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Aneesh Chopra
Chief Technology Officer
Office of Science and Technology Policy
Executive Office of the President
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Dear Mr. Chopra,

It has come to our attention that several individuals have argued for a re-examination of the standard specified for clinical summary documents. We see no justification for such a re-examination. The HITSP specification of the HL7 Continuity of Care Document (CCD) has been formally recognized by the Secretary of Health and Human Services; has been approved, appealed and re-approved by the HIT Standards Committee; and has been implemented by many health IT systems vendors and healthcare delivery organizations throughout the world. While it has been argued by a few that CCD is difficult to implement, we feel that the ultimate value to our entire healthcare delivery system of specifying a single standard for clinical summary documents far outweighs any anecdotal stories of implementation difficulties.

While the benefits of a single standard to doctors and other healthcare professionals seems obvious, the benefits to systems developers are just as clear, as we have been told by many developers. Developers must be able to support the processing of many types of clinical documents besides clinical summaries. It is indisputable that all other types of clinical documents either are or will be based on the HL7 Clinical Document Architecture (CDA). CCD is also based on CDA. Once a developer has implemented support for one type of CDA-based clinical document, less effort is required to implement the next type. Vendors have told us that they do not want to be obligated to support two entirely different formats for clinical documents - one format for all of the clinical document types that they must support (except for clinical summaries), and an unrelated format for clinical summaries. Also, while PHR vendors might not perceive a need today for all of the functionality available in the CCD/CDA, their more limited current requirements must not drive a decision that impacts other stakeholders with more demanding requirements. If PHRs are ever to achieve their goal of support for value-added patient-care processes (increased quality, decreased cost), they will eventually find that they need the more robust functionality of CDA/CCD.

We are equally concerned with the destructive precedent that would be set if a settled standards decision were to be re-examined well after the decision was finalized, and without wide consensus that the original decision was in error. Systems implementers must have confidence that formal action will allow them to proceed with product development without fear that their efforts will be wasted. There must be a very high bar set before re-examination of a standards decision is contemplated.

We believe that the interests of all of the stakeholders in healthcare are better served if a single standard for all clinical documents of all types is supported across the NHIN and its sub-networks.

Sincerely,

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