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April 20, 2010

Joseph Martin, Executive Director  
PA Health Care Cost Containment Council  
225 Market Street; Suite 400  
Harrisburg, PA 17101

Dear Mr Martin:

*In follow-up to your request for public comment on the continued collection of laboratory data for the purpose of risk adjusting healthcare outcomes, below is our response to your submitted questions:*

Note: We understand that you are also looking for input as it relates to the impact on the clinical representation of the data based on a revised collection format. Without knowing the final risk-adjustment model(s) proposed, we find it difficult to respond at this time. Our response below addresses only the technical implications.

1. What file format should PHC4 establish for the submission of lab data to the Council?

Based on input from our Laboratory and IT department, a simple comma delimited format would be best. Any other format would require investigation & development from our electronic medical record vendor.

2. What are the issues the Council should consider in collecting lab data directly or through a third party vendor?

- Collecting lab data directly:
  - While at this time this is our preferred method, we would need to limit the data elements submitted to only those identified on the current admission. Pre-admission labs would not be able to be provided.
  - We would expect that a HIPAA secure method of transmission would be assured, and if needed, an encryption package would be supplied to the hospitals or health systems.
  - We would want a data verification process that hospitals or health systems could use to demonstrate their compliance with PHC4 requirements.
- 3<sup>rd</sup> party vendor:

As with NHQM/Core data submission, we would want a list of vendors to choose from, along with your definition of an approved submission vendor. As with the performance measurement system this would include, but not be limited to providing:

  - a set of outcome measures of performance (ie, severity of illness);
  - processes for collecting, analyzing and disseminating these measures within our organization; and
  - an automated database

that together can be used to facilitate performance improvement within our organization.

In addition, hospitals & healthsystems are currently contractually obligated to Quantros, with varying contract end dates. PHC4 should consider a rolling implementation, or work with Quantros to allow an early termination of their contract at no cost, if so desired.

3. What are the potential issues, including increased or decreased costs, for hospitals in manually abstracting or electronically downloading selected lab data for submission to PHC4?

- Manual abstraction:

With around 13,000 discharges per year, manual data collection is not a feasible option. Nor is it reasonable in an era of moving towards electronic health information management. As far as costs – the most

significant would be manpower. I would estimate at least 2-3 additional FTE's would need to be added, at a cost of ~ \$45K to \$60K per year.

- Electronically downloading:  
Obviously the issues would be different if we were downloading to a PHC4 secure location or to a 3<sup>rd</sup> party vendor. We would need more details on the specifications to determine if we had the technical expertise internally to manage the extraction & transmission of laboratory values or whether we would need a vendor to do so.
  - HMC direct submission: If the file format was comma delimited & required a simple pull of the existing data, it would take about 2-3 months to build the report and approximately 2 IT FTEs to write. Though hard to estimate without file specifications, if the file format needed any kind of manipulation or other format change, we estimate that it would take about 6-8 months to build by our current EHR vendor and at a cost of about \$20K.

4. Are there any issues for providers regarding the submission of lab data for selected conditions that are included in PHC4 public reports?

This appears to be more of a clinical question. As noted above, without knowing the final risk-adjustment model(s) proposed, we find it difficult to respond at this time. This letter only addresses the technical implications.

5. What are the issues to consider regarding submission of the first or the worst lab values for selected lab tests administered early in the patient stay?

Based on input from our Laboratory and IT department, though worst value would be a better reflection of the severity of the patient's illness, without a 3<sup>rd</sup> party vendor or special programming by our EHR vendor, we would only be able to provide the 1<sup>st</sup> resulted lab value after the admission date & time.

6. What are the issues to consider in using the first or worst lab values for selected lab tests administered early in the patient stay for the purposes of risk adjusting the data?

This appears to be more of a clinical question. As noted above, without knowing the final risk-adjustment model(s) proposed, we find it difficult to respond at this time. This letter only addresses the technical implications.

7. What are the potential options to consider in continuing to collect clinical data beyond the lab data for the cardiac surgery cases included in the *Council's Cardiac Surgery in Pennsylvania Report*?

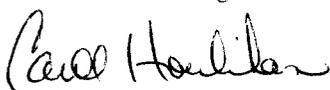
In determining your final recommendation, HMC would encourage you to assess currently existing data rather than requiring new data elements:

- Present on admission data is currently available & submitted to PHC4 via the UB-04 file.
- As a participant in the Society of Thoracic Surgery's (STS) cardiac surgery registry, we would support sharing of data from the STS registry with PHC4.

If the use of existing data is determined to not be feasible, then:

- A review of the existing additional data elements show that we could support submission of a comma delimited file for all but the clinical assessment data elements
- PHC4 could consider adding additional risk adjustment question to the existing Open Heart website.

We hope that you find our response and recommendations to be of value. HMC appreciates the opportunity to provide comments on the Council's approach to using laboratory value data to develop risk-adjustment models and look forward to learning more about the Council's final recommendations.



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