Needed: Data Content Standards. Data Content Standards Streamline Data Reporting for Performance Measurement Initiatives

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Many performance measurement data collection and reporting initiatives are under way both nationally and locally through public and private partnerships. Healthcare providers are asked, and often required, to collect and report data for quality, public health, performance, and financial measurements. This article outlines how data content standards can streamline data reporting for performance measurement initiatives.

Missing: Data Standards

There is a recognized lack of industry data standards that contain definitions and taxonomy for all metrics. For example, national patient safety goals (Joint Commission on Accreditation of Healthcare Organizations, Leapfrog, Institute for Safe Medication Practices, Institute for Healthcare Improvement, National Quality Forum) each have different statements of intent, an absence of data element definition, staffing requirements, and so on. This void in data standards results in:

- Difficult data acquisition from electronic systems
- Multiple disparate systems within a healthcare organization, which may not communicate with each other, complicating data-mining and coordination efforts
- Labor-intensive data-mapping efforts by healthcare providers to link systems and performance measurement data requirements
- Disparate information systems within and between healthcare organizations
- Conflicts between administrative data sets (e.g., CPT G-codes do not cross-reference to HCPCS G-codes)

Variations that may exist at the data element and data definition level include:

- Variations in data element descriptive titles or field names for the same fields (e.g., gen*der versus administrative sex*).
- Differences in data element definitions or values across measures and performance measurement systems. For example, system A may have four options to select from when entering the gender of a patient: male, female, other, unknown; while system B may only have two, male and female.
- Discrepancies in data element formats for similar fields across performance measurement systems (e.g., mm/dd/yy, mm/dd/yyyy, mm/yy).
- Disparate sources in the medical documentation from which measurement data can be retrieved (e.g., physician progress notes, physician orders, history and physical, and so on).
- Variations in the kinds of care provider whose documentation can be referenced when abstracting data. For example, some data element definitions allow the abstractor to collect data only from physician documentation, but other systems may allow nursing, physician assistant, and nurse practitioner documentation.
- Discrepancies between software products used for data collection. For example, some data collection software products incorporate system edits that disable specific data fields or entire measures based on algorithms, while others do not.
- Differences in the granularity of data submitted (e.g., patient-specific data, aggregated results).

What Can HIM Professionals Do?

AHIMA is involved in efforts to standardize the data used for performance measurement by monitoring and supporting key industry efforts, researching the variations among performance measurement systems, and providing content expertise. In

November 2006 the Agency for Healthcare Research and Quality (AHRQ) partnered with AHIMA's Foundation of Research and Education and the Medical Group Management Association Center for Research to host an invitational summit on healthcare data collection and reporting. The final report from that meeting is scheduled to be delivered to AHRQ later this month and then made available to the public.

AHIMA is also closely monitoring the activities of the American Health Information Community quality work group and the AQA/HQA collaborative efforts, offering professional resources to support these efforts. Additionally, AHIMA is working to position its members in the industry, build AHIMA work products into industry standards, and advance the electronic health record, personal health record, and national health information network initiatives.

In the meantime, HIM professionals need to be involved in defining and standardizing the data elements used in their organizations. You can find more information in the February 2006 practice brief "Guidelines for Developing a Data Dictionary" available online in the FORE Library: HIM Body of Knowledge at www.ahima.org.

Supporting Health IT at the Highest Level

On August 22, 2006, President Bush signed an executive order supporting the promotion of quality and efficient healthcare in federal government-administered or -sponsored healthcare programs. The president requested federal agencies implement health information technology for the direct exchange of health information and programs measuring the quality of services provided to beneficiaries or enrollees of the federal healthcare system. This directive sends a powerful message to the healthcare community that quality of care and the implementation of health IT offer a window of opportunity to develop work in a collaborative environment and to initiate a dialogue among thought leaders in the quality community.[1]

Note

1. President of the United States. "Executive Order: Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs." August 22, 2006. Available online at www.whitehouse.gov/news/releases/2006/08/20060822-2.html.

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