

CIO Forum  
July 21, 2011  
Meeting Summary

Participants

Michele Alexanian, Mass. Health Data Consortium  
Leon Barzin, Massachusetts Medical Society  
Karen Bell, MD, CCHIT  
Dominick Bizzarro, InterSystems  
Claudia Boldman, Mass. Information Technology Division  
Ray Campbell, Mass. Health Data Consortium  
Greg DeBor, CSC/NEHEN  
Bill Fandrich, Blue Cross and Blue Shield of Mass.  
Larry Garber, MD, Fallon Clinic (via phone)  
Paul Grabscheid, InterSystems  
Gerald Greeley, Winchester Hospital  
John Halamka, MD, CareGroup Healthcare System  
Jeff Holmes, InterSystems  
Joe Imbimbo, Tufts Health Plan  
John C. Kelly, NaviNet  
Arvind Kumar, CRICO/RMF  
Michael Lee, MD, Atrius Health (via phone)  
Eric Lundgren, AstraZeneca  
Marie Maloney, Senior Whole Health (via phone)  
Ted Marsh, Blue Cross and Blue Shield of Mass.  
Thomas Murphy, South Shore Hospital  
Dan Nigrin, MD, Children's Hospital (via phone)  
Janet O'Malley, Blue Cross and Blue Shield of Mass.  
Lisa Pratico, Blue Cross and Blue Shield of Mass.  
David Querusio, Harvard Pilgrim Health Care  
Craig Schneider, Mass. Health Data Consortium  
Nakhle Tarazi, MD, Caritas Christi/Mass. Health Data Consortium  
David Wessman, Health Care Finance and Policy (via phone)  
David Whitham, Dimock Community Health Center  
Bill Young, Berkshire Health (via phone)

Summary

## Announcements

The Massachusetts Health Data Consortium's next major event will be HealthMart on October 5<sup>th</sup> at the Beechwood Hotel in Worcester. Like the past two years, the event is designed to bring together clinicians with electronic health record and other vendors, and will feature five rounds of breakout sessions. Exhibitor registration is now open, and attendee registration will open on August 8<sup>th</sup> at <http://www.mahealthdata.org/Events?eventId=362370>. Flyers are attached along with this summary.

A notice was sent out to the CIO Forum on July 20<sup>th</sup> that Dr. Halamka has left his position as CIO of Harvard Medical School to focus on his CareGroup CIO role and his federal and other projects. Please let Dr. Halamka know if you are aware of anyone who might be appropriate for the Harvard Medical School CIO position.

A breach at Beth Israel Deaconess Medical Center was reported. A virus in a GE system sent encrypted data over an unencrypted network. There was no clinical or financial data transmitted, but BIDMC was required to file a potential breach report, despite the fact that this problem did not involve EHRs or HIE.

## Federal HIT and HIE Update

*John Halamka, MD, CareGroup*

There is a "summer camp for IT policy" going on in Washington this summer, as numerous policy and standards issues are being addressed.

Metadata recommendations: Addressing standards for patient identification, provenance of signatures, and privacy flags (and dealing with various different state laws related to these issues) for the metadata regarding data package transmissions for either administrative or clinical data.

Provider directory recommendations: A proposal to federate LDAP (lightweight directory access protocol) directories was rejected. Instead, the approach will be to use a MicroData tool that can see web pages as structured data. Therefore, all clinical organizations will need to have a web page (very small practices could use a larger organization's or health plan's or local HIE's ISP-like offering).

Patient matching: RAND studied the Medicare database and calculated the chances of getting a patient match wrong based on specific data elements. The recommended approach will be to use machine-to-machine matching algorithms, in the belief that this will be more protective of patient privacy than having a human intervention.

Vocabulary: Developing a code set and vocabulary for all domains so that they will be consistent (e.g., number of genders).

e-Prescribing at discharge: Doctors frequently change medical orders between when the discharge summary is prepared and the actual moment of discharge – we need standards to reconcile the final medication list.

Quality measures: Trying to find ways to make the computation of the exclusionary measures for meaningful use easier.

Transitions: Developing a single standard for the transfer summary.

Clinical data architecture (CDA): Trying to make it easier to implement.

Direct: Direct is designed for small organizations, and NHIN for more complex organizations. Working to converge the two into a single implementation guide.

Stage 2 of meaningful use: Focusing on patient engagement (are patients ready to be engaged? Google Health and Keas just folded, indicating the market for engaged patients is limited); quality measures; and HIE (CareSpark went under this week as well).

Massachusetts HIT/HIE Advisory Group: The Mass. eHealth Collaborative and the Mass. Health Data Consortium have been hired as facilitators of the workgroups that will help move the process from uses cases to transaction flows.

MassHealth: The IT plan brings a 90/10 federal/state match, and the Mass. e-Health Institute sees this as an opportunity to leverage HIT/HIE funding.

Greg DeBor added that there are also efforts federally to address the operating rules for administrative transactions, in order to reduce variation in processing. This would benefit both EHR vendors and payers.

## ICD-10 Planning and Implementation

*John Halamka, MD, CareGroup*

*Ted Marsh, Blue Cross and Blue Shield of Massachusetts*

**Dr. Halamka:**

(please see handout)

ICD-10 may be the straw that is breaking the camel's back for healthcare organization IT and financial systems, on top of meaningful use, payment reform, and other requirements. ICD-10 is Y2K on steroids.

EHRs do not have enough data to give the coders guidance on the ICD-10 codes to use. We can map codes in the interim, but at some point CMS won't allow such mapping.

Studies indicate that about 70 percent of codes will change, which means that 70 percent of provider payments are at risk.

**Discussion:**

Ray Campbell pointed out that the ICD-10 Forum that is facilitated by MHDC is addressing the mapping challenge. The group is now moving from education to operations, with a Coding/Operations Workgroup and an initiative to use a common form for provider readiness surveys (there is a conference call on August 5<sup>th</sup> to discuss the survey). The September 9<sup>th</sup> meeting will focus on the revenue cycle, and future work will involve harmonizing testing formats.

Beth Israel currently has 18 coders and needs nine more – other organizations can expect their staffing needs in this area to increase by about 50 percent. There are substantial costs to be incurred besides coders – InterMountain has budgeted \$118 million.

Dr. Larry Garber said that Fallon Clinic has hired a project manager, and they are working with Epic on the mapping effort. The impact on the IT side might not be too bad, but it will be very difficult for physicians to adjust to the new coding requirements.

Dr. Dan Nigrin reported that Children's Hospital has hired an internal project manager, and they are looking at what needs to be remediated, and considering a contractor to handle the enterprise work. No specific budget number has been determined yet.

It appears that the health plans are further along than the providers, and that the vendors are moving slowly. This is too much change too soon, and a concern is that small providers are completely reliant on their vendors.

**Bill Fandrich and Ted Marsh:**

(please see handout)

It took some time for other components of our organization to understand the impact of ICD-10, but they get it now. There will be a business process change for everything we do. Unfortunately, we are not sure that the data will be better after all this effort – there will just be more codes. This project is unlikely to bring value to our organization or yours.

PriceWaterhouseCoopers did an assessment, and found that there are 30,000 different user applications that will be affected. Our budget was \$20-30 million, but it seems to be trending towards \$30-40 million.

We have not yet formalized the plan with the provider community; the plan is in development. We do not want to change the revenue cycle if possible, and we will use analytics to monitor revenue cycle during implementation.

Testing is the scariest component of the project.

We received value from 5010 by investing in HIE. However, we will not get value out of ICD-10 unless everyone uses it appropriately, and we don't see that happening.

#### **Roundtable discussion:**

Part of the problem with this effort is that the system is moving towards global payment, and under global payments we don't need codes.

Medicare is pushing this – and unwilling at least for now to delay the deadline – because they have the money in their budget for the project.

If ICD-11 is around the corner, can we cancel ICD-10 and go straight to ICD-11 after, say, 2018?

ICD stands for the International Classification of Diseases – it is an epidemiological tool, it is not designed for billing, and that is problematic.

The way for us as a community to do this better/faster/cheaper is to collaborate on test planning and strategy, to ensure vendor readiness, and to take a common matching approach/code set.

Dr. Karen Bell said that there are about 800 certified EHR products, although many of these have not yet been implemented. Very few are ready for ICD-10, because the vendors are focused on meaningful use.

What are physicians doing about this? Most are unaware, but if they are aware, they are very scared. There will be a need for software to translate clinical information into the new codes. For health plans, ICD-10 is a data problem; for provider, it is both a clinical/workflow problem and a data problem.

#### **Next Meeting**

September 15<sup>th</sup>, 8:00 – 10:00 in the Consortium's office