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Mark Masselli: This is Conversations on Health Care. I am Mark Masselli.

Margaret Flinter: And I am Margret Flinter.

Mark Masselli: Well Margaret, moreover changes at the top of the Department of Health and Human Services, Susannah Fox has been named Chief Technology Officer at HHS, she replaces outgoing Bryan Sivak both of whom have been guest on our show.

Margaret Flinter: Susannah Fox is a self described geek but beyond her substantial abilities understanding health information technology and the impact of the internet on modern healthcare. She really understands how that data translates to the human experience.

Mark Masselli: You know she spend more than a decade the Pew Resort Center doing longitudinal studies and how computers and internet have impacted human behavior highly respected entity in the data world.

Margaret Flinter: But also HHS Secretary Sylvia Mathews Burwell, lot of disappointment saying that Fox will bring her commitment to effective and responsible use of technology throughout the healthcare sector.

Mark Masselli: And Fox says she plans to advance the open health data, initiative at HHS as well as generate more innovation through the idea lab.

Margaret Flinter: And speaking of health data and health information technology the nations practices are preparing to switch October 1 from the long used ICD-9 coding system to the ICD-10 which is expected to bring much rich or more specific health data into the spotlight.

Mark Masselli: We are going to highlight the work of WEDI which is the Work Group for Electronic Data Interchange. We have with us, today Jim Daley who is the immediate past chair, the organization was created by the department of Health and Human Services to find ways to improve the use of health IT to facilitate better health information exchange. He'll talk about the challenges to getting the medical establishment to embrace the switch over to ICD-10.

Margaret Flinter: And Lori Robertson will check in, the Managing Editor of Factcheck.org is always on the hunt for misstatements spoken about health and health policy in the public domain.

Mark Masselli: But no matter what the topic he can hear all of our shows, by going to see to chcradio.com as always if you have comments please e-mail us

at chcradio@chc1.com or find us on Facebook or twitter we love hearing from you.

Margaret Flinter: We will get to our interview with Jim Daley in just a moment.

Mark Masselli: But first, here is our producer, Marianne O'Hare with this week's Headline News.

(Music)

Marianne O'Hare: I am Marianne O'Hare with these Health Care Headlines. South Korea is attempting to clamp down on an outbreak of MERS a virus that first emerged in the Middle East that is particularly deadly. A largest outbreak outside the Middle East and hundreds of schools in that country have been closed as a precaution. Several people have died in the outbreak so far, states are raising for decision from the Supreme Court and the King vs, Burwell case which challenges the legality of the tax subsidies being used offset purchase of insurance, an estimated 8.2 million Americans could lose coverage across the country. If a high court decides in favor of the plaintiffs.

Los Angeles has launched a program aimed of getting chronically ill patients who are homeless into better care management that actually saves money by providing them housing in a newly erected facility. They're also gives these expensive patients access to better preventive care, star apartments funded by the Skid Row Housing Trust gives the chronically ill homeless an apartment and access to care coordination to better manage their conditions and keep them from costly hospital visits. Currently 700 have received such housing in the pilot program another1500 are slated to be housed next.

Today's teens are living, what might be happily described is a virtual life spending a good portion of their time online. So it's natural, that's where they go and searching for health information. The report teens health and technology took an expensive look at teen internet behavior and found well, four in five teens used the internet to research various health conditions they aren't likely to believe that information. Where did they think to most reliable health information comes from? From their parent even in the digital age mama still knows best. I am Marianne O'Hare with these Health Care Headlines.

(Music)

Mark Masselli: We are speaking today with Jim Daley immediate past chair of the Work Group for Electronic Data Interchange or WEDI leading authority on the use of health IT to improve health information exchange, improve efficiency and reduce cost in healthcare. Mr. Daley is an expert on ICD-10 readiness as well as HIPAA compliance issues. He's clearly serving as the Director of IT for BlueCross, BlueShield of South Carolina. He also serves BlueCross nationally

ad founded the BlueCross corporation information security counsel, Mr. Daley received his degree in engineering at the University of Connecticut and served as a commission officer in the US army, Jim welcome to Conversations on Health Care.

Jim Daley. Well thank you Mark. It's pleasure to be here today.

Mark Masselli: Yeah, you know, I'm going to sort of set the stage because you know WEDI is formed back in 1991 by then secretary Sullivan out of the Department of Health and Human Services to explore ways to enhance health information systems. Can you tell our listeners give us the sort of bigger picture fill in the details of how the mission is evolved and as we enter now a much more sophisticated digital age in health care./

Jim Daley: WEDI has a diverse membership we have over 300 corporate members. Our memberships are providers, software vendors, health plans government agencies such as CMS Department of Defense, state Medicaids and many industry associations. Our mission was and it's still is to provide an unbiased consensus based industry position on how best to move information healthcare in efficient in effective manner while protecting a privacy of individuals. One of the first challenges we face was to have the industry adopt standardized electronic transactions for things such as claims, noted to reduce or eliminate the use of paper forms and phone calls.

With the passes of HIPAA and the subsequent regulations the transformation was set in motion. In 2013 on the 20th anniversary of the 1993 WEDI report which really kicked all us off we published a new report looking at what the industry had accomplished in the last 20 years taking into account that many things have changed since 1993. The players essentially the same and much of the information is the same. But now there's an increase focus on the patient, and of course there's an abundance of new technology such as mobile devices. But regardless of all that our mission is still to make all this work smoothly and securely.

Margaret Flinter: But now we have got another challenge on the horizon in front of us and I know this has been an important topic for you. This is this issue of the pending switch to the ICD-10 health billing codes, this is really the nature of how we describe what it is that the patient has, what the condition is with real specificity. And while most developed countries in the world already use ICD-10 codes, the switch over in this country is about 30 years behind the times and has been delayed. So you have been analyzing and writing about the need for ICD-10 coding since the early 2000s, tell us why you saw this as such a vital issue so early on?

Jim Daley: The current ICD-9 coding system as you indicated is over 30 years old. In that time many new surgical techniques have been developed, new

diseases have been identified, such as AIDS for one, West Nile virus things of that nature. ICD-10 captures that new information including any underlying causes and severity of diseases, so that adds to greater understanding of what's actually causing that particular disease to occur. One other example the diabetes category has been expanded to provide a much more detailed description of the type and cause of the illness for the facilitate population health studies which will lead to identifying better treatments, by understanding the specifics of the patient's condition. ICD-10 also going to provide detail needed to track outbreaks of new diseases and to facilitate a more rapid response, Ebola being one of those items. Many of the new codes in ICD-10 were created to allow capture basic information and talk about how many codes on ICD-10. But some basic things like laterality, left side or right side, but that's something basic that should already be included in clinical documentation. Many of the ICD-10 enhancements were made it to request a physicians because they wanted to capture this more detailed information is important in treatment as a patients.

Mark Masselli: You know, there's sort of seems to be some controversy within the industry we have the director of the American Health Information Management Association on talking about the nations practices, spent time and money on this. But she said a majority of the practices were prepared to do so but your organization WEDI has been conducting ICD-10 readiness surveys for the past several years. And according to your surveys many practices really aren't ready to make the switch, give our listeners the sense of the sort of complications in cost around what -- what is the difficult issue to understand but you know may be give some flavor for what's happening there amongst healthcare organizations.

Jim Daley: Just several main barriers but one it's a very large effort for some organizations particularly the physicians groups don't see the value and it certainly not in a immediate value in it you don't implement ICD-10 on Monday and on Tuesday all of a sudden your finances are better or you have more time to treat patients or something like that. So it's a longer term benefit so without that short term gain there is reluctance to move forward, and everyone seems to be dealing with a multitude of other mandate whether it's a implementing the Affordable Care Act or quality measures meaningful use of the electronic health records. Now the larger organizations they have continued to move forward and have completed or nearly completed their work, they are doing final testing with their trading partners. But it's a matter of priorities and resources, physicians they are focused on other mandates and they still have the hope that the data will change again, but I crossing them don't bet your business on that.

Margaret Flinter: Jim, I want to talk about another area of interest at WEDI and that's supporting the growth of an infrastructure that supports health information exchanges. And most of the nation's hospitals and practices now have switched to electronic health records which is remarkable in and of itself but we still have this issue of communicating information systems that aren't really equipped to

talk to each other and there's illusive concept of interoperability. And one of the excuses people give for lack of interoperability is concerned over violating HIPAA regulations what you see is the hurdles to achieving this interoperability and the exchange of information and what are you doing to advance and support that, if you have any best practices that you'd like to share with our listeners.

Jim Daley: The primary issue is the systems are not interoperable, as you mentioned even within the same facility, some facilities have over 100 systems and they don't talk to each other. There's two aspects to interoperability, first you have to be able to send the information from one point to another, but secondly and equally important it must be understandable and useable by the receiver. So health care terminology and the data needs to be standardized so the sender and receiver can communicate effectively. Our 2013 WEDI report identified data harmonization as a major area for action, and WEDI's working with Louis W. Sullivan Institute for Healthcare innovation to form a work group to examine this further but it's going to be been an industry initiative not just a WEDI initiative we all need to work together on this.

Mark Masselli: We are speaking today with Jim Daley, immediate past chair of the Work Group for Electronic Data Interchange or WEDI a leading authority on the use of health IT to improve health information exchange. Mr. Daley is an expert on ICD-10 readiness as well as HIPAA compliance issues. He's currently serving as the director of IT for BlueCross BlueShield of South Carolina, Jim let's take a look at the exploiting world of health information technology. You know health care this whole area is still emerging and it raises a number of problems because it doesn't have really the sophistication that the banking world does, it raises a whole another set of issues and we have seen this, there have been major data breeches some of the nations largest healthcare and insurance providers. Can you give an assessment how is the health IT industry recalibrating to handle the growing demands of health information technology, and the very real cyber security issues that have emerged from sort of a new industry.

Jim Daley: First of all as a mind of information increases exponentially there is a corresponding amount of information at risk. Don't be alarm of this but I always say the best way to totally secure information is to turn off your computer and place it in the secure lock facility. Even then of course it could still be compromise if the device was stolen. The award is a benefit of having the information being able to share it and use it, the risk could be disclosed all sorts of destroyed. But to mitigate that to a several methods and one of the primary ones is to encryption.

But there's other methods like having effective processes to control access to the information. In the past, primary cause of data breaches was human behavior like losing your computer or smart phone, just countless devices left in airports when you go through security, they leave their smart phones or laptops there.

But recently, very recently, malicious hacking surpassed that for the first time. Bigger organizations, they have got special software to identify and block these attempts to look at network device behavior and set off an alarm that something strange occurs like an unusual amount of information being uploaded to an Internet site. But it's important for everybody to be weary of scams like links and suspicious e-mails. People should avoid using public Wi-Fi if they intent to access anything confidential or enter your passwords and login names, and I do want to reemphasized the importance of using encryption. The more difficult you make it someone to steal your information the less likely they will be successful.

Margaret Flinter: Well, now that we have terrified everybody with the nefarious possibilities around their electronic health records, I want to go back up to the big visions and goals. And may be on a positive note ask you to comment on the elements of transition to this ICD-10 that really are about the greater good. And the compelling reason that has been put forward repeatedly about the switch to the ICD-10 is it really stance to make a contribution to public health to global health and to health quality, what's the connection, how is it going to do that?

Jim Daley: The World Health Organization created the ICD code to classify diseases, and ICD-10 is their 10th version of that classification. But other countries including the U.S. have created more detailed expansions of that of that base set, our version is called ICD-10-CM to show it's our Clinical Modification, but it's still based on that WHO base set of codes. We also created a separate set of codes ICD-10-PCS to identify surgical procedures. With this, we can now identify things like implanted devices, surgical complications, and a lot of other clinically significant details that we couldn't captured in the ICD-9. By using the common set of codes into national community, they can share information that will lead to better outcome. And importantly as well, you can track disease outbreaks like the recent Ebola crisis and (inaudible 15:17) to take quick reaction. We can identify who, where, when someone has a disease and link up together to say an outbreak is occurring, it looks like it started here, and these are the points where it's manifesting itself across the country or across the globe. And again, as times goes on, we will be able to measure the effectiveness of various treatments and compare them to international results and identify what's really the best way to treat specific diseases.

Mark Masselli: Jim, you have just mentioned that the World Health Organization and they are obviously already working on ICD-11, and while we are still struggling here in the United States, they get through ICD-10. Some have suggested that we skip ICD-10. So are there things we should be thinking now about in terms of ICD-11 that are being overlooked with a current struggles to implement ICD-10?

Jim Daley: Well, ICD-11 is still a long way off. Once it becomes available, currently it's projected for 2017, but the U.S. will make its clinical modifications to add the details we need, and then you need the regulatory process to begin to

propose adoption go through all of that. Some estimate that that entire process could take well over a decade which at a minimum would places at 2027. ICD-10 is necessary step in moving to ICD-11. So well, industry need to focus efforts on completing ICD-10 implementation, it would be worthwhile for some groups to take a look at what's been propose for ICD-11 and be involved in that dialogue.

Margaret Flinter: Well Jim, when we look to the future, obviously, health information technology is just fueling so exciting in dramatic change and so many facets of the industry, and particularly around patients being engaged in their own care through remote monitoring and communication, Telehealth. Now I understand at WEDI that you assisted the U.S. Government Accountability Office on the potential of one such innovation using electronically readable Medicare cards, what was the outcome of that particular study, and what other potential game changing technologies do you see as poised to help streamline care delivery, make care better for patients, providers and the society as a whole?

Jim Daley: The purpose of the study was to determine if it was feasible to use electronically readable cards to replace the paper cards that have your Social Security Numbers on the front, using the electronic method to reduced a potential for fraud would help protect people by removing display of their SSN. The study concluded the benefits would depend on what processes could or would be automated by using the cards. But eventually, we may not need these ID cards per se if people start to use smart phones, tablets, wearable devices. So everything we need to store or share or may be handled through one of those devices, may be a single device that we choose. Recently saw a credit card computer, credit card size, you can put in your wallet, and it can do some basic functions.

WEDI with the Sullivan Institute we are working together to do something called the Virtual Clipboard Project to develop a mobile app and eliminate the manual capture of ID card information and use a clipboards. When you visit the doctor, a lot of times you have to enter your demographic and medical history information (inaudible 18:20) every time you visit, and you may not even consistently enter the same data. The Virtual Clipboard eventually can be integrated into the providers' workflow, trigger an eligibility request and subsequent says this we plan to incorporate features such as medication list and allergies, all of that good information you won't have to enter remember and provide to the provider.

Our initial stage is schedule for later this year, beyond the traditional encounter we may have our health continually monitored through wearables or even implantable devices, and we can receive an alert if something looks suspicious. Now much of this technology is not really available but may not be in widespread use at this point. Many people they are very willing to use these wearables to monitor fitness activity, but are they willing to have a device that tells them they have had too much sugar already and shouldn't have desert. That's the big

question. So it's certainly is exciting time to be in health care and I look forward to what might be coming down the road.

Mark Masselli: We have been speaking with Jim Daley, Immediate Past Chair of the Workgroup for Electronic Data Interchange or WEDI. You can learn more about their work by going to www.wedi.org or you can follow them on Twitter at WEDI online. Jim, thanks so much for joining us on Conversations on Health Care today.

Jim Daley: Thank you for inviting me. It was my pleasure.

(Music)

Mark Masselli: At Conversations on Health Care, we want our audience to be truly in the know when it comes to the facts about health care reform and policy. Lori Robertson is an award-winning journalist and managing editor of FactCheck.org, a nonpartisan, nonprofit consumer advocate for voters that aim to reduce the level of deception in U.S. politics. Lori, what have you got for us this week?

Lori Robertson: Lawmakers of both parties have made misleading claims about the government interfering with women's ability to get mammograms. The claim stem from new draft recommendations from the U.S. Preventive Services Task Force, the task force examines peer reviewed evidence and makes recommendations to help doctors and patients make decisions on preventive services. The task force has latest draft recommendations on mammography are virtually unchanged from its 2009 recommendation. They recommend biannual mammography for women ages 50 to 74 who are not at high risk of breast cancer. For women age 40 to 49, the decision to have a mammogram "should be an individual one," and the task force says there was insufficient evidence to evaluate benefits and harms for women 75 and older. The recommendation for women in their 40s was controversial to some lawmakers and cancer groups who recommended yearly mammograms. But there is a new wrinkle in how they impact the Affordable Care Act.

The law ties the task force's recommendations to requirements on insurance companies to cover certain preventive services with no cost sharing. If the draft recommendations become final, insurers no longer would be required to cover annual mammograms for free for women age 40 to 49. That doesn't mean that insurance companies wouldn't cover mammogram, the ACAs requirements are minimum standard and plenty of insurers covered mammograms for 40-year-old women before the ACA but with co-pays. Some of the claims we have seen misplaced the blame for a change in insurance requirements on the preventive services task force which doesn't issue any kind of insurance mandate. Instead it was lawmaker who added a provision to ACA tying the task force as the future

recommendations to coverage requirements in the law. And that's my fact check for this week. I am Lori Robertson, Managing Editor of FactCheck.org.

Margaret Flinter: FactCheck.org is committed to factual accuracy from the country's major political players and is a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact, that you would like checked, e-mail us at www.chcradio.com. We will have FactCheck.org's Lori Robertson check it out for you here on Conversations on Health Care.

(Music)

Mark Masselli: Each week, Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. Depression is extremely common among adolescents in this country, but it's often hard to differentiate between typically teen angst in a clinical condition that requires more intermediate intervention. Suicide is the third leading cause of death among 10 to 24-year-olds, a population that almost ubiquitously uses texting as a form of communication. Nancy Lublin is the CEO of Crisis Text Line an instant texting service design to encourage teens in crisis to reach out for health which they receive instantly.

Nancy Lublin: Texting is a fantastic way to communicate with young people so it has a huge open rates and it's really fast. But has it's one way of side effect where we are the only brands that they text with. You know, you really only text with your family and friends, and so and us and do something. And so because people texted with us they felt really comfortable, and they started sending us things that we were shocking like I don't want to go to school tomorrow because I am being bullied or about being cutting.

Mark Masselli: All they have to do is the text the numbers 741741.

Nancy Lublin: So if you're someone who is in pain you texted us, and then the councilor on the other side is not working from a phone they are on the screen that almost looks kind of like Facebook or Gmail. When messages come in with certain keywords in them they automatically get tagged as high risk. So we don't take them chronologically. If you are at risk for suicide, you are automatically bumped up in the queue and you are like the code red, you have flagged in our system.

Mark Masselli: Since she founded crisis text, the word has spread like wild fire. They receive an average of 15,000 text per day from kids experiencing everything from typical teen dilemmas such as a fight with the boyfriend, to kids contemplating suicide.

Nancy Lublin: And the supervisor would determine whether or not this person with the eminent harm, whether they have (a) a plan and (b) the means then we will trigger an active rescue.

Mark Masselli: Crisis Text Line, an instant age appropriate intervention available free of charge at 24x7 to give kids in crisis a lifeline. Now that's a bright idea.

(Music)

Margaret Flinter: This is Conversations on Health Care. I am Margaret Flinter.

Mark Masselli: And I am Mark Masselli, peace and health.

Conversations on Health Care, broadcast from the campus of WESU at Wesleyan University, streaming live at www.wesufm.org and brought to you by the Community Health Center.