Massachusetts Acute Care Hospital Data: Technical Assistance Group (TAG)

July 29, 2021

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center
for health
information
and analysis

Agenda

- Hospital Case Mix Revised Filing Requirements
  - Hospital Inpatient Discharge Data (HIDD)
  - COVID Test Results
  - Emergency Department Visit Data (EDD)
  - Outpatient Observation Stay Data (OOD)

- Hospital Case Mix Intake

- Data Quality Review

- Questions

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Hospital Case Mix Submittal Schedule - Revised

Quarter	Quarter Begin & End Dates	Data Due:	Due Date for Data File:
1	10/1 – 12/31	Preliminary Q1 (Discharges 10/1 - 12/31)	31-Jan
1	10/1 – 12/31	Final Complete Q1	16-Mar
2	1/1 – 3/31	Preliminary Q2 (Discharges 1/1 - 3/31)	30-Apr
2	1/1 – 3/31	Final Complete Q2	14-Jun
3	4/1 – 6/30	Preliminary Q3 (Discharges 4/1 - 6/30)	31-Jul
3	4/1 – 6/30	Final Complete Q3	13-Sep
4	7/1 – 9/30	Preliminary Q4 (Discharges 7/1 - 9/30)	31-Oct
4	7/1 – 9/30	Final Complete Q4	14-Dec

Hospital Case Mix Submittal Timeline

Jul 2021	Oct 2021	Jan 2022	Apr 2022
Preliminary **FY 2021** Q3 HIDD files due by July 31, 2021 Preliminary EDD/OOD files to begin with Q4 due in October 2021			
	Preliminary **FY 2021** Q4 files due by October 31, 2021		
		Preliminary **FY 2022** Q1 files due by January 31, 2022	
			Preliminary **FY 2022** Q2 files due by April 30, 2022
Final Submissions due 75 days after the close of the Quarter (9/13, 12/14, 3/16, 6/14)			

MA Hospital Case Mix Intake

➢ FY 2021 Final Q1 & Q2 files (HIDD/COVID/EDD/OOD) should be in/passed, including HIDD-COVID Match reports.

  ▪ Please work with Linda & Hadish in submitting any overdue files.

➢ FY 2021 Verification Reports to be shared soon for hospital review, data corrections and file resubmissions.

➢ FY 2021 Preliminary EDD/OOD files to begin with Q4 submissions due October 31, 2021. No HIDD/COVID files due August 7, 2021.

➢ CHIA is not making any Submission Guide updates for FY 2022.

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CHIA Email Addresses

➤ All CHIA staff have migrated to MS Office 365 and now have new email addresses.

▪ Old format: firstname.lastname@state.ma.us

▪ New format: firstname.lastname@chiamass.gov

➤ Please have your IT allow traffic from this new chiamass.gov domain. Check your spam/junk folders as well.

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MA Hospital Case Mix Data Quality

➤ Reported Race in Pediatric Population

Significant Increase in Pediatric Patients Coded as 'Unknown' Race

Over the past 8 years, use of the coding option 'Unknown' race increased for all age groups but is significantly higher for the pediatric population. Table 1 below shows the increase in percent of patients coded as 'Unknown' by age group in the hospital inpatient discharge data from FY2013 to FY2020. In FY2013, only 14% of patients ages 0 to 4 were coded as 'Unknown', in FY2020 Unknowns have increased to 34%.

Table 1. HIDD FY2013 to FY2020 Percent 'Unknown' Race by Age Group

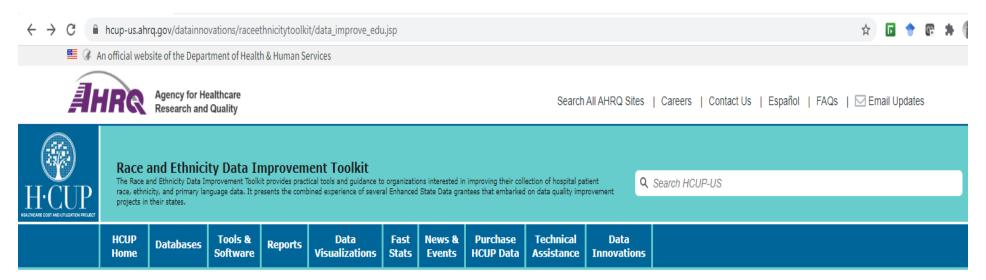| Age Group	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020
0 - 4	14%	15%	19%	21%	24%	28%	32%	34%
5 - 9	6%	8%	8%	9%	11%	12%	14%	12%
10 - 14	7%	7%	8%	9%	10%	11%	12%	11%
15 - 19	7%	7%	8%	7%	8%	9%	10%	11%
20 - 24	6%	7%	7%	6%	7%	7%	9%	10%
25 - 29	5%	6%	6%	5%	6%	7%	7%	8%
30 - 34	5%	5%	5%	5%	5%	6%	6%	7%
35 - 39	4%	5%	5%	5%	5%	6%	6%	6%
40 - 44	4%	4%	4%	4%	4%	5%	5%	6%
45 - 49	3%	3%	3%	3%	4%	4%	4%	5%
50 - 54	3%	3%	3%	3%	3%	4%	4%	4%
55 - 59	3%	3%	3%	2%	3%	3%	4%	4%
60 - 64	2%	2%	3%	2%	2%	3%	3%	3%
65 - 69	2%	2%	2%	2%	2%	3%	3%	3%
70 - 74	2%	2%	2%	2%	2%	3%	3%	3%
75 - 79	2%	2%	2%	2%	2%	2%	3%	3%
80 - 84	1%	2%	2%	2%	2%	2%	2%	3%
85+	1%	1%	1%	2%	2%	2%	2%	2%

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High Quality ED Visit Data on Race with Deterioration in Pediatric Data

Even though the use of 'Unknown' Race coding has also increased in the ED Visit Data for the pediatric population and the ED has a higher volume of data than HIDD, Table 2 below shows that the ED Visit Data continues to have higher quality data than the HIDD. The quality of known data for the adult population is among the best in the nation.

Table 2. ED FY2013 to FY2020 Percent 'Unknown' Race by Age Group

Age Group	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020
0 – 4	7%	7%	7%	6%	7%	7%	9%	10%
5 – 9	5%	6%	6%	5%	5%	6%	6%	7%
10 – 14	5%	5%	5%	4%	5%	5%	6%	6%
15 – 19	5%	5%	5%	4%	5%	5%	5%	5%
20 – 24	4%	5%	5%	4%	5%	5%	5%	5%
25 – 29	4%	4%	4%	4%	4%	4%	5%	5%
30 – 34	4%	4%	4%	4%	4%	4%	5%	4%
35 – 39	4%	4%	5%	4%	4%	4%	5%	4%
40 – 44	4%	4%	4%	4%	4%	4%	5%	4%
45 – 49	4%	4%	4%	3%	4%	4%	4%	4%
50 – 54	3%	3%	3%	3%	3%	3%	4%	4%
55 – 59	3%	3%	3%	3%	3%	3%	3%	3%
60 – 64	3%	3%	3%	3%	3%	3%	3%	3%
65 – 69	3%	2%	3%	3%	2%	2%	3%	2%
70 – 74	2%	2%	3%	2%	2%	2%	2%	2%
75 – 79	2%	2%	2%	2%	2%	2%	2%	2%
80 – 84	1%	2%	2%	2%	1%	2%	2%	2%
85+	1%	1%	1%	1%	1%	1%	1%	2%

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AHRQ has Training Toolkits for Hospitals on Race and Ethnicity Data Collection

AHRQ Training Toolkits include Information on the Rationale for Improving Race and Ethnicity Data Quality

AHRQ Agency for Healthcare Research and Quality

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Race and Ethnicity Data Improvement Toolkit

The Race and Ethnicity Data Improvement Toolkit provides practical tools and guidance to organizations interested in improving their collection of hospital patient race, ethnicity, and primary language data. It presents the combined experience of several Enhanced State Data grantees that embarked on data quality improvement projects in their states.

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The Case for Improving Race, Ethnicity, and Language Data

At the highest level, the case for improving R/E/L data is easy to understand: there is clear evidence that racial, ethnic, and language-based disparities exist in healthcare. In 2003, the Institute of Medicine released a landmark report, *Unequal Treatment*, which documented the disparities in healthcare in the United States. Each year, AHRQ produces a congressionally mandated National Healthcare Disparities Report to track the nation's progress in reducing disparities, and notes in the 2012 report that our system of healthcare often distributes services inefficiently and unevenly.

In recent years, there has been increased attention on eliminating disparities in access to care and health outcomes for racially, ethnically, and linguistically diverse populations in the United States. Passage of the Patient Protection and Affordable Care Act (ACA) in 2010 called for the improvement of health status and quality of healthcare for priority populations. Provisions in the ACA require states to collect R/E/L data in an effort to better understand and reduce healthcare disparities.

There is good reason to do so. Disparities in healthcare and health outcomes attributable to differences in R/E/L are well documented and persistent even after adjusting for differences in related characteristics such as education, income, insurance, access to care, and health status. It has been estimated by the Joint Center for Political and Economic Studies, that racial and ethnic disparities in health and healthcare cost the United States $1.24 trillion between 2003 and 2006: over $200 billion for direct medical expenses, and another $1 trillion for the indirect costs such as lost quality of life years and lost productivity ("The Economic Burden of Health Inequities in the United States" http://www.nmpha.org/Resources/Documents/Economic%20Burden%20of%20Health%20Inequalities%20-%20Fact%20Sheet.pdf). In addition, states are using R/E/L data in innovative ways to identify and reduce disparities—such as creating race and ethnic health disparities report cards, assessing statewide costs, reducing disparities through healthcare reform, and mapping healthcare disparities to identify geographic areas in need of improvement (http://www.hcup-us.ahrq.gov/reports/r_e_disparities.jsp). Therefore, there is a growing need to improve the processes and protocols to collect R/E/L patient information.

Disparities may be due to differences in access to care, provider biases, poor provider–patient communication, or poor health literacy. Americans do not always receive the care they need, or they receive care that causes harm or that is delivered too late or without full consideration of patient preferences and values. There is an obvious need to document and improve the quality of care provided to at-risk populations. Race, ethnicity, and primary language play a significant role in these disparities.

Patients with limited English proficiency and those who are members of racial/ethnic minorities are at greater risk of adverse events compared to their English-speaking white counterparts, and are more likely to be prescribed expensive tests for conditions that could have been diagnosed through basic history-taking. Such patients are also more likely to have longer hospital stays for particular medical and surgical conditions, and potentially avoidable readmissions for selected chronic conditions. When patients with limited English proficiency or those from historically underserved racial/ethnic groups have trouble understanding their medical conditions, treatment plans, or discharge instructions, it not only leads to poorer health outcomes for these patients, but also results in multiple liability exposures as well as increased costs for the treating hospital.

- Benefits to Improving the Collection of R/E/L Data

Next Meetings

➢ Quarterly TAG meetings:

October 2021

January 2022

April 2022

July 2022

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Questions?

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