ALASKA HOSPITAL DISCHARGE DATA SYSTEM

Introduction

Statewide hospital discharge data systems are maintained in most states to guide public health, policy, and market decisions. These systems typically include detailed information on all patients discharged from acute care hospitals and can be a complete ongoing source of health care information. These systems have proven useful in health care cost, quality, access, and research applications. Statewide discharge data are routinely used to study and monitor issues of public safety, injury surveillance, and prevention. Hospital discharge data systems have been widely adopted across the U.S. because they are relatively inexpensive compared to other data collection methods such as surveys and medical record reviews. The data is more reliable than other sources such as self-reporting by patients and individual physician reporting. These systems also capture utilization data on the uninsured, which is not available through reports from third-party payers.

The Alaska State Hospital and Nursing Home Association (ASHNHA) strongly supports the development and strengthening of the Alaska hospital discharge data system.   ASHNHA has been managing inpatient and outpatient discharge data reporting on behalf of Alaska hospitals since 2001.   While not all hospitals participate, they are the only provider group in Alaska to have entered into a partnership with the State to report data on utilization. When the Alaska hospital discharge data system was developed hospitals agreed to a voluntary approach to participation versus a statutorily imposed mandate under state law.

Hospitals submit their data to a contracted data clearinghouse – Hospital Industry Data Institute (HIDI). The Alaska Department of Health and Social Services (DHSS) provides financial support for the system through a grant to ASHNHA that covers the cost of the contract with HIDI and minimal administrative support for ASHNHA. DHSS has access to the compiled data under terms specified in a Memorandum of Understanding (MOU) between DHSS and ASHNHA. This MOU governs sharing of the hospital discharge data providing for data security and confidentiality, and assuring use for public health purposes.   To minimize reporting burden, the data submitted by hospitals is aligned with the Uniform Billing standard currently UB-04.

The discharge data is summarized and analyzed on an annual basis for the previous calendar year. Each reporting hospital receives a DVD with its own record-level data and a set of analytical reports for its own use with comparisons of the individual hospital to the statewide total.   These reports are valuable tools for hospital planning, market share analyses and evaluation. Discharge data is sorted and displayed by various characteristics, including major service area, DRG, county, ZIP code, age and payer category.

In 2011, ASHNHA began participating in the Health Care Utilization Project (H-CUP) submitting data for 2010. Alaska is one of 46 states to submit discharge data to the large

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national longitudinal hospital care data set to support national health services and policy analysis.

Current Status

The number of hospitals participating in the discharge reporting system has fluctuated over the years. In 2011, twelve hospitals provided inpatient data and of these eight also provided emergency room/outpatient data.

Hospital's Reporting Discharge Data - 2011
Alaska Native Medical Center
Alaska Regional Hospital
Bartlett Regional Hospital
Central Peninsula Hospital
Fairbanks Memorial Hospital
Ketchikan General Hospital
Providence Alaska Medical Center
Providence Kodiak Island Medical Center
Providence Seward Medical Center
Providence Valdez Medical Center
Sitka Community Hospital
South Peninsula Hospital

Because participants comprise the larger hospitals, this represents an estimated 75% of all inpatient discharges.   However, the hospitals not reporting create a significant data void. Among the facilities not currently participating are Mat Su Regional Medical Center, Alaska's two military hospitals, six regional tribal hospitals, two small critical access hospitals, and the long-term acute care hospital.

It is important to note that Mat Su Medical Center's lack of participation poses a significant challenge to the reporting system. Mat Su serves a growing population in Alaska and is the only major facility in the Anchorage bowl area that does not report (Elmendorf also does not report, but as a military facility serves a different population and is currently working with DHSS on a plan to report directly to the State). Other hospitals have expressed concern about submitting their data when Mat Su does not participate. Mat Su Medical Center has not responded to ASHNHA's continued efforts to bring them into the voluntary reporting system. Without the voluntary participation of all the major hospitals in Anchorage, the discharge data system will not be viable.

Another weakness with the current system is the lack of comprehensive ambulatory surgery data. Surgery is performed on an outpatient basis both in hospital-based surgery centers and increasingly at free standing ambulatory surgery centers. Currently, hospitals are asked to report outpatient surgery discharges (care that falls into one of the surgical DRG categories) as part of

the discharge data system, but free standing ambulatory surgery centers are not asked to report. This situation creates both gaps in the data and inequities in reporting expectations.

All Payer Claims Database

A number of states have implemented or are in the process of planning for All-Payers Claims Databases (APCDs) to complement data from their Hospital Discharge Data. APCDs are large-scale databases that systematically collect and aggregate medical, dental and pharmacy claims data from public and private payers.

As the Health Care Commission examines the feasibility of establishing an APCD it is important to note the different purposes between the Hospital Discharge Data System and the APCD. As part of this process it will be important to determine if the APCD were to go forward if it would replace or augment the existing facility-based discharge reporting.

Outlined below are some of the key strengths and weaknesses of both the discharge data system and a possible All Payer Claims Database. It will be important to understand the differences between the two types of data systems in planning for an APCD, and clearly articulate the purpose and value of each if both are to be implemented in Alaska.

Hospital Discharge Data System

Strengths
- Support a large range of uses and serve diverse audiences.
- Full census – possible to include all discharges in the data set including uninsured and self-pay.
- Cost effective to collect when compared to surveys and medical records abstraction.
- National standards increase consistency of data across hospitals.
- Provides baseline and trend information on health care costs, quality, and access.
- Hospitals have been voluntarily submitting data for 12 years so historical trend analysis is available.

Weaknesses
- A number of key hospitals do not report discharges to the current system (Mat Su, small tribal, military.)
- Does not include services of non-hospital providers such as physician, ambulatory surgery, imaging, labs, eye care, and pharmacy.
- Discharge data may lack timeliness due to coding, reporting, and validation of data.
- Coding practices may vary across providers.
- Lack clinical detail since data is designed for billing and administrative functions, not clinical decision making.
- Does not include amounts paid, test results, or other clinical record information.

All Payer Claims Database

Strengths
- Covers all providers and services – as long as claims have been submitted. All insured patients, regardless of facility or site of service.
- Includes payer info and actual amounts paid by insurer and patient.
- Designed for purchasing comparisons, analytics, performance improvement, research, and policy analysis.
- Fees can be distributed across the system to both payers and providers.
- Can promote understanding about the cost and efficiency of care.

Weaknesses
- Claims data does not include services provided to uninsured, denied claims, workers' comp claims, services to out of state residents, DRG assignment.
- May not meet the need for public health assessment, improvement, and prevention applications.
- Global claims aggregate multiple services into one bill masking many services.
- Medicare data acquisition is under review by CMS.
- Payers do not retain data for all fields which may limit public health studies such as injury surveillance.
- Data completeness and quality may vary more across payers than providers.
- May be costly to develop and maintain.