DEPARTMENT OF THE ARMY
HEADQUARTERS, US ARMY MEDICAL COMMAND
1216 STANLEY ROAD, SUITE 25
FORT SAM HOUSTON, TEXAS 78234-6010

REPLY TO
ATTENTION OF

MCHS-IS

6 February 2004

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: Minutes of the US Army Medical Command Data Quality for AMEDD Success Team (DQFAST)

1. The DQFAST met in Room 107, US Army Patient Administration Systems and Biostatistics Activity (PASBA) Conference Room, Building 126, at 0900 on 20 January 2004.

a. Members Present:

COL Clark, Team Leader, PASBA
MAJ Ulsher, Decision Support Branch, PASBA
MAJ Briggs-Anthony, Data Management Branch, PASBA
CPT Blocker, Decision Support Cell, OTSG
Ms. Robinson, PASBA
Ms. Mallett, PASBA
Mr. Padilla, RM, MEDCOM
Mr. Fannin, IRAC, MEDCOM

b. Members Absent:

LTC (P) Bennett, Quality Management Division, MEDCOM
LTC Petray, RM, MEDCOM
MAJ Wesloh, Deputy Director, PASBA
Ms. Cyr, ACofS, PA&E, MEDCOM
Mr. Beers, Internal Review, MEDCOM
Ms. Leaders, TRICARE Operation Division, MEDCOM
ACofS, HP&S, MEDCOM

c. Others Present:

MAJ Speights, PA&E, OTSG
Mr. Harold Cardenas, AMPO
Ms. Sherry Stone, Decision Support, OTSG
Ms. Mary Turner, Representing RM MEDCOM, LTC Petray
Mr. Bacon, Representing Data Quality Section, PASBA

2. Opening Remarks. None.

3. Old/Ongoing Business.

a. Approval of Minutes. The October 2003 minutes were approved as written. The Team Leader informed the committee that these minutes will be forwarded to MG Farmer for informational purposes.

b. Quality Management.

(1) Clinical/Clinical Practice Guidelines (CPGs). LTC Bennett reports that the information he brings to the committee is from COL Kimes. COL Kimes is currently working with the Military Health Portal, formerly the US Air Force Portal which is now Triservice. Good data are being received from the provider and patient level. We are looking at clinically interfacing that through some nursing people at the facilities. We are still validating the military health portal against some of the other systems. We were relying on Population Health Operational Tracking and Optimization to roll up data, although the military health portal is good at giving us data from the provider and patient level, it may not be the tool to give us the roll up. Good news is that it is giving us good data and moving ahead. There are many subscribers to the military health portal.

(2) Policy. No updates at this time

(3) Current Processes. No new topics to the CPG menu.

c. Data.

(1) Metrics. There are three new metrics for the 2004 Data Quality Management Control Program (DQMCP). These metrics will be addressed at the end of this section. The other DQFAST metrics are as follows:

(a) End-of-Day. This metric assesses the percent of military treatment facilities (MTFs) compliance for outpatient appointments reconciled in the Composite Health Care System (CHCS).

(b) Delayed-Booking. This metric assesses MTF's non-compliance percentage to book outpatient appointments into the CHCS system in a timely manner.

(c) Medical Expense and Performance Reporting System (MEPRS) Currency. Computed by an analysis of the MEDCOM MTF, MEPRS/MEPRS Executive Query System III (MEQSIII) database file to determine if an MTF monthly MEPRS report is in the files as of 45 days following the reported month.

(d) MEPRS Discrepancy (Errors). Assesses accuracy of MEPRS workload and expense reporting by identifying; work centers with no workload, but costs assigned to the workcenter, and work centers with workload, but no costs assigned to the workcenter.

(e) No Show/Cancellation. This metric assesses the percentage difference between a No Show encounter, a Cancelled by Facility encounter, and a Cancelled by Patient encounter versus Total encounters.

(f) DQMC versus Standard Ambulatory Data Record (SADR) Compliance. This metric compares the SADR and the Worldwide Workload Report (WWR) counts from the DQMC and the SADR Timeliness Metric each month.

(g) SADR Timeliness. This metric assesses the percentage difference between an adjusted SADR visit encounter versus visits reported in the WWR.

(h) Standard Inpatient Data Record (SIDR) Timeliness. This metric assesses the percentage difference of SIDR dispositions versus MEPRS dispositions.

(i) Provider Specialty. This metric assesses the percentage of MTF SADRs with complete fields for provider specialty in a specified period, usually one calendar month.

(j) Health Care Access. This metrics assesses the MTF compliance with TRICARE access standards (urgent, routine, specialty, and, wellness). It measures the compliance for all primary care services appointments (kept, walk-in, sick call).

(k) The three new metrics for the DQMCP fall under the Commanders' Statement, question #2a, Outpatient Encounter Coding Compliance within 3 days of encounter (minus Ambulatory Procedure Visit (APV); #2b, APV's are coded within 15 days of encounter; and #2c, Inpatient records are coded within 30 days of discharge. The PASBA is considering adding more metrics.

(2) DQMC Program Issues. The MEDCOM Data Quality Manager reported last month's report was the first month we reported the compliance rates based on the three new metrics. Eighty-three percent (Amber) reported coding compliance within 3 days; 79 percent (Red) APV coding within 15 days, and 81 percent (Amber) reported coding of Inpatient Dispositions within 30 days. Another metric on the DQMC Commanders' Statement (6e), percentage of completed and current DD 2569s are maintained in the records, 46 percent (Red) compliance reported.

d. Coding.

(1) Current Issues/Solutions.

(a) Coding Compliance Plans. This tasker has been ongoing since October 2003. Currently at 86 percent compliance, or 5 of 36 MTFs have not submitted a completed plan. Once all plans have been approved, they may be shared among the MTFs.

(b) AMEDD Coding Baseline. The study is now available from PASBA. The baseline provides the average from the past four external audits.

(c) Staff Assistance Visits. Two visits were conducted (Fort Monmouth and Fort Eustis) since the last meeting. The PASBA will custom fit the visits to accomodate the MTF's needs. Briefings are tailored for the audience (i.e., Evaluation and Management (E&M) documentation training and Relative Value Units training for the providers). Command sponsorship is needed to ensure command participation. The PASBA provides funding for the trips. Additionally, PASBA provides an informal business process assessment, a very specific MTF data analysis, and coding consultation as needed.

(d) Army Civilian Training, Education, and Development System Desktop Guide. The PASBA, through coordination with the AMEDD Personnel Proponent Directorate will develop an Army requirements-based career development program for coders. This is an orderly, systematic approach to technical, professional, and leadership training and development. It is based on knowledge, skills, and abilities. It can provide a roadmap for career progression.

(e) General Schedule-675 Series. The PASBA initiated a request for a "modification of the qualification standards" with the Civilian Personnel Advisor Center (CPAC). Justification included addressing new hires and providing waivers for personnel currently in the system. Modification request must ultimately receive tri-services agreement prior to submission to the Office of Personnel Management. The CPAC action will follow modification request to permanently change Government qualification standard that requires professional certification as a "condition of employment."

(f) Coder Web Based Education Program. Phase II to the 3M Learning Program is in development. The 3M partnered with mcStrategies to offer improvements to the current training program and to meet the requirements PASBA specified for this phase. This training will allow authorized AMEDD individuals to log on, pretest, and be assigned course work based on the pretest. At the completion of their studies, the

individual will be qualified to test for an American Health Information Management Association coding credential (Certified Coding Associate, Certified Coding Specialist, or Certified Coding Specialist Physician). We anticipate that career advancement for AMEDD coders, contractors, 91G's and/or spouses may be possible.

(g) Coding Guidelines. The PASBA has begun development on "specialty coding guidance" for the AMEDD due to the lack of any tri-service or civilian equal. The PASBA will work closely with each AMEDD Consultant to develop their specialty area and produce guidance on "exactly" what it is that we do in the AMEDD without duplicating other guidelines. Our goal is to produce at least one specialty educational product per month towards the cumulative "Coding Guidance". The Unified Biostatistical Utility Workgroup has already provided the initial endorsement of the AMEDD concept for the future tri-services Ambulatory Data Module Coding Guideline standard. The new AMEDD guidance will be a complete departure from what the AMEDD is used to:

--We will not restate what coding "is" or what the "basics" are. That is what the Current Procedural Terminology (4th Revision) (CPT-4), International Classification of Diseases, 9th Revision (ICD-9), Faye Brown, Principles of Coding, etc. are for.

--We will separate chapters by specialty services not by generic procedural or diagnoses coding.

--We will state exactly what we do code, how we code it, and why it is unique to us.

--We will provide a better understanding of what the military terminology means and where to find references to Medical Evaluation Board, Exceptional Family Member Program, and line of duty, etc.and a number of other uniquely coined terms that mean one thing in the Army Regulation but may be interpreted as another to an unsuspecting coder.

--The chapters will include E&M, CPT, Healthcare Common Procedure Coding System and ICD coding for those specialties and sub-specialties, as well as, any other pertinent data needed to assist in coding the encounters.

--We will include a detailed Anesthesia section since this was a difficulty across audits. It will include many basics (within the limits of copyrights) until we improve the coding.

--We will publish training presentations with each specialty chapter or group several "like" chapters together into one presentation. Anesthesia will have its own chapter.

--Our goal is to have this published by mid-summer.

--As we produce a training presentation, we will release it to the field (at least one per month).

--If time permits, we will include Inpatient Coding and include the Industry Based Workload Alignment packet in that guideline.

(2) System Status:

(a) Coding Compliance Editor (CCE). The CCE (Outpatient) version is awaiting form, fit, and function testing at a designated AMEDD facility. Testing is currently on-going at the US Navy Pensacola. Once deployed, the CCE can improve patient encounter coding, data quality and generate better revenue performance. Recently, a CCE (Inpatient) Joint Application Conference was held in Washington, DC to kick off the introduction of the systems development for this version of the 3M product. A tri-service workgroup participated in the 2-day seminar that included requirements development, encoder-grouper analysis, MTF process business process discussion, and a discussion of relevant coding standards. The Resource Information Technology Program Office is aggressively seeking a July/August 2004 deployment schedule for this phase of the CCE.

(b) CHCS II. It appears that two AMEDD sites undergoing early CHCS II implementation believe that the system may be the cause of much of their data quality troubles within the DQMCP reporting process. A staff assistant visit to Fort Eustis indicated there was no evidence to support this finding. That same staff assistant visit yielded many systems' issues. These issues alone were not significant, but if coupled together over and over, could yield a significant change in the data quality of the coding:

--The Specialty Exam guideline algorithm in CHCS II appears to be contributing to a lower E&M being assigned.

--Provider roles in CHCS II are not well defined. A tech role allows access to CHCS II to print labs, but the tech's name prints on the Standard Form (SF) 600 as if he/she were a provider.

--The third key component of the E&M, the Medical Decision Making algorithm in CHCS II is not well developed. For instance, the coding and auditing guideline for prescribing medications (non-over the counter) calls for the minimum level under Management Options to be a 3, CHCS II defaults to a 2.

--Difficult to audit medical decision making since all graded bullets do not appear on SF 600.

--The CHCS II cannot distinguish between new and established patients yet. Providers are required to manually change the patient status from established to new.

--Cannot enter CPT procedure codes more than once.

--Code tables difficult to navigate through. Taxonomy does not match other tables used in the Military Health System.

--Assigning Department of Defense (DOD) extender codes differs from assigning basic ICD-9 specificity. In order to get to the DOD extender codes, provider has to double click on the ICD-9 code, and then right click in order to bring up a pop-up window with a pull down menu of the extender codes.

--The disposition screen is a bit misleading to providers-they are selectively up-coding and down-coding E&M based on estimated time reported by the system.

--All results addressed above, and others, were briefed to the CHCS II Planning & Integration Team. The current processes are underway to correct deficiencies. The PASBA staff are committed to remaining closely involved with the deployment and training of all future AMEDD CHCS II sites. We are scheduled to visit Fort Lee in February and Fort Bliss shortly afterwards.

e. Resource Management.

(1) Current Resource Management Issues: No updates at this time.

(2) MEPRS: a problem was recently found when using the Expense Assignment System, Version IV (EAS IV) Consolidated Repository, Defense Medical Information System name. Somehow it corrupts the data in several classes when using the bridge. All sites have been notified of the problem and it is also posted on the TRICARE Management Activity website. The EAS Project office is working to correct the problem.

(3) Fort Gordon experienced coding problems when coding the workload to the ancillary instead of to the requesting workcenter. Concern is how it affects the data quality in M2. The CHCS is unable to correct the errors. A new metric that started this year: Work centers with zero workload/FTEs or workload with zero FTEs. We are working on this metric to determine correct reports. Thirty-four sites have reported for November. Fort Gordon was late due to CHCS problems. The representative was not sure why Fort Knox did not provide a report.

f. Data Quality for Deployed Units.

(1) PAD tool. We are attempting to deploy the PAD tool which is the patient management tool Access data base developed by PASBA to replace TAMMIS, to facilitate requirements for a single entry, and to eliminate mailing the SIDRs and forms. We have a newer version of the PAD tool that has not been deployed to existing units, but has been deployed to the new units.

(2) Records retirement. The National Personnel Records Center (NPRC) has automated the process to retire records so records are no longer sent from the field to NPRC. All deployed units' inpatient records for retirement will be sent to PASBA which means there will be an increase in PASBA's workload by re-validating, coding, submitting the records in the proper format to NPRC.

(3) Coding issues. Use of proper codes during inpatient and outpatient process continues to be problematic. We have placed the Abbreviated Narrative Summary, DD 2770 on the PAD tool that should allow us to receive a synopsis of the patient admission. The DD 2270 is replacing the SF 539. The PAD tool is the tool to use if they are not using CHCS. Kosovo and Bosnia units are not using CHCS.

4. New Business.

(a) Charter: The Charter has been revised with input from the committee members and is being staffed for MG Farmer's signature. The current Charter was signed by MG Sculley April 2001.

(b) Membership: As mentioned earlier, Dr. Bennett will replace COL Kimes.

(c) Committee Frequency: The committee voted to meet every other month, but, the Team Leader commented that we should table any further decisions and to keep it monthly until we receive feedback from the DSG.

5. The meeting adjourned at 1005. The next meeting will be on 17 February 2004.

LARRY J. CLARK
COL, MS
DQFAST Team Leader

DISTRIBUTION:
1-Each Committee Member

MCHS-IS
SUBJECT: Minutes of the US Army Medical Command Data Quality for AMEDD Success Team (DQFAST)

LARRY J. CLARK
COL, MS
Director, PASBA

out of ofc
DEBORAH WESLOH
MAJ, MS
Deputy Director, PASBA

for
JOAN USLHER
MAJ, MS
Chief, Decision Support Branch

GARNET ROBINSON
Chief, Data Quality Section

JOE ALLEY
Data Quality Section