

HIM Functions in Healthcare Quality and Patient Safety.

Appendix B: HIM's Role in Data Governance

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A solid foundation is key to any organization's structure. The same is true for HIM. Information stewardship and data governance practices provide cohesive policies, processes, and decision rights and responsibilities for effective health information management and maintenance.¹

The concept of data governance arrived not long after transaction systems and coding technologies made structured data with high integrity available. Soon structured data began feeding data warehouses/marts in order to enhance enterprise planning, forecasting, and decision making and to create competitive advantages, such as real-time quality measurement reports, improved patient engagement opportunities, and new or enhanced patient care models.

Long in the forefront of healthcare sustainability from a reimbursement standpoint, HIM professionals have a unique opportunity to support the growth, from small data management efforts to true organizational information management. Why are healthcare organizations interested in information management?

The key drivers pushing organizations to more effectively manage their information include:

- **Cost.** Organizations are recognizing that retention and storage of information is costly and difficult, a great deal of information is redundant, and not all information has value. HIM professionals can help their organizations identify what information needs to be retained for legal and/or business reasons
- **Meaningful use.** Regulatory incentives are requiring organizations to manage resources in a way that enables meaningful use of information and technology. Healthcare organizations must be able to obtain information from multiple, disparate sources. Knowledge workers are increasing in demand to support real-time analysis and information exchange.
- **Innovation.** Access to diverse information sources enables knowledge creation and enhances the likelihood of innovation, such as improved patient care models, new opportunities for clinical research, and improved care processes.
- **Patient safety.** Information management enables organizations to support patient safety improvement efforts by providing accurate and complete data.
- **Healthcare customers.** Sophisticated healthcare consumers want access to information that is readily searchable.
- **Legal/compliance pressures.** Organizations must balance cost-effective compliance with an increasing deluge of laws and regulations.

Data governance and information management involve an HIM-led team assessing an organization's information sources and functions, including:

- Inventory data sources
- Assess the nature of the information in each system
- Create or update the enterprise-wide data dictionary

The next step in data governance/information management involves establishing ownership of the information repositories and creating accountability. When HIM professionals assume ownership of the data and information residing in their domains, they also assume stewardship or accountability for the decisions that information management implies, including:

- Determining the standards for which the organization will seek compliance
- Determining the organizational requirements for information integrity and creation of agreed-upon levels of information quality.
- Documenting the metadata that lies behind each application, including:
 - How are data captured
 - What measures are taken to validate data and information

- What role the HIM professional plays in data and information maintenance
- Determining what data/information vendors will need to supply for the commissioning of new systems or the enhancement of existing systems
- Determining the impact on data and information when new systems are implemented, including:
 - Information standardization (i.e., common definitions)
 - System integrations
 - Migration and information consolidation management
- Determining what changes will occur to existing information when system changes occur, when new versions are introduced, or when it is time to decommission legacy systems, and mapping and documenting such changes for future reference
- Decisions to archive, retrieve, retain, and/or destroy information
- Security decisions, such as what information should be recovered first in the event of an interruption of system service?
- Decisions about what matters must be referred to legal services or compliance for consideration (e.g., what information is privileged? What information is sensitive?)
- Determining the competencies employees will need to correctly manage and maintain data/information
- Determining HIM's role in data/information analysis, retrieval, and reporting
- Determining HIM's role in data/information dissemination

Data Standardization

An important element in data stewardship that affects data use for healthcare quality and patient safety programs is the data standardization. This is important not only for use at the patient level but also for aggregation, reporting, and critically, for comparison both within and across organizations. There are several areas where HIM professionals can provide leadership.

Identifying key data elements that require standardization. The development and maintenance of data dictionaries for all systems that contain key healthcare data elements is a major component of standardization. This can include ensuring uniformity of data definitions, identifying data sources and how data flows through the organization, and identifying where inconsistencies may exist in how definitions are applied or code sets are used.

To identify data elements for use in quality and patient safety measures and ensure these measures are being reported correctly, HIM professionals must determine the best place to obtain the data (especially if similar data elements reside in different systems), how that data is represented (free text, codes, pick-list), and any issues that may exist with data consistency and completeness.

Forming alliances with organizational staff responsible for capturing these data elements or managing the systems that contain the data. Patient data are captured in a variety of settings and applications throughout an organization. Whether the patient record is electronic, hybrid, or paper, there will be data coming from other systems such as a laboratory information system, pharmacy information system, and clinical and caregiver documentation.

Developing a partnership with the managers of departments or vendors such as the clinical laboratory and pharmacy will provide insights into how this type of data is captured, what standards are used within these systems, and how this data should be represented within an EHR or any other database that may be used for analysis and reporting.

By coordinating with clinical informatics and working side by side with physician and nursing clinical informatics staff HIM professionals can join forces to not only improve the quality of the documentation but also improve treatment protocols, increase reliance on evidence-based medicine, and ensure that data are standardized and coded.

Clinical documentation improvement (CDI) functions. Clinical documentation in the health record is critical to the patient, the physician, and the organization. Acute care hospitals, in particular, have become more dependent on physician documentation in order to comply with the Centers for Medicare and Medicaid Services regulations regarding quality and reimbursement.²

HIM professionals can provide support for the following CDI functions:

- Identifying and clarifying missing, conflicting, or nonspecific physician documentation related to diagnoses and procedures
- Supporting accurate diagnostic and procedural coding, DRG assignment, severity of illness, and expected risk of mortality, leading to appropriate reimbursement
- Promoting health record completion during the patient's course of care
- Improving communication between physicians and other members of the healthcare team
- Providing education
- Improving documentation to reflect quality and outcome scores
- Improving coders' clinical knowledge³

Standardizing data and its capture enables the creation of reports that will accurately reflect patient treatment and outcomes.

Leveraging the use of national data standards within their organization. HIM professionals should identify what national data standards exist and ensure that these standards are being used throughout the organization wherever possible. When local or institutional standards need to be developed, these should be well documented as to their rationale and relationship with any corresponding national standard. If an organization desires more specific data elements that can be captured by a national code set, it should ensure that its data can be aggregated back to the national code set for external reporting or comparison.

As standards change over time there needs to be a mechanism to review the changes and determine how those changes will be implemented within the organization. These changes can be as simple as adding a new discharge status category to the adoption of a new classification system such as ICD-10-CM/PCS.

HIM professionals should also be involved in managing the use of vocabularies and clinical code sets within their organization. While traditionally this has primarily revolved around code sets for diagnosis and procedure classifications such as ICD and CPT, the evolution of the EHR and the increasing use of other clinical data such as laboratory results and drugs will increase the types of code sets that will need to be managed. Understanding the key concepts, strengths and weaknesses behind each code set will be important to determine the appropriate use for healthcare quality and patient safety purposes.

Managing data crosswalks between the various codes set where they may be needed and any limitations in converting data to different code sets is also necessary.

Participating in national or local initiatives to develop and promote data standards, quality measures, and patient safety programs. HIM professionals should identify opportunities to participate in standards development or reviews at the local, state, or national level. A number of organizations, including AHIMA, Health Level Seven International, National Quality Forum, and the Centers for Medicare and Medicaid Services, provide opportunities to review and comment on new and revised standards and quality and patient safety measures.

The EHR will provide a greater opportunity for access to healthcare data. Working with standards organizations and providing feedback on new or revised standards provide HIM professionals with an opportunity to provide practical information on how well the standards will work, what modifications may be needed to make the standard more effective, and ensure that organizations can achieve the standard.

The transition of quality and patient safety measures from claims based or manual collection to electronic is escalating. More than ever HIM professionals need to provide the expertise on the data and the systems being implemented in their organizations to make sure that the electronic measures can capture the same or similar data to still represent the intent of the measure.

Notes

1. AHIMA. "Leadership in Action: HIM's Role in Healthcare Transformation." HIM Core Model Extended. AHIMA Winter Team Talks. Washington, DC. 2011. Available in the AHIMA Body of Knowledge at www.ahima.org.
2. AHIMA. "Clinical Documentation Improvement Toolkit." 2010. www.ahima.org
3. Ibid.

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Article citation:

AHIMA. "HIM Functions in Healthcare Quality and Patient Safety. Appendix B: HIM's Role in Data Governance." *Journal of AHIMA* 82, no.8 (Aug 2011): expanded online version.

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