Testimony of the American Health Information Management Association
and the Medical Group Management Association
to the
Quality Workgroup of the National Committee on Vital and Health Statistics
June 19, 2007

Opening Comments
Chairman Carr, members of the Quality Workgroup, and ladies and gentlemen: On behalf of the American Health Information Management Association (AHIMA) and the Medical Group Management Association (MGMA), thank you for allowing us this opportunity to provide input on the challenges associated with collecting and reporting health care data.

About AHIMA
AHIMA is a not-for-profit professional association representing more than 51,000 health information management (HIM) professionals who work throughout the health care industry. AHIMA's HIM professionals are educated, trained and certified to serve the health care industry and the public by managing, analyzing, reporting, and using data vital for patient care, while making it accessible to health care providers and researchers.

The Foundation of Research and Education (FORE) is the charitable affiliate of AHIMA which provides financial and intellectual resources to sustain and recognize continuous innovation and advances in HIM for the betterment of the profession, health care, and the public.

AHIMA and its members participate in a variety of projects with other industry groups and federal agencies regarding the use of health care data for direct care, quality measurement, reimbursement, public health, patient safety, biosurveillance and research.

About MGMA
Since its founding in 1926, the MGMA has become the leading membership, education and research organization for professionals in medical practice management. MGMA's diverse membership includes administrators, CEOs and board members of health systems, physicians in management, office managers and many other management professionals from medical practices of all sizes and types, as well as from integrated health systems, hospital and medical school-affiliated practices and practice management organizations. MGMA's 21,000 members manage and lead more than 12,500 organizations, in which more than 270,000 physicians practice.

Founded in 1973 with funding from the W.K. Kellogg Foundation, the MGMA Center for Research (MGMA CFR) is organized as a 501(c) (3) tax-exempt charitable organization. The MGMA CFR mission, "To advance the art and science of medical group practice management to improve the health of our communities through health services research based largely in group practices and other health care delivery settings," defines the organization's scope of work.

AHRQ Conference on Health Care Data Collection and Reporting

On November 8 and 9, 2006, the Agency for Healthcare Research and Quality (AHRQ), in partnership with AHIMA and MGMA conducted the Conference on Health Care Data Collection and Reporting in Chicago. The conference brought together more than 50 experts (listed in the appendix of this testimony) from public and private health care organizations to address how to best collect and report data for quality, public health and performance incentives. The participants represented a wide array of stakeholders, including hospital and physician organizations, payers, employers, government agencies, accrediting agencies and other stakeholders with performance measurement and data management expertise.

Conference organizers set the objectives of:

- Describing the impact of federal policies on performance measurement data collection and reporting, including initiatives under development;
- Identifying data collection problems from the perspective of a variety of stakeholders;
- Establishing methods to gain commitment and consensus from all stakeholders to align performance measurement and data collection initiatives;
- Discussing how the adoption of health information technology (IT) can facilitate performance measurement data collection and reporting; and
- Developing recommendations for coordinating the various public and private performance measurement initiatives in a transparent manner that maximize value and minimize inefficiency and expense in data collection.

AHIMA and MGMA greatly appreciate AHRQ's decision to fund both the invitational conference and a task force of stakeholders and experts from the heath care community. Conference attendees used the task force's briefing paper "Health Care Data Collection and Reporting" to generate solutions that will produce coordinated, efficient and useful performance measurement.[i]

The Challenges

Health care organizations are faced with increasing and disparate data collection and reporting requirements from a wide variety of public and private organizations. As the industry moves toward widespread adoption of electronic health records (EHR), interoperability and pay-for-performance (P4P) programs; the need to align performance measurement reporting initiatives is vital. At the same time, health care providers and organizations struggle with staffing shortages, tighter reimbursement and pressures to accomplish more with less, making the ability to meet various data requirements an increasing concern.

Data Retrieval in a Paper Environment

Manual data abstraction is a time-consuming effort requiring extensive staffing resources. Employees conducting manual data abstraction must possess a certain level of knowledge and expertise to ensure information is collected and managed properly. Yet the nation has a shortage of trained professionals able to perform this work.

Retrospective manual data abstraction contributes to the lack of organizational improvements in patient care at both the individual case and overall population levels. Issues include variances in data definition and capture and the use of real-time measurement for clinical process redesign.

Retrospective data collection produces outdated analyses, with little or no ability to effectively enhance quality at the point of care.

Concurrent manual data collection and monitoring provides the opportunity to improve quality at the point of care, but generate other challenges. For example, abstractors often have difficulty locating and obtaining the required medical record data due to restrictions imposed by single-access paper medical records.

Poor legibility or incomplete documentation in paper medical records also affects the ability to obtain accurate, reliable performance measurement data. Illegible documentation impedes an abstractor's ability to understand and interpret the information.

Data Retrieval in an Electronic Environment

The costs and risks associated with implementing health IT pose significant barriers for small medical groups and solo physician offices, where just one in seven practices use any form of an EHR.[ii] Hospitals also struggle with these same concerns. Furthermore, clinicians using EHR systems may not understand how data captured by the technology will affect the performance measurement data collection and reporting efforts.

Although extracting data electronically from interoperable systems is an improvement over manual methods, it remains a challenging process. There are few broadly agreed-upon standards for defining data content. Variations in the taxonomy of terms among performance measurement systems are difficult to interpret and often require costly and labor-intensive data mapping to link and extract data from electronic systems.

EHR systems are not necessarily designed to allow aggregation of data across populations. Numerous duplications, variations and competing priorities in the performance measurement and data collection environment inhibit the use of EHRs as a performance measurement tool. If not addressed in a timely and coordinated manner, the challenges may reduce the utility and adoption of EHR systems to measure performance and improve consumer health. Vendors of electronic information systems need a clear, consistent set of functional specifications for data capture and reporting to meet quality measurement needs.

Simply having an EHR does not guarantee that health care organizations can retrieve and report data for quality measurement programs. This problem becomes even more pronounced in small physician practices with less-robust systems. These groups may need to purchase additional system modules to automate data aggregation and reporting.

Clinical vs. Administrative Data

The use of clinical information for performance measurement often requires descriptive data not available on insurance claim forms. Such information must be manually obtained from the medical record, collected in secondary systems, or uploaded to performance measurement warehouses. These processes increase costs and the potential for errors, and impose additional requirements for data validation and reliability.

The absence of complete and reliable health information, in either paper or electronic form, affects performance measurement data collection and reporting on several levels. Clinical documentation serves as the foundation for code assignments. Incomplete, untimely, or inaccurate documentation leads to incorrect coding and poor administrative claims data.

The ability to transform coded data into meaningful information, such as the severity of a patient's illness, requires that users consistently apply uniform coding rules, conventions, guidelines and definitions. Achieving high quality information through the use of administrative data therefore requires terminology and classification systems that reflect current medical practice and technology.

Secondary uses of data bring additional concerns. The lack of consistent policies and practices for the use of secondary data impede their use for performance measurement.[iii]

Variations in Performance Measurement System Design

Variations among performance measurement systems and reporting standards make information difficult to collect, aggregate, report and interpret. Providers and health care organizations are often asked to collect, process and report data about the same medical conditions, and perhaps the same populations multiple times in different formats. These variations often occur due to lack of specificity in performance measurement metrics, inconsistencies in data submission requirements and formats and inconsistencies in the types of data sources used.

Comparing measures against different reporting organizations can cause frustration and place the measures' integrity in question for physicians and other stakeholders. Findings may be discounted because of inconsistencies in data reporting requirements.

In addition, processes for updating performance measurement metrics are not streamlined or standardized. Health care providers are continually burdened with updates to data collection forms and systems as performance measurement metrics change in an uncontrolled, disorganized and nontransparent manner.

Economic Pressures

Health care providers and organizations must contend with economic pressures as they assess their ability to participate in performance measurement initiatives. Higher costs of doing business, declining reimbursement, expectations to implement information technology and the pressures to do more with less represent competing priorities.

Opportunities for Action

AHIMA and MGMA believe it is important that a public-private entity representing key stakeholders oversee efforts to provide clear policies and procedures for health care measurement. This public-private entity can establish necessary uniform operating rules and standards to aggregate quality and efficiency data used in both the public and private sectors for performance measurement and reporting.

We support the Institute of Medicine's report, *"Performance Measurement: Accelerating Improvement"* which calls for a national system supported by sustained funding to exert "strong,

independent leadership" to coordinate and guide current efforts and to broaden the scope of measurement to overcome existing gaps.[iv] This public-private effort could take place under the purview of one or more existing entities; it need not be newly created.

A public-private entity can:

- Create core data content standards as a prerequisite for a reliable and consistent data collection and reporting process;
- Standardize performance measurement systems to improve efficiency over time; and
- Promote collaboration among critical stakeholders in health care quality and performance measurement.

AHIMA and MGMA recommend that this public-private entity be empowered and held accountable to:

- Collect and prioritize the input of key stakeholders that use health care data to measure health care performance in order to prioritize and standardize measure sets across medical specialties and care settings.
- Ensure that data are gathered to support the informational needs of providers working at the point of care as well as the needs of others.
- Obtain regular input on measurement standards from specialty societies and professional associations that represent providers, measurement developers, payers (insurance companies and employers); national, state and other public health agencies; and vendors.
- Develop a plan that represents short-, mid- and long-term measurable goals and accompanying tactics.
- Reach national consensus on a starter set of basic, uniform data needed to measure health care quality and performance and the necessary standard minimum demographic data set.
- Harmonize existing measures of health care quality with the proposed national uniform-standard data set, including:
  - Inventorying data depositories for clinical and administrative data (for example, epidemiology, mortality and provider performance);
  - Setting standards for linking data depositories; and
  - Identifying and convening stakeholders of these depositories for advice and support.
- Follow the Certification Commission for Health Information Technology's (CCHIT's) process to define criteria for collecting clinical and administrative data through an EHR to promote full functionality across all systems and enable optimum data extraction for multiple uses.
- Establish the method that will guide the development, validation and approval of metrics for measuring quality. Establish standards for:
  - Acceptable sampling sizes, sampling error and other data measurement issues.
  - Beta testing of proposed measures.
  - Assessing and endorsing the acceptance (or rejection) of current and proposed measures according to criteria developed and approved by key stakeholders.
- Coordinate health information exchange and quality initiatives at the national, state and local levels to promote data integrity and responsible use of data.
- Advise public and private stakeholders in developing common national standards that outline a framework for the secondary use of health data with appropriate protections.

- Gain public- and private-sector buy in from federal, state and local agencies to work toward data-gathering goals.
- Conduct all business in a public and transparent manner.

Prior to formalizing this public-private entity, the following actions must occur in order to ensure support and success of this important effort.

- Educate and engage policy makers and elected officials about the need for a public-private effort to oversee clear evaluation policies and procedures for health care measurement;
- Solicit support from key stakeholders, including consumers and patient advocate organizations, to demonstrate support for an entity to serve in this capacity;
- Evaluate the characteristics of the proposed public-private entity and compare the proposed functions to the capabilities of existing organizations;
- Provide existing entities the opportunity to express interest in assuming the role of the public-private entity and to identify restructuring requirements necessary to fulfill this role; and
- Persuade existing health IT industry initiatives to support collaboration and information-sharing upon its implementation.

Recommendations

As recent as 2004, AHIMA testified to the National Committee on Vital and Health Statistics (NCVHS) Workgroup on Quality regarding the challenges associated with quality measure data collection and reporting activities.[v] Barbara Siegel, director of Health Information at Hackensack University Medical Center and a member of AHIMA, testified to the committee about her organization's experiences with voluntary and mandated reporting requirements.

The issues that she brought to light in 2004 still persist three years later:

- Multiple data reporting requirements with various measurement definitions, thus creating outcomes that are not comparable.
- High costs to health care organizations as demands for information exceed efficient methods for collecting and reporting data.
- Conflicting quality measurement results that create barriers to interpretation and improvement processes.
- Lack of qualified individuals to collect, report and interpret performance measurement results.

The health care industry continues to increase the performance measurement requirements without resolving these complex problems. AHIMA and MGMA believe this workgroup can address these urgent issues by supporting the following recommendations:

Recommendation #1

Form a public-private entity to oversee and evaluate policies and procedures for health care performance measurement. It is imperative that there be a unified and coordinated approach to improve quality measurement design and provide clear and consistent guidance to health care providers regarding data collection and reporting requirements. This public-private entity need not be a new organization; this mission could be placed under the purview of one or more

existing entities capable of expanding their scope of measurement-related responsibilities with sufficient support, funding and consensus among stakeholders.

Recommendation #2
Provide funding to support research on the quality of data reported for performance measurement. Both administrative and clinical data quality should be assessed and compared to inform efforts aimed at standardizing data content for performance measurement initiatives.

Recommendation #3
Provide funding to support additional research on the costs associated with performance measurement data collection and reporting. The National Committee for Quality Assurance estimates that performance measurement and improvement might result in billions of dollars of savings for the health care industry[vi], however; under current financing systems these savings generally accrue to the payer, not to the providers who collect and report the data. In the mean time, many payers, including the Centers for Medicare & Medicaid Services (CMS), are implementing programs that use financial incentives to encourage health care providers to report performance measurement data. However, without adequate data to demonstrate the costs associated with these initiatives, health care providers must prioritize their resources.

Conclusions
AHIMA and MGMA are pleased that the NCVHS Quality Workgroup takes a keen interest in the issues surrounding health care performance measurement data collection and reporting. The collection of data and the use of health IT have the potential to provide important information about performance and quality in health care and improve the health of all Americans. Unfortunately, the current, fragmented system, in which myriad organizations collect and hoard data, hinders this opportunity. Interested parties must step forward and create the entities that can bring our information systems and data collection efforts together for the common good.

Thank you,

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Appendix

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