

**BY ORDER OF THE COMMANDER
59TH MEDICAL WING**

**59TH MEDICAL WING
INSTRUCTION 33-104**

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Communications and Information

***DATA QUALITY MANAGEMENT
CONTROL PROGRAM***

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This instruction implements Air Force Policy Directive 33-1, *Information Resources Management*. This Medical Wing Instruction (MDWI) establishes 59 Medical Wing (MDW) policies, procedures, and guidelines for the systematic review, validation, reconciliation and auditing of source financial, workload and personnel data entered into the Composite Health Care System (CHCS), Armed Forces Health Longitudinal Technology Application (AHLTA), Coding Compliance Editor, and reported in the Medical Expense and Performance Reporting System and Expense Assignment System (MEPRS/EAS). They also pertain to the Uniform Business Office's (UBO) analysis and reporting of accounting-related activities as they relate to data quality. This instruction applies to the 59 MDW staff and subordinate organizations responsible for entering data into CHCS, AHLTA, MEPRS/EAS, and to the UBO accounting systems for the management and follow-up of accounts, including recovery, depositing, posting, reconciliation, and procedures for third party collection. This instruction does not apply to the Air National Guard or Air Force Reserve. This is a compliance-driven instruction. Refer recommended changes and questions about this publication to the Office of Primary Responsibility using the AF Form 847, *Recommendation for Change of Publication*. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with Air Force Manual 33-363, *Management of Records*, and disposed of in accordance with Air Force Records Information Management System Records Disposition Schedule located at <https://www.my.af.mil/afrims/afrims/afrims/rims.cfm>.

SUMMARY OF CHANGES

This publication has been modified to reflect changes in organizational process and review of Data Quality Management Committee (DQMC) information and action items. This publication has been updated to reflect the most recent reference documentation.

1. Objectives.

1.1. To improve the quality of financial and clinical workload data by providing leadership oversight and an infrastructure necessary to improve the submission and use of complete, accurate, and timely data.

1.2. To assure the uniformity and standardization of data quality across the 59 MDW.

2. Overview. Data quality is paramount to successful mission accomplishment as the 59 MDW evaluates overall effectiveness of its healthcare services, negotiates with care support contractors, and collects information to justify expenditures and budgets. Decision-makers of this data driven healthcare enterprise must have reliable information. Professional, technical, and support staff will use their expertise in the assurance of relevant and current clinical and workload data. Data is used to monitor performance improvement efforts and improve outcomes.

2.1. Key to building a “most effective organization” and achieving the objectives of this instruction is accurate and timely data. The 59 MDW must therefore have the capacity to gather meaningful data to be converted to meaningful information on which its leadership can make informed business and clinical decisions.

3. Dimensions of Data Quality.

3.1. Quality data is data that fit the customer’s intended use in daily operations, decision-making, and planning. This requires that data: (a) possess desired features of the user, be relevant, comprehensive, contain proper detail, and easy to understand, and (b) be free of defects.

3.2. Four major dimensions of data quality:

3.2.1. Accuracy — recording of facts correctly.

3.2.2. Completeness — having all relevant data collected and recorded.

3.2.3. Consistency — uniformity of the format for recording the data.

3.2.4. Timeliness — recording of the data in the required time frame following the occurrence.

4. Data Quality Validation and Reconciliation Process. The Data Quality Management Control Program (DQMCP) will provide executive leadership oversight and structure to improve the use and submission of complete, accurate, and timely data. It will assure uniformity and standardization of information within the 59 MDW.

4.1. The data quality (DQ) validation and reconciliation process requires the following actions:

4.1.1. Establish monthly internal management controls through audits of source workload information [Standard Inpatient Data Record (SIDR), Standard Ambulatory Data Record (SADR), MEPRS-EAS, Worldwide Workload Report (WWR)] and UBO compliance requirements. Workload reconciliation explains the relationship between data derived from CHCS and reported in MEPRS/EAS within pre-determined parameters and defined in relevant business rules. CHCS data must meet required outputs for MEPRS/EAS to provide for full accountability of the workload reported. Table 4.1 identifies current Data Quality Management Committee (DQMC) management tools.

Table 4.1. DQMC Management Control Tools.

DQMC Tool	Process Owner(s)	Purpose
Financial, workload, and labor hours reconciliation	59 MDW/SGAR	Validate integrity of financial, workload, and labor hours data between the Source Data Collection System (SDCS) and MEPRS/EAS
UBO program compliance (UBO programs are third party collections, medical service accounts, and medical affirmative claims)	59 MDW/SGAR	Maximize allowable health care recovery cost within compliance guidelines
In/Outpatient Workload Reconciliation	59 MDW/SGAR and organizations responsible for entering data into CHCS, AHLTA and reported in MEPRS/EAS	Assess and measure CHCS in- and outpatient DQ in MEPRS/EAS
DQMC Review List	Data Quality Assurance Team (DQAT)	Identify and correct financial and clinical workload data
Commander's Data Quality Statement	Data Quality Manager	Monthly certification statement for financial and clinical workload

4.2. The 59 MDW Commander will appoint a DQ manager responsible for achieving program goals and implementing this instruction. The DQ manager will organize a cross-functional team (paragraph 4.2.1) to monitor data quality and work with that team to align and share responsibilities for the DQMCP.

4.2.1. The DQ Manager will establish and charter a Data Quality Assurance Team (DQAT) to monitor financial and clinical workload data quality assurance and management controls, and allowable healthcare cost recovery within UBO compliance guidelines. The DQAT at the 59 MDW functions as the DQMC.

4.2.1.1. The DQMC will provide staff assistance review/analysis to clinics not meeting standards. Analysis may include formalized business process improvement initiatives, coding analysis, cost analysis, and/or other needed assistance.

4.2.1.1.1. Provide on-site in and outpatient DQMC training.

4.2.1.1.2. Provide appropriate management reports listed in paragraph 5.2.

4.2.2. Membership will include (as a minimum) the DQ Manager, representatives of clinical activities, MEPRS/EAS Coordinator, Budgeting/Accounting, Patient Administration, Health Information Manager, CHCS Functional Administrator, Information Management, and Uniform Business Office. Advisors are 59 MDW/SGAI (Information Systems Flight).

4.2.3. DQMC will be a subcommittee of the 59 MDW Information Management Committee (IMC) for tracking of data quality related issues. The Commander's Data Quality Statement will be forwarded through the IMC. Additionally, DQMC information will be forwarded to the Health Plans Management Committee (subcommittee of the Executive Committee of the Medical Staff) as appropriate (information concerning provider coding, business plan performance, provider processes, DQ Statement, etc).

4.2.4. Meeting minutes will be maintained and forwarded to the IMC. All business items will be tracked through the IMC until closure. (See 59MDWI 41-102, *Medical Committees and Functional Reviews*.)

4.2.5. Documentation of validation, reconciliation, and compliance procedures (Table 4.1) will be retained by the DQ Manager and made available to the Air Force Audit Agency, Office of the Inspector General, and other military/governmental agencies as appropriate.

4.3. Identify levels 1 and 2 functional area representatives to input data and oversee the DQMC program at clinic, squadron, and group levels.

4.4. Establish a monthly review (quarterly for UBO compliance) processes using the tools identified in Table 4.1 [processes will include monthly (or quarterly) reconciliation and validation of workload captured within the CHCS and the flow of this information into MEPRS/EAS, along with full UBO compliance].

4.5. Report findings monthly to the IMC and use those findings as an avenue to correct deficiencies and improve processes.

5. Standards, Metrics, and Management Reports.

5.1. Standards and Metrics. The DQ Manager will, by applying the four dimensions of accuracy, timeliness, completeness, and consistency, develop common sets of standards and metrics to manage and measure the quality of critical data sources for the direct care and purchased care systems (CHCS, MEPRS/EAS), the UBO, and the Commander's DQ Statement.

5.1.1. United States Air Force Standards will be used for each metric.

5.1.2. Metrics will not be ends in themselves. In addition to measurers of performance, they will serve as warning signs of problems and process improvement opportunities.

5.1.3. HQ USAF/SG-level data quality metrics are available through The Biometric Data Quality Assurance Service [Biometric Data Quality Assurance Service (BDQAS), <https://bdqas.afms.mil>] and the Air Force Executive Global Look (<https://egl.afms.mil>).

5.2. Management Reports. (This list is not intended to be all inclusive, but represents major in- and outpatient reports supporting the 59 MDW's DQMC program.)

5.2.1. DQ Review List. (Monthly review of previous month's data to support Commander's Data Quality Statement.)

5.2.2. End of Day (EOD) Processing Report. (DQMC-generated monthly report identifying clinics not completing daily EOD.)

5.2.3. Duplicate Patient Appointment Report. (DQMC-generated monthly report identifying clinics with duplicate patient appointments.)

5.2.4. CHCS Registration Date Potential Duplicate Patient List. (Identifies two or more patient data records in CHCS that belong to the same patient.)

5.2.4.1. Duplicate CHCS Patient Records Report. (DQMC-generated monthly report identifying duplicate patient electronic health records in CHCS for notification to Group Practice Administrators.)

5.2.5. Record Status Report. (Daily CHCS report showing number of uncoded inpatient records, records with Admission and Disposition errors and number of records awaiting approval.)

5.2.6. CHCS Clinical Records Delinquent List. (Report listing all medical records that are incomplete or delinquent.)

5.2.7. CHCS Ad Hoc Record Status Report. (Report listing all medical records pending coding.)

5.2.8. CHCS Records Not Received by Clinical Records Report. (Report identifying all discharged patients by unit to account for all medical records for each day.)

5.2.9. Multiple Clinic Visit Report. (Ad hoc report allows clinics to review patients having one or more appointment in their clinic on the same day.)

5.2.10. HQ USAF/SG reports are available through the Air Force BDQAS website at: <https://bdqas.afms.mil>.

5.2.10.1. Standard Ambulatory Data Record (SADR) measures timeliness and completeness of ambulatory data with Daily Outpatient Workload Report from CHCS.

5.2.10.2. Daily Outpatient Workload Report consists of completed encounters only and captures appointment status types (Appointment Scheduled, Walk-In, and Sick-Call).

5.2.10.3. Standard Inpatient Data Record (SIDR) compares SIDR completed dispositions with inpatient dispositions obtained from the Worldwide Workload Report.

5.2.10.4. Worldwide Workload Report captures visits, occupied bed days, admission, and dispositions. It measures timeliness of data submission.

6. Reporting Timelines.

6.1. MEPRS/EAS Reporting. Reviews and corrections of CHCS data must be completed at the clinical data entry level by the 4th duty day of each month to meet the 5th duty day HQ USAF/SGMC reporting requirement. The MEPRS Program Administrator has 45 days to audit MEPRS data and identify discrepancies (system output transmitted to central systems no later than 45 days after end of reporting month). Audit adjustments will normally result in resubmission of the WWR after the 5th duty day, provided the original WWR was transmitted by the 5th duty day.

6.1.1. SIDR/CHCS. System output transmitted to central systems no later than 45 days after disposition.

6.1.2. WWR/CHCS. System output transmitted to central systems no later than 10 days after end of reporting period.

6.1.3. SADR/ADS. System output transmitted to central systems no later than 14 days after encounter.

6.2. DQMC Members complete the DQ Review List and provide a completed report to the DQMC Program Coordinator by the first Wednesday of each month (or as soon as feasibly possible) to be briefed at the DQMC the third Thursday of the month, forwarded to the IMC the third Thursday, and briefed to the Board of Directors.

6.2.1. The DQ Review List should accurately reflect current DQMC efforts and outcomes.

6.3. The Data Quality Manager ensures the DQ Statement and accompanying documentation is prepared and signed by the Military Treatment Facility commander.

6.3.1. The commander's DQ Statement should accurately reflect current DQMC efforts and outcomes. It is not intended to be a statement saying all our data (transmission, validation, reconciliation, etc.) meets standards; only the status of the program at a particular date and time.

6.4. DQ Manager forwards the electronic Commander's DQ Statement to Air Force Medical Operations Agency/SGAC to arrive by the 25th day of each month. The signed Commander's DQ Statement will be retained on file/electronically for review upon request.

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Administrator

Attachment 1**GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION*****References***

AFPD 33-1, *Information Resources Management*, 27 June 2006

Composite Health Care System (CHCS) *Data Quality Users Training Guide*, Version 2.5, 5 March 2001

DOD Inspector General Report No. D-2002-141, *Financial Management, Implementation of the Data Quality Management Control Program for the Military Health System*, 29 August 2002

DoD Instruction 6040.40, *Military Health System Data Quality Management Control Procedures*, 26 November 2002

DoD 6010.15-M, *Military Treatment Facility (MTF) Uniform Business Office (UBO) Manual*, 9 November 2006

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59MDWI 41-102, *Medical Committees and Functional Reviews*, 4 March 2009

59MDWI 41-212, *Patient Admissions, In-House Transfers, Discharges, and Leaving Against Medical Advice*, 22 June 2009

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59MDWI 44-145, *Patient Assessment/Reassessment*, 8 October 2009

59MDW Strategic Plan, Volume 5a, *Management of Information Plan*, 15 April 2011

Military Health System Coding Guidance: Professional Services and Specialty Coding Guidelines, Version 2.0, Unified Bio-statistical Utility, 1 September 2010

Office of Management and Budget Circular No. A-123, *Management Accountability and Control*, 21 June 1995

Wilford Hall Medical Center Coding Compliance Plan, 1 September 2007

Adopted Form

AF Form 847, *Recommendation for Change of Publication*, 22 September 2009

Abbreviations and Acronyms

AHLTA—Armed Forces Health Longitudinal Technology Application

BDQAS—Biometric Data Quality Assurance Service

CHCS—Composite Health Care System

DQ—Data Quality

DQAT—Data Quality Assurance Team

DQMC—Data Quality Management Committee
DQMCP—Data Quality Management Control Program
EAS—Expense Assignment System
EOD—End of Day
IMC—Information Management Committee
MDW—Medical Wing
MDWI—Medical Wing Instruction
MEPRS—Medical Expense and Performance Reporting System
SADR—Standard Ambulatory Data Record
SIDR—Standard Inpatient Data Record
UBO—Uniform Business Office
WWR—Worldwide Workload Report