Hospital Quality and Transparency

Other Actions to Improve Quality

- CMS Pilot - Patient Safety Indicator Survey (Infection Control, Quality Assurance (QA) and Performance Improvement (PI), Discharge Planning)
- Improved and Frequent Communication with the NM Hospital Association (HA)
- Presentation at Hospital Conferences - Emergency Preparedness
- Training on Complaint Process through HA October and November 2015

NEW MEXICO DEPARTMENT OF HEALTH

Health Information Systems Act (SB 323)

Hospital Quality and Transparency Measures

A Presentation to the Legislative Health and Human Services Committee by the New Mexico Department of Health

October 20, 2015

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NEW MEXICO DEPARTMENT OF HEALTH

SB 323

52nd Legislature-2015

NEW MEXICO DEPARTMENT OF HEALTH

Health Information System Act (24-14A-1, et seq. NMSA 1978)

1989: The Health Information Systems Act officially is enacted.

1994 (SB 556): Changes to † 24-14A-2 - Definitions. Changes include removal of committee and addition of commission. Updated department to only include department of health (removal of environmental department).

Changes to † 24-14A-3 - Duties. Removal of department in catchline and replaced with commission.

Changes to † 24-14A-7 - Reports. Added subsection B regarding annual report.

New Sections: Annual Review of Data Needs, Investigatory Powers, Advisory Committee, and Health Information Alliance.

2009 (HB 293): Changes to † 24-14A-2 - Definitions. Changes include updates to data source and record level data.

Changes to † 24-14A-6 - Access. Changes include sharing of data between HPC and DOH and sharing of data with a federal entity.

Changes to † 24-14A-8 - Confidentiality. Changes include confidential parameters around record level data to the DOH.

2012 (HB 18): Changes to † 24-14A-2 - Definitions. Changes include the removal of commission.

Changes to † 24-14A-3 - Duties of Department.

Changes to † 24-14A-11 - Temporary Provision. Transfer of property, records, and contracts from HPC to DOH.

2015 (SB 323): Changes to † 24-14A-11 - Creation of Advisory Committee.

Changes to † 24-14A-6.1 - Website; Public Access; Data.

Changes to † 24-14A-8 - Confidentiality.

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Health Information System Act (24-14A-1, et seq. NMSA 1978)

- Provides authority for the Department of Health to collect health data.

Additional section added to HIS Act

1) § **24-14A-11 Advisory Committee**

"The secretary of health shall appoint a health information system advisory committee to advise the department in carrying out the provisions of the Health Information System Act. The secretary shall establish the membership and duties of the committee by rule."

NEW MEXICO DEPARTMENT OF HEALTH

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Health Information System Act (24-14A-1, et seq. NMSA 1978)

- Provides authority for the Department of Health to collect health data.

Additional section added to HIS Act

2) § **24-14A-8 Health Information System; Confidentiality**

"C. The individual forms, electronic information or other forms of data collected by and furnished for the health information system shall not be public records subject to inspection pursuant to Section 14-2-1 NMSA 1978. The department may release or disseminate aggregate data, **including those data that pertain to a specifically identified hospital or other type of health facility.** These data shall be public records if the release of these data does not violate state or federal law relating to the privacy and confidentiality of individually identifiable health information."

NEW MEXICO DEPARTMENT OF HEALTH

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Health Information System Act (24-14A-1, et seq. NMSA 1978)

- Provides authority for the Department of Health to collect health data.

Additional section added to HIS Act

3) § **24-14A-6.1 Website; Public Access; Data**

"By January 1, 2018, the department shall ensure that the public is provided with access, free of charge, to a user-friendly, searchable and easily accessible web site on which the department shall post and update on a regular basis cost, quality, and such other information it publishes pursuant to the Health Information System Act. The web site shall be accessible through the sunshine portal. The department shall adopt and promulgate rules to carry out the provisions of this section."

Health Information System Act (24-14A-1, et seq. NMSA 1978)

- Provides authority for the Department of Health to collect health data.

Additional section added to HIS Act

3) § **24-14A-6.1 Website; Public Access; Data**

Issues

a) Charge data in HIDD may not capture all charges (currently limited to 22 revenue line item charges per admission record).

b) A claims database is a better alternative for analyzing healthcare costs (All Payers Claims Database-APCD).

c) How will quality healthcare be defined? What measures will be used? Prevention Quality Indicators (PQIs)?

Progress Update

The Department of Health has been working to draft a set of rules governing the Advisory Committee—outlining membership, duties and responsibilities of committee members, and the setting for committee meetings.

Next Steps

Once the rules are outlined, then a public hearing will be held. This will be an opportunity for individual's outside of the Department of Health to comment on the drafted rules.

Once the rules become finalized, the Secretary of the Department of Health will appoint committee members.

NEW MEXICO DEPARTMENT OF HEALTH

HIDD 101

Hospital inpatient and discharge data in New Mexico

NEW MEXICO DEPARTMENT OF HEALTH

Health Information System Act (24-14A-1, et seq. NMSA 1978)

- Provides authority for the Department of Health to collect health data.
- NMDOH had this authority prior to the revision of this Act in 2012 based on authority in the Public Health Act.

New Mexico Administrative Code (7.1.27)

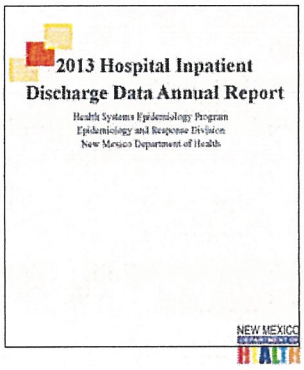
- Outlines the specific data reporting requirements for licensed inpatient and outpatient general and specialty health care facilities, pursuant to the HIS Act.

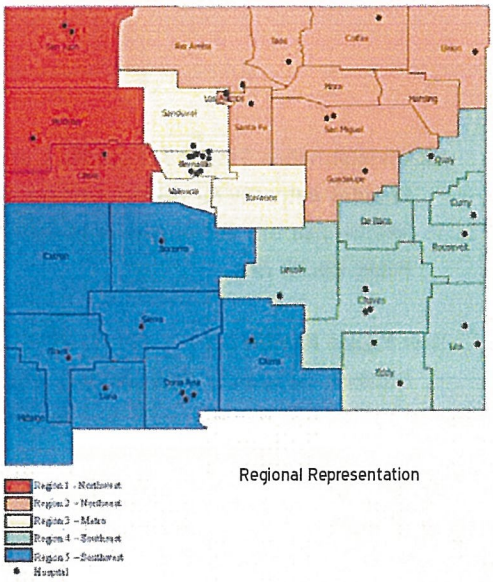
<u>Reporting</u>

- Hospitals are required to report inpatient hospitalization data quarterly.
- Information includes admission information, discharge information, diagnoses, procedures, demographics, and hospital stay costs (revenues).

<u>Data Elements</u>

- In 2015, currently collecting 268 data elements.
- Specialty Hospitals: 13
- General Hospitals: 37





Regional Representation

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How to Improve New Mexico's Hospitalization Data

- Currently the hospitalization dataset is limited to non-federal hospitals.
  - Missing
    - Veteran's Affairs Data (VA)
    - Indian Health Services Data (IHS)
    - Neighboring States Data (TX, CO, AZ)
- Improvements
  - IHS data is available for 2010-2014 (Enhanced HIDD)
  - De-identified data from CO, AZ, and TX has been obtained (looking to gather 2010-2014 data)
  - Discussions with VA have been occurring for several years
- Overall Goal: Population-based surveillance of health conditions affecting New Mexicans

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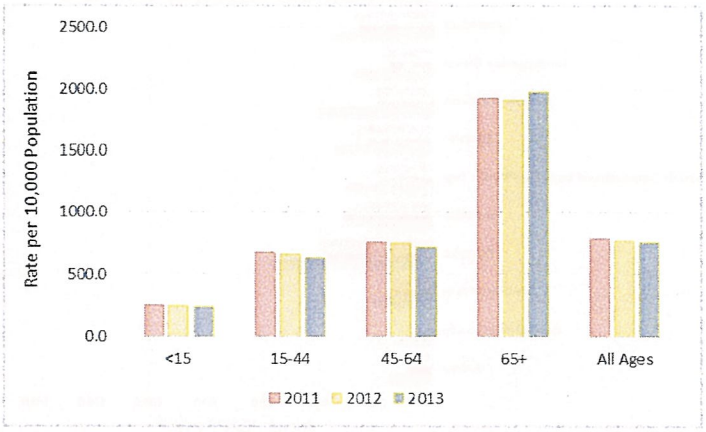
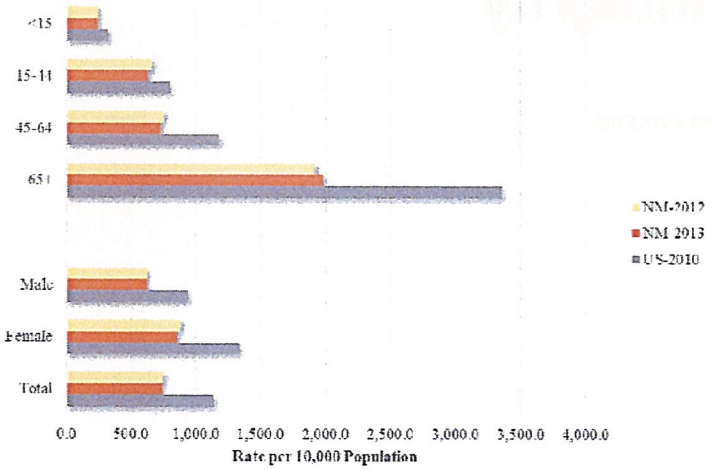
Discharge Rates by Age and Gender, NM, 2011-2013



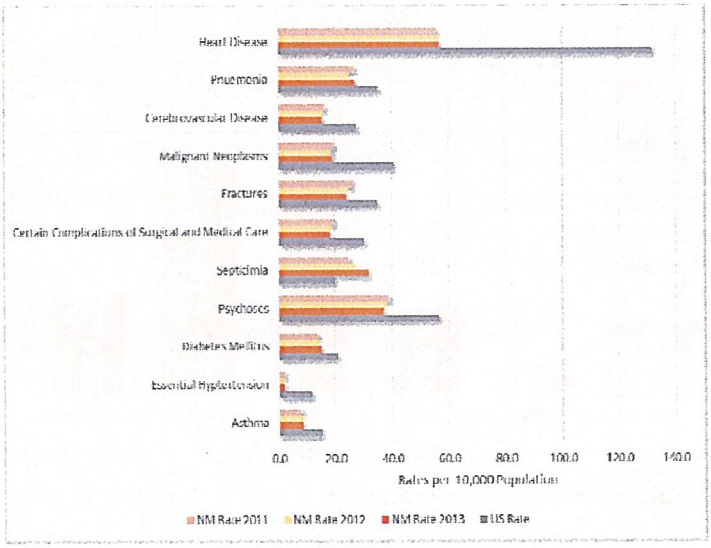
*All rates are age-adjusted to the 2000 U.S. standard population

Discharge Rates by Age and Gender, NM (2012-2013) and United State (2010)



*All rates are age-adjusted to the 2000 U.S. standard population

Discharge Rates by NCHS Category, NM, 2011-2013, and United States, 2010



*All rates are age-adjusted to the 2000 U.S. standard population

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Data Integrity

Top five concerns

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1. Timeliness of Data Submission

Reporting Period	Report Due to the division (95% of discharges)	Division returns integrity and validation errors	Final corrected report due to division (100% of discharges)
January 1 – March 31 (Q1)	May 31	June 15	June 30
April 1 – June 30 (Q2)	August 30	September 15	September 30
July 1 – September 30 (Q3)	November 30	December 15	December 31
October 1- December 31 (Q4)	February 28 (of the following year)	March 15 (of the following year)	March 31 (of the following year)

http://164.64.110.239/nmac/parts/title07/07.001.0027.pdf

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1. Timeliness of Data Submission

- If timeline was followed, NMDOH would be able to finalize a dataset by the beginning of May.
- Typically the annual dataset is available in September/October (2014 HIDD was put onto IBIS at the end of September).
- <u>Issues Encountered in 2014 HIDD</u>
  Revenue Codes not formatted as outlined in NMAC 7.1.27
  Duplication of records due to more than 22 revenue codes
  Admission and Discharge Hours and Dates the same.
- Annual 2014 HIDD report will be available November 2015.

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2. Data Formatting for Submission

- In 2011, NMDOH received a grant from the Agency for Healthcare Research & Quality (AHRQ) to improve the collection of race and ethnicity data.
- In 2011 HIDD, the following was the status of race and ethnicity data in HIDD.

	Pre-DOH Intervention	Year 1/Flux (Q1/Q2 2011)	Year 1.5 (Q3 2011)	Current Year (2014)
% of general hospitals reporting	100% (37)	100% (37)	100% (36)*	100% (50)
% of general hospitals reporting race and ethnicity values	0	81.1% (30)	91.6% (33)	100% (50)
% of general hospitals reporting valid race and ethnicity values	0	78.4% (29)	88.9% (32)	100% (50)**
% of general hospitals reporting tribal identifiers	0	75.7% (28)	88.9% (32)	100% (50)
% of general hospitals reporting valid tribal identifiers	0	2.7% (1)	2.8% (1)	100% (50)†
% of general hospitals reporting multiple race	0	2.7%(1)	0	100% (50)
% of general hospitals reporting multiple tribe	0	0	0	18% (9)

*Year 1.5 only has a total of 36 hospitals because Heart Hospital was bought by Lovelace.
**288 records had an invalid race value (11 facilities).
† 266 records had an invalid tribal value (15 facilities).

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2. Data Formatting for Submission

PATIENT ETHNICITY

Name: ETHNICITY Type: Character Length: 2 Format: $ETHNIC

DEFINITION: The gross classification of patient's self-reported ethnicity.

Codes:
E1 -- Hispanic or Latino
E2 - Non-Hispanic or Non-Latino
E6 - Declined
E7-- Unknown

Source: Input record, location 1766.

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2. Data Formatting for Submission

PATIENT RACE

Name: RACE1-RACE5 Type: Character Format: $RACE
Length: 12

DEFINITION: The classification(s) of a patient's stated race to include one or multiple reported classifications, coded as shown below. When reporting multiple classifications do not use spaces or delimiters. For example, if a patient states that he or she is both Asian and other the race field would be R1R5.

Codes:
R1 - American Indian or Alaska Native
R2 - Asian (including Asian Indian, Chinese, Filipino, Japanese, Korean and Vietnamese)
R3 - Black or African American
R4 - Native Hawaiian or Pacific Islander (including Chamorro and Samoan)
R5 - White
R6 - declined
R7 - unknown
R9 - other race

Source: Input record, location 1754.

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3. Records with Missing Diagnoses

- In 2013, 577 records were missing a primary diagnosis (←1%).
- In 2014, 753 records were missing a primary diagnosis (←1%).
- Diagnosis codes are **imperative** for surveillance.

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4. Communication between NMDOH and Hospitals

- Vendor Changes
- Changes in Staff Members
- Formatting/Coding Questions
- File Submission Formatting (Fixed Length File)

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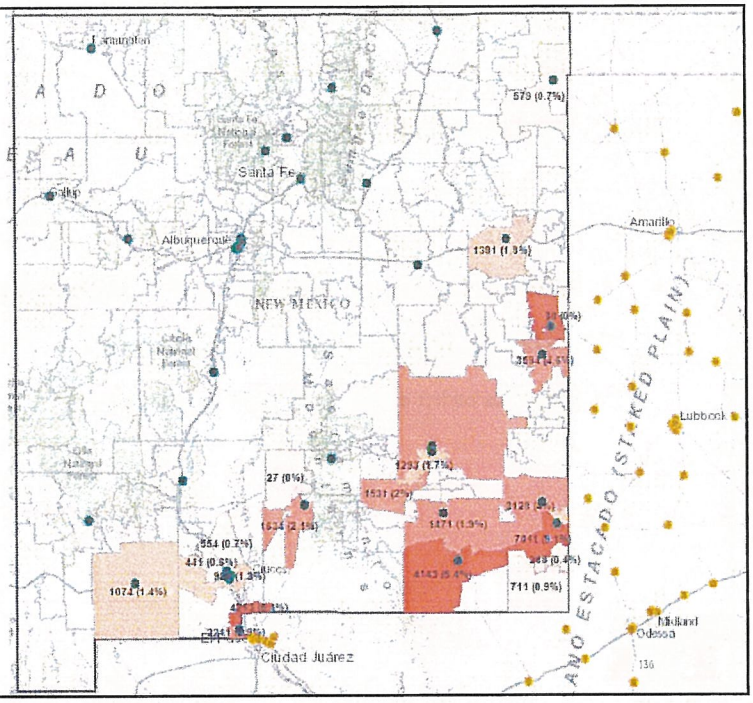
5. Data Validity

- Does HIDD capture all New Mexicans?
- Texas data from 2005-2010 shows that 77,399 hospitalizations occurred in Texas hospitals for New Mexico residents.
- Major Texas cities include Amarillo, Lubbock, Midland/Odessa, and El Paso.



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Data Usage

Hospitals and general public

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New Mexico Epidemiology

July 4, 2014 Volume 2014, Number 6

Ambulatory Care Sensitive Condition Hospitalization Rates in New Mexico

Chronic ACSC Include:

- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Angina
- Asthma (pediatric & adult)
- Hypertension
- Diabetes

Acute ACSC Include:

- Pneumonia
- Dehydration
- Urinary Tract Infection (UTI)

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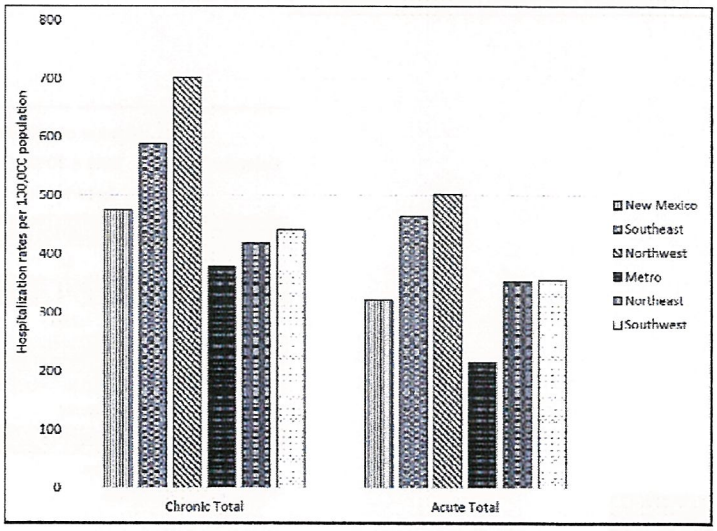
Chronic and Acute Ambulatory Care Sensitive Conditions Hospitalization Rates per 100,000 population in Five Regions of New Mexico, 2012



Ambulatory Care Sensitive Condition Hospitalization Rates in New Mexico

- High rates of ACSCs are an indication of a lack of access, availability or quality of primary care services.[1]
- In New Mexico, the Southeast and Northwest health regions had the highest ACSC rates.
- Other factors that may contribute to high ACSC rates include poor patient education, lack of patient compliance, lack of primary care providers, poor disease management by primary care providers, and socioeconomic factors like income.[2]
- High ACSC rates in the Southeast and Northwest health regions parallel a primary care physician shortage as indicated by a gap analysis performed by the New Mexico Health Workforce Committee in 2012.

[1]Saha, S., et al., Are preventable hospitalizations sensitive to changes in access to primary care? The case of the Oregon Health Plan. Med Care, 2007. 45(8): p. 712-9.
[2]Siegrist, R.B., Jr. and N.M. Kane, Exploring the relationship between inpatient hospital costs and quality of care. Am J Manag Care, 2003. 9 Spec No 1: p. SP43-9.
[2]Sanchez, M., et al., Variations in Canadian rates of hospitalization for ambulatory care sensitive conditions. Healthc Q, 2008. 11(4): p. 20-2.

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New Mexico Epidemiology
April 17, 2015 Volume 2015, Number 3

Hospital Readmissions among the Homeless Population in Albuquerque

30- Day Readmission Rates by Year for Homeless Patients, Bernalillo County, 2010-2013

Calendar Year	Number of Patients with a 30-Day Readmission	Total Number of Homeless Patients	% of Patients with a 30-Day Readmission
2010	107	368	29.1
2011	82	253	32.4
2012	93	317	29.3
Overall*	256	850	30.1
Number of Records	720	2,068	34.8
Bernalillo County Residents			
Overall*	17,798	144,710+	12.3

*Overall combines all 3 years.
+ Total number of patients.

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Hospital Readmission among the Homeless Population in Albuquerque

- Homeless patients who visited an Albuquerque hospital at least once had a higher 30-day readmission rate compared to Bernalillo county residents. This rate was also higher than the estimated readmission rate of ~20% among Medicare and Medicaid beneficiaries (CMS: Centers for Medicaid and Medicare Services).[1]
- With a readmission rate of 19%, CMS estimated the cost of these readmissions to be around $17 billion.[1]
- Homelessness impacts all age groups, including children. Children are the most vulnerable as homelessness is associated with multiple stressors, including loss of property, disruption of school and community relationships, and dramatic changes in family routine.[2]
- Readmission rates are a direct means of capturing and measuring quality of care.

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[1]Centers for Medicare & Medicaid Services. National medicare readmission findings: Recent data and trends. 2012.
[2]Grant R. Gracy D. Goldsmith G. Shapiro A. Redlener IE. Twenty-five years of child and family homelessness: Where are we now? Am J Public Health. 2013; 103 Suppl 2:e1-10

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Summary/Key Points

1. Major improvements in HIDD data collection have occurred since NMDOH became the co-data stewards for the HIDD in 2009.
   - Inclusion of more variables: revenue codes.
   - Formatting of variables for better analysis.
2. The collection of patient demographics has improved since the NMDOH intervention in 2011, improving the collection of race, ethnicity, and tribal affiliation.
3. Timeliness of data submission by hospitals will benefit the timeliness of the HIDD annual report, HIDD data on NM-IBIS, and fulfillment of data requests.
4. Communication between NMDOH and hospitals is needed to keep the data flow moving and to ensure that hospitalization data is of highest quality.
5. Hospitalization data has been used for high level analysis and will continue to be used for future analyses.

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