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MS. DOUGHERTY: My name is Michelle Dougherty. I'm from the American Health Information Management Association and I'm going to talk about the quality of data and some data issues: quality measurement and performance measurement from the record manager's perspective [and] the information manager's perspective. There are two really key emerging issues that we're seeing that I want to get on the table for today. I want to backtrack for just one second, however, and weigh in on the discussion about the privacy rules.

Some of you may be interested in knowing that the Office of the National Coordinator for HIT [Health Information Technology] issued a contract to evaluate the state and federal, or, I should say, the state privacy rules to see if there was a way to establish policies at the health information exchange level that would be stringent enough to allow information to cross over state boundaries; not having to change the laws themselves, but to actually set the standard of practice at a level that would be adequate. So there's a contract, or a project, right now in research to see if it's even possible to come up with some consistent standards or policies. So it's one other option to throw in the ring of how we'll deal with some of the differing privacy issues that we're facing in health care.

The first thing that I wanted to talk about [is] where we are in the HR [health record] job duties. We have a number of discussions, some questions around, if health care just chose to spend enough money, they could buy that one killer application, you know, that would address the issues, that would implement the EHRs [electronic health record], fully functioning EHRs, [and] we'd get over this problem. That is just not the case.

I've worked quite a bit in the HIT [and] EHR standards area and what I can tell you is that we are really in kind of a state where we are, in a way, innovating. We can see this vision for EHRs. We can see its potential. We are kind of itching to try and use it in the right way and we are working with today's technology [to try] to work through all of these issues. As a result, we have begun this process in which our vision, what we are going to have for the next ten years, [is that] the leading technology today would likely be throw-away technology.

369

We are moving into more and more sophisticated EHR systems over time. Some of you might be surprised to realize that with the attitudes of, I should say, true HR penetration, where we talk about sophisticated point-of-care collection of data at the clinician level, only about ten percent of organizations, in terms of hospitals, ambulatory centers, or physicians' practices have what you might consider the real EHR, the one in which you're doing some type of a data collection.

There [are] clinical decisions to support at the point-of-care. We are able to do more sophisticated applications like e-prescribing or computerized physician's order entering. Some of the best and brightest are implementing those things and are figuring out how to do it. The majority of health care today [is] using some type of technology, and so in hospitals you'll see surveys that say EHR[s are] used. [D]epending on how the survey is defined, EHR use is up to fifty percent. Well, that survey could define it as essentially any type of information in an electronic way. It could be just collect[ing] demographic information. And so you see a threshold really high at fifty percent, but in ambulatory settings you see maybe twenty-five percent. They are doing some type of automated data collection, not necessarily our real picture for what EHRs should be able to do that the Institute of Medicine is going to define for us. I think that is where we are progressing to and my key point here is where we are today is really in a heightened state.

In reality, the majority are using bits and pieces of components and applications of EHR systems. They don't have a fully functioning EHR system to use and collect data and information and share all across the healthcare setting with a variety of different organizations. The theory that, or the thought, is that we have this yin [and] yang, that you just buy that great killer application [and] we can get it here very quickly—[it] is just not a reality.

The reality is, it's going to be a slow progress. The best way we can say it is that, [i]n a way, it's a migration path. We're going to take incremental steps in which provider settings, consumers, as well as vendors, keep moving along this process of getting a little farther with addressing some of the problems, addressing some of the technology issues that underpin EHR systems. We see that the standards today set a high level. [However,] we're using incremental steps to have vendors and providers have a common vision for where the EHR systems need go. That's where the federal government has come into play as well, as they use money here and there looking at certification standards, trying to move the healthcare industry along on the same pathway towards fully functioning EHRs.

I bring this up because, as we get into data collection issues and some of the foundational problems that we are seeing, the fact [is] that right now we really are in this hybrid state: we are partially collecting some information, but we really are collecting a lot of information on paper. [This is] still providing some level of challenges with the information that can be used for performance and quality measurement.

I want to talk about two critical data issues from an HIM [Health Information and Management] perspective: dealing with standardization of the performance or quality measuring data, the integrity or trustworthiness of the EHR systems that are out there today, and their ability to maintain what in the HIM world we call a legal business record. Some of those HIM business rules that we apply to recordkeeping aren't necessarily evident in the HR systems today, but need to be for our downstream use of the medical record.

So I put this slide in to illustrate what the big picture problem is with collecting performance and quality measuring data. By understanding and recognizing that we have a problem, we can start moving forward to fixing it. This slide came as a result o[f] permission from HealthPartners of Minnesota. They basically illustrate, [by] put[ting] together this mapping, all of the types of performance measurements or quality measurement data that they are required to report within their organization. I don't expect you to be able to read the fine details that are on this slide, but I wanted you just to get a feel for the proliferation of the problem.

As we recognize the value of the data that's in the EHR systems and we see all the potential uses for that data, there's an increase in the number of measurements and requirements for reporting for a variety of different purposes. The result is, measurements in which data is not collected in a consistent way haven't [been] defined. Different reporting mechanisms may use a single term, but define it differently so that you can collect it within an EHR system in one way and then distribute it across the different measurement sources or measurement targets that would [need] that information.

Another problem is that the different groups or organizations that want you to report measurement data have different file formats and different requirements for how the information is transmitted to the systems for transmitting that data. So providers are in a position of having to abstract from pure medical records in many [forms] of information, make the best judgment call they can and then get it off into a variety of different recording systems. It is certainly not the most efficient way to operate. So we see this big picture, we know where we want to go. We see the resource of data that EHRs can potentially give us, so then we need to deal with one of the source problems.

In order to get some of those action stems, what are those next things that we need to do to address this? Early in November, the Agency for Healthcare Research and Quality funded a summit that the HIMA [Health Industry Manufacturers Association] and the Medical Group Management Association spearheaded. Thought leaders from around the country that deal with performance of quality measurement data came together to identify all of the challenges and a number of the issues. [The summit also tried to] grow a map and build a consensus around the action steps; what do we do or what are our key priorities to help us build a foundation for getting accurate data that supports the performance and quality measurement systems that are out there.

So they came up with three key recommendations as a result of this. Number one was the data that's being collected needs to be built on standards. So whether it be standard data definitions, a minimum dataset of performance measurement or quality measurement data, I think one of the key underlying rules was we have to have some agreement on what the standards are in the data collection and the measurement domain.

The second recommendation or action item was the need for measured systems standardization so [that] systems are efficient and can improve over time. So whether that be varying different measurement systems that are out there, how they abstract data, what they're looking for, [or] how it's reported to them, there needs to be some level of standardization throughout across the system.

Then, obviously, there has to be active coordination and collaboration by all the parties involved. The summit created a short and a long-term time frame of goals or what they'd like to see. In the near term, in the next two years, I think it's just to organize and identify what the issues are, how to bring the parties to the table, and [determine] who are the parties that are there. They set a five-year goal as well to have harmonization. They're measures across the healthcare setting. So if you look at this slide at the far left-hand side there's what's called medical group level. Those are all the measures in this health partner's scenario that, at a physician practice level, they're required to report. So one of the goals in five years is to have those measures harmonized at least at the practice level, the practice setting. Their ten-year goal is to have harmonization for an encounter across care settings. So as you measure performance you measure quality for a consumer as they're moving in and out of health care across the various settings. How can you harmonize those measures? This way you can look longitudinally across an encounter. Right now we're not there, but those are some of the key goals.

The last thing that I want to talk about in the few minutes I have is an issue that came up today in terms of accuracy, in terms of trustworthiness

and integrity. In the HIM world, we talk about the legal record, the legal HR, and I'm a little nervous about bringing that term to you in this context because, of course, depending on your professional expertise, you're going to use that term in a little different way. From an HIM perspective when we talk about the legal business record, the legal business medical record, it's that medical record that we've said is a formal of representation of the care that was delivered, so we're required to disclose medical records. When we are required by regulations to catalog records, we need to define what that is.

In the paper world that was a really easy concept. It was the pages that fell in between the file folder and covers—that was our medical record. In the EHR system, that's a very difficult concept. When it comes to EHR, it's not everything that's in the box or everything that's in the database because a lot of data that's used in EHR systems is used for risk management [and] used for compliance. You may collect it once and use it in many different ways. You really have to figure out what the substantive data is that you will formally define as your medical record and that you'll use for some of those downstream uses, secondary uses that require disclosure of medical records.

I bring this up because in the paper world we have business rules that help maintain the integrity and trustworthiness of the medical record. We made sure there [is] transparency. If there was an error, if there was a correction, if there was an amendment, we can actually date it in time—those very logical things that have been the standard of practice for decades. And the EHR system is kind of like the wild, wild west right now because some of those standards aren't there.

EHR systems were created to address the point-of-care clinician needs. They were created with physicians and doctors in mind. They weren't created with HIM professionals and attorneys in mind who are using the downstream record to spread into business practices. So at the time we were creating the infrastructure of these vendor summary applications, they weren't thinking about records management issues, they weren't thinking about recordkeeping business rules. So things like audit trails and traceability and the proper way to amend and correct entries so that you can trust the information that's there isn't built into all of the software vendor applications that are out there.

I'll give you an example. There's one very major vendor in the ambulatory market, kind of the darling of the industry that has the functionality called Make Me the Author. One of our funny stories is of course that we know who the recorder is, who the author is. They sign the data. You can tell by their handwriting right away who that was. Well, in this Make Me the Author functionality, let's say a nurse dictated a note, but

374   Annals of Health Law   [Vol. 16

the doctor could take credit for it and wipe out the fact that a nurse wrote it and take credit for it. And you can see some potential downstream issues from a compliance perspective where they didn't do the work yet they're getting the professional fees for it. There's no evidence in the system at all that the physician was not the original author. So that's just one example of the need to establish some very critical business rules and functionality to make sure that EHR systems maintain a trustworthy electronic health record that can be used for a variety of different business rules and a variety of different business purposes.

So those are the key issues that I wanted to get on to your radar screen. They're definitely very emerging issues. I think where we're moving in health care now, we focus a lot on IT [information technology], [and] what the IT infrastructure is. The fact that now we are talking about information, health IM [information management], a lot more than health IT, I think is the progress that we're going to recognize—that it's all about the data. It's important that [the data] has integrity and trustworthiness in order to support a lot of the things [we] want to use it for in quality performance measurement. Thank you.