

To the Office of the National Coordinator for Health IT and its Advisory committees:

Thank you for allowing me to present before you today.

My name is Thomas Sullivan. I'm a board-certified cardiologist from Massachusetts with over 40 years of direct patient care experience.

Over the past eight years I have also been working for a small electronic prescribing company in Rockville, Maryland called DrFirst. After a brief presentation at a conference in Arizona about eight weeks ago, describing our company experience with identity proofing and authenticating physicians to prescribe controlled substances electronically, I was invited to a small White House colloquium to promote the National Strategy for Trusted Identities in Cyberspace (NSTIC).

I was unaware of NSTIC at that point but after the colloquium I have become enthusiastically supportive of the NSTIC goals and objectives, particularly in healthcare where the redundancy and inefficiency is legendary. NSTIC could clearly make a difference.

Today, I would like to offer you some of our experience, give an example of a preliminary discussion to exchange trusted identities in cyberspace, and finally make some other recommendations.

My experience in this area - not unlike many other physicians - has elements that are both common and unique. As a past president of the Massachusetts Medical Society, the oldest continuing medical society in the country, I am aware that in 1781 we were doing the identity proofing for physicians, starting a tradition that lasted approximately 100 years. Just after the Civil War we petitioned the Massachusetts legislature to create a statewide department of public health, also the oldest in the nation which ultimately took over the licensing and IDP of physicians.

DrFirst participated in a three-year pilot project funded by AHR Q under the auspices of the controlled substance division of our state DPH. We had a DEA waiver to electronically prescribe controlled substances in western Massachusetts and share the results so everyone could learn from the experience. The pilot ended in the fall of 2011 and an analysis has been prepared by Brandeis University.

The interim final rule released by the DEA in June 2010 required among many other things, third-party identity proofing. Joining with our corporate partners Symantec and Experian, we have been rolling out identity proofing and the distribution of a hard token, one-time password device over the past several months. Since the current availability of retail pharmacies that can accept EPC S and the variability of different statutes in each and every state are limiting factors, we have seen some reluctance to become early adopters among the physician community. Approximately 12 states currently do not allow EPC S despite the presence over the past two years of the DEA interim final rule. In addition, many physicians are somewhat reluctant to reveal financial information such as credit card numbers over the telephone in order to satisfy the current interpretation of the NIST 800-63 guidance. Recently there have been some face to face meetings with NIST and others to offer acceptable alternatives to certain financial instruments and credit cards that could be adequate substitutes for creating a risk profile that would attain the benchmark level of assurance mandated by the DEA and NIST. Although we have had some verbal indications that certain alternatives are acceptable, we are still awaiting a written confirmation.

Despite a somewhat slower uptake than we initially expected, we are at least assured and pleased that once a physician or clinical prescriber has been adequately and appropriately authenticated, controlled

substance prescriptions are actually being sent, processed and received by pharmacies in several states around the country. This is real world proof that the system is working as originally designed.

As a practical example of how NSTIC might work, I was recently given verbal assurance that the Massachusetts Department of Public Health Controlled Substance Division would strongly consider substituting the DEA and NIST IDP process to eliminate their current procedure required to access the state prescription drug monitoring program. These so-called PMP's have been created over the past several years in most states and have had limited and variable success in helping manage the controlled substance fraud, abuse and addiction epidemic in our country. Sharing trusted identities efficiently has the potential to make these and many other programs much more cost-effective.

Although I personally believe the specific level of assurance in the DEA and NIST IDP process is not necessary to access each state PMP, once a clinician has successfully met the requirements there should be minimal administrative hurdles to share this identity appropriately. It should be acknowledged in the real world that practicing physicians will insist on having their trusted clinical staff assistants access these databases wherever appropriate in order to minimize disruption to office workflow. We have been talking about "administrative simplification" for many years, even prior to the passage of HIPAA. Although there has been progress, much remains to accomplish.

I believe physicians and selected other clinical providers are among the most highly credentialed and authenticated professionals in our society. There are very many examples of redundancy, unnecessary delays and excess expenses in carrying out these programs. Physicians are typically licensed in one or more states, separately credentialed by many health plans and a few hospitals and also undergo certain privileging criteria within each hospital or otherwise licensed facility. The system is getting more complex daily and cries out for a streamlined and collaborative approach which I believe is part and parcel of the vision maintained by an NSTIC.

Cost effective care and the elimination of redundancy need to be hallmarks of 21st century medicine.

Put in another way, although the first rule of medicine traditionally recommended for physicians is:

"Primum Non Nocere".....First, Do No Harm

I would add Dr. Sullivan's second rule:

"Secundo, Propera Ne Me".....Second, Don't Slow Me Down

Time does not permit additional commentary, but my colleague and I Peter Kaufman, MD - our Chief Medical Officer - would be happy to answer questions if requested.

Respectfully,

Thomas E Sullivan, MD

Chief Privacy Officer, Chief Strategic Officer

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