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APhA

HEALTH INFORMATION TECHNOLOGY

Background Paper for the 2008-09 APhA Policy Committee

Issue

The APhA Board of Trustees has directed the 2008-09 Policy Committee to recommend policy to the APhA House of Delegates related to the interface of health information technology and the practice of pharmacy. Specific areas of focus should include, but not be limited to e-prescribing as well as pharmacist roles, responsibilities and opportunities related to health information technology.

Introduction

Increasing focus on health care quality, safety and rising costs has stimulated the federal government and health care leaders across the United States to seek solutions to what many consider a crisis in health care delivery. Health information technology has emerged as a potential solution to breaking down barriers, collaboration and communication among providers and improving health information exchange among all stakeholders including payers and quality oversight organizations. While broadly recognized and desirable, much work remains to be done to address the numerous challenges and need for leadership, coordination and common agreement among the many stakeholders.

This background paper describes the structure and purposes of a health information technology (HIT) network. In addition, it addresses the opportunities and challenges confronting the United States in creating and utilizing a healthcare information technology infrastructure. Access to quality healthcare, along with the magnitude of healthcare information and the protection of privacy, were and continue to be the basis of policy-level discussions concerning HIT. While the U.S. HIT infrastructure is currently in its developmental stages, input from stakeholders can have significant impact. As policy and legislation emerges at the national and state level, APhA must clearly communicate policy that protects and promotes the role of the pharmacist in delivering high quality, safe and cost-effective medication use.

Specifically, the policy committee in its deliberations should consider the following questions:

1. What is the profession of pharmacy's role in the development of HIT infrastructure?
2. Are there micro and macro opportunities for the profession of pharmacy to establish leadership in the healthcare community in relation to HIT?
3. What barriers exist that prevent pharmacist's utilization of HIT and what needs to be done to overcome them?
4. How does HIT affect medication therapy management (MTM) core principles and practices?
5. What guiding principles should the profession of pharmacy advocate in the development of HIT infrastructure?

Background

Patient information is currently stored in a variety of locations, largely on paper forms that can not be easily accessed by the multiple providers often caring for a single patient. Consequently, comprehensive patient information is unavailable to most providers and information needed to track progress and facilitate response is difficult. Health information technology is intended to create an interoperable data exchange and mobilization of critical clinical information, privately and securely among different entities and providers. The infrastructure required, resources and methods for development will have significant impact on how pharmacists practice now and in the future.

Conceptualization of HIT

Health information technology can be thought of using a network approach. As providers of healthcare services are aware, the US healthcare system is fragmented, and is considered by many a non-system[1]. One reason for the lack of connectivity is a void in infrastructure that could connect all entities within the healthcare setting (e.g. patients, providers, payers, government entities, etc.). While the needs of each entity are not identical, information necessary to provide, receive and pay for care is similar and can be focused on each patient. Paper medical records have existed for years and this will serve as the initial bridge for conceptualizing HIT. The electronic medical record (EMR or eMAR) is an electronic record of health-related information on an individual that can be created, gathered, managed, and consulted by authorized clinicians and staff within one health care organization.[2] The goal of a HIT infrastructure is to create a network of interoperable databases in which patients' will have electronic health records (EHRs). EHRs are electronic records of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized clinicians and staff across more than one health care organization.[2] Interoperability refers to the abilities of databases of information to connect and share information, based on an established set of standards.

For the profession of pharmacy, the National Council for Prescription Drug Programs (NCPDP) is the American National Standards Institute (ANSI) accredited standards development organization. NCPDP has created numerous standards over the years for billing and teletransfer of health information. The standard for prescribing is SCRIPT. A guideline that will help map the interoperability between SCRIPT and HL7 (the language of healthcare organizations and acute centers) was created in 2005.

Another component to the system is what information is used in the identification of information being transferred. Pharmacy utilizes a few identifying systems. The national drug code (NDC) is used to identify products. More recently pharmacists have begun to use national provider identifiers (NPI) and current procedural terminology (CPT) codes to identify themselves as providers of services.

National Health Information Coordinator

On April 27, 2004, US President George W. Bush signed an executive order that established the Office of the National Health Information Coordinator (ONC) within the Department of Health and Human Services in order to create an efficient, interoperable HIT infrastructure.[3] The ONC was charged with the creation of a strategic plan based on input from public and private

stakeholders. The vision of the plan was for an interoperable system to be fully-functional and available to most patients by 2014.

American Health Information Community

In September of 2005, the Secretary of Health and Human Services created the American Health Information Community (AHIC) to serve as an advisory group to assist the ONC in its mission. The AHIC is a federally charted advisory committee that 1) makes recommendations to achieve an interoperability framework for HIT and serve as a forum for participation from a broad range of stakeholders to provide HIT input.[4] Several workgroups (consumer empowerment, chronic care, electronic health records, population health and clinical care connections, confidentiality, privacy & security, quality, personalized healthcare) are formed within the community to tackle breakthrough areas in which initiatives can be realized over the next several years.

Healthcare Information Technology Standards Panel (HITSP) & Certification Commission for Healthcare Information Technology (CCHIT)

The Secretary of Health and Human Services sponsored the HITSP in order to streamline the standards adoption process.[5] The panel's missions are centered on choosing standards where multiple standards exist and to advocate for creation of standards where there are none. Industry stakeholders and federal representatives participate on the panel and public input is regularly selected. Once a standard is approved, different companies create operational systems around the language. These systems then seek certification from the CCHIT. The CCHIT received a three year contract from HHS to certify that products can operate within the federal HIT framework. All certified products should be interoperable. [5]

One caveat, not unlike other aspects of the US health system, is that HIT products need not conform to federal standards unless they wish to interact with federal payment sources. Thus, the federal standards continue to drive the development of an interoperable HIT infrastructure.

ONC Strategic Plan

The ONC released its strategic plan to guide them through the year 2012 on June 3, 2008. The plan calls for actions to be implemented over the next 4 years to achieve the following goals and objectives[7]:

Goal 1. Patient-focused Health Care
Objective 1.1: Privacy and Security
Facilitate electronic exchange, access, and use of electronic health information, while protecting the privacy and security of patients' health information.
Objective 1.2: Interoperability
Enable the movement of electronic health information to support patients' health and care needs.
Objective 1.3: Adoption
Promote nationwide deployment of electronic health records (EHRs) and personal health records (PHRs) and other consumer health IT tools.
Objective 1.4: Collaborative Governance
Establish mechanisms for multi-stakeholder priority-setting and decision-making.

Goal 2. Population Health
Objective 2.1: Privacy and Security
Advance privacy and security policies, principles, procedures, and protections for information access in population health.
Objective 2.2: Interoperability
Enable exchange of health information to support population-oriented uses.
Objective 2.3: Adoption
Promote nationwide adoption of technologies to improve population and individual health.
Objective 2.4: Collaborative Governance
Establish coordinated organizational processes supporting information use for population health.

AHIC II

On July 17, 2008, the AHIC Successor was incorporated. The new AHIC is a private and public partnership that will further the mission of the original AHIC and broaden it to reach both for- and not-for-profit involvement. The organization expects to name its board composition late September 2008. It offers the following value propositions for clinicians and pharmacies[10]:

- Advanced interoperability between EHRs, NHIN, and specialty networks specific to ancillary services (e.g., labs, radiology and pharmacy)
- Decreased operating costs due to automated interactions directly with providers
- Interoperable health IT (Clinical Decision Tools) that allow providers to deliver the highest quality health care to their patients
- Unprecedented opportunity to participate in priority setting, ensuring that priorities are informed by clinically relevant expertise and to advance the level and quality of patient care
- Mitigation of risks to clinicians associated with liability, privacy, and security stemming through advancement of the appropriate exchange of data

Medication Gaps

Since 2006, the ONC has created "use cases" or business propositions that could be completed within 2-3 years to guide the creation of the HIT infrastructure. In 2008, it reviewed its use cases for gaps. One gap identified was "Medication". In 2009, medication gaps will be a focus based on the document of guidance released by the ONC. The draft of the document was released on August 15, 2008 and is out for public comment. [11] The final draft will focus on gaps remaining in creating an interoperable system with emphasis on pharmacy services in the inpatient, community and long-term care settings.

APhA in written comments voiced an overarching concern with the document's lack of recognition of the role of pharmacists in providing patient care services in addition to dispensing related activities. In order to avoid confusion, APhA recommended that the document's use of the term "clinician" and its glossary definition be revised to include pharmacists, stating pharmacists provide a variety of MTM services that optimize therapeutic outcomes, address medication-related problems, and build on active collaboration with the prescriber and the patient. MTM services can occur independently of or in conjunction with the dispensing of a medication. In recognition of these

additional patient care responsibilities, pharmacists must have two-way access to resources to ensure effective medication management and facilitate collaboration with other members of the health care team (including long term care facilities). Examples of such resources include: pharmacists having complete access to the electronic and personal health records; the ability for two-way electronic communications with other health care providers who are also accessing electronic records; and documentation authority for all pharmacist-provided care. Effective two-way electronic exchange of information is vital to help achieve the desired outcomes of the use case and ensure medication management interoperability for all members of the health care team, including pharmacists

e-Prescribing

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) required the Centers for Medicare & Medicaid Services (CMS) to develop uniform standards for electronic prescribing (e-prescribing) for use in the Medicare prescription drug benefit (Medicare Part D). While prescribers and pharmacists are not required to adopt e-prescribing (it is voluntary for providers), those who decide to electronically transmit prescriptions for Medicare beneficiaries must transmit those prescriptions according to the e-prescribing standards. APhA generally supported the provision, as e-prescribing has the potential to substantially benefit the health care system, create efficiencies in the delivery of health care, and provide pharmacists, physicians, and other members of the heath care team with access to patient medical record information.

In November 2005, CMS released the first set of e-prescribing standards which serve as foundation standards for the e-prescribing program. The foundation standards, which were based predominantly on current industry practice, went into effect on January 1, 2006. The law directs the Department of Health and Human Services (HHS) to develop and release final e-prescribing standards by April 1, 2008 that will take effect within one year after their release. To that end, on November 16, 2007, CMS released a proposed regulation on the transmission of information for Medicare Part D e-prescribing, proposing the adoption of the National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard version 8.1 e-prescribing standard. On April 9, 2008, CMS released the final rule that outlines the adoption of these uniform standards, as well as the adoption of a standard identifier for prescribers and dispensers (the National Provider Identifier, or NPI).

After obtaining results from pilot testing, CMS adopted the following uniform standards in the final rule:

- NCPDP SCRIPT 8.1 for the communication of prescription or prescription-related information between prescribers and pharmacists. NCPDP SCRIPT 5.0 is retired.
- Medication History Transaction Standard: Allows providers, pharmacists, and Medicare Part D plan sponsors to communicate about prescribed medications a beneficiary has taken or is taking, including those prescribed by other providers. CMS anticipates that this may help reduce the number of adverse drug events.
- Formulary and Benefits Standard: Allows prescribers to communicate with Medicare Part D plan sponsors about which drugs are covered by the patient's prescription drug benefit plan, including information about available generic medications.

- Fill Status Notification (RxFill) Standard: Allows providers to receive an electronic communication from dispensers telling them that a patient's prescription has been picked up, not picked up, or has been partially filled.
- National Provider Identifier (NPI): Requires providers, pharmacists, and Medicare Part D sponsors to use the NPI to identify individual health care providers in Medicare Part D e-prescribing transactions. CMS anticipates that this may help reduce the number of calls pharmacists make to physician offices to identify the individual prescriber.

CMS is not currently adopting standards related to RxNORM (clinical drug terminology), Structured and Codified Sig (patient instructions), or Prior Authorization. CMS stated that while these three additional standards would provide value, at this time they are not ready for implementation. The Agency will continue to work with industry and stakeholders towards readying these standards for implementation.

APhA's comments on the proposed rule were generally favorable, and focused on the initial standards pilot test findings; adoption of the National Council for Prescription Drug Program (NCDPDP) SCRIPT 8.1 standard, including the medication history standard, the NCPDP Formulary and Benefits Standard 1.0, and the National Provider Identifier (NPI); compliance timeline; and regulatory impact analysis.

APhA supported the adoption of NCPDP SCRIPT 8.1, the medication history standard, the formulary and benefits standard, and the NPI. CMS agreed with APhA's comments regarding RxNORM, Structured and Codified Sig, and Prior Authorization—that additional testing needs to occur before adoption. CMS, however, decided to adopt the Fill Status Notification, while APhA had encouraged additional monitoring before implementation.

APhA also recommended to CMS that they eliminate the exemption for long-term care (LTC) settings and adopt NCPDP SCRIPT 10.2 specifically for the LTC setting. In the final rule, CMS indicates that even though NCPDP SCRIPT 10.2 was approved in July 2007, NCPDP SCRIPT 10.5 appears to meet all of the needs of LTC settings and will be finalized in July 2008. At that time, CMS anticipates eliminating the exemption through the rulemaking process.

Further, APhA recommends that the following elements of e-prescribing be addressed:

- To enhance efficiencies, an e-prescribing system must:
  - Reduce the time spent by pharmacists obtaining authorizations and clarifying prescription orders with prescribers
  - Reduce the time spent by prescribers obtaining authorizations from payers by providing access to formulary information at the point of prescription entry so that any necessary adjustment to therapy can be made before the prescription is transmitted
  - Keep open an electronic channel of communication between prescribers and pharmacists to address prescription errors or other issues with a prescription order that are identified by pharmacists
  - Be based upon technology and information standards to allow for system interoperability
- To improve patient safety, an e-prescribing system must:

  - Eliminate transcription errors from verbal prescription orders or from transferring information between e-prescribing software and pharmacy dispensing-related software
  - Provide prescribers with information essential to assess contraindications such as drug allergies, drug interactions, and errors in drug selection and dosing
- To improve the security of our drug supply, an e-prescribing system must:
  - Provide a secure means of medication order transmission
  - Allow e-prescribing of controlled substances; maintaining two prescribing systems, one for controlled substances and one for non-controlled substances, is cumbersome, unnecessarily complex, and poses additional financial burden prescribers and pharmacists
  - Facilitate efficient, thorough and easily accessible record keeping that allows prescribers and pharmacists to comply with requirements established by regulatory agencies such as the Drug Enforcement Agency and state boards of pharmacy
- To improve patient care, an e-prescribing system must:
  - Allow health care providers to share patient information in HIPAA compliant format and focus on providing patient care rather than interfacing with the system
  - Prevent errors at the point of entry such as wrong dose or drug selection from drop-down menus
- To prevent breaches in patient confidentiality, an e-prescribing system must:
  - Protect the security of patient data to the maximum extent possible, such that the integrity of transmission from prescriber directly to pharmacist must not be compromised
  - Prevent prescription orders being sent from prescribers to pharmacists from being intercepted by third party payers. Third party claims submission must occur after the pharmacist has received the prescription and discussed it with the patient. These systems must protect health care decisions and preserve the integrity of the prescriber-patient-pharmacist relationship
- To prevent unfair business practices such as an unfunded mandate, an e-prescribing system must not burden one stakeholder with financing the system when several stakeholders benefit from the system's use.

DEA ePrescribing Controlled Substances

One of the major barriers to widespread adoption of HIT and in particular ePrescribing is the DEA's regulation that prevents electronic transfer of controlled substances prescriptions. The DEA proposed new rules on June 27, 2008 that would allow for the use of ePrescribing systems to transmit C-II prescriptions from practitioner to pharmacist.[8] The rules promote the utilization of a two factor Level 4 authentication to guarantee authenticity of the prescription. Since any EHR program that has certification from CCHIT has this level of authenticity, numerous programs are in existence with this technology. The DEA also conducted a cost-benefit assessment analysis in which it concluded that both short and long-term benefits would outweigh the costs associated with implementing the new rule.[9]

APhA's comments to the DEA on September 25, 2008 included the following main points:

- Burden of third-party audits on eRx system annually.

- Burden of the internal audit trail on pharmacy IT systems, increase in hardware/software/storage capacity, etc.
- Concern with the 'geographically different' location for copy of CS eRx data.
- Record retention and report printing shouldn't require a separate prescription system but should be able to be incorporated into existing prescription systems that already create audit reports.
- Concern with DEA number validation for each prescription that is not currently required for handwritten prescriptions.
- Concern with digitally signing the CS eRx if both the last intermediary and pharmacy are simultaneously engaged.
- Concern with the lack of flexibility to print/fax a prescription if there is a transmission failure/glitch.
- Concerned that the proposal doesn't allow RPh to alter prescription i.e. dosage/direction clarification or generic substation.
- LTC pharmacy isn't really included in the 'agent of the prescriber.
- No mention of other agents of the prescriber to include pharmacists practicing under CDTM with a DEA number.
- Impact on 340B impact where the prescriber and the pharmacy systems are all in the same facility with additional costs being incurred by the same organization.

For the Prescriber

- Need for in-person identity proofing doesn't fall in line with a typical service provider that only operates the software
- Unreasonable and question the value of prescribers reviewing a monthly log of CS eRx that would be generated by the service provider.
- Concerns with the 'time-out' of the eRx system if prescribers don't sign it in the allotted time period.

Securing Patient Privacy

Concomitant with the creation of comprehensive data information exchange is the need to balance needs and rights of individual patients against the needs of society to manage health care practices and control costs. Policy debate surrounding patient privacy will no doubt become a major factor in full adoption and utilization of health information technology. While HIPAA standards continue to be clarified and modified, the need to consider administrative burden against patient rights must also be considered as health information technology applications are developed and adopted. The need for pharmacists to access and share clinical information as part of medication therapy management must be considered and appropriately integrated into a national strategy to improve medication use, safety and quality of care.

On July 18, APhA sent a letter to the House Energy and Commerce Committee on the Protecting Records, Optimizing Treatment, and Easing Communication through Healthcare Technology (PRO(TECH)T) Act of 2008 (H.R. 6357), a bill aimed at encouraging standards and adoption of HIT. In particular, APhA was concerned with PRO(TECH)T's Act consent and disclosure requirements and the potential impact on patient care, time, and cost.

On July 23, the House Energy and Commerce Committee passed by voice vote an amended version of H.R. 6357. This new version of the bill includes several improvements that address some of APhA's concerns:

- Limits disclosure of breaches to information that is not encrypted;
- Limits accounting of disclosure to treatment, payment, and healthcare operations;
- Reduces record retention requirements from six to three years;
- Allows for one-time aggregated consent;
- Allows the provider to maintain the patient's information in an electronic medical record regardless of whether a provider receives consent; and
- Gives the Secretary the option to exempt certain healthcare operations from the consent provision.

Although these modifications improve the bill, APhA remains concerned that a pharmacist representative is not explicitly included in the memberships for the HIT policy and standards committees. APhA recommends that these committees include a pharmacist to better ensure that any system is a success, and will be operational from both the medical and pharmacy perspective.

Summary

On August 12, 2008, HHS Secretary Leavitt stated at a meeting in North Carolina that health IT and the creation of standards for health IT are one of four cornerstones necessary to create a value-driven healthcare system in the U.S.[12] The U.S. is in the midst of a transformation in healthcare information exchange that will shift from a paper to an electronic system. Pharmacists are affected by policy decisions that aide in the creation and implementation of the new HIT infrastructure. Opportunities to provide input and leadership on the transformation continue to be generated. Appropriate APhA policy representing the profession and the pharmacist's role in patient care will provide valuable guidance to the Associations' advocacy and professional practice efforts.

APPENDIX 1
Current APhA Policy related to Health Information Technology

2005/1993 Documentation
1. APhA encourages development of systems that document review of patient therapy, the type and intensity of services provided, and the result or outcome of the services.
2. APhA believes that systems of payment and documentation must be compatible with contemporary computer systems used by providers and payers and should emphasize administrative efficiency.
(Am Pharm NS33(7):54 July 1993) (JAPhA NS45(5):560 September/October 2005)

1998 Access and Contribution to Health Records
1. APhA urges the integration of pharmacy-based patient data into patient health records to facilitate the delivery of integrated care.
2. APhA recognizes pharmacists' need for patient health care data and information and supports their access and contribution to patient health records.
3. APhA supports public policies that protect the patient's privacy, yet preserve access to personal health data for research where the patient has consented to such research or where the patient's identity is protected.
4. APhA encourages interdisciplinary discussion regarding accountability and oversight for appropriate use of health information.
(JAPhA 38(4): 417 July/August 1998) (Reviewed 2005)

2005/2004/1999 Telemedicine/Telehealth/Telepharmacy
1. APhA supports the pharmacist as the only appropriate provider of telepharmacy services, a component of telehealth, for which compensation should be provided. Telepharmacy is defined as the provision of pharmaceutical care to patients through the use of telecommunications and information technologies.
2. APhA shall assist pharmacists and student pharmacists in becoming knowledgeable about telepharmacy and telehealth.
3. APhA shall participate in the ongoing development of the telehealth infrastructure, including but not limited to regulations, standards development, security guidelines, information systems, and compensation.
4. APhA acknowledges that state boards of pharmacy are primarily responsible for the regulation of the practice of telepharmacy, encourages appropriate regulatory action that facilitates the practice of telepharmacy and maintains appropriate guidelines to protect the public health and patient confidentiality.
(JAPhA 39(4):447 July/August 1999) (*JAPhA NS44(5):551 September/October 2004) (JAPhA NS45(5):559 September/October 2005)*

2001 Prescription Order Requirements
1. APhA supports the use of technology to facilitate the transmission of prescription order information from the prescriber to the pharmacist of the patient's choice at no additional cost to the pharmacy. APhA encourages all prescribers to use such technology or to legibly hand print prescriptions.
2. APhA supports the use of technology where appropriate standards for patient confidentiality and prescriber and pharmacist verification are established.

3. APhA supports the transmission of complete prescriber information on or with the prescription order that enables the pharmacist to readily identify and facilitate communication with the prescriber.
4. APhA supports the use of specific instructions with prescription orders. Use of potentially confusing terminology (such as "as directed", unclear use of Latin phrases, confusing abbreviations, etc.) should be avoided.
5. APhA supports the inclusion of the diagnosis or indication for use for which the medication is ordered on or with the transmission of the prescription order by use of standard diagnosis codes or within the directions for use. APhA further supports the inclusion of patient-specific information on or with the prescription order where appropriate.
6. APhA supports public education about the benefits and risks of technological advances in pharmacy practice.
(JAPhA NS41(5):Suppl.1:S8 September/October 2001) (Reviewed 2007)

1993 Access to Patient Information
1. APhA supports the right of pharmacists, in all practice environments, to have access to patient-specific information necessary to achieve optimal therapeutic outcomes.
2. APhA encourages the prescriber's assessment of the patient's disease state and desired or intended therapeutic outcome to accompany the prescription order.
(Am Pharm NS33(7):54 July 1993) (Reviewed 2001) (Reviewed 2007)

1994 Implications of On-line Prospective DUR on the Application of Pharmacists' Scientific and Clinical Judgments
1. APhA recognizes that effective drug utilization review (prospective, concurrent, retrospective), as a component of pharmaceutical care, depends upon complete and accurate patient information.
2. APhA advocates eliminating the economic and operational obstacles pharmacists encounter when conducting drug utilization review for optimal patient care.
3. APhA supports utilization of universal and comprehensive standards for On-line Realtime Drug Utilization Review (ORDUR).
4. APhA encourages the development of a standardized method of electronic transfer of patient medical data between all health professionals involved in the care of a patient.
(Am Pharm NS34(6):58 June 1994) (Reviewed 2005)

1994 Confidentiality of Computer-generated Patient Records
APhA, in cooperation with the National Council of Prescription Drug Programs, Inc. (NCPDP), shall encourage the development and implementation of uniform, prescription, computer software standards to prevent unauthorized access to confidential patient records.
(Am Pharm NS34(6):60 June 1994) (Reviewed 2005)

1993 Patient Information
1. APhA shall facilitate the development, dissemination, and use of an information system that documents the components of comprehensive medication-use-management services.
2. APhA encourages development of quality assurance standards that guarantee the integrity and accuracy of information included in proprietary information systems.
(Am Pharm NS33(7):53 July 1993) (Reviewed 2005)

APPENDIX 2

Current AMA Policy related to Health Information Technology

H-478.993 Implementing Electronic Medical Records

It is the policy of our AMA that public and private insurers should not require the use of electronic medical records. (Sub. Res. 707, A-06; Reaffirmation A-07)

H-478.994 Health Information Technology

Our AMA will support the principles that when financial assistance for Health IT originates from an inpatient facility: (1) it not unreasonably constrain the physician's choice of which ambulatory HIT system to purchase; and (2) it promote voluntary rather than mandatory sharing of Protected Health Information (HIPAA-PHI) with the facility consistent with the patient's wishes as well as applicable legal and ethical considerations. (Res. 723, A-05)

H-478.995 National Health Information Technology

Our AMA supports the development, adoption, and implementation of national health information technology standards through collaboration with public and private interests, and consistent with current efforts to set health information technology standards for use by the federal government. (Res. 730, I-04)

H-478.998 Health Data and Modern Medical Professionalism

Our AMA: (1) carefully prioritize its involvement with standards development organizations and other groups focusing on electronic commerce to ensure the inclusion of physicians' perspectives and to facilitate development of a standardized aggregation and analysis of clinical data; and (2) promotes the AMA/Intel Corporation Digital Certificate System to all physicians engaged in electronic transactions of medical information to ensure that the identity of individual physicians can be trusted by anyone receiving an online message from a physician. (BOT Rep. 4, A-00)

Appendix 3
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