mittee requires to evaluate and develop standards, implementation specifications, and certification criteria, or to achieve full participation of stakeholders in the adoption of a nationwide health information technology infrastructure that allows for the electronic use and exchange of health information.

(B) Implementation report

The National Coordinator shall prepare a report that identifies lessons learned from major public and private health care systems in their implementation of health information technology, including information on whether the technologies and practices developed by such systems may be applicable to and usable in whole or in part by other health care providers.

(C) Assessment of impact of HIT on communities with health disparities and uninsured, underinsured, and medically underserved areas

The National Coordinator shall assess and publish the impact of health information technology in communities with health disparities and in areas with a high proportion of individuals who are uninsured, underinsured, and medically underserved individuals (including urban and rural areas) and identify practices to increase the adoption of such technology by health care providers in such communities, and the use of health information technology to reduce and better manage chronic diseases.

(D) Evaluation of benefits and costs of the electronic use and exchange of health information

The National Coordinator shall evaluate and publish evidence on the benefits and costs of the electronic use and exchange of health information and assess to whom these benefits and costs accrue.

(E) Resource requirements

The National Coordinator shall estimate and publish resources required annually to reach the goal of utilization of an electronic health record for each person in the United States by 2014, including—

(i) the required level of Federal funding;

(ii) expectations for regional, State, and private investment;

(iii) the expected contributions by volunteers to activities for the utilization of such records; and

(iv) the resources needed to establish a health information technology workforce sufficient to support this effort (including education programs in medical informatics and health information management).

(7) Assistance

The National Coordinator may provide financial assistance to consumer advocacy groups and not-for-profit entities that work in the public interest for purposes of defraying the cost to such groups and entities to participate under, whether in whole or in part, the National Technology Transfer Act of 1995 (15 U.S.C. 272 note).[1]

[1] See References in Text note below.

(8) Governance for nationwide health information network

The National Coordinator shall establish a governance mechanism for the nationwide health information network.

(d) Detail of Federal employees

(1) In general

Upon the request of the National Coordinator, the head of any Federal agency is authorized to detail, with or without reimbursement from the Office, any of the personnel of such agency to the Office to assist it in carrying out its duties under this section.

(2) Effect of detail

Any detail of personnel under paragraph (1) shall—

(A) not interrupt or otherwise affect the civil service status or privileges of the Federal employee; and

(B) be in addition to any other staff of the Department employed by the National Coordinator.

(3) Acceptance of detailees

Notwithstanding any other provision of law, the Office may accept detailed personnel from other Federal agencies without regard to whether the agency described under paragraph (1) is reimbursed.

(e) Chief Privacy Officer of the Office of the National Coordinator

Not later than 12 months after February 17, 2009, the Secretary shall appoint a Chief Privacy Officer of the Office of the National Coordinator, whose duty it shall be to advise the National Coordinator on privacy, security, and data stewardship of electronic health information and to coordinate with other Federal agencies (and similar privacy officers in such agencies), with State and regional efforts, and with foreign countries with regard to the privacy, security, and data stewardship of electronic individually identifiable health information.

(July 1, 1944, ch. 373, title XXX, § 3001, as added Pub. L. 111–5, div. A, title XIII, § 13101, Feb. 17, 2009, 123 Stat. 230.)

REFERENCES IN TEXT

The National Technology Transfer Act of 1995 (15 U.S.C. 272 note), referred to in subsec. (c)(7), probably means section 12(d) of Pub. L. 104–113, known as the National Technology Transfer and Advancement Act of 1995, which is set out as a note under section 272 of Title 15, Commerce and Trade.

§ 300jj–12. HIT Policy Committee

(a) Establishment

There is established a HIT Policy Committee to make policy recommendations to the National Coordinator relating to the implementation of a nationwide health information technology infrastructure, including implementation of the strategic plan described in section 300jj–11(c)(3) of this title.

(b) Duties

(1) Recommendations on health information technology infrastructure

The HIT Policy Committee shall recommend a policy framework for the development and

adoption of a nationwide health information technology infrastructure that permits the electronic exchange and use of health information as is consistent with the strategic plan under section 300jj–11(c)(3) of this title and that includes the recommendations under paragraph (2). The Committee shall update such recommendations and make new recommendations as appropriate.

(2) Specific areas of standard development

(A) In general

The HIT Policy Committee shall recommend the areas in which standards, implementation specifications, and certification criteria are needed for the electronic exchange and use of health information for purposes of adoption under section 300jj–14 of this title and shall recommend an order of priority for the development, harmonization, and recognition of such standards, specifications, and certification criteria among the areas so recommended. Such standards and implementation specifications shall include named standards, architectures, and software schemes for the authentication and security of individually identifiable health information and other information as needed to ensure the reproducible development of common solutions across disparate entities.

(B) Areas required for consideration

For purposes of subparagraph (A), the HIT Policy Committee shall make recommendations for at least the following areas:

(i) Technologies that protect the privacy of health information and promote security in a qualified electronic health record, including for the segmentation and protection from disclosure of specific and sensitive individually identifiable health information with the goal of minimizing the reluctance of patients to seek care (or disclose information about a condition) because of privacy concerns, in accordance with applicable law, and for the use and disclosure of limited data sets of such information.

(ii) A nationwide health information technology infrastructure that allows for the electronic use and accurate exchange of health information.

(iii) The utilization of a certified electronic health record for each person in the United States by 2014.

(iv) Technologies that as a part of a qualified electronic health record allow for an accounting of disclosures made by a covered entity (as defined for purposes of regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996) for purposes of treatment, payment, and health care operations (as such terms are defined for purposes of such regulations).

(v) The use of certified electronic health records to improve the quality of health care, such as by promoting the coordination of health care and improving continuity of health care among health care providers, by reducing medical errors, by improving population health, by reducing health disparities, by reducing chronic disease, and by advancing research and education.

(vi) Technologies that allow individually identifiable health information to be rendered unusable, unreadable, or indecipherable to unauthorized individuals when such information is transmitted in the nationwide health information network or physically transported outside of the secured, physical perimeter of a health care provider, health plan, or health care clearinghouse.

(vii) The use of electronic systems to ensure the comprehensive collection of patient demographic data, including, at a minimum, race, ethnicity, primary language, and gender information.

(viii) Technologies that address the needs of children and other vulnerable populations.

(C) Other areas for consideration

In making recommendations under subparagraph (A), the HIT Policy Committee may consider the following additional areas:

(i) The appropriate uses of a nationwide health information infrastructure, including for purposes of—

(I) the collection of quality data and public reporting;

(II) biosurveillance and public health;

(III) medical and clinical research; and

(IV) drug safety.

(ii) Self-service technologies that facilitate the use and exchange of patient information and reduce wait times.

(iii) Telemedicine technologies, in order to reduce travel requirements for patients in remote areas.

(iv) Technologies that facilitate home health care and the monitoring of patients recuperating at home.

(v) Technologies that help reduce medical errors.

(vi) Technologies that facilitate the continuity of care among health settings.

(vii) Technologies that meet the needs of diverse populations.

(viii) Methods to facilitate secure access by an individual to such individual's protected health information.

(ix) Methods, guidelines, and safeguards to facilitate secure access to patient information by a family member, caregiver, or guardian acting on behalf of a patient due to age-related and other disability, cognitive impairment, or dementia.

(x) Any other technology that the HIT Policy Committee finds to be among the technologies with the greatest potential to improve the quality and efficiency of health care.

(3) Forum

The HIT Policy Committee shall serve as a forum for broad stakeholder input with specific expertise in policies relating to the matters described in paragraphs (1) and (2).

(4) Consistency with evaluation conducted under MIPPA

(A) Requirement for consistency

The HIT Policy Committee shall ensure that recommendations made under paragraph (2)(B)(vi) are consistent with the evaluation conducted under section 1395b–10(a) of this title.

(B) Scope

Nothing in subparagraph (A) shall be construed to limit the recommendations under paragraph (2)(B)(vi) to the elements described in section 1395b–10(a)(3) of this title.

(C) Timing

The requirement under subparagraph (A) shall be applicable to the extent that evaluations have been conducted under section 1395b–10(a) of this title, regardless of whether the report described in subsection (b) of such section has been submitted.

(c) Membership and operations

(1) In general

The National Coordinator shall take a leading position in the establishment and operations of the HIT Policy Committee.

(2) Membership

The HIT Policy Committee shall be composed of members to be appointed as follows:

(A) 3 members shall be appointed by the Secretary, 1 of whom shall be appointed to represent the Department of Health and Human Services and 1 of whom shall be a public health official.

(B) 1 member shall be appointed by the majority leader of the Senate.

(C) 1 member shall be appointed by the minority leader of the Senate.

(D) 1 member shall be appointed by the Speaker of the House of Representatives.

(E) 1 member shall be appointed by the minority leader of the House of Representatives.

(F) Such other members as shall be appointed by the President as representatives of other relevant Federal agencies.

(G) 13 members shall be appointed by the Comptroller General of the United States of whom—

(i) 3 members shall advocates[1] for patients or consumers;

(ii) 2 members shall represent health care providers, one of which shall be a physician;

(iii) 1 member shall be from a labor organization representing health care workers;

(iv) 1 member shall have expertise in health information privacy and security;

(v) 1 member shall have expertise in improving the health of vulnerable populations;

(vi) 1 member shall be from the research community;

(vii) 1 member shall represent health plans or other third-party payers;

(viii) 1 member shall represent information technology vendors;

(ix) 1 member shall represent purchasers or employers; and

(x) 1 member shall have expertise in health care quality measurement and reporting.

(3) Participation

The members of the HIT Policy Committee appointed under paragraph (2) shall represent a balance among various sectors of the health care system so that no single sector unduly influences the recommendations of the Policy Committee.

(4) Terms

(A) In general

The terms of the members of the HIT Policy Committee shall be for 3 years, except that the Comptroller General shall designate staggered terms for the members first appointed.

(B) Vacancies

Any member appointed to fill a vacancy in the membership of the HIT Policy Committee that occurs prior to the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has been appointed. A vacancy in the HIT Policy Committee shall be filled in the manner in which the original appointment was made.

(5) Outside involvement

The HIT Policy Committee shall ensure an opportunity for the participation in activities of the Committee of outside advisors, including individuals with expertise in the development of policies for the electronic exchange and use of health information, including in the areas of health information privacy and security.

(6) Quorum

A majority of the member of the HIT Policy Committee shall constitute a quorum for purposes of voting, but a lesser number of members may meet and hold hearings.

(7) Failure of initial appointment

If, on the date that is 45 days after February 17, 2009, an official authorized under paragraph (2) to appoint one or more members of the HIT Policy Committee has not appointed the full number of members that such paragraph authorizes such official to appoint, the Secretary is authorized to appoint such members.

(8) Consideration

The National Coordinator shall ensure that the relevant and available recommendations and comments from the National Committee on Vital and Health Statistics are considered in the development of policies.

(d) Application of FACA

The Federal Advisory Committee Act (5 U.S.C. App.), other than section 14 of such Act, shall apply to the HIT Policy Committee.

(e) Publication

The Secretary shall provide for publication in the Federal Register and the posting on the

[1] So in original.

Internet website of the Office of the National Coordinator for Health Information Technology of all policy recommendations made by the HIT Policy Committee under this section.

(July 1, 1944, ch. 373, title XXX, § 3002, as added Pub. L. 111–5, div. A, title XIII, § 13101, Feb. 17, 2009, 123 Stat. 234.)

REFERENCES IN TEXT

Section 264(c) of the Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (b)(2)(B)(iv), is section 264(c) of Pub. L. 104–191, which is set out as a note under section 1320d–2 of this title.

The Federal Advisory Committee Act, referred to in subsec. (d), is Pub. L. 92–463, Oct. 6, 1972, 86 Stat. 770, which is set out in the Appendix to Title 5, Government Organization and Employees.

§ 300jj–13. HIT Standards Committee

(a) Establishment

There is established a committee to be known as the HIT Standards Committee to recommend to the National Coordinator standards, implementation specifications, and certification criteria for the electronic exchange and use of health information for purposes of adoption under section 300jj–14 of this title, consistent with the implementation of the strategic plan described in section 300jj–11(c)(3) of this title and beginning with the areas listed in section 300jj–12(b)(2)(B) of this title in accordance with policies developed by the HIT Policy Committee.

(b) Duties

(1) Standards development

(A) In general

The HIT Standards Committee shall recommend to the National Coordinator standards, implementation specifications, and certification criteria described in subsection (a) that have been developed, harmonized, or recognized by the HIT Standards Committee. The HIT Standards Committee shall update such recommendations and make new recommendations as appropriate, including in response to a notification sent under section 300jj–14(a)(2)(B) of this title. Such recommendations shall be consistent with the latest recommendations made by the HIT Policy Committee.

(B) Harmonization

The HIT Standards Committee recognize[1] harmonized or updated standards from an entity or entities for the purpose of harmonizing or updating standards and implementation specifications in order to achieve uniform and consistent implementation of the standards and implementation specifications.

(C) Pilot testing of standards and implementation specifications

In the development, harmonization, or recognition of standards and implementation specifications, the HIT Standards Committee shall, as appropriate, provide for the testing of such standards and specifications by the National Institute for Standards and Technology under section 17911(a) of this title.

(D) Consistency

The standards, implementation specifications, and certification criteria recommended under this subsection shall be consistent with the standards for information transactions and data elements adopted pursuant to section 1320d–2 of this title.

(2) Forum

The HIT Standards Committee shall serve as a forum for the participation of a broad range of stakeholders to provide input on the development, harmonization, and recognition of standards, implementation specifications, and certification criteria necessary for the development and adoption of a nationwide health information technology infrastructure that allows for the electronic use and exchange of health information.

(3) Schedule

Not later than 90 days after February 17, 2009, the HIT Standards Committee shall develop a schedule for the assessment of policy recommendations developed by the HIT Policy Committee under section 300jj–12 of this title. The HIT Standards Committee shall update such schedule annually. The Secretary shall publish such schedule in the Federal Register.

(4) Public input

The HIT Standards Committee shall conduct open public meetings and develop a process to allow for public comment on the schedule described in paragraph (3) and recommendations described in this subsection. Under such process comments shall be submitted in a timely manner after the date of publication of a recommendation under this subsection.

(5) Consideration

The National Coordinator shall ensure that the relevant and available recommendations and comments from the National Committee on Vital and Health Statistics are considered in the development of standards.

(c) Membership and operations

(1) In general

The National Coordinator shall take a leading position in the establishment and operations of the HIT Standards Committee.

(2) Membership

The membership of the HIT Standards Committee shall at least reflect providers, ancillary healthcare workers, consumers, purchasers, health plans, technology vendors, researchers, relevant Federal agencies, and individuals with technical expertise on health care quality, privacy and security, and on the electronic exchange and use of health information.

(3) Participation

The members of the HIT Standards Committee appointed under this subsection shall represent a balance among various sectors of the health care system so that no single sector unduly influences the recommendations of such Committee.

[1] So in original.