

## **HIM/CHA Advisory Group**

### **Meeting Summary: May 20, 2011, 2:30 to 4 PM**

**Present:**

Sue Malone, co-chair, Clinical Information Consulting  
Linda Schwab, co-chair, Centura  
Dana Batey, HCFP  
Cathy Gilliland, Memorial  
Sheri Hager, PSL  
Faith Hoxworth, Advantage Coding Enterprises  
Jill Johnson, Spalding Rehab  
Nichole Pascale, Denver Health  
Debbie Reuppel, Parker Adventist  
Eric Ryland, Denver Health  
Carol Stanton, State Health Department  
Kristi Stanton, Haugen Consulting Group  
Julia Walker, CHAN Healthcare Auditors

**Via webinar:**

Elaine Barnett, St. Mary's, Grand Junction  
Sarah Branish, Centura  
Patricia Chaloupka, Montrose Hospital  
Nancy Dietz  
Kathleen Goedecke, Centura  
Lyndee Graham, Aspen Hospital  
Shelly Hooper  
Donna Lucas  
Jeanne McCarthy  
Linda Paro, Parkview, Pueblo  
Sue Ann Pumphrey

**CHA Staff:**

Jim Carr  
Bob Finn  
Trish Harmon-Lynch  
Curtis Sandlin

We welcomed **Holly Hedegaard, MD, MSPH**, EMTS Data Program Manager for the Health Facilities and Emergency Medical Services Division of the Colorado Department of Public Health and Environment (CDPHE).

Dr. Hedegaard presented a slide show about the use by the CDPHE of the CHA database. This included special attention to emergency services data, E-code data, and a look at data from calendar year 2010, which is the first data output using the new revised UB-04 data submission format.

Dr. Hedegaard identified the absence of race/ethnicity data as one of the inaccuracies she would most like to see fixed. Most of the missing race/ethnicity data is from one hospital, Longmont Hospital, which apparently does not collect the information. We decided that we would try to locate appropriate people at Longmont to address this issue. There was some discussion about whether or not CHA should make the field required, and put an edit on it.

Dr. Hedegaard also emphasized how much CDPHE would like additional detail on falls, taking note of the new E-codes with considerable extra detail about activities patients were engaged in at the time of injury. Attendees pointed out that while there might be more detailed codes, at the same time the documentation is becoming worse, especially with the increased use of "robo-reports". Medical records frequently have automated, canned reports that do not accurately describe the actual events. Different entries from physicians, scribes and nursing notes often have several completely different versions of what exactly happened.