amount - A hospital that has <1150 inpatient discharges for a year only base amount, a hospital with 1150 – 23,000 inpatient discharges gets a $200 per discharge payment in addition to the base amount. (D) Medicare share is also factored in (E) Transition Factor – Hospitals need to implement meaningful EHR before 2015 and ideally before 2013, otherwise these factors engage to lower payments. (3) **Meaningful EHR User** (A) (i) Meaningful Use of Certified EHR Technology - The eligible hospital demonstrates to the satisfaction of the Secretary that they are a meaningful certified EHR user.	$3,500,000 – $8,000,000+ for inpatient hospitals over 4 years. The math is complex for the inpatient calculations see HIMSS and other examples for calculations for hospitals. Medicare or Medicaid reimbursement types need to be chosen, the calculations for each are slightly different. Must be started by late 2010 or early 2011, more details to follow. Must have implemented by 2015 to prevent penalties from being assessed with reduced Medicare Reimbursement. **July 16 - July 20, 2009** – HIT Policy Committee (and Standards Committee, but Policy Committee's work more accessible at this point, although still a draft recommendation) outlined their thoughts and a matrix on. See PowerPoint and Matrix for more details.

	(ii)The eligible hospital demonstrates to the satisfaction of the Secretary that during such period such certified EHR technology is connected in a manner that provides in accordance to law and standards applicable to the exchange of information for the electronic exchange of health information to improve quality of health care, such as the promotion of care coordination. (iii) Reporting on measures Using EHR – Eligible hospital reports on such clinical quality and other measures as selected by the Secretary. (B)(ii) Reporting on Measures – Limitations – The Secretary may not require electronic reporting of information on clinical quality measures unless the Secretary has the capacity to accept the information electronically, which may be on a pilot basis. (C) **Demonstration of meaningful Use of Certified EHR technology and Information Exchange** (i) In General – A hospital may satisfy the demonstration requirements clauses through means specified by the Secretary which many include: (I) an attestation (II)Submission of claims with appropriate code indicating inpatient care was documented using certified EHR technology (III) a survey response (IV) reporting under (A)(iii) (V) other means specified by the Secretary (4)(B) Posting on Website – names of hospitals eligible for meaningful use of certified EHR technology will be posted on the Centers for Medicare and Medicaid Services website.	details. • 2009 Data Capture and Sharing • 2011 Advanced Clinical Processes • 2015 Improved Outcomes • Key Comment: Demonstrating the capability of reporting on MU measures and continuously improving its score would provide evidence of the organization's ability to use HIT to achieve goals of a transformed health system **Per HIT Policy Committee Matrix July 16, 2009 Hospitals** • **Same as Providers with following exceptions:** • 10% of all orders directly entered by providers • No sending of reminders • Generate lists of patients by specific conditions but not for quality improvement • No documenting of progress note • No provide electronic clinical summaries per encounter • Capability to provide reportable lab results for syndromic surveillance

		New information from the HIT Policy Committee The HIT Policy Committee recommends that incentives be paid according to an "adoption year" timeframe rather than a calendar year timeframe. Under this scenario, qualifying for the first-year incentive payment would be assessed using the "2011 Measures." The payment rate and phase out of payments would follow the calendar dates in the statute, but qualifying for incentives would use the "adoption-year" approach. i.e. 2011 measures apply for first adoption year, even if 2013 is the first year, those measure apply. Hospital qualifying for payments in 2011 would receive the full amount, there. Nursing homes are not eligible for Medicare incentive payments in most circumstances, but they may receive funding for EHR use under the Medicaid Nursing Home Grant Program. Per direct communication from ONC – Hospices, not eligible. On the hospital side, a provider is defined as a hospital (including acute care and critical access),

		skilled nursing facility, nursing facility, home health entity, long-term care facility, healthcare clinic, community mental health center, renal dialysis facility, blood center, ambulatory surgery center, and rural health clinic.
Section 4103	For physician ambulatory EHR's the definitions are much the same with the inclusion of e-prescribing.	
Subtitle B	**Medicaid Incentives**	
Section 4201	**Medicaid Provider HIP Adoption and Operation Payments; Implement Funding**	Complex qualification and incentive descriptions. Works with the State according to a formula which encourages certified EHR use and adoption. Eligible professionals may be physicians, dentists, certified nurse mid-wife, nurse practitioner, a physician assistant practicing in a rural health clinic