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Health System

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Marc P. Volavka
Executive Director
Pennsylvania Health Care Cost Containment Council
Suite 400
Harrisburg, PA., 17101

Dear Mr. Volavka,

Thank you for once again allowing us to make a few overall comments and suggestions concerning the Council's "2001 Hospital Performance Report".

We were encouraged that the Council responded to Hospitals' comments by drilling down below the DRG level for this year's Performance Report. Although the drill down used was limited to principal diagnosis and the coexisting conditions of HIV and abdominal trauma, the effort was a major step in the right direction.

We hope this effort is only the first step in a new Council initiative to better define its populations. The effort of removing disparate sub-groups and then comparing the remaining population will dramatically enhance the validity and meaningfulness of this report. To this end, we would recommend that the Council look at other collected data elements that would be beneficial in defining populations. For example:

- Do Not Resuscitate (DNR) status – Inclusion of DNR patients within an analysis that uses mortality as its quality outcome measure is problematic. This is especially relevant in the Council's medical comparative categories such as pneumonia, sepsis, and urinary tract infection. When an individual makes an informed decision to be a DNR, the care delivered and subsequent outcome should only be assessed in the context of other similar patients and not the population as a whole.

- Coexisting conditions – The Atlas severity adjustment methodology does not adequately account for coexisting conditions that impact expected patient outcomes. This year, the Council found several coexisting conditions that warranted exclusion of cases. We would recommend that the Council review published categories for similar instances in which coexisting conditions meet the threshold for exclusion.

In conjunction with above listed problems surrounding population definitions, we remain concerned that the Atlas severity algorithm disproportionately weights age in its acuity methodology. This fact is especially problematic since it does not weight coexisting conditions nor adjusts for DNR status.

Moreover, we continue to have concerns regarding the validity of publishing comparative re-admission rates. Re-admissions are a complex and multi-factorial issue that requires analysis far beyond that performed by the Council. Any valid analysis must assess factors such as stability at discharge, plan of care, community physician, patient compliance, mental health, substance abuse, and a significant number of social issues. Simply reporting Hospital percentages without consideration of these factors is misleading and meaningless.

Finally, a continuous criticism of the Effectiveness Report has been its reliance on charges as an indicator of cost. This remains a valid shortcoming in the Council's present reporting methodology.

As always, we stand ready to assist the Council in its goal of providing meaningful information on the cost and quality of health care.

Sincerely,

Joseph P. Kosich
Assistant Vice President
Health Information Management