

**ON THE VALUE OF  
DE-IDENTIFIED INFORMATION  
IN THE HEALTHCARE SYSTEM\***

**BY**

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**GOOD AFTERNOON, I WOULD LIKE TO THANK THE FUTURE OF PRIVACY FORUM FOR INVITING ME TO PARTICIPATE IN THIS EVENT. THE USE OF DE-IDENTIFIED INFORMATION IS A TOPIC THAT HAS GRASPED THE ATTENTION OF PROFESSIONALS IN THE MEDICAL AND LEGAL FIELD. THIS WAS MOST CLEARLY SEEN WITH THE CASE OF SORRELL V. IMS HEALTH INC., WHICH WAS DECIDED IN JUNE OF THIS YEAR. IT IS MY BELIEF, ONE THAT WAS ULTIMATELY SHARED BY THE SUPREME COURT, THAT THERE IS A SOCIAL BENEFIT TO BE GAINED WITH THE USE OF MEDICAL DE-IDENTIFIED INFORMATION.**

**IN THE HEALTH SECTOR, THERE IS WIDESPREAD AGREEMENT AMONG PRACTICING PHYSICIANS, ACADEMICIANS, AND POLICYMAKERS THAT THE READY AVAILABILITY OF COMPREHENSIVE INFORMATION ABOUT THE PRACTICES AND PERFORMANCE OF HEALTH CARE PROFESSIONALS IS VITAL TO IDENTIFYING THE**

**SUBSTANTIAL DISPARITIES IN HEALTH CARE IN THE UNITED STATES AND TO IMPROVING THE QUALITY, AFFORDABILITY, AND ACCESSIBILITY OF HEALTH CARE.**

**THE CREATION, MAINTENANCE, AND UTILIZATION OF STATISTICALLY ROBUST DATABASES ABOUT HEALTH CARE PRACTICES AND PERFORMANCE REQUIRES COLLABORATION AMONG NUMEROUS STAKEHOLDERS IN THE PUBLIC AND PRIVATE SECTORS AND A CAREFUL BALANCING OF PUBLIC AND PRIVATE INTERESTS AND INCENTIVES. THAT IS WHY THE FEDERAL GOVERNMENT AND NUMEROUS STATES HAVE ADOPTED POLICIES DESIGNED TO PROMOTE AND EXPAND THE USE OF INFORMATION TECHNOLOGY THROUGHOUT THE HEALTH CARE SYSTEM, INCLUDING TECHNOLOGY THAT FACILITATES THE COLLECTION, AGGREGATION, AND ANALYSIS OF PHYSICIAN-SPECIFIC DATA, WITH APPROPRIATE SAFEGUARDS FOR PATIENT PRIVACY AND CONFIDENTIALITY.**

**MODERN ELECTRONIC INFORMATION TECHNOLOGY  
MAKES IT POSSIBLE TO COLLECT, AGGREGATE, AND  
ANALYZE UNPRECEDENTED AMOUNTS OF INFORMATION  
ABOUT HEALTH CARE SERVICES AND PRACTICES, INCLUDING  
INFORMATION ABOUT PROVIDER TREATMENT VARIATIONS.**

**IN 1991, DURING MY TENURE AS U.S. SECRETARY OF  
HEALTH AND HUMAN SERVICES, I APPOINTED THE WORKING  
GROUP ON ELECTRONIC DATA INTERCHANGE (WEDI), CO-  
CHAIRIED BY THE HEAD OF BLUE CROSS-BLUE SHIELD OF  
AMERICA AND BY THE PRESIDENT OF TRAVELERS  
INSURANCE COMPANY.**

**THEIR CHARGE WAS TO COME UP WITH GUIDELINES  
FOR THE USE OF ELECTRONIC DATA APPLICATIONS IN THE  
NATION'S HEALTH CARE SYSTEM, LEADING TO THE  
DEVELOPMENT OF THE ELECTRONIC MEDICAL RECORD.  
THEIR WORK PROVIDED THE FOUNDATION FOR THE HEALTH  
INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF**

**1996 (HIPAA), WHICH REGULATES THE COLLECTION, MAINTENANCE, USE, AND DISCLOSURE OF “PROTECTED HEALTH INFORMATION,” INCLUDING “ELECTRONIC PROTECTED HEALTH INFORMATION,” THAT IDENTIFIES INDIVIDUAL PATIENTS. HIPAA EXPRESSLY DOES NOT RESTRICT THE USE OR DISCLOSURE OF “DE-IDENTIFIED” HEALTH INFORMATION—*I.E.*, HEALTH INFORMATION THAT HAS BEEN STRIPPED OF ANY PATIENT IDENTIFIERS.**

**ONCE INDIVIDUAL PATIENT PRIVACY IS PROTECTED, HOWEVER, DE-IDENTIFIED HEALTH INFORMATION CAN BE COLLECTED, AGGREGATED, AND ANALYZED FOR MULTIPLE PURPOSES THAT ARE VITAL TO IMPROVING THE QUALITY, AFFORDABILITY, AND ACCESSIBILITY OF HEALTH CARE. THESE PURPOSES INCLUDE “EPIDEMIOLOGICAL STUDIES, COMPARISONS OF COST, QUALITY OR SPECIFIC OUTCOMES ACROSS PROVIDERS OR PAYERS, STUDIES OF INCIDENCE OR PREVALENCE OF DISEASE ACROSS POPULATIONS, AREAS OR**

**TIME, AND STUDIES OF ACCESS TO CARE OR DIFFERING USE PATTERNS ACROSS POPULATIONS, AREAS OR TIME.”**

**DE-IDENTIFIED HEALTH INFORMATION IS PARTICULARLY VALUABLE FOR DETECTING AND MEASURING VARIATIONS IN THE AVAILABILITY AND UTILIZATION OF HEALTH SERVICES AND UNDERSTANDING HOW THESE VARIATIONS CONTRIBUTE TO HEALTH DISPARITIES THAT IMPAIR QUALITY OF LIFE, REDUCE PRODUCTIVITY, AND RESULT IN PREMATURE DEATH IN DIFFERENT COMMUNITIES AND IN DIFFERENT SEGMENTS OF OUR POPULATION.**

**INDEED, SUCH VARIATIONS IN THE AVAILABILITY AND UTILIZATION OF HEALTH CARE, AND ASSOCIATED DISPARITIES IN HEALTH STATUS, ARE CONSIDERABLE. THE NATIONAL COMMITTEE FOR QUALITY ASSURANCE, FOR EXAMPLE, HAS REPORTED BETWEEN 35,000 AND 75,000**

**AVOIDABLE DEATHS, AND \$2.7 BILLION TO \$3.7 BILLION IN AVOIDABLE HOSPITAL COSTS IN THE YEAR 2006, DUE TO UNEXPLAINED VARIATIONS IN QUALITY OF CARE.**

**THE NEED FOR STATISTICALLY ROBUST DE-IDENTIFIED HEALTH INFORMATION, REFLECTING ON THE ACTUAL DELIVERY OF HEALTH SERVICES IS EVEN MORE IMPORTANT WHEN ONE CONSIDERS THE COUNTRY'S CHANGING DEMOGRAPHICS. THERE IS AMPLE EVIDENCE OF MEASURABLE DISPARITIES IN ACCESS TO HEALTH CARE, THE DELIVERY OF HEALTH SERVICES AND HEALTH STATUS AMONG THE NATION'S GROWING ETHNIC AND RACIAL MINORITY POPULATIONS. TODAY, OUR CITIZENS WHO ARE RACIAL AND ETHNIC MINORITIES COMPRISE ONE THIRD OF OUR POPULATION. THE YEAR 2042, ACCORDING TO THE U.S. CENSUS BUREAU, THEN, WILL CONSTITUTE THE MAJORITY OF OUR CITIZENS.**

**IN PARTICULAR, IT HAS BEEN SHOWN THAT ETHNIC AND RACIAL MINORITIES TEND TO SUFFER DISPROPORTIONATELY FROM THE EFFECTS OF CHRONIC DISEASES (SUCH AS DIABETES, HEART DISEASE, CANCER, STROKE, AND ASTHMA), MENTAL HEALTH AFFLICTIONS, AND DENTAL PROBLEMS—CONDITIONS THAT USUALLY ARE PREVENTABLE AND/OR TREATABLE WITH ACCESS TO, AND UTILIZATION OF, STATE-OF-THE-ART HEALTH CARE.**

**WITH THE WIDESPREAD AVAILABILITY OF DE-IDENTIFIED HEALTH INFORMATION, IT IS POSSIBLE TO ASSESS HOW VARIATIONS IN ACCESS TO, AND UTILIZATION OF, HEALTH SERVICES CONTRIBUTE TO ETHNIC AND RACIAL HEALTH DISPARITIES, AND DEVELOP STRATEGIES AND TECHNIQUES TO ADDRESS THESE DISPARITIES.**



**FOR EXAMPLE, A CONSIDERABLE LAG FREQUENTLY EXISTS BETWEEN ADVANCES IN THE HEALTH SCIENCES AND THE INCORPORATION OF NEW KNOWLEDGE, TECHNIQUES, AND TREATMENTS INTO PHYSICIANS' PRACTICES. THIS LAG CONTRIBUTES TO INCREASED COSTS IN HEALTH CARE, AS WELL AS LOSSES IN PRODUCTIVITY AND QUALITY OF LIFE AND AN INCREASE IN PREMATURE DEATHS.**

**RESEARCH SHOWS, HOWEVER, THAT THE COLLECTION AND USE OF DE-IDENTIFIED HEALTH INFORMATION ABOUT PHYSICIANS' PRACTICES CAN REDUCE THIS LAG, BENEFIT PATIENTS, AND IMPROVE PUBLIC HEALTH. NCQA, IN THE STATE OF HEALTH CARE QUALITY 2007, ATTRIBUTES THE USE OF DE-IDENTIFIED HEALTH INFORMATION TO A DRAMATIC RISE IN THE PERCENTAGE OF HEART ATTACK PATIENTS RECEIVING INEXPENSIVE BETABLOCKER DRUGS TO PREVENT SECOND, OFTEN FATAL, HEART ATTACKS—FROM 62% IN 1996 TO 97% IN 2006, SAVING BETWEEN 4,400 AND 5,600**

**LIVES OVER A SIX-YEAR PERIOD AND THE QUALITY OF HEALTH OF TENS OF THOUSANDS. IN SHORT, WITH READY ACCESS TO COMPREHENSIVE, DEIDENTIFIED HEALTH INFORMATION ABOUT PHYSICIANS' TREATMENT PRACTICES, ACADEMICIANS, POLICYMAKERS, AND PRACTICING PHYSICIANS CAN:**

- 1. SEE HOW INDIVIDUAL PHYSICIANS' DECISIONS ALIGN WITH PATTERNS OF PRACTICE ACROSS COMMUNITIES AND WITH STATE-OF-THE-ART HEALTH CARE;**
- 2. ENGAGE IN EVIDENCE-BASED DISCUSSIONS ABOUT HOW VARIATIONS IN TREATMENTS MAY CONTRIBUTE TO SYSTEMIC HEALTH DISPARITIES; AND**
- 3. DEVELOP AND ADOPT COST-EFFECTIVE PRACTICES AND STRATEGIES THAT REDUCE OR ELIMINATE DISPARITIES, IMPROVE THE PREVENTION AND TREATMENT OF CHRONIC ILLNESSES, ENHANCE QUALITY OF LIFE,**

**BOOST PRODUCTIVITY, AND PROLONG LIVES IN EACH SEGMENT OF OUR POPULATION.**

**SUCH TRANSPARENCY IN HEALTH INFORMATION ULTIMATELY PROMOTES EFFICIENCY, COMPETITION, AND COST- EFFECTIVE PERSONALIZED CARE AND EMPOWERS CONSUMERS ABOUT PROVIDER QUALITY, CHOICES, AND PRICES. WITHOUT IT, PRACTICING PHYSICIANS, RESEARCHERS, AND POLICYMAKERS CANNOT SEE HOW INDIVIDUAL PRACTICES SHAPE PATTERNS OF HEALTH CARE AND HEALTH OUTCOMES.**

**IT SHOULD COME AS NO SURPRISE THAT THE COLLECTION AND MAINTENANCE OF COMPREHENSIVE, DE-IDENTIFIED HEALTH INFORMATION IS COMPLEX, TIME-CONSUMING, AND EXPENSIVE. OBTAINING THE DATA, AS WELL AS MAINTAINING AND IMPROVING ITS QUALITY, REQUIRES PARTICIPATION BY INDIVIDUALS AND ENTITIES**

**FROM BOTH THE PUBLIC AND PRIVATE SECTORS, INCLUDING PUBLIC HEALTH OFFICIALS, ACADEMICIANS, PRACTICING PHYSICIANS, HEALTH INSURERS, SELF-INSURED EMPLOYERS, PHARMACISTS, HEALTH INFORMATION PUBLISHERS, AND OTHER ENTITIES. IN ORDER TO BE USEFUL AND RELIABLE FOR STATISTICAL ANALYSES, DE-IDENTIFIED HEALTH INFORMATION MUST BE (1) REPRESENTATIVE OF THE ENTIRE POPULATION ACROSS TIME AND GEOGRAPHIC AREA AND WITHOUT REGARD TO HEALTH CARE PROVIDER OR PAYER, (2) GATHERED IN LARGE AMOUNTS, (3) AGGREGATED AND COMPILED INTO COMPREHENSIVE AND CUSTOMIZED DATABASES, (4) UPDATED IN A TIMELY FASHION, AND (5) SUPPORTED BY SPECIALIZED SERVICES AND ANALYTICS THAT HELP MAKE THE COLLECTED DATA UNDERSTANDABLE AND USEFUL—ALL WHILE PROTECTING THE PRIVACY AND CONFIDENTIALITY OF INDIVIDUAL PATIENTS.**

**MOREOVER, NUMEROUS STUDIES UNDERSCORE THE UNIQUE VALUE OF STATISTICALLY ROBUST DATABASES, COMPILED IN THE COMMERCIAL SECTOR, FOR NONCOMMERCIAL RESEARCH AND POLICY PLANNING. FOR EXAMPLE, HEALTH DATABASES AND SERVICES HAVE BEEN USED IN RESEARCH INTO PHYSICIANS' PRESCRIBING PRACTICES IN URBAN AREAS TO DETERMINE PATTERNS OF UNDER-TREATMENT OF ASTHMA. THIS RESEARCH SHOWED, IN TURN, THAT ASTHMA MEDICATIONS WERE BEING UNDER-UTILIZED AND THAT THERE WAS A NEED FOR IMPROVED PHYSICIAN EDUCATION AND PUBLIC OUTREACH CONCERNING ASTHMA TREATMENTS. A SERIES OF COMMERCIALLY AVAILABLE DATABASES AND SERVICES HAVE BEEN USED IN FEDERALLY- FUNDED RESEARCH ON PRESCRIPTION DRUGS, HEALTH TREATMENT PATTERNS, AND ARE CONTEMPLATED TO BE THE INITIAL BASIS FOR COMPARATIVE EFFECTIVENESS RESEARCH.**

**AS THESE EXAMPLES SHOW, WHEN PUBLIC AND PRIVATE INTERESTS ARE ALIGNED, AND DE-IDENTIFIED HEALTH INFORMATION IS TRANSPARENT AND READILY AVAILABLE TO ALL, THE VALUE OF THE AGGREGATED DATA IS MAXIMIZED, COSTS ARE REDUCED, PATIENT CARE IS ENHANCED, HEALTH STATUS IMPROVES, AND WE ALL BENEFIT.**

**FEDERAL POLICIES AND INITIATIVES SUPPORT THE GATHERING AND BROAD DISSEMINATION OF DE-IDENTIFIED HEALTH INFORMATION, INCLUDING INFORMATION ABOUT SPECIFIC PHYSICIANS' PRESCRIBING PRACTICES.**

**AS PREVIOUSLY NOTED, HIPAA REQUIRES THAT HHS ESTABLISH NATIONAL STANDARDS FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION THAT IDENTIFIES INDIVIDUAL PATIENTS, BUT DOES NOT RESTRICT THE USE OR DISCLOSURE OF DE-IDENTIFIED HEALTH**

**INFORMATION. WITH THESE PATIENT PRIVACY PROTECTIONS IN HAND, HIPAA’S REGULATORY SCHEME EXPRESSLY *ENCOURAGES* THE GATHERING AND BROAD DISSEMINATION OF DE-IDENTIFIED HEALTH INFORMATION— INCLUDING INFORMATION ABOUT SPECIFIC PHYSICIANS’ PRESCRIBING PRACTICES.**

**THE NOTICE OF PROPOSED RULEMAKING IMPLEMENTING HIPAA ALSO EXPLAINED (1) HOW DE-IDENTIFIED HEALTH INFORMATION WAS “VALUABLE” FOR BOTH “PUBLIC HEALTH ACTIVITIES (*E.G.*, TO IDENTIFY COST-EFFECTIVE INTERVENTIONS FOR A PARTICULAR DISEASE) AS WELL AS FOR COMMERCIAL PURPOSES (*E.G.*, TO IDENTIFY AREAS FOR MARKETING NEW HEALTH CARE SERVICES)” AND (2) HOW HIPAA REGULATIONS WERE DESIGNED TO ENCOURAGE PUBLIC-PRIVATE COLLABORATION IN THE GATHERING AND BROAD DISSEMINATION OF DE-IDENTIFIED HEALTH INFORMATION FOR COMMERCIAL AND NON-**

**COMMERCIAL PURPOSES. CONSISTENT WITH THESE  
AVOWED GOALS, HHS EXPRESSLY NOTED:**

**IT WOULD BE OUR HOPE THAT COVERED ENTITIES,  
THEIR BUSINESS PARTNERS, AND OTHERS WOULD MAKE  
GREATER USE OF DE-IDENTIFIED HEALTH INFORMATION  
THAN THEY DO TODAY, WHEN IT IS SUFFICIENT FOR THE  
RESEARCH PURPOSE. SUCH PRACTICE WOULD REDUCE  
THE CONFIDENTIALITY CONCERNS THAT RESULT FROM  
THE USE OF INDIVIDUALLY IDENTIFIABLE HEALTH  
INFORMATION FOR SOME OF THESE PURPOSES. THE  
SELECTIVE TRANSFER OF HEALTH INFORMATION  
WITHOUT IDENTIFIERS INTO AN ANALYTIC DATABASE  
WOULD SIGNIFICANTLY REDUCE THE POTENTIAL FOR  
PRIVACY VIOLATIONS WHILE ALLOWING BROADER  
ACCESS TO INFORMATION FOR ANALYTIC PURPOSES,  
WITHOUT THE OVERHEAD OF AUDIT TRAILS AND IRB  
REVIEW. FOR EXAMPLE, PROVIDING DE-IDENTIFIED**



**INFORMATION TO A PHARMACEUTICAL  
MANUFACTURER TO USE IN DETERMINING PATTERNS OF  
USE OF A PARTICULAR PHARMACEUTICAL BY GENERAL  
GEOGRAPHIC LOCATION WOULD BE APPROPRIATE,  
EVEN IF THE INFORMATION WERE SOLD TO THE  
MANUFACTURER.**

**FOLLOWING THE ENACTMENT OF HIPAA, A 2006 REPORT  
INDICATED THAT THE ADMINISTRATION, BOTH PARTIES'  
CONGRESSIONAL LEADERS, AND NEARLY 40 STATES HAD  
BEGUN TO PURSUE MAJOR HEALTH INFORMATION  
INITIATIVES, TO ACHIEVE GREATER VALUE FOR HEALTH  
CARE SPENDING. FOR EXAMPLE, THE CENTERS FOR  
MEDICARE AND MEDICAID SERVICES (CMS) ALSO COLLECTS  
HEALTH CARE DATA RELATED TO MEDICARE, MEDICAID,  
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP),  
AND MEDICARE CURRENT BENEFICIARY SURVEY (MCBS),**

**AND THEN DISSEMINATES IT TO ACADEMIC AND NON-PROFIT RESEARCHERS, AMONG OTHERS.**

**OTHER RECENT FEDERAL LEGISLATION LIKEWISE EMBRACES POLICIES AND INITIATIVES SUPPORTING THE GATHERING AND BROAD DISSEMINATION OF STATISTICALLY ROBUST DEIDENTIFIED HEALTH INFORMATION. FOR EXAMPLE, THE *AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009*, APPROPRIATED \$400 MILLION TO “ACCELERATE THE DEVELOPMENT AND DISSEMINATION OF RESEARCH ASSESSING THE COMPARATIVE EFFECTIVENESS OF HEALTH CARE TREATMENTS AND STRATEGIES,” INCLUDING “THE DEVELOPMENT AND USE OF CLINICAL REGISTRIES, CLINICAL DATA NETWORKS, AND OTHER FORMS OF ELECTRONIC HEALTH DATA THAT CAN BE USED TO GENERATE OR OBTAIN OUTCOMES DATA”. ALSO, THE ACT ESTABLISHES AN OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY THAT SUPPORTS THE USE AND**

**EXCHANGE OF DE-IDENTIFIED ELECTRONIC HEALTH INFORMATION THAT, AMONG OTHER THINGS, IMPROVES THE COORDINATION OF CARE AND INFORMATION AMONG HOSPITALS, LABORATORIES, PHYSICIAN OFFICES, AND OTHER ENTITIES THROUGH AN EFFECTIVE INFRASTRUCTURE FOR THE SECURE AND AUTHORIZED EXCHANGE OF DE-IDENTIFIED HEALTH CARE INFORMATION; PROMOTES EARLY DETECTION, PREVENTION, AND MANAGEMENT OF CHRONIC DISEASES; AND SUPPORTS GREATER AND MORE EFFECTIVE COMPETITION, BETTER SYSTEMS ANALYSIS, INCREASED CONSUMER CHOICE, IMPROVED OUTCOMES IN HEALTH CARE SERVICES, AND EFFORTS TO REDUCE HEALTH DISPARITIES.**

**MORE RECENTLY, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) PROVIDES FOR A SIGNIFICANT NUMBER OF PROVISIONS RELATED TO THE COLLECTION AND DISSEMINATION OF DE-IDENTIFIED HEALTH INFORMATION.**

**ANOTHER AGENCY WITHIN HHS—THE AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ)—HAS A SPECIFICALLY DEFINED MISSION OF SUPPORTING RESEARCH THAT HELPS PEOPLE MAKE MORE INFORMED DECISIONS AND IMPROVES THE QUALITY OF HEALTH CARE SERVICES, INCLUDING PROMOTING THE COLLECTION AND BROAD DISSEMINATION OF DE-IDENTIFIED HEALTH CARE DATA.**

**CONSISTENT WITH CONGRESSIONAL INTENT TO CREATE AN ENVIRONMENT TO FOSTER THE GATHERING AND DISSEMINATION OF DE-IDENTIFIED HEALTH DATA, SUBSTANTIAL MULTI-AGENCY INITIATIVES ARE UNDERWAY**

**TO COLLABORATE WITH INDUSTRY AND SHARE DE-IDENTIFIED HEALTH CARE DATA. FOR EXAMPLE, THE COMMUNITY HEALTH DATA INITIATIVE IS “A MAJOR NEW PUBLIC-PRIVATE EFFORT TO CATALYZE THE ADVENT OF A NETWORK OF COMMUNITY ... HEALTH DATA SUPPLIERS (STARTING WITH HHS) AND DATA APPLIERS ....” INDEED, IN DESCRIBING THIS PLAN, HHS STATES THAT A “CORNERSTONE OF OPEN GOVERNMENT AT HHS IS THE ABILITY TO MAKE HIGH-VALUE DATA AVAILABLE TO THE PUBLIC AND ENCOURAGE INNOVATIVE USES OF IT TO ADVANCE THE PUBLIC GOOD.”**

**FINALLY, THE PUBLIC HEALTH DATA STANDARDS CONSORTIUM (PHDSC) IS YET ANOTHER PUBLIC-PRIVATE PARTNERSHIP AMONG THE CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) AND ITS PUBLIC HEALTH PARTNERS AT THE STATE AND LOCAL LEVELS, THE EHEALTH INITIATIVE (EHI) MEMBERSHIP, AND CMS. PHDSC WORKS**

**“TOGETHER WITH HEALTH CARE PROVIDERS, STATE AND LOCAL PUBLIC HEALTH AGENCIES, AND LOCAL COALITIONS TO IDENTIFY CRITICAL PUBLIC HEALTH AND QUALITY-RELATED DATA NEEDS AND DEVELOP STRATEGIES TO RAPIDLY, EFFICIENTLY, AND SECURELY CAPTURE AND TRANSMIT RELEVANT HEALTH CARE INFORMATION TO AND AMONG PUBLIC HEALTH PARTNERS,” INCLUDING INFORMATION ABOUT “SPECIFIC LABORATORY AND PHARMACY TRANSACTIONS, EMERGENCY ROOM VISITS, HOSPITAL ADMISSION DATA, AND DATA FROM OUT-PATIENT VISITS.”**

**THERE IS GENERAL AGREEMENT ABOUT THE PURPOSE AND GOAL OF THESE REGULATIONS, POLICIES, AND INITIATIVES. THEY ALL RECOGNIZE THE PARAMOUNT IMPORTANCE OF BRINGING PUBLIC AND PRIVATE INTERESTS TOGETHER TO SUPPORT THE GATHERING AND READY DISSEMINATION OF DE-IDENTIFIED HEALTH INFORMATION**

**TO FACILITATE THE MORE EQUITABLE AND EFFECTIVE  
DELIVERY OF HIGH QUALITY, AFFORDABLE HEALTH CARE.**

**WHEN HEALTH INFORMATION IS STRIPPED OF PATIENT  
IDENTIFIERS AND MADE TRANSPARENT AND AVAILABLE TO  
ALL, PUBLIC AND PRIVATE INTERESTS ARE CLOSELY  
ALIGNED, AND IT IS POSSIBLE TO MAXIMIZE THE VALUE OF  
THAT INFORMATION TO IMPROVE THE QUALITY,  
AFFORDABILITY, AND ACCESSIBILITY OF HEALTH CARE TO  
ALL MEMBERS OF SOCIETY. FEDERAL STATUTES,  
REGULATIONS, AND POLICIES HAVE LONG RECOGNIZED THIS  
AND SHOULD CONTINUE TO DO SO.**