What Public Policy Is and How to Help Shape It

David Bates, Meryl Bloomrosen, Doug Peddicord
AMIA Annual Symposium
Monday, October 24, 2011
12:00 -1:30 pm
Overview of Workshop and AMIA’s Public Policy Committee Activities

David Bates, MD, MSC
Chair, AMIA Public Policy Committee
Senior Vice President for Quality and Brigham and Women's Hospital
Chief of the Division of General Internal Medicine and Primary Care at Brigham and Women's Hospital
Professor of Medicine Harvard Medical School
Professor of Health Policy and Management
Harvard School of Public Health
Purpose of Workshop

- To provide information about health policy development and implementation
- To provide an overview of federal and state regulatory programs affecting the health care industry in general and biomedical and health informatics in particular.
- To assist in the understanding of the purpose of policy advocacy and AMIA's role in educating and influencing policy makers
Goals and Objectives

• By the end of the workshop, participants will be able to:
  – Appreciate the complexities of federal policy making as it affects biomedical and health informatics
  – Respond to requests for comments about rules impacting biomedical and health informatics
  – Understand how individuals can impact decision-making about biomedical and health informatics policy
  – Utilize congressional visits to advance AMIA's policy agendas
  – Understand how to take action to advance policy priorities that impact biomedical and health informatics professionals
Agenda

• 12:00 - 12:30 Welcome and Introductions
  AMIA's Policy Program and Activities - David Bates

• 12:30 - 1:00 How Policy is made Inside the Beltway - Doug Peddicord

• 1:00 – 1:30 Responding to a Request for Comments – Meryl Bloomrosen

• 1:30 pm Adjourn
AMIA Policy Activities

• Compile and Submit Official AMIA Comments
• Conduct Congressional Visits
• Conduct Policy Sessions at AMIA Educational Meetings
• Conduct Corporate Policy Updates
• Convene Invitational Policy Meetings and Develop Proceedings
• Create Issue Briefs
• Develop Position Papers
• Host AMIA Hill Day
• Mentor Policy Leaders
• Monitor and Track Congressional Activities
• Provide Testimony
• Submit Nominations for Committees and Task Forces
• Track Legislation of interest to Members and the Informatics Community
• Track Federal Agency Activities
Tracking Federal Activities

- ARRA, HITECH, Health Reform
  - ONC Health IT Policy and Standards Committees
- Guidelines, Rules, Regulations
  - Meaningful Use
  - Privacy and Security
  - Metadata
  - Common Rule
- Increasing Efforts for Transparency and Accountability
AMIA’s Public Policy Committee

• Makes recommendations to the BOD regarding AMIA positions on public policy issues
• Oversees advocacy initiatives in support of AMIA positions
Purpose of AMIA’s Policy Meetings

• Convene diverse and multiple stakeholders on timely and relevant informatics-related topics

• Identify specific areas and issues for future health policy considerations

• Describe areas for further study or research

• Synthesize and disseminate the conference deliberations, findings, and outcomes to inform the policymaking process.
2011-2012 Policy Priority Topics

- Ongoing Funding for Informatics Research, Innovation, and Development
- Meaningful Use (MU)
- Ensuring safe, effective use of health IT and electronic health records (EHRs)
- Informatics and Health IT Workforce (includes education and training)
- EHR Best Practices, Lessons Learned and Successes
- EHR Evaluation
- EHR Usability
- Evolution of Clinical Decision Support
AMIA’s Health Policy Meetings

- **2006**: Toward a national framework for the secondary use of health data: an American Medical Informatics Association White Paper
- **2007**: Advancing the framework: use of health data--a report of a working conference of the American Medical Informatics Association
- **2008**: Informatics, evidence-based care, and research; implications for national policy: a report of an American Medical Informatics Association health policy conference.
- **2009**: Anticipating and Addressing Unintended Consequences of HIT and Policy
- **2010**: The Future of Health IT Innovation and Informatics
- **2011**: The Future Form and Function of Clinical Data Capture and Documentation
Policy and Politics: How the Legislative and Regulatory Processes Work – And How to Influence Them

Doug Peddicord, PhD
President
Washington Health Strategies Group
Authority and Organization of the Legislative Branch

• Organization of Legislative Branch
  – Senate: 100 members, 6-year terms
  – House of Representatives: 435 members, 2-year terms
  – Committees (Committee and Subcommittee Chairs hold the power – and usually a Member is only as powerful as the Committee he/she sits on)
Key Committees: Senate

- Finance
  - Jurisdiction
  - Leadership
- Health, Education, Labor, Pensions (HELP)
  - Jurisdiction
  - Leadership
  - Members
- Appropriations
  - Subcommittees (the Cardinals)
Key Committees: House

- Ways and Means
  - Jurisdiction
  - Leadership
- Energy and Commerce
  - Jurisdiction
  - Leadership
- Appropriations
  - Subcommittees: e.g., Defense, Labor HHS, Agriculture and FDA (member-directed funding; aka ‘earmarks’)
How a Bill Becomes a Law

• Introduction of bill by member
• Sponsors and co-sponsors
• Consideration by committee
  – Public hearings
  – Markups
  – Final committee action
• Floor debate
• Vote
• Conference – and vote again
• Send to President for signature
How A Bill Becomes A Law (Part 2)

• Ways to shorten the process
  – Unanimous Consent
  – Christmas Trees
  – ‘Must pass’ legislation (often with an associated crisis; e.g., govt. shutdown)
  – Differences between the Senate (filibuster) and the House
  – And there are still rules (e.g., the Byrd amendment)
Who Influences Public Policy?

- White House
- Executive branch
- Congressional Members, Committees, Staff
- Government Accountability Office (GAO)
- Congressional Budget Office (CBO)
- Political parties
- Media, pundits, and public opinion research firms
- Political Action Committees (PACs)
- Interest and advocacy groups and “influentials”
- Professional associations
- Individuals – “we the people”
Where are the policy analysts? (wonks)

- Congressional staff
- Federal and state agency staff
- Lobbying firms
- Think tanks
- Academic policy shops
- Consulting firms (contract research)
- Professional associations
- Trade and advocacy associations
Role of Independent Advisory Bodies in Health Policy

• Institute of Medicine
  – Chartered by Congress under President Lincoln to provide independent advice to government and industry
  – Expert committees are formed to address specific issues, sometimes by Congressional mandate
  – National Academies Press publishes reports

• National Committee on Vital and Health Statistics (NCVHS)
  – Statutory public advisory body to HHS since 1949
  – Restructured in 1996 under HIPAA
  – National Health Information Infrastructure (NHII): Information for Health, 2001
IOM and National Research Council (NRC) Reports

• The Computer-based Patient Record: An Essential Technology For Health Care (1991)
• Health Care In The Information Age: Use, Disclosure, And Privacy (1994)
• Telemedicine: A Guide To Assessing Telecommunications For Health Care (1996)
• To Err Is Human: Building A Safer Healthcare System (1999)
• Key Capabilities Of An Electronic Health Record System (2003)
• Preventing Medication Errors: Quality Chasm Series (2006)
• The Learning Healthcare System: Workshop Summary (2007)
• Computational Technology For Effective Health Care (CSTB, NRC), 2009

See www.nap.edu or www.iom.edu
Other Advisory Bodies in Health IT

- Presidential, Congressionally-mandated and Secretarial Advisory Committees
  - Commission on Systemic Interoperability (CSI) mandated by Medicare Modernization Act, 2003; report in 2005 (www.endingthedocumentgame.gov)
  - American Health Information Community (AHIC) (2005-08)
- American Reinvestment and Recovery Act (2009) created advisors to Office of the National Coordinator for Health IT (ONC)
  - Health IT Policy Committee
  - Health IT Standards Committee
How can you get involved in the policy process?

- Participate in Congressional and agency fellowships
- Write reports and publish online (such as journals, blogs, newspaper commentary)
- Participate on advisory committees and coalitions
- Write opinion pieces and letters to editors
- Become a media source
- Conduct media briefings and Editorial Board meetings
- Get involved with issues at federal, state, and local levels
  - Testimony on local issues
  - Visits with legislators
  - Organize an e-mail or letter-writing campaign
Get involved with your professional organization

• Congressional education and advocacy (e.g., Hill Day)
• Professional identity as experts bring credibility as “trusted advisors”
• Resource for staff and members of Congress
• Meet with your Members to discuss state and local issues
• Represent AMIA members’ interests: public face of the profession
Making Legislation Happen - Or Not

- Find a champion for your point of view (Members matter) – e.g., AMIA 10 X 10
- Make connections – constituents, grassroots contacts and personal relationships make a difference
- Work the bill – provide letters of support, provide testimony, recruit co-sponsors
- Be clear on your ‘asks’ – amend when you can, support or oppose when the time comes
Being A Resource (Staff Matter Too)

• Establish **credibility** (answer two questions)
  – What do you want?
  – Who won’t like it?

  – Anecdotes and hard data both matter (but brevity is always key; *one-pager* is a term of art on the Hill)
  – When asked, provide feedback (opinions, examples, answers, alternatives) *immediately* – 12 to 24 hours used to be good enough; in the age of smart phones, try 2 to 3 hours – being timely is as important as being right
Know Where You Are In The Process

• Proposing new legislation
• Commenting on draft legislation
• Commenting on (proposing amendments to) introduced legislation
• Testifying on introduced legislation
• Supporting/opposing a bill
• Doing all of the above as an individual, a professional organization, or as part of a coalition, (sign-on letters)
After Legislation Becomes Regulation

• The regulatory process is more open and transparent – primacy and recency are less important (but you still have to show up!)
• Establishing relationships within the regulatory agencies is more likely to be based on expertise; it’s time to check your passion at the door
• Precision and clarity are key – think like a lawyer (or an English major)
• Be thorough – and respond within the time allowed
From Legislation To Regulation

- Notice of Proposed Rule Making (NPRM)
- Interim Final Rule
- Final Rule
- Guidance
- FAQs

Generally there is a Comment period – and often AMIA looks to weigh in
ARRA and HITECH

• The legislative process on steroids: the 111th Congress convened on January 6, 2009 – and the President signed a $787 billion ‘stimulus bill’ on February 17

• The House – Ways & Means (Medicare) and Energy & Commerce (Medicaid) takes the lead

• Focus on ‘shovel ready’ infrastructure projects – and HIT (!)
ARRA and HITECH

• AMIA’s interests:
  ✓ ONC
  ✓ HIT incentives
  ✓ HIT standards
  ✓ Workforce
  ✓ ‘Meaningful use’
  ✓ Privacy
HIPAA 2 (selected provisions)

• BAs subject to Security and (relevant provisions of) Privacy Rules; FTC jurisdiction over PHR vendors
• Breach reporting (secured vs. non-secured PHI)
• Accounting for TPO disclosures
• Marketing and fundraising restrictions
• Minimum necessary and de-identification guidances
• Self-pay disclosures (healthcare ops)
Other AMIA Policy Activities 2011

- 19 participants for 38 Hill Day meetings
- Approximately 15 additional Congressional and Administration contacts
- HIT Policy and Standards Committees, Tiger Team
- Labor-HHS Appropriations Committee report language re: the NLM
Submitted written comments to the following (from among an astonishing number of guidances, proposed regs, reports, etc. issued):

- Common Rule – HHS OHRP (pending)
- FDA Guidance on Mobile Medical Apps October 2011
- Presentation to FDA on CDS September 2011
- HHS OCR HIPAA Privacy Rule Accounting of Disclosures NPRM August 2011
- CMS Proposed Rules for ACOs June 2011
- President’s Letter to ONC Regarding Vendor Agreements June 2011
- NQF Quality Data Model May 2011
- Federal Health IT Strategic Plan May 2011
- eMeasures, to NQF April 2011
- NINR Draft Strategic Plan 2011 March 2011
- Federal Health IT Standards Activities March 2011
- Meaningful Use Stage 2 February 2011
- PCAST Report January 2011
- Personal Health Records December 2010
- NQF Common Format, Device or Medical/Surgical Supplies November 2010
A Few Last Thoughts

• Public policy advocacy is a contact sport: in-person, by phone, by e-mail: “ninety percent of life is just showing up”

• Primacy and recency are powerful determinants of influence, as is repetition

• What’s important? Connections (personal, constituent) — expertise — responsiveness — credibility

• Participation (Hill Day, for example) is essential
Preparing a Response to A Request for Comments

Meryl Bloomrosen
AMIA Vice President
Public Policy And Government Relations
Rulemaking Process

After Congressional bills become laws, federal agencies put laws into action through regulations. This process may include the following steps:

• An agency initiates a rulemaking activity, and adds an entry to its Regulatory Agenda
• A rule or other document is published to Regulations.gov
• The public is given the opportunity to comment on this rule for a specified timeframe
• Final rules can be accessed on Regulations.gov
• Rules are published every business day by the National Archives and Records Administration in the U.S. government's Federal Register.

www.regulations.gov
What is the Regulatory Agenda?

• Twice a year in the Spring and Fall, each agency publishes a Regulatory Agenda (also known as the Unified Agenda or Semi-Annual Agenda).

• The Regulatory Agenda provides information about regulations that each agency plans to issue or has recently completed.

• Each agency's Regulatory Agenda lists all the rulemaking proceedings that are planned, underway or recently completed. Individual entries contain a variety of information about each rule, including:
  – Brief description (abstract) of the rule
  – Timetable showing any past or projected actions in connection with developing the rule
  – Contact person for further information
  – Potential effects of the rule and related matters
How to Comment on Proposed Regulations

• Regulatory agencies publish rules that establish or modify the way they regulate their respective programs.
• Agency rules have considerable impact on the nation's health, industries and economy. These rules are not created arbitrarily or in a vacuum. They are formed with the public's help.
• By law, anyone can participate in the rule-making process by commenting in writing on rules proposed.
• Agencies routinely allow plenty of time for public input and carefully consider these comments when they draw up a final rule.
• Agencies typically gather public comments through proposed rules.
Proposed Rules Process

• When an agency plans to issue a new regulation or revise an existing one, it places an announcement in the Federal Register on the day the public comment period begins.

• Published every weekday, the Federal Register is available at many public libraries and colleges, and on the government websites.

• Issues open to public comment often are reported by the news media and can also be found on agency's Website. Instructions for finding Federal Register documents and submitting comments are found on the Federal Dockets Management System Instruction Sheet.

• When submitting a comment by mail or in person, you do not need to follow any special style. If the comment is written legibly or typed on standard 8-1/2 inch by 11 inch paper, however, agencies can process the comment more effectively.
Proposed Rules Process con’t

• In the Federal Register, the "notice of proposed rulemaking" describes the planned regulation and provides background on the issue. It also gives the address for submitting written comments and the name of the person to contact for more information.

• Also noted is the "comment period," which specifies how long the agency will accept public comments.

• Usually, the file--or docket--stays open for comments at least 60 days, though some comment periods have been as short as 10 days or as long as nine months. Weekends and holidays are included in the comment period.
42 CFR Parts 412, 413, 422, and 495

[CMS–0033–P]

RIN 0938–AP78

Medicare and Medicaid Programs; Electronic Health Record Incentive Program

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS. 

ACTION: Proposed rule.

SUMMARY: This proposed rule would implement the provisions of the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. 111–5) that provide incentive payments to eligible professionals (EPs) and eligible hospitals participating in Medicare and Medicaid programs that adopt and meaningfully use certified electronic health record (EHR) technology. The proposed rule would specify the—initial criteria an EP and eligible hospital must meet in order to qualify for the incentive payment; calculation of the incentive payment amounts; payment adjustments under Medicare for covered professional services and inpatient hospital services

CMS–0033–P, P.O. Box 8013, Baltimore, MD 21244–8013.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By express or overnight mail. You may send written comments to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–0033–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. By hand or courier. If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:


(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots

headquarters. CMS wishes to ensure that public comments on its regulations and PRA notices are promptly displayed on the regulations.gov Web site for the public to review. To ensure that comments are displayed as quickly as possible, we request that the public use only one public comment submission option. These efforts are intended to ensure that CMS operations continue even during an emergency and that consideration of public comments and access to those comments occur timely.

For information on viewing public comments, see the beginning of the SUPPLEMENTARY INFORMATION section.


SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this proposed rule to assist
Sample MU Comments Timeline

- January 13- Proposed and interim final rules on meaningful use (MU) and EHR certification standards formally published.
- January 13- March 14 (or March 15)- 60 day comment period
- January 15- AMIA will provide a brief summary of each rule
- January 19 – Webinar for AMIA members
- January 26- Issue discussed at the BOD January meeting
- February 5- WGs submit their draft comments to PPC (via Meryl)
- February 15- Prepare initial draft of an AMIA comment
- February 23- AMIA BOD review and approval of initial working DRAFT
- March 1-10 - Iterations/edits of succeeding drafts
- March 12/13- Submit AMIA response to DHHS within the 60 days
Medicare and Medicaid Programs; Electronic Health Record Incentive Program 42 CFR Parts 412, 413, 422, and 495 CMS-6033-P RIN 0938-AF78
AMIA Comments

<table>
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<tr>
<th>Stage 1</th>
<th>Stage 1</th>
<th>AMIA</th>
<th>Sophisticated User Feedback</th>
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<tbody>
<tr>
<td>Objectives (EP and hospital combined)</td>
<td>Measures</td>
<td>Comments/Questions to Help Guide Responses</td>
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The care goal here is "comprehensive" patient data – how can EHRs first aim for "necessary" or "integrated" or "relevant" data?

Respondents:
Rationale
The concept "comprehensive" is too broad and overwhelming – EHRs can provide clinically meaningful enhancements in care with implementation of a relatively circumscribed number of key features.

Current EHR software just does not have the functionality and usability to support "comprehensive" data collection or "comprehensive" use by physicians, nurses and other clinicians. The systems also lack cost-effective ways to ensure that the type of interoperability provided truly helps the patient’s multidisciplinary care team stay on the same page. When the same information looks different as the patient moves around errors occur. Behind the scenes strategies such as mapping to allow multiple different looking front-ends will not work here, the format and representation of key data items must look the SAME to patients and clinicians to reduce misunderstanding and errors.

Recommendations:
Create a standardized module that would be available and required for use in all EHRs that represents the key patient care information necessary to keep the patient’s interdisciplinary team on the same page that also utilizes a common set of rules about who and how the information is kept current and accurate. Build on industry knowledge and create and fully test (within 2 years) a standardized representation of key information at the e-user interface (and rules of use) that will be available and required to be a part of all EHRs by 2013-2015. The module should at minimum include the basic information needed to keep the patient and the interdisciplinary team on the same page about care across time and settings:

The standardized module would include the following items that would be represented with coded terminologies and tested to ensure usability by clinicians and a set of rules for who and how this module is kept accurate and current:

1. interdisciplinary problems (medical, nursing and other);
2. the outcomes being followed
3. progress toward outcomes,
4. "general" interventions being performed.
AMIA’s MU Comments

• General Comments
  – AMIA strongly believes that three principles are essential to achieving meaningful use of certified electronic health record (EHR) technology:
    • we must invest in people, as well as technology
    • users need EHR systems that provide cognitive support and evidence-based functionalities
    • adoption of EHR systems requires a balancing of benefits and burdens that users will accept
• Federal Leadership Role
  – assure that HIT is seen as a strategic driver of health system strengthening – but HIT is certainly not the entire solution,
  – payment incentives should avoid fostering “technology for technology’s sake,”
  – encourage EHR system designers and implementers to focus on the use of HIT to contribute to the ultimate goal of improvement in outcomes.
AMIA’s MU Comments cont’d

• **Provisions of the Proposed Rule on Which Comments are Specifically Requested**
  – agree that the reporting period for year 2 and thereafter should be the full year
  – support the decision that hospitals deemed as meaningful users by Medicare would not have to meet any state-specific additional requirements in order to qualify for the Medicaid incentive payment – Meaningful Use should be a national, not state-by-state, objective
  – support the HIT Policy Committee recommendation that CMS allow some flexibility in the “all-or-nothing” approach to earning meaningful use incentives, “while preserving a floor of important mandatory functional use requirements
  – believe that CPOE should, ultimately, include electronic transmittal of the order, and agree with the rule’s decision to defer this requirement during Stage 1.
  – suggest that recording of advanced directives be included as an MU criterion for hospitals only in Stage 1
  – believe that MU criteria specific to research should be included during Stage 2 and Stage 3
  – concerned that the capture of relevant data elements, e.g., numerators and denominators, is likely to be a significant burden for participating EPs and hospitals
  – agree and appreciate that there should not be a higher standard in 2015 for an early adopter in comparison to requirements imposed on late adopters
At a minimum, clinicians and hospitals will need the following technologies, services, or capabilities

- **EHR system capable of**
  - basic electronic medical record creation and maintenance
  - health information exchange

- **CPOE system with**
  - electronic prescription capability (if applicable)
  - ability to maintain electronic formulary
  - Drug-drug, drug allergy checks
  - Active medication list
  - Active allergy list

- **Clinical decision support platform**
- **Robust network connection/service**
- **Quality measures**
- **Security capabilities**
  - Secure platform
  - Review and analysis
  - Updates
Commenting with Impact

- Clearly indicate if you are for or against the proposed rule or some part of it and why. Agency regulatory decisions are based largely on law and science, and agency reviewers look for reasoning, logic, and good science in comments they evaluate.

- Refer to the docket number, listed in Federal Register notice.

- Include a copy of articles or other references that support your comments. (Electronic attachments will not be forwarded if the "Comment" box is left empty.)

- Only relevant material should be submitted. If an article or reference is in a foreign language, it must be accompanied by an English translation verified to be accurate. Translations should be accompanied by a copy of the original publication.

- To protect privacy when submitting medical information, delete names or other information that would identify patients.

- Comments must be postmarked, electronically submitted or delivered in person by the last day of the comment period.
Commenting Tips and Techniques

• The drafting of regulatory comments is best thought of as a relatively ‘technical’ process.

• This is not the time to ‘argue’ with the underlying legislation or wax either poetic or emotional. Regulations are usually about ‘facts and data’ and so too should comments.

• Typically an AMIA comment will use real-life hospital or practice examples, of course, but its tack will be aimed more at influencing ‘good’ HIT policy than at ‘correcting’ regulatory errors that would have specific impact on particular stakeholders.

• Look especially at topic items for which the Agency/Department has requested comments.
Tips and Techniques con’t

• Distinguish between parochial comments that might be offered by you as an individual, or you as an employee of a particular organization (relating to Medicare fee schedules for instance), from comments that might better reflect AMIA’s position as a thought-leader on HIT and the uses of health information.

• To the extent possible, make your comments specific and detailed; don’t say, ‘these 23 meaningful use criteria are too ambitious’, but rather ‘this specific measure may be gatherable in the hospital setting, but would be problematic in the outpatient setting for the following reason (s)…’.

• Give examples to back up or support your comments. Be specific. Personal experiences are particularly effective, and often moving. Share them!

• Marshall Facts: Your argument—and you are making an argument—must be supported by facts. Don't copy and paste paragraphs of pre-written text from form letters or blogs or others’ documents. Don't misrepresent your position - decisions should be based on sound data and accurate facts.
Tips and Techniques con’t

• Clearly State Your Suggestion/Position/Request. Be specific. Clearly illustrate your support or opposition for the “regulation” or “particular provision”.

• Use non-technical words and avoid jargon or complex medical or technical terms. Cite the specific sections of regulations when commenting about them.

• Try not to develop your input based only on other people’s summaries or news reports of what the regulations say.

• Try not to cherry-pick words or phrases here and there; there are many tables in the draft regulations that briefly lay out the proposed criteria and standards – it may be particularly useful to provide input based on those.
Addressing Correspondence

To a Senator:

The Honorable (full name)
__(Rm. #)__(name of) Senate Office Building
United States Senate
Washington, DC 20510

Dear Senator:

To a Representative:

The Honorable (full name)
__(Rm. #)__(name of) House Office Building
United States House of Representatives
Washington, DC 20515

Dear Representative:

Note: When writing to the Chair of a Committee or the Speaker of the House, it is proper to address them as:
Dear Mr. Chairman or Madam Chairwoman or Dear Madam Speaker or Mr. Speaker
Selected Resources

- Contact your Senator [http://www.senate.gov/general/contact_information/senators_cfm.cfm](http://www.senate.gov/general/contact_information/senators_cfm.cfm)
- Contact your Representative [www.house.gov/house/Member](http://www.house.gov/house/Member)
- Federal Regulations [www.regulations.gov/search/Regs/home.html](http://www.regulations.gov/search/Regs/home.html)
- How Our Laws are Made [http://thomas.loc.gov/home/lawsmade.toc.html](http://thomas.loc.gov/home/lawsmade.toc.html)
- Legislative Schedule [www.senate.gov/pagelayout/legislative/d_three_sections_with_teasers/calendars.htm](http://www.senate.gov/pagelayout/legislative/d_three_sections_with_teasers/calendars.htm)
More Resources

- “Landmark: The Inside Story of America's New Health Care Law and What It Means for Us All” by the Staff of the Washington Post
- “The Dance of Legislation: An Insider's Account of the Workings of the United States Senate” by Eric Redman
Selected Acronyms and Abbreviations

- AHRQ: Agency for Healthcare Research and Quality
- ARRA: American Recovery and Reinvestment Act
- BA: Business Associate
- CDC: Centers for Disease Control and Prevention
- CE: Covered Entity
- CER: Comparative Effectiveness Research
- CMS: Centers for Medicare and Medicaid Services
- FDA: United States Food and Drug Administration
- FHA: Federal Health Architecture
- HHS: United States Department of Health and Human Services
- HIE: Health Information Exchange
- HIPAA: Health Insurance Portability and Accountability Act [of 1996]
- HITECH: Health Information Technology for Economic and Clinical Health Act
- HRSA: Health Resources and Services Administration
- IOM: Institute of Medicine
- MU: Meaningful Use
Selected Acronyms and Abbreviations con’t

• NCI: National Cancer Institute
• NCHS: National Center for Health
• NCRR: National Center for Research Resources
• NCVHS: National Committee on Vital and Health Statistics
• NHIN: National Health Information
• NIH: National Institutes of Health
• NIST: National Institute for Standards and Technology
• NLM: National Library of Medicine
• NPRM: Notice of Proposed Rulemaking
• OCR: Office of Civil Rights
• ONC (ONCHIT): Office of the National Coordinator for Health Information Technology
• ONC-ATCB: ONC-Authorized Testing and Certification Bodies
• PHI: Personal Health Information or Protected Health Information
• PHR: Personal Health Record
• REC: [Health Information Technology] Regional Extension Center