



Arkansas Department of Health

Hospital Inpatient Discharge Data

Annual Report

2009

Arkansas Department of Health
Health Statistics Branch
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INTRODUCTION

The Arkansas Hospital Discharge Data System is one of the most important tools for addressing a broad range of health policy issues. Act 670 of 1995, A.C.A. 20-7-201 et seq., requires all hospitals licensed in the state of Arkansas to report hospital information as prescribed by rules and regulations by the State Board of Health. “All hospitals” include acute care, critical access hospitals, specialty hospitals, long-term acute care hospitals, psychiatric and rehabilitation hospitals. The Act also specifically prohibits the release of any information from the collected data that identifies, or could be used to identify, any individual patient, provider, institution or health plan.

Beginning in 1996 with very limited data, the system has grown to include virtually all discharges with a stay of one or more days. Information reported includes demographics such as date of birth, gender, race and ethnicity. Clinical information includes dates of service, discharge status, diagnoses, procedures and injury data. Charges are included, as well.

The staff edits and completes these data then combines data from all the hospitals into a dataset for each calendar year. The staff then is able to access information for policy, planning, and research applications for the submitting hospitals and many other interested parties. The de-identified datasets are shared with other states, for services provided in Arkansas to residents of that state, and with the Agency for Healthcare Research and Quality for their Healthcare Cost Utilization Project (HCUP).

About This Report

This annual report is different from previous annual reports. It contains information about hospital utilization by bed size and hospital location (urbanity) as well as the inclusion of comparison data from previous years. Also, there are summaries on the Major Diagnostic Categories (MDC), Clinical Classification System (CCS) categories, mental illness/substance abuse hospitalization, as well as a section on Prevention Quality Indicators (PQIs) to enumerate avoidable hospitalizations.

The target audience for this report is hospital officials, health care agencies, and policy makers. The information in the report gives a snapshot of inpatient health services in Arkansas for 2009 and demonstrates the changes in utilization that Arkansas hospitals have seen over a period of five years.

QUICK FACTS & HIGHLIGHTS

In 2009, 106 of the 108 Arkansas Hospitals reported to the Arkansas Department of Health. Of these, 92 are also members of the Arkansas Hospital Association.

The hospitals consist of

- 52 Acute Care Hospitals
- 29 Critical Access Hospitals*
- 9 Long Term Acute Care (LTAC) Hospitals
- 8 Rehabilitation Hospitals
- 8 Psychiatric Hospitals
- 2 Veterans Affairs Hospitals

Hospitals per State Region

- 16 Arkansas Valley Region
- 24 Metro Region
- 10 North Central Region
- 13 Northeast Region
- 16 Northwest Region
- 11 Southeast Region
- 18 Southwest Region



Counties Serviced by an Arkansas Hospital

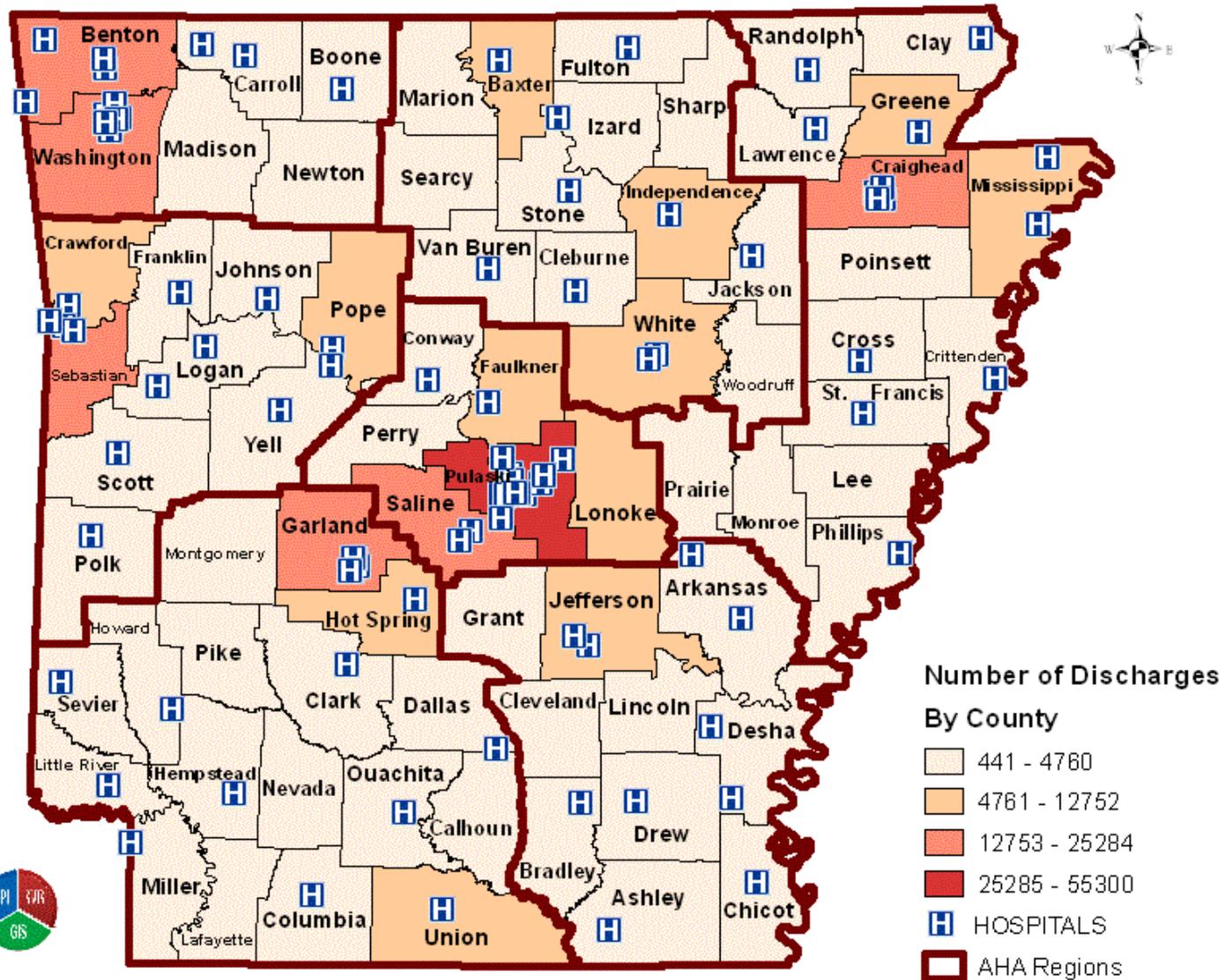
- 20 do not have access to a hospital within county boundaries
- 41 counties are serviced by a single local hospital
- 14 counties are serviced by 2 or more hospitals

*Critical Access Hospitals are a subgroup of the Acute Care hospitals. They are listed as their own group for reporting purposes.

2009 Highlights:

- There were 418,570 hospital discharges reported.
- The average length of stay was 5.18 days.
- For type of admission, over half (57%) of discharges were emergency or urgent admissions.
- For 44% of the discharges, Medicare was the primary payer followed by Private/HMO (23%) and Medicaid (21%). Self-pay, other and no-pay were reported primary payers or categories for 7% of the discharges.
- The circulatory system major diagnostic category had the highest number (68,384) of discharges with an average length of stay of 4.2 days and an average cost of \$11,246.
- There were 30,056 deliveries of which 35% were by cesarean section.

Residents Discharges by County - Arkansas 2009



Source: Hospital Discharge Data Section 2009
 Map created by: Majida Kdeiss

HOSPITAL UTILIZATION

<u>Utilization</u>		<u>2005</u>	<u>% Distribution</u>	<u>2009</u>	<u>% Distribution</u>	<u>% Change</u>
Total Discharges		429,477		418,570		-2.54%
Number of Discharges per 1,000 population		155		145		-6.36%
Discharge Status	Routine	313,708	73%	301,407	72%	-3.92%
	Another Short-Term Hospital	12,003	3%	10,341	2%	-13.85%
	LTAC and Other Facilities	57,365	13%	57,580	14%	0.37%
	Home Health Care	32,416	8%	36,598	9%	12.90%
	In-Hospital Deaths	10,613	2%	9,212	2%	-13.20%
	Against Medical Advice	2,741	1%	2,576	1%	-6.02%

Table 1: The discharges from the Veteran’s Affairs Medical Centers are not included in any counts for years 2005 to 2009. Additional Source: The population used for determining Number of Discharges per 1,000 population was acquired from the U.S Census Bureau².

Total Discharges and all of the utilization statistics related to these discharges are gathered from the reported information on the UB-04 billing form for inpatient services. They include counts from both resident and nonresident inpatients at Acute Care and Specialty, Long Term Acute Care (LTAC), Psychiatric, and Rehabilitation Hospitals in Arkansas. They are not unduplicated patient counts, but rather counts of individual episodes of care (discharges).

Total Discharges represents the aggregated totals of inpatient discharges reported by each hospital for the given calendar year.

Number of Discharges per 1,000 Population represents the ratio of inpatient discharges per 1,000 of Arkansas resident population as recorded by state census estimates for that year.

Discharge Status represents the circumstances surrounding the discharge from inpatient status and specifies where the patient went after discharge from the hospital.

Highlights

- There were 418,570 hospital discharges reported in 2009.
- Routine discharges accounted for the majority of statuses reported and represented 301,407 or 72% of inpatients in 2009.

Total Discharges and Discharges per 1,000 Population

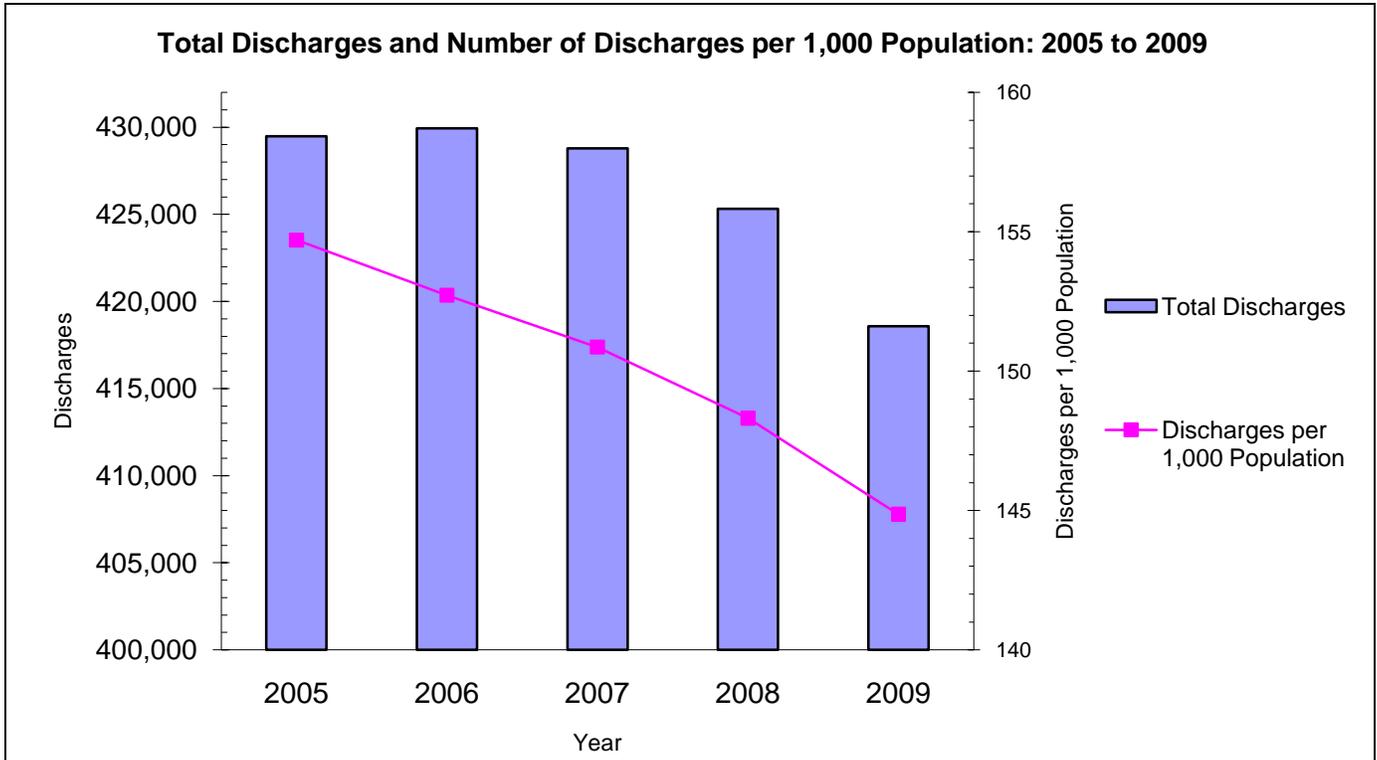


Chart 1

In 2009

- There were 418,570 discharges reported for inpatients from Arkansas hospitals.
- Comparing the number of discharges with the state population of 2,889,450 gives a ratio of approximately 145 inpatient discharges for every 1,000 Arkansas residents. ²

From 2005 to 2009

- Over the course of five years, we have seen an increase in Arkansas population and a decrease in the total number of discharges. This has led to a 6.36% drop in the number of discharges per 1,000 population, from 155 to 145 per 1,000 population.
- There was a larger percentage drop for 'Number of Discharges by 1,000 population' than for 'Total Discharges'.

Discharge Status

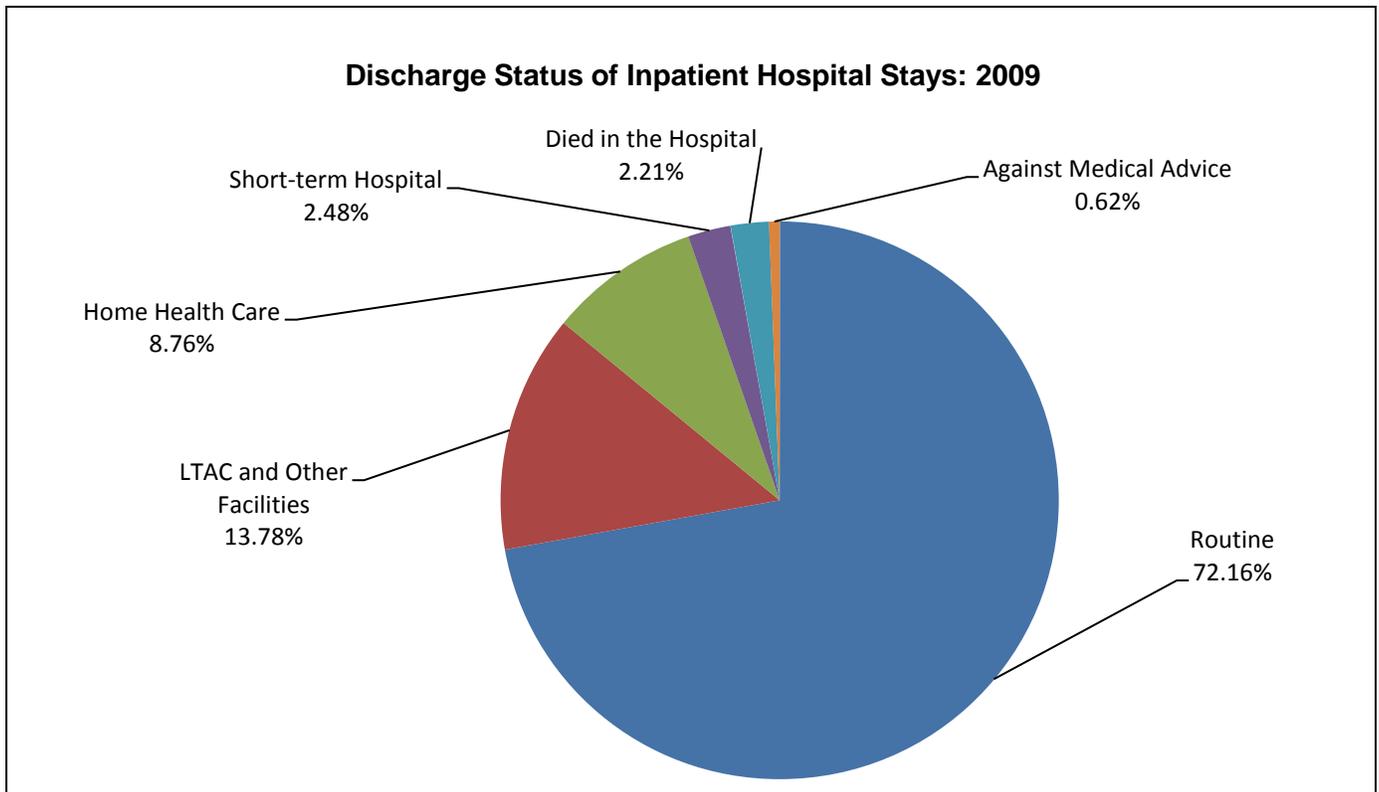


Chart 2 There were 856 records in 2009 with unknown Discharge Status

In 2009

- The majority of the 418,570 inpatient discharges were Routine discharges which accounted for 72%.
- The second most common discharge status was to LTAC (Long Term Acute Care) and Other Facilities at 13.78%.
- The least common discharge status was Against Medical Advice at 0.62%.

From 2005 to 2009

- The Discharge Statuses that saw the largest percent decrease were to Another Short-term Hospital and for In-Hospital Deaths.
- Home Health Care saw the largest percent increase in the number of inpatient discharges.

<u>Utilization: Hospital Types</u>		<u>2005</u>	<u>% Distribution</u>	<u>2009</u>	<u>% Distribution</u>	<u>% Change</u>
Urbanity	Urban	299,746	70%	300,267	72%	0.17%
	Rural	129,731	30%	118,303	28%	-8.81%
Size and Facility Type**	Small	47,851	11%	45,513	11%	-4.89%
	Medium	98,078	23%	100,077	24%	2.04%
	Large	261,908	61%	251,613	60%	-3.93%
	Psychiatric	12,628	3%	12208	3%	-3.33%
	Rehabilitation	6,798	2%	6498	2%	-4.41%
	LTAC	2,214	1%	2661	1%	20.19%
	Critical Access*	26,677	55%	24585	54%	-7.84%

Table 2

* Critical Access Hospitals are a subgroup of Small Hospitals. They are included in the counts for hospital Size: Small.

**Hospitals of Facility Type Psychiatric, Rehabilitation, and Long Term Acute Care are not given a hospital Size.

Urbanity represents the population of the core based statistical area where the hospital is established. Urban hospitals reside in a county with a core urban area of 50,000 or more population. Rural hospitals reside in a county with a core urban area of 10,000 to 49,999 population.

Hospital Size and Facility Type groups Acute Care hospitals by size and the Non-Acute Care hospitals as Psychiatric, Rehabilitation, and Long Term Acute Care (LTAC).

Acute Care facility size is determined by first identifying the hospital as rural, urban non-teaching, or urban teaching. For each of the three categories, the number of licensed beds in the hospital determines if the facility is small, medium or large.

Psychiatric, Rehabilitation, and Long Term Acute Care facilities individually make up their own group and are not further divided into subgroups. Psychiatric hospitals provide services for mental, emotional, or substance disorders. Rehabilitation hospitals provide restoration and support services for the disabled. Long Term Acute Care hospitals focus on patients that require special treatment for a long time.

Critical Access hospitals are a specific type of small, rural acute care hospitals that receive federal cost-based reimbursement for their Medicare patients. The Critical Access group is included in the count for small acute care hospitals, but as a group of interest, it is listed separately to show its specific utilization.

Highlights

- There were more discharges from Urban hospitals than from Rural hospitals by 43.5%.
- Hospitals of Medium Size were the only Acute Care hospital size group to see an overall increase in inpatient discharges from 2005 to 2009.
- Of the Non-Acute Care facilities, Psychiatric hospitals had the most discharges at 12,208 inpatients.

Urban and Rural Hospitals

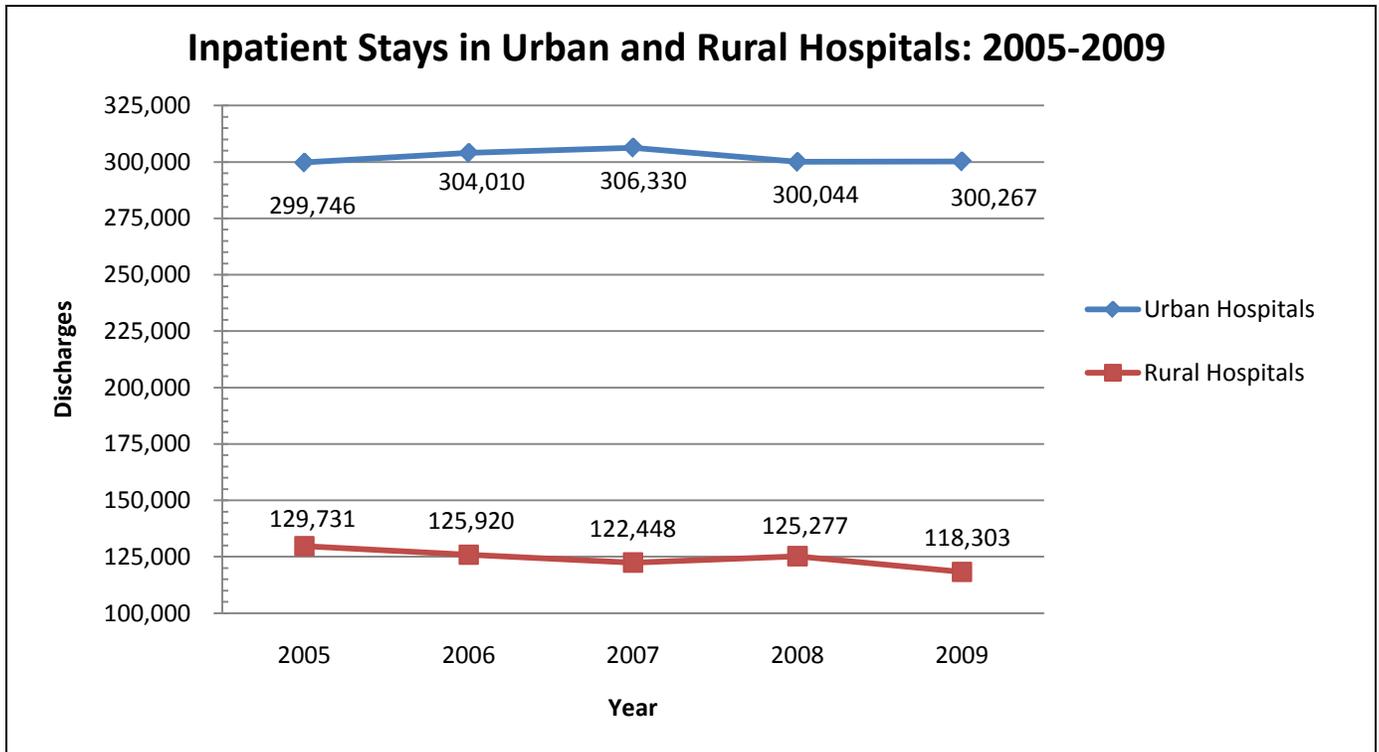


Chart 3

In 2009

- Approximately 72% of inpatient visits to Arkansas Hospitals were to an Urban hospital whereas the remaining 28% of patients were attended at a Rural hospital.

From 2005 to 2009

- There was a very small increase in the number of inpatients discharged from Urban hospitals at 0.17%.
- Even with the differences in growth, the 2009 ratio of Urban to Rural inpatients of 254 inpatient discharges from an Urban hospital for every 100 at a Rural hospital is very similar to the 2005 ratio of 231 for every 100.

Hospital Size and Type

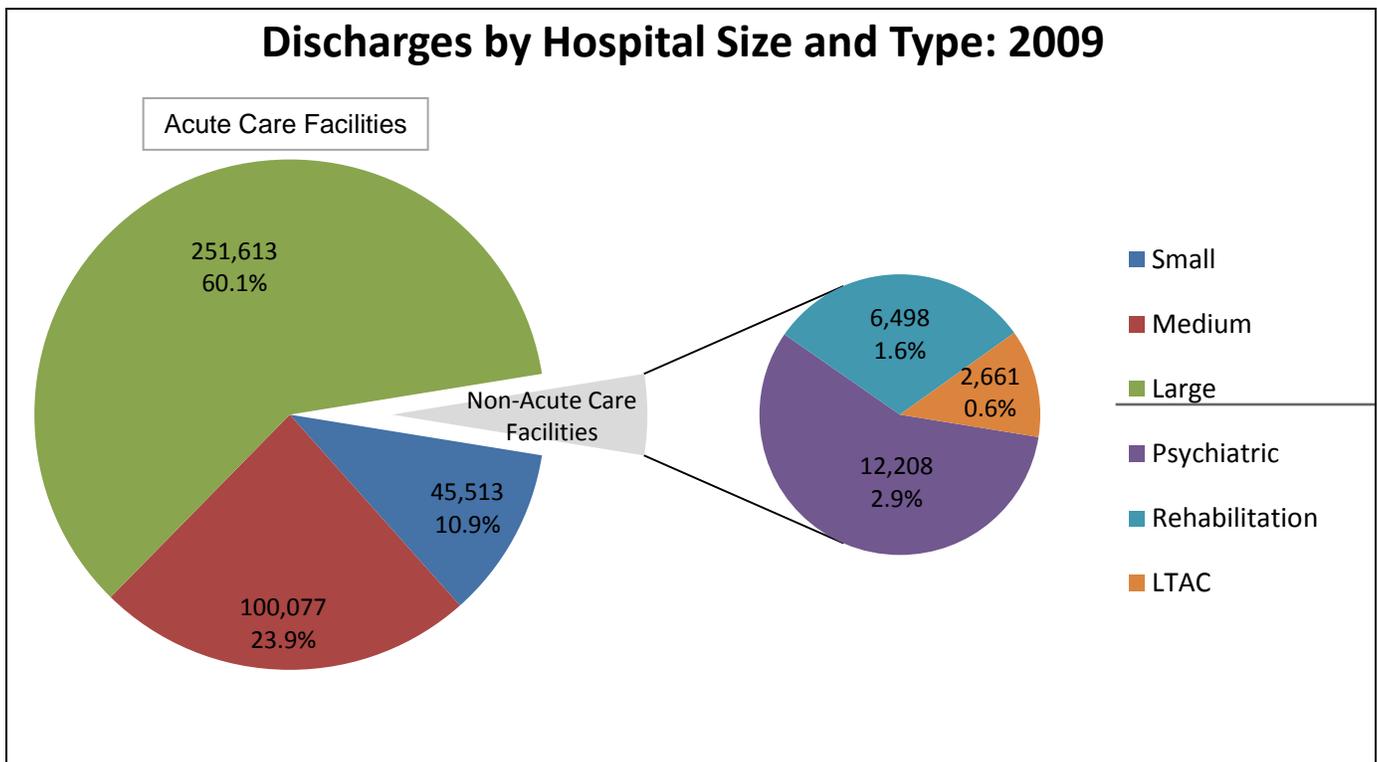


Chart 4: The Acute Care hospital size category small includes the 24,585 discharges from Critical Access Hospitals.

In 2009

- Large size hospitals accounted for 60.1% (251,613 discharges) of the inpatient discharges; Medium size hospitals accounted for 23.9% (100,077 discharges); Small size hospitals accounted for 10.9% (45,513) of the inpatient discharges.
- The remaining 5.1% (21,367 discharges) of inpatient discharges were from Long Term Acute Care (LTAC), Rehabilitation, and Psychiatric hospitals.

From 2005 to 2009

- While Small and Large hospitals had a decrease in inpatient discharges, Medium size hospitals had a 3.23% increase.
- Inpatient discharges for Long Term Acute Care facilities increased by 447 discharges. While this is a relatively small number, it equates to a 20.2% increase for the LTAC hospital category.

<u>Utilization: Inpatient Demographics</u>		<u>2005</u>	<u>% Distribution</u>	<u>2009</u>	<u>% Distribution</u>	<u>% Change</u>
Age	Under 1 year	44,824	10%	45,036	11%	0.47%
	1 - 17 years	22,391	5%	22,242	5%	-0.67%
	18 - 44 years	102,310	24%	97,759	23%	-4.45%
	45 - 64 years	95,144	22%	97,913	23%	2.91%
	65 - 84 years	127,742	30%	121,144	29%	-5.17%
	85 years and above	37,040	9%	34,471	8%	-6.94%
Gender	Male	172,622	40%	171,106	41%	-0.88%
	Female	256,829	60%	247,459	59%	-3.65%
Race	White	347,512	81.6%	335,334	80.1%	-3.50%
	Black	62,797	14.7%	63,467	15.2%	1.07%
	Hispanic	10,692	2.5%	11,209	2.7%	4.84%
	Asian or Pacific Islander	1,812	0.4%	2,319	0.6%	27.98%
	Native American	647	0.2%	1,477	0.4%	128.28%
	Other	2,614	0.6%	4,764	1.1%	82.25%
Residency	AR	408,058	95%	398,274	95%	-2.40%
	Other	21,343	5%	20,252	5%	-5.11%

Table 3: In 2005, there were 3403 inpatient records with unknown race and ethnicity.

Note: There was a concerted effort to increase the quality of collected race and ethnicity from 2005 to 2009.

Age represents the patient's age in years at the time of admission to the hospital as an inpatient.

Gender includes the counts for mothers delivering and both male and female newborns discharged from the hospital as well.

Race represents a combination of two collected fields, patient race and patient ethnicity. For the purposes of this report, the ethnicity Hispanic is included as a mutually exclusive category with the other races.

Residency refers to where the patient lives, Arkansas for inpatients with a home zip code in Arkansas, and Other for inpatients with a home address in another state, out of country, or unknown.

Highlights

- The infant and children age groups saw the least percent change from 2005 to 2009, each having less than a 1% increase or decrease.
- The female to male patient ratio has consistently been 6 to 4 from 2005 to 2009.
- For 2009, white inpatients make up the majority of discharges, representing 80.1% of the inpatient discharges.
- Approximately 5% of inpatient discharges were for non Arkansas residents.

Patient Age

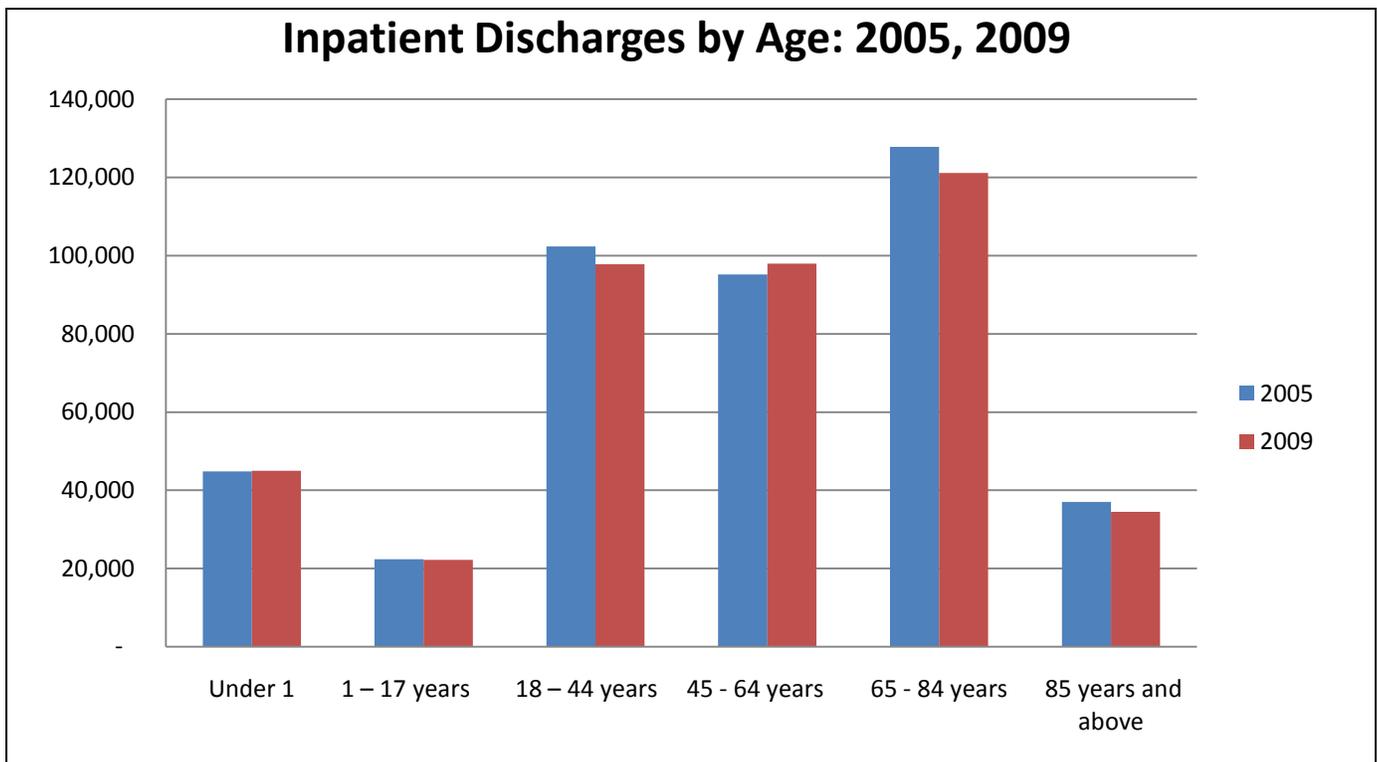


Chart 5

In 2009

- The senior adult age group (65 to 84 years) had the largest number of discharges at 29%.
- Children (1-17 years) had the smallest number of discharges at 5%, the elderly (85+ years) represented the next smallest at 8%, and infants (Under 1 year) represented the third smallest at 11%.
- Newborn discharges account for 38,406 of the 45,038 infant discharges.

From 2005 to 2009

- Middle age adults were the only group to see a noticeable increase in the number of inpatient discharges.
- The largest decreases in the discharges of inpatients occurred in the age ranges of 18-44 years at 4.45%, 65-84 years at 5.57%, and 85+ years at 6.94%.
- Children (1-17 years) and Infants (under 1 year) each changed less than 1 %.

Patient Gender

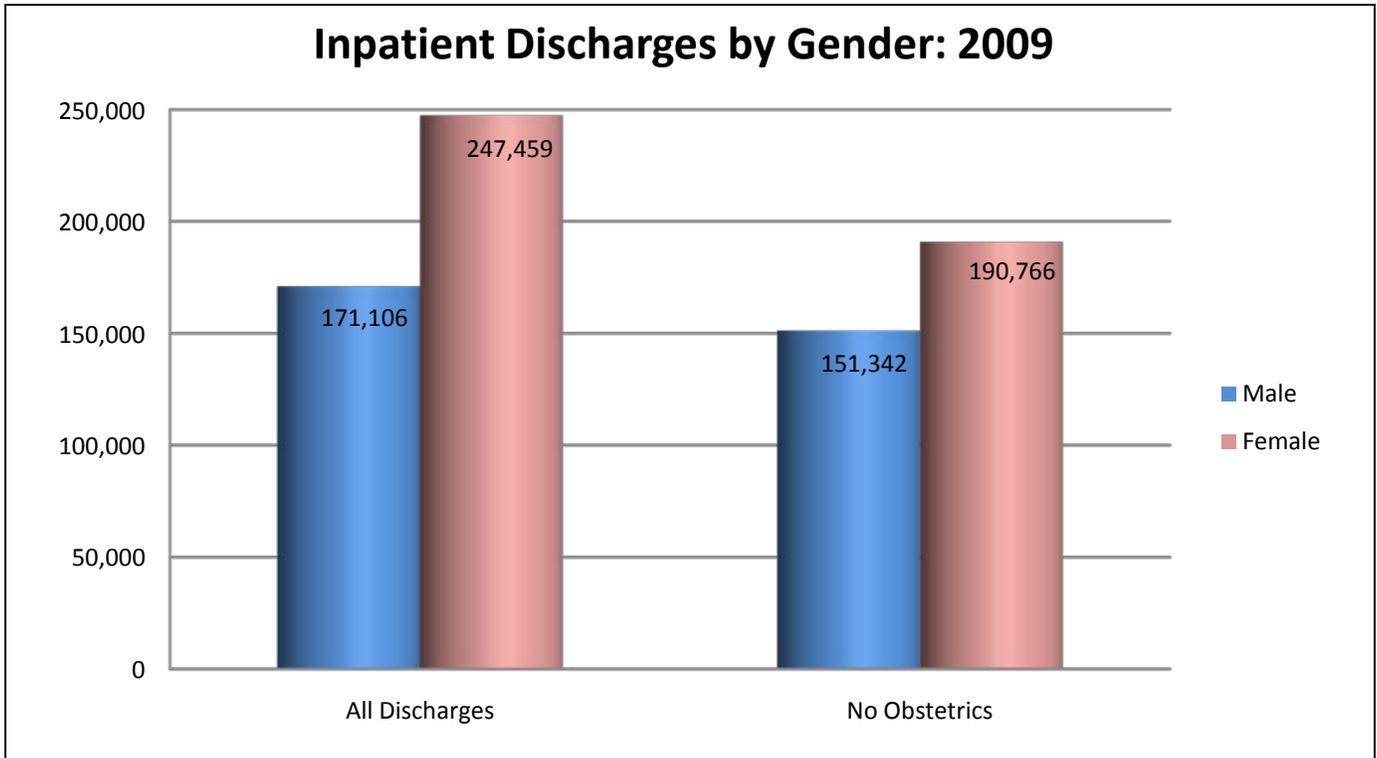


Chart 6: In 2009, there were five discharges with unknown/unreported gender.

In 2009

- More inpatient visits were from females (59 %) than males (41%).
- Even when discharges for newborns or birthing were excluded (total of 76,462 discharges excluded), females still account for 56% of inpatient discharges compared to 44% male discharges.

From 2005 to 2009

- There was a 3.65% decrease in the number of female discharges, which includes newborns and females delivering.
- There was less than a 1% decrease in the number of male discharges, also including newborns.
- There was very little difference in the ratio of female to male inpatient discharges.

Patient Race

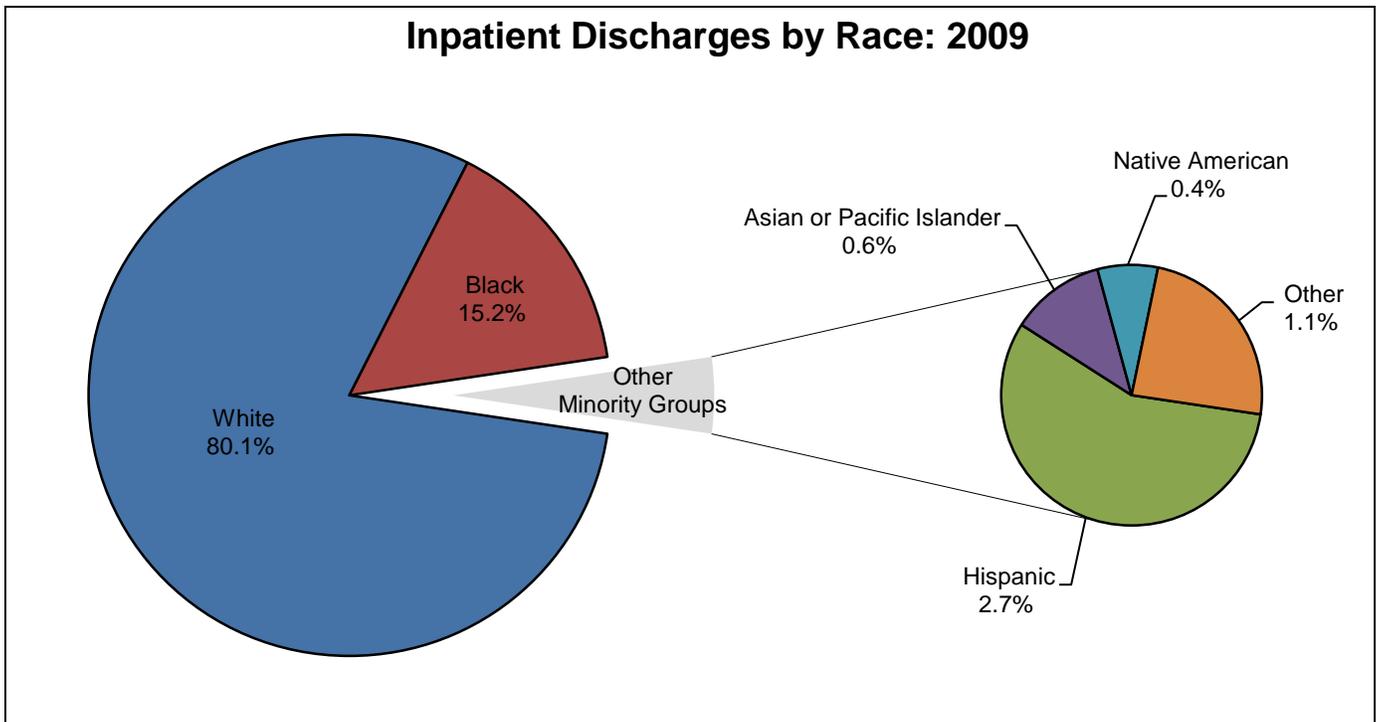


Chart 7

In 2009

- White inpatient discharges were the majority, accounting for 80%. The second most common discharge race was black, accounting for 15%.
- The Hispanic, Asian and Pacific Islander, Native American, and Other categories combined make up the remaining 5%.

From 2005 to 2009

- White inpatients were the only racial group to see a decrease in inpatient visits over the 5 year period.
- Black inpatient discharges increased by 1.07%.
- Inpatient discharges of Hispanic ethnicity increased by 4.84%.
- Overall, there was no noticeable change in the race distribution between 2005 and 2009.

<i>Utilization: Groups of Interest</i>		2005	% Distribution	2009	% Distribution	% Change
Primary Payer	Medicare	194,160	45%	182,898	44%	-5.80%
	Medicaid	85,454	20%	88,959	21%	4.10%
	Private/HMO	105,205	24%	94,272	23%	-10.39%
	Self-Pay	27,635	6%	30,193	7%	9.26%
	No charge	1,386	0%	651	0%	-53.03%
	Other	15,623	4%	20,943	5%	34.05%
Admission Type	Emergency	128,057	30%	154,497	37%	20.65%
	Urgent	121,875	28%	85,971	21%	-29.46%
	Elective	143,220	33%	139,708	33%	-2.45%
	Newborn	36,226	8%	37,621	9%	3.85%
Obstetrics	Normal Deliveries	25,234	67%	24,624	65%	-2.42%
	Cesarean Deliveries	12,351	33%	13,432	35%	8.75%
	Total Deliveries	37,585	100%	38,056	100%	1.25%
	Total Births	37,869	-	38,406	-	1.42%

Table 4

Primary Payer refers to the expected payer for the hospital stay. The primary payer reported may not be responsible for the whole of the inpatient charges.

The Admission Type describes the situation under which the patient was admitted into the hospital as an inpatient.

The obstetrics groups presented are the number of inpatient discharges that were admitted for childbirth or that were born. The delivery types are divided into Normal Deliveries and Cesarean Deliveries and do not distinguish between childbirth with or without complications. Total Deliveries is a count of mothers, where Total Births is the number of children born and does not include stillbirths.

Highlights

- Inpatient claims where Medicare is the primary payer is the largest group, accounting for 44%.
- The admission type that saw the largest increase was Emergency at 20.65%.
- The number of Cesarean Deliveries increased by 8.75% from 2005 to 2009, whereas the number of Normal (vaginal) Deliveries decreased by 2.42%

Primary Payer

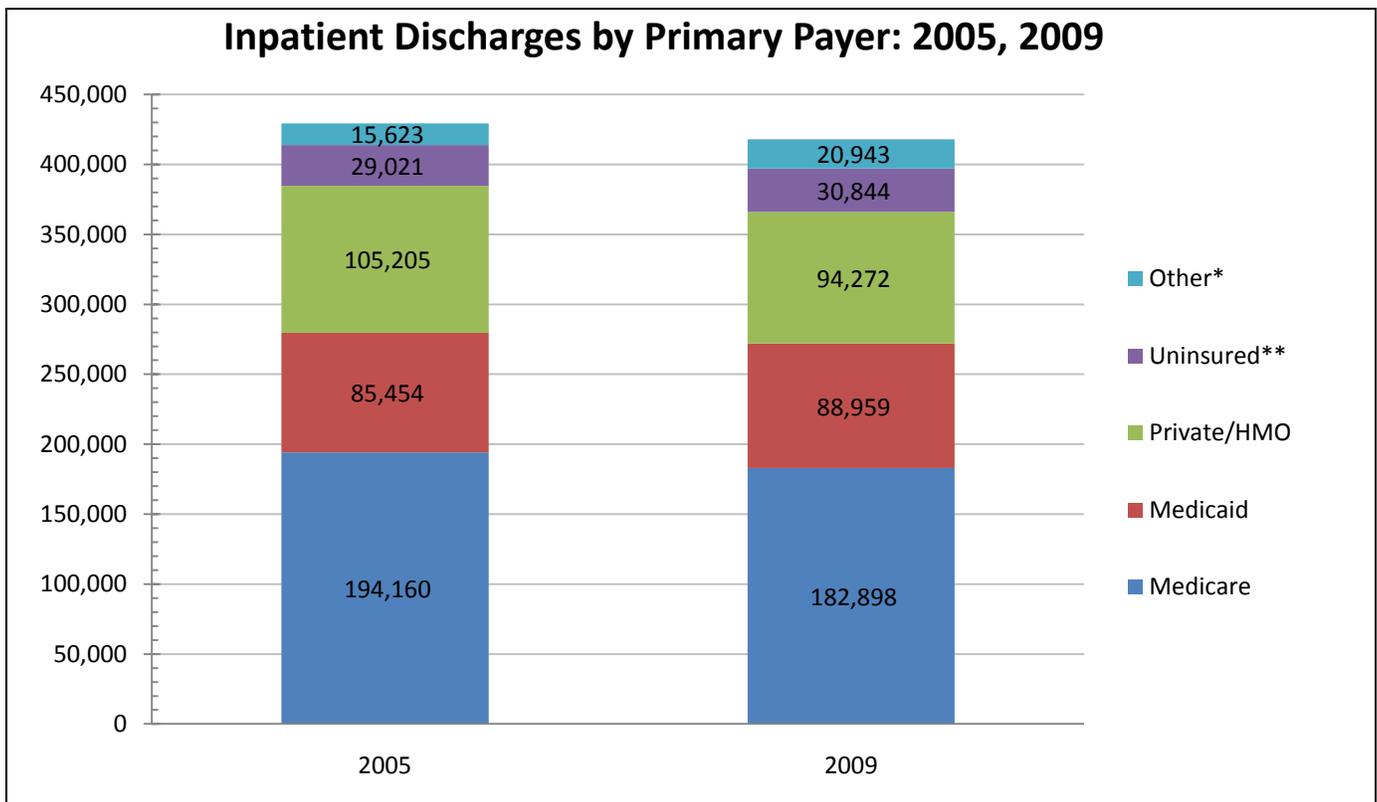


Chart 8: Excludes 654 (from 2005) and 14 (from 2009) discharges where Primary Payer was missing.

* Includes other payers such as Workers' Compensation, TRICARE, CHAMPUS, CHAMPVA, Title V, and other government programs.

**Includes discharges classified as self-pay or no charge.

In 2009

- Medicare is the primary payer for the largest group, accounting for 44%.
- Private/HMO insurance is the primary payer for the second largest group, accounting for 23%, followed closely by Medicaid at 21%.

From 2005 to 2009

- The two largest groups both had a decrease in inpatient discharges, Medicare having 5.80% fewer and Private/HMO having 10.39% fewer.
- The overall distribution for Primary Payer representation has only marginally changed. The ranking has not changed at all.

Admission Type

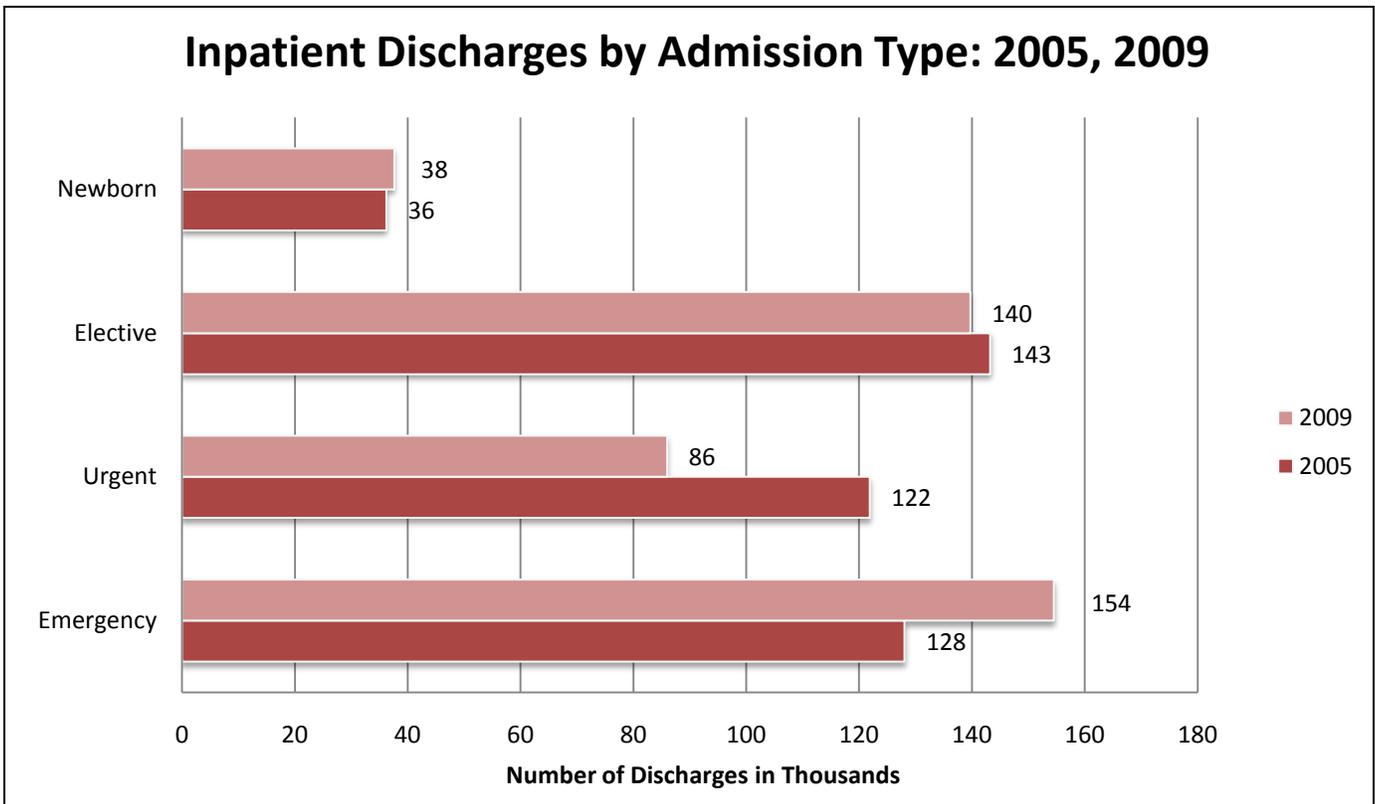


Chart 9: Excludes 99 (from 2005) and 773 (from 2009) discharges of unknown admission type.

In 2009

- Emergency and Elective were the two largest categories of admission type, representing 37% and 33% respectively.
- Newborns accounted for 9% of all hospital inpatient discharges.

From 2005 to 2009

- Emergency admission saw the largest increase at 20.65%.
- Urgent admission saw the largest decrease at 29.46%.

Delivery Type (Newborns)

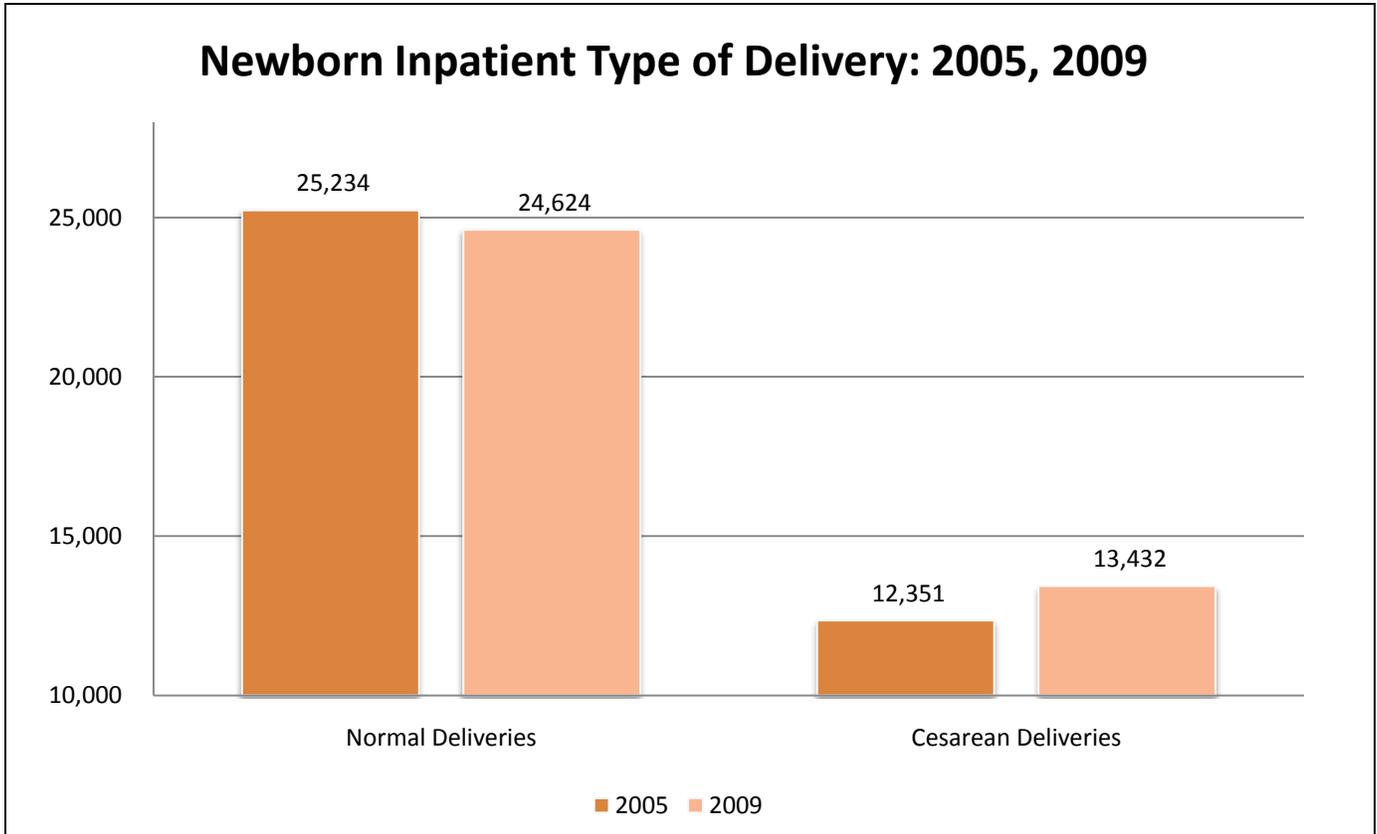


Chart 10

In 2009

- Normal (vaginal) deliveries represented the majority at 65%, while Cesarean deliveries accounted for the remaining 35%.
- Mothers aged 18 to 44 years had the majority of the deliveries representing 36,340 of the 38,056, or 95.49%.
- Teenage mothers represented 1,696 of the deliveries, or 4.46%; the remaining 20, or 0.05%, were by mothers aged 45 years and older.

From 2005 to 2009

- The number of Cesarean Deliveries increased by 8.75% from 2005 to 2009, whereas the number of Normal (vaginal) Deliveries decreased by 2.42%.
- While there was an overall increase in the number of inpatient deliveries of 1.25%, deliveries from teen or child mothers decreased by 1.1% from 1,714 to 1,696.

<u>Utilization: Length Of Stay</u>		<u>2005</u>		<u>2009</u>		<u>% Change</u>
Total Patient Days (TPD)		2,223,590		2,166,459		-2.6%
Average Length of Stay in Days (ALOS)		5.18		5.18		0.0%
		<u>2005 (ALOS)</u>	<u>% (TPD)</u>	<u>2009 (ALOS)</u>	<u>% (TPD)</u>	
Urbanity	Urban	5.66	76%	5.65	78%	-0.2%
	Rural	4.07	24%	3.98	22%	-2.1%
Size and Facility Type**	Small	4.25	8%	4.31	8%	1.4%
	Medium	4.36	21%	4.43	22%	1.7%
	Large	4.75	56%	4.67	54%	-1.7%
	Psychiatric	16.65	9%	16.85	9%	1.2%
	Rehabilitation	12.54	4%	12.29	4%	-1.9%
	LTAC	26.63	3%	26.54	3%	-0.3%
	Critical Access*	3.74	4%	3.91	4%	4.5%

Table 9

* Critical Access Hospitals are a subgroup of Small Hospitals. They are included in the counts for hospital Size: Small.

**Hospitals of Facility Type Psychiatric, Rehabilitation, and Long Term Acute Care (LTAC) are not given a hospital Size.

Total Patient Days (TPD) represents the sum of inpatient hospital days.

Average Length of Stay (ALOS) is the mean of the length of stays for all inpatient discharges.

Highlights

- The Average Length of Stay for inpatients at an Urban hospital (5.65 days) was more than a day and a half longer than for inpatients at a Rural hospital (3.98 days).
- A little over half of all acute or specialty care patient days were served at a Large hospital, at 54%.
- Long Term Acute Care, expectedly, had the longest Average Length of Stay at 26.54 days.

Total Patient Days and Average Length of Stay by Hospital Types

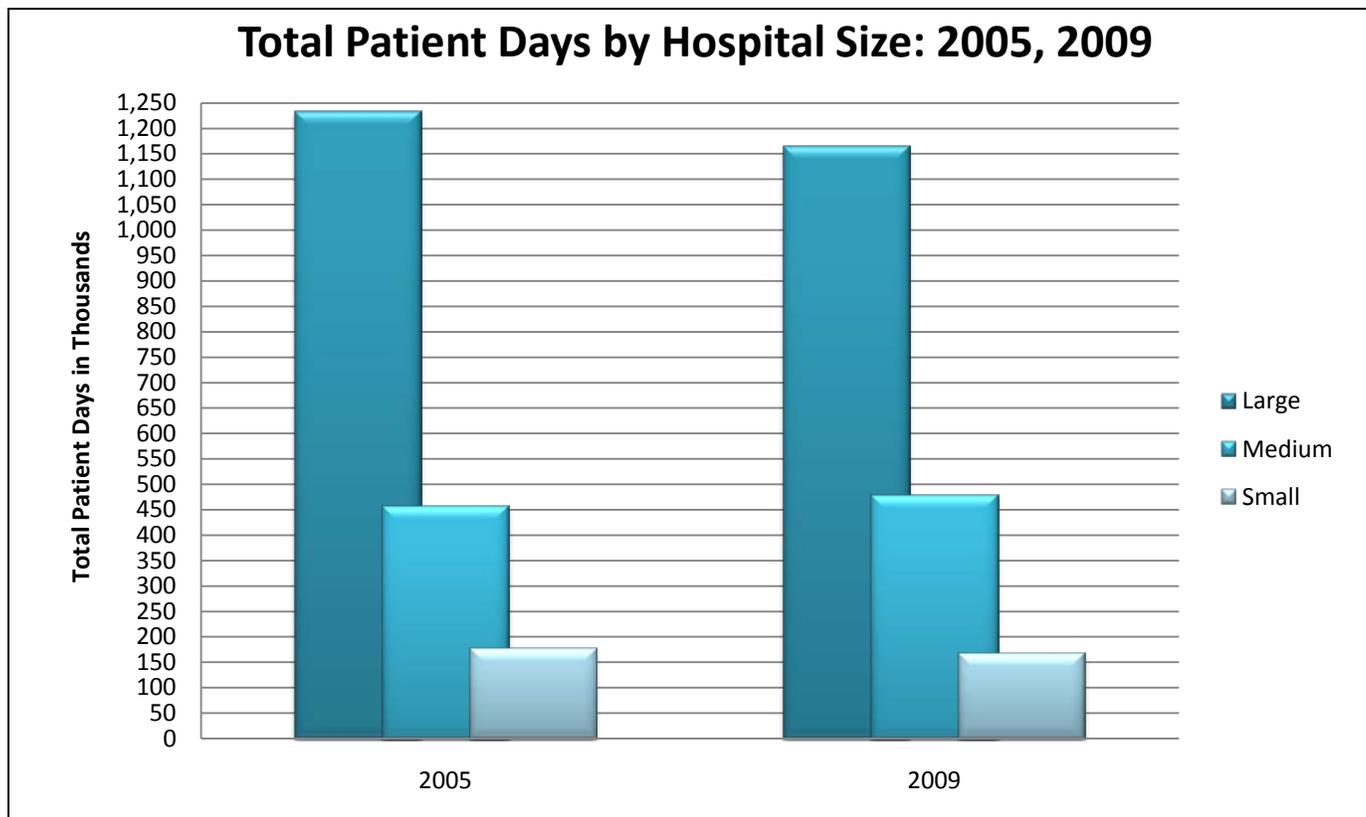


Chart 11

* Critical Access Hospitals are a subgroup of Small Hospitals. They are included in the counts for hospital Size: Small.

In 2009

- Urban hospitals had a longer Average Length of Stay (ALOS) by 42% for their inpatients compared to Rural acute care hospitals.
- Long Term Acute Care Hospitals had the longest ALOS by an overwhelming amount at over 26 days.
- Critical Access Hospitals had the shortest ALOS at just under 4 days.

From 2005 to 2009

- The Average Length of Stay per inpatient discharge has remained steady, while the Total Patient Days has slowly and marginally decreased.
- There were only small changes in the Total Patient Days (TPD) among hospitals in the same size category, with Large hospitals showing the most noticeable change from 56% of TPD to 54%.
- The Average Length of Stay differs among hospitals with different urbanity, and is longer among the Psychiatric, Rehabilitation, and Long Term Acute Care hospital types. However, there is only a very slight difference in Average Length of Stay due to hospital size.

<u>Utilization: Charges & Costs</u>		<u>2005</u>	<u>2009</u>	<u>% Change</u>
Charges	Avg. Charges/Day	\$3,332	\$4,275	28.3%
	Avg. Charges	\$17,251	\$22,126	28.3%
	Avg. Inflation Adjusted Charges	\$18,910	\$22,126	17.0%
Costs	Avg. Costs/Day	\$1,335	\$1,502	12.5%
	Avg. Costs	\$6,910	\$7,774	12.5%
	Avg. Inflation Adjusted Costs	\$7,574	\$7,774	2.6%

Table 10: Neither Charges nor Costs represents the actual amounts hospitals collected for services rendered.

The Average Charges represents the mean total amount billed per discharge, as shown on the billing form, while the average charges per day represents the mean amount charged per day of inpatient hospital status.

The Average Costs tends to reflect the mean estimated actual costs of production, in contrast to the Average Charges. Total charges are converted to estimated costs using hospital level cost-to-charge ratios (CCR) based on hospital accounting reports from the Centers for Medicare and Medicaid Services (CMS). The CCRs used are specific to each year; however, it is important to note that the most recent CCR year file available for use with the 2009 data was 2008.

The Average Charges per Day and Average Costs per Day are calculated by dividing the total respective amount (charges or costs) by Total Patient Days.

The Average Inflation Adjusted Charges and Costs use the Cost of Living Index to inflate the Average Charges or Costs value to represent 2009 dollars. 2005 dollars inflate to 2009 dollars at an index of 1.09618. 2009 dollars do not need to be inflated, as they are from the target cost of living year.

Highlights

- Average Charges consistently increased from 2005 to 2009, producing an overall 28.3% increase over the five year period.
- Average Charges and Average Costs increased by about the same rates.
- From 2005 to 2009, Average Charges increased by 0.6% more than average costs.

Average Charges and Total Patient Days

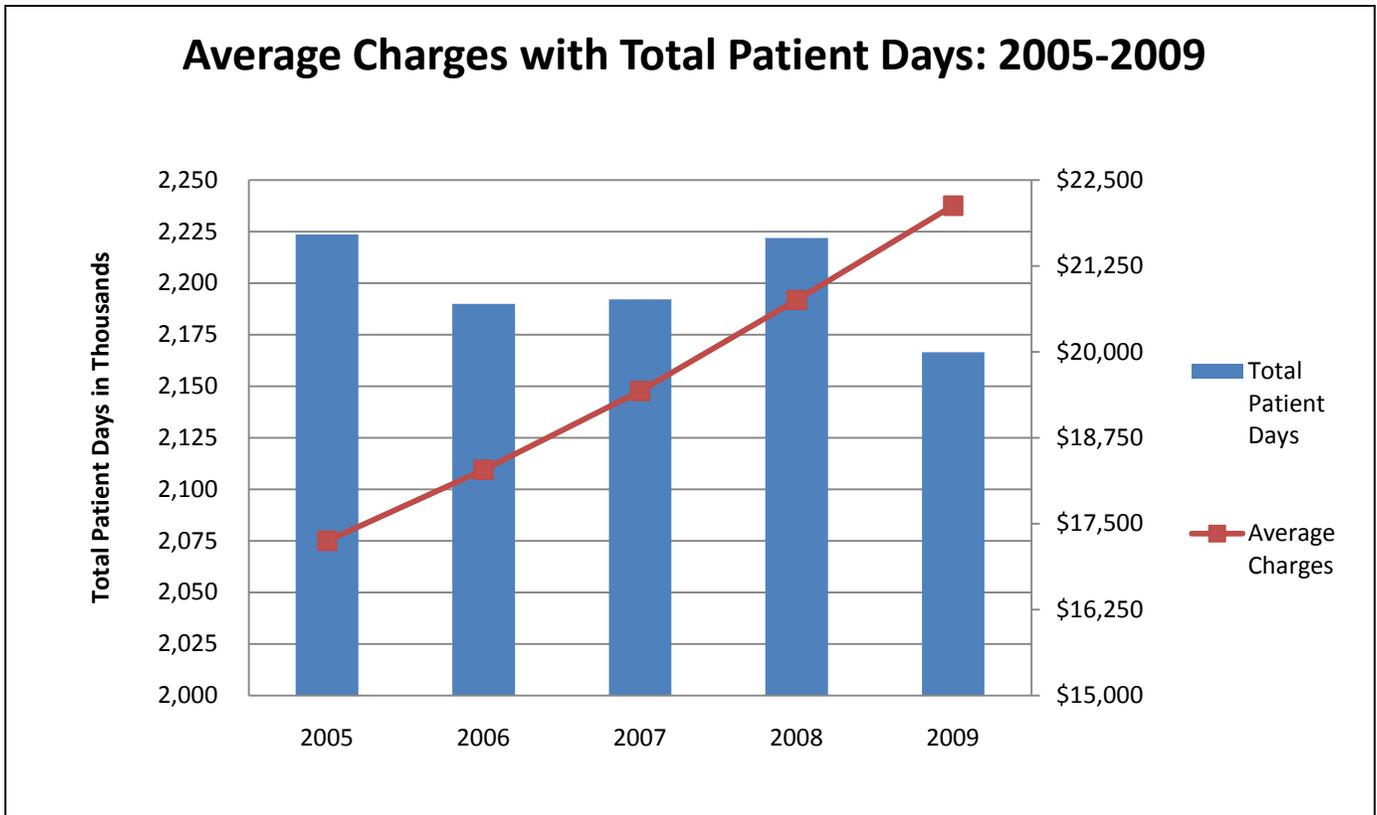


Chart 12

In 2009

- Average Charges for an inpatient stay was \$22,126.
- Average Charges per Day of inpatient stay was \$4,275.

From 2005 to 2009

- The Total Patient Days has fluctuated, but overall has dropped. At the same time, Average Charges have increased, resulting in an increase for Average Charges per Day of 28.3%.

Average Charges and Average Costs

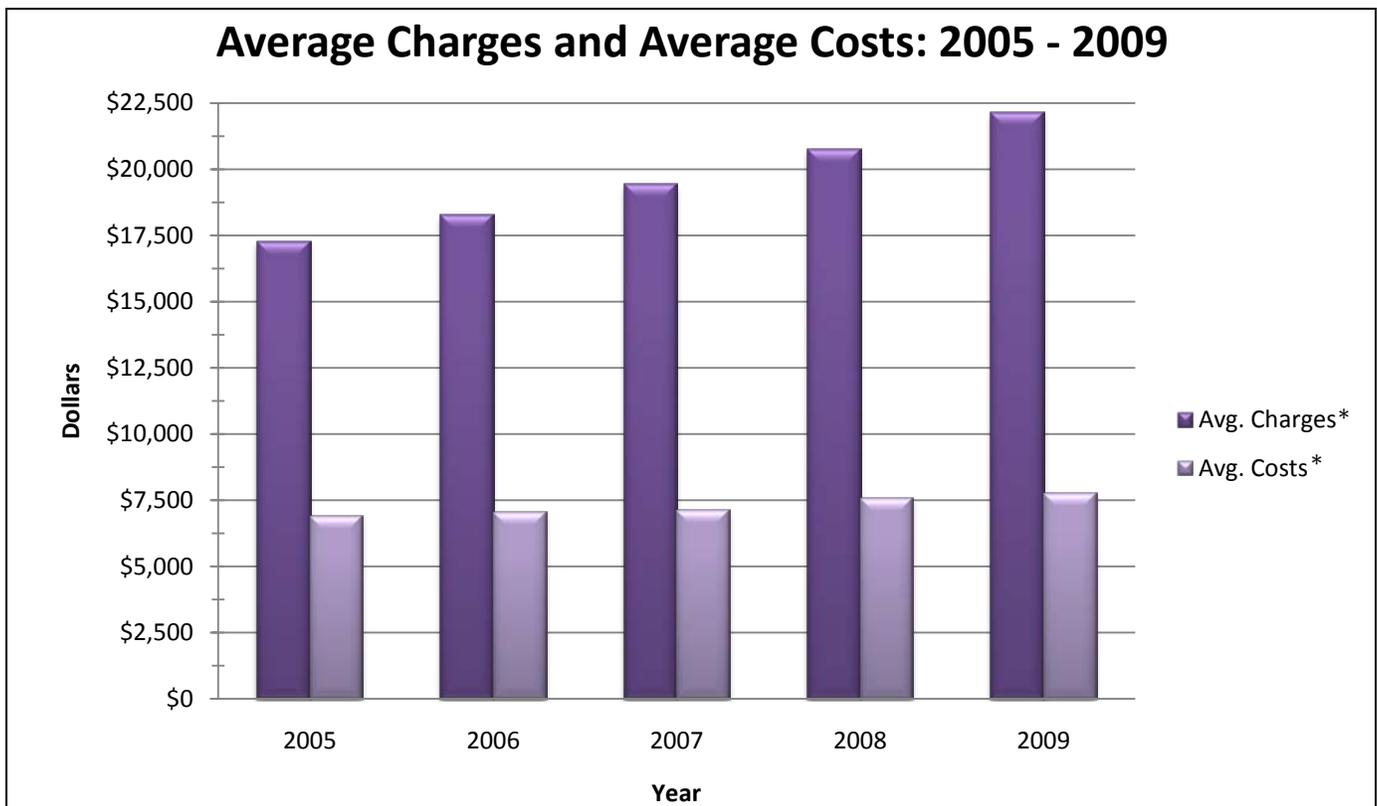


Chart 13

* Neither Average Charges nor Average Costs is representative of the actual amounts hospitals collected for services rendered.

In 2009

- The average charge was 185.62% higher than the average cost.

From 2005 to 2009

- The average charge has consistently increased from 2005 to 2009, producing an overall increase for the 5 year period of 28.26% (5.98% from 2005 to 2006, 6.28% from 2006 to 2007, 6.80% from 2007 to 2008, and 6.62% from 2008 to 2009).
- The average cost per inpatient discharge increased by 12.5%.

Average Inflation Adjusted Charge and Cost

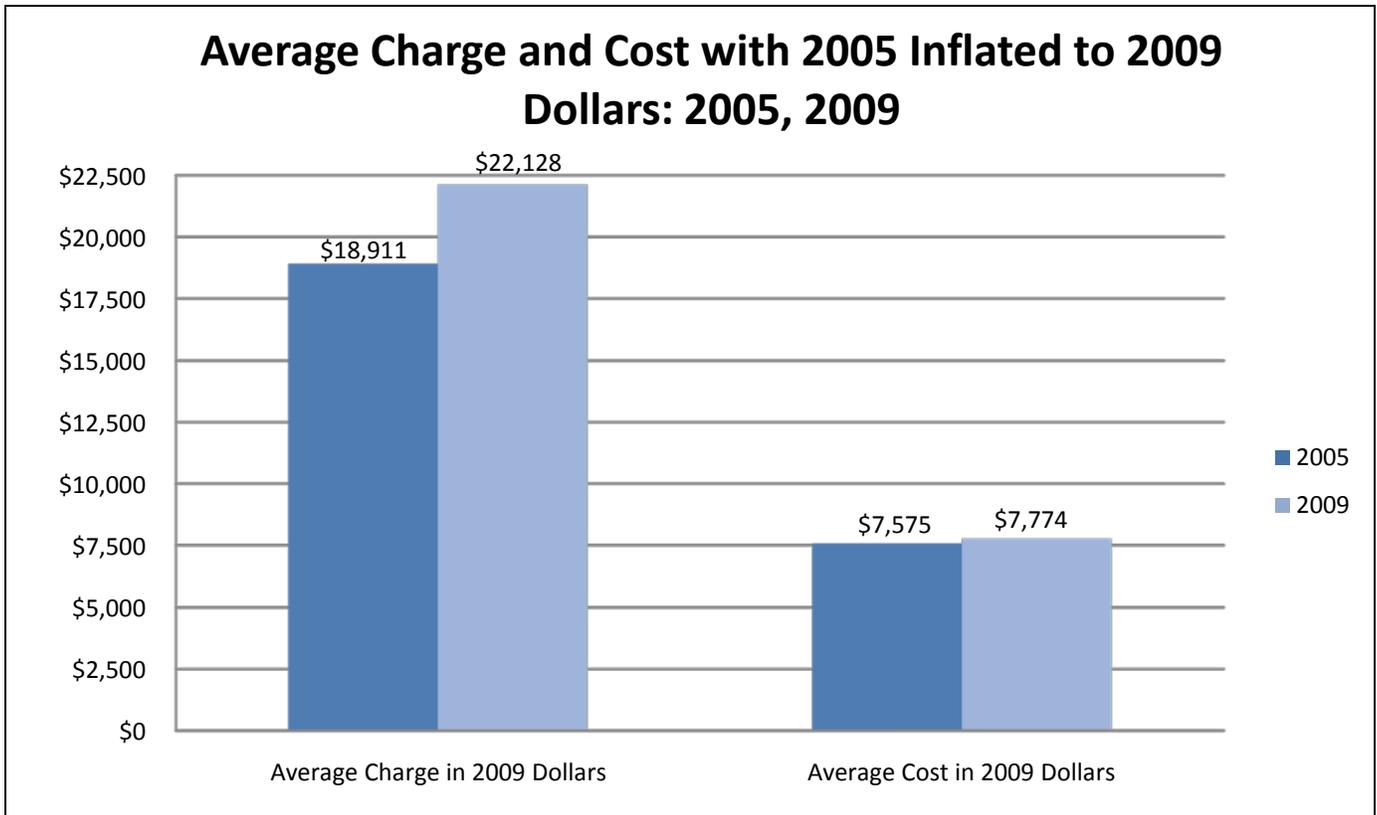


Chart 14: 2005 Inflated to 2009 Dollars⁴

* Neither Average Charges nor Average Costs is representative of the actual amounts hospitals collected for services rendered.

In 2009

- The average charges were \$22,128 and the average costs were \$7,774.

From 2005 to 2009

- Even with inflation taken into account, the 2009 average charges were 17.0% higher than in 2005.
- The 2009 average costs were 12.5% higher.
- The gap between charges and costs have increased. In 2005, the difference between average inflated charges and average inflated costs is \$11,336 while the difference between average charge and average cost in 2009 is \$14,354.

Utilization: Charges & Costs by

Category: 2009

HOSPITAL CATEGORIES

		Avg. Charges	Avg. Charges/Day	Avg. Cost	Avg. Cost/Day
Urbanity:	Urban	\$25,248	\$4,470	\$8,713	\$1,543
	Rural	\$14,207	\$3,571	\$5,390	\$1,355
Size and Facility Type:	Small	\$11,366	\$3,103	\$5,430	\$1,482
	Medium	\$25,431	\$5,324	\$10,207	\$2,137
	Large	\$22,267	\$4,807	\$6,935	\$1,497
	Psychiatric	\$16,069	\$953	\$5,495	\$326
	Rehabilitation	\$22,267	\$1,811	\$10,383	\$845
	Long Term Care	\$96,210	\$3,625	\$39,787	\$1,499
	Critical Access*	\$7,662	\$1,961	\$5,172	\$1,324
PATIENT CATEGORIES					
Gender:	Male	\$25,305	\$4,446	\$8,945	\$1,572
	Female	\$19,931	\$4,135	\$6,964	\$1,445
Age:	Under 1 year	\$10,312	\$2,819	\$4,687	\$1,281
	1 - 17 years	\$17,574	\$2,231	\$8,063	\$1,024
	18 - 44 years	\$15,940	\$4,143	\$5,544	\$1,441
	45 - 64 years	\$28,220	\$5,354	\$9,519	\$1,806
	65 - 84 years	\$28,032	\$4,705	\$9,462	\$1,588
	85 years and above	\$19,997	\$3,240	\$7,057	\$1,144
Race:	White	\$22,498	\$4,411	\$7,864	\$1,542
	Black	\$21,671	\$3,831	\$7,679	\$1,357
	Hispanic	\$13,927	\$3,618	\$5,573	\$1,448
	Other	\$21,745	\$3,450	\$7,853	\$1,246
Obstetrics:	Mother Inpatients	\$9,482	\$4,236	\$3,270	\$1,461
	Newborn Inpatients	\$5,547	\$1,932	\$1,953	\$680
Primary Payer:	Medicare	\$26,374	\$4,347	\$8,944	\$1,474
	Medicaid	\$14,813	\$3,283	\$5,826	\$1,291
	Private/HMO	\$21,818	\$5,229	\$7,641	\$1,831
	Uninsured*	\$19,490	\$3,883	\$6,899	\$1,374
	Other**	\$21,357	\$4,292	\$7,699	\$1,547

Table 11

Highlights

- The lowest average charges and costs in each hospital category were Rural and Small (Critical Access is a subgroup of Small).
- The lowest average charges and costs in each patient category were Female, Under 1 year, Hispanic, Newborn Inpatients, and Medicaid.

ARKANSAS INPATIENT DISCHARGES BY DIAGNOSTIC CATEGORY

<u>Major Diagnostic Category - 2009</u> (MDC)	<u># of</u> <u>Discharges</u>	<u>Avg.</u> <u>Length of Stay</u>	<u>Avg.</u> <u>Charge</u>	<u>Avg.</u> <u>Cost</u>
Circulatory System	61,376	4.2	\$33,606	\$10,861
Respiratory System	47,273	5.6	\$23,315	\$8,558
Pregnancy, Childbirth and Puerperium	42,138	2.3	\$9,496	\$3,279
Newborn and Other Neonates	40,395	3.6	\$9,788	\$4,340
Musculoskeletal System and Connective Tissue	33,467	4.3	\$32,121	\$10,748
Digestive System	33,286	5.0	\$23,940	\$8,055
Mental Diseases and Disorders	24,541	11.6	\$13,976	\$4,886
Nervous System	22,055	5.7	\$23,913	\$8,640
Factors Influencing Health Status	18,796	11.1	\$21,648	\$8,332
Kidney and Urinary Tract	16,164	4.6	\$19,447	\$6,783
Endocrine, Nutritional and Metabolic System	13,843	3.9	\$15,426	\$5,484
Infectious and Parasitic Diseases and Disorders	11,528	7.3	\$33,803	\$11,799
Hepatobiliary System and Pancreas	10,443	5.2	\$26,101	\$8,865
Skin, Subcutaneous Tissue and Breast	9,761	5.0	\$17,275	\$6,218
Female Reproductive System	7,819	2.6	\$17,945	\$5,959
Injuries, Poison And Toxic Effect of Drugs	5,890	4.2	\$20,612	\$7,356
Blood, Blood Forming Organs and Immunological Disorder	4,992	4.4	\$20,567	\$7,622
Ear, Nose, Mouth, and Throat	3,754	3.3	\$14,148	\$5,411
Alcohol/Drug Use or Induced Mental Disorders	3,107	5.1	\$9,705	\$3,409
Myeloproliferative Diseases and Disorders	2,925	8.6	\$55,006	\$22,388
Male Reproductive System	2,182	3.1	\$19,661	\$6,652
Ungroupable	909	13.6	\$44,903	\$17,626
Multiple Significant Trauma	772	9.8	\$64,945	\$24,277
Burns	514	8.9	\$68,320	\$38,545
Human Immunodeficiency Virus Infections	347	7.2	\$33,914	\$12,719
Eye	293	3.8	\$15,315	\$5,855

Table 12

Major Diagnostic Categories (MDCs) are broad groups of Diagnosis Related Groups (DRGs) that relate to an organ or a system (such as the digestive system) and not to an etiology. Each hospital stay has one DRG and one MDC assigned to it.

Highlights

- The Circulatory System represents the most common category for inpatient discharges.
- Aside from inpatients with Ungroupable (undefined) diagnosis, Mental Diseases and Disorders has the longest average length of stay for inpatient discharges.
- Burns have the highest average charge and cost of any MDC group.

ARKANSAS INPATIENT DISCHARGES BY CLINICAL CLASSIFICATION SYSTEM

<u>Clinical Classification System Category - 2009</u> (CCS)	<u># of</u> <u>Discharges</u>	<u>Avg.</u> <u>Length of Stay</u>	<u>Avg.</u> <u>Charge</u>	<u>Avg.</u> <u>Cost</u>
Diseases Of The Circulatory System	68,384	4.2	\$31,311	\$10,130
Diseases Of The Respiratory System	43,890	5.4	\$21,983	\$8,183
Complications Of Pregnancy; Childbirth; And The Puerperium	41,893	2.3	\$9,501	\$3,282
Certain Conditions Originating In The Perinatal Period	40,427	3.6	\$9,789	\$4,341
Diseases Of The Digestive System	35,449	4.8	\$22,824	\$7,701
Mental Illness	31,614	10.7	\$14,128	\$5,011
Injury And Poisoning	30,418	5.5	\$31,988	\$11,206
Symptoms; Signs; Ill-Defined Conditions And Factors Influencing	23,056	9.7	\$20,853	\$7,868
Diseases Of The Musculoskeletal System And Connective Tissue	20,297	3.8	\$32,963	\$10,967
Diseases Of The Genitourinary System	19,432	3.9	\$17,354	\$5,973
Neoplasms	16,610	6.2	\$36,421	\$13,014
Endocrine; Nutritional; And Metabolic Diseases And Immunity	15,054	4.3	\$17,103	\$6,137
Infectious And Parasitic Diseases	9,944	7.4	\$35,206	\$12,271
Diseases Of The Skin And Subcutaneous Tissue	7,618	5.9	\$18,120	\$6,658
Diseases Of The Nervous System And Sense Organs	7,091	4.4	\$19,446	\$7,293
Diseases Of The Blood And Blood-Forming Organs	4,576	4.3	\$19,388	\$7,148
Residual Codes; Unclassified; All E Codes	1,783	4.2	\$10,568	\$3,863
Congenital Anomalies	913	5.9	\$54,152	\$26,098
Missing/Unknown	121	6.9	\$1,285	\$524

Table 13

Clinical Classifications System (CCS) categorizes patient diagnoses and procedures into a manageable number of clinically meaningful categories. Instead of wading through the 12,000 diagnosis codes and 3,500 procedure codes from the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), the CCS groups them into about 260 diagnosis categories and 230 procedure categories. This "clinical grouper" makes it easier to quickly understand patterns of diagnoses and procedures. Each hospital stay can have multiple diagnoses and multiple procedures.

Highlights

- As with the results from MDC groupings, Diseases of the Circulatory System represents the most common category for inpatient discharges.
- Mental Illness has the longest average length of stay for inpatient discharges, as also seen in the MDC category.
- When grouped by CCS, inpatients with Congenital Anomalies have the highest average charge and cost of any other group. Note, there is not a CCS for burns in general.

INPATIENT DISCHARGES FOR MENTAL ILLNESS/SUBSTANCE ABUSE SUMMARY

<u>Mental Health Conditions - 2009</u> (listed as Principal Diagnosis)	<u># of</u> <u>Discharges</u>	<u>Avg.</u> <u>Length of Stay</u>	<u>Avg.</u> <u>Charge</u>	<u>Avg.</u> <u>Cost</u>
Mood Disorders	16,255	10.0	\$12,002	\$4,149
Schizophrenia And Other Psychotic Disorders	4,701	17.3	\$19,134	\$6,725
Delirium, Dementia, And Amnestic And Other Cognitive Disorders	4,211	10.9	\$18,137	\$6,983
Alcohol-Related Disorders	1,848	5.0	\$10,532	\$3,690
Substance-Related Disorders	1,789	5.0	\$10,764	\$3,806
Anxiety Disorders	539	7.2	\$10,428	\$3,727
Screening And History Of Mental Health And Substance Abuse	539	5.8	\$27,257	\$9,564
Attention Deficit, Conduct, And Disruptive Behavior Disorders	517	30.6	\$25,286	\$8,858
Miscellaneous Mental Disorders	485	3.9	\$11,859	\$4,111
Adjustment Disorders	355	4.9	\$7,750	\$2,738
Suicide And Intentional Self-Inflicted Injury	148	2.0	\$6,125	\$2,022
Impulse Control Disorders, Not Elsewhere Classified	94	8.7	\$12,502	\$4,587
Personality Disorders	70	9.4	\$14,063	\$4,781
Disorders Diagnosed In Infancy, Childhood, Or Adolescence	39	31.9	\$28,899	\$10,343
Developmental Disorders	24	12.9	\$17,794	\$6,275
<u>TOTALS</u>	<u>31,614</u>	<u>10.7</u>	<u>\$14,128</u>	<u>\$5,011</u>

Table 14

The Mental Health Conditions represents a more detailed look at the CCS category Mental Illness.

Highlights

- Mood Disorders is the most common category for inpatient discharges with a mental illness.
- Disorders Diagnosed in Infancy, Childhood, or Adolescence has the longest average length of stay for inpatient discharges, followed by Attention Deficit, Conduct, and Disruptive Behavior Disorders.
- In addition to having the longest average length of stay, Disorders Diagnosed in Infancy, Childhood, or Adolescence also has the highest average charge and cost.

ARKANSAS INPATIENT QUALITY INDICATOR MAPS

Prevention Quality Indicators

“The Prevention Quality Indicators (PQIs) are a set of measures that can be used with hospital inpatient discharge data to identify "ambulatory care sensitive conditions" (ACSCs) in adult populations. ACSCs are conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease.” (AHRQ, Guide to Prevention Quality Indicators, 2007)

AHRQ has identified 14 PQIs. PQIs can be used in the identification of potential healthcare concerns in a community or population. For example, if there is a high admission rate for diabetes complications, it could suggest that there is not adequate and/or appropriate provision of outpatient care to this population. (AHRQ)

This report contains the five PQIs with the highest admission rates for Arkansas (Diabetes Short-term Complications Admission Rate, Diabetes Long-term Complications Admission Rate, Congestive Heart Failure Admission Rate, Dehydration Admission Rate and Bacterial Pneumonia Admission Rate) as well as the Overall PQI Admission Rate Composite, Chronic Condition PQI Admission Rate Composite, and Acute Condition PQI Admission Rate Composite.

Each PQI is represented by county as one of five value ranges. The values of these five ranges vary according to the PQI rate’s quintiles and are defined on each map. In all cases, a lower Admission Rate is considered better. Additionally, the Admission Rate and Potential Cost Savings for the whole state is given in a table. The cost savings “can be used to assist decision-makers allocation of resources and efforts to reduce cases in certain areas.”¹

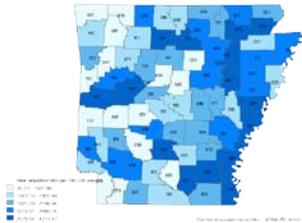
For more information on PQIs, see the AHRQ website at www.qualityindicators.ahrq.gov/.

Highlights

- The Delta region of Arkansas (eastern Arkansas close to and along the Mississippi River) has high admission rates for most of the PQIs. In overall comparisons, the rate is higher in chronic conditions than in acute conditions.
- The North-West corner of Arkansas consistently shows lower admission rates for most of the PQIs and in all of the composite PQIs.
- The Bacterial Pneumonia Admission Rate appears to be highest in the North-Central region of Arkansas.

Prevention Quality Indicators: Explanation of Map and Rate Table

State/County Map:



Each county in the State of Arkansas (AR) is labeled for ease of identification with its 3 digit FIPS county code, as assigned by the U.S. Census Bureau.

A list of each code and its corresponding county are given in the columns to the right.

001 - Arkansas	039 - Dallas	077 - Lee	115 - Pope
003 - Ashley	041 - Desha	079 - Lincoln	117 - Prairie
005 - Baxter	043 - Drew	081 - Little River	119 - Pulaski
007 - Benton	045 - Faulkner	083 - Logan	121 - Randolph
009 - Boone	047 - Franklin	085 - Lonoke	123 - St. Francis
011 - Bradley	049 - Fulton	087 - Madison	125 - Saline
013 - Calhoun	051 - Garland	089 - Marion	127 - Scott
015 - Carroll	053 - Grant	091 - Miller	129 - Searcy
017 - Chicot	055 - Greene	093 - Mississippi	131 - Sebastian
019 - Clark	057 - Hempstead	095 - Monroe	133 - Sevier
021 - Clay	059 - Hot Spring	097 - Montgomery	135 - Sharp
023 - Cleburne	061 - Howard	099 - Nevada	137 - Stone
025 - Cleveland	063 - Independence	101 - Newton	139 - Union
027 - Columbia	065 - IZard	103 - Ouachita	141 - Van Buren
029 - Conway	067 - Jackson	105 - Perry	143 - Washington
031 - Craighead	069 - Jefferson	107 - Phillips	145 - White
033 - Crawford	071 - Johnson	109 - Pike	147 - Woodruff
035 - Crittenden	073 - Lafayette	111 - Poinsett	149 - Yell
037 - Cross	075 - Lawrence	113 - Polk	

Table 15

Description:

Beneath each PQI map is the definition, as provided with the MONAHRQ software, of the Prevention Quality Indicator(s) rates that are represented on the map. The definition indicates the type of inpatient cases that make up the numerator for calculating the rate.

Disclaimer: The rates shown for each county are based on inpatient discharges from the 106 reporting Arkansas Hospitals. Some county rates, particularly those on the state border, may be biased due to resident usage of out of state or non reporting hospital facilities.

State / All County Rate Table:

Numerator	Denominator	Rates per 100,000			Cost Savings* with Reduction in the numerator of		
		Observed Rate	Risk Adjusted (R.A) Rate	S.E. of R.A Rate	10%	30%	50%

“The table presents data on a selected quality indicator for the entire state of AR. Information provided in the table is derived from discharge records with the given condition, procedure, or occurrence. The numerator is the number of individuals who actually experience the event or outcome of interest. The denominator is the number of individuals who are potentially capable of experiencing the event or outcome of interest (based on US Census Bureau data). Together, the numerator and denominator can be used to calculate rates; the numerator is the top half of the fraction and the denominator is the bottom half of the fraction.

Rates are presented per 100,000 population at risk. Risk-adjustment is a statistical process that adjusts a hospital's estimated performance if the hospital had an "average" case mix. The comparison to an average case mix is estimated from the AHRQ nationwide inpatient sample. Most of the quality indicators present a risk-adjusted rate. The standard error (S.E.) is an estimate of the variability surrounding risk-adjusted rates.

The final three columns in the table present estimates of the potential [lifetime] cost savings associated with a 10, 30, and 50 percent reduction in the number of cases in the numerator. These calculations are based on the Total Charge of the inpatients' visits.”¹

Prevention Quality Indicator Composite Map - Overall

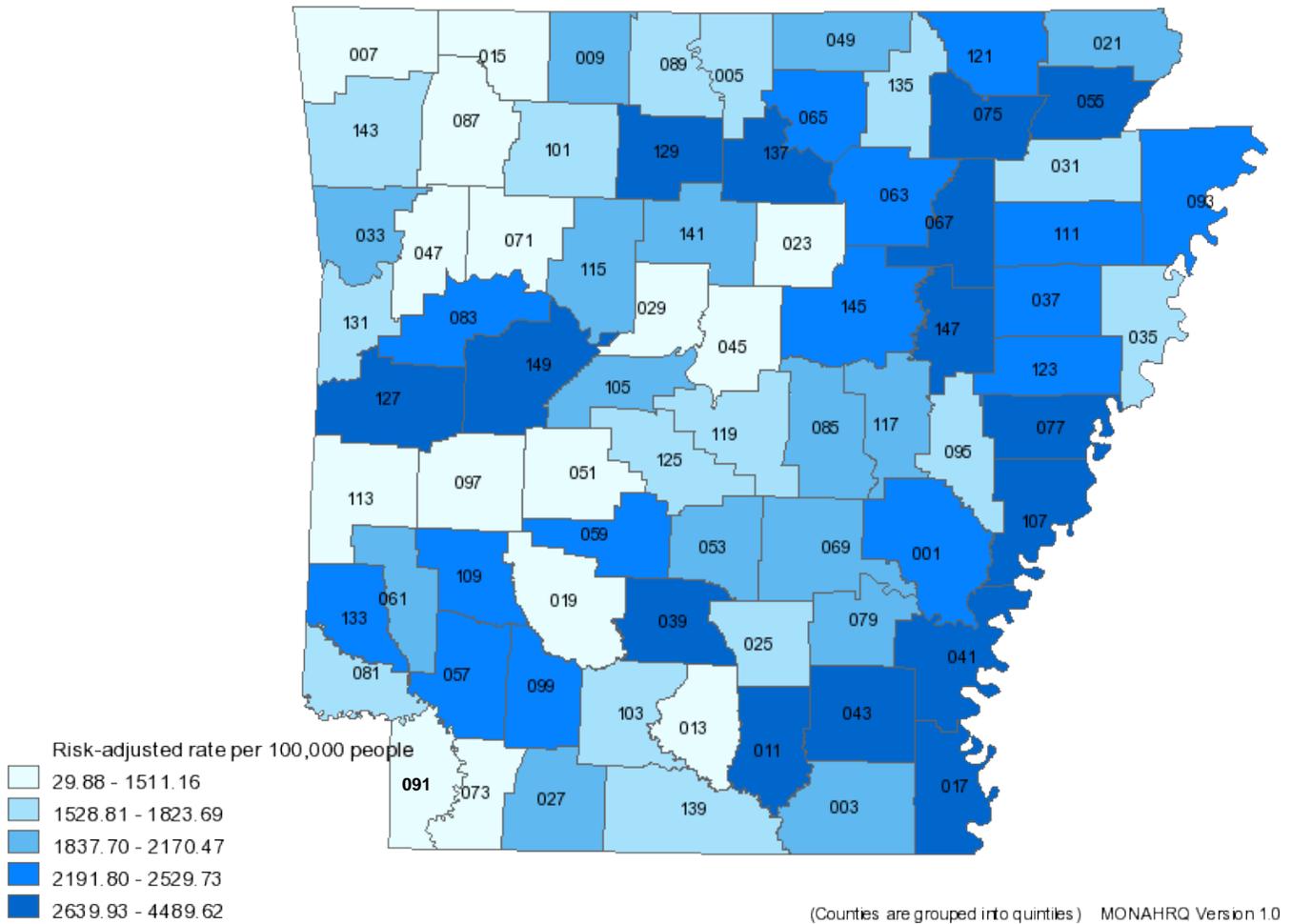


Figure 1: Prevention Quality Indicator Composite - Overall

“The overall PQI composite is based on rates of admission for diabetes short-term complications, diabetes long-term complication, chronic obstructive pulmonary disease, hypertension, congestive heart failure, angina without procedure, uncontrolled diabetes, adult asthma, lower-extremity amputation among patients with diabetes, dehydration, bacterial pneumonia, and urinary tract infections.”¹

State (All Counties) Rate Table:

Numerator	Denominator	Rates per 100,000			Cost Savings* with Reduction in the numerator of		
		Observed Rate	Risk Adjusted (R.A) Rate	S.E. of R.A Rate	10%	30%	50%
45,178	2,169,907	2082.02	1876.27	7.33	\$26,804,300	\$80,412,900	\$134,021,400

Prevention Quality Indicator Composite Map – Acute Conditions

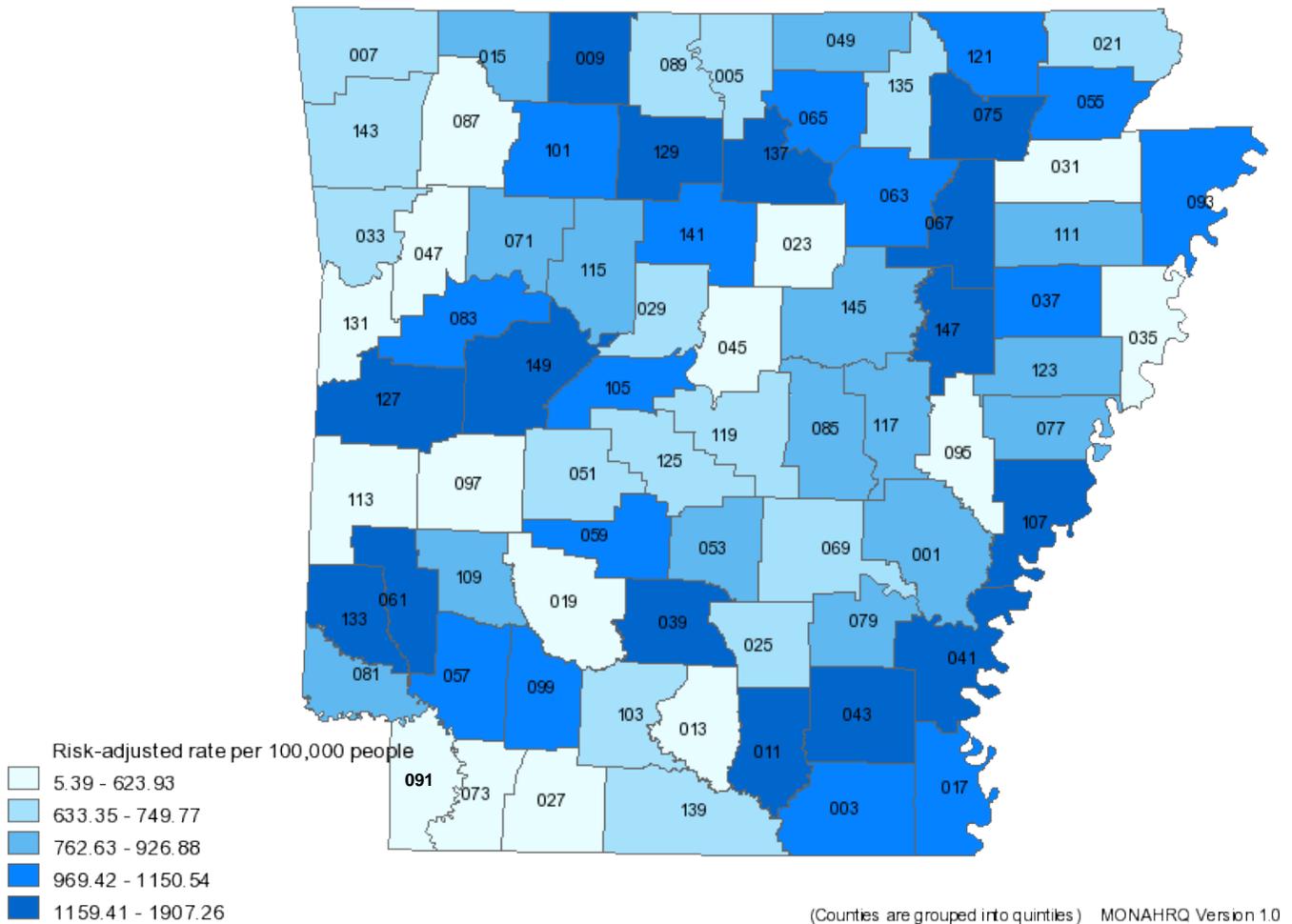


Figure 2: Prevention Quality Indicator Composite – Acute Conditions

“The acute care PQI composite is based on rates of admission for dehydration, bacterial pneumonia, and urinary tract infections.”¹

State (All Counties) Rate Table:

Numerator	Denominator	Rates per 100,000			Cost Savings* with Reduction in the numerator of		
		Observed Rate	Risk Adjusted (R.A) Rate	S.E. of R.A Rate	10%	30%	50%
19,178	2,169,907	883.82	793.31	4.63	\$11,160,900	\$33,482,600	\$55,804,300

Prevention Quality Indicator Composite Map – Chronic Conditions

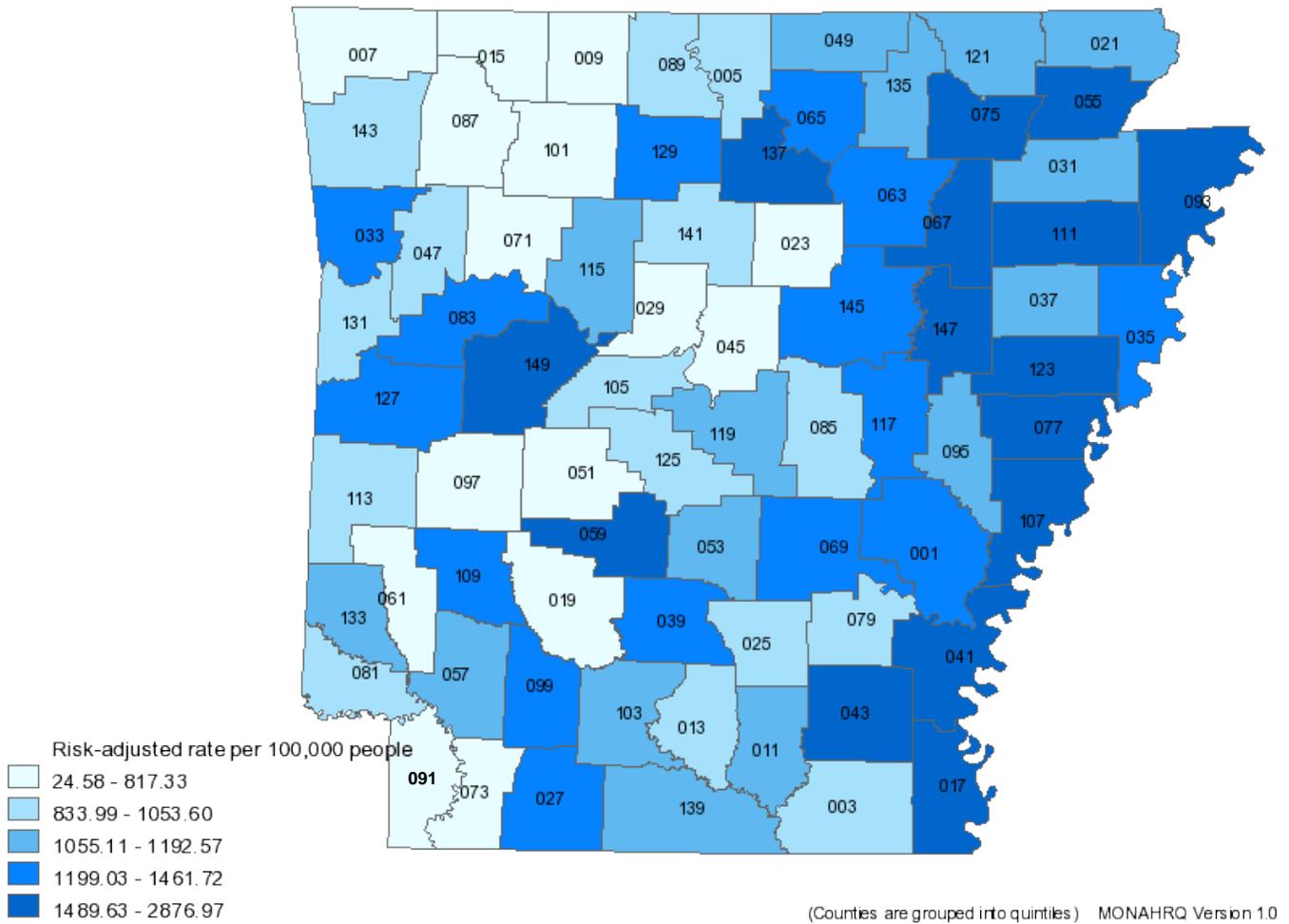


Figure 3: Prevention Quality Indicator Composite – Chronic Conditions

“The chronic care PQI composite is based on rates of admission for diabetes short-term complications, diabetes long-term complication, chronic obstructive pulmonary disease, hypertension, and congestive heart failure, angina without procedure, uncontrolled diabetes, adult asthma, and lower-extremity amputation among patients with diabetes.”¹

State (All Counties) Rate Table:

Numerator	Denominator	Rates per 100,000			Cost Savings* with Reduction in the numerator of		
		Observed Rate	Risk Adjusted (R.A) Rate	S.E. of R.A Rate	10%	30%	50%
26,004	2,169,907	1198.39	1082.62	5.78	\$15,655,000	\$46,965,000	\$78,274,900

Prevention Quality Indicator Map – Diabetes Short Term Complication Admission Rate

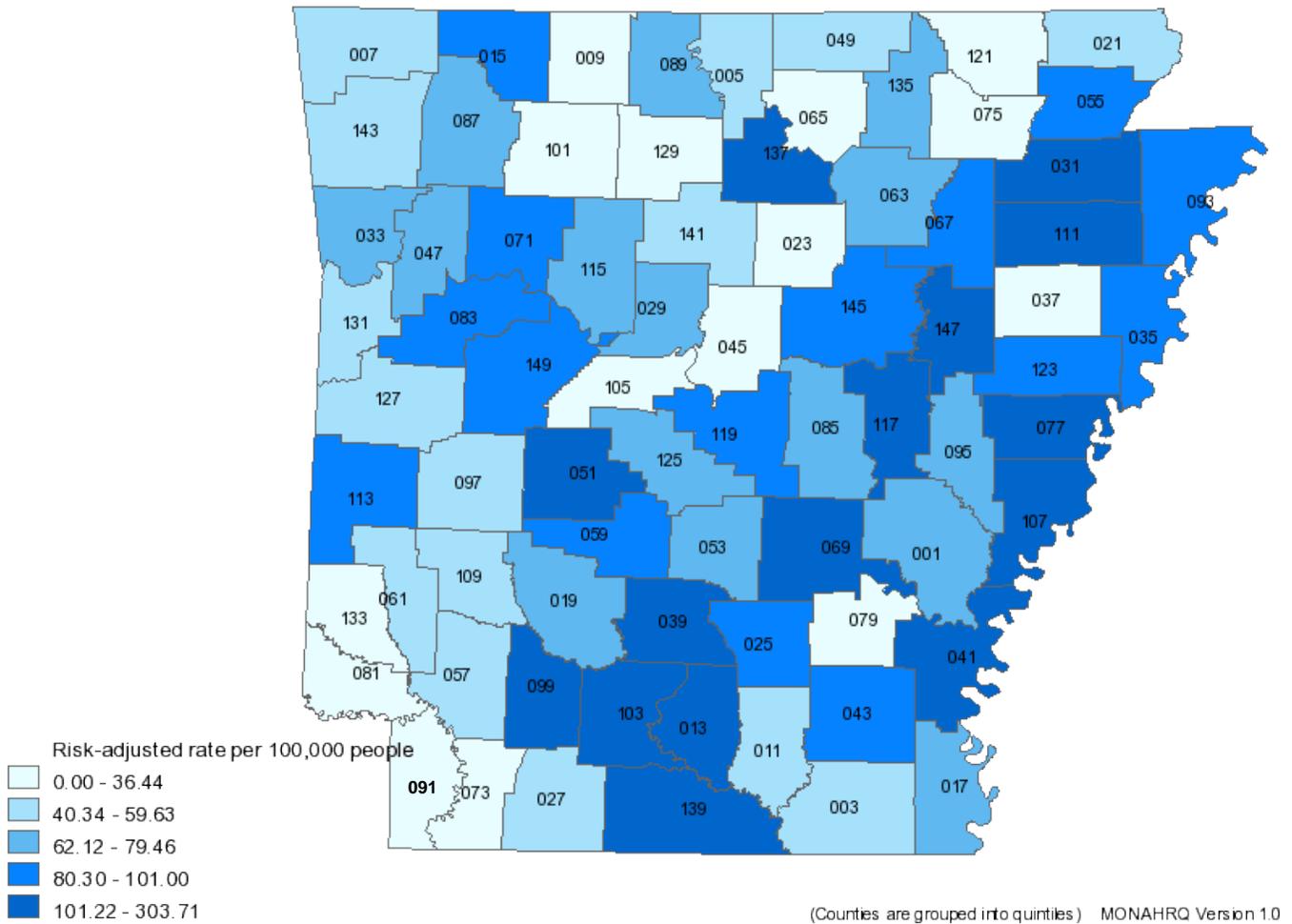


Figure 4: Diabetes Short-term Complication Admission Rate

“Diabetes Short-Term Complication Admission rate is defined as admissions for diabetic short-term complications per 100,000 population. Short-term complications of diabetes mellitus include diabetic ketoacidosis, hyperosmolarity, and coma. These life-threatening emergencies arise when a patient experiences an excess of glucose (hyperglycemia) or insulin (hypoglycemia). Proper outpatient treatment and adherence to care may reduce the incidence of diabetic short-term complications, and lower rates represent better quality care.”¹

State (All Counties) Rate Table:

Numerator	Denominator	Rates per 100,000			Cost Savings* with Reduction in the numerator of		
		Observed Rate	Risk Adjusted (R.A) Rate	S.E. of R.A Rate	10%	30%	50%
1,626	2,169,907	74.93	74.52	1.47	\$925,600	\$2,776,700	\$4,627,900

The Risk Adjusted Rate in 2007 was 59.881 with a S.E. 1.522 for the Nation and 71.198 with a S.E. 2.946 for the inpatients seen in the Southern U.S. Region.⁵

Prevention Quality Indicator Map – Diabetes Long Term Complication Admission Rate

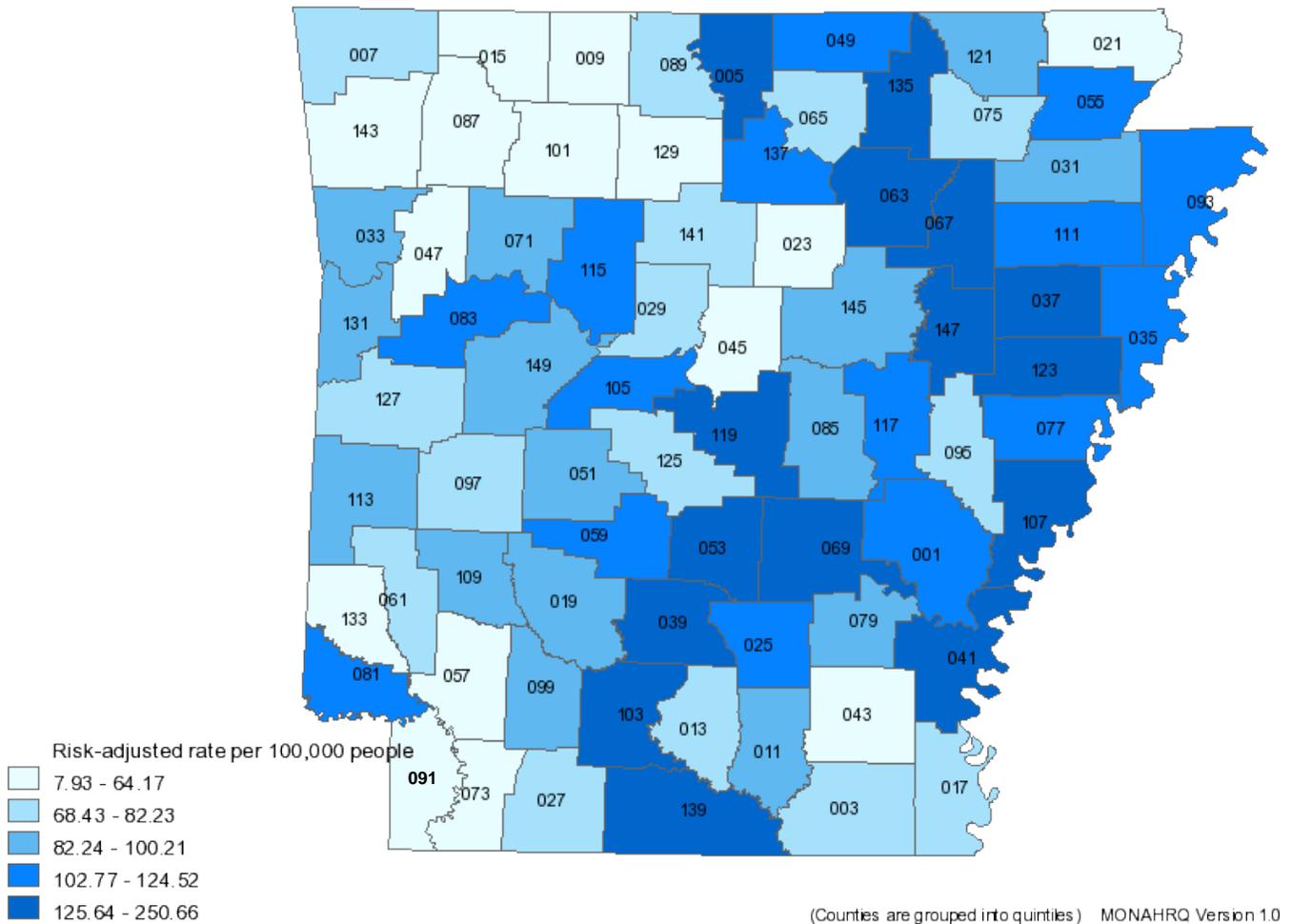


Figure 5: Diabetes Long-term Complication Admission Rate

“Diabetes Long-Term Complication Admission Rate is defined as admissions for diabetic long-term complications per 100,000 population. Long-term complications of diabetes mellitus include renal, eye, neurological, and circulatory disorders. Long-term complications occur at some time in the majority of patients with diabetes to some degree. Proper outpatient treatment and adherence to care may reduce the incidence of diabetic long-term complications, and lower rates represent better quality care.”¹

State (All Counties) Rate Table:

Numerator	Denominator	Rates per 100,000			Cost Savings* with Reduction in the numerator of		
		Observed Rate	Risk Adjusted (R.A) Rate	S.E. of R.A Rate	10%	30%	50%
2,351	2,169,907	108.35	99.06	2.06	\$1,865,300	\$5,595,800	\$9,326,300

The Risk Adjusted Rate in 2007 was 123.780 with a S.E. 3.113 for the Nation and 134.702 with a S.E. 5.605 for the inpatients seen in the Southern U.S. Region.⁵

Prevention Quality Indicator Map – Congestive Heart Failure Admission Rate

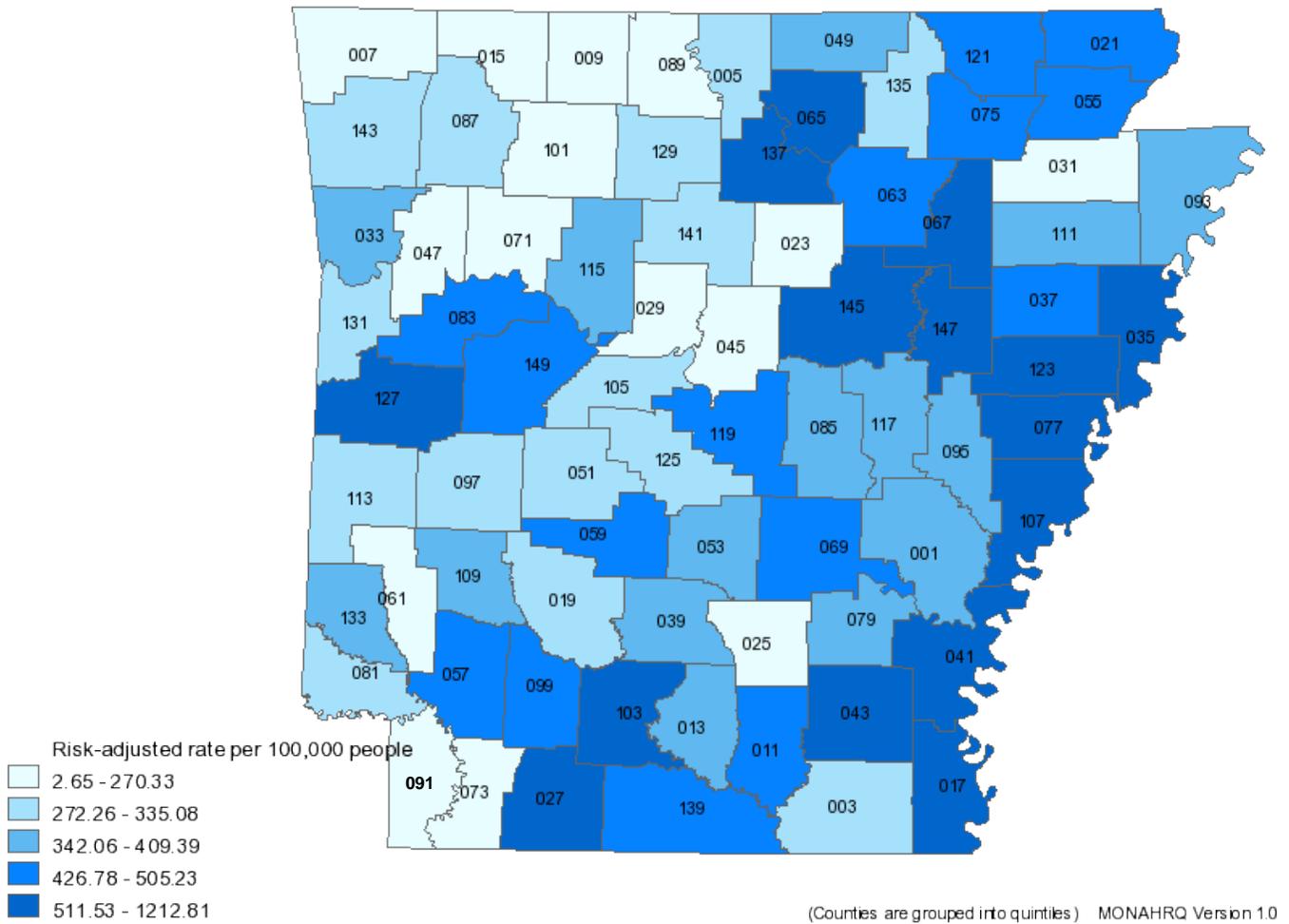


Figure 6: Congestive Heart Failure Admission Rate

“Congestive Heart Failure Admission Rate is defined as admissions for congestive heart failure per 100,000 population. CHF can be controlled in an outpatient setting for the most part; however, the disease is a chronic progressive disorder for which some hospitalizations are appropriate. Proper outpatient treatment may reduce admissions for CHF, and lower rates represent better quality care.”¹

State (All Counties) Rate Table:

Numerator	Denominator	Rates per 100,000			Cost Savings* with Reduction in the numerator of		
		Observed Rate	Risk Adjusted (R.A) Rate	S.E. of R.A Rate	10%	30%	50%
9,434	2,169,907	434.77	383.77	3.57	\$5,756,900	\$17,270,800	\$28,784,600

The Risk Adjusted Rate in 2007 was 415.519 with a S.E. 9.598 for the Nation and 474.166 with a S.E. 17.900 for the inpatients seen in the Southern U.S. Region.⁵

Prevention Quality Indicator Map – Dehydration Admission Rate

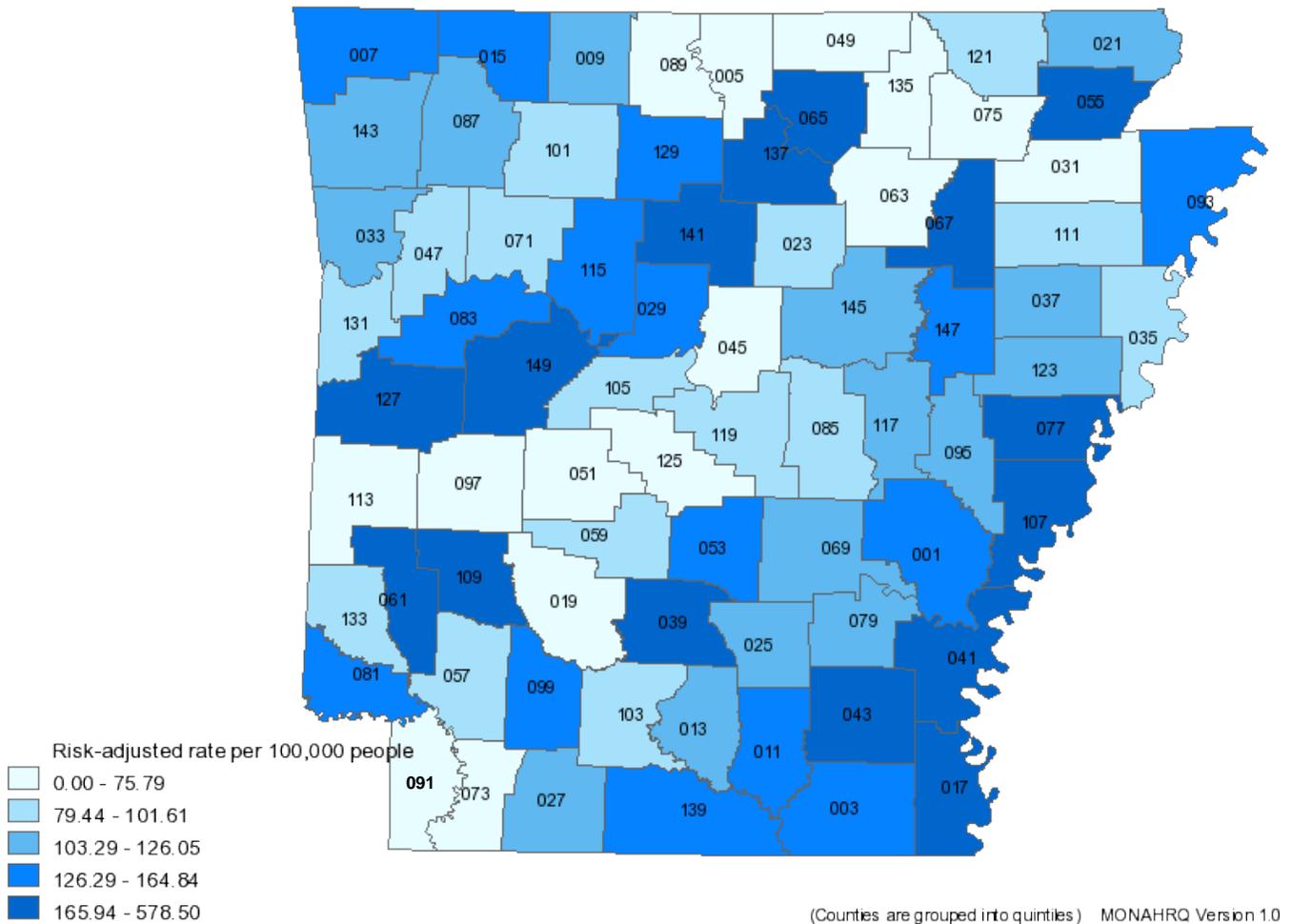


Figure 7: Dehydration Admission Rate

“Dehydration admission rate is defined as admissions for dehydration per 100,000 population. Dehydration is a serious acute condition that occurs in frail patients and patients with other underlying illnesses following insufficient attention and support for fluid intake. Dehydration can for the most part be treated in an outpatient setting, but it is potentially fatal for elderly, very young children, frail patients, or patients with serious comorbid conditions. Proper outpatient treatment may reduce admissions for dehydration, and lower rates represent better quality care.”¹

State (All Counties) Rate Table:

Numerator	Denominator	Rates per 100,000			Cost Savings* with Reduction in the numerator of		
		Observed Rate	Risk Adjusted (R.A) Rate	S.E. of R.A Rate	10%	30%	50%
2,664	2,169,907	122.77	109.94	1.89	\$1,112,100	\$3,336,300	\$5,560,500

The Risk Adjusted Rate in 2007 was 105.680 with a S.E. 2.396 for the Nation and 116.706 with a S.E. 3.953 for the inpatients seen in the Southern U.S. Region.⁵

Prevention Quality Indicator Map – Bacterial Pneumonia Admission Rate

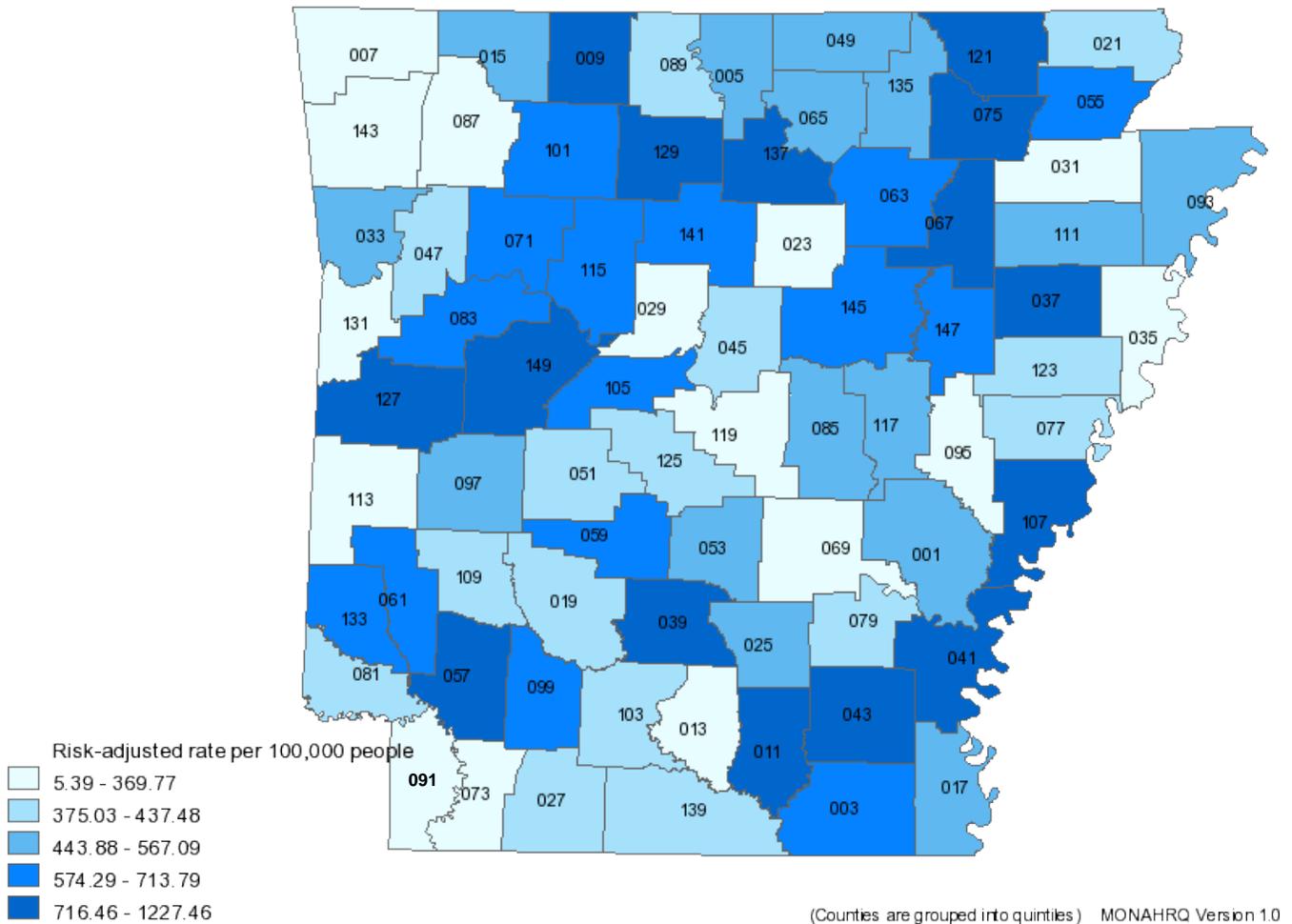


Figure 8: Bacterial Pneumonia Admission Rate

“Bacterial pneumonia admission rate is defined as admissions for bacterial pneumonia per 100,000 population. Bacterial pneumonia is a relatively common acute condition, treatable for the most part with antibiotics. If left untreated in susceptible individuals, such as the elderly, pneumonia can lead to death. Proper outpatient treatment may reduce admissions for bacterial pneumonia in non-susceptible individuals, and lower rates represent better quality care.”¹

State (All Counties) Rate Table:

Numerator	Denominator	Rates per 100,000			Cost Savings* with Reduction in the numerator of		
		Observed Rate	Risk Adjusted (R.A) Rate	S.E. of R.A Rate	10%	30%	50%
11,380	2,169,907	524.45	469.54	3.45	\$7,586,700	\$22,760,100	\$37,933,400

The Risk Adjusted Rate in 2007 was 374.788 with a S.E. 7.256 for the Nation and 403.415 with a S.E. 12.544 for the inpatients seen in the Southern U.S. Region.⁵

APPENDIX A: HOSPITALS BY SIZE CATEGORY & FACILITY TYPE

LARGE

Arkansas Methodist Medical Center	Greene County, Paragould
Baptist Health Medical Center - Little Rock	Pulaski County, Little Rock
Baptist Health Medical Center - North Little Rock	Pulaski County, North Little Rock
Baxter Regional Medical Center	Baxter County, Mountain Home
Forrest City Medical Center	St Francis County, Forrest City
Great River Medical Center	Mississippi County, Blytheville
Harris Hospital	Jackson County, Newport
Helena Regional Medical Center	Phillips County, Helena
Jefferson Regional Medical Center	Jefferson County, Pine Bluff
Johnson Regional Medical Center	Johnson County, Clarksville
Medical Center Of South Arkansas	Union County, El Dorado
North Arkansas Regional Medical Center	Boone County, Harrison
Northeast Arkansas Medical Center	Craighead County, Jonesboro
Northwest Medical Center - Springdale	Washington County, Springdale
Ouachita County Medical Center	Ouachita County, Camden
Sparks Health System	Sebastian County, Fort Smith
St. Bernard's Medical Center	Craighead County, Jonesboro
St. Edward Mercy Medical Center	Sebastian County, Fort Smith
St. Joseph's Mercy Health Center Inc.	Garland County, Hot Springs
St. Mary's Regional Medical Center	Pope County, Russellville
St. Vincent Infirmiry Medical Center	Pulaski County, Little Rock
Washington Regional Medical Center	Washington County, Fayetteville
White County Medical Center	White County, Searcy
White River Medical Center	Independence County, Batesville

MEDIUM

Arkansas Children's Hospital	Pulaski County, Little Rock
Arkansas Heart Hospital	Pulaski County, Little Rock
Baptist Health Medical Center - Stuttgart	Arkansas County, Stuttgart
Chambers Memorial Hospital	Yell County, Danville
Conway Regional Medical Center	Faulkner County, Conway
Crittenden Regional Hospital	Crittenden County, West Memphis
Drew Memorial Hospital	Drew County, Monticello
Five Rivers Medical Center	Randolph County, Pocahontas
Hot Spring County Medical Center	Hot Spring County, Malvern
Magnolia Regional Medical Center	Columbia County, Magnolia
Mena Regional Health System	Polk County, Mena
Mercy Medical Center	Benton County, Rogers
National Park Medical Center	Garland County, Hot Springs
North Metro Medical Center - Pulaski County.	Pulaski County, Jacksonville
Northwest Medical Center - Bentonville	Benton County, Bentonville
Saline Memorial Hospital	Saline County, Benton
Summit Medical Center	Crawford County, Van Buren
U.A.M.S. Medical Center	Pulaski County, Little Rock

SMALL (including Critical Access Hospitals*)

Arkansas Department Of Correction - Care Facility	Jefferson County, Pine Bluff
Arkansas Surgical Hospital	Pulaski County, North Little Rock
Ashley County Medical Center*	Ashley County, Crossett
Baptist Health Medical Center - Arkadelphia*	Clark County, Arkadelphia
Baptist Health Medical Center - Heber Springs*	Cleburne County, Heber Springs
Booneville Community Hospital*	Logan County, Booneville
Bradley County Medical Center*	Bradley County, Warren
Chicot Memorial Hospital*	Chicot County, Lake Village
Community Medical Center Of IZARD County*	Izard County, Calico Rock
Crossridge Community Hospital*	Cross County, Wynne

Dallas County Medical Center*
 Dardanelle Hospital*
 De Queen Medical Center Inc.*
 De Witt Hospital & Nursing Home Inc.*
 Delta Memorial Hospital*
 Eureka Springs Hospital*
 Fulton County Hospital*
 Healthpark Hospital
 Howard Memorial Hospital*
 Lawrence Memorial Hospital*
 Levi Hospital
 Little River Memorial Hospital*
 Mc Gehee-Desha County Hospital*
 Medical Park Hospital
 Mercy Hospital Of Scott County*
 Mercy Hospital/Turner Memorial*
 North Logan Mercy Hospital*
 Ozark Health*
 Ozarks Community Hospital Of Gravette*
 Physicians Specialty Hospital
 Piggott Community Hospital*
 Pike County Memorial Hospital
 S.M.C. Regional Medical Center*
 Siloam Springs Memorial Hospital
 St. Anthony's Medical Center*
 St. John's Hospital - Berryville*
 St. Vincent Medical Center - North
 Stone County Medical Center*
 Willow Creek Women's Hospital

PSYCHIATRIC FACILITIES

Arkansas State Hospital
 Pinnacle Pointe Behavioral Healthcare System
 Rivendell Behavioral Health Services Of Arkansas
 The Bridgeway
 United Methodist Behavioral Hospital
 Vista Health - Fayetteville
 Vista Health - Fort Smith
 Vista Health - Texarkana

LONG TERM ACUTE CARE FACILITIES

Advance Care Hospital Of Fort Smith
 Advance Care Hospital Of Hot Springs
 Advanced Care Hospital Of White County
 Allegiance Specialty Hospital Of Little Rock Llc
 Baptist Health Extended Care
 Regency Hospital Of Northwest Arkansas
 Regency Hospital Of Springdale
 Select Specialty Hospital - Fort Smith
 Select Specialty Hospital - Little Rock/Stvi

REHABILITATION FACILITIES

Baptist Health Rehabilitation Institute
 Conway Regional Rehabilitation Hospital
 Healthsouth Rehabilitation Hospital
 Healthsouth Rehabilitation Hospital Of Fort Smith
 Healthsouth Rehabilitation Hospital Of Jonesboro
 Hot Springs Rehabilitation Center
 Southeast Rehabilitation Hospital
 St. Vincent Rehabilitation Hospital

Dallas County, Fordyce
 Yell County, Dardanelle
 Sevier County, De Queen
 Arkansas County, De Witt
 Desha County, Dumas
 Carroll County, Eureka Springs
 Fulton County, Salem
 Garland County, Hot Springs
 Howard County, Nashville
 Lawrence County, Walnut Ridge
 Garland County, Hot Springs
 Little River County, Ashdown
 Desha County, Mcgehee
 Hempstead County, Hope
 Scott County, Waldron
 Franklin County, Ozark
 Logan County, Paris
 Van Buren County, Clinton
 Benton County, Gravette
 Washington County, Fayetteville
 Clay County, Piggott
 Pike County, Murfreesboro
 Mississippi County, Osceola
 Benton County, Siloam Springs
 Conway County, Morrilton
 Carroll County, Berryville
 Pulaski County, Sherwood
 Stone County, Mountain View
 Washington County, Johnson

Pulaski County, Little Rock
 Pulaski County, Little Rock
 Saline County, Benton
 Pulaski County, North Little Rock
 Pulaski County, Maumelle
 Washington County, Fayetteville
 Sebastian County, Fort Smith
 Miller County, Texarkana

Sebastian County, Fort Smith
 Garland County, Hot Springs
 White County, Searcy
 Pulaski County, Little Rock
 Pulaski County, Little Rock
 Washington County, Fayetteville
 Washington County, Springdale
 Sebastian County, Fort Smith
 Pulaski County, Little Rock

Pulaski County, Little Rock
 Faulkner County, Conway
 Washington County, Fayetteville
 Sebastian County, Fort Smith
 Craighead County, Jonesboro
 Garland County, Hot Springs
 Chicot County, Lake Village
 Pulaski County, Sherwood

APPENDIX B: GLOSSARY

Acute Care Hospital –any facility used for the purpose of providing short-term inpatient diagnostic care and treatment, including general medical care, surgical care, obstetrical care and specialized services or specialized treatment.

Acute conditions - are severe and sudden in onset. Symptoms appear, change, or worsen rapidly, as in a heart attack or broken bone.

Admission Type – the conditions under which the patient was admitted into the hospital as an inpatient. Divided into the four groups Emergency, Urgent, Elective, and Newborn.

Admission Type: Elective – The patient’s condition permitted adequate time to schedule the availability of a suitable accommodation.

Admission Type: Emergency – the patient required immediate medical intervention as a result of severe, life threatening, or potentially disabling conditions.

Admission Type: Newborn – the patient was born inside (intramural) the hospital or was born outside (extramural) the hospital.

Admission Type: Urgent – the patient required immediate attention for the care and treatment of a physical or mental disorder.

Age - the patient’s age is calculated on the basis of the admission date to the hospital and date of birth. Information is listed as provided in the medical record. Categories: Less than 1 year, 1 to 17 years, 18 to 44 years, 45 to 64 years, 65 to 84 years, 85 years and older.

Average (mean) - the sum of all values divided by the number of values. For example, to determine the average charge per discharge for seven pneumonia patients in a particular hospital, the charges for each patient are added together and divided by seven.

Average length of stay (ALOS) - The number of days of care accumulated by patients discharged during the year divided by the number of these patients. Length of stay affects charges because longer stays generate higher charges. In addition, it may be a rough indicator of hospital efficiency or program philosophy.

CCS- Clinical Classifications Software - categorizes patient diagnoses and procedures into a manageable number of clinically meaningful categories. Instead of analyzing the 12,000 diagnosis codes and 3,500 procedure codes from the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), the CCS groups them into about 260 diagnosis categories and 230 procedure categories. This "clinical grouper" makes it easier to quickly understand patterns of diagnoses and procedures. Each hospital stay can have multiple diagnoses and multiple procedures.

Change, % - the percent change represents the percentage amount by which the utilization statistic changed going from 2005 to 2009. % Change is calculated by dividing the difference of 2005 and 2009 by 2005.

Charges –represents the amounts billed to the inpatient for services provided and does not include professional (MD) fees. Charges does not represent the actual amount hospitals collected for services rendered nor does it reflect the cost of operation.

Charges: Average Charges – the mean total amount billed per discharge, as shown on the billing form.

Charges: Average Charges per Day – the mean amount charged per day of inpatient hospital status.

Charges: Average Inflation Adjusted Charges – represents the charges inflated to represent 2009 dollars. Inflation is done using the Cost of Living Index from the tables produced by the BEA at the US Department of Commerce. The index for inflating 2005 dollars to 2009 is 1.09618.

Chronic condition - a condition that lasts twelve months or longer and meets one or both of the following tests: (a) it places limitations on self-care, independent living, and social interactions; and (b) it results in the need for ongoing intervention with medical products, services, and special equipment.

Costs –estimates and reflects the costs of production. Total charges were converted to costs using cost-to-charge ratios (CCR) acquired through the HCUP Central Distributor. The files provided individual hospital and hospital group CCR ratios based on hospital accounting reports from the Centers for Medicare and Medicaid Services (CMS). In general, costs are less than charges. Costs does not represent the actual amount hospitals collected for services rendered.

Costs: Average Costs – the mean estimated actual costs of production related to the Average Charges.

Costs: Average Costs per Day –the mean estimated actual costs of production related to the Average Charge per Day.

Costs: Average Inflation Adjusted Costs – represents the costs inflated to represent 2009 dollars. Inflation is done using the Cost of Living Index from the tables produced by the BEA at the US Department of Commerce. The index for inflating 2005 dollars to 2009 is 1.09618.

Denominator - the number of people (population) who are potentially capable of experiencing the event or outcome of interest. The denominator, along with the numerator, is used to calculate rates. The denominator is the bottom half of a fraction.

Diagnosis - a disease or injury (or factor that influences health status and contact with health services that is not itself a current illness or injury) listed on the medical record of a patient. (Also see Principal Diagnosis.) All-listed diagnoses include all diagnoses reported on the discharge record. There is space for up to nine diagnoses to be coded prior to calendar year 2008. From 2008 onward, there is space to code up to eighteen diagnoses.

Discharge - the formal release of a patient by a hospital; that is, the termination of a period of hospitalization by death, by disposition to place of residence, nursing home, another hospital or facility, or by the patient's choice. The terms "discharges," "patients discharged" and "hospitalizations" are used synonymously. The number of discharges from a hospital affects how a hospital is staffed, what types of services a hospital offers and how well it competes in the broader health care system. To some degree, it also affects costs because, when viewed relative to the facility's capacity, the number of discharges is a partial indicator of efficiency. The number of discharges is used to calculate the average charge and average length of stay at a hospital.

Discharge Status – represents the circumstances surrounding the discharge from inpatient status and specifies the destination of the patient after discharge as Routine, Another Short-Term Hospital, LTAC and Other Facilities, Home Health Care, In-Hospital Deaths, and Against Medical Advice are the present categories.

Discharge Status: Against Medical Advice – the patient discontinued care or left against medical advice.

Discharge Status: Another Short-Term Hospital –the patient was discharged to be directly and immediately admitted as an inpatient to another short-term acute care hospital.

Discharge Status: Home Health Care –the patient was discharged to the care of home health services or to a hospice.

Discharge Status: In-Hospital Deaths –the patient expired (died) while admitted as an inpatient to the hospital.

Discharge Status: LTAC and Other Facilities –the patient was discharged to be directly and immediately admitted as an inpatient to a long term acute care (LTAC) hospital, skilled nursing facility (SNF), intermediate care facility (ICF), psychiatric hospital, inpatient rehabilitation facility (IRF), designated cancer center, or children's hospital.

Discharge Status: Routine –the patient was discharged to home or self care.

DRG – Diagnosis Related Group – diagnosis codes doctors and hospitals put on patient's medical bills that Medicare uses to determine payment to the hospital.

General Medical-Surgical (GMS) Hospitals - provide diagnostic and therapeutic services to patients with the widest variety of medical conditions, both surgical and non-surgical.

Gender – coded as male or female, and appears as provided on the medical record

Gender: Female – all woman and girl inpatients, including female newborns and females giving birth, unless otherwise noted.

Gender: Male – all man and boy inpatients, including male newborns, unless otherwise noted.

ICD-9-CM - stands for "International Classification of Diseases - 9th revision - Clinical Modification." All diagnoses (or conditions) and all procedures that patients receive in the hospital are assigned an ICD-9-CM code. Codes for diagnoses can be up to 5 digits long. Codes for procedures can be up to 4 digits long. There are about 12,000 diagnosis codes and about 3,500 procedure codes. Each hospital stay can have multiple diagnoses and multiple procedures.

Length of stay (LOS) - the number of nights the patient remained in the hospital for this stay. A patient admitted and discharged on the same day has a length of stay = 0.

MDC – Major Diagnostic Categories - broad groups of Diagnosis Related Groups (DRGs) that relate to an organ or a system (such as the digestive system) and not to an etiology. Examples include MDC 01 - Diseases and Disorders of the Nervous System, MDC 02 - Diseases and Disorders of the Eye, MDC 03 - Diseases and Disorders of the Ear, Nose, Mouth and Throat. Each hospital stay has one DRG and one MDC assigned to it

Mental Illness- a CCS category representing inpatient hospitalizations with a reported primary diagnosis of a mental disorder or substance/drug abuse. The Mental Illness/Substance Abuse Summary table lists the 15 subcategories of the CCS group and gives more specific details on the Total Discharges, Length of Stay, Average Charges, and Average Costs.

Number of Discharges per 1,000 Population- the ratio of inpatient discharges per 1,000 of Arkansas resident population as recorded by state census estimates for the given calendar year.

Numerator - is the number of individuals who actually experience the event or outcome of interest. The numerator, along with the denominator, is used to calculate rates. The numerator is the top half of a fraction.

Observed Rate - the raw rate generated by MONAHRQ from the data the user provided. If the observed rate is higher than the expected rate (i.e., the ratio of observed/expected is greater than 1.0, or observed minus expected is positive), then the implication is that the provider performed worse than the reference population for that particular indicator. Users may want to focus on these indicators for quality improvement.

Obstetrics – the number of inpatient discharges that were admitted for childbirth or that were born. The delivery types are divided into Normal and Cesarean Deliveries and do not distinguish between childbirth with or without complications.

Obstetrics: Cesarean Deliveries –a surgical method of delivering babies through an abdominal incision in the womb.

Obstetrics: Normal Deliveries – a method of delivering babies vaginally.

Obstetrics: Total Births –the number of children born not including stillborns.

Obstetrics: Total Deliveries –a count of mothers admitted as an inpatient for delivering. This number includes mothers who give birth to a stillborn child. A mother who gives birth to multiple children (twins, triplets, etc.) would only be counted once in this number.

Patient - a person who is formally admitted to the inpatient service of an Arkansas licensed hospital for observation, care, diagnosis or treatment. For the purposes of this report, the terms “patient” and “inpatient” are used synonymously.

Primary Payer – the expected source of payment for this hospitalization bill. The primary payer listed on an inpatients UB may not be responsible for the total inpatient charges. Payer combines the more detailed categories into the more

general groups of Medicare, Medicaid, Private/HMO Insurance, Self-Pay, No Charge, and Other. Sometimes Self-Pay and No Charge records are reported under the category Uninsured.

Primary Payer: Medicare - reimbursement under Part A (facility care) of Title 18. Medicare is a federal health insurance program for the elderly and disabled. It includes fee-for-service and managed care Medicare patients.

Primary Payer: Medicaid - reimbursement from Arkansas' Medicaid (Title 19) program. Medicaid is a federal/state program that helps pay for health care for indigent and other eligible persons.

Primary Payer: No Charge - the facility did not charge for the inpatient treatment provided. Medically Indigent/Free.

Primary Payer: Other - reimbursement from CHAMPUS (Civilian Health and Medical Program of the Uniformed Services, county general relief and other programs, medical assistance from a state other than Arkansas, and other government sources including Worker's Compensation and Title V.

Primary Payer: Private/HMO - reimbursement from Blue Cross/Blue Shield and other traditional insurance companies, alternative payment systems (e.g., HMO's, PPO's), self-funded plans.

Primary Payer: Self-pay - reimbursement from a patient's own resources. Self-pay may also include insurance that has not been assigned (reimbursement made directly to the patient, rather than to the hospital).

Primary Payer: Uninsured - a more general category used to represent the combined insurance statuses of "self-pay" and "no charge".

Percent - A part of a whole, represented as a fraction of 100 and symbolized with %. For example, if, of 3467 patients, 1520 are male, the percent male is calculated as $(1520/3467)*100=43.8\%$.

Potentially avoidable hospitalizations - hospital admissions that could have been eliminated if the patient had received appropriate care earlier.

PQI - The PQIs are a set of measures that can be used with hospital inpatient discharge data to identify "ambulatory care sensitive conditions" (ACSCs) in adult populations. ACSCs are conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease. Additional information can be found at www.qualityindicators.ahrq.gov/pqi_overview.htm. Even though IQIs are based on hospital inpatient data, they provide insight into the quality of the health care system outside the hospital setting. Patients with diabetes may be hospitalized for diabetic complications if their conditions are not adequately monitored or if they do not receive the patient education needed for appropriate self-management. Patients may be hospitalized for asthma if primary care providers fail to adhere to practice guidelines or to prescribe appropriate treatments. Patients with appendicitis who do not have ready access to surgical evaluation may experience delays in receiving needed care, which can result in a life-threatening condition-perforated appendix. Rates of low birth weight can be reduced by providing mothers with adequate prenatal care. The PQIs consist of the following 14 ACSCs, which are measured as rates of admission to the hospital.

PQI: Bacterial Pneumonia Admission Rate - admissions for bacterial pneumonia per 100,000 population. Bacterial pneumonia is a relatively common acute condition, treatable for the most part with antibiotics. If left untreated in susceptible individuals, such as the elderly, pneumonia can lead to death. Proper outpatient treatment may reduce admissions for bacterial pneumonia in non-susceptible individuals, and lower rates represent better quality care.

PQI: Composite - Acute Conditions - the acute care PQI composite is based on rates of admission for dehydration, bacterial pneumonia, and urinary tract infections.

PQI: Composite - Chronic Conditions - The chronic care PQI composite is based on rates of admission for diabetes short-term complications, diabetes long-term complication, chronic obstructive pulmonary disease, hypertension, congestive heart failure, angina without procedure, uncontrolled diabetes, adult asthma, and lower-extremity amputation among patients with diabetes.

PQI: Composite - Overall – is based on rates of admission for diabetes short-term complications, diabetes long-term complication, chronic obstructive pulmonary disease, hypertension, congestive heart failure, angina without procedure, uncontrolled diabetes, adult asthma, lower-extremity amputation among patients with diabetes, dehydration, bacterial pneumonia, and urinary tract infections.

PQI: Congestive Heart Failure Admission Rate –is defined as admissions for congestive heart failure per 100,000 population. CHF can be controlled in an outpatient setting for the most part; however, the disease is a chronic progressive disorder for which some hospitalizations are appropriate. Proper outpatient treatment may reduce admissions for CHF. Lower rates represent better quality care.

PQI: Dehydration Admission Rate – admissions for dehydration per 100,000 population. Dehydration is a serious acute condition that occurs in frail patients and patients with other underlying illnesses following insufficient attention and support for fluid intake. Dehydration can for the most part be treated in an outpatient setting, but it is potentially fatal for elderly, very young children, frail patients, or patients with serious comorbid conditions. Proper outpatient treatment may reduce admissions for dehydration. Lower rates represent better quality care.

PQI: Diabetes Short-term Admission Rate – admissions for diabetic short-term complications per 100,000 population. Short-term complications of diabetes mellitus include diabetic ketoacidosis, hyperosmolarity, and coma. These life-threatening emergencies arise when a patient experiences an excess of glucose (hyperglycemia) or insulin (hypoglycemia). Proper outpatient treatment and adherence to care may reduce the incidence of diabetic short-term complications. Lower rates represent better quality care.

PQI: Diabetes Long-Term Admission Rate – admissions for diabetic long-term complications per 100,000 population. Long-term complications of diabetes mellitus include renal, eye, neurological, and circulatory disorders. Long-term complications occur at some time in the majority of patients with diabetes to some degree. Proper outpatient treatment and adherence to care may reduce the incidence of diabetic long-term complications. Lower rates represent better quality care.

Principal Diagnosis - the condition established after study to be primarily responsible for causing the admission of the patient to the hospital for care. The principal diagnosis should be the first listed diagnosis in the hospital discharge record.

Procedure - A surgical or non-surgical operation or a series of steps or tests made to reach a diagnosis, or a special treatment, reported on the medical record of a patient. There is space for up to six procedures to be coded prior to calendar year 2008. From 2008 onward, there is space to code up to eight procedures.

Race – the Race category presented in this summary report combine both billing form fields race and ethnicity. The racial designations collected are American Indian or Alaskan Native, Asian or Pacific Islander, Black, White, Other, and Unknown. The ethnicity designations collected are: Hispanic Origin, Not of Hispanic Origin, Unknown. Any patient with a recorded ethnicity of Hispanic Origin is in the Race category Hispanic, otherwise each patient is in a category containing the race reported on the billing form.

Race: Asian or Pacific Islander – represents inpatients whose reported demographics for race were Asian or Pacific Islander and for ethnicity were Not of Hispanic Origin or Unknown.

Race: Black – represents inpatients whose reported demographics for race were Black and for ethnicity were Not of Hispanic Origin or Unknown.

Race: Hispanic – represents all inpatients whose reported demographics for ethnicity were Hispanic Origin

Race: Native American – represents inpatients whose reported demographics for race were American Indian or Alaskan Native and for ethnicity were Not of Hispanic Origin or Unknown.

Race: Other – represents inpatients whose reported demographics for race were Other and for ethnicity were Not of Hispanic Origin or Unknown

Race: White – represents inpatients whose reported demographics for race were White and for ethnicity were Not of Hispanic Origin or Unknown.

Rate - rate is how often a particular event occurs in a population. For example, how often a procedure was done in a population, or how many cases of a particular condition occur in a population. Sometimes the rate is displayed as the number of procedures out of 100, 1,000, 10,000 or 100,000. This information is noted at the bottom of each chart.

Residency – where the inpatient lives according to the fips code of the patient address field on the billing form. Residency is divided into two categories, Arkansas residents and Other residents.

Residency: Arkansas – patients whose fips code is for a county in Arkansas, 05001 to 05149.

Residency: Other – patients with a home address in another state, out of country, or unknown.

Risk Adjustment - Hospitals that treat sicker patients do not necessarily have worse death rates. The hospital-specific 30-day death (mortality) rates used in this report have been adjusted to account for differences in patients' health before their hospital admission. Sicker patients or patients with more health-related risks may be more likely to die than healthier patients. Moreover, patients who are sicker may be more likely to be treated at particular hospitals while patients who are healthier may be more likely to be treated at other hospitals. To compare hospitals fairly (and to avoid penalizing those that treat sicker patients) it is therefore important to consider differences in patients' health before they were admitted to the hospital. The statistical process of accounting for differences in patients' sickness before they were admitted to the hospital is called risk-adjustment. This statistical process aims to 'level the playing field' by accounting for health risks that patients have before they enter the hospital.

Size and Facility Type – categorizes the general medical surgery licensed hospitals as Small, Medium, or Large based on the number of inpatient beds it has, and categorizes the other licensed hospitals as Rehabilitation, Psychiatric, and Long Term Acute Care. It also lists a specialized type of small acute care hospital, Critical Access Hospitals, as they are a group of interest. For the acute care hospitals, the number of beds for each size differs if the hospital is rural, urban non-teaching, or urban teaching. A table detailing these ranges can be found in Appendix C.

Size and Facility Type: Large –size category for rural hospitals with 75+ beds, urban nonteaching hospitals with 200+ beds, and urban teaching hospitals with 450+ beds.

Size and Facility Type: Medium –size category for rural hospitals with 40-74 beds, urban nonteaching hospitals with 100-199 beds, and urban teaching hospitals with 250-449 beds.

Size and Facility Type: Small – size category for rural hospitals with 1-39 beds, urban nonteaching hospitals with 1-99 beds, and urban teaching hospitals with 1-249 beds.

Size and Facility Type: Rehabilitation Hospitals - provide a comprehensive array of restoration services for the disabled, with support services necessary to help them attain their maximum health and competence.

Size and Facility Type: Psychiatric Hospitals - provide diagnostic and therapeutic services to patients with mental, emotional and/or substance-dependency (drug or alcohol) disorders.

Size and Facility Type: Long-Term Acute Care Hospitals – focus on patients with serious medical problems that require intense, special treatment for a long time (usually 20-30 days).

Size and Facility Type: Critical Access Hospitals (CAH) - small, generally rural hospitals meeting certain criteria that certify them to receive cost-based reimbursement from Medicare to improve their financial stability and reduce chance of closure. CAH certification is under a different set of Medicare Conditions of Participation (CoP) that are more flexible than the acute care hospital CoPs. Some of the general criteria that must be met include that the hospital be over 35 miles from another hospital or 15 miles if in mountainous terrain or areas with only secondary roads, have a maximum of 25 acute care inpatient beds, provide 24-hour emergency services, and maintain an annual average length of stay of 96 hours or less for their acute care patients.

South Region – Refers to the southern area of the U.S. as grouped by the HCUP Nationwide Inpatient Sample, and is comprised of the states Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia.

Total Discharges – aggregated totals of both resident and nonresident inpatient discharges reported by each hospital for the given calendar year. Reporting hospitals include all Acute Care, Long Term Acute Care (LTAC), Psychiatric, and Rehabilitation hospitals in Arkansas and do not include the discharges from the two Veteran’s Affairs Medical Centers.

UB-04 form - A uniform patient billing form (HCFA-1450) developed by a national uniform billing committee under the auspices of the Federal Health Care Financing Administration.

Urbanity – the U.S Office of Management and Budget defines urbanity depending on county’s geographical area around an urban core as metropolitan and micropolitan statistical areas. Each metropolitan or micropolitan area along with its urban core that is defined is made up of 1 or more counties containing the urban core and any counties adjacent with high integration with the urban core.

Urbanity: Urban – A metropolitan (urban) area contains an urban core of 50,000 or more population.

Urbanity: Rural – A micropolitan (rural) area contains an urban core of at least 10,000 but less than 50,000 population.

Utilization –statistics reporting on the usage of hospital facilities and services.

APPENDIX C: DOCUMENTATION

Sources

- ¹ AHRQ Agency for Healthcare Research and Quality. (2011) MONAHRQ- My Own Network powered by AHRQ. Retrieved from <http://www.monahrq.ahrq.gov/>.
- ² Arkansas Department of Health, Arkansas Hospital Discharge Data System, Little Rock, AR. <http://www.healthy.arkansas.gov/programsServices/healthStatistics/Pages/HospitalDischarge.aspx>
- ³ U.S Census Bureau MSA – Urbanity - U.S. Census Bureau, Population Division, Washington, DC. <http://www.census.gov/population/www/metroareas/metroarea.html>
- ⁴ U.S. Department of Commerce, Bureau of Economic Analysis. (2011) National Economic Accounts. Retrieved from <http://www.bea.gov/index.htm>.
- ⁵ U.S. Department of Health & Human Services. (2011) 2008 National Statistics on All Stays – HCUPnet. Retrieved from <http://hcupnet.ahrq.gov/>.
- ⁶ U.S. Department of Health & Human Services. (2011) HCUPnet – Bedsizes – HCUPnet Definitions. Retrieved from [http://hcupnet.ahrq.gov/HCUPnet.jsp?Id=24C37275CB8B027A&Form=MAINSEL&JS=Y&Action=%3E%3ENext%3E%3E&HCUPnet definitions.x=1](http://hcupnet.ahrq.gov/HCUPnet.jsp?Id=24C37275CB8B027A&Form=MAINSEL&JS=Y&Action=%3E%3ENext%3E%3E&HCUPnet%20definitions.x=1).

For more information see:

AHRQ Quality Indicators - <http://qualityindicators.ahrq.gov>

Software Used:

MONAHRQ - www.monahrq.ahrq.gov

SAS - www.sas.com