

AMENDMENT-IN-THE-NATURE-OF-A-SUBSTITUTE
OFFERED BY MR. THOMAS
TO H.R. 4889, AS REPORTED BY THE
SUBCOMMITTEE ON HEALTH

Strike all after the enacting clause and insert the following:

1 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

2 (a) SHORT TITLE.—This Act may be cited as the “Patient
3 Safety Improvement Act of 2002”.

4 (b) TABLE OF CONTENTS.—The table of contents of this
5 Act is as follows:

Sec. 1. Short title; table of contents.

Sec. 2. Patient safety improvements.

“PART D—PATIENT SAFETY IMPROVEMENTS

“Sec. 1181. Voluntary reporting of patient safety data; definitions.

“Sec. 1182. Confidentiality and peer review protections.

“Sec. 1183. Center for Quality Improvement and Patient Safety.

“Sec. 1184. Interoperability standards for health care information technology systems.

“Sec. 1185. Voluntary adoption of methods to improve patient safety.

“Sec. 1186. Evaluation and report.

Sec. 3. Medical Information Technology Advisory Board.

6 **SEC. 2. PATIENT SAFETY IMPROVEMENTS.**

7 Title XI of the Social Security Act is amended by adding
8 at the end the following new part:

9 “PART D—PATIENT SAFETY IMPROVEMENTS

10 “VOLUNTARY REPORTING OF PATIENT SAFETY DATA;

11 DEFINITIONS

12 “SEC. 1181. (a) COLLECTION AND VOLUNTARY REPORT-
13 ING OF PATIENT SAFETY DATA.—In order to improve patient
14 safety and the quality of health care delivery, a health care pro-
15 vider (as defined in subsection (d)) may voluntarily collect and
16 develop patient safety data (as defined in subsection (e)) and
17 report such data to one or more patient safety organizations

1 (as defined in subsection (f)) in a manner that is confidential
2 and privileged (as described in section 1182).

3 “(b) USE OF PATIENT SAFETY DATA BY PATIENT SAFE-
4 TY ORGANIZATIONS.—Patient safety organizations shall ana-
5 lyze the patient safety data reported and develop (and report
6 back to health care providers) information to improve patient
7 safety and the quality of health care delivery and shall submit
8 non-identifiable information derived from such data in a uni-
9 form manner to the Center for Quality Improvement and Pa-
10 tient Safety (for inclusion in the Patient Safety Database, if
11 applicable). Such non-identifiable information may be disclosed
12 and shared with other patient safety organizations. Identifiable
13 patient safety data may be disclosed to other patient safety or-
14 ganizations with the explicit authorization for each such disclo-
15 sure by the reporting provider involved.

16 “(c) FUNCTIONS OF CENTER.—The Center for Quality
17 Improvement and Patient Safety conducts patient safety activi-
18 ties consistent with section 1183.

19 “(d) HEALTH CARE PROVIDERS COVERED.—For purposes
20 of this part, the term ‘health care provider’ means—

21 “(1) a provider of services (as defined in section
22 1861(u) and including a hospital, skilled nursing facility,
23 home health agency, and hospice program) that provides
24 services for which payment may be made under part A of
25 title XVIII and the provider’s employees;

26 “(2) a health care entity or individual that furnishes
27 medical or other health services (as defined in section
28 1861(s)), other services described in section 1832(a)(2), or
29 other items and services for which payment may be made
30 under such title, including a physician (as defined in sec-
31 tion 1861(r)); and

32 “(3) an organization offering a plan under part C of
33 title XVIII.

34 “(e) PATIENT SAFETY DATA COVERED.—

35 “(1) IN GENERAL.—For purposes of this part, the
36 term ‘patient safety data’ means any data, reports, records,
37 memoranda, analyses, deliberative work, statements, or

1 root cause analyses that are collected or developed to im-
2 prove patient safety or health care quality and that—

3 “(A) are collected or developed by a health care
4 provider for the purpose of reporting to a patient safety
5 organization and that are reported on a timely basis to
6 such an organization;

7 “(B) are collected or developed by a patient safety
8 organization or by (or on behalf of) the Center for
9 Quality Improvement and Patient Safety, regardless of
10 whether the data are transmitted to the health care
11 provider that reported the original data; or

12 “(C) describes corrective actions taken by a health
13 care provider in response to the provider’s reporting of
14 data to that organization, regardless of whether the or-
15 ganization has transmitted under subsection (f)(2) in-
16 formation to the health care provider that reported the
17 original data, and that are reported on a timely basis
18 to such an organization.

19 “(2) CONSTRUCTION REGARDING USE OF DATA.—

20 “(A) INTERNAL USE PERMITTED TO IMPROVE PA-
21 TIENT SAFETY, QUALITY, AND EFFICIENCY.—Nothing
22 in this part shall be construed to limit or discourage a
23 health care provider from developing and using patient
24 safety data within the provider to improve patient safe-
25 ty, health care quality, or administrative efficiency of
26 the provider.

27 “(B) TREATMENT.—Information that is collected
28 or developed as patient safety data is not disqualified
29 from being treated as patient safety data because of its
30 development or use for the purposes described in sub-
31 paragraph (A) and such development or use shall not
32 constitute a waiver of any privilege or protection estab-
33 lished under section 1182 or under State law.

34 “(f) QUALIFICATIONS OF PATIENT SAFETY ORGANIZA-
35 TIONS.—

36 “(1) IN GENERAL.—For purposes of this part, the
37 term ‘patient safety organization’ means a private or public

1 organization that conducts activities to improve patient
2 safety and the quality of health care delivery by assisting
3 health care providers that report to such organizations and
4 that has been certified by the Secretary as—

5 “(A) performing each of the activities described in
6 paragraph (2); and

7 “(B) meets the other requirements of paragraphs
8 (3) through (5).

9 “(2) ACTIVITIES DESCRIBED.—The activities referred
10 to in paragraph (1)(A) are the following:

11 “(A) The collection and analysis of patient safety
12 data that are voluntarily reported by more than one
13 health care provider on a local, regional, State, or na-
14 tional basis.

15 “(B) The development and dissemination of infor-
16 mation to health care providers and other patient safe-
17 ty organizations with respect to improving patient safe-
18 ty, such as recommendations, protocols, or information
19 regarding best practices.

20 “(C) The utilization of patient safety data to carry
21 out activities under this paragraph to improve patient
22 safety and to provide assistance to health care pro-
23 viders to minimize patient risk.

24 “(3) CONDUCT OF ACTIVITIES.—In conducting activi-
25 ties under paragraph (2), a patient safety organization
26 shall—

27 “(A) maintain confidentiality with respect to indi-
28 vidualy identifiable health information;

29 “(B) submit non-identifiable information to the
30 Center for Quality Improvement and Patient Safety in
31 a format established by the Secretary; and

32 “(C) maintain appropriate security measures with
33 respect to patient safety data.

34 “(4) ORGANIZATION REQUIREMENTS.—The require-
35 ments of this paragraph for an organization are that—

1 “(A) the organization is managed, controlled, and
2 operated independently from health care providers
3 which report patient safety data to it under this part;

4 “(B) if the organization no longer qualifies as a
5 patient safety organization, with respect to any patient
6 safety data that it received from a health care provider,
7 the organization shall do one of the following:

8 “(i) with the approval of the provider and an-
9 other patient safety organization, transfer such
10 data to such other organization;

11 “(ii) if practicable, return the data to the pro-
12 vider; or

13 “(iii) destroy the patient safety data;

14 “(C) if the organization charges a fee for the ac-
15 tivities it performs with respect to health care pro-
16 viders, the fee shall be uniform among all classes or
17 types of health care providers (taking into account the
18 size of the health care provider);

19 “(D) the organization seeks to collect data from
20 health care providers in a standardized manner that
21 permits valid comparisons of similar cases among simi-
22 lar health care providers; and

23 “(E) the organization meets such other require-
24 ments as the Secretary may by regulation require.

25 For purposes of subparagraph (A), an organization is con-
26 trolled by a health care provider if the provider is able to
27 significantly influence or direct the actions or policies of
28 the organization.

29 “(5) LIMITATION ON USE OF PATIENT SAFETY DATA
30 BY PATIENT SAFETY ORGANIZATIONS.—A patient safety or-
31 ganization may not use patient safety data reported by a
32 health care provider in accordance with this part to take
33 regulatory or enforcement actions it otherwise performs (or
34 is responsible for performing) in relation to such provider.

35 “(6) TECHNICAL ASSISTANCE.—The Secretary may
36 provide technical assistance to patient safety organizations
37 in providing recommendations and advice to health care

1 providers reporting patient safety data under this part.
2 Such assistance shall include advice with respect to meth-
3 odology, communication, dissemination of information, data
4 collection, security, and confidentiality concerns.

5 “(g) CONSTRUCTION.—Nothing in this part shall be con-
6 strued to limit or discourage the reporting of information relat-
7 ing to patient safety within a health care provider.

8 “CONFIDENTIALITY AND PEER REVIEW PROTECTIONS

9 “SEC. 1182. (a) IN GENERAL.—Notwithstanding any
10 other provision of law, patient safety data shall be privileged
11 and confidential in accordance with this section.

12 “(b) SCOPE OF PRIVILEGE.—Subject to the succeeding
13 provisions of this section, such data shall not be—

14 “(1) subject to a civil or administrative subpoena;

15 “(2) subject to discovery in connection with a civil or
16 administrative proceeding;

17 “(3) disclosed pursuant to section 552 of title 5,
18 United States Code (commonly known as the Freedom of
19 Information Act) or any other similar Federal or State law;
20 or

21 “(4) admitted as evidence or otherwise disclosed in
22 any civil or administrative proceeding.

23 “(e) CLARIFICATION OF SCOPE.—The privilege established
24 by this section with respect to patient safety data described in
25 section 1181(e)(1)(A) shall apply to information, such as
26 records of a patient’s medical diagnosis and treatment, other
27 primary health care information, and other information, to the
28 extent that such information was collected or developed for the
29 purpose specified in such section and is reported in accordance
30 with such section. Such privilege shall not apply to information
31 merely by reason of its inclusion, or the fact of its submission,
32 in a report under such section. Information available from
33 sources other than a report made under such section may be
34 discovered or admitted in a civil or administrative proceeding,
35 if discoverable or admissible under applicable state law.

1 “(d) INFORMATION NOT SUBJECT TO PRIVILEGE.—The
2 privilege established by this section shall not apply to one or
3 more of the following:

4 “(1) MEDICAL RECORDS AND OTHER PRIMARY
5 HEALTH RECORDS.—Records of a patient’s medical diag-
6 nosis and treatment and other primary health records of a
7 health care provider. Such privilege shall not apply to such
8 information by reason of its inclusion within patient safety
9 data.

10 “(2) FDA.—Relevant information disclosed by a
11 health care provider or patient safety organization to the
12 Food and Drug Administration, or to a person that is sub-
13 ject to the jurisdiction of such Administration, with respect
14 to an Administration-regulated product or activity for
15 which that entity has responsibility, for the purposes of ac-
16 tivities related to quality, safety, or effectiveness of such
17 Administration-regulated product or activity, subject to sec-
18 tion 520(c) of the Federal Food, Drug, and Cosmetic Act.

19 “(3) NON-IDENTIFIABLE INFORMATION USED BY
20 DATABASE.—Non-identifiable information from a patient
21 safety organization to the Patient Safety Database and the
22 further disclosure of such data by the Center for Quality
23 Improvement and Patient Safety.

24 “(e) REPORTER PROTECTION.—

25 “(1) IN GENERAL.—A health care provider may not
26 use against an individual in an adverse employment action
27 described in paragraph (2) the fact that the individual in
28 good faith reported—

29 “(A) to the provider with the intention of having
30 it reported to a patient safety organization, or

31 “(B) directly to a patient safety organization,
32 information that would constitute patient safety data under
33 section 1181(e)(1)(A) if the provider were to have sub-
34 mitted it on a timely basis to a patient safety organization
35 in accordance with such section.

1 “(2) ADVERSE EMPLOYMENT ACTION.—For purposes
2 of this subsection, an ‘adverse employment action’
3 includes—

4 “(A) the failure to promote an individual or pro-
5 vide any other employment-related benefit for which the
6 individual would otherwise be eligible;

7 “(B) an evaluation or decision made in relation to
8 accreditation, certification, credentialing or licensing of
9 the individual; and

10 “(C) a personnel action that is adverse to the indi-
11 vidual concerned.

12 “(3) REMEDIES.—The provisions of the first sentence
13 of section 1128A(a) shall apply with respect to a health
14 care provider’s violation of paragraph (1) in the same man-
15 ner as they apply to an act referred to in section
16 1128A(a)(7).

17 “(f) PENALTY.—It is unlawful for any person to disclose
18 any patient safety data in violation of the provisions of this sec-
19 tion. Any person violating such provisions shall subject to the
20 same sanctions under section 1160(c) (relating to, upon convic-
21 tion, a fine of not more than \$1,000, imprisonment for not
22 more than 6 months, or both, per disclosure and payment of
23 the costs of prosecution) as a person who discloses any infor-
24 mation described in section 1160(a).

25 “(g) RULES OF CONSTRUCTION.—

26 “(1) NO LIMITATION OF OTHER PRIVILEGES.—Subject
27 to paragraph (2), nothing in this section shall be construed
28 as affecting other privileges that are available under Fed-
29 eral or State laws that provide greater peer review or con-
30 fidentiality protections than the peer review and confiden-
31 tiality protections provided for in this section.

32 “(2) NO EFFECT ON STATE MANDATORY REPORTING
33 REQUIREMENTS.—Nothing in this part shall be construed
34 as preempting or otherwise affecting any State law manda-
35 tory reporting requirement for health care providers.

36 “(h) APPLICATION OF PRIVACY REGULATIONS.—For pur-
37 poses of applying the regulations promulgated pursuant to sec-

1 tion 264(c) of the Health Insurance Portability and Account-
2 ability Act of 1996 (Public Law 104-191; 110 Stat. 2033)—

3 “(1) patient safety organizations shall be treated as
4 business associates;

5 “(2) activities of such organizations described in sec-
6 tion 1181(f)(2)(A) in relation to a health care provider are
7 deemed to be health care operations of the provider; and

8 “(3) the disclosure of identifiable information under
9 the voluntary program under this part by such an organiza-
10 tion shall be treated as necessary for the proper manage-
11 ment and administration of the organization.

12 Nothing in this section shall be construed to alter or affect the
13 implementation of such regulation or such section 264(c).

14 “(i) WAIVERS.—Nothing in this part shall be construed as
15 precluding a health care provider from waiving the privilege or
16 confidentiality protections under this section. Disclosure of pa-
17 tient safety data under subsection (d)(2) shall not constitute a
18 waiver of any privilege or protection established under this sec-
19 tion or under State law.

20 “(j) CONTINUATION OF PRIVILEGE.—Patient safety data
21 of an organization that is certified as a patient safety organiza-
22 tion shall continue to be privileged and confidential, in accord-
23 ance with this section, if the organization’s certification is ter-
24 minated or revoked or if the organization otherwise ceases to
25 qualify as a patient safety organization until the data are oth-
26 erwise disposed of in accordance with section 1181(f)(4).

27 “(k) SURVEY AND REPORT.—

28 “(1) SURVEY.—The Comptroller General of the
29 United States shall conduct a survey of State laws that re-
30 late to patient safety data peer review systems, including
31 laws that establish an evidentiary privilege applicable to
32 data developed in such systems, and shall review the man-
33 ner in which such laws have been interpreted by the courts
34 and the effectiveness of such laws in promoting patient
35 safety.

36 “(2) REPORT.—Not later than 9 months after the
37 date of enactment of this section, the Comptroller General

1 shall prepare and submit to Congress a report concerning
2 the results of the survey conducted under paragraph (1).

3 “CENTER FOR QUALITY IMPROVEMENT AND PATIENT SAFETY

4 “SEC. 1183. (a) IN GENERAL.—The Secretary, acting
5 through the Director of the Agency for Healthcare Research
6 and Quality, shall ensure that the Center for Quality Improve-
7 ment and Patient Safety (in this section referred to as the
8 ‘Center’) supports public and private sector initiatives to im-
9 prove patient safety for items and services furnished through
10 health care providers.

11 “(b) DUTIES.—

12 “(1) IN GENERAL.—The Secretary, acting through the
13 Director, shall ensure that the Center carries out the fol-
14 lowing duties:

15 “(A) Provide for the certification and recertifi-
16 cation of patient safety organizations in accordance
17 subsection (d).

18 “(B) Collect and disseminate information related
19 to patient safety.

20 “(C) Establish a Patient Safety Database to col-
21 lect, support, and coordinate the analysis of non-identi-
22 fiable information submitted to the Database in accord-
23 ance with subsection (e).

24 “(D) Facilitate the development of consensus
25 among health care providers, patients, and other inter-
26 ested parties concerning patient safety and rec-
27 ommendations to improve patient safety.

28 “(E) Provide technical assistance to States that
29 have (or are developing) medical errors reporting sys-
30 tems, assist States in developing standardized methods
31 for data collection, and collect data from State report-
32 ing systems for inclusion in the Patient Safety Data-
33 base.

34 “(2) CONSULTATION.—In carrying out the duties
35 under paragraph (1) (including the establishment of the
36 Database), the Secretary shall consult with and develop
37 partnerships, as appropriate, with health care organiza-

1 tions, health care providers, public and private sector enti-
2 ties, patient safety organizations, health care consumers,
3 and other relevant experts to improve patient safety.

4 “(c) CERTIFICATION AND RECERTIFICATION PROCESS.—

5 “(1) IN GENERAL.—The initial certification and recer-
6 tification of a patient safety organization under subsection
7 (b)(1)(A) shall be made under a process that is approved
8 by the Secretary and is consistent with criteria published
9 by the Secretary.

10 “(2) REVOCATION.—Such a certification or recertifi-
11 cation may be revoked by the Secretary upon a showing of
12 cause (including the disclosure of data in violation of sec-
13 tion 1182).

14 “(3) TERMINATION.—Such a certification provided for
15 a patient safety organization shall terminate (subject to re-
16 certification) on the earlier of—

17 “(A) the date that is 3 years after the date on
18 which such certification was provided; or

19 “(B) the date on which the Secretary revokes the
20 certification.

21 “(d) IMPLEMENTATION AND CONSULTATION.—In carrying
22 out subsection (c)(1), the Secretary shall—

23 “(1) facilitate the development of patient safety goals
24 and track the progress made in meeting those goals; and

25 “(2) ensure that data submitted by a patient safety
26 organization to the Patient Safety Database, as provided
27 for under subsection (e), are comparable and useful for re-
28 search and analysis and that the research findings and pa-
29 tient safety alerts that result from such analyses are pre-
30 sented in clear and consistent formats that enhance the
31 usefulness of such alerts.

32 “(e) PATIENT SAFETY DATABASE.—

33 “(1) IN GENERAL.—The Secretary, acting through the
34 Director, shall—

35 “(A) establish a Patient Safety Database to collect
36 non-identifiable information concerning patient safety
37 that is reported on a voluntary basis; and

1 “(B) establish common formats for the voluntary
2 reporting of data under subparagraph (A), including
3 the establishment of necessary data elements, common
4 and consistent definitions, and a standardized com-
5 puter interface for the processing of such data.

6 “(2) DATABASE.—In carrying out this subsection, the
7 Secretary—

8 “(A) shall establish and modify as necessary cri-
9 teria to determine the organizations that may volun-
10 tarily contribute to, and the data that comprises, the
11 Patient Safety Database;

12 “(B) shall ensure that the Patient Safety Data-
13 base is only used by qualified entities or individuals as
14 determined appropriate by the Secretary in accordance
15 with criteria applied by the Secretary; and

16 “(C) may enter into contracts for the administra-
17 tion of the Database with private and public entities
18 with experience in the administration of similar data-
19 bases.

20 “(3) NON-IDENTIFIABLE INFORMATION.—For pur-
21 poses of this part, the term ‘non-identifiable information’
22 means information that is presented in a form and manner
23 that prevents the identification of any health care provider,
24 patient, and the reporter of the information.

25 “(f) AUTHORIZATION OF APPROPRIATIONS.—There are
26 authorized to be appropriated such sums as may be necessary
27 for each fiscal year to carry out this section.

28 “INTEROPERABILITY STANDARDS FOR HEALTH CARE
29 INFORMATION TECHNOLOGY SYSTEMS

30 “SEC. 1184. (a) IN GENERAL.—By not later than 2 years
31 after the date of the enactment of this part, the Secretary shall
32 develop or adopt (and shall periodically review and update) vol-
33 untary, national standards that promote the interoperability of
34 health care information technology systems across all health
35 care settings. In promulgating regulations to carry out this sec-
36 tion, the Secretary shall take into account the cost that meet-
37 ing such standards would have on providing health care in the

1 United States and the increased efficiencies in providing such
2 care achieved under the standards.

3 “(b) CONSULTATION AND COORDINATION.—The Secretary
4 shall develop and update such standards in consultation with
5 (and with coordination between)—

6 “(1) the National Committee for Vital and Health
7 Statistics, and

8 “(2) the Medical Information Technology Advisory
9 Board (established under section 3 of the Patient Safety
10 Improvement Act of 2002).

11 “(c) DISSEMINATION.—The Secretary shall provide for the
12 dissemination of the standards developed and updated under
13 this section.

14 “(d) AUTHORIZATION OF APPROPRIATIONS.—There are
15 authorized to be appropriated such sums as may be necessary
16 for each fiscal year to carry out this section.

17 “VOLUNTARY ADOPTION OF METHODS TO IMPROVE PATIENT
18 SAFETY

19 “SEC. 1185. The Secretary shall encourage health care
20 providers to adopt appropriate evidence-based methods to im-
21 prove patient safety. Such methods shall not constitute national
22 practice guidelines.

23 “EVALUATION AND REPORT

24 “SEC. 1186. (a) EVALUATION.—The Comptroller General
25 of the United States shall conduct a comprehensive evaluation
26 of the implementation of this part. Such evaluation shall in-
27 clude an examination of the following:

28 “(1) The health care providers that reported patient
29 safety data under this part and the patient safety organiza-
30 tions to which they reported the information.

31 “(2) What types of events were so reported on.

32 “(3) The usefulness of the analyses, information, and
33 recommendations provided by patient safety organizations
34 in response to such reported information.

35 “(4) The response of health care providers to such
36 analyses, information, and recommendations, including a
37 survey of providers to obtain estimates of the percentage of

1 providers by category who have adopted specific error-re-
2 duction methods and, if applicable, reasons for not adopt-
3 ing specific practices.

4 “(5) The effectiveness of the program under this part
5 in reducing medical errors.

6 “(b) REPORT.—Not later than 5 years after the date the
7 provisions of this part are first implemented, the Comptroller
8 General shall submit to Congress a report on the evaluation
9 conducted under subsection (a).”.

10 **SEC. 3. MEDICAL INFORMATION TECHNOLOGY ADVI-**
11 **SORY BOARD.**

12 (a) ESTABLISHMENT.—

13 (1) IN GENERAL.—Not later than 3 months after the
14 date of the enactment of this Act, the Secretary of Health
15 and Human Services (in this section referred to as the
16 “Secretary”) shall appoint an advisory board to be known
17 as the “Medical Information Technology Advisory Board”
18 (in this section referred to as the “MITAB”).

19 (2) CHAIRMAN.—The Secretary shall designate one
20 member as chairman. The chairman shall be an individual
21 affiliated with an organization having expertise creating
22 American National Standards Institute (ANSI) accepted
23 standards in health care information technology and a
24 member of the National Committee for Vital and Health
25 Statistics.

26 (b) COMPOSITION.—

27 (1) IN GENERAL.—The MITAB shall consist of not
28 more than 17 members that include—

29 (A) experts from the fields of medical information,
30 information technology, medical continuous quality im-
31 provement, medical records security and privacy, indi-
32 vidual and institutional health care clinical providers,
33 health researchers, and health care purchasers;

34 (B) one or more staff experts from each of the fol-
35 lowing: the Centers for Medicare & Medicaid Services,
36 the Agency for Healthcare Research and Quality, and

1 the Institute of Medicine of the National Academy of
2 Sciences;

3 (C) representatives of private organizations with
4 expertise in medical infomatics;

5 (D) a representative of a teaching hospital; and

6 (E) one or more representatives of the health care
7 information technology industry.

8 (2) TERMS OF APPOINTMENT.—The term of any ap-
9 pointment under paragraph (1) to the MITAB shall be for
10 the life of the MITAB.

11 (3) MEETINGS.—The MITAB shall meet at the call of
12 its chairman or a majority of its members.

13 (4) VACANCIES.—A vacancy on the MITAB shall be
14 filled in the same manner in which the original appoint-
15 ment was made not later than 30 days after the MITAB
16 is given notice of the vacancy and shall not affect the power
17 of the remaining members to execute the duties of the
18 MITAB.

19 (5) COMPENSATION.—Members of the MITAB shall
20 receive no additional pay, allowances, or benefits by reason
21 of their service on the MITAB.

22 (6) EXPENSES.—Each member of the MITAB shall
23 receive travel expenses and per diem in lieu of subsistence
24 in accordance with sections 5702 and 5703 of title 5,
25 United States Code.

26 (c) DUTIES.—

27 (1) IN GENERAL.—The MITAB shall on an ongoing
28 basis advise, and make recommendations to, the Secretary
29 regarding medical information technology, including the fol-
30 lowing:

31 (A) The best current practices in medical informa-
32 tion technology.

33 (B) Methods for the adoption (not later than 2
34 years after the date of the enactment of this section)
35 of a uniform health care information system interface
36 between and among old and new computer systems.

1 (C) Recommendations for health care vocabulary,
2 messaging, and other technology standards (including a
3 common lexicon for computer technology) necessary to
4 achieve the interoperability of health care information
5 systems for the purposes described in subparagraph
6 (E).

7 (D) Methods of implementing—

8 (i) health care information technology inter-
9 operability standardization; and

10 (ii) records security.

11 (E) Methods to promote information exchange
12 among health care providers so that long-term compat-
13 ibility among information systems is maximized, in
14 order to do one or more of the following:

15 (i) To maximize positive outcomes in clinical
16 care—

17 (I) by providing decision support for diag-
18 nosis and care; and

19 (II) by assisting in the emergency treat-
20 ment of a patient presenting at a facility where
21 there is no medical record for the patient.

22 (ii) To contribute to (and be consistent with)
23 the development of the patient assessment instru-
24 ment provided for under section 545 of the Medi-
25 care, Medicaid, and SCHIP Benefits Improvement
26 and Protection Act of 2000, and to assist in mini-
27 mizing the need for new and different records as
28 patients move from provider to provider.

29 (iii) To reduce or eliminate the need for re-
30 dundant records, paperwork, and the repetitive tak-
31 ing of patient histories and administering of tests.

32 (iv) To minimize medical errors, such as ad-
33 ministration of contraindicated drugs.

34 (v) To provide a compatible information tech-
35 nology architecture that facilitates future quality
36 and cost-saving needs and that avoids the financing

1 and development of information technology systems
2 that are not readily compatible.

3 (2) REPORTS.—

4 (A) INITIAL REPORT.—No later than 18 months
5 after the date of the enactment of this Act, the MITAB
6 shall submit to Congress and the Secretary an initial
7 report concerning the matters described in paragraph
8 (1). The report shall include—

9 (i) the practices described in paragraph
10 (1)(A), including the status of health care informa-
11 tion technology standards being developed by pri-
12 vate sector and public-private groups;

13 (ii) recommendations for accelerating the de-
14 velopment of common health care terminology
15 standards;

16 (iii) recommendations for completing develop-
17 ment of health care information system messaging
18 standards; and

19 (iv) progress toward meeting the deadline de-
20 scribed in paragraph (1)(B) for adoption of meth-
21 ods described in such paragraph.

22 (B) SUBSEQUENT REPORTS.—During each of the
23 2 years after the year in which the report is submitted
24 under subparagraph (A), the MITAB shall submit to
25 Congress and the Secretary an annual report relating
26 to additional recommendations, best practices, results
27 of information technology improvements, analyses of
28 private sector efforts to implement the interoperability
29 standards established in section 1184 of the Social Se-
30 curity Act, and such other matters as may help ensure
31 the most rapid dissemination of best practices in health
32 care information technology.

33 (d) STAFF AND SUPPORT SERVICES.—

34 (1) EXECUTIVE DIRECTOR.—

35 (A) APPOINTMENT.—The Chairman shall appoint
36 an executive director of the MITAB.

1 (B) COMPENSATION.—The executive director shall
2 be paid the rate of basic pay for level V of the Execu-
3 tive Schedule.

4 (2) STAFF.—With the approval of the MITAB, the ex-
5 ecutive director may appoint such personnel as the execu-
6 tive director considers appropriate.

7 (3) APPLICABILITY OF CIVIL SERVICE LAWS.—The
8 staff of the MITAB shall be appointed without regard to
9 the provisions of title 5, United States Code, governing ap-
10 pointments in the competitive service, and shall be paid
11 without regard to the provisions of chapter 51 and sub-
12 chapter III of chapter 53 of such title (relating to classi-
13 fication and General Schedule pay rates).

14 (4) EXPERTS AND CONSULTANTS.—With the approval
15 of the MITAB, the executive director may procure tem-
16 porary and intermittent services under section 3109(b) of
17 title 5, United States Code.

18 (e) POWERS.—

19 (1) HEARINGS AND OTHER ACTIVITIES.—For the pur-
20 pose of carrying out its duties, the MITAB may hold such
21 hearings and undertake such other activities as the MITAB
22 determines to be necessary to carry out its duties.

23 (2) DETAIL OF FEDERAL EMPLOYEES.—Upon the re-
24 quest of the MITAB, the head of any Federal agency is au-
25 thorized to detail, without reimbursement, any of the per-
26 sonnel of such agency to the MITAB to assist the MITAB
27 in carrying out its duties. Any such detail shall not inter-
28 rupt or otherwise affect the civil service status or privileges
29 of the Federal employee.

30 (3) TECHNICAL ASSISTANCE.—Upon the request of the
31 MITAB, the head of a Federal agency shall provide such
32 technical assistance to the MITAB as the MITAB deter-
33 mines to be necessary to carry out its duties.

34 (4) OBTAINING INFORMATION.—The MITAB may se-
35 cure directly from any Federal agency information nec-
36 essary to enable it to carry out its duties, if the information
37 may be disclosed under section 552 of title 5, United States

1 Code. Upon request of the Chairman of the MITAB, the
2 head of such agency shall furnish such information to the
3 MITAB.

4 (f) TERMINATION.—The MITAB shall terminate 30 days
5 after the date of submission of its final report under subsection
6 (c)(2)(B).

7 (g) APPLICABILITY OF FACCA.—The provisions of the Fed-
8 eral Advisory Committee Act (5 U.S.C. App.) shall apply to the
9 MITAB.

10 (h) AUTHORIZATION OF APPROPRIATIONS.—There are au-
11 thorized to be appropriated to the Secretary of Health and
12 Human Services such sums as are necessary to carry out this
13 section.