No Downhill Coast for Data Standards

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by Dan Rode, MBA, FHFMA

As committees meet, there is tension between gathering data and reworking process.

A summit is a high point. The problem is that many expect the road to be downhill all the way after a summit. In the case of this summer's summit on health information technology, the nation isn't ready for a downhill cruise, particularly given the need for the healthcare community to collect data for population health improvement. This article highlights the tension between collecting health data and building the interoperability, infrastructure, and processes necessary to see the goals of population health improvement achieved.

Much has been written about the electronic health record (EHR) standard and the need for a national health information infrastructure (NHII). In the last decade, numerous reports from the Institute of Medicine have called for a variety of information changes to ensure the elimination of medical errors and the improvement of patient care. Across the country, various employer groups have been formed to address the issues of medical error and quality improvement.

Each of these activities relies on healthcare data, information, or medical records. As technologies have improved, it is reasonable to expect that data related to these quality issues should be collected at the source and used at the source and in aggregate to improve patient care.

While one sector is looking at data for information on quality of care, another, public health, is looking for data that can identify situations that could endanger the health of the community. When disease outbreaks occur, there can be great challenges in obtaining the right data and providing the correct remedy to contain the outbreaks and treat the sick. Public health professionals also collect data on immunizations and similar information to understand how best to inform the public when outbreaks occur.

As more individuals become part of the information exchange through their personal health records, the amount of data that can be collected becomes even greater, the value of the data becomes more vital, and interoperability and the process of collecting the data become more difficult.

Unfortunately, the information paths for public health data are not smooth and not necessarily connected. The links between healthcare professionals and local and state health departments are tenuous at best. And the connections between states or between states and the federal government leave a lot to be desired. Certainly, the Centers for Disease Control and Prevention (CDC) have been addressing this issue, but the CDC's National Electronic Disease Surveillance System (or NEDSS) is still in its infancy. While money has been provided to states to increase their ability to collect bioterrorism data, the funds have not been used wisely and the information highway remains unbuilt.

Data Collection: Process versus Results

In recent meetings of two federal agencies, a new issue has surfaced. Tension surrounds collecting healthcare data for an immediate or short-term resolution of a healthcare problem (e.g., improvement of care for diabetes or chronic disease) versus spending time to construct a data collection process that includes standardized healthcare data terms and definitions. The discussion was initiated earlier in 2004 when the National Committee on Vital and Health Statistics (NCVHS) work group issued its paper "Measuring Health Care Quality."[1]

In June the NCVHS work group held hearings on the paper's recommendations.[2] It heard from a number of healthcare sectors regarding the need for the collection of data and some of the problems encountered in today's environment of piecemeal data. Before the hearings, AHIMA had approached the work group to suggest that it address the data collection processes that are paper-based or in the process between paper and the EHR. AHIMA noted that while institutions with an electronic record indicated that data collection was not difficult, most healthcare providers were not using such a record.

AHIMA also raised the need for standardized data and data definitions, noting that many providers will be expected to provide data for quality improvement, medical error reduction and reporting, public health reporting, bioterrorism reporting, as well as for reimbursement and research. AHIMA also noted that use of the ICD-10-CM and ICD-10-PCS classification systems would impart a much richer data set that could be used for a variety of quality and public health purposes.

AHIMA urged the work group to convene the various entities that are working to collect healthcare data and develop a consensus on data and data definitions to meet their requirements. The association noted that providers and healthcare data suppliers do not want to be faced with overlapping data requirements that include different definitions or terminology. Moreover, AHIMA noted that in addition to “quality” groups, public health, homeland security, and other federal and state agencies are also seeking healthcare data.

Data Collection and the EHR

Similar issues have appeared in discussions at the Agency for Health Research and Quality (AHRQ). In July AHIMA was invited to attend a small AHRQ conference to address the role of the HL7 EHR standard in the collection of data for quality and medical errors. That same month the AHRQ advisory committee discussed this issue and others regarding the agency’s role with quality data. Like the NCVHS work group, the committee also revealed the tension between data collection now, with potential results and goals achieved in just a few years, versus working to develop a process to facilitate richer and potentially more efficient data collection in the future through local and national data exchanges. This discussion will continue in the fall and during the coming year.

While these federal advisory committees discussed data for quality measurements and medical error detection, Congress took steps forward in this direction. In July the Senate passed the Patient Safety and Quality Improvement Act (S. 720). This legislation establishes a confidential and voluntary reporting system of medical errors, seen by the Senate as a step to improve patient safety. The bill requires the development or adoption of voluntary national standards within three years and that collection occur electronically. The bill must be reconciled with a similar House bill passed in March. There is a good chance that these bills will become law by the end of the year.

The August meeting of the National Uniform Billing Committee (NUBC) included discussion of a request by the Consumer-Purchaser Disclosure Project for certain data quality elements to be included in the NUBC 2004 version of its data set. Across a variety of providers, communities, and states, the discussion continues on what data to collect, how it will be collected, and how it will be reported. These discussions require significant HIM professional involvement. Currently there is little knowledge outside of HIM circles on how data is originated, collected, verified, and forwarded and why there are inconsistencies in the data. The external demand for such data may be concurrent, within hours, or post-discharge or post-billing. The internal needs for such data may conflict with the external needs for such data. A variety of attempts have been made in the last few years for novel, less painful methods of data collection. Most have been connected with billing, yet the claim form is not necessarily the best means of transmitting data.

Nationally, AHIMA is working with government and private agencies to address the problems of data collection beyond the claims data now in existence. As work continues on how the new HL7 EHR standard will function, the requirements for data collection will be kept in mind. AHIMA is also involved in discussions and planning for data collection efforts and especially advocating for the standardization of data and data definitions. AHIMA continues to make the case for the final adoption of ICD-10-CM and -PCS, pointing out the inconsistency between requestors’ demand for information on quality data while ignoring the detail that could easily be provided by these modern and detailed classification systems.

It might be nice to think these issues can be resolved on a national basis; however, this will not be the case. Many electronic information exchange processes will be developed on a local basis, and this effort is already under way in many communities. HIM professionals must get involved in this development and planning so that the exchange systems and processes work with both existing paper and future EHR systems. While communities must agree on what data should be collected, HIM professionals can help determine how it will be collected and transmitted. Without HIM involvement in these local, state, and national efforts, the environment tomorrow could be more difficult than today.

Take steps to get involved in the building of this information exchange. Join the leaders in your community to ensure that data standards and the EHR standard are implemented. Let your community leaders and state and federal representatives know that while you support efforts to improve quality and protect public health, you also need them to ensure that standards are in place to ensure data integrity, privacy, and a process that will achieve these

Notes

1. National Committee on Vital and Health Statistics (NCVHS), Workgroup on Quality. “Measuring Health Care Quality: Obstacles and Opportunities.” Available online at www.ncvhs.hhs.gov/040531rp.pdf.
2. NCVHS, Workgroup on Quality. “Department of Health and Human Services, National Committee on Vital and Health Statistics Workgroup on Quality, June 24, 2004.” Available online at http://ncvhs.hhs.gov/040624tr.htm.
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