Ensuring the Quality of Quality Data Hearing

Testimony by

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Good Morning, my name is Janice Nicholson, and I am the co-founder and CEO of i2i Systems. For more than a decade we have been dedicated to delivering solutions that help the health sector make the best use of their clinical data. Our technology supports easier and greater access to data and improves the efficiency of the care team staff.

I am honored to be here today to share my thoughts and suggestions and represent our customers, most notably the hundreds of health centers and smaller practices that we serve.

Today 80% of our customers have adopted EHR. We currently interface with most of the leading EHR systems and our greatest challenge to meeting MU requirements is the lack of standards in data capture. Documentation for something as simple as a diabetic foot exam requires custom mapping since it is typically documented in an unstructured text field. Our experience shows us that every EHR uses very different structures for their structured data; and every EHR install can customize that structure.

Simply stated, the biggest challenge to EHR-generated data is that much of the data required for quality reporting is captured in text fields that are not codified. Meaningful Use specifications define measures as CPT, ICD9-10, and SNOMED codes, but very few of the EHRs (none that I've been exposed to) use these coding methodologies universally. The intent to aggregate this data for quality measure reporting was not at the forefront of the EHR design. As a result, there is a huge gap between data quality and the quality measures those data are intended to compute. And practices are now facing the daunting challenge of generating meaningful clinical quality measures from a database populated with custom text fields that are not codified.

This leaves the organization to interpret the NQF measure definitions within the context of each EHR install. But the interpretations are inconsistent -- while there are standard measure definitions, there lacks standard translation for computing those measures across EHR systems.

We believe there are three main barriers to meaningful exchange and quality reporting:

First, accessibility to data in EHRs is proprietary and continues to be extremely difficult and costly to extract.

Second, the significant amount of data required for generating clinical quality measures is not in a reportable format across the multitude of EHRs.

Third, mainly a result of the first two barriers, there is a lack of comparative data and benchmarks that could enable a valuable cross-check on clinical quality measure results and help providers prioritize data validation requirements and performance improvement focus.

Lessons from Stage One Meaningful Use are: asking for the data is one thing but using the data is another. We see our customers drowning in their new found technology and focusing so heavily on data capture and compliance with reporting that improvement has been put on the back burner. The production of a report has become more important than what the report is saying.

If we agree on the need for a health care industry that focuses on quality and outcomes – and I think we do – then we need to build a healthy ecosystem of tools around the EHR. EHR companies should be concentrating on their core business of supporting the care documentation process while maintaining a solid patient health record. We need EHR to address the lack of commonality of how data is represented and stored so that it can be counted and reported accurately.

Let the data focused Analytics and Reporting companies use their core expertise- data integrity, aggregation and clinical performance reporting.

What can the committee do today to promote a more productive tomorrow? Support policies that safeguard data quality standards, ensuring validity of measurement; encourage standards of communications that include sufficient meta-data; and do it all in a way that opens the market for professionals of every field to develop third-party tools that can do data analytics on populations of patients regardless of which EHR repository a facility uses.

Thank you