

23 Building Blocks for Quality: The View from 2008

Overview

In May, 2004, the Quality Workgroup of the National Committee on Vital Health Statistics (NCVHS) put forward an ambitious report, *Measuring Health Care Quality: Obstacles and Opportunities*. The report synthesized the learnings from 17 panels over the previous four years, in four areas: 1) assessing health care and health outcomes, 2) reducing disparities in outcomes, 3) building data infrastructure to support quality improvement, and 4) balancing patients' interests in health care quality and in privacy. In these areas, the Workgroup proposed a total of 23 "candidate recommendations," each linked to specific data needs and suggested options for meeting them.

For a number of reasons, the report has remained an internal NCVHS document. Many public and private sector initiatives were developing in the quality arena in mid-2004, and the Committee believed it important to consult with other stakeholders on the best ways to proceed. Members agreed to treat the candidate recommendations as possible agenda items for NCVHS subcommittees and workgroups.

Since then, as described below, activities by the Committee and others have moved some elements forward. NCVHS held hearings on the first six candidate recommendations; and its recommendation to the Secretary that the *present on admission* flag be implemented (candidate recommendation #3) has come to fruition. None of the other candidate recommendations went forward to the Secretary in the form expressed in the 2004 document. Nevertheless, NCVHS found it useful to revisit the report to assess progress and identify gaps related to data on quality..

The present document reviews selected quality-related data developments between 2004 and 2008 and offers a brief status report on each of the 23 candidate recommendations. It is primarily intended as background for NCVHS as it plans new efforts to strengthen the data foundation for transforming health care and health in the U.S. The report is being made available to the public as an historical record of major issues, perspectives and options in 2004 and as a compilation of quality data issues that remain in mid-2008. The Committee looks forward to continued collaboration with colleague organizations in 1) assessing health care and health outcomes, 2) reducing disparities in outcomes, 3) building data infrastructure to support quality improvement, and 4) balancing patients' interests in health care quality and in privacy.

This report includes a summary of the 23 candidate recommendations, each of which is a building block for quality. The status of each candidate recommendation is described using one of the following descriptors:

- This issue remains open.
- The process has begun.
- Demonstrable progress has been made.

The summary is followed by a brief review of key developments for quality measurement and improvement that occurred between 2004 and 2008. Then the status of each candidate recommendation (as of 7/17/08) is described, with attention to progress both in specific technical (i.e., standards-related) areas and in the elaboration and development of concepts that underlie each recommendation. A Glossary is appended to the report.

SUMMARY OF 23 “BUILDING BLOCKS” (CANDIDATE RECOMMENDATIONS)

Assessing Health Care and Health Outcomes

1. Create a mechanism for reporting selected inpatient and outpatient laboratory results in a standard transaction. *(The process has begun.)*
2. Create a mechanism for reporting selected vital signs and objective data measurements for inpatient encounters and outpatient visits in a standard transaction. *(The process has begun.)*
3. Facilitate the reporting of a diagnosis modifier to flag diagnoses that were present on admission on secondary diagnosis fields in all inpatient claims transactions. *(Demonstrable progress has been made.)*
4. Modify the usage instructions for the existing data element for Operating Physician such that it is a required data element for the principal inpatient procedure. *(The process has begun.)*
5. Modify the requirements for reporting Admission Date/Time and selected Procedure Dates/Times on Institutional claims transactions. *(The process has begun.)*
6. Encourage payers to modify billing instructions to providers to align procedure start and end dates with services included in selected global procedure codes in standard HIPAA claims transactions (episode start & end dates). *(The process has begun.)*
7. Review the available options for coding patients’ functional status in EHRs and other clinical data sets and recommend standard approaches. Conduct the research recommended by NCVHS in 2001 and CHI in 2003, as endorsed by NCVHS. *(The standardization process has begun.)*
8. Create a mechanism for reporting functional status codes in a standard transaction *(The process has begun.)*
9. Develop survey sampling approaches that can assure the availability of adequate benchmarking data at the state and metropolitan area levels and for racial and ethnic sub-populations. *(This issue remains open.)*

10. Standardize currently inconsistent items that are used to report the same measure of quality (e.g., immunization and screening rates) across federal surveys. Coordinate with states and private sector quality measurement/oversight organizations on the adoption of common items across federal, state and private sector surveys. *(This issue remains open.)*

Reducing Disparities in Outcomes

11. Modify existing mechanisms for reporting race & ethnicity of subscribers and dependents on the HIPAA enrollment transaction. *(The process has begun.)*
12. Investigate how best to capture race & ethnicity on a standard provider transaction. *(The process has begun.)*
13. Modify existing mechanisms for reporting the primary language of both subscribers and dependents on the HIPAA enrollment transaction. *(The process has begun.)*

Building the Data Infrastructure to Support Quality Improvement

14. Adopt standard clinical terminologies, including a crosswalk or meta-thesaurus of clinical synonyms that can be used to consistently identify and describe clinical conditions, procedures, treatments and outcomes across EHRs, administrative transactions and provider and patient surveys. *(The process has begun.)*
15. Promote the identification of lay synonyms for standard clinical terms that are easily comprehensible to patients of different cultures and educational attainment. Include these lay terms in the meta-thesaurus of clinical synonyms to facilitate their use in personal health records and patient surveys. *(This issue remains open.)*
16. Adopt ICD 10-CM for coding and classification of diagnoses and health conditions in administrative transactions. *(This issue remains open.)*
17. Create a mechanism for efficiently mapping procedure codes across current and proposed HIPAA standard coding systems to facilitate querying and aggregating procedure information across care settings. *(This issue remains open.)*
18. Standard functionality requirements for electronic health records should include clinical decision support to facilitate planning and delivery of evidence-based care to individual patients and groups. *(This issue remains open.)*
19. EHRs should employ uniform data standards for core content and data storage formats to facilitate population health surveillance and reporting functions. *(The process has begun.)*
20. Promote standards for interoperability of electronic clinical data systems and EHRs, and adopt a core set of output record formats that EHRs should be capable of exporting and importing to support care coordination and QA/QI. *(The process has begun.)*

21. HHS should recommend the adoption of the NPI as a consistent provider identifier, not only in administrative transactions but also in clinical data systems, EHRs, provider surveys, and clinical record and reporting formats. HHS should implement this recommendation within all federally funded health information systems. *(The process has begun.)*
22. Develop a voluntary, standardized Patient Identifier or Patient Identifier logic that, when authorized by the patient, can be used to link healthcare records for the same patient across payers, providers and care settings. *(This issue remains open.)*

Balancing Patients' Interests in Health Care Quality and Privacy

23. Examine privacy protections under existing federal laws that inhibit access to and linkage of patient records across payers, providers and care settings for purposes of care coordination and management and quality assessment and improvement. Revise and/or clarify current regulations to reduce obstacles while effectively balancing the best interests of patients and populations. *(The process has begun.)*

Key Developments, 2004-2008

Several activities by the Federal government and its advisory groups have been significant in creating today's environment for quality measurement and improvement.

- In 2004, the President issued an Executive Order establishing the position of the **National Coordinator for Health Information Technology (ONC)** within the Office of the Secretary of Health and Human Services (HHS). NCVHS had recommended the establishment of such a position in 2001. The primary purpose of this position is to aid the Secretary in achieving the President's Goal for most Americans to have access to an interoperable electronic medical record by 2014.
- The **American Health Information Community (AHIC)** was established in 2005, and an **AHIC Quality Work Group** was convened in 2006. The latter was charged with determining how health information technology can be used for the development of quality measures helpful to patients and others in the health care industry; automating the measurement and reporting of a comprehensive current and future set of quality measures; and accelerating the use of clinical decision support that can improve performance on those quality measures. Liaison between the AHIC Quality Workgroup and the NCVHS Quality Subcommittee is ongoing.
- Many activities by the **NCVHS Subcommittees** on Privacy, Populations, and Standards and Security and by the NCVHS Quality Work Group and ad hoc NCVHS workgroups have furthered the goals outlined in the 2004 report. Key NCVHS activities are described in the status reports below; in addition, the Committee's activities can be reviewed on its website, where all NCVHS

reports are posted <<http://ncvhs.hhs.gov>>. (A May 2008 reorganization resulted in the Quality Work Group being elevated to a Subcommittee and security issues being moved to the Privacy Subcommittee.)

Status of the 23 Candidate Recommendations

Assessing Health Care and Health Outcomes

1. Create a mechanism for reporting selected inpatient and outpatient laboratory results in a standard transaction. *(The process has begun.)*
2. Create a mechanism for reporting selected vital signs and objective data measurements for inpatient encounters and outpatient visits in a standard transaction. *(The process has begun.)*
3. Facilitate the reporting of a diagnosis modifier to flag diagnoses that were present on admission on secondary diagnosis fields in all inpatient claims transactions. *(Demonstrable progress has been made.)*

Conceptual

- The concept of refining administrative data with clinical elements remains at the forefront of contemporary thinking about quality as part of the interim hybrid data strategy. The AHIC Quality Work Group has developed a vision roadmap for quality and health information technology. While actively working to develop structural electronic health record fields that facilitate capture and reporting on quality, the AHIC QWG also has stated that the “Workgroup recognizes that transition to clinical data will be lengthy and that a hybrid of claims and clinical data will be required to measure quality for the foreseeable future.” *(AHIC Quality Workgroup Vision Summary 2008: Defining Characteristics of the Health Care System in the Context of a National Quality Enterprise)*
http://www.hhs.gov/healthit/ahic/materials/qual_execsum.htm
- NCVHS heard testimony in June 2007 on the current state of hospital performance measurement and public reporting of quality data. Models were presented demonstrating the powerful impact of the addition of laboratory data, vital signs and present on admission flag in the risk adjustment of administrative data. In January 2008, the Committee sent a letter report to the Secretary on the emerging use of hybrid data to measure and report quality.

Technical

- The *present on admission* (POA) flag was implemented in the UB-04 data set in 2007. As recommended by NCVHS, the National Uniform Billing Committee worked with the Cooperating Parties for ICD-9-CM and ASC X12N to specify the code set, reporting conditions and use cases for the flag or indicator. The POA indicator will be included in the next version (5010) of the HIPAA claim/encounter transaction. As of FY 08, Medicare is requiring

the indicator in the transaction standard for inpatient conditions. In FY 09, as an incentive to improve care by reducing hospital acquired complications, Medicare will adjust reimbursement when selected conditions are found to be acquired during an acute care hospital stay.

- It has not yet been determined whether laboratory data to be used with administrative data will be retrieved from HL7 Laboratory Attachment Standard, the Clinical Reports Attachment, or otherwise drawn from electronic health records. Although a Notice of Proposed Rulemaking for Standards for Electronic Health Care Claims Attachments was issued in 2005, a final rule has not yet been promulgated. However, the value of the data and the ongoing need to use and risk adjust administrative data remain strong.

4. Modify the usage instructions for the existing data element for Operating Physician such that it is a required data element for the principal inpatient procedure. (*The process has begun.*)
5. Modify the requirements for reporting Admission Date/Time and selected Procedure Dates/Times on Institutional claims transactions. (*The process has begun.*)

Conceptual

- Availability of Operating Physician information has enabled public reporting on physician-specific volume and outcomes in several states (e.g., New York and Massachusetts). Understanding the impact of the reporting is an area of ongoing discussion.

Technical

- The X12 837 Institutional claim standard in the 4010 and 5010 implementation guides and Health Care Service Data Reporting Guide (HCSDRG) in the 5010 allow for one operating physician per inpatient claim. For outpatients, an operating physician is identified for each procedure. Both support procedure dates, but not times.

6. Encourage payers to modify billing instructions to providers to align procedure start and end dates with services included in selected global procedure codes in standard HIPAA claims transactions (episode start & end dates). (*The process has begun.*)

Conceptual

- In addition to the interest in episodes of care related to procedures, there is growing interest in episodes of care related to medical conditions. CMS has begun reporting 30 day mortality of Medicare patients after discharge for treatment of acute myocardial infarction or congestive heart failure, and will add pneumonia in FY 09.
- The National Quality Forum (NQF) has convened the “National Priorities Partners” Committee to develop a comprehensive measurement framework for evaluating quality and costs across episodes of care-- from primary prevention through acute and post-acute care and secondary prevention. NQF also convened a panel of experts to develop a patient-centered “episode

of care” framework to address major gaps in current measures and care, particularly transitions and care coordination. In May 2008, NQF held a workshop entitled “Toward a Comprehensive Cancer Measure Set: Episodes of Care.” The purpose of the workshop was to provide recommendations for cancer quality measurement, moving toward an episodic assessment of what constitutes optimal cancer care. ,

- In May 2008, NCVHS held a hearing on information needs for the “Patient-Centered Medical Home” care delivery model. This model entails coordination of care and also may involve an episode approach to data collection.

Technical

- While all versions of the 837 guide provide for a statement date range, these data elements are primarily used for admission and discharge dates. However, the concept of *episodes of care* has gained increasing attention, encompassing the individual’s course before, during and after a procedure and following discharge.

7. Review the available options for coding patients’ functional status in EHRs and other clinical data sets and recommend standard approaches. Conduct the research recommended by NCVHS in 2001 and CHI in 2003, as endorsed by NCVHS. (*The standardization process has begun.*)
8. Create a mechanism for reporting functional status codes in a standard transaction (*The process has begun.*)

Conceptual

- In 2006, the Federal Consolidated Health Informatics (CHI) Initiative endorsed both International Classification of Functioning, Disability and Health (ICF) and SNOMED CT as standards for vocabulary content in the functioning and disability domains.
- The National Library of Medicine and the World Health Organization have agreed to incorporate ICF into UMLS as a "Category 4," which will make it freely available for all uses in the U.S. This will facilitate applications in information systems and mappings with terminologies and assessment instruments. (<http://www.hhs.gov/healthit/chiinitiative.html>)
- In 2007, the Institute of Medicine Committee on Disability in America issued a report titled “Future of Disability in America,” where it advocated for adoption and refinement of ICF as the conceptual framework for disability monitoring and research.

Technical

- Currently, functional status is not reported as part of a standard HIPAA transaction. The HL7 EHR-S Functional Model includes functional status within the problem list information. Coding of functional status, however, is not currently supported by the UB-92, UB-04 or by the ANSI X12 claim standards.

9. Develop survey sampling approaches that can assure the availability of adequate benchmarking data at the state and metropolitan area levels and for racial and ethnic sub-populations. *(This issue remains open.)*
10. Standardize currently inconsistent items that are used to report the same measure of quality (e.g., immunization and screening rates) across federal surveys. Coordinate with states and private sector quality measurement/ oversight organizations on the adoption of common items across federal, state and private sector surveys. *(This issue remains open.)*

Conceptual

- Standard methods for reporting quality measures are under development through state and national collaboration and under the leadership of NQF. NQF endorsement involves rigorous, evidence-based review and a formal Consensus Development Process that has become the “gold standard” for healthcare performance measures.

Technical

- The Health Care Services Data Reporting Guide (HCSDRG) is serving as a model for capturing data for state outcome measures. The data content in the HCSDRG fully supports the UB data content. This content is used throughout the country to derive outcome measures.

Reducing Disparities in Outcomes

11. Modify existing mechanisms for reporting race & ethnicity of subscribers and dependents on the HIPAA enrollment transaction. *(The process has begun.)*
12. Investigate how best to capture race & ethnicity on a standard provider transaction. *(The process has begun.)*
13. Modify existing mechanisms for reporting the primary language of both subscribers and dependents on the HIPAA enrollment transaction. *(The process has begun.)*

Conceptual

- In November 2005, NCVHS issued a report to the Secretary entitled *Eliminating Health Disparities: Strengthening Data on Race, Ethnicity, and Language in the U.S.*, developed from extensive review, hearings, and testimony. Its two overarching recommendations were: 1) Enhance the quality, reliability, and completeness of data collection and data integration on racial, ethnic, and linguistic subpopulations in the United States and territories; and 2) Increase and strengthen the capacity of the health statistics infrastructure to analyze, report, and disseminate data on the various ethnic/racial/linguistic subpopulations in the United States and territories.
- The Agency for Healthcare Research and Quality (AHRQ) publishes the National Healthcare Disparities Report on behalf of HHS and provides it annually to Congress. This report is a comprehensive national overview of disparities in health care among racial, ethnic, and socioeconomic groups

within the U.S. population and within priority populations. AHRQ tracks disparities related to quality of health care and access to health care, and the progress of activities to reduce disparities.

Technical

- New versions of HIPAA transaction standards and related standards have increased capacity to capture information on race and ethnicity, but these data elements still are not regularly reported and available. The 5010 version of the X12 834 (enrollment transaction) implementation guide supports reporting of race and ethnicity in the DMG05-2&3, but the 837 claim Institutional Guide does not. The 5010 version of the X12 834 implementation guide supports reporting of the collection method for obtaining race and ethnicity information in the DMG10. The HCSDRG 4050 and 5010 support reporting of codes for race and ethnicity and for collection method as identified in the CDC Race and Ethnicity collection code table. The UB-04 has a new “code-to-code” section that could be used for reporting race and ethnicity. Data maintenance has been presented to X12 to support modifications to the standard to support reporting the primary language of both subscribers and dependents.

Building the Data Infrastructure to Support Quality Improvement

14. Adopt standard clinical terminologies, including a crosswalk or meta-thesaurus of clinical synonyms that can be used to consistently identify and describe clinical conditions, procedures, treatments and outcomes across EHRs, administrative transactions and provider and patient surveys. *(The process has begun.)*

Conceptual

- In 2006, NCVHS generated three letters to the Secretary in support of advancement of CHI standards in the areas of Multimedia Domain (June 22), Allergy domain (September 13) and Functioning and Disability domains (November 28). These recommendations were accepted by the Secretary and forwarded to the Office of the National Coordinator for HIT. Prior to 2006, NCVHS also sent the Secretary letters on a variety of CHI standards, all of which are posted on the NCVHS website.

Technical

- Standards harmonization activities currently underway include: (1) HITSP Foundations Committee; (2) HL7 Vocabulary Committee (with an initial focus on sex structure and marital status data element harmonization); and (3) NLM contract to make HL7 vocabulary consistent with CHI where appropriate.

15. Promote the identification of lay synonyms for standard clinical terms that are easily comprehensible to patients of different cultures and educational attainment. Include these lay terms in the meta-thesaurus of clinical synonyms to facilitate their use in personal health records and patient surveys. *(This issue remains open.)*

Conceptual

- Consumer demand for lay health vocabularies has resulted in both commercial and open-access initiatives aimed at facilitating online health information translation, including mapping ICD-9 codes to consumer-friendly terminology.

Technical

- HITSP Consumer Empowerment Technical Committee chose to use the HL7 "InfoButton" standard to facilitate integration of vocabulary resources that define medical terms in lay person language. These vocabulary resources are not standard terminologies; rather they are often created and owned by organizations that sell them. The InfoButton standard was selected to enable integration of these resources into PHR systems. While there have been some efforts to focus on what terms resonate with consumers, more work focused on consumer testing and validation is required.

16. Adopt ICD 10-CM for coding and classification of diagnoses and health conditions in administrative transactions. (*This issue remains open.*)

Conceptual

- NCVHS continues to call for ICD-10 code set adoption as noted in letters to the Secretary on the *Urgent Need for Revisions to HIPAA Transaction Standards* (September 26, 2007) and *Quality Measurement and Public Reporting in the Current Health Care Environment* (January 29, 2008).

Technical

- Implementation is tied to implementation of 5010. A Notice of Proposed Rulemaking for 5010 transactions and a Notice of Proposed Rulemaking for replacing ICD-9-CM with ICD-10-CM and ICD-10-PCS are through clearance in the Department and have been accepted by the Office of Management and Budget for formal review.

17. Create a mechanism for efficiently mapping procedure codes across current and proposed HIPAA standard coding systems to facilitate querying and aggregating procedure information across care settings. (*This issue remains open.*)

Conceptual

- NCVHS continues to monitor national and international work on classification and terminology developments. A key observation and concern of NCVHS is that this activity lacks an official "home."

Technical

- Mapping procedure codes to SNOMED CT may facilitate harmonization. NLM has initiated some work in this area. However, ICD-9-CM, Volume 3 needs to be replaced with ICD-10-PCS, as recommended by NCVHS.

18. Standard functionality requirements for electronic health records should include clinical decision support to facilitate planning and delivery of evidence-based care to individual patients and groups. *(This issue remains open.)*

Conceptual

- AHIC Workgroups submitted recommendations to the Secretary in April, 2008, calling for acceleration of clinical decision support development and adoption.
http://www.hhs.gov/healthit/ahic/materials/04_08/ehr/cd_recs.html

Technical

- HL7 EHR Functional Model includes some clinical decision support functions.
- EHR functional profiles have been developed specific to Child Health, Long Term Care and Behavioral Health to facilitate planning and delivery of evidence-based care.

19. EHRs should employ uniform data standards for core content and data storage formats to facilitate population health surveillance and reporting functions. *(The process has begun.)*

Conceptual

- The National Center for Health Statistics (NCHS) is investigating, through contract, data normally expressed in an EHR that are useful for health statistics. As part of the work, terminology and formats are also under investigation. NCHS is basing this work in part on a study of the use of EHR data for national health statistics in four countries conducted by Dan Friedman, a former NCVHS Member. *(Assessing the Potential of National Strategies for Electronic Health Records for Population Health Monitoring and Research)* <http://www.cdc.gov/nchs/data/series/sr_02/sr02_143.pdf>
- AHRQ has begun standardization efforts in the area of patient safety. The Patient Safety and Quality Improvement Act of 2005 calls for the development of common data formats for patient safety events that are standardized and can be aggregated to inform quality improvement efforts and to track the nation's progress in this vital area.

Technical

- HL7 Clinical Document Architecture (CDA) and ASTM Continuity of Care Record (CCR) led to the development of the Continuity of Care Document (CCD) that includes a core set of data elements in a common exchange framework.
- The AHIC 2006 Harmonized Use Case for Biosurveillance (Visit, Utilization and Lab Result Data) resulted in development of the HITSP Biosurveillance Interoperability Specification (IS 02).

20. Promote standards for interoperability of electronic clinical data systems and EHRs, and adopt a core set of output record formats that EHRs should be capable of exporting and importing to support care coordination and QA/QI. *(The process has begun.)*

Conceptual

- In October 2005, HHS awarded the Certification Commission for Healthcare Information Technology (CCHIT) a contract to develop, create prototypes for, and evaluate the certification criteria and inspection process for EHRs. As of mid-2008, 9 inpatient and 29 outpatient EHRs have been certified.
www.cchit.org
- In 2007 NQF convened the Health Information Technology Expert Panel to recommend the way quality should be measured from data in electronic health records, with the goal of accelerating efforts to identify a set of common data elements used in measurement that can be standardized. This panel is working with the Health Information Technology Standards Panel (HITSP) Population Technical Committee to more precisely specify the data elements for the AHIC Quality use case. This should lead to recognition of interoperability standards for quality measures by the HHS Secretary.

Technical

- HITSP has defined several Interoperability Specifications that relate to format and content of messages used for clinical interoperability:
 - IS01 Electronic Health Record (EHR) Laboratory Results Reporting
 - IS02 Biosurveillance
 - IS04 Emergency Responder Electronic Health Record (ER-EHR)
 - IS06 Quality
 - IS07 Medication Management

21. HHS should recommend the adoption of the NPI as a consistent provider identifier, not only in administrative transactions but also in clinical data systems, EHRs, provider surveys, and clinical record and reporting formats. HHS should implement this recommendation within all federally funded health information systems. *(The process has begun.)*

Conceptual

- The NCVHS Subcommittee on Standards and Security has played an active role in the adoption of the National Provider Identifier (NPI), with letters to the Secretary in November 2006, February 2007 and June 2007.

Technical

- CMS implemented the NPI on May 23, 2008.
- Full access to the NPI data base for population health purposes is not assured at this time and must await resolution of NPI implementation issues.

22. Develop a voluntary, standardized Patient Identifier or Patient Identifier logic that, when authorized by the patient, can be used to link healthcare records for the same patient across payers, providers and care settings. *(This issue remains open.)*

Conceptual

- AHIC Quality Workgroup has also identified “Patient Record Matching” as a key gap that must be addressed in the “Roadmap for Developing the HIT Capabilities to Achieve Quality Workgroup Vision”
<http://www.hhs.gov/healthit/ahic/quality/quality_materials.html>

Technical

- Congress halted implementation of the National Patient Identifier in 1998.
- The NCVHS Subcommittee on Standards and Security held hearings on the Patient Identifier logic in matching patients to their records during 2005-2006. The 2006 NCVHS report on initial functional requirements for a Nationwide Health Information Network includes a summary of the testimony received.

Balancing Patients’ Interests in Health Care Quality and Privacy

23. Examine privacy protections under existing federal laws that inhibit access to and linkage of patient records across payers, providers and care settings for purposes of care coordination and management and quality assessment and improvement. Revise and/or clarify current regulations to reduce obstacles while effectively balancing the best interests of patients and populations. *(The process has begun.)*

Conceptual

- NCVHS has made recommendations regarding privacy protections in several reports and letters to the Secretary (all posted on the NCVHS Website):
 - June 22, 2006—*Letter to the Secretary— Recommendations Regarding Privacy and Confidentiality in the Nationwide Health Information Network*
 - June 21, 2007—*Letter to the Secretary—Update to Privacy Laws and Regulations Required to Accommodate NHIN Data Sharing Practices*
 - June 21, 2007—*Letter to the Secretary—Recommendation Letter on Data Linkages to Improve Health Outcomes*
 - December 22, 2007—*Report on Enhanced Protections for Uses of Health Data: A Stewardship Framework for "Secondary Uses" of Electronically Collected and Transmitted Health Data*
 - February 20, 2008—*Letter to the Secretary—Individual Control of Sensitive Health Information Accessible Via the Nationwide Health Information Network for Purposes of Treatment*

Technical

- During the 2007 hearings for the Report on Enhanced Protections for Uses of Health Data, NCVHS heard testimony from several commercial entities on emerging technologies for individual consent applications.

23 Building Blocks for Quality: The View from 2008
Glossary of Terms

AHIC	American Health Information Community
AHIMA	American Health Information Management Association
ANSI	American National Standards Institute
AQA	Ambulatory Quality Alliance
ASC X12N	Accredited Standards Committee (X12N is a specific ASC standard)
ASTM	American Society for Testing and Materials
CCHIT	Certification Commission for Health Information Technology
CCR	Continuity of Care Record
CDA	Clinical Documentation Architecture
CDS	Clinical Decision Support
CHII	Consolidated Health Informatics Initiative
CMS	Centers for Medicare and Medicaid Services
EHR	Electronic Health Record
HCSDRG	Health Care Service Data Reporting Guide
HHS	Health and Human Services
HIMSS	Health Information Management Systems Society
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology
HITSP	Health Information Technology Standards Panel
HL-7	Health Level 7
HQA	Hospital Quality Alliance
ICD9-CM	International Classification of Disease...
ICD 10 PCS	International Classification of Disease...
ICF	International Classification of Functioning, Disability and Health
IT	Information technology
NCHS	National Center for Health Statistics
NCVHS	National Committee on Vital and Health Statistics
NHIN	National Health Information Network
NLM	National Library of Medicine
NPI	National Provider Index
NQF	National Quality Forum
NUBC	National Uniform Billing Committee
OMB	Office of Management and Budget
POA	Present on admission
QA	Quality Assessment
QI	Quality Improvement
SNOMED CT	Systematized Nomenclature of Medicine—Clinical Terms
UB	Uniform Billing
UMLS	Unified Medical Language System