Connecticut General Statutes Section 19a-654
Outpatient Data Workgroup Report

Statutory Background

Section 19a-654 of the Connecticut General Statutes was amended by Section 12 of PA-11-58 and Section 143 of PA-11-61 during the 2011 legislative session. One of the changes made to 19a-654 requires outpatient surgical facilities and facilities that provide outpatient surgical services as part of the outpatient surgery department of a short-term acute care general or children's hospital, to submit patient-identifiable encounter data to the Department of Public Health, Office of Health Care Access (the Office).

Statutory Charge

The statute requires the Office to convene a working group consisting of representatives of outpatient surgical facilities, hospitals and other individuals necessary to develop recommendations that address current obstacles to, and proposed requirements for, patient-identifiable data reporting. The Office submits this report, due on or before February 1, 2012, on the group's findings and recommendations to the joint standing committees of the General Assembly relating to public health, and insurance and real estate.

The Outpatient Data Workgroup

The Outpatient Data Workgroup members are:

- Kimberly Martone, Director of Operations, Department of Public Health, Office of Health Care Access, Workgroup Chair
- Olga Armah, Associate Research Analyst, Department of Public Health, Office of Health Care Access
- Jane Deane Clark, PhD, Vice President, Data Services, Connecticut Hospital Association
- Ken Ferrucci, Senior Vice President of Government and Society Affairs, Connecticut State Medical Society
- James Iacobellis, Senior Vice President, Government and Regulatory Affairs, Connecticut Hospital Association
- Jacqueline Kozin, Legislative Program Manager, Office of CT State Comptroller
- Mary Lyon, Vice President, Integrated Health Information, Connecticut Hospital Association
- Kaila Riggott, Planning Specialist, Department of Public Health, Office of Health Care Access
- Lisa Winkler, Executive Director, Connecticut Association of Ambulatory Surgery Centers

Meeting Overview

The workgroup held meetings on November 22, 2011, December 21, 2011 and January 25, 2012 to establish the parameters for implementing the statute.

There are 99 surgical facilities in Connecticut; 31 in general, children's and chronic disease hospitals, 9 hospital satellite locations and 59 licensed outpatient surgical facilities. Each facility is either a member of the Connecticut Hospital Association or the Connecticut Association of Ambulatory Surgery Centers. Both associations were asked to survey their members to determine specifics on billing or data systems, vendors and users, each facility's method of claims submission (electronic or paper) and the individuals responsible for assessing facilities' ability to submit complete, useable, electronic patient-identifiable encounter data on a regular basis. Survey results were intended to facilitate a phased-in data collection approach with respect to facilities and data elements, with full reporting by all facilities by July 1, 2015 at minimum cost to the health care system.

To facilitate and standardize data collection, the workgroup will continue to meet to (1) identify the data elements of greatest utility to the state and (2) determine availability of data which is submitted by facilities using the two types of national provider billing forms (institutional and professional). When data elements to be collected and the data layout are finalized by the workgroup, the Office will embark on a pilot data collection effort beginning with the facilities most readily able to provide the data points, as determined by the results of the survey. The pilot will include both hospital-based and free-standing surgery centers and will begin six months from when these facilities are identified via the survey. Data collection from the remaining facilities will be phased in, with the associations providing annual progress reports until all facilities are fully reporting.

Data elements to be collected may also be phased in, as certain data elements, e.g., patient race and ethnicity, are either not currently collected by most outpatient surgical facilities or not uniformly reported by patients at hospitals, but are important data for identifying and resolving health inequality issues. Additional consideration will be given, especially for smaller facilities, to the potential impact of transitioning from ICD-9-CM to ICD-10, the new version of the federally mandated International Classification of Diseases, Clinical Modification which goes into effect October 1, 2013.

The Office will draft regulations, with input of workgroup members, on data elements to be collected, format of collection, timing and submission cycles.

Issues, Barriers and Obstacles Identified by the Workgroup

The workgroup identified three major areas with respect to barriers and obstacles to data collection. The areas are related to: information technology (IT) infrastructure and staff; data elements; and cost and access.

IT Infrastructure and Staffing-Related Issues

Currently, facilities' information systems have different levels of sophistication with respect to data collection and reporting. Not all outpatient surgical facilities are collecting/billing electronically, especially the smaller entities. Even those that do *bill* electronically may not have the ability to *report* electronically, through billing system data, although those billing commercial insurers or Medicaid/Medicare may be at an advantage. Non-hospital facilities are at a disadvantage with respect to use of new electronic medical record (EMR) technologies designed to collect specific data elements (i.e. meaningful use data). In fact, ambulatory surgery centers are specifically excluded from the federally funded electronic health record (EHR) incentive dollars offered through the Health Information Technology for Economic and Clinical Health (HITECH) Act. Moreover, billing systems are not primarily designed for data collection and reporting. In addition to a lack of infrastructure, freestanding facilities typically do not have IT departments or staff dedicated to data collection and reporting. Although a subset of freestanding facilities were providing data to the Office in the past as part of Certificate of Need (CON) requirements, in some cases staffing has changed at those facilities, which may slow the process considerably.

Data Element-Related Issues

Not every facility is currently collecting all data elements that the Office may ultimately require. For example, race/ethnicity is not currently collected at outpatient surgical facilities and the requirement to do so may have adverse impact on patient throughput, as this is not a data element that is appropriately ascertained by observation alone. In addition, there is currently no agreement on what data elements should be or could be collected. For instance, outpatient surgical facilities consider charge data to be proprietary information, although it is important to collect if the state wishes to estimate the cost of care and to conduct comparative analyses on both inpatient and outpatient care. In addition, there is currently no direct, financial incentive for non-hospital facilities through the HITECH Act to move toward increased data collection/reporting prior to the 2015 effective data for full implementation of electronic filing.

Increasing Cost to System and Hindering Access

There may be significant costs associated with the collecting, reporting, cleaning and maintaining outpatient data which will be borne by both the state and reporting facilities. It is critical that the cost of such data collection is not exacerbated by duplicating other, complementary, state data collection efforts currently underway (e.g., all payer claims data (APCD), Sustinet, Health Exchange Cabinet). In addition, increased time and staffing may be necessary to increase data collected during patient registration.

Workgroup Recommendations to Address Barriers/Obstacles

The workgroup provided the following recommendations that attempt to address the barriers and obstacles noted above:

- Develop a greater understanding of what will be required to make all facilities able to report by 2015. The group recommends conducting further research on the differences between billing systems and reporting systems; establish an internal working group of outpatient surgical center "point persons" to assist in developing a knowledge base on the myriad systems in existence and their capabilities; and conduct discussions with existing system vendors used by outpatient facilities to understand what systems modifications would be necessary to facilitate reporting.

- Conduct a phased-in approach to data collection which would include phasing in (1) those data elements that are not currently collected and (2) those facilities which are able to submit data prior to the 2015 deadline. Such a process will facilitate data testing required on the part of the state.

- Contact the National Association of Health Data Organizations (NAHDO) for assistance in determining how barriers and obstacles were overcome in other states that have full implementation of outpatient surgery data collection from outpatient surgical facilities and hospitals.

- Work to ensure that multiple data collection efforts currently underway requiring the submission of data by hospitals and outpatient surgical facilities to the state are not unnecessarily duplicative.

- Follow national data standards such as those provided by the National Uniform Billing Committee (NUBC) and National Uniform Claim Committee (NUCC) to identify data elements and data definitions that would be required in the collected data.

- Conduct discussions with outpatient surgical facilities data vendor(s) to inform the workgroup on current systems' limitations and potential reporting capabilities.

- Request from the Connecticut Association of Ambulatory Surgical Centers quarterly reports on progress toward meeting statutory reporting requirements.