



Quality Reporting Alignment

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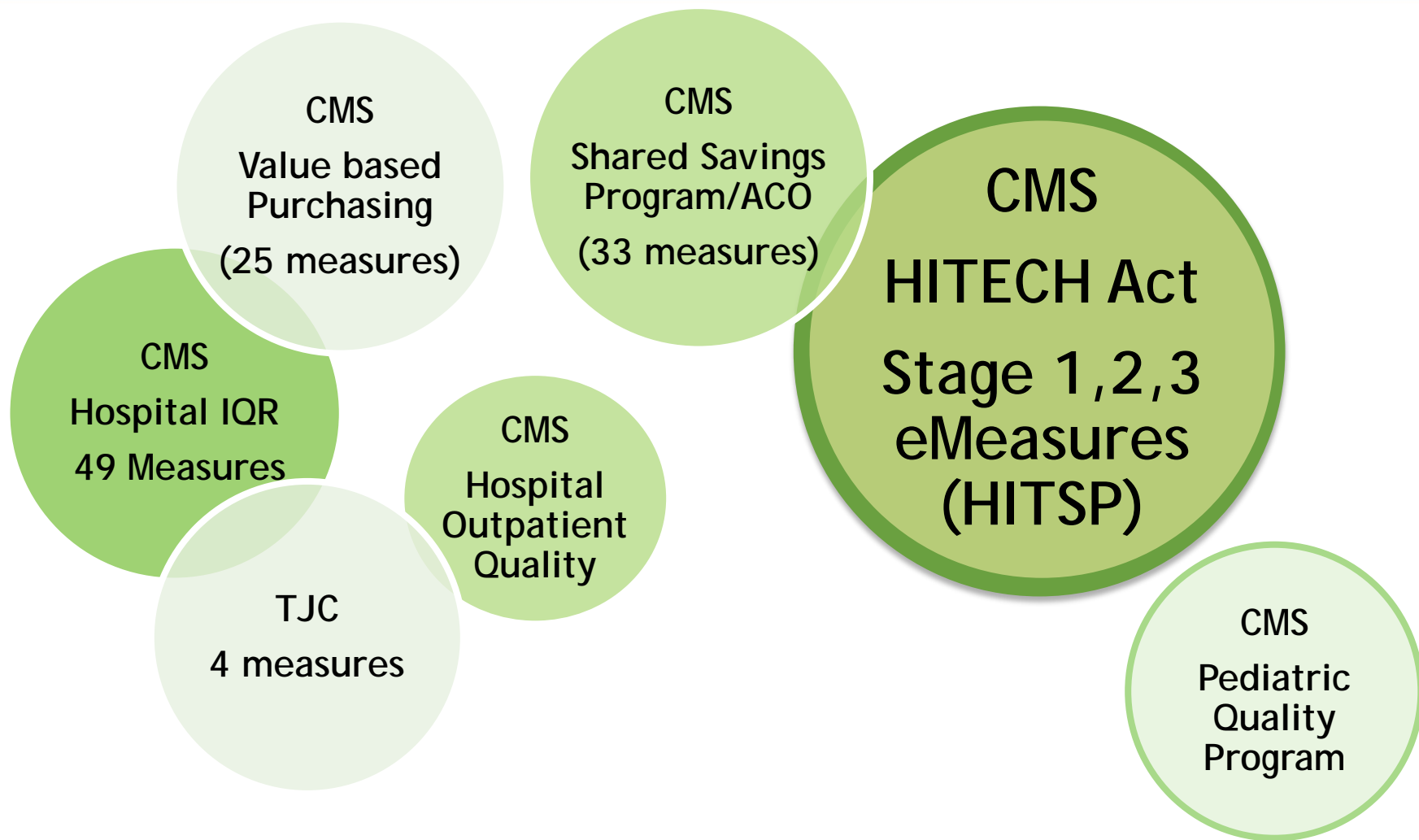
Learning Objectives

- Compare and contrast the requirements for quality measure reporting as required for the Meaningful Use, Value-Based Purchasing and Shared Savings/ACO programs. Identify strategies to ensure compliance with quality reporting.
- Describe the four current or proposed programs that will affect Medicare quality reporting for hospitals and the potential impact to hospital reimbursement.
- Compare and contrast the quality reporting requirements in the Medicare Shared Savings Program (MSSP) for Accountable Care Organizations (ACO) with existing quality reporting programs.
- Evaluate the quality reporting implications for organizations desiring to participate as an ACO.

Secret Decoder Ring

| | |
|------|---|
| ACO | •Accountable Care Organization |
| AHRQ | •Agency for Healthcare Research and Quality |
| CMS | •Centers for Medicare and Medicaid |
| HAC | •Hospital Acquired Conditions |
| HHS | •Department of Health and Human Services |
| HQA | •Hospital Quality Alliance |
| IQR | •Hospital Inpatient Quality Reporting program (aka RHQDAPU) |
| MU | •Meaningful Use |
| MSSP | •Medicare Shared Savings Program |
| NQF | •National Quality Forum |
| PQRI | •Physician Quality Reporting Initiative, also known as PQRS |
| TJC | •The Joint Commission, formerly known as JCAHO |

Quality Programs Are Evolving



In The Beginning

- RHQDAPU (now IQR)
 - In 2003, CMS established Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU)
 - In 2005, hospitals treating Medicare patients were required to submit ten quality measures or be subject a reduction of 0.2 percent in their annual Medicare payment.
- HOP & PQRS
 - CMS established outpatient reporting through the Hospital Outpatient Quality Data Reporting Program (HOP QDRI)
 - Reporting for physicians and other eligible professionals was through the Physician Quality Reporting System (PQRS)

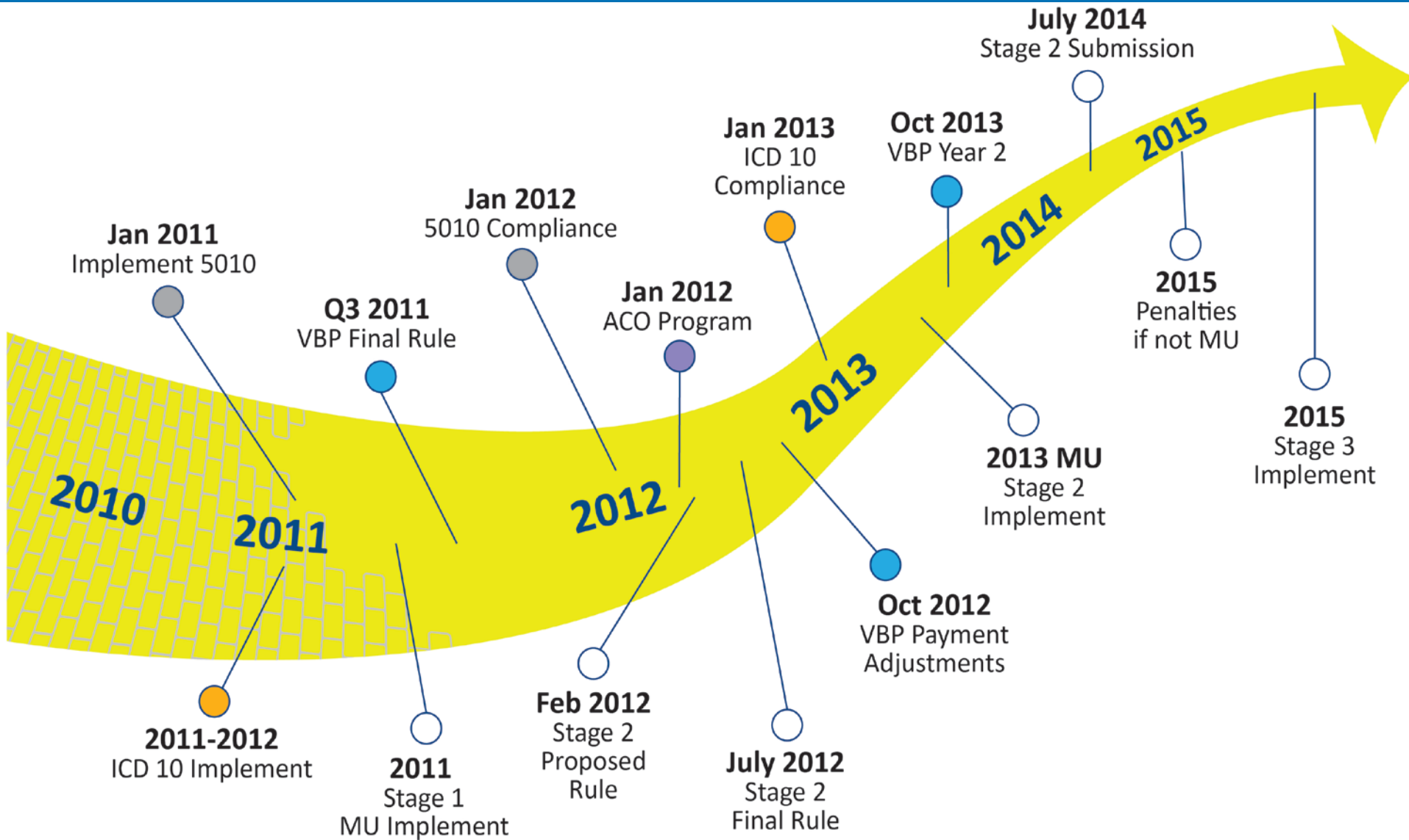
Hospital Compare

- In 2005, CMS worked in conjunction with the Hospital Quality Alliance (HQA) to develop the Hospital Compare website.
- The measures were agreed to be reliable and valid by stakeholders including:
 - CMS
 - TJC
 - National Quality Forum (NQF)
 - Agency for Healthcare Research and Quality (AHRQ)

Hospital IQR Program Today

- Consists of 49 measures for FY 2012:
 - 31 are chart-based, process of care measures for AMI, HF, PN, SCIP, ED, and Immunization.
 - 15 are claims-based, outcomes measures for mortality and readmissions.
 - 3 are structural, reflecting hospital participation in registries.
- Also includes the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey as a measure of patient experience of care.

The Road Ahead



New Programs

- Since 2009, the federal government has introduced three programs aimed at reducing the cost of healthcare and improving quality:
 - Value-Based Purchasing
 - Medicare Shared Savings Program/ACO
 - EHR Incentive program/Meaningful Use
- All begin with requirements for quality reporting tied to Medicare reimbursement.
- All will move towards payment for achievement of quality metrics in subsequent years.

Value-based Purchasing

- Applies to all Medicare discharges, starting October 1, 2012.
- All quality measures for VBP must come from Hospital IQR.
 - 12 process of care – AMI, HF, PN, SCIP
 - 3 outcomes – mortality for AMI, HF, and PN (starts in 2013)
 - 8 experience of care – HCAHPS
- Quality measures are abstracted. There are no eMeasures in this program.

Value-based Purchasing (VBP)

- CMS will withhold 1% of all Medicare inpatient operating payments from hospitals based on their performance across a set of specified quality measures
 - Withhold increases 0.25% annually through 2018
 - VBP scores determine how much of the withhold a hospital earns back
- Budget neutral program—winners and losers

Points awarded for performance relative to achievement threshold and benchmark

Achievement Score

Achievement Threshold
50th Percentile

National Benchmark

Used for all process and experience of care measures



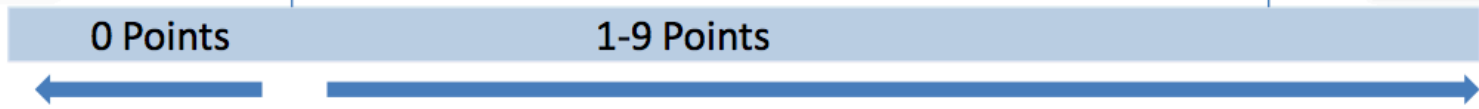
Points awarded for performance relative to baseline score

Improvement Score

Baseline Score
(Improvement Threshold)

National Benchmark

Used for all process and experience of care measures



Points awarded based on lowest dimension score relative to median baseline score

Consistency Score

50th Percentile

Used for experience of care domain only



FY 2013 - Clinical Process of Care

| Measure | Achievement Threshold | Benchmark |
|-------------|-----------------------|-----------|
| AMI-7a | 0.6548 | 0.9191 |
| AMI-8a | 0.9186 | 1.0 |
| HF-1 | 0.9077 | 1.0 |
| PN-3b | 0.9643 | 1.0 |
| PN-6 | 0.9277 | 0.9958 |
| SCIP-Inf-1 | 0.9735 | 0.9998 |
| SCIP-Inf-2 | 0.9766 | 1.0 |
| SCIP-Inf-3 | 0.9507 | 0.9968 |
| SCIP-Inf-4 | 0.9428 | 0.9963 |
| SCIP-VTE-1 | 0.9500 | 1.0 |
| SCIP-VTE-2 | 0.9307 | 0.9985 |
| SCIP Card-2 | 0.9399 | 1.0 |

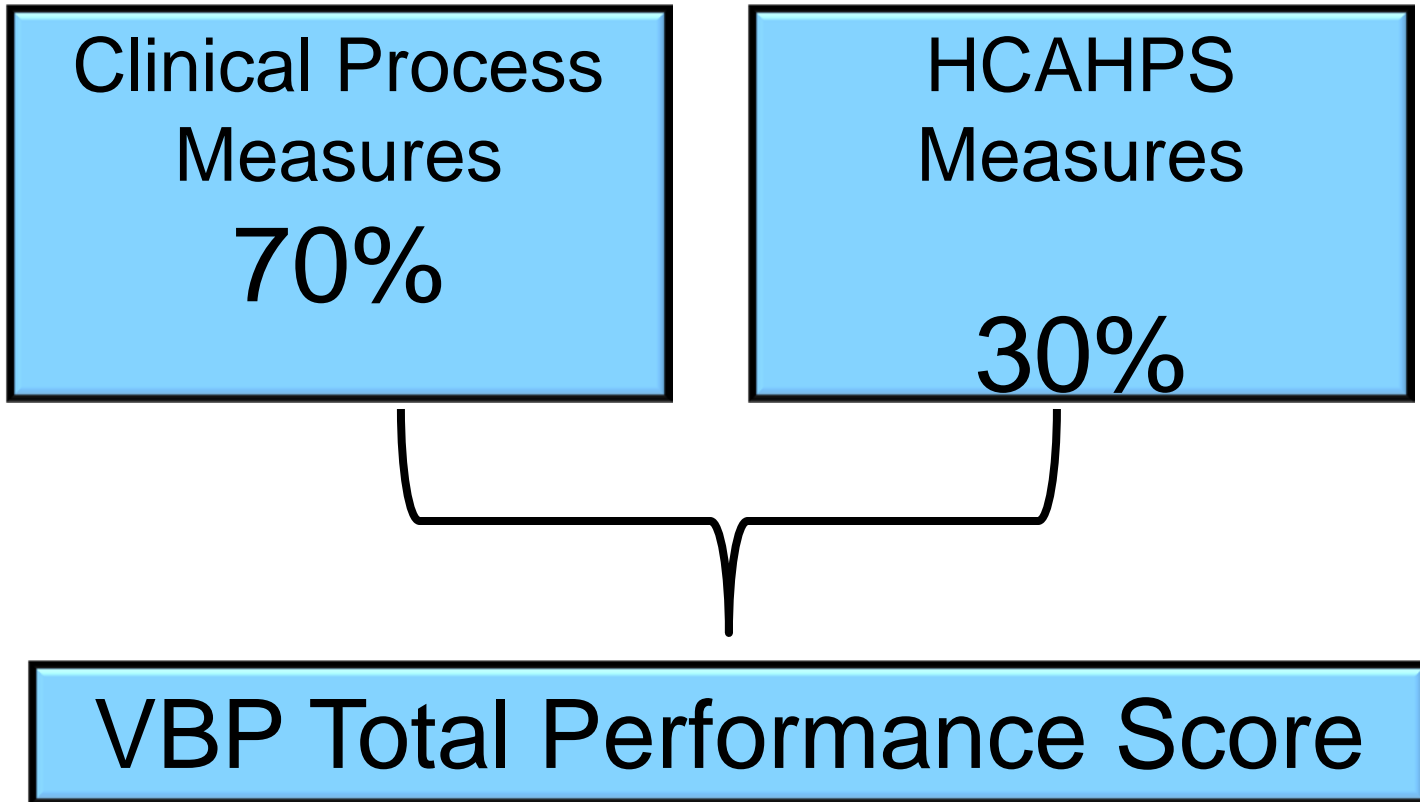
FY 2013 - Experience of Care

| Measure | Achievement Threshold | Benchmark |
|---|-----------------------|-----------|
| Communication with Nurses | 75.18% | 84.70% |
| Communication with Doctors | 79.42% | 88.95% |
| Responsiveness of Hospital Staff | 61.82% | 77.69% |
| Pain Management | 68.75% | 77.90% |
| Communication About Medicines | 59.28% | 70.42% |
| Cleanliness and Quietness of Hospital Environment | 62.80% | 77.64% |
| Discharge Information | 81.93% | 89.09% |
| Overall Rating of Hospital | 66.02% | 82.52% |


FY 2014 – Outcomes (Mortality Only)

| Measure | Achievement Threshold | Benchmark |
|------------------------|-----------------------|-----------|
| 30 Day Mortality - AMI | 84.8082% | 86.9098% |
| 30 Day Mortality - HF | 88.6109% | 90.4861% |
| 30 Day Mortality - PN | 88.1795% | 90.2563% |

VBP Payment Methodology



Just the First Step

| | Enhanced P4P | Bundled Payments | Shared Saving |
|-----------------------|---|--|--|
| Description | Financial bonuses, penalties, or withholds assessed based on outcome or process performance | Payer disburses single payment to cover hospital physician or other services performed during an inpatient stay or episode of care | Total expense (to payer) for a given patient population compared to risk-adjusted benchmark; portion of any savings below benchmark returned to provider |
| Reform law elements | Hospital VBP Readmissions penalties HAC penalties | Integrated Care Demonstration National Episodic Bundling Pilot | Shared savings voluntary program Pediatric Accountable Care Organization |
| Underlying assumption | Adherence to best demonstrated practice can improve outcomes and reduce long-term utilization | Better care coordination can reduce expenses associated with care episodes | Better care coordination can minimize inappropriate or duplicative utilization |
| | Started July 1, 2011 | Coming soon...  | |

Accountable Care/Shared Savings

- In October 2011, HHS released final rules for the Medicare Shared Savings Program to help doctors, hospitals and other providers better coordinate care through Accountable Care Organizations (ACOs).
- This is a voluntary program. Providers are not required to affiliate with an ACO.
- The amount of shared savings that an ACO would receive depends on meeting or exceeding quality performance standards.

MSSP/ACO Quality Improvement

- Two additional models of ACO organizations have been defined: the Pioneer model and the Advanced Payment model. All models share the same quality reporting requirements.
- The program includes 33 quality measures in four key areas that affect patient care:
 - Patient/caregiver experience of care (7 measures)
 - Care Coordination/Patient Safety (6 measures)
 - Preventative Health (8 measures)
 - At-risk population/frail elderly (12 measures)

Methods of Data Submission

- CMS will populate the ACO reporting requirements for measures that are claims-based or reported through the EHR Incentive Program, aka Meaningful Use.
- The ACO will submit data for the other 22 measures through the Group Practice Reporting Option (GPRO) data collection tool.
 - The GPRO is based on the current tool used in the Physician Quality Reporting System and the Physician Group Practice (PGP) demonstration.

Shared Savings

- For year 1, the standard is full and accurate reporting.
 - Full and accurate reporting of ALL quality measures in ALL domains would result in an ACO earning 50-60 percent of sharable savings the first year of the Shared Savings Program.
- For year 2, CMS will pay for performance in 25 of measures and pay for reporting in the other 8.
- For year 3, CMS will pay for performance in 32 of the measures while requiring reporting only for the CAPHS Health Status /Functional Status survey

Performance Scores

- There are a total of 48 available points in the weighted domain scoring model. Each of the domains is worth 25 percent of the total.
- In year 2 and 3, ACO's must meet a minimum quality standard of the top 30th percentile of the national Medicare Fee for Service Providers in 70% of the pay for performance measures.
- A maximum of two points per measure could be earned for achievement over and above the 30% threshold.
 - One measure related to the percent of PCP's who qualify for Meaningful Use is double-weighted.

Performance Scores – Year 2 and 3

| Domain | Total Individual Measures | Total Measures for Scoring | Total Potential Points per Domain | Domain Weight |
|--------------------------------------|---------------------------|--|-----------------------------------|---------------|
| Patient/Caregiver Experience | 7 | 2 measure - 6 individual CAPHS measures counted as one, plus 1 additional survey measure of health/functional status. | 4 | 25 % |
| Care Coordination/ Patient Safety | 6 | 5 measures plus one EHR measure that is double weighted and worth 4 points . | 14 | 25% |
| Preventative Health | 8 | 8 measures | 16 | 25% |
| At Risk Population | 12 | 7 measures (5 Diabetes measures rolled into one for scoring, 2 CAD measures rolled into one for scoring. 5 stand alone measures. | 14 | 25 % |
| Total | 33 | | 48 | 100 % |

EHR Incentive Program

- Established in 2009 as part of ARRA.
 - There are 14 core and 10 menu objectives in Meaningful Use Stage 1.
- One of the core measures is to submit 15 quality measures for stroke, VTE and ED using eMeasures.
- Non-meaningful users penalized by loss of market basket adjustments – similar mechanism as in in the IQR program.
- Stage 2 proposed rule to be released any minute now.

Key Points

- MSSP quality measures are focused on the management of chronic conditions—diabetes, HF, CAD, HTN, COPD. Therefore, measures are aligned more closely with MU eMeasures for EP and PQRI.
- There is no overlap for EH's between Meaningful Use Stage 1 and the MSSP/ACO program.
- There is no overlap in quality measures between ACO and VBP; however, both would use surveys to measure patient experience of care.

Quality Crosswalk

| Process of Care | Data Source | Required for IQR? | VBP | Stage 2? | MSSP/ACO |
|-----------------------|-------------|-------------------------|-----|-------------|----------|
| AMI | Abstracted | 8 | 2 | | |
| HF | Abstracted | 4 | 1 | | |
| PN | Abstracted | 6 | 2 | | |
| SCIP | Abstracted | 8 | 7 | | |
| VTE | Abstracted | N - to be added in 2015 | N | | |
| VTE eMeasure | Electronic | | | Stage I - 6 | |
| Stroke | Abstracted | N - added in 2015 | N | | |
| Stroke eMeasure | Electronic | | | Stage I- 7 | |
| ED | Abstracted | N | N | | |
| ED eMeasure | Electronic | | | Stage I- 2 | |
| Experience of Care | | | | | |
| HCAHPS | Survey | Y | Y | | Y |
| Outcomes | | | | | |
| Mortality | Claims | Hospital Compare | Y | | |
| Readmission | Claims | Hospital Compare | | | |
| Complications (AHRQ) | Claims | Hospital Compare | | | |

Stage 2 Preview

- June, 2011 – NQF and the eMeasure task force completed their review of 115 “re-tooled” eMeasures.
- July, 2011 – HITPC issued their recommendation for Stage 2 to the ONC. Included was a recommendation to allow hospitals who attest in 2011 an extra year (total of 3) at Stage 1, therefore Stage 2 would be required in 2014.
- July, 2011 – The NPRM for the annual update to Medicare Outpatient PPS contains language stating that for the second year of Stage 1 MU submission, EH’s would be able to continue to attest to CQM rather than perform actual electronic submissions. The rule describes a new pilot program for submission of patient level quality data. Participation in this program would be counted as meeting the MU measure for submission of CQM.

Quality Measures beyond 2012

- In December 2011, CMS published a list of all measures under consideration for inclusion in rulemaking for 2012.
- There are 39 potential measures for MU, 26 of which exist in some form in some other CMS program. 9 were in the initial set of quality measures in the proposed rule and were removed before the final.
 - AMI 2, 3, 5 and 8a.
 - PN 3b, PN6
 - SCIP-INF 1, 2,3
- 13 others net new, currently not in any CMS program. New measures for OB, NICU, and asthma care.

Quality Measures Stage 3

- Planned joint workshop with HITSC/ONC/CMS on Quality Measures- May
- IF we were to assume stage 3 begins 2 years after stage 2 (await NPRM and Final Rule)
 - Jan, 2013 RFC on draft stage 3 recommendations
 - Jul, 2013 Final HITPC recommendations
- Could Stage 3 be pushed to 2016 ???

Quality Crosswalk

| Process of Care | Data Source | Required for IQR? | VBP | EHR MU Stage 2 ?? | MSSP/ACO |
|---------------------------|-------------|-------------------------|-----|-------------------|----------|
| AMI | Abstracted | Y | Y | AMI 2. 3. 5 , 8a | |
| HF | Abstracted | Y | Y | | |
| PN | Abstracted | Y | Y | PN 3b, PN6 | |
| SCIP | Abstracted | Y | Y | SCIP –INF 1, 2,3 | |
| VTE | Abstracted | N - to be added in 2015 | N | | |
| VTE eMeasure | Electronic | | | Y | |
| Stroke | Abstracted | N - added in 2015 | N | | |
| Stroke eMeasure | Electronic | | | Y | |
| ED | Abstracted | N | N | | |
| ED eMeasure | Electronic | | | Y | |
| Experience of Care | | | | | |
| HCAHPS | Survey | Y | Y | | Y |
| Outcomes | | | | | |
| Mortality | Claims | Hospital Compare | Y | | |
| Readmission | Claims | Hospital Compare | | | |
| Complications (AHRQ) | Claims | Hospital Compare | | | |

eMeasure Challenges – Exclusions

- Comfort measures
 - How is it defined across the organization?
Palliative Care? DNR? Hospice?
- Clinical trials
 - For specific diagnosis and disease
- Medication contraindications
 - Tied to medication reconciliation (menu set)

eMeasure Challenges – Niche Systems

- Interfaced vs. integrated systems
 - ED and OB are commonly in a specialty system other than the certified EHR
 - SCIP measures, when added, will probably require data for surgery and anesthesia systems that may not be fully integrated into the EHR
 - Some areas like NICU may still be on paper
- Some duplicate documentation may be needed to ensure that all data points necessary for clinical quality measures are captured electronically

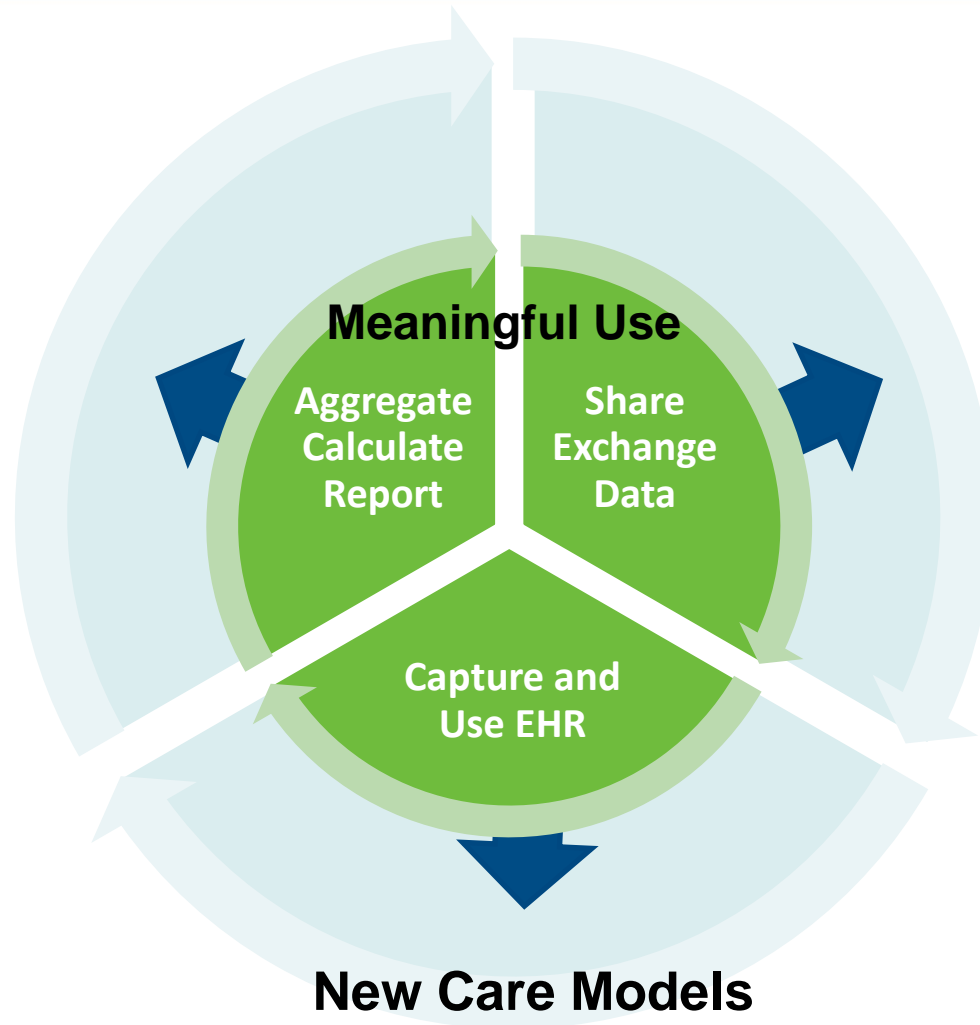
eMeasure Challenges – MD Workflow

- Documentation of exclusions
 - How do you capture if you are not implementing physician documentation concurrently?
- Proliferation of new screens for clinician data entry
 - How to design for usability to ensure widespread adoption?
- Problem list management and medication reconciliation
 - How to ensure that all data points necessary are captured consistently?

eMeasure Challenges – Data Quality

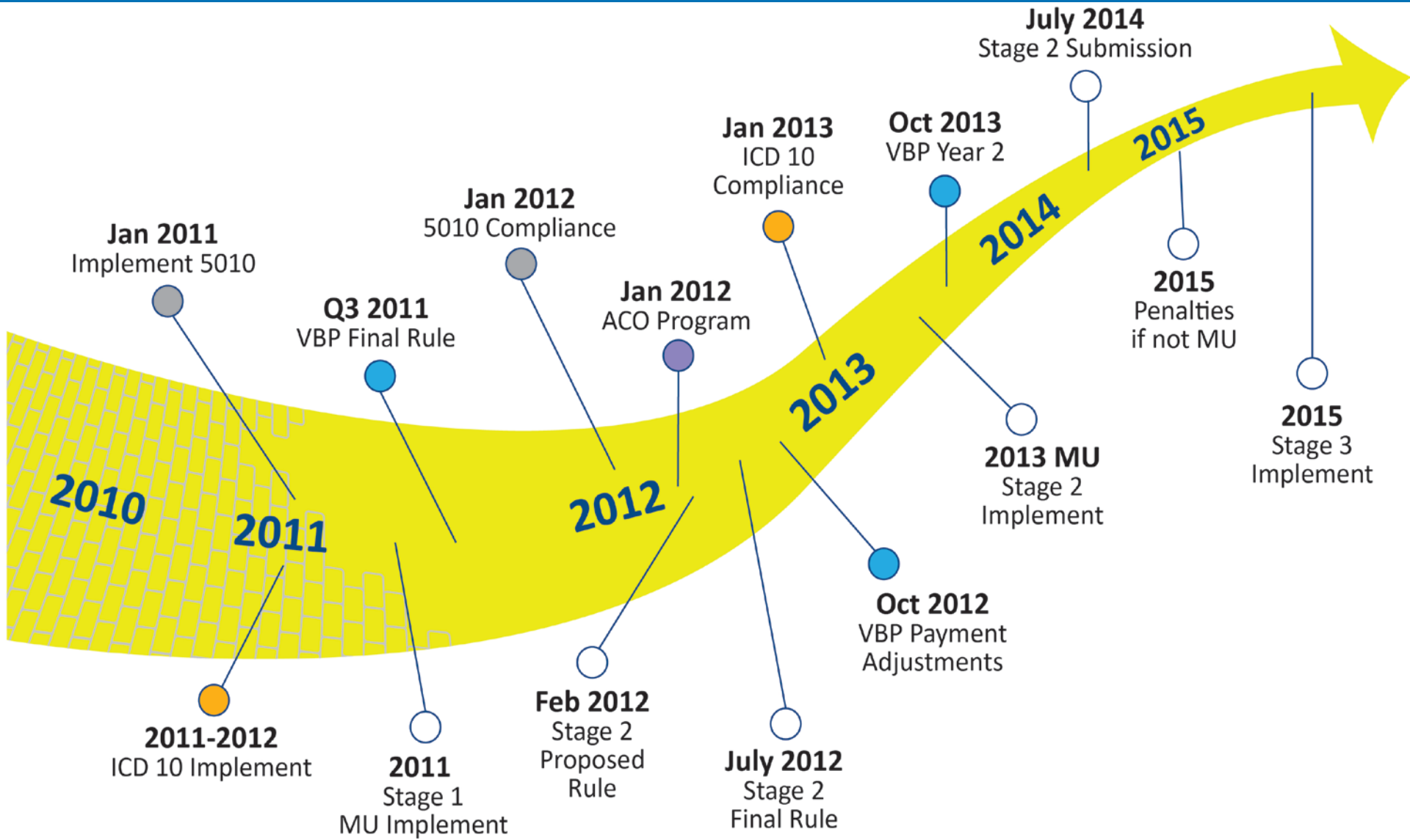
- Stage 1 MU is pay for reporting. There are no performance thresholds.
 - VBP and the ACO program have already defined a mechanism to phase in pay for reporting. MU Stage 2?
- What is the long term plan for monitoring data quality and validity?
 - Is it documented in the EHR, and if not, why not? Develop remediation plan with frontline staff
 - If documented, is it interfaced correctly to the reporting system? Can you tie exclusions back to source system? Are you able to account for events like merges of duplicate medical record numbers?
- Could you substantiate in event of an audit?

Stage 1 is Just the 1st Step



In the next (and last) 30 minutes

1. Provide context (our reality as a hospital...system)
2. Who are we? (and what do we do... will do?)
3. What does it mean for QP? (the quality reporting paradigm)
4. Four strategies:
 - Making hard decisions (really hard...\$\$\$)
 - A single source of truth
 - We all agree... data is a valuable asset
 - Preparing for new roles as quality professionals



Challenges?
What
challenges?
I don't see any
challenges.







- SLEH
- 1954
- First heart transplant
- First artificial heart transplant
- First laser angioplasty
- Texas Heart Institute
- 720 beds licensed for 900



- SLVH
- 2010
- 102 beds



- SLWH
- 2003
- 150 beds



- SLPMC
- 2010
- 61 beds



- SLLH
- 2009
- 30 beds

Community Emergency Center - San Felipe



St. Luke's Medical Clinic - TMC



St. Luke's Medical Clinic - San Felipe



- SLSL
- 2008
- 100 beds

Community Emergency Center- Holcombe St. Luke's Radiation Therapy and CyberKnife Facility



Community Emergency Center - Pearland



Diagnostic & Treatment Center - Kirby Glen





Gastroenterology and General Surgery
Every one of the 28,000 patients who comes to St. Luke's is treated as a whole person - mind, body and spirit.



Neurosciences Services
Our Neurosciences Program is the heart of our comprehensive approach to patient care.



Heart Care
The Texas Heart Institute is a unique partnership between St. Luke's and the University of Texas at Dallas.



Liver Clinical Services
Our Liver Clinical Services include specialized services in the diagnosis, treatment and prevention of liver disease.



Infectious Diseases Care
We specialize in treatment for infectious diseases, either in the hospital or in the community.



Urology Services
Our Urology Center provides quality medical care for men and women.



Emergency Services
Our Emergency Department is open 24 hours a day, primarily to the adult population.



Plastic and Reconstructive Surgery
Our cosmetic surgeons specialize in reconstructive surgery. The right surgeon for your surgery is very important.



Otolaryngology (Ear, Nose and Throat)
Our ENT Physicians are leaders in diagnosis and treatment. Learn more about our Otolaryngology Service.



Endocrinology Services
We specialize in diseases of the endocrine system, both overactive and underactive.



Lung Transplant Program
Our Lung Transplant Program has performed transplants since the 1980s, with a focus on patient care.



Liver Transplant Program
Our Liver Transplant Program has performed more than 440 liver transplants since 1982.



Rehabilitation Services
The mission of St. Luke's Rehabilitation Services is to provide a continuum of care for our patients.



Cancer Care
Our mission is to provide comprehensive cancer care services, from diagnosis to treatment.



Pain Management Services
Our multidisciplinary approach in pain management provides individualized treatment plans for our patients.



Sleep Disorder Services
St. Luke's Center of Sleep Medicine provides comprehensive care in pulmonology, neurophysiology and more.



Women's Health Services
Women of all ages can find the care they need at St. Luke's Women's Health Services.



Kidney Transplant Program
Our Kidney Transplant Program has performed more than 1,500 kidney transplants since 1982.



International Patient Services
We provide services to patients from around the world at Episcopal Hospital.



Family and Internal Medicine
We offer both inpatient and outpatient care for patients and their families. Let us show you why.



St. Luke's Medical Clinics
Building on more than 50 years of experience, our medical clinics provide compassionate, primary care.



Bariatric Surgery
Our Comprehensive Bariatric Program provides surgical weight loss solutions for our patients.



Pulmonary Care
Our Pulmonary Care services include referral services and comprehensive care for our patients.



Heart Transplant Program
Our Heart Transplant Program provides care for patients with heart failure and other cardiac conditions.



Ophthalmology (Eye Care)
Problems with your eyes can range from minor to severe. St. Luke's world-class ophthalmologists provide lenses to treating cataracts or glaucoma.



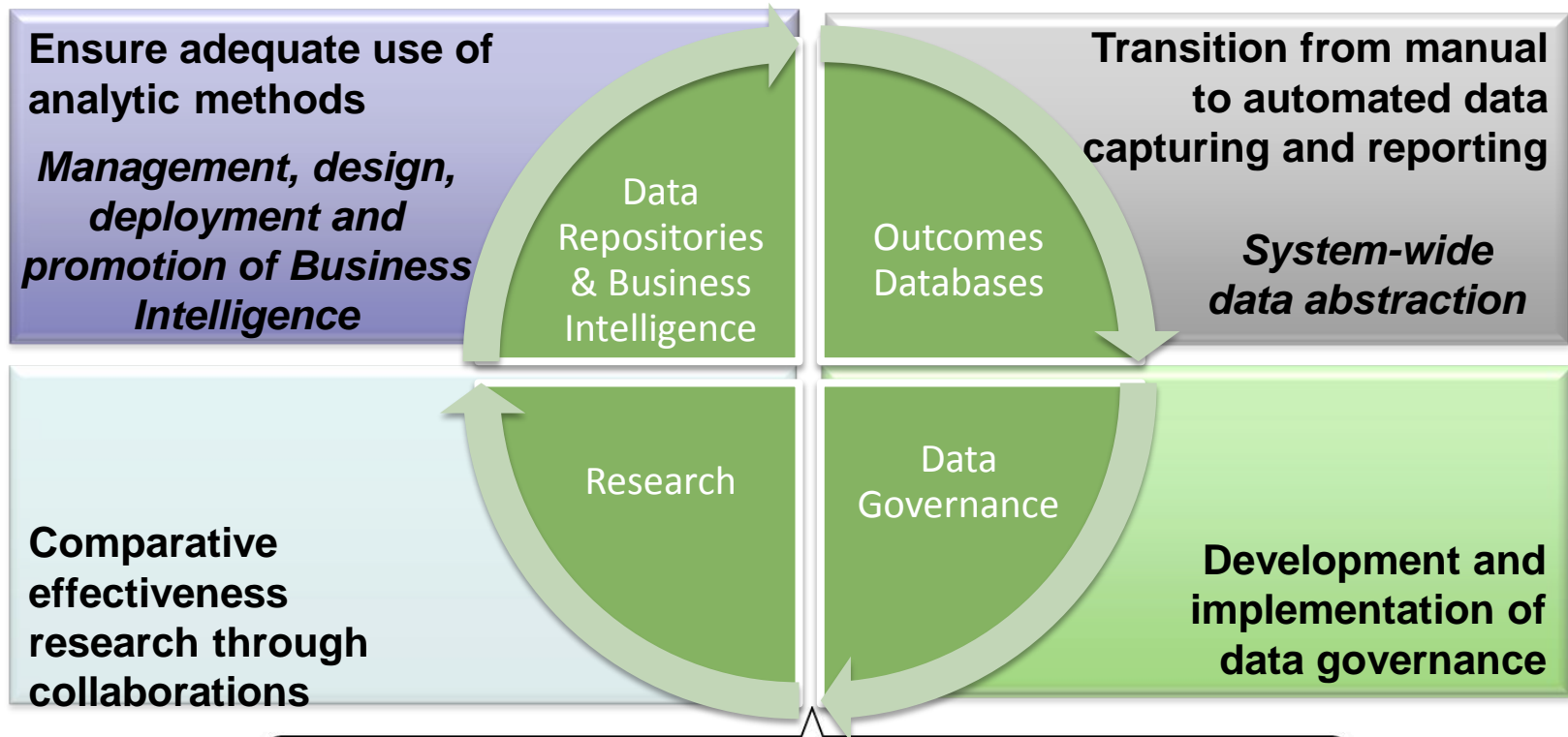
Transplant Services
Since 1982, The Cooley Transplant Program has provided heart, lung, kidney and liver transplants.



Orthopedic Surgery
We treat a full range of orthopedic conditions, including shoulder, arthritis, back and more.

Clinical Effectiveness & Performance Measurement

Selection, management, integration and coordination of performance measurement systems

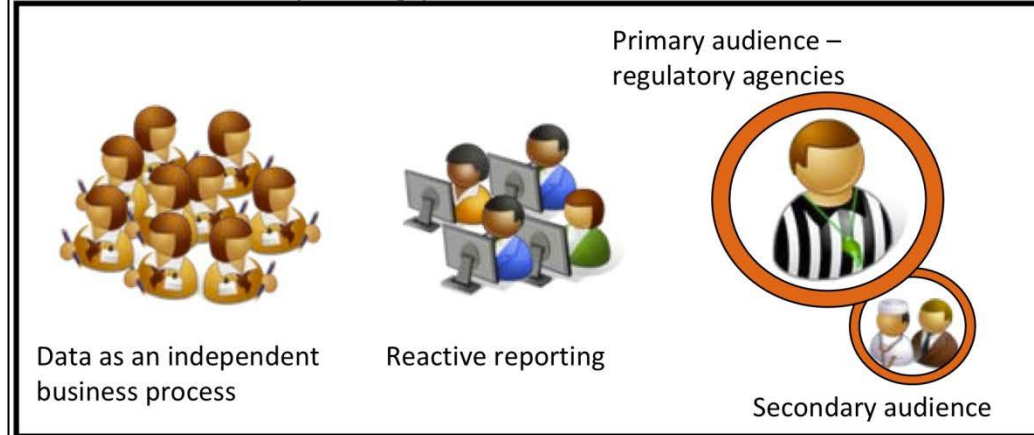


Clinical Effectiveness & Performance Measurement

| | HF | SCIP | PN | AMI | HOP Surgery | HOP CP/AMI | STS | PCI | ICD | Global ED | Global IMM | HOP ED | HOP Stroke | GWTG | ACTION | CAS | Translate-ACS |
|--------------------------------------|----|------|----|-----|-------------|------------|-----|-----|-----|-----------|------------|--------|------------|------|--------|-----|---------------|
| St. Luke's Episcopal Hospital TMC | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X |
| St. Luke's Hospital at the Vintage | X | X | X | X | X | X | | X | X | X | X | X | X | | X | | |
| St. Luke's Lakeside Hospital | X | X | X | X | X | X | | X | X | X | X | X | X | | | | |
| St. Luke's Hospital at the Woodlands | X | X | X | X | X | X | X | X | X | X | X | X | X | | X | | |
| St. Luke's Patients Medical Center | X | X | X | X | X | X | | | | X | X | X | X | | | | |
| St. Luke's Sugar Land | X | X | X | X | X | X | | X | X | X | X | X | X | X | X | | |

The Quality Reporting Paradigm

Current clinical reporting process



Data as an independent business process

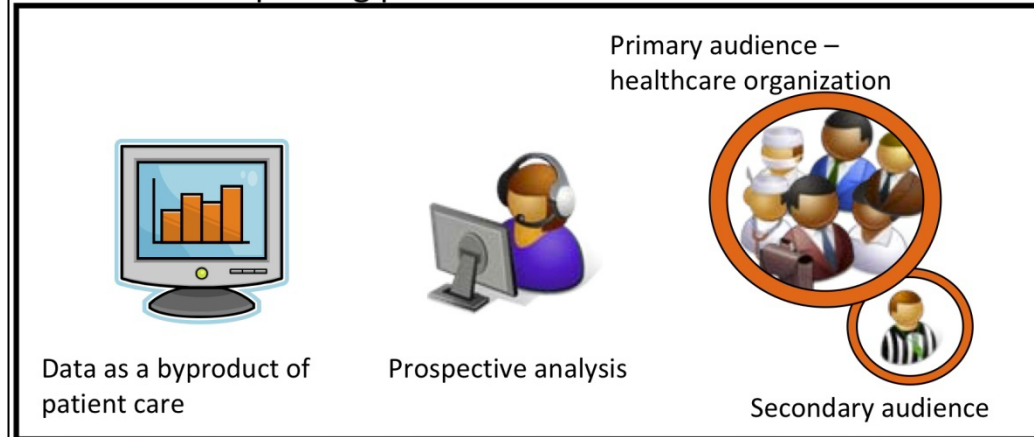
Reactive reporting

Primary audience – regulatory agencies

Secondary audience

- ▶ Non standard data
- ▶ Manual chart review
- ▶ Reactive reporting
- ▶ 3 – 6 month delay
- ▶ Regulatory-centric
- ▶ Single focus

Ideal clinical reporting process



Data as a byproduct of patient care

Prospective analysis

Primary audience – healthcare organization

Secondary audience

- ▶ Standard data
- ▶ Electronic capture
- ▶ Ongoing analysis
- ▶ Near real-time
- ▶ Patient-centric
- ▶ Integrated focus

The Quality Reporting Paradigm

Today...

Manual data
collection and
abstraction

HIS

EHR

We rely on ICD and billing codes from hospital information systems (HIS). We supplement with manual data collection which requires *human reasoning over distributed free text*



Tomorrow...

HIS EHR

Relies on SNOMED and clinical vocabularies. EHR supports *computerized reasoning over discrete coded data entered through prescriptive workflows.*

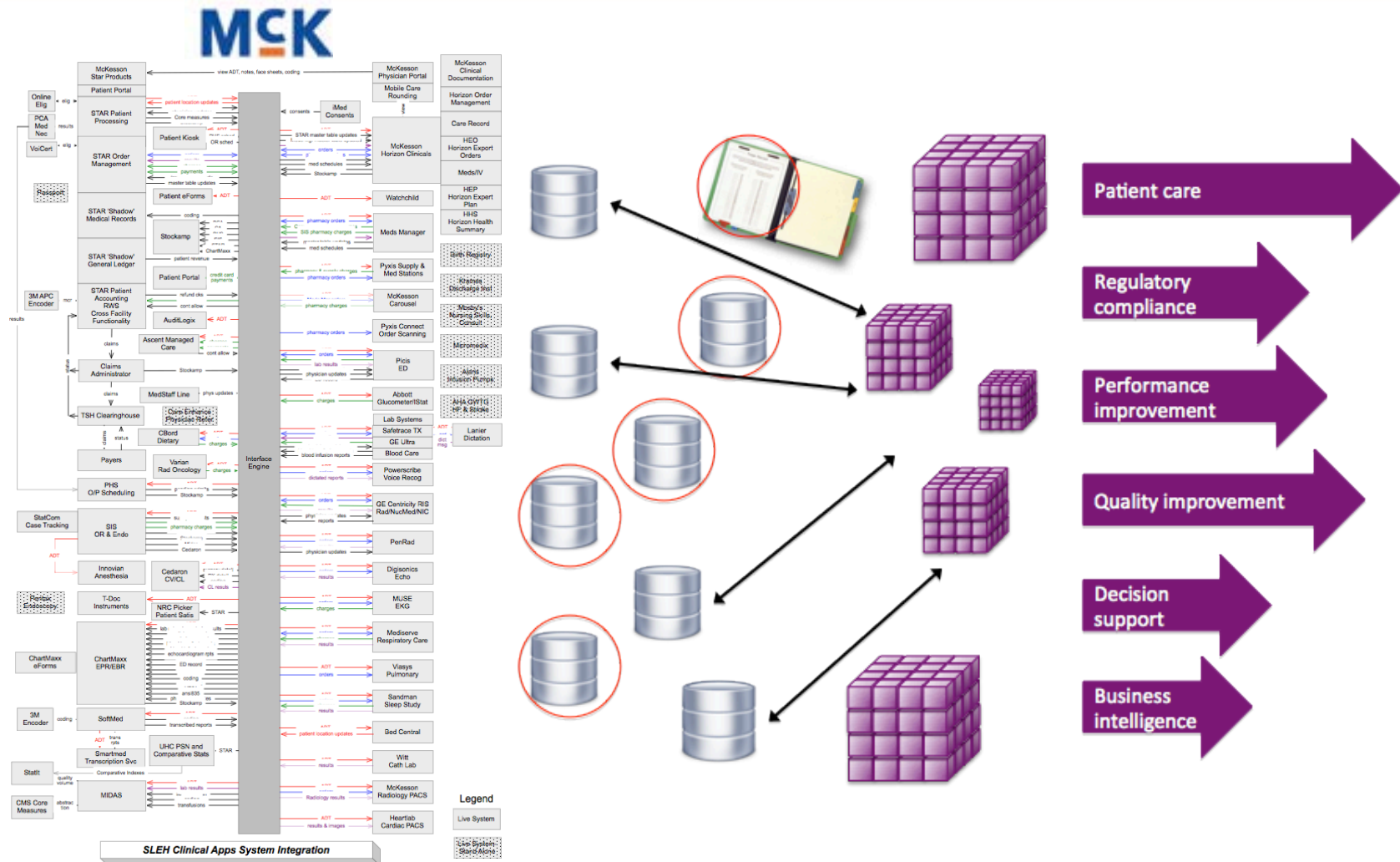
The Good News...

- No more manual abstraction!

The bad news...

- No more manual abstraction!

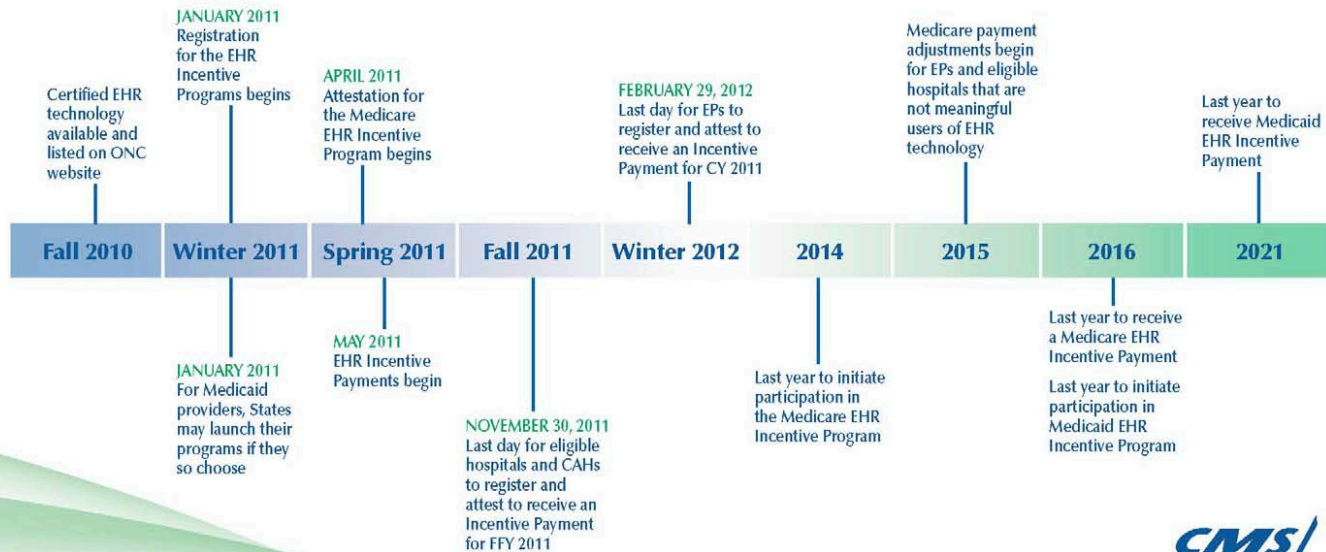
SLEHS Yesterday (literally yesterday)...



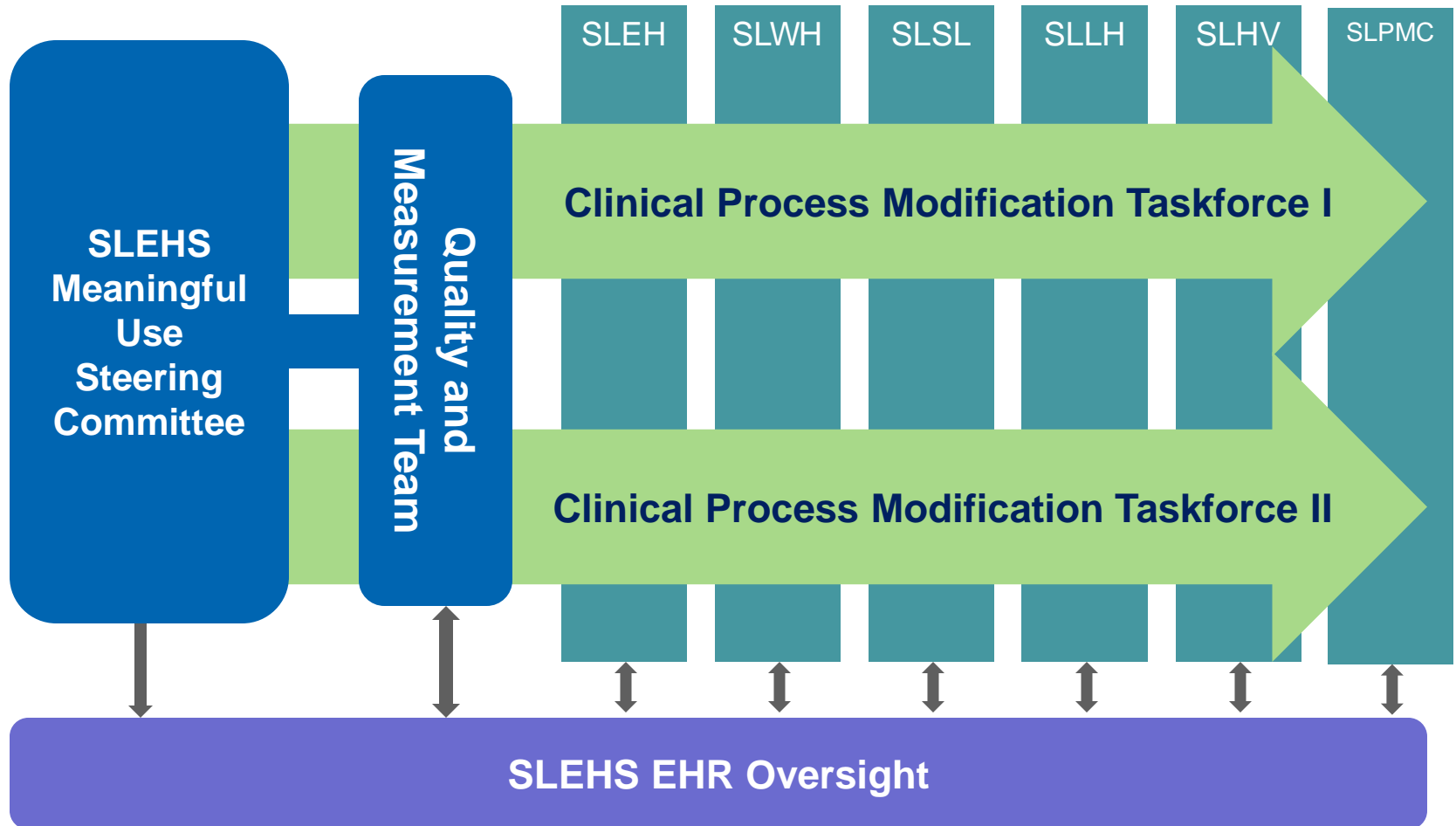
HITECH → MU



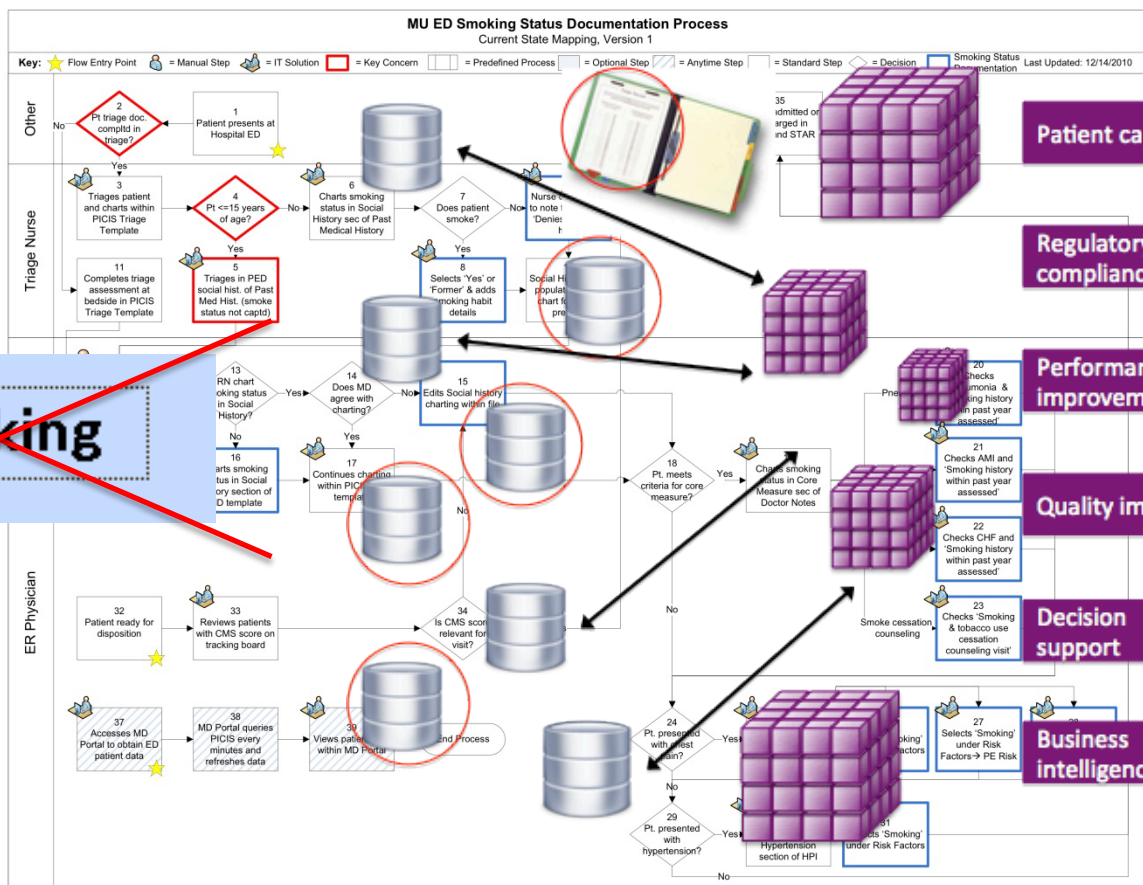
CMS Medicare and Medicaid EHR Incentive Programs Milestone Timeline



MU: Current State → Future State



Reality Check





UGM

10/1/12 – Eligible Physicians
Latest to begin meaningful use to collect maximum incentive

UGM

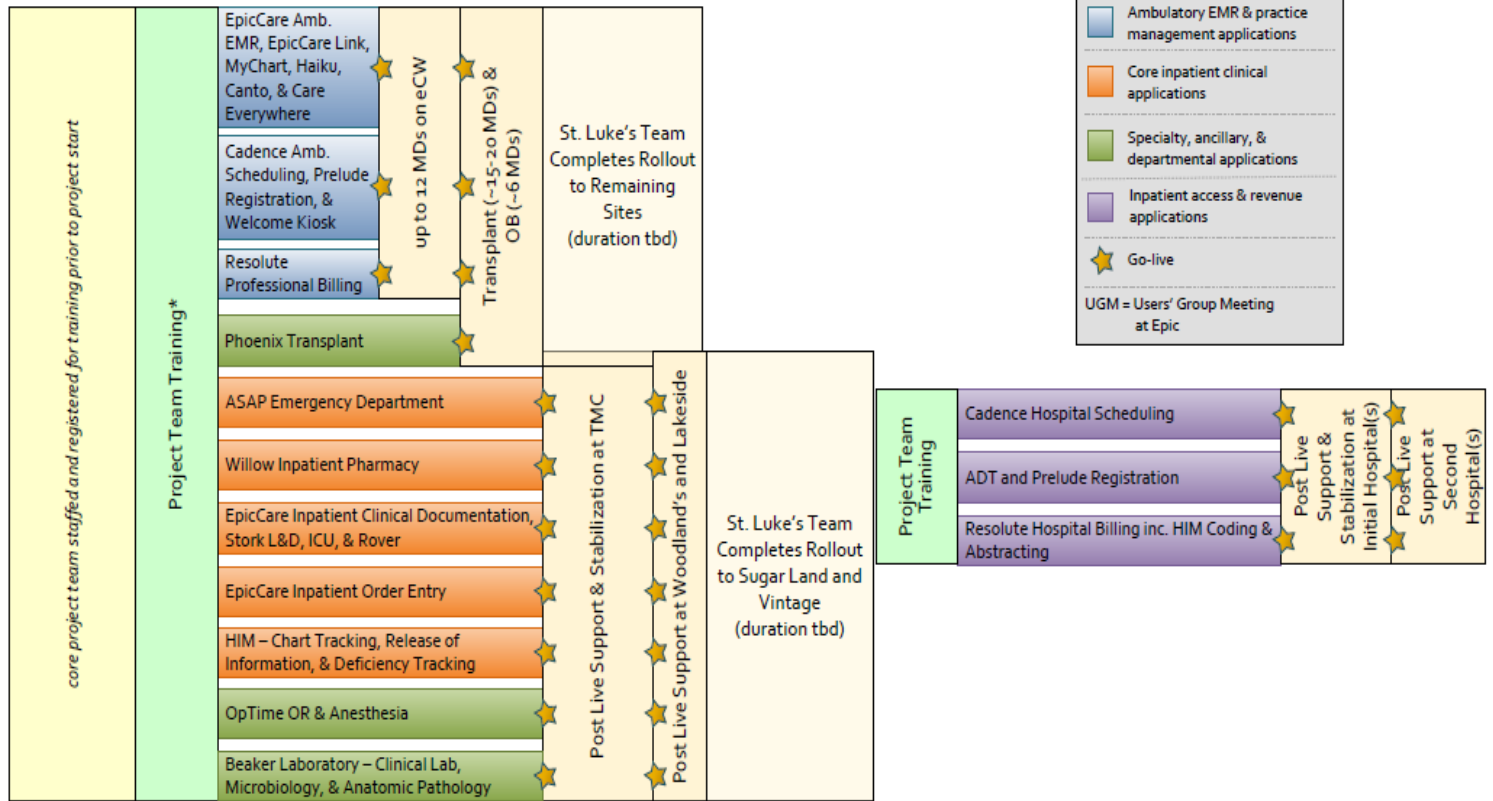
07/01/13 – Hospitals
Latest to begin meaningful use to collect maximum incentive

UGM

10/1/13 – Eligible Physicians
Latest to begin meaningful use to collect ~90% maximum incentive

UGM

UGM



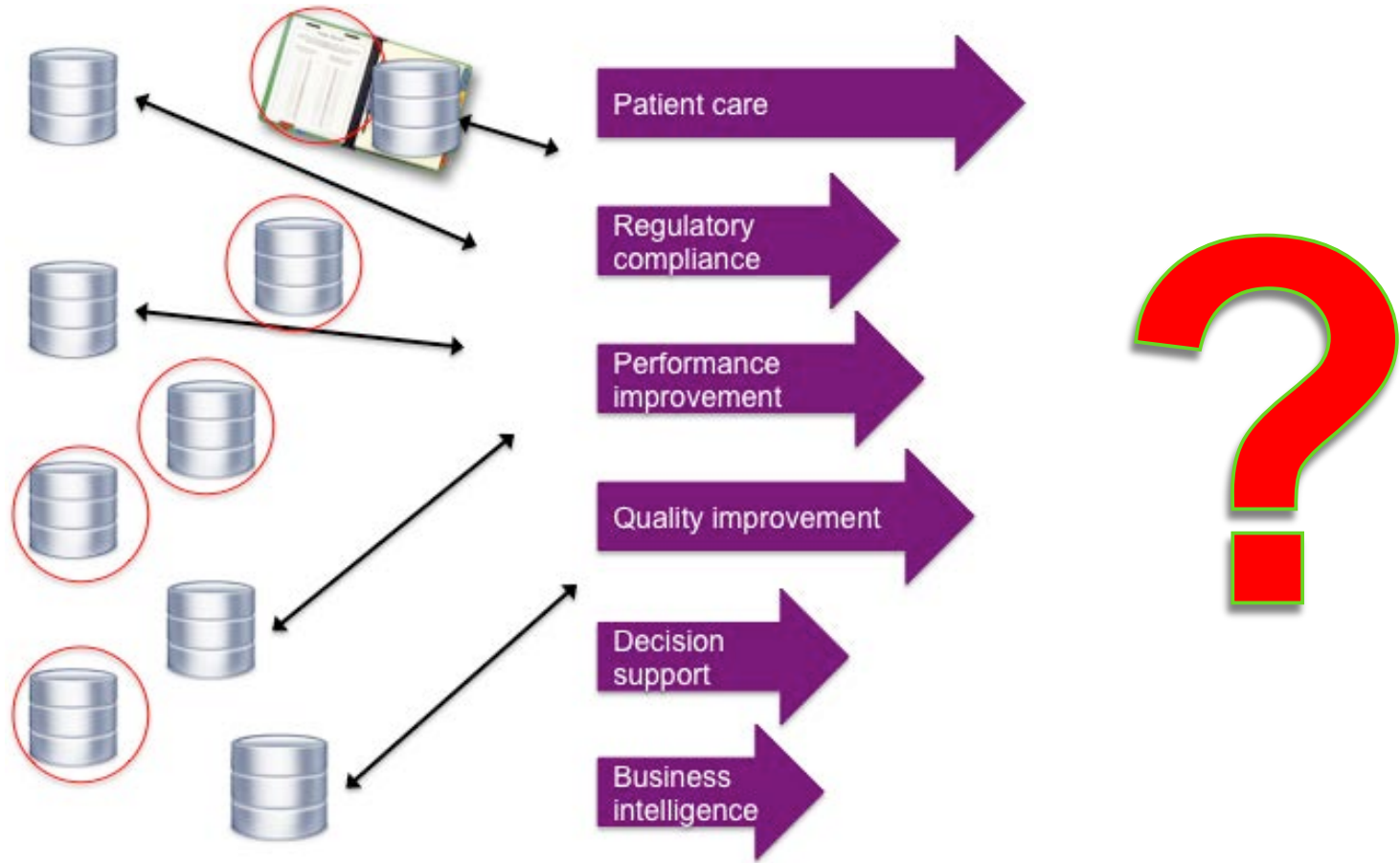
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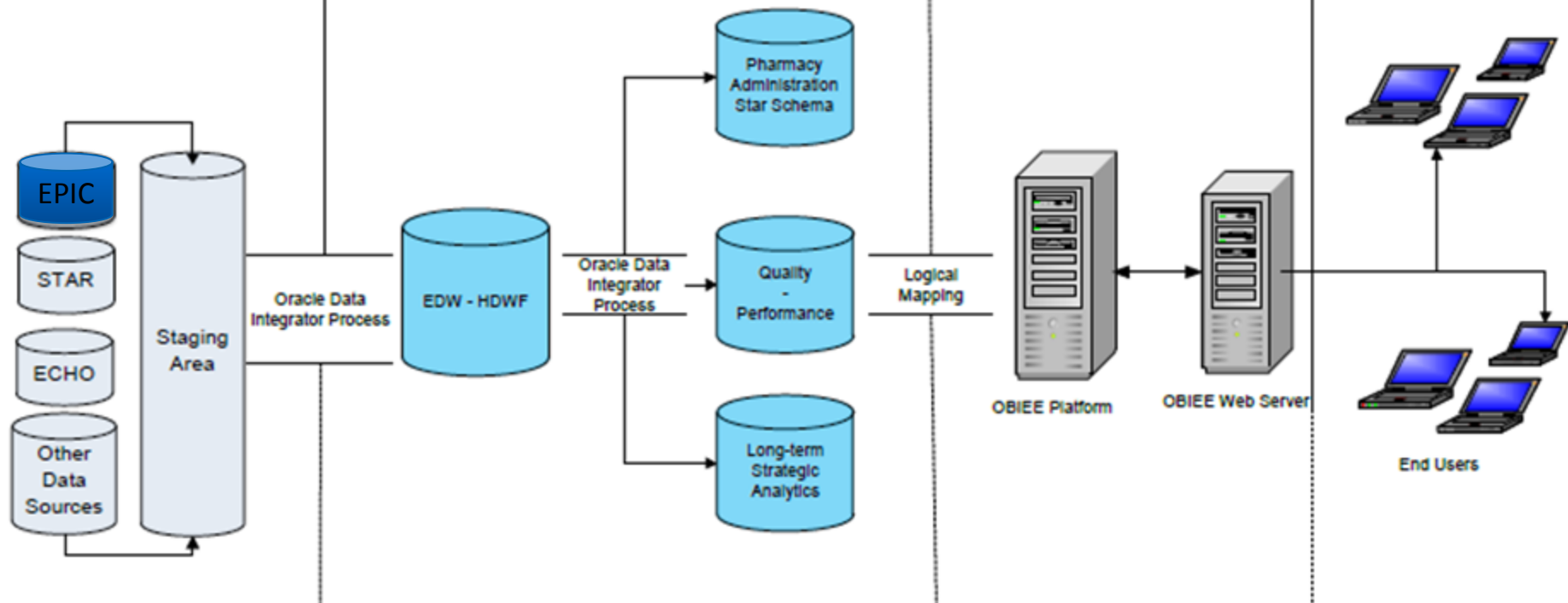
- Ambulatory EMR & practice management applications
- Core inpatient clinical applications
- Specialty, ancillary, & departmental applications
- Inpatient access & revenue applications
- ★ Go-live

UGM = Users' Group Meeting at Epic

*Project team should complete certification within 6 weeks of the last class.

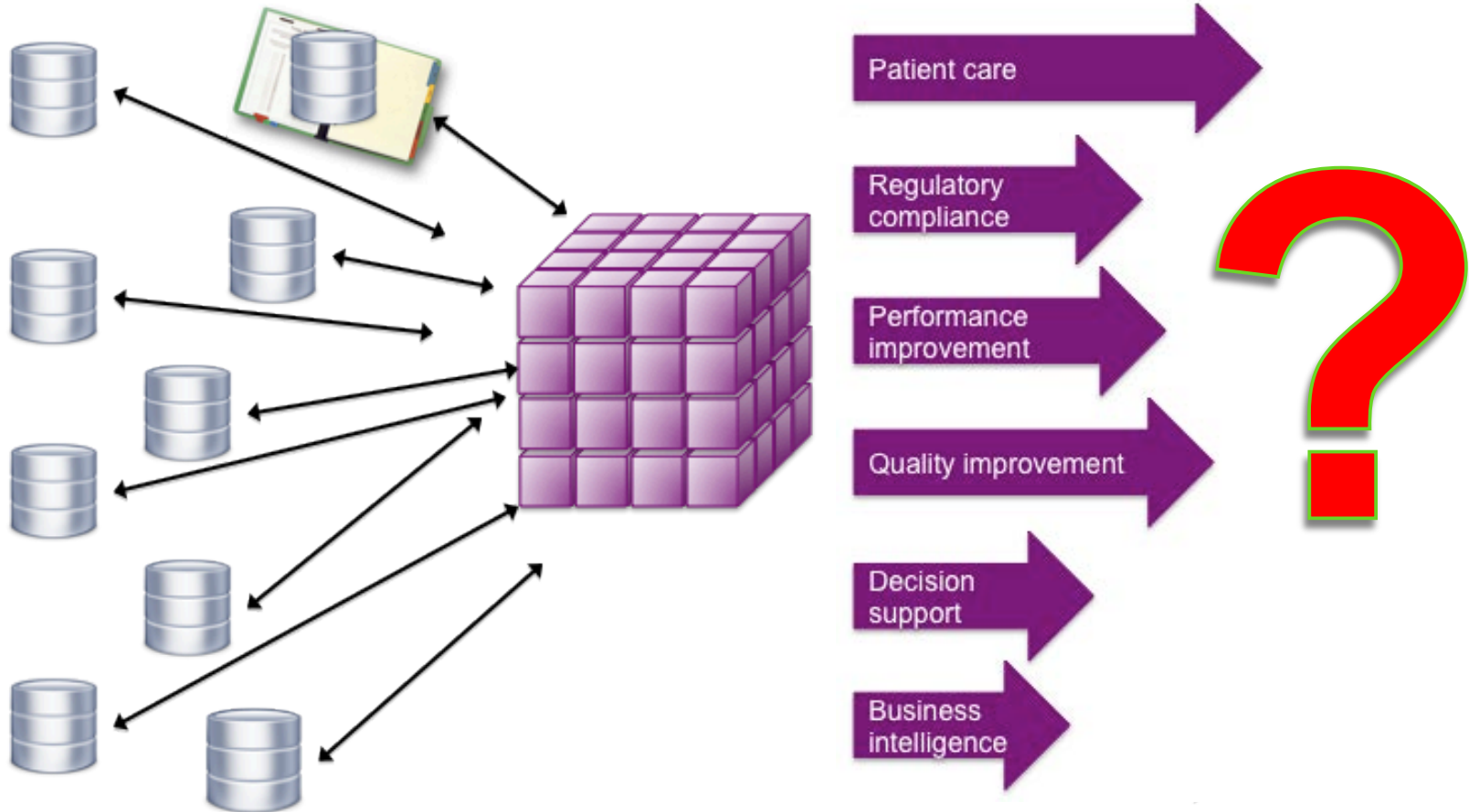
SLEHS Tomorrow



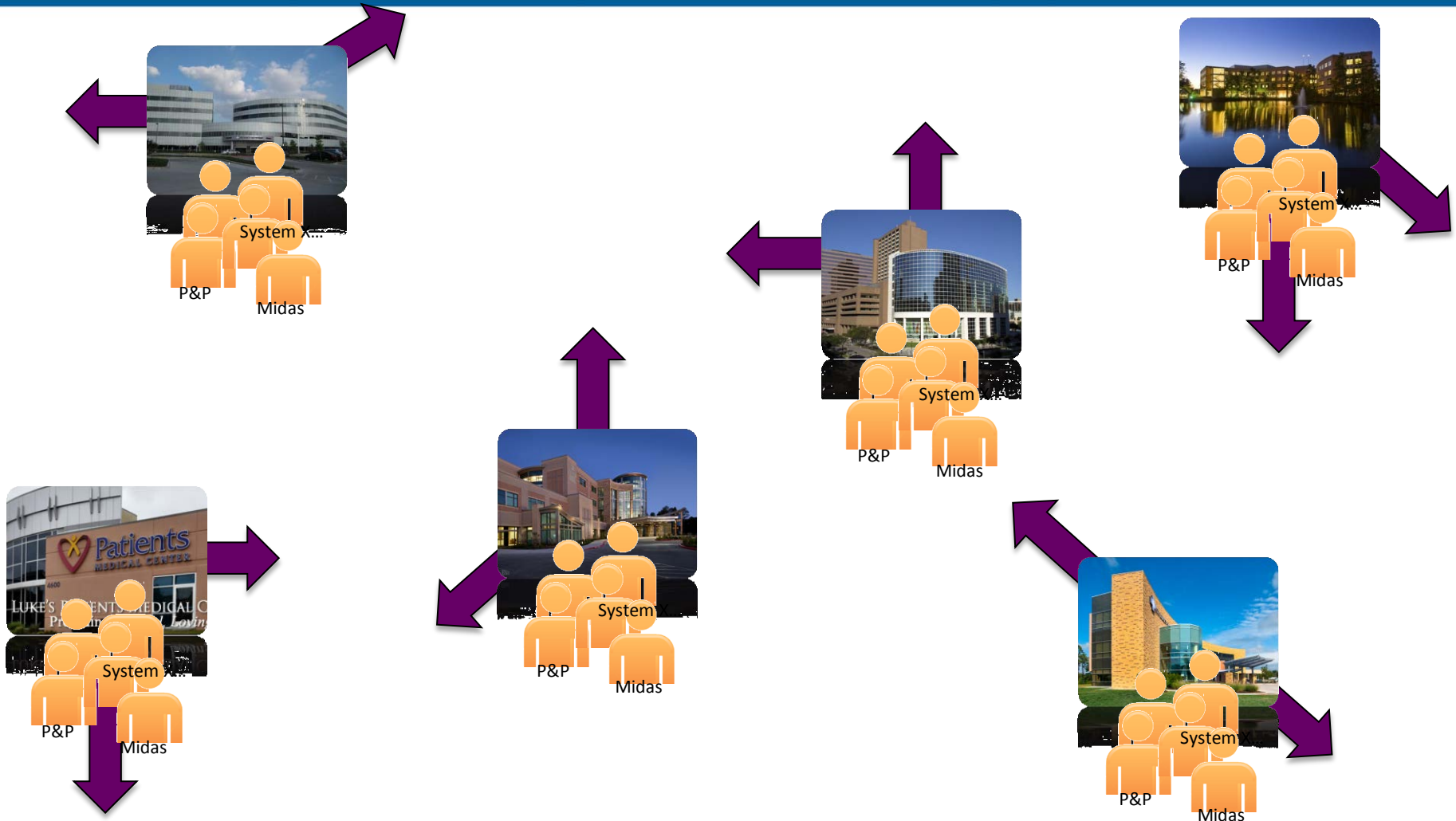


| Application Admin / Developer | Oracle Data Integrator Developer | Data Modeler | OBIEE Administrator | Report Developer/End Users |
|---|--|--|--|---|
| <ul style="list-style-type: none"> Administration of Progress Application Support Progress Changes and Configuration Ensure application performance and availability | <ul style="list-style-type: none"> Development of customized ETL scripts Knowledge of ODI Functionality Run scripts and make changes Monitor production jobs to assure no abends Make changes and fixes to load processes Automate and schedule jobs | <ul style="list-style-type: none"> Integration of customized table Star Schema (Kimball) techniques Identify additional tables and variables needed to add and integrate into current or new data marts Responsible for overall integration from source to data marts. | <ul style="list-style-type: none"> Platform Mapping data marts to the OBIEE Platform Logical field and relationship creation Metadata Management Security Integration and maintenance OBIEE APP and Web Server Administration Performance tuning of platform and report SQL generation | <ul style="list-style-type: none"> Development of Corporate Reports Development/Support of all end users Development/Support of Dashboards Answers (ad-hoc) reporting Customize look and feel Maintain front end query capability Interface with OBIEE Admin Data Subject Area Expert |
| <p style="text-align: center;">Database Administrator Maintain underlying technical architecture and performance management</p> | | | | |

SLEHS the Day after Tomorrow

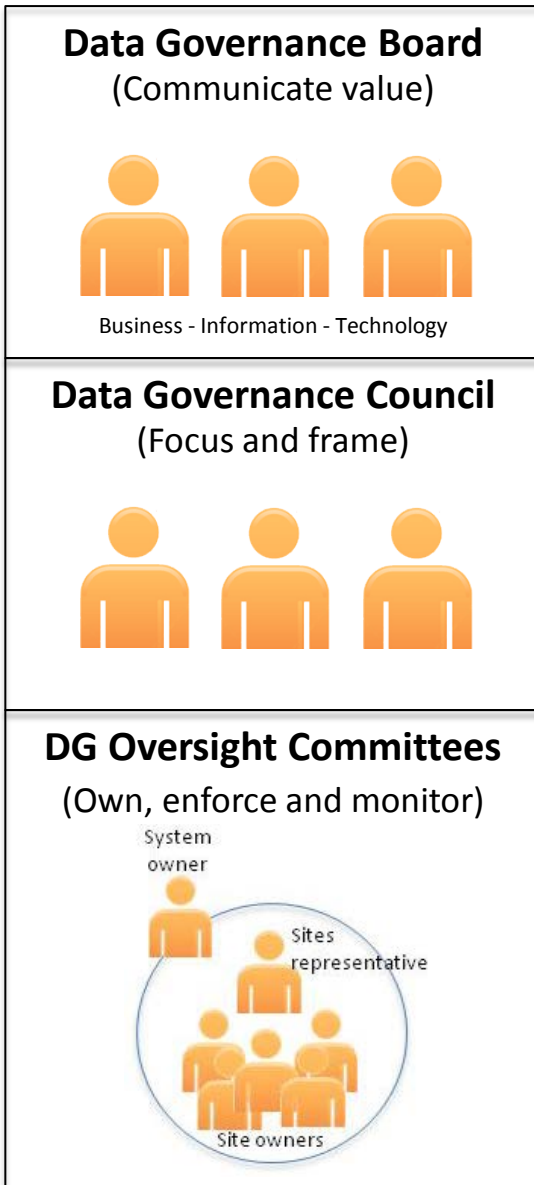


Our Other Challenges



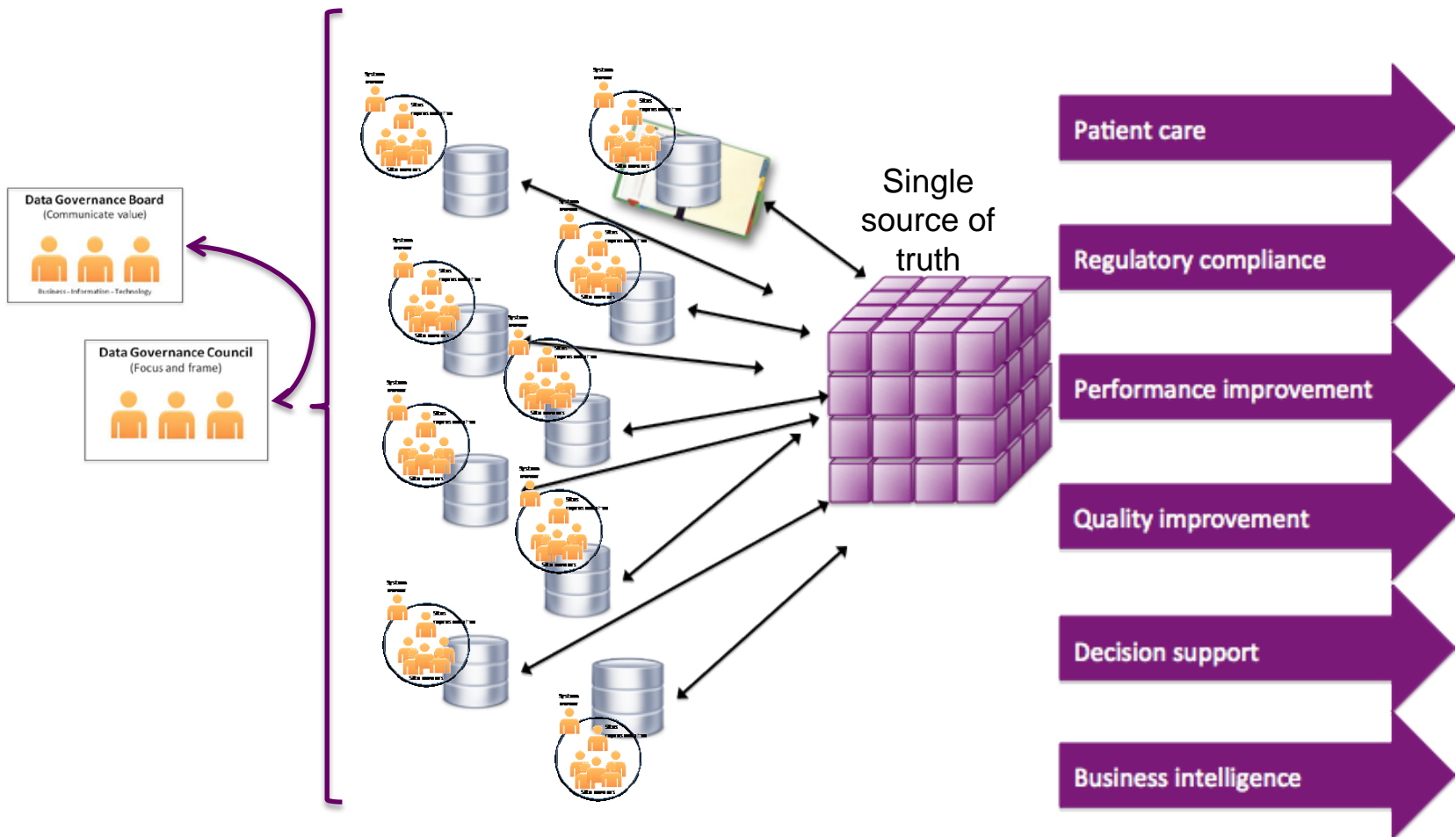
Data Governance (Our Definition)

Our system of **decision rights** and **accountabilities** for information-related processes, to be executed according to agreed principles which describe **who can take what actions** with what information, **when**, under **what circumstances**, and using **what methods**



- Organization's leadership
- Sets the vision, mission and values
- Defines guiding principles
- Data Stewards
- Provide guidance
- Help define objectives, policies, priorities
- Manage DG's resources
- Data owners and data users
- Exercise data governance

SLEHS in the Near Future (not too long from now)



The Changing Role of QP

- Jobs strictly paper-based will need to be overhauled or eliminated.
- More than 50,000 health information management jobs are expected to be created.
- HIT and changes in the quality reporting paradigm promises faster turnaround and easier data analysis which will benefit patient care, reimbursement and clinicians.

The Changing Role of QP

- Informatics nurses will be key as the US healthcare system continues to evolve.
- QP are likely to respond to new expectations:
 - Help train other health professionals
 - Work with vendors and IT teams to create specifications for electronic measures
 - Ensuring documentation compliance using the EHR
- QP/Informatics nurses will be tasked with:
 - Assuring accurate data capture, data quality, and data integrity
 - Conducting real time data analysis for point of care and organizational decision support.

I didn't understand the significance when they said this was a "bleeding edge" project.



Thank You!