

Volume 11, Issue 3 / 2009 - Competition

The DATABANK Programme

During last autumn's economic crisis, the American Hospital Association (AHA) turned to the Colorado Hospital Association's (CHA) DATABANK Programme for timely data not available from any other sources in the country. The database of monthly hospital information helped the national trade association publish two executive briefs on the impact of the worsening US economy on community hospitals across the country. Without the timeliness of the DATABANK Programme, AHA would have had to rely solely on an ad-hoc survey.

The story was quite similar in the mid- 1980's, but certainly more on a local scale. CHA advocates on behalf of all the hospitals in the state of Colorado but again, we did not have as much information about our members as we needed, to effectively talk to state legislators about the issues affecting Colorado hospitals.

The genesis for the DATABANK Programme was born, vetted with councils and finally the Board of Trustees. Data collection from Colorado hospitals began in 1985, starting very simply with discharges, patient days, a few outpatient data elements, charges, contractual allowances, charity care, expenses and gross patient accounts receivable. By 1988, three state hospital associations were using the database for management of their hospitals. One of the main stumbling blocks for data programmes during that period was lack of timeliness. Hospital administrators and their staff were often frustrated when they received reports that were months old. One of the driving goals for DATABANK was to be timely and give hospital managers as much relevant, current and complete data as possible.

Other states with similar issues soon found DATABANK to meet their needs. By the end of the 90's, DATABANK was in 17 states. However, acquiescing to states' individual needs had compromised uniformity. In 1998, CHA presented a case to the state members to standardise on a common data set and move the platform to the Internet. The group was enthusiastic about the advantages of what the Internet could offer them and their member hospitals.

Along with the move to the Internet, AHA and CHA formed a partnership to move the database in a new direction where more US hospitals and state associations could take advantage of DATABANK's virtues. By 2001, more than 30 states were using the webbased programme.

Many of the initial issues were solved by moving the database to the Internet; the hospital administrations were then able to design their own reports with their own peer comparisons, the information was available as soon as hospitals entered their data and hospital associations had more information at their fingertips in which to advocate on behalf of their members, the number one reason a hospital pays association dues.

Hospital administrations, primarily the Chief Financial Officers have found the DATABANK information to be especially effective when comparing their hospital's performance with other "like" hospitals. DATABANK not only offers hospitals a tool for creating local peer groups but also a cross-state search tool that builds peer groups from the entire national database. A manager can search for large urban, teaching hospitals with beds between 500 and 750. Or, a small rural hospital can build a group of hospitals with an average daily census between 16 and 30 days. Then, that peer group can be used instantly in a variety of reports.

Online DATABANK reports are accessible to hospitals that submit monthly data. If a hospital falls behind, they only have access to the time periods they have entered data for; the DATABANK philosophy is "you get what you give". If a hospital participates in the Balance Sheet module, introduced in 2003, they get 18 financial ratios.

CFOs and their staff use the data at their monthly board meetings to present various cases on a variety of issues. Board members depend on their hospital managers to apprise them on how their hospital is performing compared to peer hospitals.

The hospital managers of the sample hospital already know they don't make money on patient care. What DATABANK can tell them is where they've been so they can map a strategy as to turn their patient service margin around.

Data confidentiality has been a mainstay of the programme throughout the years. It should be noted that certain states share data amongst hospitals. Other states keep it strictly to peer group comparisons of five hospitals or more. DATABANK allows the hospital association to set the confidentiality rules for how the programme operates in their state and how the hospitals will be able to access data.

One rather extreme example is a hospital association that does not allow their members to access data unless 100% have reported for the time period. However, most states allow their hospital managers to not only create their own comparisons but they also encourage them to give feedback about what they'd like to see from the programme.

The benefits of participating in the DATABANK Programme far outweigh the time required to collect and enter the data on a monthly basis. A few of these benefits for the hospital managers are:

Timely data;

Comparable data;

Custom peer group creation;

Scheduled reports, graphs sent right to their email every month;

Requires 1-2 hours of work every month;

Enables hospital associations to use current, accurate and complete data for advocacy.

The DATABANK programme has been a success in the states that have committed the resources and made a concerted effort in making sure their state is represented in any national debate using current healthcare data.

Not participating has been compared to not voting in an election. DATABANK has always been an easy programme to participate in and reaps many benefits, either at local and state level or even in the nation's capitol.

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How it Works

The DATABANK programme is a webbased database of hospitalisation and financial performance indicators. The programme is licensed in 28 states with each state able to customise the programme to their specific needs.

It provides comparable information on average length of stay, outpatient statistics, charges and expenses per day and per stay, uncollected charges, number of days in accounts receivable, gross profitability and a number of personnel statistics. 28 balance sheet data elements and two supplemental data elements are also reported to the programme with corresponding output.

Hospitals submit their monthly data on the secure DATABANK website www.databank.org. Data submission takes less than an hour and once submitted on the web, member hospitals are able to run their facilities' reports and graphs. The data is used by hospitals for budgeting, marketing and internal management and can also be used on the association level for public policy decisions.

One DATABANK contact person per hospital is selected to collect and enter the aggregated hospital level information 25 days after month's end. If the data is not submitted by the 25th then no reports can be made.

Data is entered for the following areas:

Discharges by payer and level of service, patient days by payer and level of service;

Other statistics including outpatient data in total;

Gross charges by payer and levels of service;

Contractual adjustments by payer;

Charity care in total;

Operating expenses, other operating revenue, operating margin, net nonoperating gains, tax subsidies and total margin;

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Gross patient accounts receivable;

Balance sheet data.

The reports display financial and utilisation data in the following categories:

Utilisation

- Inpatient and Outpatient;

Financial Data;

Uncollected Charges;

Operating Revenue;

Operating Expenses;

Profitability Other Financial Data;

Personnel Data, and

Days in Accounts Receivable Gross.

Peer groups for comparison range from standard peer groups such as geographic, congressional districts, trauma levels, etc to customised peer groups created and maintained by the user. Another facility of the programme is the national peer group builder (NPGB) allowing the creation of peer groups across state lines. These groups can be created using criteria such as licensed or available beds, teaching status and trauma levels. For this tool the identities of the hospitals are not revealed due to confidentiality issues.

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