



STATE OF WASHINGTON
DEPARTMENT OF HEALTH
Office of the Secretary
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January 12th, 2024
Department of Health and Human Services
National Committee on Vital and Health Statistics
3311 Toledo Road
Hyattsville, Maryland 20782

Re: Request for Information addressing the potential use of ICD–11 for morbidity coding in the U.S.

The Washington State Department of Health (DOH) offers the following comments in response to the questions posed in the Request for Information from the Department of Health and Human Services, National Committee on Vital and Health Statistics (NCVHS) Workgroup to Inform International Classification of Diseases (ICD) 11 Policy, published October 16, 2023 (88 FR 71369). As a public health agency, DOH operationalizes the ICD at the state level for recording, reporting, and monitoring diseases to support our national vital statistics system.

1. Related to ICD–11 content and addressing U.S.-specific needs, which enhancements in classification content would be most useful?

a. Coding to assess and address population health equity, social, behavioral, and community health

The codes to assess social determinants of health (QD71: Problems associated with housing or QD60: Problems associated with inadequate drinking water) address the need of diagnosis codes for social factors determining health of a person. The codes that have been defined may fulfill most of the stratification needs, but the social factors may need to be updated after pilot implementation if there are gaps in the assessment of social factors affecting health.

b. Coding to measure health care quality and patient safety

The safety of medical devices and environmental factors have been covered well. Aspects related to health care quality could be more specific and well differentiated.

c. Coding for rare diseases

Rare disease and new disease codes are well covered.

d. Content on other topics

Some diseases that were categorized by the body location have been re-categorized to different groups by etiopathology. This may or may not be significant depending upon the context. For example, some re-

categorization would matter more in terms of statistical calculations whereas some others may matter more in terms of reimbursement (although not directly in scope for National Vital Statistics System).

2. What is the potential to reduce burdens and improve quality/accuracy through the greater automation offered by the ICD–11 online classification systems?

Assuming that cause of death coding would still be done at Centers for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS), the algorithm could be automated to increase accuracy and timeliness.

a. How might automation reduce burdens of clinical documentation and coding for reimbursement, risk adjustment, clinical registry, and public health reporting?

If a tool was available that was able to code death certificates in a timely manner, it would be helpful for monitoring trends near real-time without relying on laborious text mining or NCHS. The tool would be beneficial if the processing speed is faster than the existing Application Programming Interface (API), similar to the tool developed by the World Health Organization (WHO). If, however, this is tool that will mirror WHO's API for coding single records with ICD10s, the value is limited as it is time consuming to code even a few hundred records.

b. What might be the role of artificial intelligence for your organization?

Currently, master person indexing and linkage work is being done at DOH.

c. What might be the role of standardized cross-maps to other coding systems?

Cross-maps to ICD-9 and SNOMED CT would be useful and very helpful for some workflows at the agency. They will mostly be used in the estimation of morbidity and syndromic surveillance reports and perform comparative analysis against definitive diagnosis coded in ICD 11.

d. What other potential features could promote burden reduction?

If the computability of ICD-11 system makes it easier to implement on a terminology service, this would help in the automation and burden reduction processes.

3. What standards, systems, workforce, and processes must change to accommodate ICD–11?

DOH would have to update all the flags, code, and standards used for monitoring everything from drug overdoses to influenza reporting to match the new codes. Based on the current processes, text mining and use of 'regex' is the preferred method to assign codes. This might be more complicated with the new code format. As an alternative, standing up a terminology service and mapping text to terminology would be a simpler approach.

a. How would your organization assess the cost and impact of these changes?

Increase of FTE's dedicated to handling coding issue from ICD-11 evolve over time. There are also the requirements of DOH vendors to consider. Vendors will likely require a contract for maintenance and transition of systems within our database to adapt to ICD-11.

4. What are the most important considerations and requirements for a U.S. governing body for ICD–11?

For implementation of ICD-11 at DOH, guidance on the recommended modalities, methods, and architecture would be helpful.

c. Ongoing management and maintenance of U.S. ICD–11 and its use.

On-going maintenance, quality assurance and system management will be required so the plan needs to be in place beforehand.

5. What financial, educational, or human resources will be needed for:

a. Implementing ICD–11 in your organization.

Technical documentation and resources for database updates, system implementations and terminology services set up will be part of the implementation plan.

b. Managing and maintaining U.S. ICD–11 in your organization.

On-going maintenance, quality assurance and system management will be required so the plan needs to be in place beforehand.

c. Meeting the needs of smaller, less resourced, or less externally supported entities.

Education and support systems will be needed for the smaller entities to ensure mortality reporting is set up correctly.

Thank you for the opportunity to provide comments on the proposed rules.

A handwritten signature in blue ink, appearing to read 'Bryant Karras', with a stylized flourish at the end.

Bryant Thomas Karras M.D.
Chief Medical Informatics Officer
Office of Innovation and Technology

Cc: Les Becker, Deputy Secretary for Innovation