

108TH CONGRESS  
1ST SESSION

# H. R. 877

To amend title XI of the Social Security Act to improve patient safety.

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## IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 25, 2003

Mrs. JOHNSON of Connecticut (for herself, Mr. STARK, Mr. THOMAS, Mr. CAMP, Mr. LEWIS of Kentucky, Mr. MCINNIS, Mr. HOUGHTON, Mr. HERGER, Mr. WELLER, Mr. SMITH of New Jersey, Mr. ENGLISH, and Mr. PETERSON of Pennsylvania) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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## A BILL

To amend title XI of the Social Security Act to improve patient safety.

1 *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*

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

4 (a) SHORT TITLE.—This Act may be cited as the  
5 “Patient Safety Improvement Act of 2003”.

6 (b) TABLE OF CONTENTS.—The table of contents of  
7 this 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.

**1 SEC. 2. PATIENT SAFETY IMPROVEMENTS.**

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

4 “PART D—PATIENT SAFETY IMPROVEMENTS

5 “VOLUNTARY REPORTING OF PATIENT SAFETY DATA;

6 DEFINITIONS

7 “SEC. 1181. (a) COLLECTION AND VOLUNTARY RE-  
8 PORTING OF PATIENT SAFETY DATA.—In order to im-  
9 prove patient safety and the quality of health care delivery,  
10 a health care provider (as defined in subsection (d)) may  
11 voluntarily collect and develop patient safety data (as de-  
12 fined in subsection (e)) and report such data to one or  
13 more patient safety organizations (as defined in subsection  
14 (f)) in a manner that is confidential and privileged (as  
15 described in section 1182).

16 “(b) USE OF PATIENT SAFETY DATA BY PATIENT  
17 SAFETY ORGANIZATIONS.—Patient safety organizations  
18 shall analyze the patient safety data reported and develop  
19 (and report back to health care providers) information to  
20 improve patient safety and the quality of health care deliv-  
21 ery and shall submit non-identifiable information derived

1 from such data in a uniform manner to the Center for  
2 Quality Improvement and Patient Safety (for inclusion in  
3 the Patient Safety Database, if applicable). Such non-  
4 identifiable information may be disclosed and shared with  
5 other patient safety organizations. Identifiable patient  
6 safety data may be disclosed to other patient safety orga-  
7 nizations with the explicit authorization for each such dis-  
8 closure by the reporting provider involved.

9 “(c) FUNCTIONS OF CENTER.—The Center for Qual-  
10 ity Improvement and Patient Safety conducts patient safe-  
11 ty activities consistent with section 1183.

12 “(d) HEALTH CARE PROVIDERS COVERED.—For  
13 purposes of this part, the term ‘health care provider’  
14 means a provider of services (as defined in section 1861(u)  
15 and including a hospital, skilled nursing facility, home  
16 health agency, and hospice program) that provides services  
17 for which payment may be made under part A of title  
18 XVIII and the provider’s employees, and includes physi-  
19 cians insofar as they furnish health care services in the  
20 health care provider.

21 “(e) PATIENT SAFETY DATA COVERED.—

22 “(1) IN GENERAL.—For purposes of this part,  
23 the term ‘patient safety data’ means any data, re-  
24 ports, records, memoranda, analyses, deliberative  
25 work, statements, or root cause analyses that are

1 collected or developed to improve patient safety or  
2 health care quality and that—

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

8 “(B) are collected or developed by a pa-  
9 tient safety organization or by (or on behalf of)  
10 the Center for Quality Improvement and Pa-  
11 tient Safety, regardless of whether the data are  
12 transmitted to the health care provider that re-  
13 ported the original data; or

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

22 “(2) CONSTRUCTION REGARDING USE OF  
23 DATA.—

24 “(A) INTERNAL USE PERMITTED TO IM-  
25 PROVE PATIENT SAFETY, QUALITY, AND EFFI-

1 CIENCY.—Nothing in this part shall be con-  
2 strued to limit or discourage a health care pro-  
3 vider from developing and using patient safety  
4 data within the provider to improve patient  
5 safety, health care quality, or administrative ef-  
6 ficiency of the provider.

7 “(B) TREATMENT.—Information that is  
8 collected or developed as patient safety data is  
9 not disqualified from being treated as patient  
10 safety data because of its development or use  
11 for the purposes described in subparagraph (A)  
12 and such development or use shall not con-  
13 stitute a waiver of any privilege or protection  
14 established under section 1182 or under State  
15 law.

16 “(f) QUALIFICATIONS OF PATIENT SAFETY ORGANI-  
17 ZATIONS.—

18 “(1) IN GENERAL.—For purposes of this part,  
19 the term ‘patient safety organization’ means a pri-  
20 vate or public organization that conducts activities  
21 to improve patient safety and the quality of health  
22 care delivery by assisting health care providers that  
23 report to such organizations and that has been cer-  
24 tified by the Secretary as—

1           “(A) performing each of the activities de-  
2           scribed in paragraph (2); and

3           “(B) meets the other requirements of para-  
4           graphs (3) through (5).

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

7           “(A) The collection and analysis of patient  
8           safety data that are voluntarily reported by  
9           more than one health care provider on a local,  
10          regional, State, or national basis.

11          “(B) The development and dissemination  
12          of information to health care providers and  
13          other patient safety organizations with respect  
14          to improving patient safety, such as rec-  
15          ommendations, protocols, or information re-  
16          garding best practices.

17          “(C) The utilization of patient safety data  
18          to carry out activities under this paragraph to  
19          improve patient safety and to provide assistance  
20          to health care providers to minimize patient  
21          risk.

22          “(3) CONDUCT OF ACTIVITIES.—In conducting  
23          activities under paragraph (2), a patient safety orga-  
24          nization shall—

1           “(A) maintain confidentiality with respect  
2 to individually identifiable health information;

3           “(B) submit non-identifiable information  
4 to the Center for Quality Improvement and Pa-  
5 tient Safety in a format established by the Sec-  
6 retary; and

7           “(C) maintain appropriate security meas-  
8 ures with respect to patient safety data.

9           “(4) ORGANIZATION REQUIREMENTS.—The re-  
10 quirements of this paragraph for an organization are  
11 that—

12           “(A) the organization is managed, con-  
13 trolled, and operated independently from health  
14 care providers which report patient safety data  
15 to it under this part;

16           “(B) if the organization no longer qualifies  
17 as a patient safety organization, with respect to  
18 any patient safety data that it received from a  
19 health care provider, the organization shall do  
20 one of the following:

21           “(i) with the approval of the provider  
22 and another patient safety organization,  
23 transfer such data to such other organiza-  
24 tion;

1                   “(ii) if practicable, return the data to  
2                   the provider; or

3                   “(iii) destroy the patient safety data;

4                   “(C) if the organization charges a fee for  
5                   the activities it performs with respect to health  
6                   care providers, the fee shall be uniform among  
7                   all classes or types of health care providers  
8                   (taking into account the size of the health care  
9                   provider);

10                  “(D) the organization seeks to collect data  
11                  from health care providers in a standardized  
12                  manner that permits valid comparisons of simi-  
13                  lar cases among similar health care providers;  
14                  and

15                  “(E) the organization meets such other re-  
16                  quirements as the Secretary may by regulation  
17                  require.

18                  For purposes of subparagraph (A), an organization  
19                  is controlled by a health care provider if the provider  
20                  is able to significantly influence or direct the actions  
21                  or policies of the organization.

22                  “(5) LIMITATION ON USE OF PATIENT SAFETY  
23                  DATA BY PATIENT SAFETY ORGANIZATIONS.—A pa-  
24                  tient safety organization may not use patient safety  
25                  data reported by a health care provider in accord-



1       ance with this part to take regulatory or enforce-  
2       ment actions it otherwise performs (or is responsible  
3       for performing) in relation to such provider.

4               “(6) TECHNICAL ASSISTANCE.—The Secretary  
5       may provide technical assistance to patient safety or-  
6       ganizations in providing recommendations and ad-  
7       vice to health care providers reporting patient safety  
8       data under this part. Such assistance shall include  
9       advice with respect to methodology, communication,  
10      dissemination of information, data collection, secu-  
11      rity, and confidentiality concerns.

12              “(g) CONSTRUCTION.—Nothing in this part shall be  
13      construed to limit or discourage the reporting of informa-  
14      tion relating to patient safety within a health care pro-  
15      vider.

16      “CONFIDENTIALITY AND PEER REVIEW PROTECTIONS

17              “SEC. 1182. (a) IN GENERAL.—Notwithstanding any  
18      other provision of law, patient safety data shall be privi-  
19      leged and confidential in accordance with this section.

20              “(b) SCOPE OF PRIVILEGE.—Subject to the suc-  
21      ceeding provisions of this section, such data shall not be—

22                      “(1) subject to a civil or administrative sub-  
23      poena;

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

1           “(3) disclosed pursuant to section 552 of title  
2           5, United States Code (commonly known as the  
3           Freedom of Information Act) or any other similar  
4           Federal or State law; or

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

7           “(c) CLARIFICATION OF SCOPE.—The privilege estab-  
8           lished by this section with respect to patient safety data  
9           described in section 1181(e)(1)(A) shall apply to informa-  
10          tion, such as records of a patient’s medical diagnosis and  
11          treatment, other primary health care information, and  
12          other information, to the extent that such information was  
13          collected or developed for the purpose specified in such  
14          section and is reported in accordance with such section.  
15          Such privilege shall not apply to information merely by  
16          reason of its inclusion, or the fact of its submission, in  
17          a report under such section. Information available from  
18          sources other than a report made under such section may  
19          be discovered or admitted in a civil or administrative pro-  
20          ceeding, if discoverable or admissible under applicable  
21          state law.

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

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

7           “(2) NON-IDENTIFIABLE INFORMATION USED  
8 BY DATABASE.—Non-identifiable information from a  
9 patient safety organization to the Patient Safety  
10 Database and the further disclosure of such data by  
11 the Center for Quality Improvement and Patient  
12 Safety.

13           “(e) REPORTER PROTECTION.—

14           “(1) IN GENERAL.—A health care provider may  
15 not use against an individual in an adverse employ-  
16 ment action described in paragraph (2) the fact that  
17 the individual in good faith reported—

18                   “(A) to the provider with the intention of  
19 having it reported to a patient safety organiza-  
20 tion, or

21                   “(B) directly to a patient safety organiza-  
22 tion, information that would constitute patient  
23 safety data under section 1181(e)(1)(A) if the  
24 provider were to have submitted it on a timely

1 basis to a patient safety organization in accord-  
2 ance with such section.

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

6 “(A) the failure to promote an individual  
7 or provide any other employment-related benefit  
8 for which the individual would otherwise be eli-  
9 gible;

10 “(B) an evaluation or decision made in re-  
11 lation to accreditation, certification,  
12 credentialing or licensing of the individual; and

13 “(C) a personnel action that is adverse to  
14 the individual concerned.

15 “(3) REMEDIES.—The provisions of the first  
16 sentence of section 1128A(a) shall apply with re-  
17 spect to a health care provider’s violation of para-  
18 graph (1) in the same manner as they apply to an  
19 act referred to in section 1128A(a)(7).

20 “(f) PENALTY.—It is unlawful for any person to dis-  
21 close any patient safety data in violation of the provisions  
22 of this section. Any person violating such provisions shall  
23 be subject to the same sanctions under section 1160(c)  
24 (relating to, upon conviction, a fine of not more than  
25 \$1,000, imprisonment for not more than 6 months, or

1 both, per disclosure and payment of the costs of prosecu-  
2 tion) as a person who discloses any information described  
3 in section 1160(a).

4 “(g) RULES OF CONSTRUCTION.—

5 “(1) NO LIMITATION OF OTHER PRIVILEGES.—

6 Subject to paragraph (2), nothing in this section  
7 shall be construed as affecting other privileges that  
8 are available under Federal or State laws that pro-  
9 vide greater peer review or confidentiality protec-  
10 tions than the peer review and confidentiality protec-  
11 tions provided for in this section.

12 “(2) NO EFFECT ON STATE MANDATORY RE-

13 PORTING REQUIREMENTS.—Nothing in this part  
14 shall be construed as preempting or otherwise affect-  
15 ing any State law mandatory reporting requirement  
16 for health care providers.

17 “(h) APPLICATION OF PRIVACY REGULATIONS.—For

18 purposes of applying the regulations promulgated pursu-  
19 ant to section 264(c) of the Health Insurance Portability  
20 and Accountability Act of 1996 (Public Law 104–191; 110  
21 Stat. 2033)—

22 “(1) patient safety organizations shall be treat-  
23 ed as business associates;

24 “(2) activities of such organizations described  
25 in section 1181(f)(2)(A) in relation to a health care

1 provider are deemed to be health care operations of  
2 the provider; and

3 “(3) the disclosure of identifiable information  
4 under the voluntary program under this part by  
5 such an organization shall be treated as necessary  
6 for the proper management and administration of  
7 the organization.

8 Nothing in this section shall be construed to alter or affect  
9 the implementation of such regulation or such section  
10 264(c).

11 “(i) WAIVERS.—Nothing in this part shall be con-  
12 strued as precluding a health care provider from waiving  
13 the privilege or confidentiality protections under this sec-  
14 tion.

15 “(j) CONTINUATION OF PRIVILEGE.—Patient safety  
16 data of an organization that is certified as a patient safety  
17 organization shall continue to be privileged and confiden-  
18 tial, in accordance with this section, if the organization’s  
19 certification is terminated or revoked or if the organization  
20 otherwise ceases to qualify as a patient safety organization  
21 until the data are otherwise disposed of in accordance with  
22 section 1181(f)(4).

23 “(k) SURVEY AND REPORT.—

24 “(1) SURVEY.—The Comptroller General of the  
25 United States shall conduct a survey of State laws

1 that relate to patient safety data peer review sys-  
2 tems, including laws that establish an evidentiary  
3 privilege applicable to data developed in such sys-  
4 tems, and shall review the manner in which such  
5 laws have been interpreted by the courts and the ef-  
6 fectiveness of such laws in promoting patient safety.

7 “(2) REPORT.—Not later than 9 months after  
8 the date of enactment of this section, the Comp-  
9 troller General shall prepare and submit to Congress  
10 a report concerning the results of the survey con-  
11 ducted under paragraph (1).

12 “CENTER FOR QUALITY IMPROVEMENT AND PATIENT  
13 SAFETY

14 “SEC. 1183. (a) IN GENERAL.—The Secretary shall  
15 ensure that the Center for Quality Improvement and Pa-  
16 tient Safety (in this section referred to as the ‘Center’)  
17 supports public and private sector initiatives to improve  
18 patient safety for items and services furnished through  
19 health care providers.

20 “(b) DUTIES.—

21 “(1) IN GENERAL.—The Secretary shall ensure  
22 that the Center carries out the following duties:

23 “(A) Provide for the certification and re-  
24 certification of patient safety organizations in  
25 accordance with subsection (d).

1           “(B) Collect and disseminate information  
2 related to patient safety.

3           “(C) Establish a Patient Safety Database  
4 to collect, support, and coordinate the analysis  
5 of non-identifiable information submitted to the  
6 Database in accordance with subsection (e).

7           “(D) Facilitate the development of con-  
8 sensus among health care providers, patients,  
9 and other interested parties concerning patient  
10 safety and recommendations to improve patient  
11 safety.

12           “(E) Provide technical assistance to States  
13 that have (or are developing) medical errors re-  
14 porting systems, assist States in developing  
15 standardized methods for data collection, and  
16 collect data from State reporting systems for  
17 inclusion in the Patient Safety Database.

18           “(2) CONSULTATION.—In carrying out the du-  
19 ties under paragraph (1) (including the establish-  
20 ment of the Database), the Secretary shall consult  
21 with and develop partnerships, as appropriate, with  
22 health care organizations, health care providers,  
23 public and private sector entities, patient safety or-  
24 ganizations, health care consumers, and other rel-  
25 evant experts to improve patient safety.



1       “(c) CERTIFICATION AND RECERTIFICATION PROC-  
2    ESS.—

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

8           “(2) REVOCATION.—Such a certification or re-  
9       certification may be revoked by the Secretary upon  
10      a showing of cause (including the disclosure of data  
11      in violation of section 1182).

12          “(3) TERMINATION.—Such a certification pro-  
13      vided for a patient safety organization shall termi-  
14      nate (subject to recertification) on the earlier of—

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

17           “(B) the date on which the Secretary re-  
18           vokes the certification.

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

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

24           “(2) ensure that data submitted by a patient  
25           safety organization to the Patient Safety Database,

1 as provided for under subsection (e), are comparable  
2 and useful for research and analysis and that the re-  
3 search findings and patient safety alerts that result  
4 from such analyses are presented in clear and con-  
5 sistent formats that enhance the usefulness of such  
6 alerts.

7 “(e) PATIENT SAFETY DATABASE.—

8 “(1) IN GENERAL.—The Secretary shall—

9 “(A) establish a Patient Safety Database  
10 to collect non-identifiable information con-  
11 cerning patient safety that is reported on a vol-  
12 untary basis; and

13 “(B) establish common formats for the vol-  
14 untary reporting of data under subparagraph  
15 (A), including the establishment of necessary  
16 data elements, common and consistent defini-  
17 tions, and a standardized computer interface  
18 for the processing of such data.

19 “(2) DATABASE.—In carrying out this sub-  
20 section, the Secretary—

21 “(A) shall establish and modify as nec-  
22 essary criteria to determine the organizations  
23 that may voluntarily contribute to, and the data  
24 that comprises, the Patient Safety Database;

1           “(B) shall ensure that the Patient Safety  
2           Database is only used by qualified entities or  
3           individuals as determined appropriate by the  
4           Secretary in accordance with criteria applied by  
5           the Secretary; and

6           “(C) may enter into contracts for the ad-  
7           ministration of the Database with private and  
8           public entities with experience in the adminis-  
9           tration of similar databases.

10          “(3) NON-IDENTIFIABLE INFORMATION.—For  
11          purposes of this part, the term ‘non-identifiable in-  
12          formation’ means information that is presented in a  
13          form and manner that prevents the identification of  
14          any health care provider, patient, and the reporter  
15          of the information.

16          “(f) FUNDING.—The Secretary shall transfer from  
17          the Federal Hospital Insurance Trust Fund established  
18          under section 1817 such sums as are necessary for each  
19          fiscal year to carry out this section.

20          “INTEROPERABILITY STANDARDS FOR HEALTH CARE  
21                                   INFORMATION TECHNOLOGY SYSTEMS

22          “SEC. 1184. (a) IN GENERAL.—By not later than 2  
23          years after the date of the enactment of this part, the Sec-  
24          retary shall develop or adopt (and shall periodically review  
25          and update) voluntary, national standards that promote  
26          the interoperability of health care information technology

1 systems across all health care settings. In promulgating  
2 regulations to carry out this section, the Secretary shall  
3 take into account the cost that meeting such standards  
4 would have on providing health care in the United States  
5 and the increased efficiencies in providing such care  
6 achieved under the standards.

7 “(b) CONSULTATION AND COORDINATION.—The Sec-  
8 retary shall develop and update such standards in con-  
9 sultation with (and with coordination between)—

10 “(1) the National Committee for Vital and  
11 Health Statistics, and

12 “(2) the Medical Information Technology Advi-  
13 sory Board (established under section 3 of the Pa-  
14 tient Safety Improvement Act of 2003).

15 “(c) DISSEMINATION.—The Secretary shall provide  
16 for the dissemination of the standards developed and up-  
17 dated under this section.

18 “(d) FUNDING.—The Secretary shall transfer from  
19 the Federal Hospital Insurance Trust Fund established  
20 under section 1817 such sums as are necessary for each  
21 fiscal year to carry out this section.

22 “VOLUNTARY ADOPTION OF METHODS TO IMPROVE  
23 PATIENT SAFETY

24 “SEC. 1185. The Secretary shall encourage health  
25 care providers to adopt appropriate evidence-based meth-

1 ods to improve patient safety. Such methods shall not con-  
2 stitute national practice guidelines.

3 “EVALUATION AND REPORT

4 “SEC. 1186. (a) EVALUATION.—The Comptroller  
5 General of the United States shall conduct a comprehen-  
6 sive evaluation of the implementation of this part. Such  
7 evaluation shall include an examination of the following:

8 “(1) The health care providers that reported  
9 patient safety data under this part and the patient  
10 safety organizations to which they reported the in-  
11 formation.

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

13 “(3) The usefulness of the analyses, informa-  
14 tion, and recommendations provided by patient safe-  
15 ty organizations in response to such reported infor-  
16 mation.

17 “(4) The response of health care providers to  
18 such analyses, information, and recommendations,  
19 including a survey of providers to obtain estimates  
20 of the percentage of providers by category who have  
21 adopted specific error-reduction methods and, if ap-  
22 plicable, reasons for not adopting specific practices.

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

25 “(b) REPORT.—Not later than 5 years after the date  
26 the provisions of this part are first implemented, the

1 Comptroller General shall submit to Congress a report on  
2 the evaluation conducted under subsection (a).”.

3 **SEC. 3. MEDICAL INFORMATION TECHNOLOGY ADVISORY**  
4 **BOARD.**

5 (a) ESTABLISHMENT.—

6 (1) IN GENERAL.—Not later than 3 months  
7 after the date of the enactment of this Act, the Sec-  
8 retary of Health and Human Services (in this sec-  
9 tion referred to as the “Secretary”) shall appoint an  
10 advisory board to be known as the “Medical Infor-  
11 mation Technology Advisory Board” (in this section  
12 referred to as the “MITAB”).

13 (2) CHAIRMAN.—The Secretary shall designate  
14 one member as chairman. The chairman shall be an  
15 individual affiliated with an organization having ex-  
16 pertise creating American National Standards Insti-  
17 tute (ANSI) accepted standards in health care infor-  
18 mation technology and a member of the National  
19 Committee for Vital and Health Statistics.

20 (b) COMPOSITION.—

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

23 (A) experts from the fields of medical in-  
24 formation, information technology, medical con-  
25 tinuous quality improvement, medical records

1 security and privacy, individual and institu-  
2 tional health care clinical providers, health re-  
3 searchers, and health care purchasers;

4 (B) one or more staff experts from each of  
5 the following: the Centers for Medicare & Med-  
6 icaid Services, the Agency for Healthcare Re-  
7 search and Quality, and the Institute of Medi-  
8 cine of the National Academy of Sciences;

9 (C) representatives of private organizations  
10 with expertise in medical infomatics;

11 (D) a representative of a teaching hospital;  
12 and

13 (E) one or more representatives of the  
14 health care information technology industry.

15 (2) TERMS OF APPOINTMENT.—The term of  
16 any appointment under paragraph (1) to the  
17 MITAB shall be for the life of the MITAB.

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

20 (4) VACANCIES.—A vacancy on the MITAB  
21 shall be filled in the same manner in which the origi-  
22 nal appointment was made not later than 30 days  
23 after the MITAB is given notice of the vacancy and  
24 shall not affect the power of the remaining members  
25 to execute the duties of the MITAB.

1           (5) COMPENSATION.—Members of the MITAB  
2 shall receive no additional pay, allowances, or bene-  
3 fits by reason of their service on the MITAB.

4           (6) EXPENSES.—Each member of the MITAB  
5 shall receive travel expenses and per diem in lieu of  
6 subsistence in accordance with sections 5702 and  
7 5703 of title 5, United States Code.

8           (c) DUTIES.—

9           (1) IN GENERAL.—The MITAB shall on an on-  
10 going basis advise, and make recommendations to,  
11 the Secretary regarding medical information tech-  
12 nology, including the following:

13                   (A) The best current practices in medical  
14 information technology.

15                   (B) Methods for the adoption (not later  
16 than 2 years after the date of the enactment of  
17 this section) of a uniform health care informa-  
18 tion system interface between and among old  
19 and new computer systems.

20                   (C) Recommendations for health care vo-  
21 cabulary, messaging, and other technology  
22 standards (including a common lexicon for com-  
23 puter technology) necessary to achieve the  
24 interoperability of health care information sys-



1           tems for the purposes described in subpara-  
2           graph (E).

3           (D) Methods of implementing—

4                 (i) health care information technology  
5                 interoperability standardization; and

6                 (ii) records security.

7           (E) Methods to promote information ex-  
8           change among health care providers so that  
9           long-term compatibility among information sys-  
10          tems is maximized, in order to do one or more  
11          of the following:

12                 (i) To maximize positive outcomes in  
13                 clinical care—

14                         (I) by providing decision support  
15                         for diagnosis and care; and

16                         (II) by assisting in the emer-  
17                         gency treatment of a patient pre-  
18                         sented at a facility where there is no  
19                         medical record for the patient.

20                 (ii) To contribute to (and be con-  
21                 sistent with) the development of the pa-  
22                 tient assessment instrument provided for  
23                 under section 545 of the Medicare, Med-  
24                 icaid, and SCHIP Benefits Improvement  
25                 and Protection Act of 2000, and to assist

1 in minimizing the need for new and dif-  
2 ferent records as patients move from pro-  
3 vider to provider.

4 (iii) To reduce or eliminate the need  
5 for redundant records, paperwork, and the  
6 repetitive taking of patient histories and  
7 administering of tests.

8 (iv) To minimize medical errors, such  
9 as administration of contraindicated drugs.

10 (v) To provide a compatible informa-  
11 tion technology architecture that facilitates  
12 future quality and cost-saving needs and  
13 that avoids the financing and development  
14 of information technology systems that are  
15 not readily compatible.

16 (2) REPORTS.—

17 (A) INITIAL REPORT.—No later than 18  
18 months after the date of the enactment of this  
19 Act, the MITAB shall submit to Congress and  
20 the Secretary an initial report concerning the  
21 matters described in paragraph (1). The report  
22 shall include—

23 (i) the practices described in para-  
24 graph (1)(A), including the status of  
25 health care information technology stand-

1           ards being developed by private sector and  
2           public-private groups;

3                 (ii) recommendations for accelerating  
4           the development of common health care  
5           terminology standards;

6                 (iii) recommendations for completing  
7           development of health care information  
8           system messaging standards; and

9                 (iv) progress toward meeting the  
10          deadline described in paragraph (1)(B) for  
11          adoption of methods described in such  
12          paragraph.

13                 (B) SUBSEQUENT REPORTS.—During each  
14          of the 2 years after the year in which the report  
15          is submitted under subparagraph (A), the  
16          MITAB shall submit to Congress and the Sec-  
17          retary an annual report relating to additional  
18          recommendations, best practices, results of in-  
19          formation technology improvements, analyses of  
20          private sector efforts to implement the inter-  
21          operability standards established in section  
22          1184 of the Social Security Act, and such other  
23          matters as may help ensure the most rapid dis-  
24          semination of best practices in health care in-  
25          formation technology.

1 (d) STAFF AND SUPPORT SERVICES.—

2 (1) EXECUTIVE DIRECTOR.—

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

5 (B) COMPENSATION.—The executive direc-  
6 tor shall be paid the rate of basic pay for level  
7 V of the Executive Schedule.

8 (2) STAFF.—With the approval of the MITAB,  
9 the executive director may appoint such personnel as  
10 the executive director considers appropriate.

11 (3) APPLICABILITY OF CIVIL SERVICE LAWS.—  
12 The staff of the MITAB shall be appointed without  
13 regard to the provisions of title 5, United States  
14 Code, governing appointments in the competitive  
15 service, and shall be paid without regard to the pro-  
16 visions of chapter 51 and subchapter III of chapter  
17 53 of such title (relating to classification and Gen-  
18 eral Schedule pay rates).

19 (4) EXPERTS AND CONSULTANTS.—With the  
20 approval of the MITAB, the executive director may  
21 procure temporary and intermittent services under  
22 section 3109(b) of title 5, United States Code.

23 (e) POWERS.—

24 (1) HEARINGS AND OTHER ACTIVITIES.—For  
25 the purpose of carrying out its duties, the MITAB

1 may hold such hearings and undertake such other  
2 activities as the MITAB determines to be necessary  
3 to carry out its duties.

4 (2) DETAIL OF FEDERAL EMPLOYEES.—Upon  
5 the request of the MITAB, the head of any Federal  
6 agency is authorized to detail, without reimburse-  
7 ment, any of the personnel of such agency to the  
8 MITAB to assist the MITAB in carrying out its du-  
9 ties. Any such detail shall not interrupt or otherwise  
10 affect the civil service status or privileges of the  
11 Federal employee.

12 (3) TECHNICAL ASSISTANCE.—Upon the re-  
13 quest of the MITAB, the head of a Federal agency  
14 shall provide such technical assistance to the  
15 MITAB as the MITAB determines to be necessary  
16 to carry out its duties.

17 (4) OBTAINING INFORMATION.—The MITAB  
18 may secure directly from any Federal agency infor-  
19 mation necessary to enable it to carry out its duties,  
20 if the information may be disclosed under section  
21 552 of title 5, United States Code. Upon request of  
22 the Chairman of the MITAB, the head of such agen-  
23 cy shall furnish such information to the MITAB.

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

4           (g) APPLICABILITY OF FACA.—The provisions of the  
5 Federal Advisory Committee Act (5 U.S.C. App.) shall  
6 apply to the MITAB.

7           (h) FUNDING.—The Secretary shall transfer from the  
8 Federal Hospital Insurance Trust Fund established under  
9 section 1817 of the Social Security Act (42 U.S.C. 1395i)  
10 such sums as are necessary for each fiscal year to carry  
11 out this section.

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