Issue No. 5, 2011 $3.00

Western Pennsylvania
Hospital News

Dedicated to the spirit of unity, community, and sharing

25th Anniversary

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EHRs Target Quality, Safety, Efficiency & Access

By Brian O'Neill

Just a decade ago, the adoption of electronic health records and other health information technology (such as computer physician order entry) was minimal in the United States. Fewer than 10 percent of American hospitals had implemented HIT while a mere 16 percent of primary care physicians used any form of EHRs. But that is all changing.

The HITECH Act, part of the 2009 economic stimulus package passed by Congress, aimed at inducing more physicians to adopt EHR as a way to improve quality, safety, efficiencies and access. Title IV of the act, in fact, promises maximum incentive payments for Medicaid to those physicians who adopt and use "certified EHRs" beginning in 2011. On the flip side, physicians who do not convert to EHRs by 2015 will be penalized by a reduction in Medicare payments.

In order to be eligible to receive the stimulus money, providers must use EHR technology that has been certified to allow providers to achieve "meaningful use." These are categorized as technology that improves care coordination, reduces healthcare disparities, engages patients and their families, improves population and public health, and ensures adequate privacy and security.

This combination of financial incentives, political pressure, and the rapid acceptance of communication technology is causing physicians here in Pennsylvania and around the rest of the nation to scramble to get their electronic health

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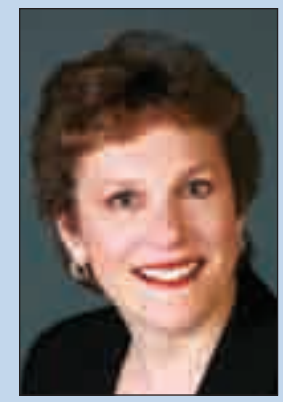
Eliminating Duplicate Records to Achieve Meaningful Use



By Beth Haenke Just

The new buzzword in healthcare technology, meaningful use plays an important role in a hospital's ability to qualify for incentive funds under The Health Information Technology for Economic and Clinical Health (HITECH) Act. With payments starting at $4 million for hospitals that qualify under both Medicare and Medicaid programs, hospitals are eager to comply with meaningful use criteria. However, a high volume of duplicate records may hinder a hospital's ability to do so.

That is because several Stage 1 qualifying criteria are tied to a percentage of unique patients. When that percentage is based on records, which is the recommended approach, even a relatively low duplicate volume will falsely inflate the number of patients to which the criteria must be applied.

For example, one criterion is that 80% of patients must have a problem list within the EMR in a structured data format. If a hospital has 1 million unique patient records in its system, 10% of which

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McKeesport Hospital Foundation Invitational Now in 34th Year

By John Fries

In 1977, a physician named named Dr. Frank Bondi joined his love for and dedication to his community hospital with his affinity for golf to give birth to a golf outing to benefit UPMC McKeesport. In the years since, Dr. Bondi's legacy has grown and flourished thanks to the vision of the McKeesport Hospital Foundation and the growing wave of community support for the hospital and this signature event.

This summer, the McKeesport Hospital Foundation is planning UPMC McKeesport's 34 annual Invitational, which has grown from that golf outing into a three-day event that includes a July 30 tennis event at Renzie Park, a July 31 fashion show with a "Classic Hollywood" theme and an August 1 golf outing and dinner at the Youghiogheny Country Club.

The kickoff for this year's gala took place at the annual Invitational luncheon held last month at the Country Club, where Michele Matuch, executive director of the McKeesport Hospital Foundation, joined UPMC McKeesport President Cynthia M. Dorundo, and the Reverend Earlene Coleman of Bethlehem Baptist Church in providing a preview of the 2011 Invitational and the Foundation's history of support for the hospital and myriad contributions

The Daily News Publishing Company

Michele Matuch (right) reviews planning for the new Frew Courtyard project with (from the left) Cindy Dorundo, president, UPMC McKeesport, State Senator Jim Brewster, and Merle Taylor, vice president, Operations, UPMC McKeesport. Construction on the project, funded in partnership with the McKeesport Hospital Foundation to enhance patient access and provide a warm, welcoming park-like setting for the hospital's entry, will begin within the next month.

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are duplicates, compliance would require problem lists for 800,000 patients. Eliminating those duplicates drops that number to a more easily attained 720,000 patients. If that same hospital had a duplicate volume of 15%, eliminating that would drop the number of problem lists required to just 680,000.

A Very Real Problem

Duplicate patient records are more prevalent than many realize. Industry estimates place the volume of duplicates at a typical hospital at 3-15%. That can be 30% or higher at facilities that have been acquired, merged with another or that are part of an integrated network.

One three-hospital system determined that its duplicate volume was more than 17,000 records. While this number created a challenge in achieving meaningful use to qualify for incentive funds, the burden it placed on the hospitals financial stability was even greater. The estimated annual cost of those duplicates was anywhere from $554,000 to more than $1.2 million for repeated tests and treatment delays, as well as incremental costs related to longer registration times and correcting duplicate records.

Duplicate patient records can also complicate a hospital's ability to achieve meaningful use of health IT and to realize its full financial benefits by hindering adoption and straining staff resources. That was the case at one of the nation's top 10 pediatric academic medical centers, which learned almost too late that an electronic health record (EHR) system is only as good as the data it contains.

When the data from the hospital's old master patient index (MPI) was loaded into the new system, chaos ensued. Because the new system's search routine was programmed to deal only with exact matches, something as minor as a misspelled name, or a missing space or a comma between a first and last name yielded a separate medical record.

When surveyed, 45% of the hospital's physicians said they encountered duplicate records, 25% said the duplicate rate was affecting quality of care and 30% said they re-ordered tests because of lack of access to previous records.

It is for these reasons that hospitals must make eliminating existing duplicates and preventing the creation of new ones an integral part of their data management strategy. The challenge, however, is that the process for doing so is error-prone and resource-intensive.

Leveraging Automation

The solution for a growing number of hospitals is leveraging automation. Advances in technology enable facilities to replace what is currently a largely manual process with one that eases the strain on resources and lessens the potential for human error.

Traditionally, the reconciliation process is executed entirely on paper. Potential duplicate records are identified as patient charts are pulled. They are then assigned to a team of HIM experts who must analyze previous charts and other information to verify whether or not they are actual duplicates before they can be eliminated.

Even if a hospital's information system provides reports of potential duplicate records, the data they contain is typically limited to basic identifiers such as name and date of birth. More research is generally required to resolve duplicates. Further, progress is typically tracked on paper, widening the margin for error and creating a duplicative workflow.

By automating key portions of the reconciliation workflow, hospitals can quickly and efficiently weed out existing duplicates and prevent the creation of new ones. By allowing multiple duplicates to be reviewed in a single view, automation also heightens user control over merging, lessens the time required to complete the process and enables more effective quality assurance.

Automating high-level processes supports merging records in downstream systems while reducing manual steps and associated costs. Further, automation can reduce the time and resources required for reconciliation. The best systems will also automatically document decision validity, track productivity and generate comprehensive, user-friendly reports that provide a complete view of efforts and insights into problem origination points.

By leveraging workflow tools that automate key processes within an otherwise time-consuming, tedious and error-prone reconciliation process, hospitals can quickly and easily implement efficient, cost-effective solutions to identify and correct duplicate patient records. This will also free valuable human resources, which can be redeployed to manage other core needs.

Ultimately, by automating the process by which duplicates are eliminated from the system, hospitals are able to significantly reduce the human errors and process failures that lead to their creation in the first place. As a result, they are able to reclaim lost revenues, increase clinician satisfaction with and adoption of health IT and ease the path to qualifying for incentive funds under HITECH.

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