

**Recommendations from the  
Information Systems Workgroup**

**A Report to the  
Indian Health Leadership Council**

**Presented  
September 16, 1998**

*Amended Sept. 17, 1998*

## Forward

In the summer of 1998, the Indian Health Leadership Council (IHLC) chartered an Information Systems Workgroup (ISW) to provide recommendations in seven critical areas of concern. Their decision was based on commentary received from Tribes, Urban programs and IHS staff recommending areas for improvement in the overall information systems of the Indian health program. Seven specific charges were identified for the workgroup addressing the immediate concerns of the Indian Health Service, Tribal health, and Urban health (I/T/U) community.

1. Information Resource Mgmt. (IRM) -Tribal Negotiations guide,
2. IRM Strategic Plan,
3. Information for HQ's Core Functions,
4. Integration of Clinical and Fiscal Information,
5. IRM Management,
6. Immediate Third Party Billing Needs,
7. Establishment of an Information Systems Advisory Committee.

This short-term workgroup would be dissolved upon completion of the work. Longer-term issues were to be defined for further analysis by an Information Systems Advisory Committee (ISAC) that would be formed as a result of the ISW recommendations.

The ISW met and corresponded through out the summer. The ISW coordinated and combined the results from other workgroups charged with addressing similar issues. The results of the discussions are contained in the recommendations for each charge. In addition, recommendations that were broad in nature were also included in an "Additional Recommendations" section. Also included is an "Appendix" section, which provides further background or detail with documents that were used or generated by the workgroup.

## Background

In the rapidly changing Indian health system of Tribal, IHS and Urban programs (I/T/U), it is critical to supply the information needed for effective health care and management of resources at the I/T/U level. This information is equally important for IHS HQ to perform its core functions. Determining which information systems are required to meet these needs and how IHS will participate with Tribal and Urban partners to assure availability of essential information is vital. If the essential information and the system requirements are not in place, and if a plan to provide for this is not developed, then IHS, Tribal, and Urban organizations will not be able to aggregate data effectively to demonstrate need for resources, to monitor health conditions, or to direct resources appropriately to improve patient care.

Numerous reports, studies and recommendations generated in the recent years have described improvement strategies for the overall IHS information systems. It is our conclusion that serious efforts must be undertaken by IHS leadership to assure improvements take place. Moreover, it is a fact, this function is critically vital for both patient care and administrative support, that leadership must carry it forward beyond the year 2000.

## **Assumptions**

1. The overall information system is not limited to the Division of Information Resources (DIR), but encompasses all levels of the I/T/U from local data generator through the Headquarters data user;
2. Contracting and compacting will continue to be an available option for the Tribes;
3. There is a need to more effectively integrate the Urban health programs into the Indian health information system infrastructure;
4. The IHS appropriations will not afford new resources for information systems;
5. The I/T/U will be increasingly dependant on collections from third parties;
6. IHS will not get a waiver from HCFA for the APG/APC implementation deadline of Jan. 1, 1999;
7. Areas Offices will continue to seek shared services agreements with other areas as appropriate;
8. New information requirements such as GPRA, ORYX, will continue and increase;
9. The Government Computer-based Patient Record standards will be applied to IHS when implemented;
10. The present RPMS software environment will be maintained, with migration to a standard graphical user interface as resources allow; and
11. The ISW recommendations will be written to address the short-term immediate information systems needs of the I/T/U, including infrastructure. Additional work by the ISAC will be required for the longer-term solutions.

## Membership

The membership of the ISW included:

<b>Keith Longie,</b> Dir. Planning, Evaluation and Information Resources, IHS Phoenix Area Office	<b>Margo Kerrigan,</b> Area Director, IHS California Area Office
<b>Bob Whitener,</b> General Manager, Squaxin Island Tribe	<b>Garfield Littlelight,</b> Executive Officer, Billings Area, NCEO Rep.
<b>Doni Wilder,</b> Exec. Director, NW Portland Area Indian Health Board	<b>Richard Church,</b> Director, Division of Information Resources IHS Office of Management Support
<b>Tony D'Angelo,</b> Principal Statistician, IHS Office of Public Health	<b>Seh Welch,</b> Director, American Indian Health & Svcs, Urban Representative
<b>Dale Armstrong,</b> Chief Dental Officer, IHS Navajo Area Office	<b>Stan Griffith,</b> IHS Office of Public Health

## **Charge 1. IRM -Tribal Negotiations Guide**

### **Charge:**

- Recommendations for a guide to be used by the IHS and Tribes for self determination and self governance negotiations, that describes programs, functions, services, and activities under respective budget items, and the resources currently dedicated to providing these services

### **Background:**

- IHS and Tribal negotiators had expressed their concern over the difficulty understanding, explaining and negotiating IRM shares. They expressed a need for a clear, concise and simple guide to be used in negotiations, to enable the Tribes to make an informed choice when considering IRM shares.

### **Recommendation:**

- Complete the Simplified Negotiations Guide (example included in Appendix):
  - The financial sheet simplifies the existing 34 choices down to 4 major categories:
    - National Database Repository,
    - Telecommunications,
    - RPMS Software Development and Maintenance,
    - RPMS Systems Support and Training.
  - Treat elements as all inclusive, i.e. includes all functional costs regardless of location;
  - Description of the inter-relationship of IRM functions at local, Area and national levels;
  - Includes a Frequently Asked Questions (FAQ) section that gives Tribes a case study example of IRM functions, e.g.,
    - “What functions should we leave if we wanted to participate in ORYX?”
    - “What do we leave if we wanted to be included in the IHS’ report to Congress?”
  - Consult and review draft guide with Tribal and IHS negotiators
- Develop and provide an IRM training session for IHS and Tribal negotiators in an open forum.

### **Responsibility:**

- DIR, Self-Governance Team

### **Due:**

- November, 1998 for discussion at fall Self-Governance Conference

## **Charge 2. IRM Strategic Plan**

### **Charge**

- Review and comment on the draft strategic plan for IRM

### **Background**

- Does the Agency have an IRM strategic plan addressing the needs of the I/T/U?

### **Discussion:**

A strategic plan should layout a roadmap of future goals, directions and activities based on the consultation of the stakeholders (I/T/U). The Information Technology Management and Reform Act (ITMRA) requires the development of an agency strategic plan.

We have reviewed the existing IRM strategic plan and found that although it provides a clear idea of agency activity to an audience above the agency within the Department, there needs to be effort devoted to developing an IRM strategic plan for and with the I/T/U customers. Significant sections of the plan are included in the appendix.

### **Recommendation:**

- Expand the existing IRM strategic plan with the appropriate participation of the I/T/U.

### **Responsibility:**

- This plan should be developed and guided by the Information Systems Advisory Committee (see recommendation # 7) with broad input from the I/T/U.

### **Due:**

- Fall, 1999

### Charge 3. Information Needed for HQ's Core Functions

#### Charge:

- Description of information needed by IHS HQ to carry out its residual functions of health leadership, advocacy, policy development, and budget formulation and execution.

#### Background:

The IHS performs certain functions in carrying out its mission to the American Indian and Alaska Native (AI/AN) population that can only be effectively performed by a single entity. These are national-level or "non-divisible" functions. They are non-divisible mainly for technical reasons (i.e., it is not feasible for the function to be performed by multiple parties) or occasionally for efficiency reasons (i.e., the economies of scale are so great that performance of the function by multiple parties would be cost prohibitive). Some of these non-divisible functions are inherently federal or residual. Formulating the agency budget is an example of a non-divisible function that is also residual. On the other hand, advocating for the agency budget to the Department of Health and Human Services (HHS) and the Office of Management and Budget (OMB) is not residual, but it is non-divisible since it cannot be readily and effectively done separately by the various contracting and compacting Tribes.

Key non-divisible functions include:

- ✓ Reports to Congress e.g., Government Performance and Results Act, Indian Health Care Improvement Act,
- ✓ Budget formulation
- ✓ Budget justification
- ✓ Strategic planning
- ✓ Program evaluation and performance measurement
- ✓ Reports to OMB (e.g., Accountability Report)
- ✓ Reports to HHS (e.g., Healthy People 2000)

#### Discussion:

The IHS requires aggregate program and administrative data to adequately perform non-divisible functions. This is a finding of various IHS, Tribal, and Urban (I/T/U) groups over the last several years. The **Baseline Measures Workgroup** strongly recommended in the mutual self-interest of all "to preserve a recognition of an AI/AN specific health care agenda at the national level". In addition to "maintain a unified data system that is useful to advocate effectively for AI/AN people" on both a local and national basis. The **Data Policy Roundtable** also endorsed the concept of aggregate program and administrative data.

The Data Policy Roundtable, however, clarified "aggregate data does not necessarily have to be in a centralized database, but that it is important that it be easily accessible in a user-friendly format for planning, budgeting, and advocacy of the Indian health care delivery system on the local, regional, and national levels." Their suggestions for aggregating data included housing the data in a central and/or regional repositories or

pulling the data directly from local databases. The Data Policy Roundtable recognized the need for the establishment of standards associated with an aggregate database. Along these lines, they recommended the development of a uniform data set. This would be a subset of data collected at the facility level that needs to be aggregated for national and local planning and advocacy purposes. The data set would include only essential, non-burdensome data to be used by those providers who choose to participate. The Roundtable also recommended that, along with the uniform data set, data content and transmission standards be adopted to ensure that aggregate data are comparable and can be transmitted between systems, independent of hardware and software configurations.

The IHS currently aggregates program data in its central database in Albuquerque, NM. The IHS is in the process of upgrading this central database via a database conversion that entails new hardware and software. Due to this effort and investment, IHS has committed for the short term in the continuance of a central database approach for aggregating data. However, IHS is not wedded to a central database in the long term or to IHS operation of a central database in Albuquerque. IHS believes that aggregate data are essential to the successful management of the I/T/U system, but that there are several viable ways of achieving aggregate data, as indicated previously.

Operation of the IHS central database was originally classified by IHS as being not inherently federal and therefore, non-residual. However it is recognized as a core Headquarters function. IHS further made the resources for central database operation available as Tribal shares. This has caused two main problems:

- 1) Most Tribes that have taken these shares still want to participate in the IHS central database; and
- 2) It is becoming increasingly difficult to properly operate the central database for those that have left their shares given a budget affected by shrinking Congressional appropriations and opted for Tribal shares.

Some have questioned whether the operation of the IHS central database should continue to be classified as non-residual. Most would agree that the operation of the IHS central database is not inherently federal, since a contractor could successfully operate it. However, the key issue is whether the operation is divisible, i.e., whether individual contractors and compactors can take their Tribal shares and separately operate the central database. It is clear that the operation of a central database or the aggregation of data from various sites can only be effectively achieved through one entity. Therefore, it can be argued that although the operation of the IHS central database is not inherently federal and therefore non-residual, the operations budget is not divisible and therefore does not lend itself to Tribal shares.

#### *Types of Data that Should be Aggregated*

The types of data needed to successfully perform the non-divisible functions include both program and administrative sets. IHS is in the process of addressing administrative data needs through the development of a cost accounting system. The program data needs were previously defined through the publication of **Core Data Set Requirements** in January 1994. However, this program data set does not correspond to current needs.

In order to respond to non-divisible issues, IHS needs at a minimum:

- ✓ Patient Counts & Demographics;
- ✓ Workload Counts;
- ✓ Types Of Health Services Provided (e.g., Inpatient, Ambulatory Patient Care, Dental, Ancillary, Community Health);
- ✓ Purpose of Visit and/or Health Condition (e.g., Diagnoses, Procedures, Clinic Type);
- ✓ Provider Type;
- ✓ Location Of Visit, etc.,

**Recommendation:**

- The ISAC through an I/T/U sub-committee should analyze these data requirements and develop a uniform data set that incorporates these essential data elements as recommended by the Data Policy Roundtable; and
- The ISAC should reassess the central database activities available for tribal shares.

**Due:**

- Fall, 1999

## **Charge 4. Integration of Clinical and Fiscal Information**

### **Charge:**

- Definition of clinical and fiscal integration required to accommodate billing and revenue needs, budget needs, and clinical and public health data needs.

### **Discussion:**

The Indian Health Service (IHS) has a good program database and a good administrative database, but not a good integrated program – administrative database. We define program data as data that characterizes the health services that the Indian health system provides. Administrative data is data that identifies the costs of operating the Indian health system. Different parties are involved in collecting these data and maintaining the databases. The program database is primarily maintained in Albuquerque and the administrative database is primarily maintained in Rockville, Maryland.

#### *Need to Integrate Program and Administrative Data*

The Indian health system has been under budget constraints for the last several years, and this is likely to continue in the immediate future. The Indian health system is being pressured to increase efficiency and to find more effective ways of providing and purchasing health services. This requires resource management and resource management requires cost accounting information on the actual costs of providing different types of health services under various conditions.

Sound cost accounting information is essential to a wide range of activities. These include:

- determining the proper amount to bill for services,
- evaluating alternative ways of providing services,
- analyzing the costs and benefits of moving into new markets,
- strategic and operational planning,
- budget formulation,
- conducting performance measurement (e.g., GPRA, baseline measures), and
- determining more effective delivery systems.

#### *Achieving Integrated Program and Administrative Data*

The IHS is currently determining the requirements for a cost accounting system under contract. Such a system will entail linking the program and administrative databases. The coding systems used in the two databases will either need to be made compatible or crosswalks will need to be developed. This, in particular, involves the location or facility codes. Also, costs will need to be associated with functions and services. This will enable costs to be associated with the running of a department (e.g., the nursing department) and the providing of a service (e.g., a dental examination).

Mitretek provided the IHLC an in-depth analysis of the IHS business and IRM operations and recommended sweeping changes at every level. Although the Mitretek recommen-

dations surpassed cost accounting and seemed overwhelming, but taken in achievable steps, most if not all of the recommendations can be achieved

**Recommendations:**

- In the short term, efforts should be taken to achieve an integration of the clinical, financial and personnel systems through an Executive Information System, to provide essential day-to-day management information for management at all levels.
- Recommend the continued long-term effort to improve the Agency's business operations as a priority task, using the Mitretek recommendations as a guide.

**Responsibility:**

- This is considered cross cutting issue beyond the scope of an information resources management activity involving both administrative and clinical functions. The leadership should come from the highest levels of the IHS with input from the I/T/U.

**Due:**

- Short Term: Fall, 1999
- Long Term: FY 2002

## **Charge 5. The Management of the IHS Information Resources Program**

### **Charge:**

- Recommendations for management and staffing infrastructure to meet the IHS Information System needs;

### **Background:**

At the time the Workgroup was charged by IHLC, it was hoped that our recommendations could be consistent with the Indian Health Design Team's Blueprint initiative under the auspices of the Director of Headquarters Operations. The Blueprint recommendations were not available to the Workgroup at this time.

### **Discussion:**

Overall, the Workgroup observed a lack of continuity in leadership and management in the new Division of Information Resources (DIR). The Director, DIR, had been detailed for a period exceeding three years to other critical assignments, with the concurrent assignment to an acting Director, DIR. All the while, the demands for information resource management were increasing. The Tribal Self-Governance Demonstration Project, and the recent amendments to the P.L. 93-638 contracting process, resulted in the complete information management systems function being available for Tribal shares with the exception of a small contract that supports Headquarters office automation.

Other initiatives also competed for scarce Headquarters resources. These include, but are not limited to administrative requirements associated with self-determination; growing demands associated with the National Performance Review, e.g., Government Performance and Results Act (GPRA), Information Management and Reform Act (ITMRA), Departmental Initiatives, Quality of Work Life; requirements for increased collaboration with other Departments and Agencies; the explosion of new technology; and the dramatic increase in the implementation, availability, and use of information technology throughout all IHS levels. This created an overwhelming situation. In addition, due to downsizing, the DIR suffered a significant loss of talented staff along with their essential knowledge, skills and abilities in this highly technical area. The Workgroup discussed staffing patterns and identified critical vacancies that must be filled immediately. Although contracting for additional staff has alleviated some of the problems, management attention is needed to address key problems and priorities.

The Workgroup reviewed the current organizational infrastructure and placement of the Division of Information Resources (DIR) recently published in the Federal Register.

### *Management Infrastructure:*

The operational aspect of DIR is located at the Information Technology Support Center in Albuquerque, New Mexico.

□ The Workgroup recommends improvement of the vertical involvement of IHS managers in the information systems function. If the primary function of DIR is to issue policy, procedures and standards to the field, then accordingly, the ISW recommends that the DIR begin use of a framework that governs policies and procedures issued as guidance's in accordance with IHS policy practices, to assure managerial and technological understanding. The current infrastructure of DIR includes the following Directives, Delegations Of Authority, and Agency Designations:

- IHS Circular 70-1: Development of Automated Data Processing dated 12/15/71;
- IHS Circular 93-6; Automated Information Systems Security Program dated 9/10/93;
- Part 5, Chapter 5, Section 12; Automated Data Processing and Telecommunications Contracting dated 9/30/94
- Part 5, Chapter 17, Acquisition of Federal Information Processing Resources RESERVED by not filled
- #4 Program DOA P.L. 94-437, Indian Health Care Improvement Act
- #10 Program DOA
- #35 Administrative / Contracting DOA to Grant Exceptions to Exec. Order 12845 Requiring Agencies to Purchase Energy Efficient Computers
- Designation of the Agency Senior Information Resources Management Official
- Designation of the Agency Senior Information Resources Management Liaison to the Veteran's Administration and Department of Defense
- Designation of the Agency Information Systems Security Officer
- #2 Administrative /Contracting DOA for Acquisition of ADP Equipment, Software, Maintenance, Services, and Support Services
- Designation of the Agency Telecommunications Liaison

The ISW did note the existence of several "information system guides" targeted to end-users. However, it is difficult to ensure uniform distribution to IHS managers. The practice of issuing such guides without an Agency-wide review and comment period, as appropriate, omits IHS managers from providing feedback on the prescribed practices in those guides or the resources necessary to carry out the activities. Whenever a new guide is issued, it is difficult to ascertain which previously issued guides are obsolete and/or superceded.

### *Staffing:*

There are 5 operational teams in the DIR primarily located at the Albuquerque Information Technology Support Center, which is staffed by 52 federal and 55 contract FTE for a total of 107 staff in all Headquarters locations including Rockville, Albuquerque and Tucson, as of September 1998. The Division of Information Resources includes:

- **Self-Determination Services Team.**
  - Develops policies and related materials to support tribal operations of information management activities and services
- **Applications Software Development and Support Team**
  - (1) Designs, develops/purchases, implements and supports application software and related services used in the IHS, tribal, and Urban Indian health programs;
  - National Patient Information Reporting System (formerly known as the "Data Center") Maintains and operates the aggregate Indian Health program and administrative data base
- **Telecommunications Management Team.**
  - (1) Develops and implements policies, procedures, and standards for telecommunication services in the IHS; (2) designs, develops/purchases, implements and supports telecommunication services used in the IHS, tribal and Urban Indian health programs;
- **Computer Systems Management Team.**
  - (1) Develops and implements policies, procedures, and standards for computer systems management activities and services in the IHS; (2) designs, develops/purchases, implements, and supports computer systems used in the IHS; (3) provides computer systems services and support to IHS, tribal and Urban Indian health programs;

## **Recommendations:**

The IHS Information Systems Workgroup makes the following recommendations in the spirit of revitalizing collective information systems that will best serve the I/T/Us with the balance of resources retained after tribal shares

1. The Workgroup recommends improvement of the vertical involvement of managers in the information systems function. Accordingly, the Workgroup recommends that the DIR begin use of a framework that governs policies and procedures issued as guidances in accordance with IHS policy practices, to assure managerial and technological understanding.

### **Due:**

☐ Spring, 1999

2. The workgroup recommends that an information systems component be integrated with management in the coordination, planning, implementation, and training process of current and future information requirements. Management across all levels of the organization needs to become more aware and knowledgeable of their own information operations and current and future requirements. The trend in the federal government and in the private sector is to combine the broad technical and management requirements in interfacing with organizational direction by establishing an Area Chief Information Officer (CIO) *in each Area*.

**Due:**

- Fall, 1999

***Staffing & Management of IRM:***

The Workgroup understands the need for responsiveness to external authorities, however, it is recommended that equal or greater priority be placed on internal customers, i.e. the I/T/U

***Short Term for Immediate Implementation:***

- Placement (through hire or reassignment) of a qualified full time manager at the Albuquerque Information Technology Support Center to provide leadership and direction to the operating teams, and to provide the point of contact for Area leadership to resolve immediate issues.
  - This manager must have the administrative and budget authority and responsibility to resolve issues locally. This position will provide support to the reorganization transition identified below.

**Due:**

- As soon as possible

***Near Term Recommendations for Organizational and Structural Improvement:***

- Assess the Division of Information Resources based on the support requirement of the intended customers (I/T/U):
  - Need to ensure that there is an effective separation of policy from field operations and support functions with adequate overall direction,
  - Need to re-examine location of field operations and support functions and whether they are Headquarters or field focused. This should be consistent with the IHDT Blue Print committee principles;
  - Need to develop a Resource Requirement Module for Area Offices and I/T/U Service Units that specifies level of staffing for the IRM functions, services and activities and to be carried out at each level.

**Due:**

- Fall, 1999

## **Charge 6. Immediate Third Party Billing Needs**

### **Charge:**

- Immediate solutions to resolving data issues and needs related to the implementation of Ambulatory Patient Groups (APGs) and to Medicaid collections in New Mexico;

### **Discussion:**

The Business Office Coordinators led by Elmer Brewster have been addressing this problem and have developed a set of recommendations for implementation IHS wide to meet the established APG target date of 1-1-99.

In the Balance Budget Act of 1997, Congress directed the Health Care Financing Administration (HCFA) to implement a new Prospective Payment System (PPS) for hospital outpatient department services. HCFA responded by completing the development of the Ambulatory Patient Grouping/Ambulatory Payment Classification (APG/APC) system. This new process applies only to Hospital outpatient services and does not effect the billing and reimbursement process for Hospital Inpatient stays.

In the past, the IHS has billed Medicare using an all-inclusive rate, although the tribally operated programs could choose to use an alternative billing method. Urbans do not have access to the all-inclusive rate. This method of billing required only limited information from the IHS database, (patient, date of service, diagnosis, provider), thus limiting the need of documentation of procedures. The new PPS billing/payment system allows for payment to providers based on actual procedures performed. This method will require that all services rendered during a visit be coded using the industry standards (Common Procedural Coding System, CPT).

### **Recommendations:**

- The ISW workgroup reviewed and supports the Business Office Coordinators task group recommendations as contained in the Appendix and summarized here:

In order to accommodate HCFA's new requirements, ensure a smooth transition to the new way of billing Medicare, and limit any disruption of reimbursements, the I/T/U must begin to address the key components and process changes needed for implementation of this new system. Collection of CPT codes will be in addition to the ICD-9-CM procedure codes. ICD-9-CM codes are needed for statistical, epidemiological, and research purposes to be consistent with the Centers for Disease Control and Prevention and its National Center for Health Statistics. Continuity in data coding in the Patient Care Component (PCC) is required for effective planning and advocacy activities.

**TRAINING:** Training will be an ongoing requirement for all to fully understand the process changes. The following are examples of training courses that are required to fully implement this new process:

- APG/APC Educational Awareness and Training (National, Area, Service Units)
- Correct Coding Initiatives (CPT, ICD-9, ADA, DSM, Medical Terminology, etc.) (PCC Data Entry, Business Office, and Medical Records Staff)
- Patient Care Component Data Entry Version 2.0 (PCC Data Entry and Business Office Staff)
- Provider Documentation (All Providers)

**DOCUMENTATION:** Provider documentation is the foundation for accurate coding and maximum billing and collections. Currently, the norm for Indian Health Service, Urban and Tribal Facilities is to use a Superbill to capture procedures performed on Private Insurance patients only. This is not sufficient to accommodate the new billing requirements.

- Ensure all inpatient, ER, and outpatient visits are completely, legibly, and accurately documented in the Medical Record.
- Review various methods of documentation, i.e., dictation, scribe, revised PCC form, superbills, etc.
- Require the Development and Implementation of Superbills / Charge tickets for all Clinics for all Patients
- Input all Diagnosis and Procedures (CPT and ICD-9-CM) for all Patients in the database (PCC)

**SYSTEM CHANGES** - Several system modifications need to take place to enhance the capabilities of streamlining an automated billing process. Currently, some I/T facilities utilize the Centralized Data Center for billing purposes, and others use the RPMS Third Party Billing Package to bill Medicare directly, while some, in particular Urban programs, are using commercial off-the-shelf software or outside billing service. Regardless of the method used to bill, the following changes are imperative to the transition to the new coding system:

- Development and release of PCC Data Entry Version 2.0. This new version will allow for CPT (in addition to ICD-9-CM) procedures to be directly entered and extracted for billing purposes.
- Data Export from Service Units to Area to Data Center needs to include CPT (in addition to ICD-9-CM) Procedures.
- Data Center files need to be modified to accept CPT (in addition to ICD-9-CM) Procedures from the Data Export.
- Data Center billing process needs to be modified to include CPT Procedures to be sent to BC/BS of Texas for processing.
- Develop an interface between 3M Health Data Management System (Encoder).

- **Standardization of Software Utilized.** Field programs are currently using too many versions of existing software, which increases the amount of unnecessary programming and support needed. Areas will need to assure that all RPMS software is current and up-to-date within 62 days of software release.
- **Separate Field Support from Software Development.** This is necessary to ensure that equal time and effort is given to these important activities.

#### **OTHER CONSIDERATIONS:**

- **Staffing** - Due to increased documentation, data input, and direct billing (optional) staffing levels could be a factor. If departments are understaffed now, the new billing and payment method will intensify the existing problems. A planning team review of the current and projected workload should take place considering the following facility positions: Certified Coding Specialists, Exit Staff (accuracy of documentation), Data Entry Staff, Business Office Staff, and Provider Staff.
- **Consolidated Effort** - In order for this new process to succeed, it will take the cooperation of all facility departments. Every department must contribute their share. The APG process represents a major change to the entire facility, including clinical, administrative, and management. Each facility/area should develop an implementation team to meet all requirements of change. This team should consist of representatives from all disciplines at the facility and area level.
- **Business Office Operations Support** - Support and utilize Area/Field expertise to assist with Technical Assistance, Training, Medical Billing Relief, Fee Schedule Development, Superbill development and implementation, System requirements/development, etc.

#### **Recommendations:**

- The Information Systems Workgroup endorse the recommendations of the Business Office Coordinators.

##### **Due:**

- Fall, 1998, (immediately)
- Leadership for the implementation needs to come from the National Council of Executive Officers, Area and Service Unit Directors and Chief Medical Officers in consultation with Tribal and Urban representatives.

## **Charge 7. Establishment of an Information Systems Advisory Committee**

### **Charge:**

- Recommendations for establishment of an ISAC including membership, charter and accountability.

### **Discussion:**

- The charter for the Information Systems Advisory Committee has been written and is in draft for review and comment

### **Recommendation:**

Recommend approval of the draft ISAC charter.

### **Due:**

- Fall, 1999

## **INFORMATION SYSTEMS ADVISORY COMMITTEE TO THE INDIAN HEALTH SERVICE CHARTER**

### **Preamble**

The Information Systems Advisory Committee (ISAC) is established to guide the development of a co-owned and co-managed Indian health information infrastructure and information systems. The goal of the ISAC is to assure the creation of flexible and dynamic information systems that assist in the management and delivery of health care and contribute to the elevation of the health status of Indian people. The ISAC will assist in insuring that information systems are available, accessible, useful, cost effective, and user friendly for local level providers, while continuing to create standardized aggregate data that supports advocacy for Indian health programs at the national level. In recognition of the fact that the health care delivery environment and the information technologies that support it are rapidly changing, the ISAC will be flexible in interpretation of the roles and rules of this document, and revise them as necessary to best meet its goal.

### **Authority**

The ISAC will report to the Director of the Indian Health Service. The ISAC will carry out such responsibilities and authorities as provided in this charter and delegated to it, in writing, by the Director of the Indian Health Service. The ISAC will be administratively accountable to the Director, Headquarters Operations.

### **Charge**

The Information Systems Advisory Committee is charged to:

1. Advise the Indian Health Service Director on direction, priorities and resource allocation for information systems through review and approval of the IHS Information Resources Management Strategic Plan.
2. Annually prioritize key issues in information systems to be addressed by the IHS.
3. Develop an open process, relationship, and environment which supports collaboration between tribal and Urban programs and the IHS in information system development.
4. Develop a process for working cooperatively with states and other federal agencies to share activities and costs to meet the information systems needs of Indian communities.
5. Provide advocacy and support for IHS, Tribal and Urban information resource management partnerships.
6. Coordinate the development of standard data sets, disseminate information regarding the status of existing data sets, and market the need for maintaining standardized aggregate data.
7. Establish and appoint ad-hoc technical workgroups composed of industry experts, and representatives of Indian health programs to advise on and perform activities dealing with current information technology issues, such as the Year 2000 remediation (Y2K)
8. Communicate and report to all I/T/U constituents.
9. Advocate for resources for needed information systems.

## **ACTIVITIES**

The Information Systems Advisory Committee will meet no less than twice annually for no less than two full days to carry out its responsibilities. Special meetings may be called by the Director of IHS or by the Co-Chairs. Minutes documenting action items and responsibilities will be produced within 15 working days following each meeting and distributed to ISAC and published on the IHS external web page.

## **STRUCTURE**

Permanent Members of the ISAC include:

- Indian Health Service Chief Information Officer
- A Board Member of the National Indian Health Board
- A Member of the Self-Governance Advisory Committee
- A Board Member of the National Council of Urban Indian Health
- A Member of the National Council of Executive Officers
- A Member of one of the national clinical councils
- A representative from Office of Environmental Health

## **Chair**

At the first meeting of each calendar year, the members of the ISAC will by majority vote, select two Co-Chairs to serve for a one-year term.

## **ADDITIONAL MEMBERSHIP**

An additional ten - (10) members will be appointed to serve staggered two-year terms. The ratio of tribal to IHS representatives will match the current ratio of IHS direct service delivery programs to tribally operated programs in federally appropriated budget dollars. At least one member will represent those Tribes that are primarily receiving their health services through the IHS direct service delivery program until such time as the Indian Health program is fully compacted or contracted. An IHS and tribal representative from the same service unit / facility location can not serve at the same time on the ISAC. Attention will be given to providing for a diversity of perspective in terms of geography, size of program, and mode of service and/or contracting instrument. The Director, Indian Health Service will appoint the representatives based on recommendations submitted by IHS Area Directors, Area health boards, and individual Tribal and Urban organizations. Officially appointed members will designate, in writing, an alternate who will be an official voting member in the absence of the member.

## **Changes in Membership**

Current members who desire to end their term of service will request resignation through the ISAC, to the Director, IHS, in writing. The ISAC may recommend to the Director, IHS, the replacement of any member missing two consecutive committee meetings.

## **STAFF SUPPORT**

Staff support will be coordinated by the IHS Division of Information Resources and could include personnel from IHS, Tribal and Urban programs.

## **DECISION-MAKING**

A quorum will exist when over half of the tribal representatives and over half of the IHS representatives are present. Decisions will be by consensus of those present at each meeting. If a consensus cannot be reached the pros and cons of opposing arguments will be submitted in advice to the IHS Director and documented in the minutes.

**AGENDA SETTING AND SUBMISSION OF ISSUES FOR CONSIDERATION**

The ISAC Co-Chairs will jointly establish meeting agendas. Issue papers should be submitted for consideration on the agenda in the format of Background; Issues/Alternatives; financial costs, benefits, impacts; and recommendations. Agendas will be distributed to ISAC members at least 15 working days prior to meeting.

**Charter REVIEW**

This Charter will be reviewed on a bi-annual basis to evaluate its effectiveness and incorporate any improvements. Changes to the Charter must be approved by a 2/3 majority vote of the ISAC.

Adopted xx/xx/xx

# Appendix

# Appendix Tab 1

## Information Systems Workgroup Charge Memo

Appendix Tab 2  
Record of Meeting:  
Indian Health Leadership Council

## Appendix Tab 3 Draft Negotiations Guide

## Appendix Tab 4

### **IHS Ambulatory Patient Grouping / Ambulatory Payment Classification (APG/APC) Implementation Guidelines**

## Appendix Tab 5

### Selected Excerpts from IRM Strategic Plan