Hospital Performance Report
for Pennsylvania

What is the purpose of this report?

The Pennsylvania Health Care Cost Containment Council's (PHC4) *Hospital Performance Report* (HPR) displays volume and outcome information about a variety of medical conditions for Pennsylvania general acute care hospitals. The HPR can assist consumers and purchasers in making more informed health care decisions. The report can also 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 13 different medical conditions, as defined by ICD-10-CM (International Classification of Diseases, Tenth Revision, Clinical Modification) codes and MS-DRGs (Medicare Severity – Diagnosis-Related Groups). 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 2020 through September 2021.
- Cases with a diagnosis of COVID-19 were not included in this report.
- 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 typically treat few cases relevant to the conditions included in this report. Hospitals that closed or merged with other facilities 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.

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Special Note about Conditions not included in the 2021 HPR

Two conditions typically reported in the HPR, Pneumonia-Aspiration and Pneumonia-Infectious, are not included in this FFY 2021 report due to limitations in the methodologies used to account for high-risk patients hospitalized for pneumonia during the period of the COVID-19 pandemic. This is similar to the recent approach taken by the Centers for Medicare and Medicaid Services (CMS)*.

* Centers for Medicare and Medicaid Services. “Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2023 Rates”, 87 Fed. Reg. 49081, 49109 (August 10, 2022). Available at https://www.federalregister.gov/d/2022-16472.

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 lies with each individual hospital.

Medicare fee-for-service payment data was obtained from the Centers for Medicare and Medicaid Services (CMS).

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 higher-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. To account for differences in patient risk, 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.

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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, diabetes, 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 deaths. (Please see "Understanding the Symbols" box on the next 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

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be readmitted, after accounting for patient risk, with the actual number of readmissions. (Please see "Understanding the Symbols" box on this page.) While some re-hospitalizations can be expected, high quality care may lessen the need for subsequent hospitalizations. For all conditions in this report, planned readmissions were excluded from the analysis. Identifying readmissions that were planned was based on methods developed by the CMS for identifying planned readmissions (please refer to the Technical Notes at **www.phc4.org**). In addition, for this report, readmissions with a diagnosis of COVID-19 were not counted.

- ***Case Mix Adjusted Average Hospital Charge.*** This report also includes the average hospital charge for each of the 13 conditions. 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, hospitals typically receive actual payments from private insurers and government payers that are considerably less than the listed charge.

Understanding the Symbols

The symbols displayed in this report represent a comparison of a hospital's actual outcome rate 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.

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 13 medical conditions included in this report. This information is also broken down by the MS-DRGs within each condition.

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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.

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. PHC4 is governed by a board of directors representing business, labor, consumers, health care providers, insurers, health economists and state government.

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