

About the Report

Hospital Performance Report for Pennsylvania

Produced by the Pennsylvania Health Care Cost Containment Council (PHC4), this report displays hospital-specific results for inpatient hospital discharges from the period October 2016 through September 2017. In addition to this **About the Report** document, which provides a full description of the *Hospital Performance Report*, the PHC4 website also presents the following accompanying materials:

- ⇒ **Key Findings**
- ⇒ **Hospital Results**
- ⇒ **Medicare Payments**
- ⇒ **Hospital Comments**
- ⇒ **Technical Notes**
- ⇒ **Downloadable Data**

About PHC4

Created by the PA General Assembly in 1986, the PA Health Care Cost Containment Council (PHC4) is an independent state agency charged with collecting, analyzing and reporting information that can be used to improve the quality and restrain the cost of health care in the state. Today, PHC4 is a recognized national leader in public health care reporting, and nearly 100 organizations and individuals annually utilize PHC4's special requests process to access and use data. PHC4 is governed by a 25-member board of directors, representing business, labor, consumers, health care providers, insurers, and state government.

Joe Martin, Executive Director
225 Market Street, Suite 400, Harrisburg, PA 17101
717-232-6787 • www.phc4.org

About the Report

What is the purpose of this report?

Before we make a major purchase, we usually gather as much information as we can about the available product or service. By comparing what we learn about the quality of the product as well as what will be charged for it, we decide on what we believe is the best product for the best possible price. When it comes to health care services, unfortunately, the information available to consumers and purchasers to make such decisions is limited and often not widely accessible. PHC4's *Hospital Performance Report* (HPR) can help to fill the information vacuum and assist consumers and purchasers in making more informed health care decisions. The HPR can serve as an aid to providers in highlighting additional opportunities for quality improvement and cost containment. It should not be used in emergency situations.

About this report

- This report includes hospital-specific outcomes for 16 different medical conditions and surgical procedures, as defined by ICD-10-CM/PCS (International Classification of Diseases, Tenth Revision, Clinical Modification/Procedure Coding System) codes and Medicare Severity – Diagnosis-Related Groups (MS-DRGs). Technical Notes relevant to this report provide additional detail. They are posted to PHC4's website at www.phc4.org.
- This report covers adult (18 years and older) inpatient hospital discharges, regardless of payer, during the period October 2016 through September 2017.
- This report is divided into three regional versions: Western Pennsylvania, Central and Northeastern Pennsylvania, and Southeastern Pennsylvania. (Please see sidebar on this page for details.)
- All Pennsylvania general acute care and several specialty general acute care hospitals are included. Children's hospitals and some specialty hospitals are not reported because they

This report is divided into three regional versions: **Western Pennsylvania, Central and Northeastern Pennsylvania, and Southeastern Pennsylvania.**

Western Pennsylvania includes the following counties:

Allegheny ▪ Armstrong ▪ Beaver
Bedford ▪ Blair ▪ Butler ▪ Cambria
Cameron ▪ Clarion ▪ Clearfield
Crawford ▪ Elk ▪ Erie ▪ Fayette
Forest ▪ Greene ▪ Indiana
Jefferson ▪ Lawrence ▪ McKean
Mercer ▪ Potter ▪ Somerset
Venango ▪ Warren ▪ Washington
Westmoreland

Central and Northeastern Pennsylvania includes the following counties:

Adams ▪ Bradford ▪ Centre
Clinton ▪ Columbia ▪ Cumberland
Dauphin ▪ Franklin ▪ Fulton
Huntingdon ▪ Juniata
Lackawanna ▪ Lancaster
Lebanon ▪ Luzerne ▪ Lycoming
Mifflin ▪ Monroe ▪ Montour
Northumberland ▪ Perry ▪ Pike
Snyder ▪ Sullivan ▪ Susquehanna
Tioga ▪ Union ▪ Wayne ▪ Wyoming
York

Southeastern Pennsylvania includes the following counties:

Berks ▪ Bucks ▪ Carbon ▪ Chester
Delaware ▪ Lehigh ▪ Montgomery
Northampton ▪ Philadelphia
Schuylkill

About the Report

typically treat few cases relevant to the conditions and procedures included in this report. Hospitals that closed or merged with other facilities during the study period are not reported, nor are hospitals that recently opened since the data available does not represent the full time frame of the report.

- Hospital names have been shortened in many cases for formatting purposes. Hospital names may be different today than they were during the period covered in this report due to mergers and name changes.

About the data

Hospital discharge data compiled for this report was submitted to PHC4 by Pennsylvania hospitals. The data was subject to standard validation processes by PHC4 and verified for accuracy by the hospitals at the individual case level. The ultimate responsibility for data accuracy and completeness lied with each individual hospital.

Medicare fee-for-service payment data was obtained from the Centers for Medicare and Medicaid Services (CMS). The most recent Medicare payment data available to PHC4 for use in this report was for federal fiscal year 2017.

Accounting for high-risk patients

Included in the data PHC4 receives from Pennsylvania hospitals is information indicating, in simple terms, “how sick the patient was” on admission to the hospital—information that is used to account for high-risk patients. Even though two patients may be admitted to the hospital with the same illness, there may be differences in the seriousness of their conditions. In order to report fair comparisons among hospitals, PHC4 uses a complex mathematical formula to risk adjust the mortality and readmission data included in this report, meaning that hospitals receive “extra credit” for treating patients who are more seriously ill or at a greater risk than others. Risk adjusting the data is important because sicker patients may be more likely to die or be readmitted.

PHC4 uses clinical laboratory data, patient characteristics such as age, gender, race/ethnicity, and socioeconomic status, and billing codes that describe the patient’s medical conditions such as the presence of cancer, heart failure, etc., to calculate risk for the patients in this report.

About the Report

PHC4 uses clinical laboratory data, patient characteristics such as age, gender, race/ethnicity, and socioeconomic status, and billing codes that describe the patient's medical conditions such as the presence of cancer, heart failure, etc., to calculate risk for the patients in this report. A comprehensive description of the risk-adjustment techniques used for this report can be found in the Technical Notes on PHC4's website at www.phc4.org.

What is measured in this report and why is it important?

In the hospital results section of the report are the following measures, reported for each hospital:

- **Total Number of Cases.** For each hospital, the number of cases for each condition, after exclusions, is reported. This can give a patient or a purchaser an idea of the experience each facility has in treating such patients. Studies have suggested that, in at least some areas, the volume of cases treated by a physician or hospital can be a factor in the success of the treatment. The number of cases represents separate hospital admissions, not individual patients. A patient admitted several times would be included each time in the number of cases. Outcome data are not reported for hospitals that have fewer than five cases evaluated for a measure; such low volume cannot be considered meaningful and, as such, the outcome data are not displayed. Not Reported (NR) appears in the table when this occurs. Note that small or specialty hospitals may report low volume due to the unique patient population they serve or geographic location.
- **Risk-Adjusted Mortality.** This measure is reported as a statistical rating that represents the number of patients who died during the hospital stay. To determine the mortality rating, PHC4 compares the number of patients one could reasonably expect to die in a given hospital for a given condition, after accounting for patient risk, with the actual number of

Understanding the Symbols

The symbols displayed in this report represent a comparison of a hospital's actual rate of mortality or readmission to what is expected after accounting for patient risk.

- **Hospital's rate was significantly lower than expected.** Fewer patients died or were readmitted than could be attributed to patient risk and random variation.
- ◉ **Hospital's rate was not significantly different than expected.** The number of patients who died or were readmitted was within the range anticipated based on patient risk and random variation.
- **Hospital's rate was significantly higher than expected.** More patients died or were readmitted than could be attributed to patient risk and random variation.

About the Report

deaths. (Please see “Understanding the Symbols” box on this page.) PHC4 has used risk-adjusted mortality statistics as a measure of quality since it began publishing reports in 1989. The mortality analysis includes Do Not Resuscitate (DNR) cases. Because DNR is defined and utilized differently across Pennsylvania hospitals, such records are retained in the analysis to avoid potential biases in mortality ratings.

- ***Risk-Adjusted 30-Day Readmissions.*** This measure is reported as a statistical rating that represents the number of patients who are readmitted following their initial hospital stay. A readmission is defined as a subsequent acute care hospitalization to any Pennsylvania general and specialty general acute care hospital, where the admit date is within 30 days of the discharge date of the original hospitalization. To determine the risk-adjusted readmission rating, PHC4 compares the number of patients one could reasonably expect to be readmitted, after accounting for patient risk, with the actual number of readmissions. (Please see “Understanding the Symbols” box on the previous page.) While some re-hospitalizations can be expected, high quality care may lessen the need for subsequent hospitalizations. For most conditions and procedures in this report, potentially planned readmissions were excluded from the analysis (noted in the results where this occurs). Identifying readmissions that were potentially planned was based on methods developed by the CMS for identifying potentially planned readmissions (please refer to the Technical Notes at www.phc4.org).
- ***Case Mix Adjusted Average Hospital Charge.*** This report also includes the average hospital charge for each of the 16 conditions and procedures. The average hospital charge represents the entire length of the hospital stay. It does not include professional fees (e.g., physician fees) or other additional post-discharge costs, such as rehabilitation treatment, long-term care and/or home health care. The average charge is adjusted for the mix of cases that are specific to each hospital. (For more information, please refer to the Technical Notes at www.phc4.org). While charges are what the hospital reports on the billing form, they may not accurately represent the amount a hospital receives in payment for the services it delivers. Hospitals usually receive less in actual payments than the listed charge.

In the payments section of the report is information about Medicare payments:

- ***Medicare Payments.*** This section of the report displays the average payments made by Medicare fee-for service for the 16 medical conditions/surgical procedures included in this report. This information is also broken down by the MS-DRGs associated with each condition. The most recent payment data available to PHC4 is for federal fiscal year 2017.

About the Report

Uses of this report

This report can be used as a tool to examine hospital performance in specific treatment categories. It is not intended to be a sole source of information for making decisions about health care, nor should it be used to generalize about the overall quality of care provided by a hospital. Readers of this report should use it in discussions with their physicians who can answer specific questions and concerns about their care.

- **Patients/Consumers** can use this report as an aid in making decisions about where to seek treatment for the conditions detailed in this report. This report should be used in conjunction with a physician or other health care provider when making health care decisions.
- **Group Benefits Purchasers/Insurers** can use this report as part of a process in determining where employees, subscribers, members, or participants should go for their health care.
- **Health Care Providers** can use this report as an aid in identifying opportunities for quality improvement and cost containment.
- **Policymakers/Public Officials** can use this report to enhance their understanding of health care issues, to ask provocative questions, to raise public awareness of important issues, and to help constituents identify health care options.
- **Everyone** can use this information to raise important questions about why differences exist in the quality and efficiency of care.

The measurement of quality is highly complex, and the information used to capture such measures is limited. A hospital death or a readmission is sometimes an unavoidable consequence of a patient's medical condition. Hospitals and physicians may do everything right, and the patient may still die or need to be readmitted. However, the statistical methods used for this report eliminate many of the clinical and medical differences among the patients in different hospitals, thereby allowing us to explore the real differences in the measures presented. The pursuit of these issues can play an important and constructive role in raising the quality while restraining the cost of health care in the Commonwealth of Pennsylvania.