Validating Subsets through Audit and Payment

IHTSDO Showcase 2014
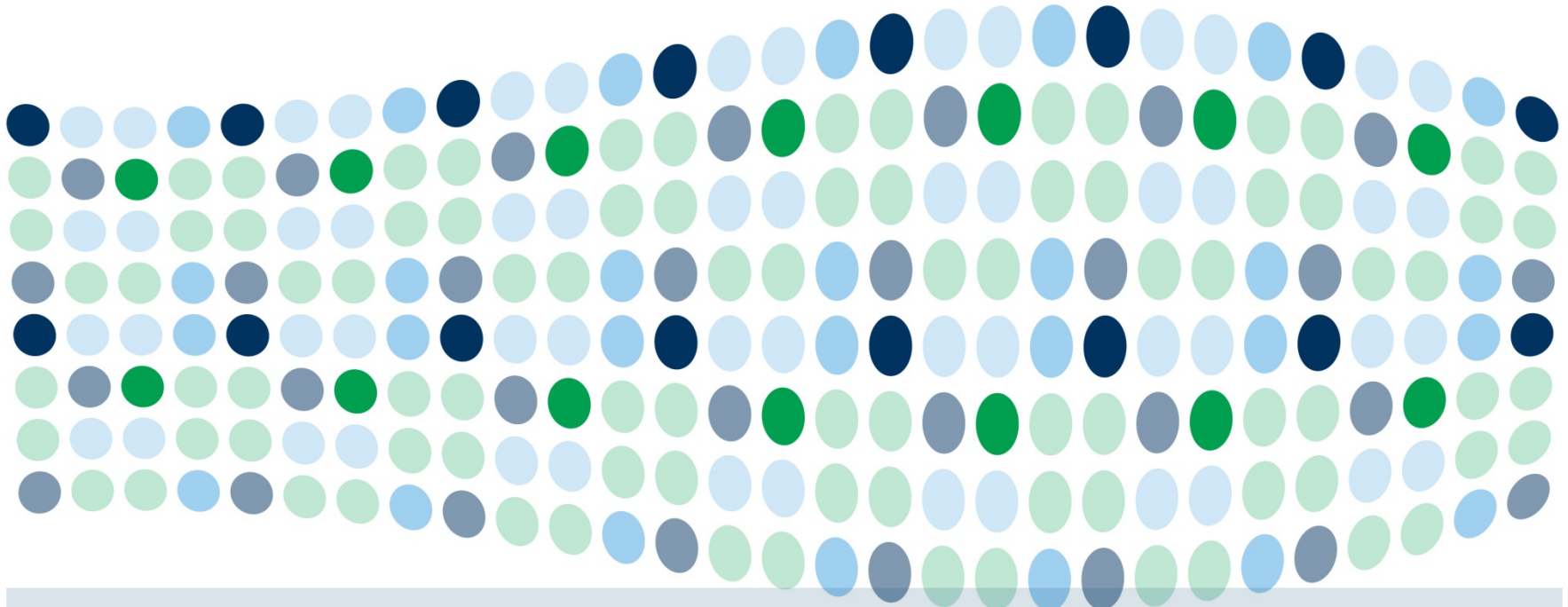
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Motivation for session

'Share and Tell'

So please interject with own experiences

Profile:

- denise.downs@hscic.gov.uk
- Work in UK Terminology Centre, HSCIC
  - We author SNOMED CT, Read v2 and CTV3
- Informatics and Education Specialist
- Role is to support implementation of SNOMED CT in systems and education
- Been in current role since July 2009

Background:

NHS organisations

In the NHS in England there are currently :

- 211 clinical commissioning groups
- 160 acute trusts (including 101 foundation trusts)
- 56 mental health trusts (including 41 foundation trusts)
- 34 community providers (18 NHS trusts and 16 social enterprises)
- 10 ambulance trusts (including 5 foundation trusts)
- c.8,000 GP practices
- c2300 hospitals in the UK

Systems Deployed

- The National Programme for IT (NPfIT) resulted in a number of systems that utilised SNOMED CT as their clinical vocabulary

- Some trusts have procured their own solutions with a requirement for SNOMED CT

- Trusts have used different approaches to 'require' SNOMED CT in the clinical record

- The provision of subsets is seen as a key requirement for adoption

National Subsets

- NPfIT produced a set of specialty subsets (350 in total) to enable services to indicate their provision against a defined list – these contain diagnosis, findings and procedures.

- Substantial effort has bene expended in producing subsets in a variety of ways by various organisations

- 'Not invented here' issue

What to Nationally Provide?

- Interest mainly for data entry:
    - Starter subsets (most frequent)
    - Exhaustive subsets (contain all terms)
    - General subsets (defined by the terms all junior doctors would be expected to know)
    - Defined by the scope of current classifications

- We have spent time exploring different approaches
- We lack robust validation and feedback

Approaches used so far:

- Take terms from junior doctor curriculum
- Train staff to search effectively and collate subsets from records based on usage
- Brainstorm with experts
- Review paper records
- Work with expert reference group and use keywords to search using a subset tool
- Use the ICD-10 / OPCS codes and find candidates

The GP consults with the patient and evaluates the problem

Patient visits GP

Patient is referred to appropriate service

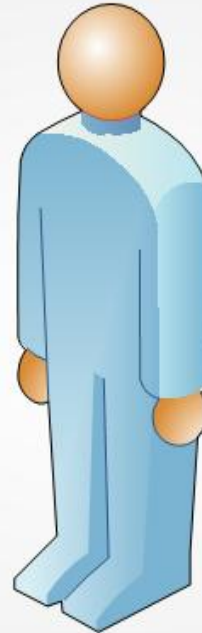Appointment made using Choose & Book

Patient attends clinic

The Patient Journey

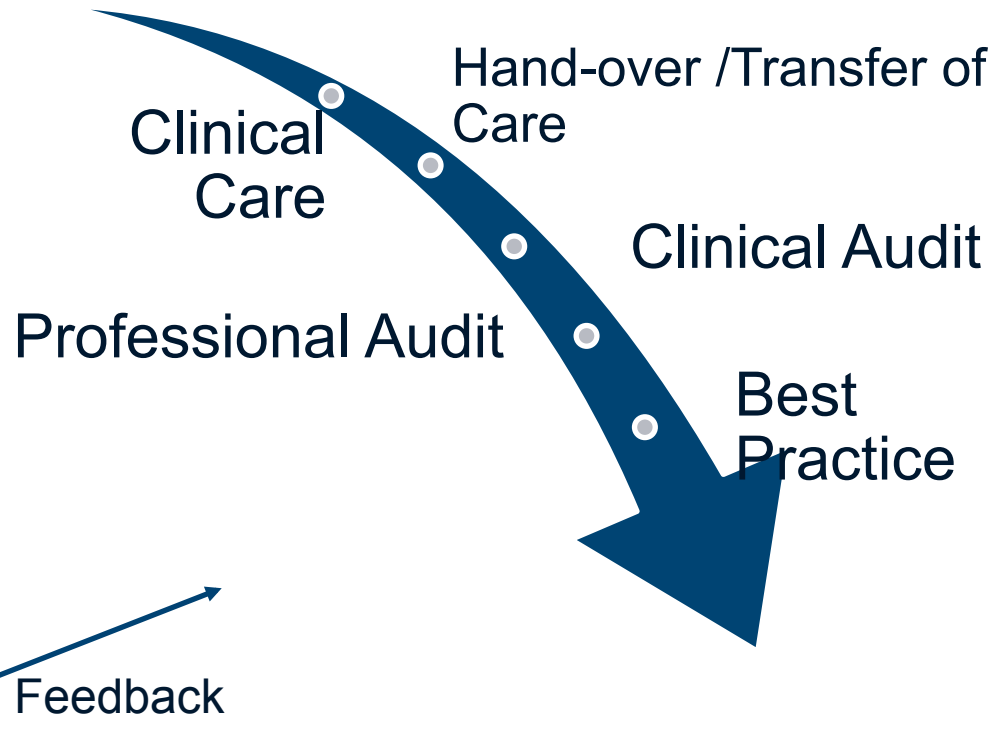Clinician makes a diagnosis and plans the intervention

The Patient Journey

- Patient visits GP
- Consultation and evaluation
- Referral to appropriate service
- Appointment made using Choose & Book
- Attends clinic
- Clinician makes diagnosis
- Discharge summary returned to GP

Intervention completed and the patient discharged

Discharge summary is sent to GP

'Testing the subsets'

Principles:

- We code data we wish to re-use 'electronically' – either in reporting, to trigger an alert, to extract to create say a discharge summary ….

- Now we have produced the subsets, we should test these meet current and planned requirements

Clinician Processes

Clinical Care

Hand-over /Transfer of Care

Clinical Audit

Professional Audit

Best Practice

Subset

Feedback

Business Processes

Payment

National Reporting

Clinical
Outcomes

Service
Improvement

Monitoring trends

Feedback

Subset

Clinical Process and Business Process

- Clinical Care
  - NICE Guidelines / Quality Indicators
  - Best Practice
  - Professional Body guidance
- Clinical Audit
- Professional Audit
- Transfer of Care (ED, Clinician, GP)

- Clinical Coding and Payment
- Service Improvement
- Responding to change in trends

Quality Indicators

- Stroke:

- 'Patients with acute stroke receive brain imaging within 1 hour of arrival at the hospital if they meet any of the indications for immediate imaging'

Report

Stroke Patients seen between <date> and <date>						
Timeframe	No. patients	No. Acute	Total had imaging	Total acute had imaging	% imaging	% acute had imaging

Decide what percentages trigger traffic light indicators

Report

Stroke Patients seen between <date> and <date>						
		Time to imaging				
Timeframe	No acute patients	30 mins	60 mins	90 mins	120 mins	>120 mins

Lessons Learnt

- We didn't get completeness from just clinical input and review
- Validating with payment resulted in a number of more detailed codes being offered to the clinician – and they preferred these
- One of the audits had additional groups that needed to be recorded with own codes – these are well grouped in SNOMED CT
- There is increased interest from clinical staff now they are seeing the reporting possibilities
- There is an increased interest in standardisation by the professional bodies and linking with best practice guidance
- We are increasingly signposting the SNOMED CT terms on national guidance and information

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