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Chairman Gordon, Mr. Hall, and members of the committee, good morning and thank you for this opportunity to testify on the issues relating to *Meeting the Need for Interoperability and Information Security in Healthcare IT*. This topic is of great importance to my colleagues in healthcare information management and has been for many years.

I am Linda Kloss and I represent the American Health Information Management Association (AHIMA) as its chief executive officer. AHIMA is an association of over 51,000 health information management (HIM) professionals deeply committed to and actively participating in the adoption of standards-based and interoperable health information technology (IT). Since 1928, HIM professionals have worked to improve the accuracy, completeness, confidentiality and security of medical record information to support clinical care and improve healthcare of all Americans.

Today, HIM professionals are on the front lines in implementing electronic health records and other technologies to improve healthcare. This includes information exchange among providers and new ways for consumers to access their own health information. Confidentiality, privacy, security, data integrity, and consumer access are core values we bring to this important work.

As I speak this morning, I must inform you that AHIMA, through its Foundation of Research and Education (FORE) has been a contractor for several health information improvement projects initiated by the Department of Health and Human Services' (HHS) Office of the National Coordinator for Health Information Technology (ONC), the Agency for Healthcare Research and Quality (AHRQ), and the National Institute of Health's (NIH) National Library of Medicine (NLM). These projects have included evaluating the mapping of classification systems, studies of the potential for improved fraud deterrence through the use of electronic health record technology (EHR), analyses of privacy and security roadblocks to implementation of EHRs and health information exchange, and development of best practices for state level health information exchange. The FORE foundation, in conjunction with the Medical Group Management Association (MGMA) also addressed aspects of the collection and reporting of performance measurement data. AHIMA is also one of three organizations that founded the Certification Commission for Health Information Technology (CCHIT) which later received a three-year contract from ONC and is now an independent not-for-profit organization recognized by the Secretary of HHS as a certifying organization for HIT.

AHIMA is active in a number of standards activities. Currently AHIMA is a voting member of the Health Information Technology Standards Panel (HITSP) and representatives are active on its Security Technical Committee. AHIMA and several of its members have been active for a number of years in the Health Level 7 (HL7) standards development organization (SDO). Currently our involvement is in developing EHR system and personal health record (PHR) system functional models, legal EHR functionality, and the clinical document architecture CDA.

AHIMA is also an active participant in a number of national and international terminology and classification standards organizations. We serve as a member of the ICD-9-CM Coordination and Maintenance Committee with the American Hospital Association (AHA), the Centers for Medicare and Medicaid Services (CMS), and the Centers for Disease Control and Prevention's (CDC), National Center for Health Statistics (NCHS). We also serve as a member of the Cooperating Parties, the group that sets the guidance for use of ICD-9-CM in the US, the editorial advisory panels for the American Medical Association's Common Procedure Terminology (CPT®), and the Healthcare Common

Procedure Coding System (HCPCS), which is operated by CMS. Internationally we have been appointed by the NCHS to serve with the World Health Organization's (WHO's) education, and ICD-10 and ICD-11 reference terminology work groups. We also have worked with the International Healthcare Terminology Standards Development Organization (IHTSDO), which is the standards group that has taken up the SNOMED® terminology system.

This morning I would like to respond to your questions on the progress associated with efforts toward an interoperative healthcare information system, and the standards, security and privacy, and global harmonization associated with this progress or lack of progress. I am going to limit my comments to address the standards, guidelines, coordination, and commitment needed for interoperability. I am going to ask your support for:

- Addressing the need for coordination of terminologies and classifications and quality measurement and secondary data set needed to achieve interoperability;
- Addressing the need for permanent resources to support the harmonization of technical standards, and the establishment and uniform adoption of industry guidelines;
- Addressing the need for permanent resources to provide tools for certification of HIT products and providing the healthcare industry with security standards necessary to achieve confidentiality and consumer trust; and
- Addressing the goal of universal adoption and adherence to standards and guidelines to achieve global harmonization and industry health information interoperability.

I realize that not all the problems and issues raised can be addressed today, nor can this Committee resolve all the barriers to progress, but we can raise questions for future discussions. You have my commitment that AHIMA and its members will work with you in anyway possible to achieve these goals.

Costs and Benefits

Standards-based electronic health record technology is the essential building block for much of what we seek to achieve in interoperability. After years of slow and inconsistent progress, I believe that considerable progress is being made to define core functionality and data exchange standards and to drive their adoption. The greater focus on standards over the past five years has led to progress by standards development organizations (SDO), formation of the Health Information Technology Standards Panel (HITSP) and the Certification Commission for Health IT (CCHIT) and other collaborative projects, which have in effect broken the logjam. However, the recent momentum must be supported so progress can continue and even accelerate. With the continual evolution of technology and growing experience of those who are using it, this work will require effective leadership, incentives for adoption, and financial support for the effort for some years to come.

With a solid road map and full support, the benefits of interoperability include the ability to:

- Exchange crucial health information between healthcare providers so that medical treatment for any individual can be rendered accurately and completely.
- Access, transfer, and use the extraordinary body of knowledge about medical care and personal health and to expand that body of knowledge through accelerated research and dissemination of learning.

- Report and transfer crucial public health data in seconds to improve effective local and national response to individual and population events and be effective participants in improving global health.
- Achieve a high performing health system in terms of outcomes, safety and cost through performance improvement and public reporting.
- Engage people as full participants in improving their health and wellness.
- Understand effective ways to transform care delivery, including how we pay for it.

There are numerous forecasts and models about the costs of implementing EHRs and health information exchange by researchers at Rand, the Center for Information Technology Leadership, the Robert Wood Johnson Foundation, and the Commonwealth Fund to name a few, as well as studies by AHRQ and ONC. While the specific estimates may vary depending on the sets of assumptions used in the forecasts, the conclusion is clear: The benefits of investing in secure and interoperable health IT will outweigh the cost. Even so, it will not be inexpensive and the return on investment will not be quick. Any consideration of cost must take into account the costs of the current state of healthcare. For example,

- What is the cost of treating patients with limited and inaccessible information about their medical condition and history?
- What is the cost of our inability to manage an individual's care across a multiple number of providers just in trying to get the information needed?
- What is the cost increased related to administrative duties and operations due to our inability to exchange uniform data electronically for secondary purposes such as research, claims processing and a variety of other administrative activities? These activities are now restricted by our paper-based information system, restrained by our ability to review and analyze paper data, and our ability to locate and exchange information when and where it is needed.
- What is the cost of having limited data due to the inappropriate use or limits placed on our terminology and classification standards and systems?
- What is the cost in loss of life and poor health, because the right data is not available at the right time?

Real improvements are being documented by medical practices and hospitals using health information technology. Except for delivery systems such as the Veteran's Health Administration, other integrated systems and networks such as e-prescribing, improvement are for the most part isolated. Without consistent standards it is difficult to accrue the values that require interoperability.

Standards, Guidelines, and Coordination.

I will address three interoperability and security issues in my comments today that we believe are important for the committee to take into account in its work. These are: terminologies and classifications, data stewardship, and the harmonization of standards.

Terminologies and Classifications

The US needs greater uniformity and coordination of healthcare terminologies and classifications, a type of health information standard that is perhaps not as well understood as are other types of

standards. Clinical terms and concepts are the language of medicine and form the information content in electronic health records. Terminologies and classifications catalog these terms and concepts so they can be stored, exchanged, retrieved and analyzed. Interoperability requires that the sender and receiver understand the exchange and interpret it correctly. Terminology and classification systems are critical for information exchange, for public health reporting, performance measurement, quality reporting, research, and billing and payment for healthcare services.

AHIMA and the American Medical Informatics Association recently published a white paper entitled *Healthcare Terminologies and Classifications: An Action Agenda for the United States.* I have attached a short summary of that paper and its recommendations, *Healthcare Terminologies and Classifications: Essential Keys to Interoperability* to my testimony. This report was prepared by a joint task force of experts who call for the establishment of a public-private authority responsible for ensuring the US has:

- Robust and up-to-date terminologies and classifications for interoperability between systems;
- Standards for developing terminologies and classifications in the EHR and PHR, including implementation guides;
- Principles and guideline for development, distribution, and maintenance of systems and coordination across systems;
- Timely and reliable industry guidance;
- A coherent set of policies and procedures to ensure openness and performance for terminologies, classifications, and the systems that convert data encoded in one terminology or classification to another; and,
- Business process automation to ensure cost-effective development of systems and cost-effective use by providers, payers, and other organizations.

While federal and private entities have made genuine progress, the task force recommends public funding for a research and development project to design a permanent governance mechanism and formulate strategies and plans for:

- Contemporary and standardized processes for development, adoption, and maintenance of terminologies and classifications;
- The structure, function, and operating practices for a US public/private authority to oversee terminologies and classifications;
- Gaining commitment of terminology and classification stakeholders including developers, end users, and other service and technology suppliers to the principles and guidelines for open and transparent approaches that permit cost-effective interoperability of complete and accurate information; and
- US participation in the IHTSDO – the international organization now addressing SNOMED terminology which we believe is the base terminology for a standard EHR.

AHIMA and AMIA are prepared to coordinate such an effort, and I ask your consideration to support this effort. Without standard and consistent data content– which comes from terminologies and classifications – the US will not achieve interoperability of useable information. As described in the task force report, the US has fallen behind other countries in developing; deploying and using these critical and new approaches to coordination are urgently needed.

Data Stewardship

A second and similar effort is needed in the area of quality measurement and secondary data. Recently, AHRQ issued a request for information related to the data measures, data sets, or standards used for the collection of quality measurement information – the potential to have a data steward to coordinate the groups and the group processes for developing data collection. This concept was expanded to include data also collected for a variety of secondary purposes, research, public health, reimbursement, and other public policy requirements.

As I noted earlier, the ability to use secondary data from a large population offers vast opportunities to improve the health of this nation and reduce error and costs. At the same time secondary data also supports reimbursement for healthcare services not only in the traditional sense of the billing claim, but also in the form of information to support effective payment policy.

As with terminologies and classifications, the US lacks a coordinating body with requisite authority to set a vision and operating policies for secondary use of data, a data stewardship entity. An acknowledged data steward entity would coordinate the various public/private groups working on quality measurement and the employer/purchaser, research, and public health communities which use these data. AHIMA's members oversee the collection of these data in many healthcare organizations. They report that lack of uniformity in the data sets requested and uniformity of definitions results in costly manual work and concerns about the quality and validity of data used to measure quality. Standardizing measures and policies regarding secondary uses of health information will enable the IT industry to design solutions capture data once and use it for multiple legitimate and authorized purposes.

Standards Harmonization

The third area relates to the harmonization of technical standards and consistent guidelines for their use, including standards for clinical terminologies and classifications, as described earlier. *Harmonized* or *harmonization*, according to ONC, means "*the function of developing, reconciling, setting and maintaining standards required to achieve interoperability. The scope of the term 'standards' is restricted to the structure and content of health care data, information, or concepts that are usefully exchanged or provided between and among care providers and public health authorities, and the interchange methods used to facilitate these exchanges."*

In the 1980s, HL7 was formed to address healthcare institutions' inability to share data between or among their own data systems and programs. Today, HL7 and other SDOs have become and are addressing international information exchange.

Throughout the US, industries are sharing data and cutting their administrative costs because they are using uniform standards, such as the Accredited Standards Organization X12 standards, for financial transactions, supply logistics, and so forth. Besides using standards, however, these industries have also formed industry councils that choose what standards will be used for what purposes and under what conditions by the industry and its trading partners. These rules are often called guidelines. The councils then mandate the use of the new or modified standard or guide and set a compliance date. In

many industries, trading partners that fail to adopt and use the new transactions are no longer included in the business of the industry.

The healthcare industry has not formed such a council and therefore has not taken the approach used in other industries. Thus, in the 1980s, the healthcare industry's attempt to adopt a uniform claim failed to eliminate the need for actual invoices to be sent due to lack of support in the industry. Under HIPAA, the National Committee for Vital and Health Statistics (NCVHS) was chosen as a substitute for an industry group. In this role, the NCVHS chose, for example, to use the ASC X12 standard for claims, the X12-837, and the ASC X12's guide for using its standard. This was not seen as an industry council by many sectors, and testimony at a recent NCVHS meeting highlighted that there are now more than 1,000 different instructions being used for the use and transmission of the X12-837. If interoperability and use of standards similar to other industries is to be achieved, such variations cannot be tolerated.

The healthcare industry has over 1 million providers, thousands of health plans and payers, a potential consumer base of more than 300 million individuals, and some 1.44 million employers offering some level of healthcare, along with numerous government agencies, clearinghouses, and vendors. Achieving consensus on complex standards and an understanding of their uniform application is a monumental task even with a shared vision. In the US, our standards data organizations are essentially groups of volunteers that come from industry and the professions. It is difficult to find and keep volunteers who work for provider organizations working on standards, yet their participation is critical.

To address the consistent use of a standard, the harmonization of standards – to make the standards work with each other, and to choose the collection of standards necessary to perform a function or functions – requires a significant effort. Over the last three years we have seen, through the efforts of HHS, ONC, and the American Health Information Community (AHIC), the establishment of the Health Information Technology Standards Panel (HITSP). HITSP and its numerous volunteers have addressed the need for standards for a variety of healthcare functions and performed the harmonization task. While the question of adherence to this harmonization still remains to be seen, the task is the first time (outside of some limited and similar work done by the NCVHS with e-prescribing and the HIPAA standards) such an effort has occurred in healthcare.

AHIMA has three concerns with HITSP in its current capacity. First, it is largely a volunteer effort and while this improves acceptance, it is a slow process. HR 2406, introduced in this committee, has the potential to provide some of the resources, through the National Institute of Standards and Technology (NIST), needed to sustain and accelerate the role that HITSP plays. This does not negate the need for an industry (public-private) oversight group with a role to approve, reject, or amend the final choices for harmonization of standards. Public/private involvement is crucial for acceptance, buy-in and use.

Similarly, NIST could also provide some of the tools for groups like CCHIT, whose role is to identify and test the standards harmonized by HITSP and other groups, and ensuring those standards are contained and functioning within the products sold on the market. This assures buyers that the products they are purchasing technology that will allow them to be interoperable with the industry and the networks under development.

Our second concern related to the need for overall coordination among HITSP, CCHIT, and the entities charged with coordinating terminologies and classifications, data stewardship, health information exchange and other related functions critical to achieve a secure, interoperable system.

Our third concern with HITSP is funding. How does the nation fund a body that does not itself develop standards, but rather provides the harmonization process necessary to bring us to interoperability? As noted, industries engage councils with dedicated staff. No such council in totality exists in healthcare. If the benefits from harmonization and eventual interoperability accrue to the population, should the population, as a whole, pick up this cost? That is a discussion Congress should undertake. Should HR 2406 become law and the NIST involvement occur, the investment in NIST will assume some of the costs incurred in the harmonization process, but not all of the costs.

Barriers to Interoperability

I was asked to address barriers to interoperability and I have already mentioned several. Let me recap the barriers we see relevant to today's conversation:

- The current healthcare reimbursement system
- The lack of financial support and staffing for the coordination and harmonization of standards and the development of guidelines,
- The lack of industry consensus guidelines for the prioritization, adoption, and use of standards, and a mechanism for uniform adoption and implementation of standards.

Reimbursement is a key barrier. Reimbursement runs the show.

Reimbursement immediately arises when we discuss why healthcare providers are not adopting EHRs. Many physicians indicate they will not consider adoption of HIT and standards until the Medicare reimbursement formulas are corrected and they are paid adequately for the care they deliver. With the potential for significant Medicare cuts, year after year, physicians hesitate to begin any discussion on transaction to e-health and HIT. Medicare is not the only payer, but the federal government pays such a huge portion of the healthcare bill, its reimbursement levels in reality become a barrier to adoption.

Reimbursement is associated with providing incentives for transformation. Even with reimbursement to cover the cost of providing care today, small, and medium – sized providers have limited capital to invest in conversion to HIT. These small entities often raise the objection that the benefits from conversion accrue to other entities, not the practice or organization itself. Incentives must be considered that adequately provide the capital to cover not only the cost of hardware and software, but also the process changes and implementation and training costs associated with adopting HIT. Add-ons to reimbursement, grants, loans, and tax credits all have been raised as possibilities, but little has been forthcoming to make adoption feasible. If we are serious about moving the healthcare industry into the 21st century, then investment and other incentives must be designed to assist the transformation.

The third impact of our reimbursement system is not about the amounts being reimbursed, but rather the processes and functions of reimbursement – claims legacy systems – that use standards which include classification standards. Resistance to upgrading these classification standards have successfully limited our ability to report data that reflects 21st century medicine, and supports

numerous secondary data uses, as well as hampers our ability to move forward to achieve interoperability. Many health plans and payers have used multiple excuses to oppose an upgrade in our current ICD-9-CM classification system, but often the reason for resistance boils down to not wishing to upgrade legacy claims systems.

In the US, the ICD-9-CM classification system is seen as coding system for reimbursement and not a means to report on health status and treatment for a variety of secondary uses beyond reimbursement. This perspective is now affecting quality measurement as these data sets take on a reimbursement mechanism. By opposing the upgrades to the classification system, we have forced vast increases in technology and disease into generalized categories that prevent a clear picture of the disease and the care provided. Today, as we build our EHRs and expand our ability to use health information we are forced to eliminate details that could be provided for many purposes in our reporting systems. On top of that we are building new data repositories, such as personal health records that are using this limited data in the guise of full information, and limiting our capabilities to exchange data for public health and research nationally and certainly internationally.

As we build a system to adopt and harmonize standards and design guidelines and implementation, we have to build it as intended to provide data that accurately describes the patient and medical encounter. Payers or health plans need to be involved in these processes, but let's first build our EHRs and information systems to maximize our health information and ensure data integrity, and not for just parochial interests.

I have identified the need for financial support and staffing for coordination and harmonization and its impact on achieving interoperability. Without such support we create a time barrier, forcing the quest for interoperability to last years. Other nations and industries found the means of financing such activities and coordination and surely a means can be found to support the needs I have previously noted. I have often suggested that perhaps a small fee can be associated with each claim or some other mechanism that will allow the industry and its consumers to support the cost of the work needed to be done. At a minimum, we need to fund the coordination for terminologies and classifications as well as the data stewardship that will facilitate interoperability for a variety of secondary purposes, which will in turn provide the benefits we discussed. I have also described the support needed for activities like HITSP and CCHIT, where the funds associated with NIST will significantly assist in the efforts toward interoperability.

Finally, once we have resolved funding and addressed reimbursement constraints, we must deal with the consistent and uniform use of standards and guides. How do we compel or insure their use? This is a question I hear often. Standards have been around for many years, yet the healthcare industry or market hasn't achieved the universal compliance seen in other industries and countries.

HIPAA was a first attempt, but use of the NCVHS and guidelines written by the SDO (ASC X12 for the most part) did not achieve necessary industry involvement and buy-in at the level needed. There was, and is, limited industry pressure to make covered entities abide by the few rules HIPAA contains, including the federal government.

We noted that HITSP is working diligently to harmonize standards and recommend guidelines, but we have not had an opportunity to see if the industry will actually buy-in to these recommendations and

adopt and consistently use the standards proposed. Without consistent adoption and use, uniformity cannot be achieved. Having "uniform standards" does not mean that all HIT products have to look and work the same, but the data being exchanged, and the mechanisms for transmitting and receiving it, must meet criteria for interchange and data integrity.

If we cannot develop an entity or mechanism to oversee the choice standards and guidelines and compel their use, then we will see a very slow achievement of the steps necessary for full interoperability, if we see any achievement at all. This is a somber statement, and I want to acknowledge the work of the Secretary, ONC, and AHIC who are trying an approach based on federal government market power and the assumption that the federal government will itself adopt and abide by the selected standards and guidelines. Essentially, this is an industry-wide voluntary system compelling no uniform and timely adoption and use of standards. We have not yet seen the results of this effort, and much more has to be done. Unfortunately, if we do not overcome this barrier, as an industry interoperability will not occur on any large scale.

Security and Privacy

HIM professionals are deeply involved in securing the confidentiality necessary for consumer trust in our health information system. We are committed to implementing, complying with, and explaining to consumers the applicable laws, regulations, and adhering to best practices ensure maximum data and individual protections and rights. HIM professionals often fill the privacy officer position in healthcare institutions, and involved in the process of releasing an individual's health information for its intended use. I have attached a recent statement on the issue of confidentiality that we produced jointly with AMIA.

AHIMA and its members have been involved in the recent review of laws, regulations, and practices associated with confidentiality, privacy, and security across the states and the federal government. Many of these laws and regulations go back decades and are intertwined with purposes now forgotten. Our members and others in the industry and government, and consumers are attempting to take time to unravel these relationships and allow the states and the federal government to develop uniform laws that protect health information. Today we are also involved in a tremendous effort directed at developing maximum uniform protections and the security mechanisms necessary to secure our data and networks

We believe that standard electric health records will permit more secure protections for personal health information than exists for current paper records. But, we are in a transition period, moving from a paper-based system to an electronic record. This change is not without confusion and gaps. These gaps are being addressed to bring us into a secure electronic era. We support HR 2406's approach to having NIST assist in the identification of potential security standards that should be considered under the HITSP process. NIST has a demonstrated expertise in this arena that can benefit and accelerate the industry's efforts and we welcome this assistance.

With the adoption of electronic health records we have multiple technologies to provide various levels of confidentiality or privacy. Just how we adopt and use these technologies is under considerable and appropriate debate. Identified health information flows throughout the healthcare industry, to other industries, as well as to consumers and in some cases employers. This flow occurs as a result of

consumer requests, reimbursement processes, government reporting, public health monitoring, school requirements, and so on. The process is complex and some of the uses of technology just as complex. We must be careful to use technology wisely or we could impede the movement of information when it is most needed. At the same time, consumers must be assured that we are protecting their information.

Consumer surveys over the last few years indicate that most individuals want their health information where it is most needed for their own clinical care and to benefit the population. What consumers do not want is to have their health information or personal data misused, and they do not want to be inappropriately discriminated against because of their health status or information.

Beyond uniform laws, regulations, and technology standards to achieve health information confidentiality and security, AHIMA believes in essentially three basic principles that need to be in place for overall consumer protection and trust:

1. Personal health information should be protected wherever it lays or is transported; whether or not the entity or person accessing, transferring, storing, or holding the information is a healthcare entity or an entity covered by HIPAA.
2. Individuals should be protected against inappropriate discrimination on the basis of their health information. This includes situations of employment and insurance.
3. Individuals should be protected against the intentional misuse of their health information.

There are two caveats to these three principles. To be effective, laws and regulations related to discrimination and misuse must include provisions for active prosecution and penalties; and the public must see active prosecution and penalties applied to those convicted.

There will never be an absolutely secure system that will provide the confidentiality or privacy sought by the public. But interoperability will be a failure if we cannot build trust in the system of EHRs, PHRs, and health information exchange. We can never undo an actual disclosure of an individual's health information, but steps can be taken to ensure that anyone intentionally discriminating against an individual or misusing health information will know they face severe penalties for doing so.

Global Harmonization

My comments on terminologies and classifications gave a glimpse of international collaboration. Many of the classifications used in the US are either international standards, or US versions of international standards. The SNOMED terminology, for instance, has moved from a US-based standard to an international standard. HL7 standards are international standards, and there are other standards as well. Disease and public health are not controlled or limited by state or international borders; so, global harmonization must be considered as we select and use standards in US healthcare, especially terminology and classification standards used for clinical care.

While many of our terminology, classification, and even transaction standards are global, the US has not maintained leadership in the development and use of such standards. For instance while most of the world is using the a version of the current WHO ICD-10 classification standard for disease the US remains 10 years behind, using ICD-9-CM for morbidity reporting, while using ICD-10 for mortality reporting. This creates problems such as being able to report that someone died of avian flu, but not capable of reporting that someone survived avian flu. This particular problem is close to being

resolved, but similar gaps have occurred with other outbreaks due to the differences in the codes used between the two systems, making it necessary for the US to manufacture an alternative code when needed and possible. When we exchange information with most other countries, the codes must be converted, and information coming from outside the US, has to be maintained in a separate database.

WHO has begun the process to update the global ICD-10 to the next version—ICD-11. A final ICD-11 classification is not expected for eight or nine years. Since the ICD-11 structure is the same as the ICD-10 structure, its development will be based on the experience from users of ICD-10, which limits US input. The failure to move our national terminologies, classifications, and transfer standards forward and in sync with international progression leaves our industry behind and exposes our public health system to additional barriers and costs, because we did not keep up with public health standards in the rest of the world.

We believe our recommendations on terminologies and classifications will help change our role in the international community. Groups like HITSP should continue to be supported, as with the NIST recommendation, and encouraged to adopt standards for clinical care that allow user to compete and participate internationally. For instance, the user must adopt a terminology to serve as the base for the standard EHR. The federal government has supported SNOMED as has AHIMA, but the US has yet to adopt SNOMED use for industry products. While our healthcare systems and reimbursement systems might differ, our ability to share data for clinical care, research, and public health should not be restrained. The US is a world leader in health research and technology, and a move to ensure globalization of standards can only help make our role internationally stronger.

Mr. Chairman, Mr. Hall, this concludes my responses to the committee's questions. There has been remarkable progress in the last four years to move healthcare from paper to a technology-enabled, interoperable system. Developing and deploying standards is a fundamental prerequisite, as is sound policy and sound governance to ensure that technology and policy are aligned and being advanced over time. This is an effort that requires the full engagement of all three sectors of our society, government, industry, and private non-profits. It is not a project like Y2K with an end point. It is a process that requires a long term view and a public and private commitment to the public good. Federal and state funding is required as is the authority that can only come through intelligent government action. The HIM profession and AHIMA stand ready to work with Congress, the administration, and our healthcare colleagues to continue on a path that becomes ever more critical.

I thank you for your invitation, your time, and your attention, and I am ready to answerer any questions you might have.

Thank you again.

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