COVER STORY:

DATA EXCHANGE: THE COMING ICD-10 ONSLAUGHT

Time is running out to prepare for the ICD-10 conversion, while the wave of federal initiatives pushing for greater openness and data exchange across patient and provider settings continues to pressure healthcare organizations to take on more implementation projects.

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Beyond ICD-10: Next-Generation Technology Alleviates Data Silos

WHILE OTHER INDUSTRIES might describe the morass of unstructured clinical documents floating around health-care systems as “big data,” it’s probably more accurately described as unstructured clinical data.

Marooned in network backwaters such as noninteroperable data silos, free-text fields in electronic health records—or worse yet, paper—some of this unstructured clinical data will form the statistical DNA of population health management, a key to reimbursement for accountable care organizations. Other data points stashed in these network hiding places will provide crucial documentation for claims reimbursement under the new world order of ICD-10 coding, after the present ICD-9 sunsets Oct. 1, 2014.

Accessing all the clinical data on a network and harmonizing it across information systems for the accountable care and ICD-10 era will require next-generation technology tools. This issue of Pulse delves into several of those issues, including content management systems and workflow automation, along with its cost-cutting efficiency cousin, supply chain management.

Furthermore, we offer tips into best practices for ICD-10 implementation, along with using telemedicine services to cut emergency room visits and create further efficiencies in patient care. While it might not be possible to be completely prepared for 2015 by the time you read through this Pulse, we hope it will at least provide a good start. ■

Don Fluckinger
News director, SearchHealthIT.com
Telemedicine’s Providers Bemoan EHR Interoperability

AT THE AMERICAN Telemedicine Association’s 2013 Annual International Meeting & Trade Show, beyond the EHR vendor marketing sphere and beyond the reach of the Office of the National Coordinator for Health IT’s spin zone, health system IT leaders were telling it like it is. Their focus, for the most part, was on problems with interoperability among EHR systems that are getting in the way of ambitious telemedicine initiatives to the point that some telemedicine providers are not even bothering to connect to physician EHRs.

National Coordinator for Health IT Farzad Mostashari, M.D., and his colleagues advocate breaking down data silos in U.S. healthcare. But an IT executive in charge of rolling out a number of fledgling telemedicine services at one of the country’s largest integrated health systems blames major EHR vendors for keeping telemedicine systems in silos. For now, the executive (who asked not to be named) said, telemedicine providers need to keep away from the “blast radius” of EHR vendor conflicts, lest their budgets get consumed by building interfaces to the various non-interoperable EHR systems.

“EHRs don’t talk to each other, interoperability’s still a major challenge,” the executive said. “If they’re not going to talk to each other, they’re not going to talk to telemedicine. If that’s the case right now, we’ll have to use them as best as possible. But telemedicine has to be separate from the EHRs and move forward.”

The CommonWell Health Alliance, an interoperability initiative announced at HIMSS 2013 by five EHR vendors, provides hope for solving the problem, the executive concluded. “But it’s incumbent upon EHR vendors to solve their family feud before we get involved.”

Telemedicine Vendors Struggling With Interoperability

Telemedicine vendors are feeling some interoperability pain too. Seattle-based Carena Inc. provides primary care services to patients via phone and video for several groups of clients including payers, employers and private-pay patients. The company also is beginning to make inroads into primary care groups, recently inking a deal to provide off-hours support for primary care physicians at Franciscan Health System in Tacoma, Wash. Franciscan, which includes seven hospitals, is bringing an Epic implementation online in June and July. It ultimately hopes to pipe clinical data from Carena’s practitioners directly into the EHR so its physicians can see
what takes place when their patients log a telemedicine call. That is a change from the typical method the company uses to update physicians after a call, Carena CEO Ralph Derrickson said.

Carena’s own EHR system has the capacity to hand off searchable PDF documents for inclusion into a patient EHR for care coordination, but most of the company’s clients request data via non-searchable, flat-text fax, Derrickson said. Eventually, he believes, a common EHR data interchange format will evolve and it will “raise all boats,” he said.

“That’s going to happen,” Derrickson said, but for now interoperability with his clients’ clinical data systems is a work in progress. “Our point of view is that everyone should use an EMR, whatever works best with their workflow. That EMR should be able to express itself through other EMRs in a common interchange format.”

Matt Levi, Franciscan’s director of virtual health services, said the health system chose to implement Epic because, among other reasons, “80% to 90%” of Seattle area providers were already on it. As is happening in Portland, Ore., Seattle health organizations appear to be moving to Epic.

That might be good for Epic as a business, but national leaders such as Mostashari advocate interoperability among all EHR vendors, which allows patients to move...
freely between care providers as they please. Non-interoperable silos create what he calls “walled gardens” of health IT, where a health system, in effect, uses health IT to hold patients hostage. He has gone as far as threatening to regulate EHR vendors to create interoperability, if that’s what it takes.

As the interoperability debate rages on nationally, local health systems still must serve their patient population.

As the interoperability debate rages on nationally, local health systems still must serve their patient population. In Franciscan’s case, that might involve a certain amount of capitulation to the status quo. After Epic goes live, the health system must determine how best to connect Carena to its EHR. One possible solution would be to sidestep interoperability issues between Carena’s custom EHR and Epic by setting up Carena’s after-hours service as its own clinic within Franciscan’s Epic installation. That would open up patient records in Epic to Carena practitioners, who could enter the results of patient calls directly into the EHR.

U.S. primary care doctors using EHRs as of 5/31/13

<table>
<thead>
<tr>
<th>Speciality</th>
<th>Total Providers Live on EHR</th>
<th>Total Providers Demonstrating Meaningful Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent Med and Pediatrics</td>
<td>18,438</td>
<td>7,069</td>
</tr>
<tr>
<td>Family Practice</td>
<td>49,439</td>
<td>27,426</td>
</tr>
<tr>
<td>General Practice</td>
<td>4,162</td>
<td>1,339</td>
</tr>
<tr>
<td>Geriatrics</td>
<td>783</td>
<td>361</td>
</tr>
<tr>
<td>Gynecology and OBGyn</td>
<td>13,338</td>
<td>6,165</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>28,741</td>
<td>18,155</td>
</tr>
</tbody>
</table>

SOURCE: REGIONAL EXTENSION CENTER DASHBOARD, WWW.HEALTHIT.GOV
Telemedicine Providers’ Interoperability Problems Affect Patient Safety

Telemedicine pioneer Herb Rogove, D.O., who helped develop and implement intensive-care “e-ICU” telemedicine systems as a practicing physician at several U.S. hospitals, said the issue of clinical data interoperability is likely to be solved when national health information exchange becomes reality. If that doesn’t happen, innovative third-party software developers will creatively find a way to connect presently non-interoperable systems. “It’s going to take a groundswell of people on the front lines, doing it, pushing it forward,” said Rogove, who presently is CEO of C3O Telemedicine.

In a presentation on telehospitalist services, Rogove said that the crucial data component of hospital telemedicine services comes at the point of patient handoff between practitioners. The current morass of system interoperability problems, security protocols and privacy compliance issues all make handoff more difficult than it should be.

“[Patient handoff is] one of the biggest patient safety issues,” Rogove told the audience. “I think that’s one of the most constant, ongoing headaches that I face on a daily basis.”

DON FLUCKINGER covers health care IT technology issues for SearchHealthIT.com. His 20 years of journalism experience includes covering topics as diverse as document technologies, hospital safety, nutrition, respiratory care department management and clinical research regulations.

The Twitter Buzz from the Health IT Social Media Community

Advanced_AV@Advanced_AV
#Telemedicine is bringing better quality healthcare to inmates and saving money in the process http://bit.ly/135L4l3 #gov20 #healthIT

Erin Trimble@erintrim
How Digital Health Is Reinventing the House Call http://onforb.es/13dyb8B #digitalhealth #telemedicine

Heather Pepe@HeatherPepe
Slideshow: Top 10 states for EHR incentive payments | PhysBizTech http://shar.es/wxsiI via @sharethis #EHR #EMR

Brian Ahier@ahier
Ambulatory #EHR Usability 2013: More Nurture than Nature http://bit.ly/18RWo8j via @KLAS-research
“Accountable care depends on us working together. You cannot actually survive as a healthcare organization unless you break down IT silos.”
—JOHN HALAMKA, CIO of Beth Israel Deaconess Medical Center, speaking at MIT’s CIO Forum in May.

“When we talk about big data we have a real problem on our hands because we can’t move too fast. If we don’t correct the garbage in our data we can’t move forward.”
—JEFF BROWN, CIO of Lawrence General Hospital, saying at the iHT2 2013 Boston Health IT Summit that incomplete or inaccurate EHR data is holding back analytics initiatives.

“Younger physicians tend to look at the EMR first, and the test results first, and then talk to the patient. Older physicians tend to talk to the patient first and then go validate and verify with the EMR. The younger generation will almost always go the EMR when they get a new patient first, to find out what the [emergency department] said it was. Then they’ll walk into the patient’s room. We try to demonstrate why that is wrong, because it generates a bias.”
—WESLEY VALDES, D.O., telehealth services medical director for Intermountain Healthcare on what younger, tech-savvy physicians can learn from older docs who didn’t grow up with health IT.
CATHOLIC HEALTH SYSTEM in Buffalo, N.Y., is a non-profit organization serving Western New York across a network of hospitals, primary care centers, imaging facilities and several other community health ministries. With 1,400 physicians and more than 8,500 full- and part-time associates, the system is turning to automated solutions to help keep staff and projects on track.

Tony Pappagallo, IT director of project management, is focused on implementing integrated project portfolio management (PPM) solutions for increased efficiency and a smarter allocation of resources. Pappagallo recently talked with SearchHealthIT to share his perspective on PPM integration and how using this system has increased efficiency and decreased the complexities around project management within Catholic Health.

What IT projects rise to the need of a project manager and PPM system (versus those that don’t)? All our IT projects with substantial resource needs (greater than 40 hours of labor) make it to the PM [project management] team and to the PPM tool. There are some smaller items— upgrades and single PC deployments—[that] we treat as small enhancement requests.

What kinds of things in IT project management go more efficiently in a healthcare environment? This is not for healthcare only, but project management goes more efficiently when you have a well-defined project objective, a solid team of internal and external resources to work with and significant support from IT and the business unit leadership affected.

Describe your typical project and walk me thorough the steps, specifically noting how using a PPM system has increased efficiency and decreased complexity (i.e., employee training for a software implementation, etc.)?
We’ve been able to streamline and improve the initiation process as well as the execution and closure project processes. Over the last year, we’ve brought on three new PMs [project managers] and the training process has been much easier with the help of the Innotas’ PPM tool.

**How has your project management load/initiatives changed in the last couple years (i.e., since HIPAA, meaningful use and bring your own device have risen to the top of CIOs’ priority lists)?**

Meaningful use (MU) has raised the need for project management because many of our clinical initiatives are requirements for MU. We need to ensure the proper oversight, organization, communication, etc., are in place for these important initiatives. As well, our overall increased workload has put a premium on project management to help keep it all straight across our department and our organization.

**What characteristics do you feel make the best health care IT project manager types? Do they have to have started working the floors so they understand workflow? Is being organized and understanding the order of steps most important?**

Working the floors is not a bad thing. One of the best project managers I’ve worked with came from a nurse manager background. However, it is not a mandatory thing. More important is the ability to deal with a changing environment where requirements are not always real clear; resources are shared across multiple projects, vendors are not always top-shelf and clear communication is a strong suit of the project manager.

**JENNY LAURELLO** serves as senior community manager for the Health IT Exchange, SearchHealthIT’s dedicated community and networking portal, working with some of today’s most influential health care leaders and stakeholder groups, collaborating with industry associations and diving head first into the robust world of health care social media strategy.
THE CMS HAS confirmed Oct. 1, 2014, as the date when the ICD-10-CM/PCS code sets will replace ICD-9-CM for reporting medical diagnoses and inpatient procedures. Every healthcare entity covered by HIPAA must make this transition to ICD-10-CM/PCS: no excuses, no pardons.

Current Procedural Terminology coding for outpatient procedures and services is not affected by the transition to ICD-10-CM/PCS. However, the new version of the electronic health care transactions standard (Version 5010 of the X12 standard that became effective Jan. 1, 2012) is essential to the use of ICD-10-CM/PCS codes.

ICD-9-CM, developed in the 1970s, is outdated and can’t provide the precise data about patient conditions and procedures that ICD-10-CM/PCS offers. Most countries quickly adopted ICD-10 after its release in 1990, with the United States being the last major holdout. Some of our delay can be attributed to the process of adapting ICD-10 to meet our specific healthcare needs and settings and creating ICD-10-CM/PCS.

ICD-9 was developed before the widespread adoption of digital technologies. ICD-10’s detailed codes allow modern technologies to provide improved analyses of evolving disease patterns and treatment outcomes, and those in turn contribute to improved quality of care and reporting, as well as reimbursement.

ICD-10-CM/PCS is expanding from ICD-9-CM’s approximately 14,000 codes to roughly 150,000, with about 70,000 in ICD-10-CM and about 80,000 in ICD-10-PCS. The additional codes accommodate many more precise diagnoses and procedures that reflect advances in medicine that ICD-9 cannot accommodate, and countries that have been using ICD 10 for many years report consequent advantages in healthcare delivery and management. Compare our continued use of ICD-9 to trying to use manual or electric typewriters to meet the communication demands of today’s world.

Keep in mind that not all 150,000 codes will be applicable in every setting. Rather, specialties and particular settings will have a range of codes (or multiple ones) that will be regularly applicable, and they only occasionally will go outside those ranges.

Why Not Skip ICD-10 and Wait for ICD-11?
One could argue that even ICD-10 is insufficient for
today’s healthcare environment. The next version, ICD-11, is expected to be ready by 2016, but it doesn’t make sense to wait for it because it would be like moving high-school graduates directly into master’s and doctoral programs without making them first attend an undergraduate school. Further, the development of U.S. modifications to ICD-10 will take several years beyond 2016. After all, it’s taken more than 20 years for the U.S. to prepare for ICD-10-CM/PCS. Also, by that time, integration with SNOMED CT is likely to be on the agenda, providing even greater functionality. Additionally, the investment to date on implementing ICD-10-CM/PCS is huge, and retreating to ICD-9-CM would not only waste that investment but also require further expenditures.

The American Medical Association (AMA), the most vocal critic of the transition, has committed itself to working with the CMS to mitigate the problems it sees with ICD-10. Further, the AMA recently acknowledged that skipping ICD-10 and going directly to ICD-11 is not advisable. Its reasons, shared by others, include the fact that transitioning to ICD-11 would cost as much as the transition to ICD-10. Its content requires more computerization, for which the industry is not prepared. Skipping ICD-10 would delay the positive impacts of ICD-10, including the anticipated reduction in payers’ reliance on repeatedly asking for additional information (“attachments”), thus reducing burdens on physicians. In summary, there is no excuse to not move to ICD-10 now.

All that being said, we must acknowledge that a new threat to the October 2014 transition date for ICD-10 recently arose when two bills were introduced into Congress (one in the House, the other in the Senate) with the aim to stop or delay implementation. A consortium including the American Health Information Management Association and several other organizations has spoken out strongly against these bills, for all the reasons noted above. The consensus is that, given the strong industry opposition and the usual slow process of moving bills through Congress, the healthcare world is advised not to stall preparations for its implementation.

**Conduct a Self-Assessment of ICD-10 Readiness**

It’s prudent for any organization to consider the following in preparing for the change to ICD 10: If a healthcare entity doesn’t already have a steering committee, it’s imperative to form one. Members should include both C-level executives, whose leadership signifies commitment and support, as well as those charged with implementation, in particular the heads of health IT and health information management (HIM). The latter two should serve as leaders of the project (planning and implementation) team, which should also include members of the medical staff, nursing, case management, clinical documentation improvement, quality assurance, accounting and other teams. All these team members will serve as champions and stewards of the transition within their realm of responsibility. The financial impact is especially important, both in terms of reimbursement and the costs associated with the change.

The project team must ensure that all those who will be affected are thoroughly informed about the transition. A transitional assessment should evaluate policies, procedures, computer systems and other data and systems inventories. Internal stakeholders, as well as vendors and payers, must participate in an effort to align all parties in this effort. Health IT and HIM must work closely...
together to ensure that all necessary integrations and upgrades are identified and implemented; this includes not just equipment and software, but also policies, procedures, applications and databases.

The transition is also a valuable stimulus to evaluate and improve workflows, including replacing manual processes with electronic ones, eliminating redundancies and improving communications. It is a great opportunity to introduce or upgrade an institution’s clinical documentation improvement program and to reinforce the links between documentation and coding and their influence on quality of care and reimbursement.

**Coder Recruitment Required**

Personnel needs for the new coding system must be assessed. Industry experts estimate that productivity will drop by as much as 50% initially, and although this will improve over time, it will never match the productivity associated with ICD-9-CM. Does that mean you’ll need twice as many coders?

Well, it’s not as simple or stark as that. Determine which of your coders are willing and qualified to learn the new system. Widespread anecdotal reports indicate that some very experienced coders are choosing not to stay in the profession—some because they are approaching retirement and others because they don’t want to make the effort to learn a very different system. Many who are willing to learn the new system recognize that they are in a very good negotiating position with their current or future employer regarding pay and working conditions. Most institutions will have to recruit coders, especially those who can code in both ICD-9 and ICD-10. Dual coding is recommended at least initially because analytics will require data from both systems to compare the effect on case mix, reimbursement and so forth.

So, how do providers retain and recruit coders in this very competitive market? Contracts, retention bonuses and improved benefits are among the answers. Still, retaining coders won’t be sufficient to fill the gap created by the drop in productivity, and recruitment may be difficult. Some providers are turning to Coding as a Service companies (similar to medical transcription businesses), the number of which is growing both in the U.S. and offshore.

Internal and external training will also be necessary. Consider ICD-10-CM/PCS to be a new language, based on knowledge of anatomy and physiology, pathophysiology, pharmacology, disease processes, and surgery, as well as the health record’s content and organization. Many professionals have these skills already and can be trained for coding ICD-10. Coding courses are available through community colleges, four-year college programs and online courses.

The pool for additional coders includes not just newly trained coders, but also existing healthcare professionals. Nurses, medical transcriptionists, medical students, HIM and health IT graduates, foreign-trained nurses
and doctors who can’t find work in their own profession or are looking for better opportunities, as are retiring clinicians—all have the right experience. Some coding programs, such as Coding for Healthcare Professionals, which I co-founded, are aimed specifically at healthcare personnel seeking an alternative career, as well as at clinicians who want to learn coding themselves, both to be free of their dependence on coders and to better understand reimbursement.

**Update Software and Identify Documentation Weaknesses**

The need for coders must be coupled with systems changes and supporting software. Healthcare documentation is the primary source for identifying the appropriate codes and, therefore, reimbursement. This is the time to identify weaknesses in documentation, whether related to the electronic medical record, transcription or other systems, and to address policies and procedures and make necessary changes. A clinical documentation improvement program can be especially valuable, even essential, for successful implementation.

Coding software developments are coming of age. Medical encoders identify possible codes based on the diagnosis or procedure entered, reducing the time spent in looking up codes manually. Computer-assisted coding (CAC) reads and interprets documentation and generates the most likely codes by using natural language processing (NLP) to analyze the syntax and semantics of patient documentation. Even more than encoders, CAC can reduce productivity loss, particularly as coders become adept at using the new system.

Most of these systems support dual coding—that is, they identify both ICD-9-CM and ICD-10-CM/PCS codes, which can be valuable in business analytics regarding the impact of the change on reimbursement and case mix. Keep in mind that, even with encoders and CAC, special knowledge is needed to select the appropriate codes among the possibilities presented, and additional searching and researching might be required to assure accuracy. Computer-assisted coding with NLP software can be compared to the use of speech recognition with NLP in documenting care: These systems don’t completely eliminate the need for human review or confirmation of their results, but great hopes persist that in time they will do so.

The transition to ICD-10-CM/PCS holds the potential to improve documentation and reimbursement, while at the same time contributing to improved quality of care and public health data. The transition is challenging, however, and demands early attention to its potential effect on finances, personnel, workflow, documentation, systems, communication, relationships with vendors and payers and so forth. That said, the transition remains an important component to success in the new digital age of healthcare.

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Automating the Supply Chain

BY ED BURNS

HEALTH REFORM AND the transition away from fee-for-service payment models are putting a lot of pressure on hospitals to find savings or boost revenues. Rather than starting with cutting back physician compensation or trying to bring in more patients, hospitals may want to consider supply chain automation.

Virginia Mason Medical Center in Seattle focused on automation in an endeavor to become more efficient. Milrose Mercado, Virginia Mason’s administrative director of supply chain management, said the hospital’s efforts to reduce manual order entries have decreased waste on transactions and provided the organization with a greater amount of data, which makes it easier to spot inefficiencies.

The hospital will soon be implementing a “perpetual inventory” system, which Mercado said allows administrators to see exactly what products are on hand at any given time, reducing overstocking and eliminating the problem of expired stock.

Expired stock is a prevalent problem in healthcare. Organizations have a tendency to overstock rather than understock—but most products have limited shelf lives, so overstocking can lead to waste.

Mike Deluca, senior director of supply chain solutions and consulting services at the University of Pittsburgh Medical Center (UPMC), said the need to have the right supplies on hand has typically been an excuse for hospitals to stock too much of everything. This not only leads to the problem of expired products, but it also means hospitals are devoting valuable space to storing unnecessary items.

“There’s not a problem of having the right product at the right time,” Deluca said. “There’s a problem of having too much product all over the health system without any tracking or controls.”

To try to solve this problem, UPMC consolidated all purchasing into a centralized department. This made it easier to eliminate pockets of buying among the health system’s various departments and automated greater pieces of the procurement process. The system commercialized its supply chain services in 2008 with the creation of Prodigo Solutions, which is still affiliated with UPMC. The company helps other hospitals follow a similar path toward contract compliance, automation and improved data quality throughout procurement.
Deluca said eliminating manual ordering helps hospitals prepare for health reform by enabling them to understand the true cost of treating patients. Few providers have a true understanding of their supply costs, which makes it impossible for them to charge uniform rates for care. This is part of the reason why costs differ so much from hospital to hospital and physician to physician. But when orders are digitized, it allows administrators to analyze costs more closely and helps them start to squeeze out variations.

Understanding where variations in costs come from is important now, but it will become even more important in the future as providers are increasingly moved to global or capitated payment systems.

“Not only do we have to get the care right, and not only do we have to take care of a patient both inside the hospital and when they leave, but we also have to make sure that from procedure to procedure we are coming up with an average cost and holding physicians accountable for that cost,” Deluca said.

But supply chain automation isn’t just about reducing costs. Karen Conway, executive director of industry relations at trade exchange vendor GHX, said supply chain sits at the intersection of cost and quality. By getting automation right, hospitals can improve care.

For example, automating the ordering of implantable devices—such as hip and knee replacements and cardiac rhythm management devices or stents—could support value-based purchasing quality improvement initiatives. Additionally, Conway said these devices, especially orthopedic implants, often come with many ancillary parts, all of which make tracking usage complex. Still, nurses and device representatives are forced to manually write down items used, including lot and serial numbers, to track orders and make sure everything is ready for surgeries.

There’s a lot of room for error in this process, Conway said, but eliminating it is key to meeting requirements of health reform that task hospitals with improving cost transparency and taking a population health approach. Accurate documentation improves adverse event reporting and helps clinicians gauge quality among specific patient populations.

“If we’re not doing the basics right, we’ll never get there,” Conway said.

Hospitals are increasingly catching on to the importance of supply chain automation, she added. But data remains unstandardized and integrating procurement systems with EHRs and practice management systems remains a barrier that must be broken.

ED BURNS covers health care technology for SearchHealthIT.com. Prior to joining the site, he wrote news stories for a variety of health care clients covering areas such as information technology, wellness, insurance and behavioral health.
Healthcare organizations are slowly, but surely, making headway in implementing many different initiatives. From EHR implementations, health information exchange, ICD-10 conversion, and meaningful use mandates to data privacy and security regulations, IT experts are expected to remain on top of the latest requirements. In the opening months of 2013, the federal government offered providers a number of resources to ease the strain of new technology and workflow adoption. In addition, the government implemented legislative measures to keep IT leaders accountable to policy.

This exclusive SearchHealthIT infographic summarizes what resources are available, from tools to improve HIE and meaningful use audits, to the final installment of the HIPAA omnibus rule and updated certification standards for EHRs.

EMILY HUIZENGA is a SearchHealthIT editorial assistant.
New Resources for Providers

CONNECT 4.0: Federal Health Architecture releases CONNECT 4.0 global open source platform for secure HIE; provides more flexibility and supports federal IT rules like meaningful use stage 2

TIP SHEET: CMS issues tip sheet on changes to stage 1 measures and specialist tip sheet to help specialty providers meet meaningful use requirements, navigare EHR incentive programs

RURAL WEBPAGE: ONC’s critical access hospitals and rural hospitals toolkit. Guide to HIE, ROI calculator, information on the DIRECT Project, policy recommendations, privacy and security requirements.

STAGE 2 TOOLKIT: CMS’s Medicare and Medicaid EHR Incentive Programs: Stage 2 Toolkit reviews meaningful use regulations, stage 1 impact and FAQs on payment adjustments, hardships exemptions.

Policy Updates

HIPAA OMNIBUS RULE
ONC’s final rule for HITECH Act strengthens privacy and security protections for health information established under HIPAA.

MORE ELIGIBLE PHYSICIANS
CMS: 15,600 physicians, previously excluded from Medicare EHR Incentive Program due to a claims processing limitation, are now eligible.

STAGE 3 ON HOLD
Health IT Standards Committee discussed meaningful use stage 3 draft requirements, but proposed rulemaking will not be used during 2013.

PRE-PAYMENT AUDITS
5-10% of CMS audit providers attested to meaningful use in January 2013, selecting at random and by suspicious data.

104 Venture Capital Funding Deals in Q1 2013
Compared to quarters 1-4 of 2012, venture capital funding deals in Q1 2013 have more than doubled.

Source: Mercom Capital
Seeking Public Comment:
CMS and ONC Request Public Feedback

ONC seeks feedback on “National Action Plan to Support Consumer Engagement via E-Health”

ONC collects comments on “EHR Interoperability Intake” certification scenario

CMS seeks public ideas on electronic and interoperable HIE acceleration

Gravitytank wins best overall design of patient-centered health record in ONC’s Health Design Challenge

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COVER IMAGE: FUSE/THINKSTOCK