



April 5, 2010

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

Dear Mr. Martin:

On behalf of WellSpan Health's hospital – Gettysburg Hospital and York Hospital – I welcome the opportunity to respond to the request for public comments regarding the collection of laboratory data for the purpose of risk adjusting healthcare outcomes as part of the Council's public reporting of hospital performance.

Consistent with our principles of transparency, WellSpan Health supports the Council's efforts to provide information to the public on outcomes of care provided by various health care providers in the Commonwealth. We have actively participated in a variety of public reporting initiatives sponsored by various governmental and non-governmental agencies including CMS, the Joint Commission, various commercial payers, and have published information regarding our hospital, physician, and home care performance on our public web site. Our participation in these initiatives does entail some degree of additional cost which we bear as part of our commitment to provide the public with sufficient information to judge the quality of our care.

We recognize that some information reported by these entities involves risk-adjustment of the severity of illness treated by our providers. For example, CMS's reports of 30 day mortality for acute myocardial infarction, pneumonia, and congestive heart failure all use risk-adjustment methodologies that have been validated in peer reviewed journals. These risk adjustment methodologies all use administrative data such as age, gender, primary and secondary diagnoses, and procedures performed during the hospitalization.

WellSpan also uses an internal performance measurement system, Premier's Quality Manager (formerly marketed by CareScience Corporation), that also provides risk-adjusted comparisons of our outcomes of care, including inpatient mortality data and expected length of stay. This system uses a proprietary risk-adjustment methodology and provides all the variables that are used in the risk-adjustment process. This system also does not use laboratory data as part of its comparison of expected to actual mortality.

Based on these widely used reporting systems, we question why the Council has repeatedly used proprietary risk-adjustment models that lack transparency and wider comparisons beyond the Commonwealth. Even so, we agree that a greater number of data inputs should statistically produce more robust models of risk adjustment.

The question the Council must ask is what is to be gained to the public from models that are labor intensive and costly. Are we truly improving the quality and value of care provided by Pennsylvania's hospitals by this approach? I would suggest that despite more than 20 years of operations, the Council's reports have not yielded information that has consistently enabled hospitals to improve the quality of care. Contrast this approach with that taken by the Pennsylvania Patient Safety Authority which, in its brief existence, has published a wealth of practical information to improve the safety of our hospitals. I recognize that the Council must operate within the statutory requirements that demand published reports comparing the quality of acute-care hospitals across the Commonwealth, yet wonder if Council should be doing more to actually help our hospitals improve outcomes of care.

At its meeting on April 1, The Hospital and Healthsystem Association of Pennsylvania (HAP) Committee on Quality and Care Management endorsed your Technical Advisory Group's recommendation to continue to include laboratory data as part of the risk-adjustment methodology. We concur with their findings that the inclusion of laboratory data will enhance the discriminatory power of your model to more accurately predict the likelihood of death compared to using present-on-admission diagnoses along with baseline demographic data. As such, it might be best to frame your request for comments in the context of the most practical and affordable means hospitals might use to transmit these laboratory data values to the Council.

WellSpan's laboratory information system is one component of our larger, fully integrated inpatient electronic health record which we license from a single vendor, Cerner Corporation. Using in house resources we have been able to produce a variety of data extracts of laboratory data for numerous business needs including quality management, disease management, and day to day clinical management of individual patients. We suspect that our capabilities match those of other larger health systems that have the in-house capability for data extraction, file formatting, and data transmission. Since you have not provided the specific details of your extraction, formatting, and data transmission requirements, we are unable to comment on the feasibility of any model that the Council might adopt. We would expect that you would offer a similar comment period once these specifications are publically available.

Although we believe we have the ability to extract, format and transmit our own data using internal resources, we recognize that many smaller hospitals may not be technically capable to do so. As such,

the Council should publically publish these specifications and invite a number of vendors to perform such a service. The Council could adopt a data verification process that vendors or health systems could use to demonstrate their compliance with your standards. We are opposed to using a single designated vendor for laboratory data extraction, formatting, and transmissions as this would likely increase our costs.

We strongly support the use of "worst-value" laboratory data as opposed to first data. Many initial laboratory values may reflect normal values which subsequently become abnormal values based on therapeutic interventions such as rehydration or correction of acid-base disturbances. The Council should develop and enforce requirements regarding the time period following admission when these laboratory values may be considered for data extraction. We also wonder if the Council has the ability to perform a discriminant analysis on a condition versus condition basis to determine which lab values are the key drivers for each clinical process. The Council should give priority to such research in the future to help improve the risk adjustment methodology used for public reporting.

You have also asked for comments regarding the submission of data for cardiac surgery analyses performed by the Council. We would strongly urge you to consider the use of the results of the Society for Thoracic Surgery's (STS) quarterly reports as the basis for your risk-adjustment model for this particular condition. If allowed by STS, this might lead to a process that has greater acceptance by physicians, consistency with a widely used marker of cardiac surgery quality, and help contain the data collection costs for our hospitals.

I thank you for the opportunity to provide comments to the Council.

Respectfully,

Charles H. Chodroff, MD, MBA, FACP
Senior Vice President, Chief Clinical Officer

- c. Susan Nelson, WellSpan Director of Quality Management
Richard Seim, President, York Hospital
Kevin Mosser, MD, President, Gettysburg Hospital