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Posted on Mon, Jun. 23, 2008

# Editorial: Health Care Cost Containment Council

## A Pa. watchdog worth keeping

The state watchdog agency whose groundbreaking research has armed Pennsylvanians with crucial medical data that just might help them survive their next hospital stay could be facing its own untimely demise.

If Harrisburg lawmakers and Gov. Rendell don't extend its authorization by June 30, the agency known as PHC4 - the Pennsylvania Health Care Cost Containment Council - will leave patients to fend for themselves.

As a national leader in mining data on the cost and quality of medical care, the 40-person agency with a modest $5 million annual budget has prompted hospitals across the state to mount an all-out effort to enhance safeguards for patients. That's saving lives every day.

Beginning in 2005, PHC4's reports on hospital infections revealed that thousands of patients suffer and hundreds die needlessly each year from infections they acquire during treatment. In response, hospital officials have begun implementing cutting-edge strategies to stem infection rates. They know full well, of course, that PHC4 will report to the public on hospitals' progress or lack of it.

The agency not only monitors problems with care, but also shines a light on hospitals' financial health. Its annual survey on hospital budget deficits reminds policymakers of the need to aid large urban hospitals like those in Philadelphia that serve the state's poorest patients.

Given the impact of PHC4's work in recent years, it is not surprising the agency enjoys strong support in the General Assembly. Only the powerful insurance lobby has suggested that, somehow, the agency has failed in its mission because health-care costs are still galloping ahead. But that's a far-too-literal reading of the agency's title.

If anything, PHC4's oversight of medical quality and spending should be expanded. Above all, keep this watchdog on guard.

***Editorial***

# Collateral damage in the budget wars

By The Sentinel, July 3, 2008

Last updated: Thursday, July 3, 2008 10:18 AM EDT

By most assessments, the Pennsylvania Health Care Cost Containment Council does a great job of monitoring the state's health infrastructure.

The organization collects some 4 million hospital records annually, which allows it to assess how well people are being served by the health care industry in the state. And if the state does move forward with a plan to reduce the number of citizens without health insurance, the council's work will be invaluable in determining the costs and benefits associated with the changes.

Assuming it's still in business, that is.

The council is chartered by the Legislature and its authority expired Monday along with last year's budget. Thirty-eight workers were let go Tuesday, and the remaining five employees are expected to be out of work by the end of the work week unless legislators reauthorize the council.

Rep. Todd Eachus, D-Luzerne, called the lapse of authorization "a black eye for Pennsylvania," citing the agency's function as a resource for people and employers trying to decide how to purchase insurance or determine the clinical quality of local hospitals. And he criticized the termination of the council's employees as demoralizing to people doing "fantastic work." Like most issues in the state Capitol, there's a political standoff behind the council shutdown and the agency itself was simply caught in the middle. Republicans are bargaining for the council's reauthorization with a demand to extend the subsidy paid to doctors to help them with onerous malpractice insurance bills. Democrats have already tied the malpractice provision to the governor's proposal to expand health coverage to the uninsured.

It appears there is no real hostility to the council on either side of the aisle. Republicans point out that the council's authorization lapsed back in 2003 during budget talks with no real damage to the agency's future existence, and they expect the same result this time around.

Nevertheless, the council's precarious situation remains the fault of legislators and the governor stretching out budget negotiations past the end of the fiscal year, allowing issues unrelated to the budget to slip through the cracks.

Given past history, it's unlikely this lapse will do any permanent damage to the council, but as Eachus pointed out, making the council a political football is bad for employee morale — and it's the employees who do the work that both parties agree is important and worthwhile.

We hope this dispute is short-lived, but more importantly, we hope all sides take this object lesson and apply it to a prompt resolution of next year's budget deliberations.

The Patriot-News

Reauthorization awaits

# Health council nearly a victim of wrangling

Monday, July 21, 2008

Although it shouldn't have taken a week after its shutdown, Gov. Ed Rendell correctly issued an executive order extending the Pennsylvania Health Care Cost Containment Council until November.

Not only should such an order have been in hand the second the council's authorization expired at midnight on June 30, it never should have been in this situation.

The governor shouldn't have forced the shutdown and Senate Republicans were wrong in linking reauthorization to a battle with Rendell over malpractice insurance payments to doctors.

It was political football at its worst to kick around an organization that has made Pennsylvania a national leader in the research of medical industry finances and patient care.

But this isn't over. The council, one of taxpayers' better bargains with a $5 million budget and only a 40-person staff, still needs legislation extending it for a longer period. When the Legislature returns in September, a simple, clean bill reauthorizing the council should be sent to the governor post haste.

Article published Jul 27, 2008

## Watchdog agency key to good health

Unlike news about a promising treatment for cancer, the fate of a watchdog health-care agency doesn't capture the public imagination.

But the future of the Pennsylvania Health Care Cost Containment Council, known as PHC4, is important to you as a health-care consumer and to the businesses that insure employees.

Gov. Ed Rendell shut down the agency on July 1, saying the Pennsylvania Legislature had failed to reauthorize spending for the PHC4 . Rendell then signed an executive order on July 8 to reopen the agency temporarily, through November.

The Legislature will have to revisit the authorization question when it reconvenes in the fall.

The PHC4 provides valuable services by collecting data and making it public.
Thanks to the PHC4, you know how much profit Pennsylvania hospitals made in 2007 (our local hospitals are financially sound).

In its 22-year existence, the PHC4 has compared hospital costs on open-heart surgery and other treatments.

It has tracked readmission rates following common medical procedures and reported mortality rates for various surgeries.

The PHC4 was the first in the country to publicly list hospital-acquired infection rates by hospital.

Such infections not only lead to more expensive care -- they could cost patient lives.
Consumers and businesses, not always allied on social issues, agree that this agency serves a useful function.

Local lawmakers need to advocate for PHC4 reauthorization when they get back to business.

# PHC4 = Value

**Health care quality improves with public reporting!**

- Since PHC4 began publicly reporting patient mortality rates for Pennsylvania hospitals in its annual *Hospital Performance Report* in the early 1990s, in-hospital mortality rates for all conditions dropped from significantly above to significantly below the national average. The resulting improvement of in-hospital mortality rates represents the equivalent of more than 49,000 lives and $1.7 billion in hospital charges saved since 1991!
- Also mirroring PHC4's years of public reporting is the decline of in-hospital mortality for coronary artery bypass graft (CABG) surgery. In Pennsylvania, mortality rates for CABG have dropped 51.7% in the past 15 years.
- Pennsylvania has already begun to see a decline in the rate of hospital-acquired infections since PHC4 began publicly reporting hospital-specific information. The hospital-acquired infection rate decreased from 16.3 per 1,000 cases to 15.1 per 1,000 cases between Quarter 4, 2005 and Quarter 4, 2006, the two most similar data collection time periods.

**Businesses and labor unions need PHC4 to fight rising health care costs!**

- Without PHC4 data, the Delaware Valley Health Care Coalition – a labor/management coalition with 400,000 covered lives and $1.5 billion in annual medical spending – will have to discontinue its initiative to improve quality and restrain costs for its members through the creation of a hospital centers of excellence preferred provider network
- Transparency of data is increasingly useful due to the cost-shifting to deductibles, co-payments, and catastrophic loss plans
- While it is difficult to quantify cost savings in our complex healthcare delivery system, PHC4 data has clearly had a significant impact on several major drivers of health care costs: hospital-acquired infections, complications from misadventures, readmissions, and avoidable hospitalizations. For example, when a patient dies in the hospital, it costs more than twice that of a patient who survives their stay.
- Hospitals reported that 30,237 patients hospitalized during 2006 contracted an infection during their hospitalization. The mortality rate for patients with a hospital-acquired infection was 12.3%, while the mortality rate for patients without a hospital-acquired infection was 2.1%. The mean length of stay for patients with a hospital-acquired infection was 19.3 days, while the mean length of stay for patients without a hospital-acquired infection was 4.4 days. The mean total hospital charge for patients with a hospital-acquired infection was $175,964, while the mean for those patients without such infections was $33,260.

**Experts say that Pennsylvania is the national leader in health care data. Without PHC4, Pennsylvania will cede its leadership position– just as other states and the federal government is looking to extend their work in this area.**

- "It would be very hard to contend that Pennsylvania is still a leader in public accountability for quality and value in health care without the council," said David B. Nash, chairman of the department of health policy at Jefferson Medical College and chair of PHC4's Technical Advisory Group.
- According to Carolyn Clancy, director of the U.S. Agency for Healthcare Research and Quality, "PHC4 has been ahead of the curve in understanding how to use data generated by health care to help policy makers learn where they can get the most bang for the buck and where to target their efforts to improve quality and safety."

**Pennsylvania families have access to an independent, credible source of health care information!**

- The number of public reports distributed by PHC4 continues to grow each year. In fiscal year 2007 alone, visitors downloaded more than 570,000 reports from the Web site with a total of 5 million hits. The first hospital infection report recorded more than one million hits in one month.

**A valuable resource for health care researchers!**

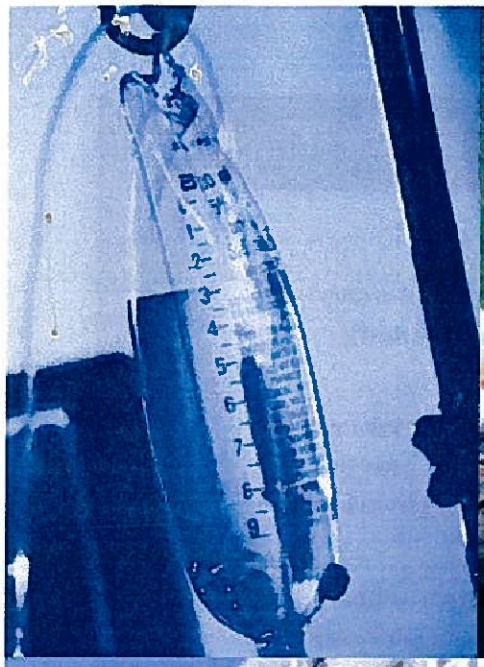
- The use of PHC4 special requests data in national research projects is becoming more and more extensive. Pennsylvania researchers could lose millions of dollars in funding from the National Institutes of Health and other funding sources for their important public health research projects if this rich database is lost.
- Three-quarters of the health care costs in Pennsylvania can be traced to 25% of residents with chronic illness.

**Pennsylvania is forging ahead in the quest for pricing transparency!**

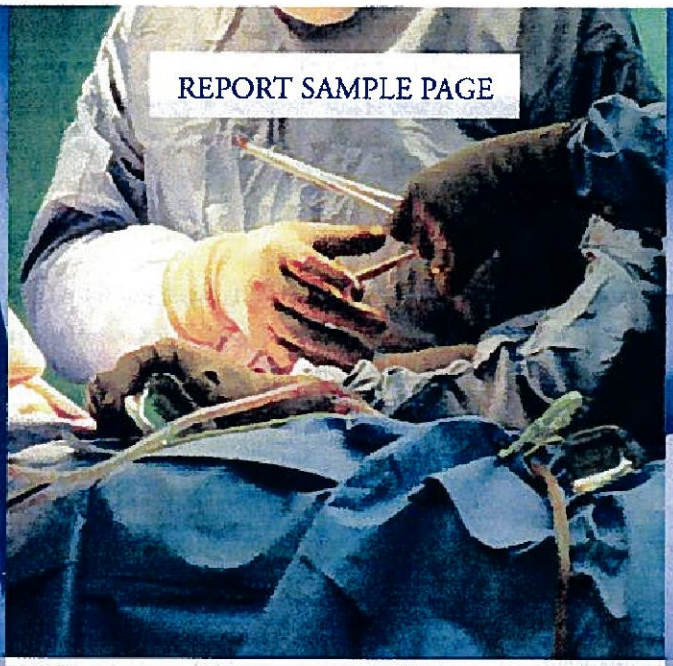
- PHC4 collects payment data from third-party commercial insurers, Medicare and Medicaid. Currently, PHC4 is working with a Payment Data Advisory Group, made up of the state's insurers, hospitals, and labor union and business representatives, to find the best way for purchasers and consumers to get payment and pricing information, especially vital in this era of consumer-driven health care.

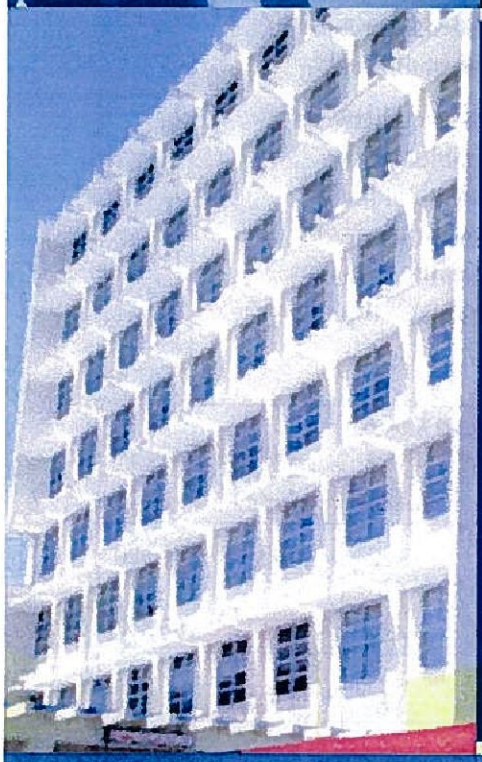
**Objective analyses about mandated health insurance benefits!**

- From 1987 to 2007, PHC4 has reviewed 27 proposed mandated benefits bills. This has provided government officials and other policy analysts with an independent review of healthcare mandates.



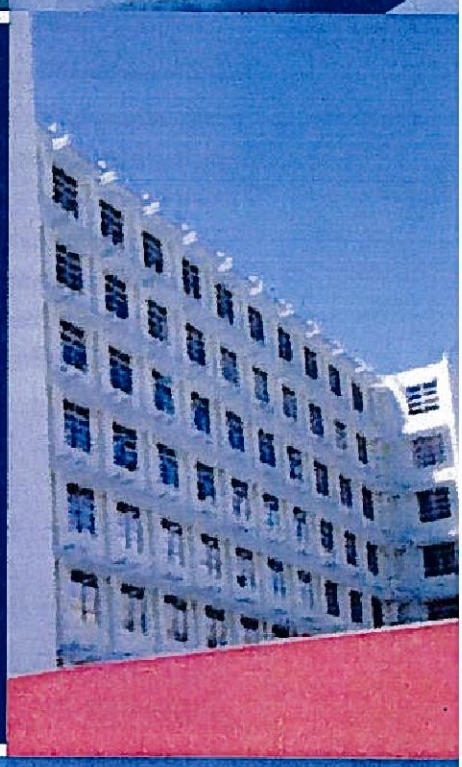






# Hospital-acquired Infections in Pennsylvania

Calendar Year 2006



PHC4

**Pennsylvania Health Care Cost Containment Council**

April 2008

# Report Highlights

- This report includes information on infections that were contracted by patients in Pennsylvania hospitals in 2006. It is the Pennsylvania Health Care Cost Containment Council's second hospital-specific report on these types of infections.
- Data on hospital-acquired infections is provided for each of Pennsylvania's 165 general acute care hospitals. Because not all hospitals treat the same types of patients, they were categorized by "peer groups" so that hospitals that offer similar types and complexity of services and treat similar numbers of patients are displayed together.
- In 2006, hospitals reported that 30,237 patients contracted an infection during their hospitalization, a rate of 19.2 per 1,000 cases. This rate is higher than the 12.2 per 1,000 cases reported in 2005 due, in large part, to an expansion in the hospital-acquired infection reporting categories and improved reporting by hospitals as the process became more established.
- Differences in mortality, length of stay, and average hospital charges can be observed between patients with hospital-acquired infections and those without, as shown in the table below. The differences in mortality, length of stay, and charges may not be entirely attributable to the infections. The degree to which the presence of hospital-acquired infections influenced these numbers is not known. In almost all cases, hospitals do not receive full reimbursement of charges; on average statewide in 2006, for all inpatient cases (not just infections), hospitals were paid approximately 27% of established charges.

| | Number of Cases | Infection Rate Per 1,000 | Mortality | | Average Length of Stay in Days | | Average Charge | |
|---|---|---|---|---|---|---|---|---|
| | | | Number | Percent | Mean | Median | Mean | Median |
| Total Cases | 1,574,170 | NA | 36,119 | 2.3 | 4.7 | 3.0 | $36,001 | $18,900 |
| Cases with a hospital-acquired infection | 30,237 | 19.2 | 3,716 | 12.3 | 19.3 | 14.0 | $175,964 | $79,670 |
| Cases without a hospital-acquired infection | 1,543,933 | NA | 32,403 | 2.1 | 4.4 | 3.0 | $33,260 | $18,538 |

- The expansion of hospital-acquired infection reporting requirements from 2005 to 2006 restricts the comparisons that can be made between the two years; however, some limited comparative data is included in the report for the two most similar data collection time periods: Quarter 4, 2005 and Quarter 4, 2006. The hospital-acquired infection rate decreased from 16.3 per 1,000 cases to 15.1 per 1,000 cases between these two time periods. The number of hospital-acquired infections decreased from 6,226 in Quarter 4, 2005 to 5,859 in Quarter 4, 2006. ("Quarter 4" represents the time period October 1 through December 31.)
- The collection and reporting of hospital-acquired infections is still evolving. PHC4 believes the most important use of the report is to measure individual hospital performance over time and as a tool to ask physicians and hospital representatives informed questions about infection control and prevention, rather than to compare hospitals to each other.

# Calendar Year 2006 Data

## Peer Group 1 Hospitals

| | Number of Cases | Infection Rate per 1,000 Cases | Mortality | | Average Length of Stay (in Days) | | Average Charge † | |
|---|---|---|---|---|---|---|---|---|
| | | | Number | Percent | Mean | Median | Mean | Median |
| **Abington Memorial** | **34,186** | **NA** | **583** | **1.7** | **4.3** | **3.0** | **$54,888** | **$34,288** |
| Cases with Infections | 689 | 20.2 | 85 | 12.3 | 20.0 | 13.0 | $270,255 | $148,977 |
| Urinary Tract | 417 | 12.2 | 31 | 7.4 | 14.9 | 10.0 | $178,401 | $103,095 |
| Pneumonia | 32 | 0.9 | 4 | 12.5 | 17.0 | 15.0 | $263,012 | $209,231 |
| Bloodstream | 76 | 2.2 | 20 | 26.3 | 22.9 | 18.0 | $351,501 | $244,629 |
| Surgical Site | 33 | 3.8 | 3 | 9.1 | 25.6 | 21.0 | $365,286 | $302,296 |
| Gastrointestinal | 48 | 1.4 | 4 | 8.3 | 13.4 | 10.0 | $164,141 | $105,319 |
| Other Infections | 1 | < 0.1 | NR | NR | NR | NR | NR | NR |
| Multiple | 82 | 2.4 | 23 | 28.0 | 46.1 | 38.5 | $691,052 | $593,772 |
| Cases without Infections | 33,497 | NA | 498 | 1.5 | 4.0 | 3.0 | $50,458 | $33,701 |
| **Albert Einstein** | **24,179** | **NA** | **636** | **2.6** | **4.7** | **3.0** | **$42,845** | **$24,971** |
| Cases with Infections | 459 | 19.0 | 98 | 21.4 | 24.1 | 20.0 | $219,124 | $151,268 |
| Urinary Tract | 132 | 5.5 | 15 | 11.4 | 20.6 | 16.0 | $176,313 | $132,149 |
| Pneumonia | 13 | 0.5 | 3 | 23.1 | 24.0 | 20.0 | $210,015 | $186,330 |
| Bloodstream | 99 | 4.1 | 31 | 31.3 | 22.6 | 20.0 | $209,642 | $159,703 |
| Surgical Site | 13 | 2.6 | 1 | 7.7 | 21.5 | 19.0 | $219,076 | $163,070 |
| Gastrointestinal | 97 | 4.0 | 14 | 14.4 | 18.6 | 14.0 | $147,292 | $110,299 |
| Other Infections | 14 | 0.6 | 0 | 0.0 | 11.1 | 7.5 | $115,571 | $55,183 |
| Multiple | 91 | 3.8 | 34 | 37.4 | 39.0 | 35.0 | $385,348 | $265,227 |
| Cases without Infections | 23,720 | NA | 538 | 2.3 | 4.3 | 3.0 | $39,434 | $24,471 |
| **Allegheny General** | **27,281** | **NA** | **711** | **2.6** | **5.2** | **3.0** | **$40,777** | **$22,460** |
| Cases with Infections | 731 | 26.8 | 103 | 14.1 | 21.5 | 17.0 | $190,647 | $118,471 |
| Urinary Tract | 386 | 14.1 | 35 | 9.1 | 16.9 | 14.0 | $139,631 | $91,123 |
| Pneumonia | 60 | 2.2 | 16 | 26.7 | 25.6 | 23.0 | $264,555 | $228,934 |
| Bloodstream | 79 | 2.9 | 20 | 25.3 | 28.0 | 17.0 | $236,273 | $121,820 |
| Surgical Site | 20 | 1.9 | 1 | 5.0 | 24.6 | 22.0 | $165,312 | $115,369 |
| Gastrointestinal | 63 | 2.3 | 6 | 9.5 | 20.8 | 16.0 | $152,484 | $96,901 |
| Other Infections | 45 | 1.6 | 4 | 8.9 | 24.2 | 21.0 | $264,699 | $216,300 |
| Multiple | 78 | 2.9 | 21 | 26.9 | 33.1 | 32.5 | $334,646 | $313,788 |
| Cases without Infections | 26,550 | NA | 608 | 2.3 | 4.8 | 3.0 | $36,650 | $21,936 |
| **Altoona Regional*** | **17,228** | **NA** | **530** | **3.1** | **4.5** | **3.0** | **$20,744** | **$13,901** |
| Cases with Infections | 298 | 17.3 | 37 | 12.4 | 18.9 | 16.0 | $74,922 | $50,527 |
| Urinary Tract | 139 | 8.1 | 10 | 7.2 | 17.8 | 15.0 | $59,731 | $40,882 |
| Pneumonia | 30 | 1.7 | 9 | 30.0 | 21.5 | 20.5 | $108,568 | $88,977 |
| Bloodstream | 28 | 1.6 | 8 | 28.6 | 17.1 | 15.5 | $88,190 | $76,266 |
| Surgical Site | 17 | 3.5 | 0 | 0.0 | 11.7 | 10.0 | $49,315 | $36,000 |
| Gastrointestinal | 31 | 1.8 | 5 | 16.1 | 16.5 | 16.0 | $48,231 | $38,877 |
| Other Infections | 19 | 1.1 | 0 | 0.0 | 21.2 | 18.0 | $78,038 | $56,479 |
| Multiple | 34 | 2.0 | 5 | 14.7 | 26.8 | 27.5 | $131,809 | $101,839 |
| Cases without Infections | 16,930 | NA | 493 | 2.9 | 4.2 | 3.0 | $19,790 | $13,705 |

† In almost all cases, hospitals do not receive full reimbursement of charges; on average statewide in 2006, for all inpatient cases (not just infections), hospitals were paid approximately 27% of established charges.

* Hospital status change – Please see page 10.

NA Not applicable.

NR Not reported. Had fewer than 5 cases evaluated.

# Comparison of Quarter 4 - CY 2005 & CY 2006



| | Quarter 4, 2005 | | Quarter 4, 2006 | |
|---|---|---|---|---|
| | Number of Cases | Infection Rate per 1,000 Cases | Number of Cases | Infection Rate per 1,000 Cases |
| **Brandywine** | **1,781** | **NA** | **1,827** | **NA** |
| Cases with the Following Infections | 26 | 14.6 | 23 | 12.6 |
| Urinary Tract | 15 | 8.4 | 9 | 4.9 |
| Pneumonia | 5 | 2.8 | 6 | 3.3 |
| Bloodstream | 2 | 1.1 | 4 | 2.2 |
| Surgical Site | 0 | 0.0 | 2 | 5.8 |
| Multiple | 4 | 2.2 | 2 | 1.1 |
| ES **Butler Memorial (Q1-2004)** | **2,481** | **NA** | **2,701** | **NA** |
| Cases with the Following Infections | 111 | 44.7 | 76 | 28.1 |
| Urinary Tract | 75 | 30.2 | 44 | 16.3 |
| Pneumonia | 4 | 1.6 | 0 | 0.0 |
| Bloodstream | 8 | 3.2 | 6 | 2.2 |
| Surgical Site | 2 | 3.6 | 9 | 13.1 |
| Multiple | 22 | 8.9 | 17 | 6.3 |
| **Chester County** | **3,344** | **NA** | **3,465** | **NA** |
| Cases with the Following Infections | 42 | 12.6 | 39 | 11.3 |
| Urinary Tract | 14 | 4.2 | 15 | 4.3 |
| Pneumonia | 12 | 3.6 | 12 | 3.5 |
| Bloodstream | 11 | 3.3 | 6 | 1.7 |
| Surgical Site | 2 | 2.4 | 2 | 2.2 |
| Multiple | 3 | 0.9 | 4 | 1.2 |
| **Doylestown** | **2,985** | **NA** | **3,058** | **NA** |
| Cases with the Following Infections | 54 | 18.1 | 40 | 13.1 |
| Urinary Tract | 34 | 11.4 | 23 | 7.5 |
| Pneumonia | 12 | 4.0 | 10 | 3.3 |
| Bloodstream | 6 | 2.0 | 2 | 0.7 |
| Surgical Site | 1 | 1.3 | 1 | 1.2 |
| Multiple | 1 | 0.3 | 4 | 1.3 |
| **DuBois Regional** | **1,707** | **NA** | **1,684** | **NA** |
| Cases with the Following Infections | 41 | 24.0 | 26 | 15.4 |
| Urinary Tract | 30 | 17.6 | 19 | 11.3 |
| Pneumonia | 6 | 3.5 | 6 | 3.6 |
| Bloodstream | 2 | 1.2 | 1 | 0.6 |
| Surgical Site | 3 | 6.8 | 0 | 0.0 |
| Multiple | 0 | 0.0 | 0 | 0.0 |

ES Indicates the use of electronic surveillance which began during the period noted next to the hospital name. For more information about electronic surveillance, please see page 8.

NA Not applicable.

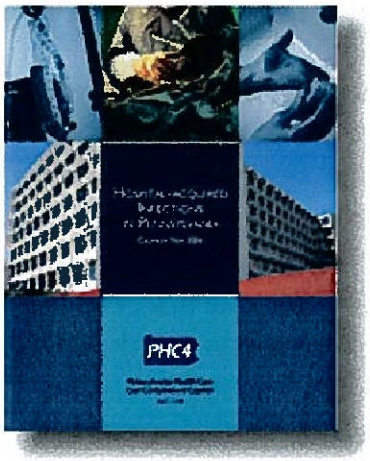
### *Impact of the report, continued*

have also highlighted the quality-of-care and financial consequences of hospital-acquired infections.

But, perhaps the most important result of PHC4's work has been its contribution to the discussion among patients, policymakers, purchasers and medical professionals that hospital-acquired infections are not inevitable, unavoidable by-products of health care, and that many can be prevented or minimized. This has helped to lend force to the tidal wave of positive action already occurring in many health care institutions. These actions include cultural and behavioral changes that are saving numerous patient lives, improving the quality of life for countless others and saving real health care dollars today.

In 2007, due in large part to PHC4's groundbreaking work, the Governor and General Assembly enacted Act 52 to adopt a more comprehensive approach to the problem of hospital-acquired infections. The legislation has outlined a multi-pronged initiative to prevent, track and reduce such infections, with the potential to save thousands of lives, avoid countless complications and significantly restrain health care costs.

# Hospital-acquired Infections in Pennsylvania




***PHC4's infection reports are unrivaled because they can compare hospitalizations with and without hospital-acquired infections in terms of mortality, length of stay, readmissions and hospital charges.***

## About the report

This report includes information on infections that patients contracted while in the hospital. The original, published in November 2006, was the first of its kind in the nation and garnered over 188,000 Web site downloads within the first two months of its release. In addition to the number of cases and infection rate per 1,000 cases, information on mortality, mean and median length of stay, and mean and median charges are presented for each hospital. Because not all hospitals treat the same types of patients, the hospitals are categorized by "peer groups" so that hospitals that offer similar types and complexity of services and treat a similar number of patients are displayed together. So far, PHC4 has published two hospital-specific reports on hospital-acquired infections. The next version of this report is expected to be released in the fall of 2008.

## What sets it apart?

To create hospital-specific infection reports, other states can report hospital-acquired infections through the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). However, what makes Pennsylvania unique is that it can link the information reported by hospitals to NHSN with PHC4's comprehensive database so policymakers can learn more about the hospitalization in which the infection occurred. PHC4's infection reports are unrivaled because they can compare hospitalizations with and without hospital-acquired infections in terms of mortality, length of stay, readmissions and hospital charges.

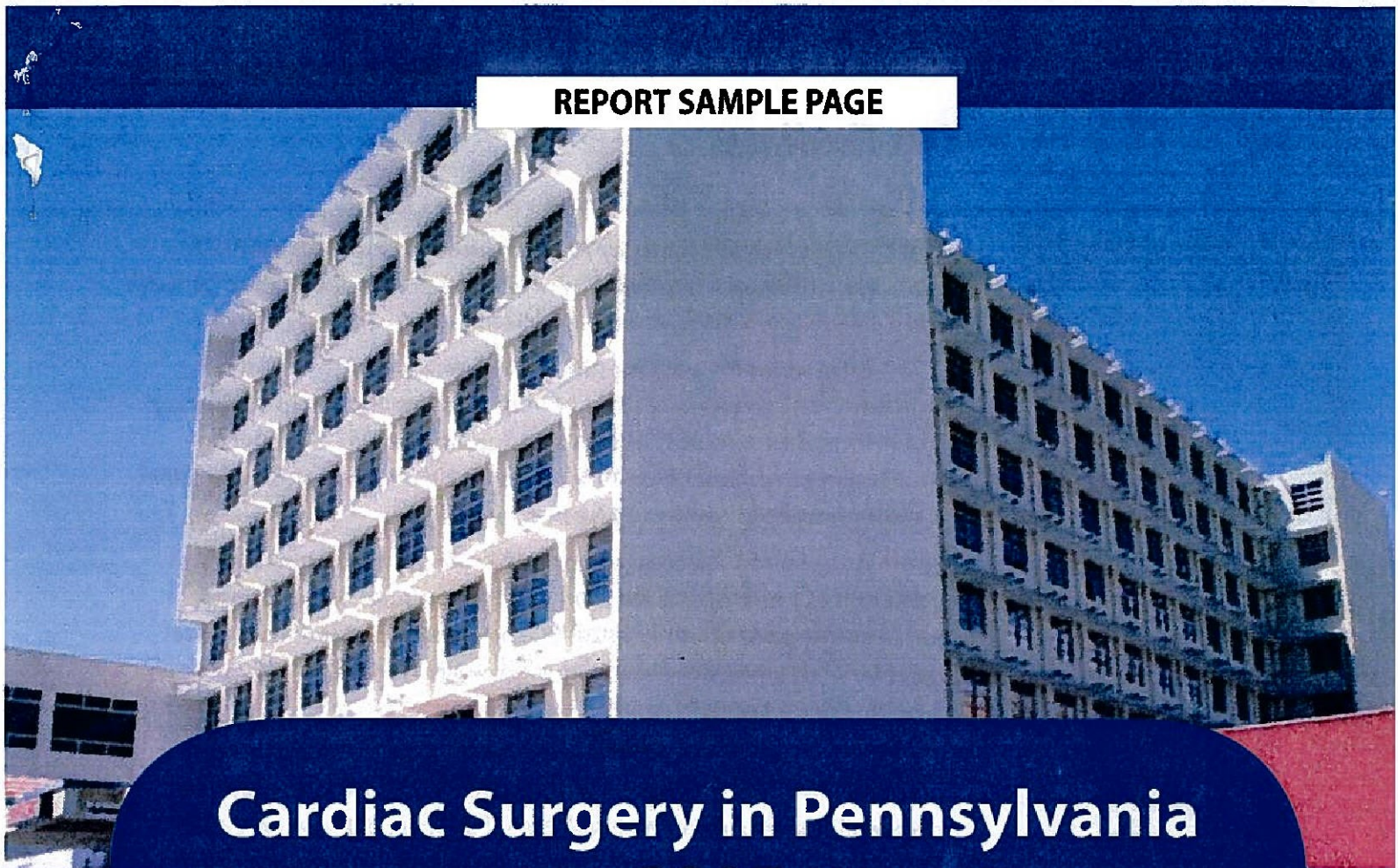
| | Number of Cases | Infection Rate Per 1,000 Cases | Mortality | | Average Length of Stay in Days | | Average Charge | |
|---|---|---|---|---|---|---|---|---|
| | | | Number | Percent | Mean | Median | Mean | Median |
| Total Cases | 1,574,170 | NA | 36,119 | 2.3 | 4.7 | 3.0 | $36,001 | $18,900 |
| Cases with a hospital-acquired infection | 30,237 | 19.2 | 3,716 | 12.3 | 19.3 | 14.0 | $175,964 | $79,670 |
| Cases without a hospital-acquired infection | 1,543,933 | NA | 32,403 | 2.1 | 4.4 | 3.0 | $33,260 | $18,538 |

## Impact of the report

PHC4's reporting has helped to change the national discourse regarding hospital-acquired infections. The reports received significant national and international attention because for the first time, actual data, rather than estimates or extrapolations, were made public. They

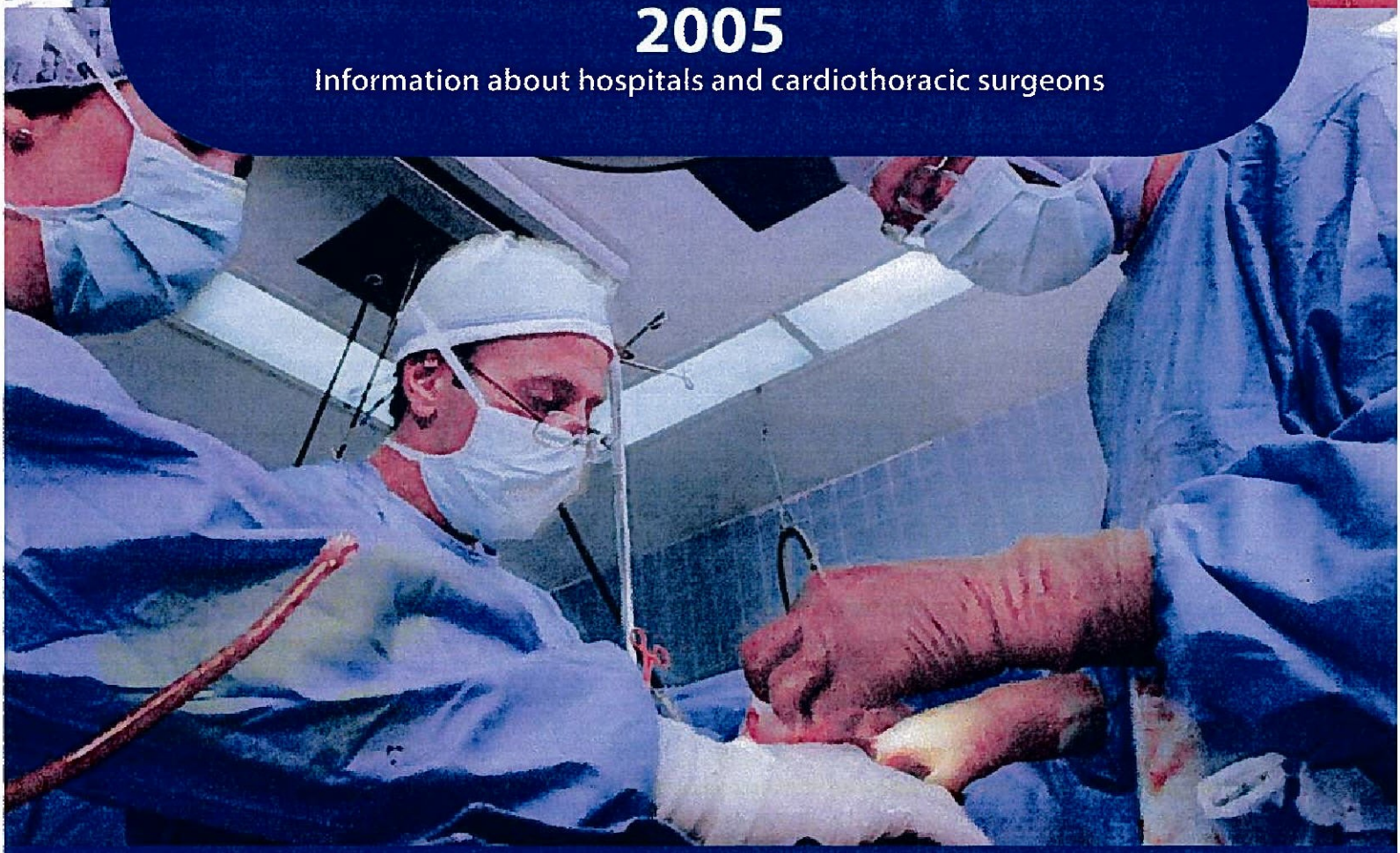
(Continued on back)

REPORT SAMPLE PAGE



# Cardiac Surgery in Pennsylvania 2005

Information about hospitals and cardiothoracic surgeons



Pennsylvania Health Care Cost Containment Council • June 2007

# Key Findings



- In 2000, the in-hospital mortality rate for patients undergoing a CABG procedure (without a valve procedure) was 2.39 percent; the rate had declined to 1.98 percent in 2004, and further declined to 1.90 percent in 2005.
- The 7-day readmission rate for patients undergoing a CABG procedure (without a valve procedure) declined from 6.2 percent in 2000 to 5.2 percent in 2004 and then increased slightly to 5.5 percent in 2005. The 30-day readmission rate declined from 14.5 percent in 2000 to 13.2 percent in 2004 and then increased slightly to 13.6 percent in 2005.
- Between 2004 and 2005, the average number of open heart procedures performed by surgeons declined from 131 cases per surgeon to 121 cases per surgeon—down from 149 in 2000. The average number of open heart procedures per hospital declined from 376 cases per hospital to 346 cases per hospital—down from 499 in 2000.
- Patients who underwent both valve and CABG surgery during the same hospitalization had the highest mortality rates and the highest readmission rates, while those patients who underwent CABG, but did not have a valve procedure, had the lowest mortality and readmission rates (see table below).

### Statewide Figures by Reporting Group

| | Reporting Group | | | |
|---|---|---|---|---|
| | CABG without Valve | Valve without CABG | Valve with CABG | Total Valve |
| Number of Cases | 11,875 | 2,846 | 2,610 | 5,456 |
| In-Hospital Mortality Rate | 1.9 % | 3.0 % | 7.5 % | 5.2 % |
| 30-Day Mortality Rate | 2.3 % | 3.6 % | 8.6 % | 6.0 % |
| 7-Day Readmission Rate | 5.5 % | 6.6 % | 7.8 % | 7.2 % |
| 30-Day Readmission Rate | 13.6 % | 17.8 % | 19.2 % | 18.4 % |

- The top three reasons for readmission within 7 days of discharge after undergoing CABG and/or valve procedures were heart failure (21.2 percent), infections (16.9 percent), and cardiac dysrhythmias (10.6 percent). These were also the top three reasons for readmission within 30 days of discharge, with infections at 21.0 percent, heart failure at 20.1 percent, and cardiac dysrhythmias at 10.7 percent.

# REPORT SAMPLE PAGE

- In 2005, the average commercial payment and the average Medicare payment for CABG and/or valve surgeries were similar. However, there were differences in the number of days that patients with commercial insurance and those covered by Medicare stayed in the hospital. The differences in total length of stay appear to stem from differences in post-surgical length of stay, rather than differences in time spent in the hospital prior to surgery. The average payment reported is for the entire length of stay.

## Average Payments and Length of Stay (LOS) by Reporting Group

| | Reporting Group | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | CABG without Valve | | Valve without CABG | | Valve with CABG | | Total Valve | |
| Payor | Average Payment | Average Post-Surgical LOS | Average Payment | Average Post-Surgical LOS | Average Payment | Average Post-Surgical LOS | Average Payment | Average Post-Surgical LOS |
| Commercial Insurance | $30,247 | 5.6 days | $41,651 | 6.7 days | $47,471 | 8.6 days | $43,500 | 7.3 days |
| Medicare | $29,175 | 7.5 days | $42,433 | 9.4 days | $44,119 | 10.6 days | $43,343 | 10.0 days |

- In 2005, hospitals submitted data on the following hospital-acquired infections: urinary tract infections, surgical site infections, pneumonias, and bloodstream infections. Of the 17,331 patients who underwent CABG and/or valve surgery, hospitals reported that 755 (4.4 percent) contracted one or more of these infections during their stay. Patients who underwent both CABG surgery and a valve procedure during the same hospitalization were the most likely to contract a hospital-acquired infection (8.0 percent), and patients who underwent CABG with no valve procedures were the least likely to contract a hospital-acquired infection (3.6 percent). The following table displays the differences in outcomes for patients who did and those who did not contract an infection during their hospital stay.

| Patients... | In-Hospital Mortality Rate | Average Post-Surgical Length of Stay | Average Hospital Charge | Average Commercial Payment | Average Medicare Payment |
|---|---|---|---|---|---|
| *With* a Hospital-Acquired Infection | 13.5 % | 21.7 days | $328,992 | $65,514 | $57,883 |
| *Without* a Hospital-Acquired Infection | 2.4 % | 7.1 days | $122,454 | $32,764 | $32,911 |

## What do the symbols mean?

The symbols in this report represent the results of how well hospitals and surgeons performed surgery and cared for the patient. A statistical test is done to determine whether differences in the results are simply due to chance or random variation. A difference is called "statistically significant" when we are 95 percent confident that the difference is not likely to result from chance or random variation. Using in-hospital mortality as an example:

- ○ lower than expected (meaning that the hospital or surgeon had fewer deaths than expected after accounting for how sick the patients were)
- ⊙ same as expected (meaning that the hospital or surgeon had as many deaths as expected after accounting for how sick the patients were)
- ● higher than expected (meaning that the hospital or surgeon had more deaths than expected after accounting for how sick the patients were)

## More data on PHC4's Web site

Additional information is posted on the PHC4 Web site at www.phc4.org:

- Numbers associated with the outcome figures and symbols
- Technical Notes

**TABLE NOTES**

**For Hospital and Surgeon Data** - 30-day mortality includes in-hospital mortality. The mortality, readmission, and length of stay figures account for varying illness levels among patients. Length of stay is the average number of days spent in the hospital following CABG/valve surgery.

**For Hospital Data Only** - Average charge was trimmed and case-mix adjusted. Average payment was not trimmed or adjusted. Medicare average payment for hospitals with less than 13 cases was suppressed to meet current Centers for Medicare and Medicaid Services privacy guidelines. Average charge and average payment are for the entire length of stay.

**For Surgeon Data Only** - The actual number of CABG/valve surgeries performed may be underreported (e.g., procedures done in Veterans' hospitals and in other states are not included in this analysis). Total figures on all open heart surgeries performed (including CABG and/or valve) are available on PHC4's Web site.

## Statewide Figures

### CABG without Valve

| | |
|---|---|
| Number of cases | 11,875 |
| In-hospital mortality rate | 1.9% |
| 30-day mortality rate | 2.3% |
| 7-day readmission rate | 5.5% |
| 30-day readmission rate | 13.6% |

### Valve without CABG

| | |
|---|---|
| Number of cases | 2,846 |
| In-hospital mortality rate | 3.0% |
| 30-day mortality rate | 3.6% |
| 7-day readmission rate | 6.6% |
| 30-day readmission rate | 17.8% |

### Valve with CABG

| | |
|---|---|
| Number of cases | 2,610 |
| In-hospital mortality rate | 7.5% |
| 30-day mortality rate | 8.6% |
| 7-day readmission rate | 7.8% |
| 30-day readmission rate | 19.2% |

### Total Valve

| | |
|---|---|
| Number of cases | 5,456 |
| In-hospital mortality rate | 5.2% |
| 30-day mortality rate | 6.0% |
| 7-day readmission rate | 7.2% |
| 30-day readmission rate | 18.4% |

**REPORT SAMPLE PAGE**

# Hospital Data

| Hospital | Number of Cases | Mortality | | Readmissions | | Post-Surgical Length of Stay | Average Hospital Charge | Average Payment | |
|---|---|---|---|---|---|---|---|---|---|
| | | In-Hospital | 30-Day | 7-Day | 30-Day | | | Commercial | Medicare |
| **Abington Memorial** | | | | | | | | | |
| CABG without Valve | 153 | ⊙ | ⊙ | ⊙ | ⊙ | 7.2 | $212,544 | $36,144 | $36,185 |
| Valve without CABG | 123 | ⊙ | ⊙ | ⊙ | ⊙ | 8.6 | $226,698 | $59,241 | $44,738 |
| Valve with CABG | 46 | ⊙ | ⊙ | ⊙ | ⊙ | 10.5 | $286,552 | NR | $46,488 |
| Total Valve | 169 | ⊙ | ⊙ | ⊙ | ⊙ | 9.4 | $245,770 | $59,669 | $45,331 |
| **Albert Einstein** | | | | | | | | | |
| CABG without Valve | 116 | ● | ⊙ | ⊙ | ⊙ | 6.1 | $213,420 | $75,440 | $44,535 |
| Valve without CABG | 19 | NR | NR | NR | NR | NR | $227,692 | NR | NR |
| Valve with CABG | 6 | NR | NR | NR | NR | NR | $376,164 | NR | NR |
| Total Valve | 25 | NR | NR | NR | NR | NR | $266,602 | NR | NR |
| **Allegheny General** | | | | | | | | | |
| CABG without Valve | 251 | ⊙ | ⊙ | ○ | ○ | 7.0 | $83,626 | $23,715 | $30,363 |
| Valve without CABG | 87 | ⊙ | ⊙ | ⊙ | ⊙ | 8.4 | $100,826 | $31,756 | $41,595 |
| Valve with CABG | 54 | ⊙ | ⊙ | ⊙ | ⊙ | 11.5 | $134,865 | NR | $55,872 |
| Total Valve | 141 | ⊙ | ⊙ | ⊙ | ⊙ | 9.6 | $117,401 | $33,972 | $47,714 |
| **Altoona Regional** | | | | | | | | | |
| CABG without Valve | 216 | ⊙ | ⊙ | ⊙ | ⊙ | 4.9 | $61,918 | $24,079 | $25,622 |
| Valve without CABG | 59 | ⊙ | ● | ● | ● | 5.4 | $71,881 | $22,871 | $43,224 |
| Valve with CABG | 42 | ⊙ | ⊙ | ⊙ | ⊙ | 6.0 | $83,290 | NR | $35,249 |
| Total Valve | 101 | ⊙ | ⊙ | ⊙ | ⊙ | 5.7 | $77,733 | $23,645 | $39,063 |
| **Brandywine** | | | | | | | | | |
| CABG without Valve | 57 | ⊙ | ⊙ | ● | ⊙ | 5.3 | $256,003 | $44,785 | $29,812 |
| Valve without CABG | 5 | NR | NR | NR | NR | NR | $282,631 | NR | NR |
| Valve with CABG | 7 | NR | NR | NR | NR | NR | $393,875 | NR | NR |
| Total Valve | 12 | NR | NR | NR | NR | NR | $343,265 | NR | NR |
| **Butler Memorial** | | | | | | | | | |
| CABG without Valve | 219 | ⊙ | ⊙ | ⊙ | ⊙ | 6.2 | $46,650 | $18,613 | $24,209 |
| Valve without CABG | 39 | ● | ⊙ | ⊙ | ⊙ | 8.3 | $71,371 | $30,886 | $41,108 |
| Valve with CABG | 44 | ⊙ | ⊙ | ⊙ | ⊙ | 9.7 | $80,865 | $28,811 | $38,112 |
| Total Valve | 83 | ⊙ | ⊙ | ⊙ | ⊙ | 8.9 | $76,714 | $30,194 | $39,194 |
| **Chester County** | | | | | | | | | |
| CABG without Valve | 91 | ⊙ | ⊙ | ⊙ | ⊙ | 5.8 | $78,869 | $24,977 | $27,521 |
| Valve without CABG | 26 | NR | NR | NR | NR | NR | $85,021 | $31,377 | NR |
| Valve with CABG | 24 | NR | NR | NR | NR | NR | $117,307 | NR | NR |
| Total Valve | 50 | ⊙ | ⊙ | ⊙ | ⊙ | 6.9 | $99,966 | $33,343 | $35,987 |
| **Community/Scranton** | | | | | | | | | |
| CABG without Valve | 204 | ⊙ | ⊙ | ⊙ | ○ | 5.6 | $63,150 | $26,534 | $26,935 |
| Valve without CABG | 29 | NR | NR | NR | NR | NR | $84,382 | $29,469 | NR |
| Valve with CABG | 39 | ⊙ | ⊙ | ⊙ | ⊙ | 8.3 | $107,271 | NR | $38,811 |
| Total Valve | 68 | ○ | ⊙ | ⊙ | ○ | 7.3 | $96,118 | $35,888 | $37,566 |

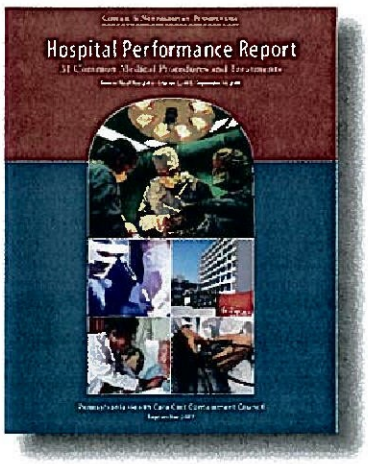
○ Lower than expected ⊙ Same as expected ● Higher than expected NR Not rated (too few cases)

# Surgeon Data

| Surgeon | Number of Cases | Mortality | | Readmissions | | Post-Surgical Length of Stay |
|---|---|---|---|---|---|---|
| | | In-Hospital | 30-Day | 7-Day | 30-Day | |
| **Sortino, Antonio** | | | | | | |
| CABG without Valve | 58 | ⊙ | ⊙ | ⊙ | ⊙ | 5.7 |
| Valve without CABG | 33 | ⊙ | ⊙ | ● | ● | 7.0 |
| Valve with CABG | 41 | ⊙ | ⊙ | ⊙ | ● | 10.2 |
| Total Valve | 74 | ⊙ | ⊙ | ● | ● | 8.5 |
| **Stahl, Russell** | | | | | | |
| CABG without Valve | 97 | ⊙ | ⊙ | ⊙ | ⊙ | 6.0 |
| Valve without CABG | 19 | NR | NR | NR | NR | NR |
| Valve with CABG | 23 | NR | NR | NR | NR | NR |
| Total Valve | 42 | ⊙ | ⊙ | ⊙ | ○ | 7.3 |
| **Stella, Joseph** | | | | | | |
| CABG without Valve | 118 | ⊙ | ⊙ | ⊙ | ⊙ | 4.8 |
| Valve without CABG | 11 | NR | NR | NR | NR | NR |
| Valve with CABG | 22 | NR | NR | NR | NR | NR |
| Total Valve | 33 | ⊙ | ⊙ | ⊙ | ⊙ | 5.5 |
| **Stephenson, Edward R.** | | | | | | |
| CABG without Valve | 80 | ⊙ | ⊙ | ⊙ | ○ | 5.5 |
| Valve without CABG | 11 | NR | NR | NR | NR | NR |
| Valve with CABG | 11 | NR | NR | NR | NR | NR |
| Total Valve | 22 | NR | NR | NR | NR | NR |
| **Stivala, Charles** | | | | | | |
| CABG without Valve | 11 | NR | NR | NR | NR | NR |
| Valve without CABG | 0 | NR | NR | NR | NR | NR |
| Valve with CABG | 0 | NR | NR | NR | NR | NR |
| Total Valve | 0 | NR | NR | NR | NR | NR |
| **Strong III, Michael D.** | | | | | | |
| CABG without Valve | 87 | ⊙ | ⊙ | ⊙ | ⊙ | 8.2 |
| Valve without CABG | 18 | NR | NR | NR | NR | NR |
| Valve with CABG | 19 | NR | NR | NR | NR | NR |
| Total Valve | 37 | ⊙ | NR | NR | NR | 10.6 |
| **Strzalka, Christopher T.** | | | | | | |
| CABG without Valve | 125 | ⊙ | ⊙ | ⊙ | ⊙ | 5.2 |
| Valve without CABG | 1 | NR | NR | NR | NR | NR |
| Valve with CABG | 3 | NR | NR | NR | NR | NR |
| Total Valve | 4 | NR | NR | NR | NR | NR |
| **Sullivan, Lawrence X.** | | | | | | |
| CABG without Valve | 80 | ⊙ | ⊙ | ● | ⊙ | 6.4 |
| Valve without CABG | 9 | NR | NR | NR | NR | NR |
| Valve with CABG | 18 | NR | NR | NR | NR | NR |
| Total Valve | 27 | NR | NR | NR | NR | NR |

○ Lower than expected ⊙ Same as expected ● Higher than expected NR Not rated (too few cases)

# Hospital Performance Report




***The resulting improvement in in-hospital mortality rates represents the equivalent of an estimated 49,000 lives saved!***

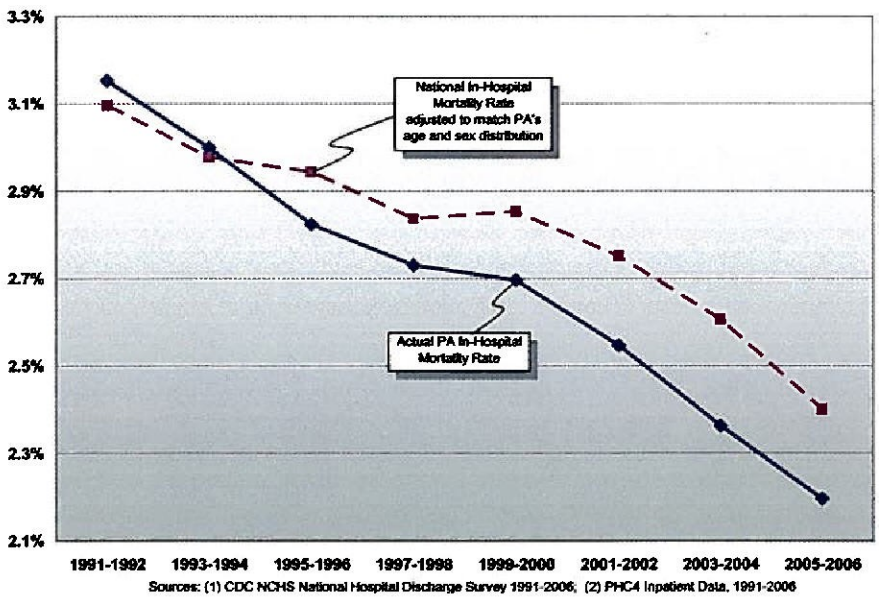
## About the report

PHC4 publishes one of the nation's most comprehensive hospital performance reports based on the number of conditions and measures reported. As one of PHC4's flagship publications, this report assists consumers and purchasers in making more informed health care decisions and offers guidance to providers by highlighting opportunities for quality improvement. It includes mortality rates, readmission rates, length of stay, and hospital charges for numerous medical procedures and treatments that are commonly performed at Pennsylvania hospitals. To provide the most up-to-date data possible, both an annual printed version and Web-based quarterly updates are published. The next edition of this report is scheduled for public release in September 2008.

## What sets it apart?

While other states only use administrative data in their reports, Pennsylvania's risk adjustment is based on clinical findings, such as lab test results, EKG findings, vital signs, and the patient's medical history. This attention to scientific rigor is one reason Pennsylvania has the strong support of its physician community.

**In-hospital Mortality for All Conditions**




Sources: (1) CDC NCHS National Hospital Discharge Survey 1991-2006; (2) PHC4 Inpatient Data, 1991-2006

## Impact of the report

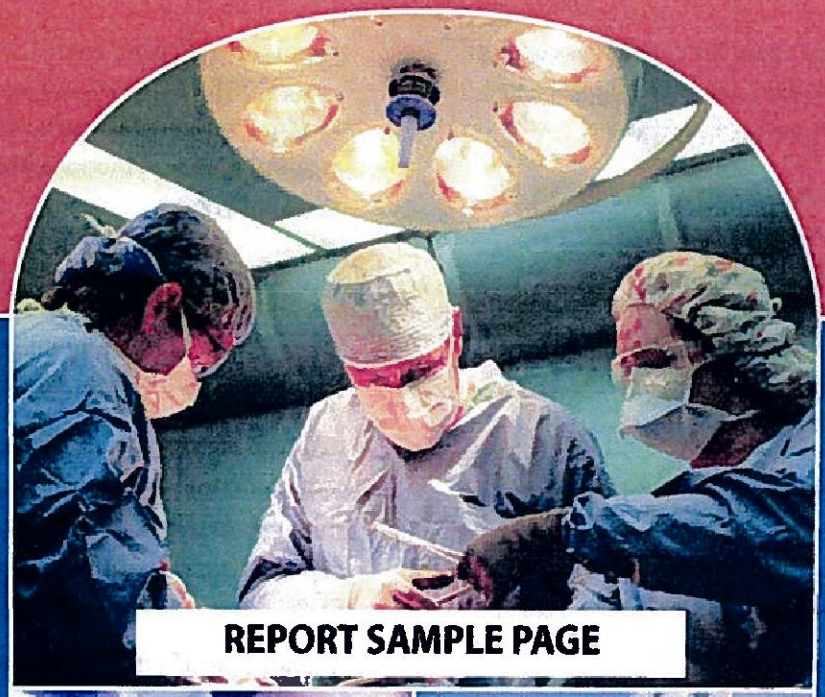
Since PHC4 began publicly reporting patient mortality rates for Pennsylvania hospitals in its annual *Hospital Performance Report* in the early 1990s, in-hospital mortality rates for all conditions dropped from significantly above to significantly below the national average. The resulting improvement in in-hospital mortality rates represents the equivalent of an estimated 49,000 lives saved!

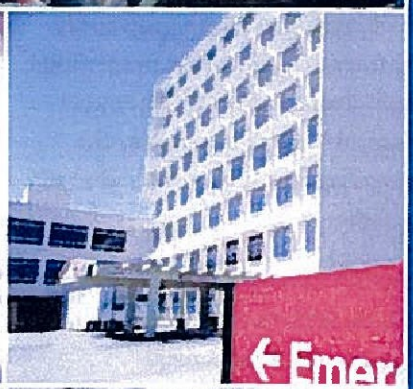
SOUTHEASTERN PENNSYLVANIA

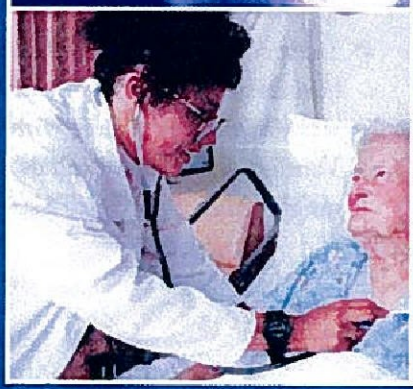
# Hospital Performance Report

## 31 Common Medical Procedures and Treatments

Federal Fiscal Year 2006 • October 1, 2005 - September 30, 2006



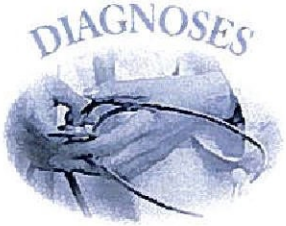



Pennsylvania Health Care Cost Containment Council

September 2007

## Key Findings

- The overall mortality rate for conditions reported for both 2004 and 2006 decreased significantly, from 4.7% in 2004 to 4.4% in 2006.
- Patient mortality decreased significantly in 18 of the 26 treatment categories between 2004 and 2006 (in categories where three years of mortality data were available). The largest decline was in Respiratory Failure without Mechanical Ventilation, where the mortality rate decreased from 17.0% in 2004 to 13.5% in 2006.
- Among the conditions reported, Respiratory Failure with Mechanical Ventilation had the highest mortality rate at 29.1%, and Removal of Blockage of Neck Vessels had the lowest rate at 0.2%.
- The average length of stay decreased significantly for 18 of the 30 treatment categories between 2004 and 2006. The largest decline was in Respiratory Failure with Mechanical Ventilation, where the average length of stay decreased from 10.5 days in 2004 to 9.7 days in 2006.
- There was wide variation in length of stay among hospitals. The condition with the most variation was Respiratory Failure with Mechanical Ventilation, where hospitals' average length of stay ranged from 4.1 to 16.1 days after taking patient risk factors into account.
- The overall readmission rate for conditions reported for both 2004 and 2006 increased significantly, rising from 18.7% in 2004 to 19.1% in 2006. The largest increase was in Respiratory Failure without Mechanical Ventilation, where the readmission rate increased from 24.3% in 2004 to 26.2% in 2006.
- There were 57,993 readmissions for any reason in 2006 (for the categories covered in the report). These readmissions amounted to approximately $2.3 billion in charges and 352,000 hospital days.
- Among the conditions reported, Respiratory Failure with Mechanical Ventilation had the highest readmission rate at 27.6%, and Hysterectomy - Vaginal had the lowest rate at 3.3%.
- There were 15,057 readmissions for complication or infection in 2006 (for the categories covered in the report). These readmissions amounted to approximately $734 million in charges and 111,000 hospital days.
- The condition with the highest readmission rate for complication or infection was Respiratory Failure without Mechanical Ventilation (12.7%). The condition with the lowest rate was Hysterectomy - Vaginal (2.1%).
- There was wide variation in charges among hospitals. The condition with the most variation was Respiratory Failure with Mechanical Ventilation, where hospitals' average charges ranged from $10,956 to $261,899.






# Abnormal Heartbeat

| Hospital | Cases | Mortality Rating | Length of Stay | Outlier Cases: Short Length of Stay % | Outlier Cases: Short Length of Stay Rating | Outlier Cases: Long Length of Stay % | Outlier Cases: Long Length of Stay Rating | Readmission Rating: For Any Reason | Readmission Rating: For Complication or Infection | Average Charge |
|---|---|---|---|---|---|---|---|---|---|---|
| Methodist Division/TJUH | 224 | ⊙ | 3.6 | 3.6 | ⊙ | 13.5 | ● | ● | ⊙ | $42,698 |
| Montgomery | 189 | ⊙ | 3.0 | 4.3 | ⊙ | 3.7 | ⊙ | ● | ⊙ | $23,645 |
| Nazareth | 323 | ⊙ | 4.5 | 3.1 | ⊙ | 13.2 | ● | ⊙ | ⊙ | $51,225 |
| Palmerton | 57 | ⊙ | 2.4 | 12.3 | ● | 1.8 | ⊙ | ⊙ | ⊙ | $12,582 |
| Penn Presbyterian | 562 | ⊙ | 3.6 | 2.7 | ○ | 2.0 | ○ | ⊙ | ⊙ | $41,643 |
| Pennsylvania | 221 | ⊙ | 3.1 | 4.1 | ⊙ | 5.1 | ⊙ | ⊙ | ⊙ | $44,856 |
| Phoenixville | 216 | ⊙ | 3.1 | 4.7 | ⊙ | 2.8 | ⊙ | ⊙ | ● | $22,965 |
| Pottstown Memorial | 277 | ⊙ | 2.6 | 5.1 | ⊙ | 2.2 | ○ | ● | ● | $27,004 |
| Pottsville Warne Clinic | 149 | ⊙ | 3.7 | 2.7 | ⊙ | 9.5 | ● | ⊙ | ⊙ | $10,945 |
| Reading | 503 | ⊙ | 3.4 | 5.5 | ⊙ | 6.1 | ⊙ | ⊙ | ⊙ | $15,336 |
| Riddle Memorial | 240 | ⊙ | 2.8 | 5.9 | ⊙ | 4.7 | ⊙ | ⊙ | ⊙ | $43,509 |
| Roxborough Memorial | 143 | ⊙ | 3.9 | 2.1 | ⊙ | 5.0 | ⊙ | ⊙ | ⊙ | $29,065 |
| Sacred Heart/Allentown | 102 | ⊙ | 3.7 | 1.0 | ⊙ | 7.1 | ⊙ | ⊙ | ⊙ | $21,735 |
| Saint Catherine | 20 | ⊙ | 3.1 | 0.0 | ⊙ | 5.0 | ⊙ | ⊙ | ⊙ | $16,033 |
| Springfield | 55 | ⊙ | 3.4 | 7.3 | ⊙ | 5.5 | ⊙ | ⊙ | ⊙ | $55,888 |
| St Joseph/Reading | 223 | ⊙ | 2.6 | 15.4 | ● | 1.8 | ○ | ⊙ | ⊙ | $15,517 |
| St Joseph's/Philadelphia | 39 | ⊙ | 3.6 | 0.0 | ⊙ | 10.3 | ⊙ | ⊙ | ⊙ | $21,306 |
| St Luke's Miners | 47 | ⊙ | 4.5 | 0.0 | ⊙ | 13.0 | ● | ⊙ | ⊙ | $21,970 |
| St Luke's Quakertown | 80 | ⊙ | 2.7 | 5.0 | ⊙ | 1.3 | ⊙ | ⊙ | ⊙ | $19,903 |
| St Luke's/Bethlehem | 636 | ⊙ | 2.9 | 7.1 | ● | 1.1 | ○ | ⊙ | ○ | $18,988 |
| St Mary | 720 | ⊙ | 3.5 | 3.8 | ⊙ | 6.0 | ⊙ | ⊙ | ⊙ | $24,870 |
| Taylor | 214 | ⊙ | 4.0 | 0.9 | ○ | 8.0 | ⊙ | ⊙ | ⊙ | $59,946 |
| Temple East | 168 | ⊙ | 4.2 | 3.0 | ⊙ | 16.3 | ● | ⊙ | ⊙ | $53,612 |
| Temple Lower Bucks | 176 | ⊙ | 3.9 | 1.7 | ○ | 12.1 | ● | ● | ⊙ | $52,345 |
| Temple University | 350 | ⊙ | 3.3 | 7.0 | ⊙ | 9.6 | ● | ● | ⊙ | $79,520 |
| Thomas Jefferson Univ | 483 | ⊙ | 3.5 | 4.4 | ⊙ | 7.9 | ● | ● | ⊙ | $41,428 |
| Warminster | 92 | ⊙ | 3.6 | 5.6 | ⊙ | 4.4 | ⊙ | ⊙ | ⊙ | $49,581 |
| Southeastern Pennsylvania | 16,802 | | 3.4 | 4.5 | | 5.7 | | | | $37,711 |
| TOTAL: Statewide | 38,651 | | 3.3 | 5.0 | | 5.0 | | | | $26,132 |

The mortality, length of stay and readmission figures account for varying illness levels among patients. See page 3.

- ● Significantly higher than expected.
- ⊙ Not significantly different than expected.
- ○ Significantly lower than expected.
- NR Not reported. Had fewer than five cases evaluated.
- NC Non-compliant. Not reported due to missing/incomplete data.

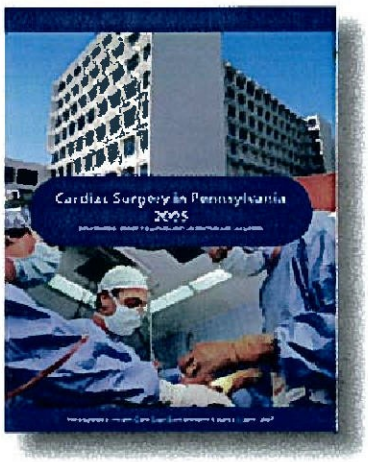

# Gallbladder Removal - Laparoscopic

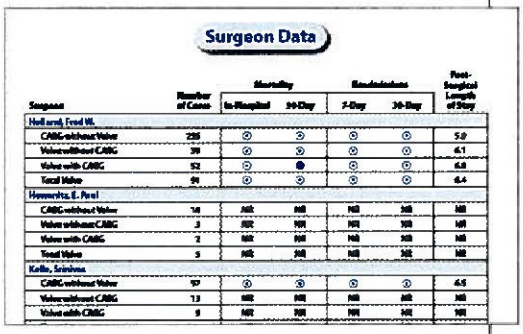
| Hospital | Cases | Mortality Rating | Length of Stay | Readmission Rating: For Any Reason | Readmission Rating: For Complication or Infection | Average Charge |
|---|---|---|---|---|---|---|
| Abington Memorial | 403 | ⊙ | 3.1 | ⊙ | ⊙ | $41,381 |
| Albert Einstein | 193 | ⊙ | 3.6 | ⊙ | ⊙ | $49,710 |
| Brandywine | 53 | ⊙ | 3.6 | ⊙ | ⊙ | $52,849 |
| Central Montgomery | 111 | ⊙ | 3.3 | ⊙ | ⊙ | $27,248 |
| Chester County | 237 | ⊙ | 3.5 | ⊙ | ⊙ | $16,769 |
| Chestnut Hill | 131 | ⊙ | 2.9 | ⊙ | ⊙ | $31,571 |
| Crozer-Chester | 68 | ⊙ | 4.6 | ⊙ | ⊙ | $89,033 |
| Delaware County Memorial | 87 | ⊙ | 3.9 | ⊙ | ⊙ | $62,936 |
| Doylestown | 221 | ⊙ | 3.0 | ⊙ | ⊙ | $28,284 |
| Easton | 108 | ⊙ | 3.2 | ⊙ | ⊙ | $55,108 |
| Frankford | 277 | ⊙ | 3.8 | ⊙ | ⊙ | $39,932 |
| Gnaden Huetten Memorial | 20 | ⊙ | 2.8 | ⊙ | ⊙ | $10,912 |
| Good Samaritan Regional | 83 | ⊙ | 3.8 | ⊙ | ⊙ | $12,691 |
| Graduate | 35 | ⊙ | 3.1 | ⊙ | ⊙ | $77,833 |
| Grand View | 142 | ⊙ | 3.7 | ⊙ | ⊙ | $36,344 |
| Hahnemann University | 87 | ⊙ | 3.6 | ⊙ | ⊙ | $86,646 |
| Holy Redeemer | 93 | ⊙ | 3.5 | ⊙ | ⊙ | $51,181 |
| Hospital Fox Chase Cancer | 4 | NR | NR | NR | NR | NR |
| Hospital University PA | 173 | ⊙ | 3.3 | ⊙ | ⊙ | $44,139 |
| Jeanes | 82 | ⊙ | 3.7 | ⊙ | ⊙ | $63,140 |
| Jennersville Regional | 40 | ⊙ | 3.3 | ⊙ | ⊙ | $32,015 |
| Lehigh Valley | 306 | ⊙ | 3.7 | ⊙ | ⊙ | $35,817 |
| Lehigh Valley/Muhlenberg | 130 | ⊙ | 3.3 | ⊙ | ⊙ | $29,911 |
| Main Line Bryn Mawr | 195 | ⊙ | 2.8 | ⊙ | ⊙ | $29,544 |
| Main Line Lankenau | 163 | ⊙ | 3.2 | ⊙ | ⊙ | $33,665 |
| Main Line Paoli | 268 | ⊙ | 2.4 | ⊙ | ⊙ | $16,885 |
| Mercy Fitzgerald | 78 | ⊙ | 3.4 | ⊙ | ⊙ | $64,917 |
| Mercy Philadelphia | 56 | ⊙ | 3.3 | ⊙ | ⊙ | $47,873 |
| Mercy Suburban | 28 | ⊙ | 3.2 | ● | ⊙ | $45,107 |

The mortality, length of stay and readmission figures account for varying illness levels among patients. See page 3.

- ● Significantly higher than expected.
- ⊙ Not significantly different than expected.
- ○ Significantly lower than expected.
- NR Not reported. Had fewer than five cases evaluated.
- NC Non-compliant. Not reported due to missing/incomplete data.

# Cardiac Surgery in Pennsylvania




*In Pennsylvania, mortality rates for CABG have dropped 51.7% in the past 15 years.*

## About the report

Pennsylvania, through PHC4, is one of a handful of states that publicly report quality measures for hospitals and surgeons on cardiac surgery and was only the second in the country to do so. This report examines the results of coronary artery bypass graft (CABG) and/or valve surgeries performed in Pennsylvania by both hospitals and surgeons. It includes outcomes on in-hospital mortality, 30-day mortality, 7-day and 30-day readmission rates and post-surgical length of stay. In the upcoming 2006 edition, average charges and Medicare average payments will be listed for each hospital. PHC4 released its first CABG surgery guide (featuring 1990 data) in 1992. The next edition of this report is scheduled for public release in September 2008.

## What sets it apart?

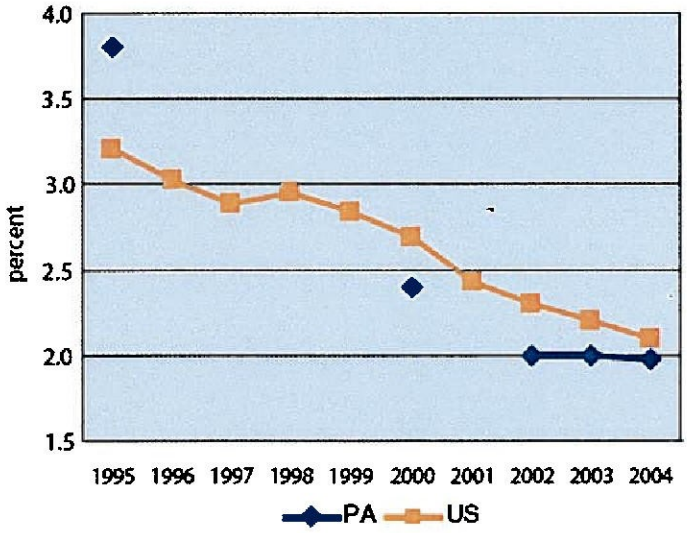
Only nine other states produce some type of public cardiac surgery report. While four of these states include both hospital and surgeon-specific information like Pennsylvania does, none of them are as comprehensive as PHC4's guide in terms of measures reported. Most of the other states only focus on procedure volume and mortality rates.

## Impact of the report

In Pennsylvania, mortality rates for CABG have dropped 51.7% in the past 15 years. In 2005, in-hospital patient mortality following CABG surgery in Pennsylvania was 1.90% – the lowest mortality rate for this cardiac procedure since PHC4 began publicly reporting.

The benefits of reporting CABG surgery outcomes have been documented in the recent literature. Hannan et al.'s "Provider Profiling and Quality Improvement Efforts in Coronary Artery Bypass Graft Surgery" (*Medical Care*, 2003) found that while CABG mortality rates have dropped nationally, they have dropped more significantly in states with public reporting, like Pennsylvania.

**In-hospital Mortality for CABG Surgery**




Sources: (1) U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality, Healthcare Costs and Utilization Project (HCUP); (2) PHC4

# Hospital Financial Analysis


***PHC4 financial reports are the only source of consistent and accurate financial and utilization data for the more than 250 hospitals and 200 surgery centers in the state.***

## About the reports

Three of the reports PHC4 releases annually are part of the Hospital Financial Analysis series, which examines financial measures specific to all hospitals and surgery centers in Pennsylvania. *Volume One* provides a comprehensive profile of the financial health of Pennsylvania's general acute care (GAC) hospitals, and is preceded every year by a statewide preview summary. These two reports are typically released in the spring. *Volume Two* looks at the financial status of non-GAC hospitals (rehabilitation, long-term acute, psychiatric and specialty), as well as ambulatory surgery centers and is expected to be released in fall 2008.

## What sets them apart?

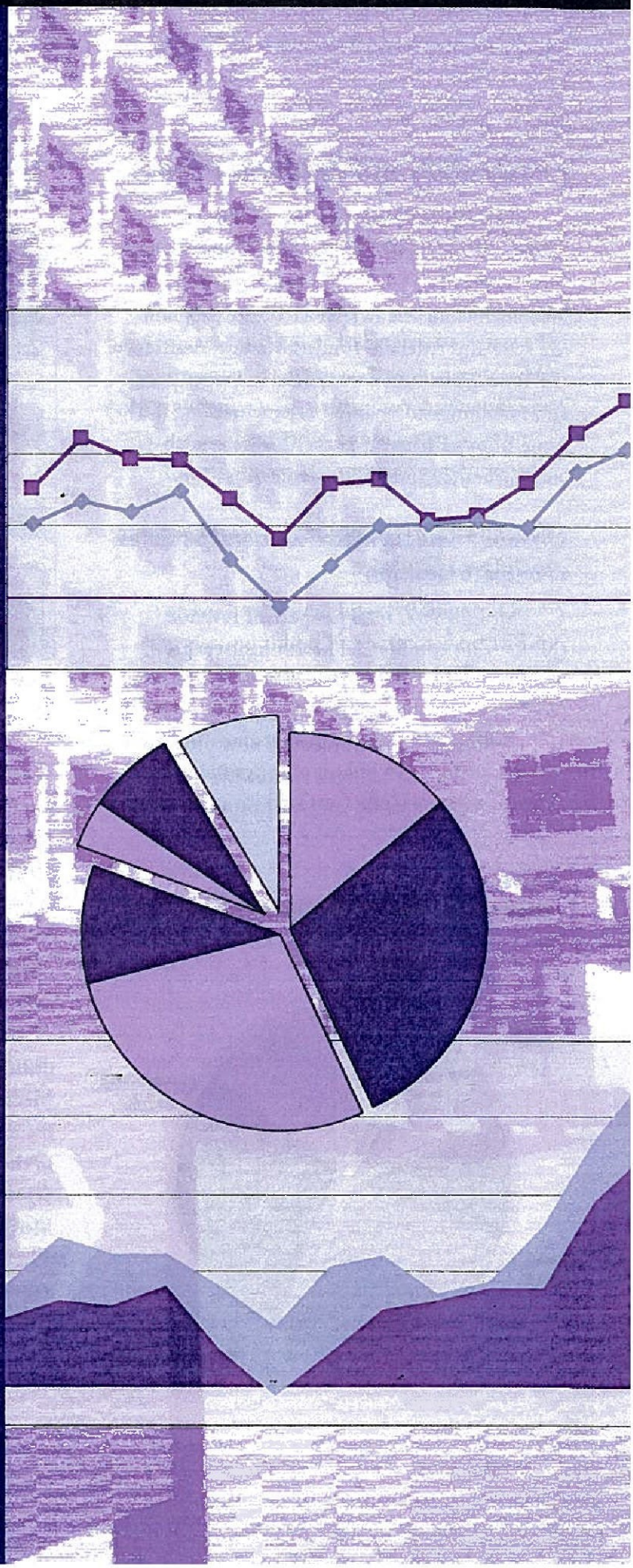
Since accounting standards give hospitals and surgery centers relatively broad latitude in developing their individual annual financial statements, the financial and utilization data submitted to PHC4 by these facilities undergoes a rigorous review system in which PHC4 and facility staff members interact very closely. Thanks to this process, PHC4 financial reports are the only source of consistent and accurate financial and utilization data for the more than 250 hospitals and 200 surgery centers in the state.

## Impact of the reports

The uniform data featured in these reports permits meaningful analysis of the trends in patient utilization and the financial health of hospitals and surgery centers. That's one of the reasons the state of Massachusetts decided to pattern its hospital financial analysis after PHC4's. One component of the report that is always of great importance to policymakers and industry officials are hospitals in financial distress as their fiscal health may affect the delivery of care in certain regions of the Commonwealth.

In addition, PHC4's hospital financial data also is used by the Pennsylvania Department of Public Welfare to calculate payments under the Hospital Uncompensated Care Program and the Hospital Extraordinary Expense Program. Created as part of Act 77 of 2001, these programs distribute funds from the Master Settlement Agreement with tobacco manufacturers to qualified hospitals.

AN ANNUAL REPORT ON THE FINANCIAL HEALTH OF PENNSYLVANIA'S HOSPITALS



# FINANCIAL ANALYSIS 2007

## Volume One • General Acute Care Hospitals

PHC4

Pennsylvania Health Care Cost Containment Council

June 2008

## UTILIZATION AND REVENUE BY PAYOR

Hospitals received 92.0% of their net patient revenue (NPR) from third-party health care insurers in FY07. These third-party health insurers include the federal Medicare program, the state and federally-funded Medical Assistance (MA) program, and commercial managed care and indemnity companies. The remaining 8.0% came from patients and other insurers, such as auto insurance and workers compensation.

### Revenue from Commercial Insurers Continues to Outpace Medicare

During FY07, total net patient revenue (NPR) from commercial health insurers grew 9.4% or $1.131 billion dollars compared to the 6.0% or $623 million growth in Medicare NPR.

Commercial health insurers now provide 44.2% or $13.164 billion of statewide net patient revenue (NPR) at GAC hospitals. Since hospitals reported slight declines in the statewide number of commercial discharges (-0.8%) and patient days (-0.1%), the increase in NPR from commercial insurers was the result of higher average reimbursement rates. Hospitals reported an 8.6% increase in the average revenue per discharge and 7.9% increase in average revenue per day in FY07.

After a 2.2% decline in Medicare discharges during FY06, there was a 1.0% increase in Medicare discharges reported for FY07. This 1.0% increase in discharges coupled with a 4.5% increase in the average revenue per discharge resulted in a 5.5% increase in statewide inpatient NPR from Medicare patients. During FY07, Medicare funded 37.1% of GAC hospital inpatient and outpatient care in Pennsylvania.

**FIGURE 7**
**Statewide Net Patient Revenue by Payor, FY07**

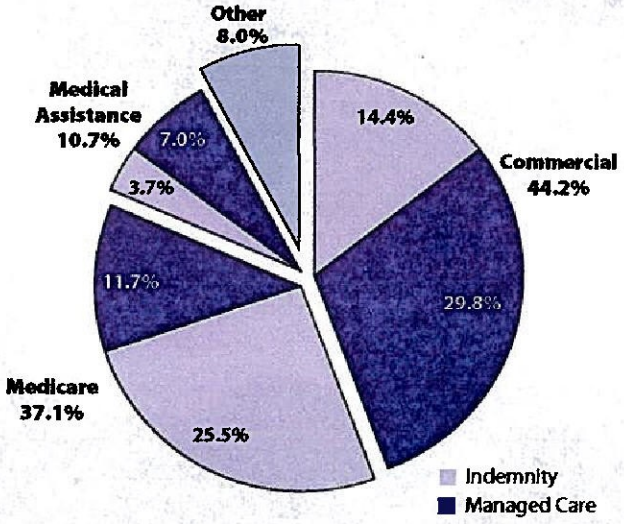



**TABLE 2**
**Net Patient Revenue by Payor (millions)**

| | FY06 | FY07 | Percent Change FY06 to FY07 |
|---|---|---|---|
| **Commercial** | $12,033 | $13,164 | 9.40% |
| Indemnity | $3,772 | $4,277 | 13.38% |
| Managed Care | $8,261 | $8,887 | 7.58% |
| **Medicare** | $10,436 | $11,060 | 5.97% |
| Indemnity | $7,637 | $7,584 | -0.69% |
| Managed Care | $2,799 | $3,475 | 24.14% |
| **Medical Assistance** | $3,059 | $3,189 | 4.26% |
| Indemnity | $1,059 | $1,092 | 3.08% |
| Managed Care | $2,000 | $2,097 | 4.88% |
| **Other** | $2,327 | $2,375 | 2.08% |
| STATEWIDE | $27,855 | $29,788 | 6.94% |

# Individual Hospital Data

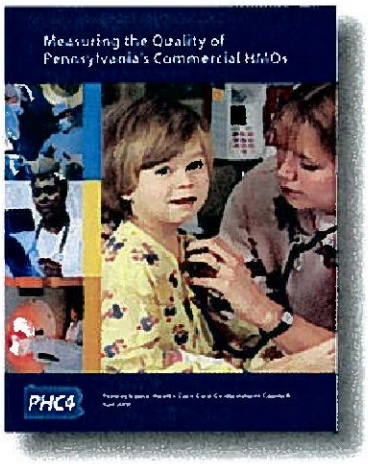
| Hospital | Net Patient Revenue NPR (millions) | | | | 3-yr Avg Change in NPR FY04-FY07 | Total Operating Expenses TOE (millions) | | | | 3-yr Avg Change in TOE FY04-FY07 |
|---|---|---|---|---|---|---|---|---|---|---|
| | FY07 | FY06 | FY05 | FY04 | | FY07 | FY06 | FY05 | FY04 | |
| **Region 1** | **$199** | **$179** | **$161** | **$143** | **6.71%** | **$206** | **$183** | **$166** | **$150** | **6.06%** |
| ACMH Hospital [5] | $76 | $72 | $68 | $67 | 4.87% | $77 | $72 | $69 | $68 | 4.49% |
| Aliquippa Community [11,12,13,14] | $20 | $21 | $24 | $22 | -2.65% | $28 | $32 | $27 | $26 | 2.04% |
| Allegheny General [5,9] | $566 | $557 | $536 | $485 | 5.54% | $595 | $570 | $545 | $496 | 6.63% |
| Alle-Kiski [5,7] | $107 | $103 | $98 | $93 | 4.66% | $107 | $97 | $93 | $88 | 7.10% |
| Butler Memorial [5] | $160 | $149 | $140 | $130 | 7.69% | $152 | $142 | $135 | $126 | 6.84% |
| Canonsburg General [5] | $47 | $44 | $44 | $44 | 2.39% | $51 | $47 | $44 | $43 | 5.87% |
| Children's Hosp Pgh [7] | $323 | $300 | $273 | $244 | 10.72% | $387 | $354 | $314 | $288 | 11.54% |
| Frick [5] | $46 | $45 | $44 | $43 | 2.42% | $45 | $46 | $46 | $45 | -0.06% |
| Highlands [5] | $24 | $23 | $23 | $21 | 4.60% | $25 | $25 | $24 | $24 | 1.04% |
| Jefferson Regional [5,6] | $182 | $175 | $165 | $157 | 5.24% | $191 | $184 | $173 | $171 | 3.85% |
| Latrobe Area [5] | $110 | $108 | $108 | $110 | -0.18% | $115 | $114 | $114 | $122 | -1.78% |
| Magee-Womens [5] | $301 | $259 | $210 | $190 | 19.64% | $263 | $234 | $195 | $183 | 14.63% |
| Medical Center Beaver [5] | $190 | $177 | $175 | $167 | 4.74% | $192 | $180 | $178 | $171 | 4.15% |
| Mercy Jeannette [1,3,5,7] | $52 | $50 | $47 | $44 | NA | $53 | $51 | $50 | $45 | NA |
| Mercy Pittsburgh [1,5,8,11] | $270 | $262 | $260 | $239 | 4.31% | $282 | $287 | $286 | $271 | 1.40% |
| Monongahela Valley [5] | $107 | $102 | $97 | $94 | 4.70% | $108 | $103 | $98 | $95 | 4.65% |
| Ohio Valley General [1,5,13] | $56 | $54 | $51 | $49 | 4.23% | $57 | $54 | $52 | $51 | 3.83% |
| Sewickley Valley [5,7] | $110 | $100 | $95 | $92 | 6.35% | $118 | $111 | $107 | $105 | 4.20% |
| Southwest Regional MC [3,5,10,13] | $29 | $19 | $23 | $24 | 7.37% | $34 | $20 | $25 | $26 | 10.14% |
| St Clair Memorial [5] | $167 | $159 | $152 | $143 | 5.38% | $176 | $173 | $160 | $151 | 5.53% |
| Uniontown [5] | $112 | $99 | $94 | $88 | 9.02% | $112 | $100 | $94 | $89 | 8.40% |
| UPMC Braddock [5] | $58 | $53 | $51 | $46 | 8.18% | $61 | $58 | $56 | $53 | 5.09% |
| UPMC McKeesport [5] | $107 | $102 | $100 | $87 | 7.59% | $115 | $108 | $105 | $96 | 6.70% |
| UPMC Passavant [5,9] | $238 | $208 | $154 | $138 | 24.04% | $215 | $190 | $145 | $136 | 19.33% |
| UPMC Presby Shadyside [5] | $1,645 | $1,615 | $1,414 | $1,285 | 9.35% | $1,732 | $1,611 | $1,442 | $1,360 | 9.12% |
| UPMC South Side [5,9] | $81 | $78 | $60 | $57 | 14.17% | $81 | $78 | $60 | $57 | 13.47% |
| UPMC St Margaret [5] | $203 | $188 | $172 | $152 | 11.22% | $195 | $179 | $169 | $152 | 9.43% |
| Washington [5] | $192 | $180 | $172 | $161 | 6.47% | $208 | $196 | $183 | $175 | 6.30% |
| Western PA Hosp/Forbes [5] | $131 | $125 | $119 | $114 | 5.00% | $126 | $121 | $116 | $111 | 4.67% |
| Western Pennsylvania [5] | $303 | $309 | $313 | $294 | 1.04% | $326 | $324 | $315 | $308 | 1.96% |
| Westmoreland Regional [5] | $163 | $155 | $150 | $139 | 5.93% | $161 | $154 | $150 | $140 | 5.04% |

See footnotes on pages 36 and 37.

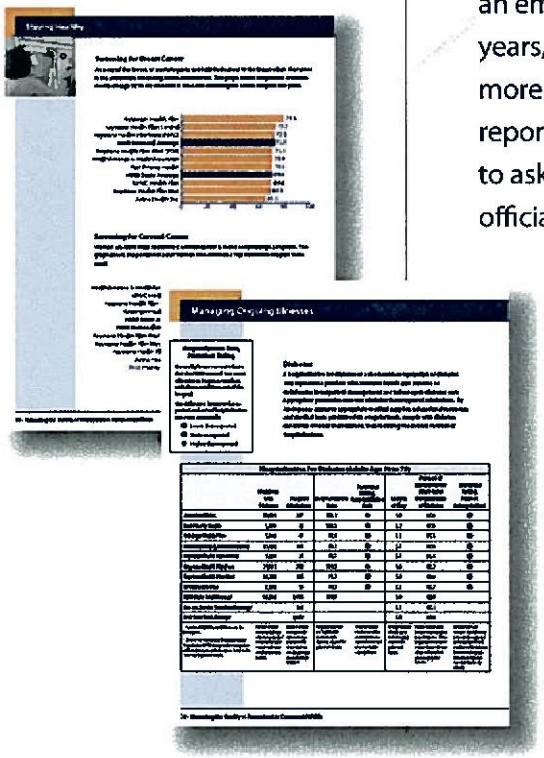
| Hospital | Operating Margin FY07 | Total Margin FY07 | 3-yr Average Total Margin FY05-FY07 | Percent of Uncompensated Care FY07 | Medicare Share of NPR FY07 | Medical Assistance Share of NPR FY07 |
|---|---|---|---|---|---|---|
| **Region 1** | **4.25%** | **6.14%** | **6.20%** | **1.78%** | **41.21%** | **10.44%** |
| ACMH Hospital [5] | 1.62% | 3.06% | 3.25% | 1.80% | 46.64% | 8.44% |
| Aliquippa Community [11, 12, 13, 14] | -35.45% | -35.45% | -26.00% | 2.18% | NR | NR |
| Allegheny General [5,9] | -1.66% | -0.28% | 1.54% | 1.30% | 41.07% | 10.90% |
| Alle-Kiski [5,7] | 3.33% | 3.33% | 5.69% | 1.31% | 60.25% | 6.05% |
| Butler Memorial [5] | 7.28% | 9.95% | 8.61% | 1.73% | 48.10% | 7.78% |
| Canonsburg General [5] | -1.20% | -1.20% | 1.47% | 1.31% | 58.50% | 3.44% |
| Children's Hosp Pgh [7] | 5.40% | 13.40% | 9.91% | 1.36% | 3.16% | 32.18% |
| Frick [5] | 2.73% | 2.79% | 0.51% | 2.60% | 53.01% | 6.72% |
| Highlands [5] | 0.67% | 2.64% | -1.00% | 2.81% | 45.36% | 18.70% |
| Jefferson Regional [5,6] | 4.57% | 6.64% | 6.12% | 1.59% | 60.75% | 3.82% |
| Latrobe Area [5] | -0.10% | 3.86% | 5.17% | 1.99% | 47.77% | 9.96% |
| Magee-Womens [5] | 17.58% | 16.78% | 14.72% | 2.31% | 13.04% | 15.82% |
| Medical Center Beaver [5] | 2.96% | 8.24% | 6.64% | 1.42% | 50.07% | 6.43% |
| Mercy Jeannette [1,3,5,7] | -1.69% | -1.35% | -2.31% | 1.57% | 55.70% | 5.66% |
| Mercy Pittsburgh [1,5,9,11] | 5.97% | 5.97% | 1.86% | 3.07% | 44.33% | 11.07% |
| Monongahela Valley [5] | 0.45% | 2.59% | 3.07% | 2.13% | 61.58% | 9.42% |
| Ohio Valley General [1,5,13] | 1.23% | 5.79% | 7.02% | 2.65% | 56.52% | 7.66% |
| Sewickley Valley [5,7] | 4.16% | 7.87% | 5.49% | 1.52% | 45.10% | 5.60% |
| Southwest Regional MC [3,5,10,13] | -11.94% | -8.01% | -6.14% | 3.06% | 54.12% | 10.53% |
| St Clair Memorial [5] | 2.97% | 7.20% | 4.61% | 1.37% | 51.43% | 2.86% |
| Uniontown [5] | 2.02% | 4.25% | 3.48% | 3.05% | 52.72% | 14.14% |
| UPMC Braddock [5] | -3.16% | -3.16% | -5.65% | 4.50% | 51.27% | 17.95% |
| UPMC McKeesport [5] | -1.15% | -1.15% | -0.66% | 2.91% | 62.83% | 10.18% |
| UPMC Passavant [5,9] | 12.25% | 16.07% | 13.35% | 1.18% | 44.63% | 1.72% |
| UPMC Presby Shadyside [5] | 4.97% | 5.72% | 8.54% | 1.77% | 35.56% | 10.60% |
| UPMC South Side [5,9] | 2.93% | 2.93% | 3.25% | 2.49% | 46.96% | 7.49% |
| UPMC St Margaret [5] | 7.38% | 7.40% | 6.90% | 1.32% | 48.10% | 3.51% |
| Washington [5] | 0.17% | 4.86% | 4.04% | 1.99% | 45.43% | 8.93% |
| Western PA Hosp/Forbes [5] | 7.83% | 7.83% | 6.42% | 1.34% | 52.43% | 8.52% |
| Western Pennsylvania [5] | 2.96% | 2.96% | 5.31% | 1.16% | 45.25% | 11.77% |
| Westmoreland Regional [5] | 3.47% | 6.64% | 6.52% | 1.46% | 51.67% | 6.45% |

See footnotes on pages 36 and 37.

# Measuring the Quality of Pennsylvania's Commercial HMOs




***PHC4's commercial HMO report is the only public report in the nation to combine data on preventive care and member satisfaction with a broad mix of clinical results.***



## About the report

First released in 2000, this report focuses on the quality of health care services received by members of Pennsylvania's commercial health maintenance organizations (HMOs). To complement the annual printed version of this report, PHC4 has also developed an interactive database that allows users to customize and trend PHC4's commercial HMO data for their own needs. This annual report is typically released each spring.

## What sets it apart?

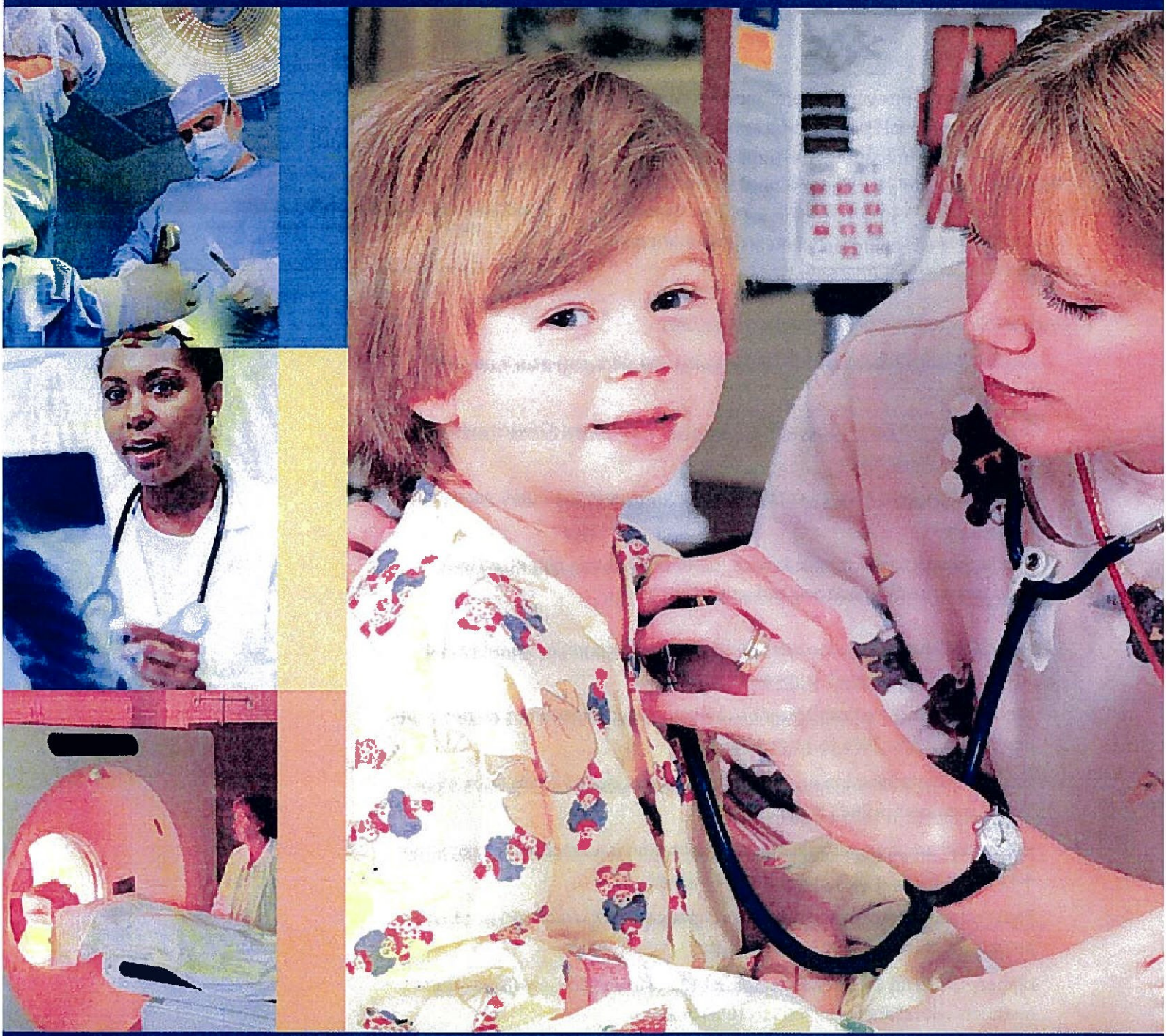
PHC4's commercial HMO report is the only public report in the nation to combine data on preventive care and member satisfaction with a broad mix of clinical results. Inpatient hospital and ambulatory procedure data used in the report's analysis of treatment measures is submitted to PHC4 by Pennsylvania hospitals. PHC4 also uses Quality Compass® data and Health Plan Employer Data and Information Set® (HEDIS) data from the National Committee for Quality Assurance (NCQA). Member satisfaction measures are taken from the Consumer Assessment of Health Plans Survey® (CAHPS).

## Impact of the report

The quality of care provided by a managed care network directly affects the health of employees and their families, workforce productivity, and an employer's direct and indirect health care costs. And for the past eight years, this report has given purchasers, policymakers and consumers a more complete picture of how well HMOs serve their members. The report provides HMO members with the type of information they need to ask HMO representatives informed questions about their care. HMO officials use the report to identify areas for quality improvement.

REPORT SAMPLE PAGE

# Measuring the Quality of Pennsylvania's Commercial HMOs

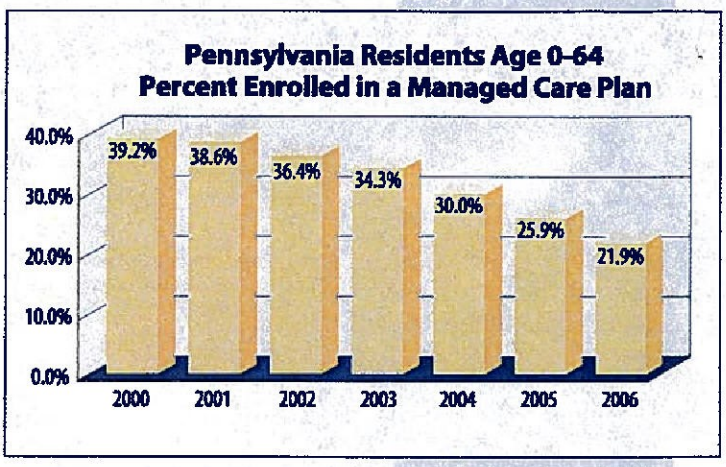


PHC4

**Pennsylvania Health Care Cost Containment Council**
April 2008

# Key Findings

- Enrollment in commercial managed care organizations has been steadily decreasing, from 39.2% of Pennsylvania residents age 0-64 in 2000 to 21.9% in 2006.



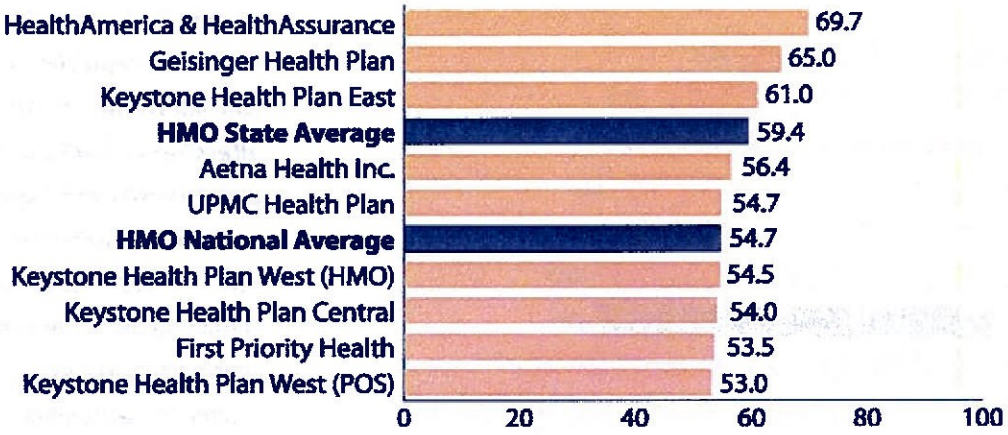

- Pennsylvania HMOs on average performed better than or equal to the national HMO average in 14 of the 17 "Staying Healthy" measures. The three measures for which Pennsylvania had lower rates than the national average included: screening for breast cancer, colorectal cancer screening, and annual monitoring for patients on persistent medication.

- For the following Member Satisfaction measures:
  - Overall Rating of Plan – Six of the nine plans outperformed their national counterparts.
  - Getting Needed Care – Seven of the nine plans performed better than or equal to the national average.
  - Seeing a Specialist – Seven of the nine plans outperformed their national counterparts.
  - Getting Help from Customer Service – Four of the seven plans that were reported outperformed their national counterparts.

- Statewide HMO hospitalization rates for the following conditions printed in this report increased significantly compared to last year:
  - High blood pressure hospitalization rates increased 13.9% from 2.6 per 10,000 adult members in 2005 to 3.0 in 2006.
  - Gastrointestinal infection hospitalization rates increased 20.9% from 3.9 per 10,000 members in 2005 to 4.8 in 2006.
  - Kidney and urinary tract infection hospitalization rates increased 11.8% from 4.4 per 10,000 members in 2005 to 5.0 in 2006.
  - Pediatric asthma hospitalization rates increased 26.2% from 14.6 per 10,000 pediatric members in 2005 to 18.5 in 2006.
  - Diabetes hospitalization rates increased 12.3% from 94.3 per 10,000 adult members with diabetes in 2005 to 105.9 in 2006.

## Eye Exams Performed for Members with Diabetes

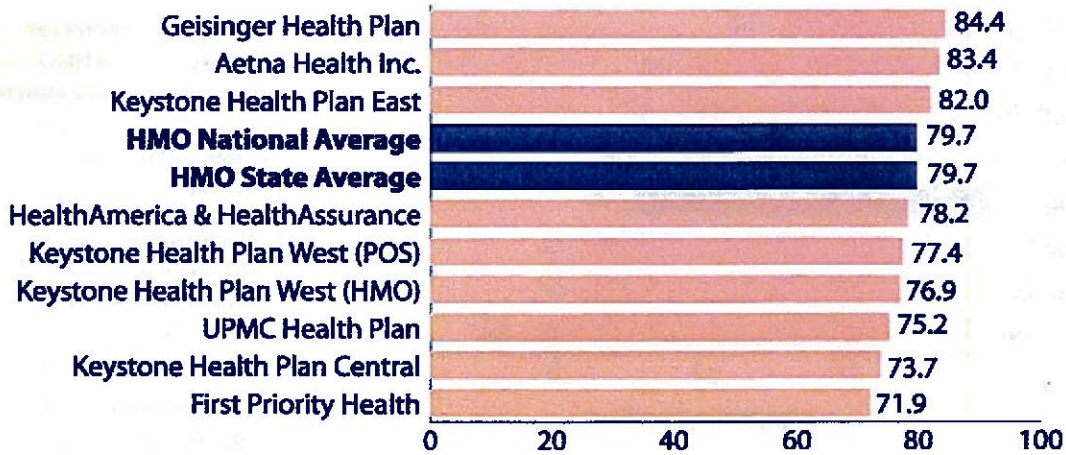
Retinal eye exams are recommended on a regular basis (usually annually) to reduce the risk of blindness from diabetes. The graph shows the percent of members with diabetes who received an eye exam in the past year.



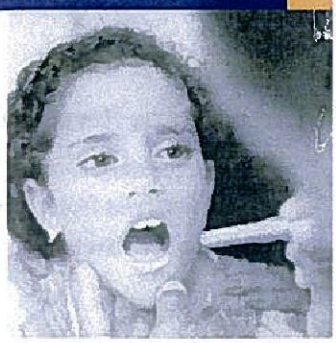

Generally, those HMOs with the **higher percentages** are doing a **better** job of preventing illness and helping their members stay healthy. The **one exception** is the first measure, Poorly Controlled Hemoglobin A1c Levels, in which the lowest percentage is the best outcome.

## Monitoring Kidney Disease for Members with Diabetes

Kidney disease may be a problem for members with diabetes. The graph shows the percent of members with diabetes who were screened or treated for kidney disease.



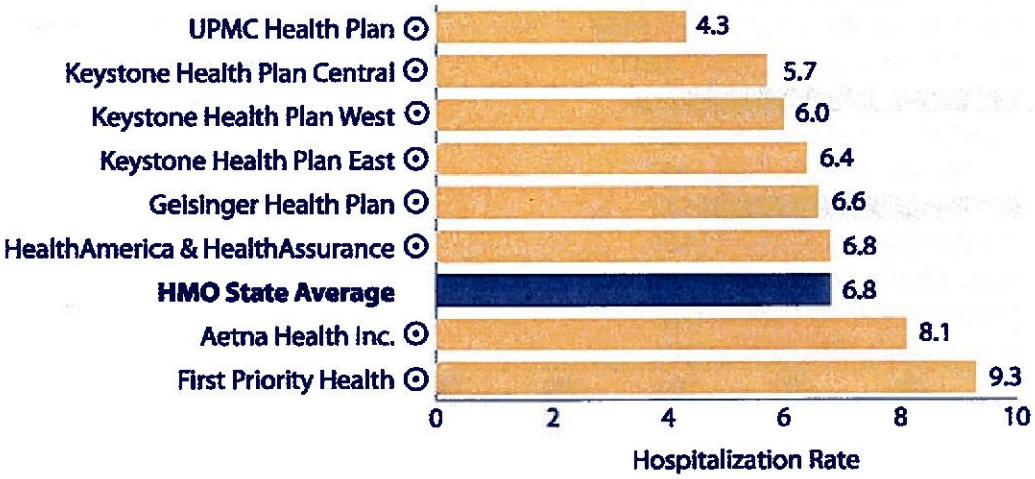
# Preventing Hospitalization through Primary Care



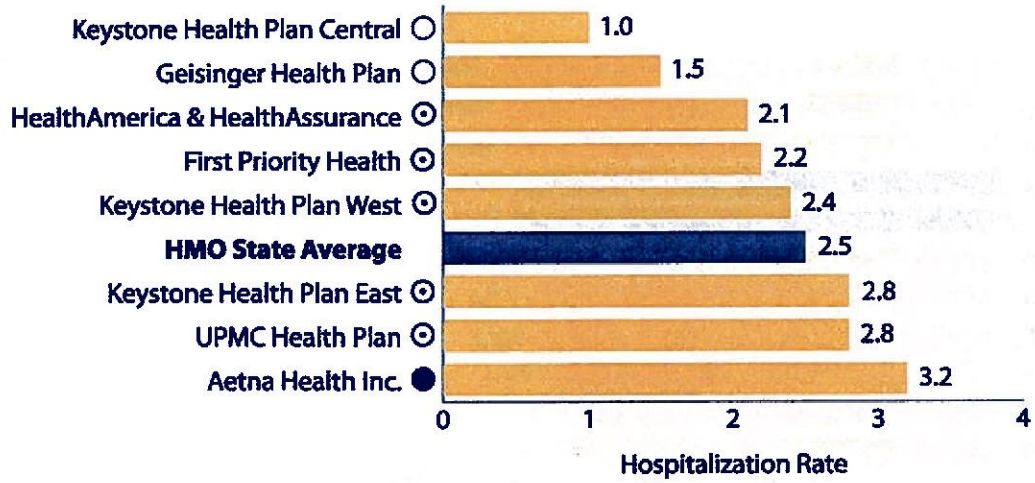
## Ear, Nose and Throat Infections

Includes medical conditions that cause an inflammation of the various parts of the head and throat. Outcomes are reported separately for pediatric and adult members.

### Pediatric (under Age 18)




### Adult (Age 18 to 64)




**Pages 15 through 17 include several clinical conditions for which effective primary care can prevent or manage an illness. When the HMO provider network is functioning properly, care for these conditions can generally be provided on an outpatient basis, thereby avoiding "unnecessary" or "preventable" hospitalizations.**

### Hospitalization Rate*, Statistical Rating

Generally, **lower scores** indicate that the HMO network was **more effective** in keeping members with these conditions out of the hospital.

The difference between the expected and actual hospitalization rates was statistically:

- ○ Lower than expected
- ⊙ Same as expected
- ● Higher than expected

* The number of hospital admissions per 10,000 members, adjusted for patient risk factors.

## Asthma

Asthma is a chronic inflammatory disease of the lungs' airways which makes breathing difficult. It is the most common chronic childhood disease. Studies have shown that when patients are taught how to control their disease by following established asthma management guidelines, hospitalizations, repeat hospitalizations and emergency room visits can be decreased and quality of life improved.

### Hospitalization Rate, Statistical Rating

Generally, **lower scores** indicate that the HMO network was **more effective** in keeping members with these conditions out of the hospital.

The difference between the expected and actual hospitalization rates was statistically:

- ○ Lower than expected
- ⊙ Same as expected
- ● Higher than expected

**Hospitalization for Asthma**

| | Pediatric (Under 18) | | | | Adult (Age 18 to 64) | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Hospital Admissions | Hospitalization Rate | Statistical Rating, Hospitalization Rate | Length of Stay | Hospital Admissions | Hospitalization Rate | Statistical Rating, Hospitalization Rate | Length of Stay | Statistical Rating, Percent Rehospitalized |
| Aetna Health Inc. | 342 | 24.1 | ● | 1.8 | 349 | 9.1 | ⊙ | 3.1 | ⊙ |
| First Priority Health | 35 | 12.9 | ○ | 2.1 | 71 | 8.9 | ⊙ | 3.5 | ⊙ |
| Geisinger Health Plan | 40 | 11.0 | ○ | 1.8 | 91 | 7.8 | ⊙ | 3.3 | ● |
| HealthAmerica & HealthAssurance | 84 | 10.0 | ○ | 1.9 | 192 | 7.7 | ○ | 3.3 | ⊙ |
| Keystone Health Plan Central | 36 | 11.3 | ○ | 1.9 | 40 | 4.5 | ○ | 3.0 | ⊙ |
| Keystone Health Plan East | 434 | 28.7 | ● | 1.9 | 493 | 10.9 | ● | 3.2 | ⊙ |
| Keystone Health Plan West | 75 | 9.9 | ○ | 1.9 | 225 | 9.1 | ⊙ | 3.4 | ⊙ |
| UPMC Health Plan | 33 | 9.4 | ○ | 1.8 | 117 | 10.8 | ⊙ | 3.3 | ⊙ |
| HMO State Total/Average[1] | 1,079 | 18.5 | | 1.9 | 1,578 | 9.1 | | 3.2 | |
| Fee-for-Service State Total/Average[2] | 28 | | | 2.2 | 120 | | | 3.5 | |
| PPO State Total/Average[2] | 649 | | | 1.9 | 1,118 | | | 3.5 | |
| [1] Includes HMO, POS and GPPO records for listed plans. [2] The Fee-for-Service and Preferred Provider Organization (PPO) data provide a comparison with traditional health insurance. Refer to the Technical Report for details. | Number of pediatric HMO members hospitalized in 2006 where asthma was the principal reason for hospitalization. | Hospitalization rate per 10,000 pediatric HMO members, adjusted for patient risk factors. | Symbols indicate whether the difference between the expected and actual rates was statistically significant. | Average number of days spent in the hospital, adjusted for patient risk factors. | Number of adult HMO members hospitalized in 2006 where asthma was the principal reason for hospitalization. | Hospitalization rate per 10,000 adult HMO members, adjusted for patient risk factors. | Symbols indicate whether the difference between the expected and actual rates was statistically significant. | Average number of days spent in the hospital, adjusted for patient risk factors. | Symbols indicate whether the difference between the expected and actual percent of members rehospitalized within 180 days was statistically significant. |

## Mastectomy

Mastectomy is the surgical removal of the whole breast and possibly some lymph nodes under the arm. Most mastectomy procedures are performed as a treatment of breast cancer and are inpatient (the law mandates that a patient has a right to choose an inpatient procedure). Mastectomies performed as a preventive measure (removal of the breast before cancer is diagnosed) are not included in this analysis.

**Percent of Complications, Statistical Rating**

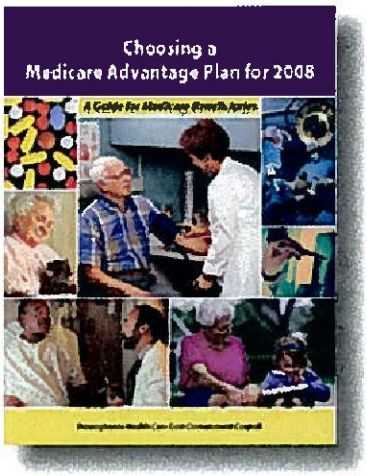
The difference between the expected and actual percent of complications was statistically:

- ○ Lower than expected
- ⊙ Same as expected
- ● Higher than expected

| | Inpatient Mastectomy | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | In-Hospital Complications | | |
| | Mastectomy Procedures | Procedure Rate | Percent Performed Inpatient | Length of Stay | Expected (Percent) | Actual (Percent) | Statistical Rating |
| Aetna Health Inc. | 167 | 8.6 | 91.0 | 2.2 | 6.6 | 6.0 | ⊙ |
| First Priority Health | 14 | 3.4 | 85.7 | 2.5 | 5.4 | 9.1 | ⊙ |
| Geisinger Health Plan | 36 | 5.9 | 80.6 | 2.1 | 5.8 | 6.9 | ⊙ |
| HealthAmerica & HealthAssurance | 76 | 6.1 | 69.7 | 1.8 | 5.8 | 9.4 | ⊙ |
| Keystone Health Plan Central | 19 | 4.1 | 47.4 | NR | NR | NR | NR |
| Keystone Health Plan East | 158 | 6.6 | 97.5 | 2.1 | 6.7 | 5.3 | ⊙ |
| Keystone Health Plan West | 79 | 5.8 | 89.9 | 2.1 | 6.4 | 7.0 | ⊙ |
| UPMC Health Plan | 35 | 5.8 | 97.1 | 2.1 | 6.4 | 8.8 | ⊙ |
| HMO State Total/Average[1] | 584 | 6.5 | 88.0 | 2.1 | 6.4 | 6.7 | |
| Fee-for-Service State Total/Average[2] | 72 | | | 2.1 | 6.2 | 4.2 | |
| PPO State Total/Average[2] | 474 | | | 2.1 | 6.5 | 8.6 | |
| [1] Includes HMO, POS and GPPO records for listed plans.<br>[2] The Fee-for-Service and Preferred Provider Organization (PPO) data provide a comparison with traditional health insurance. Refer to the Technical Report for details. | Number of mastectomy procedures performed in 2006. | Procedure rate per 10,000 female members, adjusted for patient risk factors. | Percent of mastectomies performed in an inpatient setting. | Average number of days spent in the hospital, adjusted for patient risk factors. | Expected percent of complications is calculated taking into account patient risk factors. | The actual number of complications divided by the total number of inpatient mastectomy procedures. | Symbols indicate whether the difference between the expected and actual percents was statistically significant. |

NR - Not reported due to small numbers.

# Choosing a Medicare Advantage Plan




***PHC4 retooled this publication several years ago, and the revisions turned the already popular guide into the most consumer-requested report in PHC4 history.***

## About the report

This report, which is updated annually, helps older Pennsylvanians choose a Medicare Advantage Plan. Medicare Advantage Plans (also called Part C) are managed care plans offered by private insurance companies that manage the health care of their enrolled members. The easy-to-understand guide lists managed care plans by county, provides comparisons on monthly premiums and co-payments, gives an overview of the benefits offered, and presents information about several quality measurements, as well as the results of patient satisfaction surveys. Updated information about the Medicare "Part D" Prescription Drug Program is also included in the report. This report is typically released in November or early December.

## What sets it apart?

In addition to an overview of the "Part D" drug benefit, the report features county-specific information about the Medicare Advantage Plans that offer this prescription drug coverage. Consumers can request county-specific inserts so they can make meaningful comparisons among the multitude of plan options available. To ensure that this report is as user-friendly as possible, PHC4 gets input from Pennsylvania AARP officials on its content.

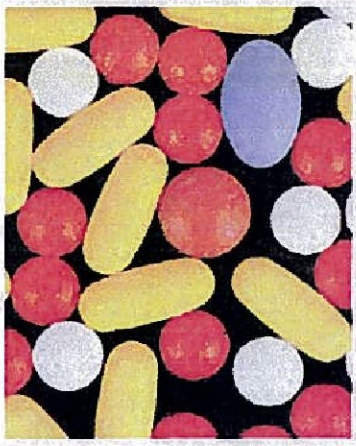
## Impact of the report

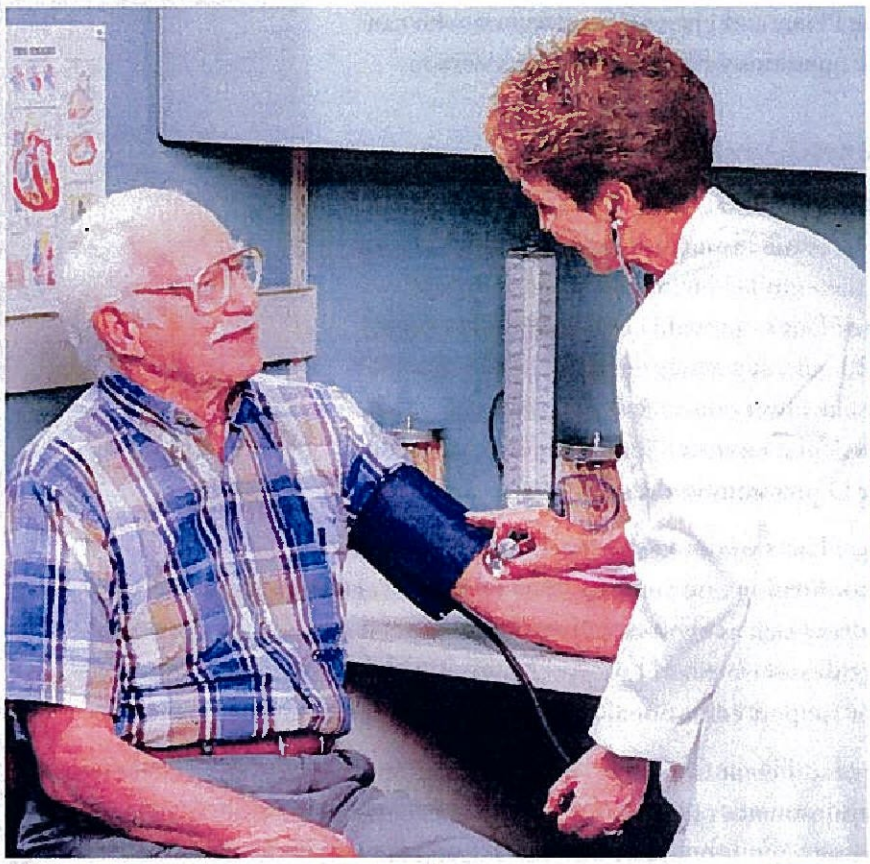
PHC4 retooled this publication several years ago, and the revisions turned the already popular guide into the most consumer-requested report in PHC4 history.

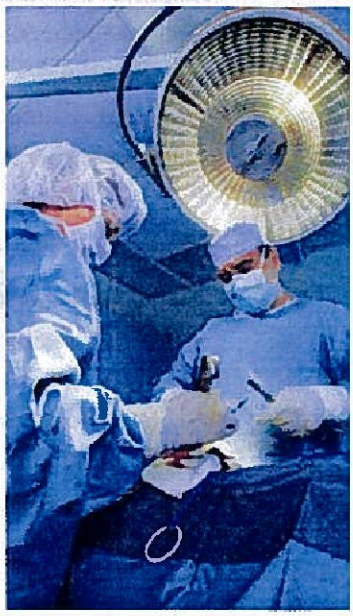
REPORT SAMPLE PAGE

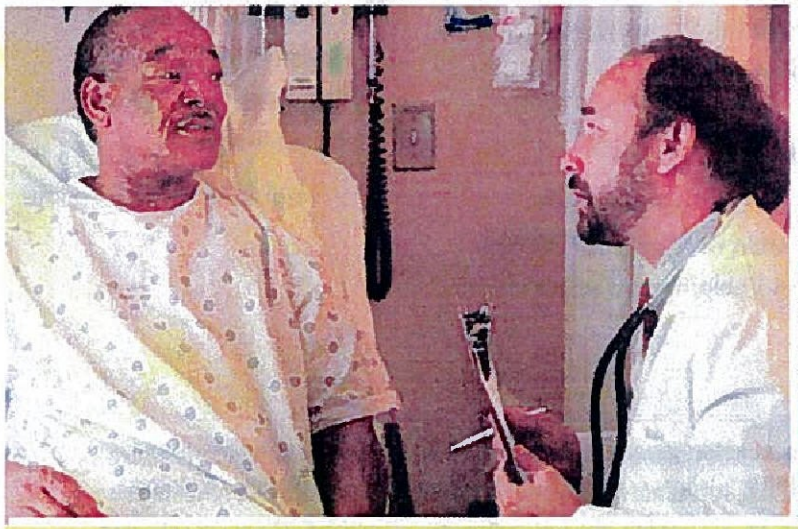
# Choosing a Medicare Advantage Plan for 2008

## A Guide for Medicare Beneficiaries









Pennsylvania Health Care Cost Containment Council

REPORT SAMPLE PAGE

# Choosing a Medicare Advantage Plan*

## What is the purpose of this booklet?

If you are thinking about joining a Medicare Advantage Plan, this booklet is for you. This guide provides information about Medicare Advantage Plans and how their coverage differs from Original Medicare, discusses the "Part D" prescription drug benefit, compares the costs and benefits offered by different Medicare Advantage Plans, and gives information on who can answer your specific questions while making your decision.

## What is a Medicare Advantage Plan?

Medicare Advantage Plans (also called Part C) are managed care plans offered by private insurance companies that manage the health care of their enrolled members. Medicare pays Medicare Advantage Plans to provide basic Medicare benefits (Parts A and Part B), and any savings must be used to provide additional benefits, like lower out-of-pocket spending, vision care, and preventive dental services. Some Medicare Advantage Plans also offer Part D prescription drug coverage.

Medicare Advantage Plans work to keep the cost of health care under control by coordinating care among different doctors, encouraging members to seek preventive services (such as cholesterol tests and flu shots) and helping members to manage ongoing diseases (such as heart problems or diabetes). Medicare Advantage Plans also provide or support educational programs and guidelines for treatment.

Medicare Advantage is different from Medigap. Medigap (or Medicare Supplemental Insurance) is a health insurance policy sold by private insurers to fill in the "gaps" with Original Medicare. You should not buy a Medigap plan if you are in a Medicare Advantage Plan. For more information about Medigap, call the Pennsylvania Insurance Department Consumer Hotline at 1-877-881-6388.

## What if I still have questions about Medicare Advantage?

If you have questions after reading this guide, contact APPRISE, a free health insurance counseling service of the Pennsylvania Department of Aging. APPRISE provides assistance in understanding Medicare benefits and helping you select the best plan for your situation. Call 1-800-783-7067.

## In this Guide:



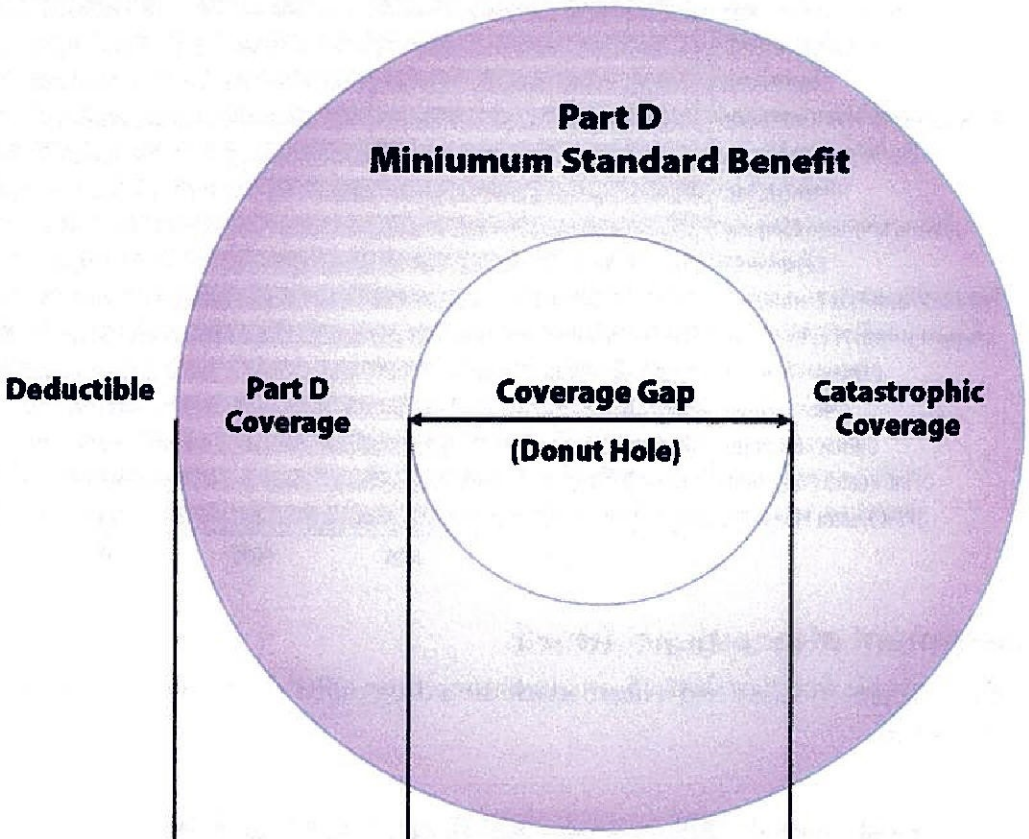
**In Pennsylvania, 664,518 persons were enrolled in Medicare Advantage Plans in 2007. Medicare Advantage enrollees represented 30% of the state's Medicare population, a significantly higher percentage than the 19% in the nation.**

*The Henry J. Kaiser Family Foundation*

*There are five different kinds of Medicare Advantage Plans. This guide includes information on **Medicare Advantage Health Maintenance Organizations (HMOs)** and **Preferred Provider Organizations (PPOs)**. It does not include information about other Medicare Advantage options such as Private Fee-for-Service Plans, Medicare Special Needs Plans, or Medical Savings Account Plans. It also does not include Medigap/ Medicare Supplemental Insurance, or Medicare-approved "stand-alone" drug plans that only offer the prescription drug benefit.

# Medicare Prescription Drug Coverage

**This chart identifies benefits and out-of-pocket costs for the *minimum standard benefit* in 2008. Many Medicare drug plans offer better benefits than the minimum standard benefit. Therefore, out-of-pocket costs will vary by Medicare drug plan.**




**Deductible**
If your plan has a deductible, you pay 100% of costs up to $275.

Some plans have no deductible.

**Part D Coverage**
The plan pays 75% and you pay 25% (coinsurance).

When your total drug costs reach $2,510, you enter the coverage gap.

**Coverage Gap**
Once your total drug costs reach the coverage limit ($2,510), you are responsible for 100% of your drug costs, plus your premium.

Your out-of-pocket costs in the coverage gap will not be more than $3,216.25.

Some plans offer gap coverage.

**Catastrophic Coverage**
Once your total drug costs reach $5,726.25 and you have paid no more than $4,050 out-of-pocket*, your plan pays 95% and you pay a small coinsurance (like 5%) or a small copayment ($2.25 for generic and $5.60 for brand name drugs) for the rest of the calendar year.

* Your True Out-of-Pocket costs include your deductible, copayments, coinsurance and expenses during the coverage gap.

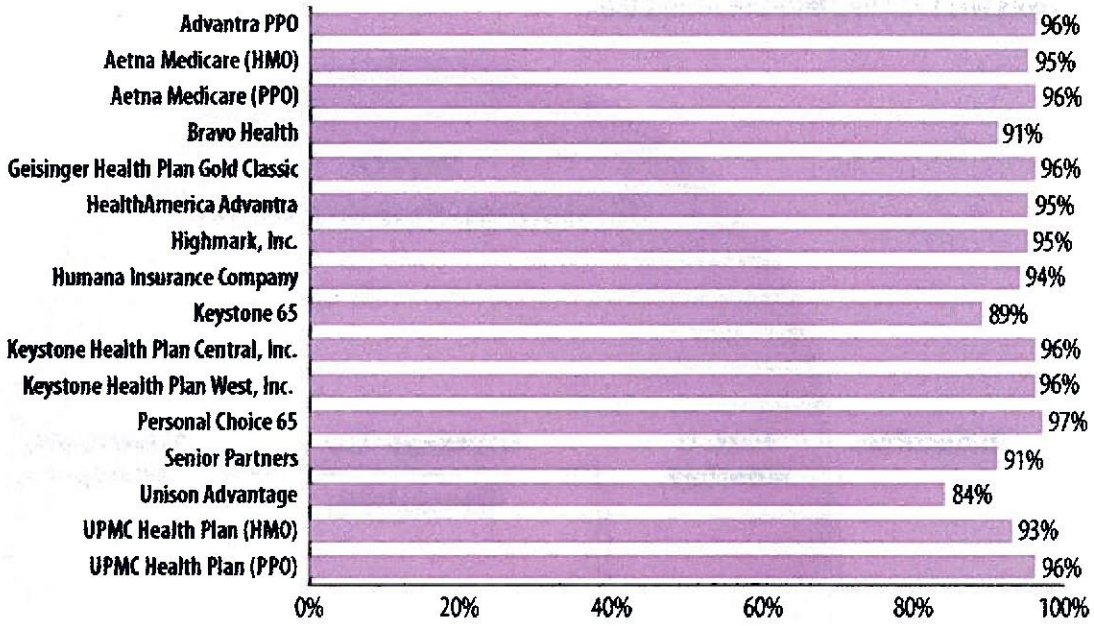
Note: Persons with limited incomes and assets may qualify for "extra help," a program that helps pay for prescription drug costs, including your monthly premium, yearly deductible, coinsurance and copayments. With extra help, there will be no coverage gap.

# Comparing Quality

## Access to Primary Care Doctor Visits

It is important to see your doctor on a regular basis so that health problems can be detected early.

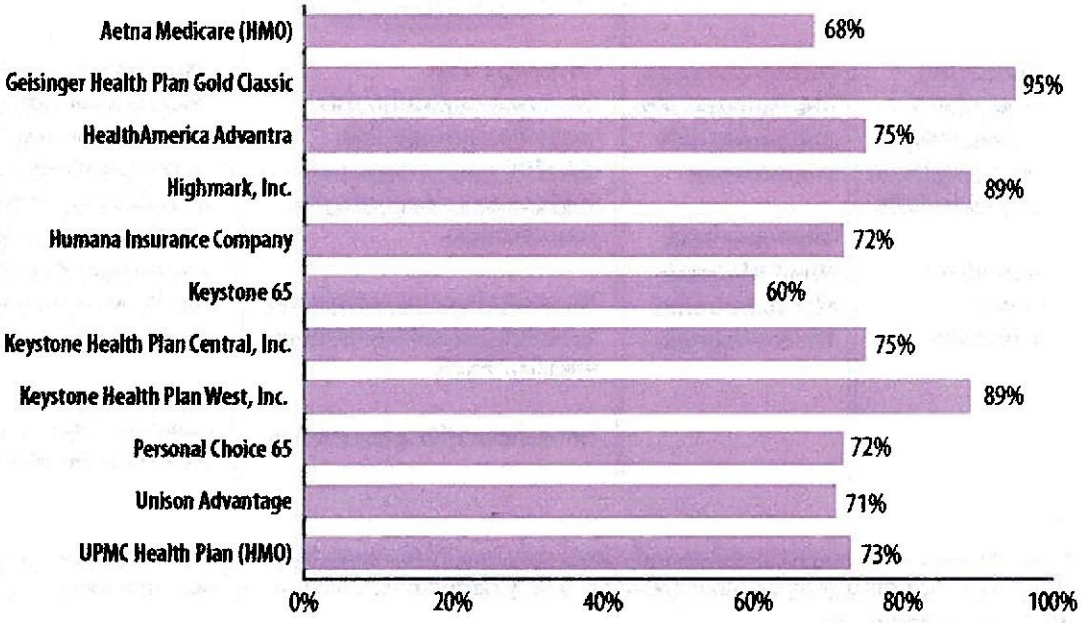
**Plan members who saw their primary care doctor during the year.**



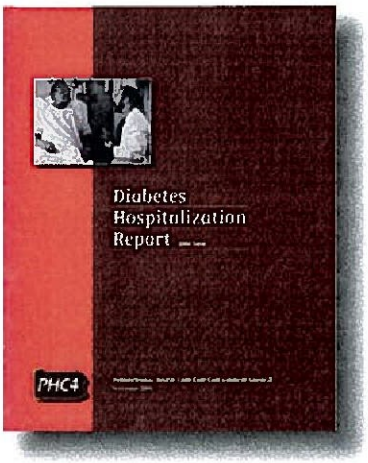

## Beta Blocker Treatment after a Heart Attack

Research shows that when people who have had a heart attack use a drug called a "beta blocker," future heart attacks may be prevented.

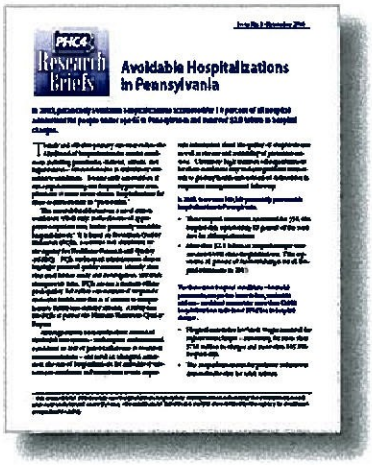
**Plan members who were hospitalized for a heart attack and were treated with a beta blocker for a full six months after they left the hospital.**



# Chronic Care Reporting




***In 2003, potentially avoidable hospitalizations accounted for 10 percent of all hospital admissions for people under age 65 in Pennsylvania and incurred $2.8 billion in hospital charges.***




## *About the reports*

PHC4 has produced a number of reports on the profound impact of chronic diseases in Pennsylvania. Two of the most notable publications are its report on hospitalizations for diabetes and its research brief on avoidable hospitalizations. The diabetes report, which is usually released in conjunction with National Diabetes Awareness Month, highlights the hospital admission rates for this disease, compares rates by county, and details various complications. The research brief focuses on a set of 16 conditions which may, in the absence of appropriate outpatient care, lead to potentially avoidable hospitalizations. Plans are underway for a late fall report on diabetes and other chronic care conditions.

## *What sets them apart?*

PHC4's reports on chronic conditions highlight areas where the Commonwealth can potentially focus increased prevention efforts. The diabetes report, for example, can help officials target certain areas of the state where diabetes hospitalization rates may be high and which complications from the disease need added attention. The research brief on avoidable hospitalizations found that, in 2003, there were more than 109,000 potentially avoidable hospitalizations for conditions like pneumonia, diabetes, asthma, and hypertension, which accounted for $2.8 billion in hospital charges and 550,000 hospital days. These results show that advances in education, detection and disease management efforts are essential.

## *Impact of the reports*

Chronic diseases have an enormous financial impact on the state's economy. PHC4's reports provide valuable information on the burden of these illnesses and insights as to where the Commonwealth needs to focus additional prevention efforts. It is important to note that PHC4 also examines the topic of diabetes in its commercial HMO and hospital performance reports.

# Collaboration with Commonwealth Agencies

PHC4 works with other agencies to provide data and customized reports for a variety of projects and studies. These agencies use PHC4 data to develop public policy and to advance state-administered, health-related programs. Below are just several examples of how state sister agencies are using PHC4 data and/or collaborating with our agency:

## *Pennsylvania Department of Public Welfare:*

- To provide data that assists PA DPW in computing reimbursement payments to qualified hospitals under the Tobacco Settlement Act of 2001.
- A study of older Pennsylvanians hospitalized for mental diseases, alcohol or drug related disorders, or induced organic mental disorders.
- Establishment of a hospital quality outcomes program for the Medical Assistance Fee-for-Service program.
- A study on hospital-acquired infections among the Medical Assistance population.

## *Pennsylvania Department of Health*

- A long-standing cardiac catheterization and open heart surgery study, which provides information on patient characteristics, volume, and risk-adjusted mortality.
- A Crash Outcome Data Evaluation Study (CODES), evaluation of trauma triage protocols, pediatric treatment protocols, and the Trauma Systems Plan.
- Development of a Birth Defects Registry.
- An Injury Prevention Program to improve the ability of health officials and practitioners for planning and evaluation of programs and policies.
- A DOH Web site containing state and local data (including trend data) corresponding to the Healthy People 2010 objectives, as developed by the Centers for Disease Control and Prevention (CDC).
- Hospital audits conducted by the Department's Licensing and Quality Assurance surveyors.
- A study of discharge patterns to be used in quality assurance and licensing by the Division of Acute and Ambulatory Care.
- An epidemiological study of asthma in Pennsylvania.

(Continued on back)

# Collaboration with Commonwealth Agencies

### *Governor's Office of Health Care Reform*

- Governor Rendell's Prescription for Pennsylvania (quality information on avoidable hospitalizations and hospital-acquired infections).
- Analysis on the impact of chronic diseases delivered by the Chronic Care Management, Reimbursement and Cost Reduction Commission.

### *Pennsylvania Office of the Auditor General*

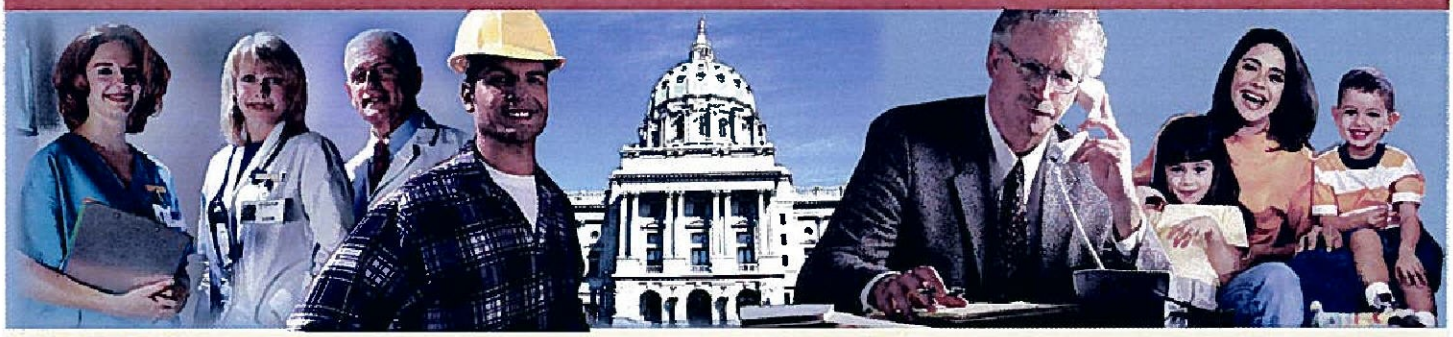
- An audit of hospitals that received Tobacco Settlement reimbursement monies for uncompensated care.

### *Pennsylvania Office of the Attorney General*

- A study on health fraud.
- An analysis of hospital mergers to enforce antitrust laws.

# PHC4: The National Leader in Health Care Reporting & Transparency

THE PENNSYLVANIA HEALTH CARE COST CONTAINMENT COUNCIL



HEALTH CARE PROVIDERS • LABOR • STATE GOVERNMENT • BUSINESS • INSURERS • CONSUMERS

*Working together to improve health care quality and restrain costs*

**Pennsylvania Health Care Cost Containment Council**
225 Market Street, Suite 400, Harrisburg, PA 17101
Phone: (717) 232-6787 • Fax: (717) 232-3821
www.phc4.org

# About PHC4

The Pennsylvania Health Care Cost Containment Council (PHC4) is an independent state agency established in 1986 in order to address rapidly growing health care costs. PHC4 was formed under Pennsylvania law (Act 89 of 1986) as a result of years of efforts by a coalition of business and organized labor leaders working together to pass market-oriented reforms. PHC4 is charged with collecting, analyzing and reporting information that can be used to improve the quality and restrain the cost of health care in Pennsylvania. PHC4 has twice been reauthorized, most recently under Act 14 of 2003.

**"By collecting valuable data on health care costs and quality, PHC4 has increased public scrutiny of the health care system. Their work is indispensable."**
Bill George, President, AFL-CIO

PHC4 is governed by a 25-member Council, which consists of individuals who represent labor and business health care group purchasers, providers, insurers, and consumers, as well as three members of the Governor's Cabinet. PHC4 is funded through the Pennsylvania state budget. In addition, the agency receives revenue through the sale of its data to health care stakeholders around the state, the nation, and the world.

PHC4's strategy to contain costs is to stimulate competition in the health care market by:

- giving comparative information about the most efficient and effective health care providers to individual consumers and group purchasers of health services; and
- giving information to health care providers that they can use to identify opportunities to contain costs and improve the quality of care they deliver.

Act 89, as amended by Act 14, specifically assigns PHC4 three primary responsibilities:

- to collect, analyze and make available to the public data about the cost and quality of health care in Pennsylvania;
- to study, upon request, the issue of access to care for those Pennsylvanians who are uninsured;
- to review and make recommendations about proposed or existing mandated health insurance benefits upon request of the legislative or executive branches of the Commonwealth.

## Council Composition

As outlined in Act 14 of 2003

**Purchasers**
- 6 business
- 6 labor
- 1 consumer

**Insurers**
- 1 commercial
- 1 Blue Cross/Blue Shield
- 1 HMO

**Providers**
- 2 hospitals
- 2 physicians
- 1 nurse
- 1 health care quality improvement expert

**State Government**
- Secretary of Health
- Secretary of Public Welfare
- Insurance Commissioner

**"There is no better way to get patients and purchasers to change their health care buying habits than to give them precise information about costs and results. PHC4 does just that."**
Floyd Warner, President, Pennsylvania Chamber of Business and Industry

## Why PHC4 is the national leader in public health care reporting

PHC4 is the national leader in public health care reporting and transparency. Since its inception, PHC4 has released internationally renowned, groundbreaking reports on hospital performance, hospital-acquired infections, physician-specific cardiac surgery results, the quality of services provided by Pennsylvania's HMOs and other topics. Hundreds of thousands of these free reports have been disseminated.

Pennsylvania has the largest and most complex health care database of any state. PHC4 collects approximately 4 million inpatient hospital discharge and outpatient records each year from hospitals and ambulatory surgery centers in Pennsylvania. This data – which includes hospital charge and treatment information as well as other financial data – is collected and verified on a quarterly basis. PHC4 also collects data from health insurance plans. This data forms the basis for PHC4's public reporting, and for the many special data requests ordered each year by hospitals, insurers, consultants, health care purchasers, researchers and consumers.

Pennsylvania stands out among other states that have mandates to collect health care data for several reasons: 1) PHC4 data are public; 2) PHC4 data are used to drive competition among providers to enhance quality and restrain costs; and 3) PHC4 data are risk-adjusted. This means that the clinical data used to calculate mortality, readmission, complications and length of stay are derived from patients' medical records and adjusted to account for differences in patient illness levels and other important risk factors. In essence, these methods give extra credit to hospitals and physicians that treat higher proportions of higher risk or sicker patients. This allows for fair public comparisons.

## Examples of PHC4 Reports

- *Hospital Performance Report*
- *Cardiac Surgery in Pennsylvania*
- *Financial Analysis* of PA hospitals and ambulatory surgery centers
- *Hospital-acquired Infections in Pennsylvania*
- *Measuring the Quality of Commercial HMOs*
- *Choosing a Medicare Advantage Plan*
- *Critical Condition: The State of Health Care in Pennsylvania*
- Research briefs on various health care topics
- Reports on diabetes, C-sections and other conditions and procedures


**"Officials here [in Illinois] can look to the Pennsylvania report for a primer on how to do it right."**
Chicago Tribune, "A Report Card for Health Care" (7-11-2007)

# Ten Reasons PHC4 Makes a Difference

### *The quality of health care for Pennsylvanians has improved!*

☑ **In-hospital Mortality Rates** – Mortality rates are key indicators of health care quality. Since PHC4 began publicly reporting patient mortality rates for Pennsylvania hospitals in its annual *Hospital Performance Report* in the early 1990s, in-hospital mortality rates for all conditions dropped from significantly above to significantly below the national average. The resulting improvement in in-hospital mortality rates represents the equivalent of over 28,000 lives saved!

☑ **Coronary Artery Bypass Graft (CABG) Surgery Mortality Rates** – Also mirroring PHC4's years of public reporting is the decline in in-hospital mortality for coronary artery bypass graft (CABG) surgery. In Pennsylvania, mortality rates for CABG have dropped 51.7% in the past 15 years.

### *Hospital-acquired infections have come to the forefront in patient safety.*

☑ **The First State to Publicly Report Hospital-acquired Infections** – In 2005, Pennsylvania – through PHC4 – became the first state to publicly report hospital-acquired infections. PHC4's groundbreaking work was the catalyst for the Governor and General Assembly to enact Act 52 of 2007 – the most comprehensive and progressive approach to preventing, tracking and reducing hospital-acquired infections in the nation.

### *Pricing transparency is becoming a reality.*

☑ **The First State to Link the Cost of Health Care Services to the Quality Outcomes** – In *Cardiac Surgery in Pennsylvania 2005*, PHC4 showed how much hospitals were actually paid by commercial insurers and Medicare for cardiac surgery. Reporting the average amounts that hospitals are actually paid, not just the amount hospitals charge, is a giant step forward in empowering both health care purchasers and consumers.

### *Mandated benefits reviews provide objective analysis.*

☑ **PHC4's Mandated Benefits Review Process is a Model** – From 1987 to 2007, legislative leaders have referred 27 proposed mandated benefits bills to PHC4 for cost-benefit analyses, a service PHC4 provides under its authorizing law. PHC4's objective reviews of proposed mandated health insurance benefits have saved countless health care dollars.

***PHC4 data is a valuable resource for health care purchasers, providers, insurers and others.***

- ☑ **Special Requests for Data and Customized Reports** – PHC4 produces customized reports and datasets called special requests for clients who wish to conduct their own analysis beyond the information that PHC4 makes available to the public through its reports. In particular, PHC4 data is being used more extensively in national research projects. Since 1994, PHC4 has filled more than 1,000 special requests for data for academic researchers, hospitals, physicians, health benefits consulting firms, insurers, purchasers of benefits, state agencies, the Governor's office, and members of the Pennsylvania General Assembly.

- ☑ **Businesses and Labor Unions Use PHC4 Data** – Health care purchasers, such as businesses and labor unions, use PHC4 data to help negotiate agreements with insurers for benefit packages, identify quality providers and aid their members' health care decision making. They have used PHC4 data to study the effect of hospital errors on patient charges and other trends that affect health care costs, as well as to identify local health issues that impact employee wellness.

- ☑ **Hospitals, Physicians and Other Health Care Providers Use PHC4 Data** – The Council's reports are utilized extensively by the medical community in areas ranging from internal benchmarking and process improvement to specialized clinical research. Pennsylvania hospitals use PHC4 quarterly patient safety data in their patient safety analyses, and use PHC4's MediQual Atlas data in their internal quality improvement processes and physician credentialing. Hospitals and ambulatory surgery centers use PHC4 market share data in their trending and marketing activities.

- ☑ **Insurers Use PHC4 Data** – A number of insurers use PHC4 data in their pay-for-performance initiatives. Additionally, PHC4 provides insurers who submit payment data to the Council with a quarterly report that shows how much hospital-acquired infections and hospital misadventures are costing their organization. Insurers use this information to see how they compare against statewide averages and if they are paying for quality performance. As more health plans feature health savings accounts, it is crucial that the kind of information PHC4 provides becomes more widely available.

- ☑ **Consumers Use PHC4 Data** – PHC4's public reports are valuable tools that assist consumers in their health care decision making. In fiscal year 2006/2007, visitors downloaded more than 440,850 reports from the PHC4 Web site.

# A Timeline of Accomplishments

## 1986

- Created under Pennsylvania statute (Act 89).
- Council's first members appointed and first meeting held.

## 1987

- Launched Indigent Care Study Committee.
- Received first mandated benefits review requests (to review mandatory insurance coverage for mental health disorders and mandatory outpatient chemotherapy treatment at the patient's request).
- Adopted a uniform claims and billing form format for data collection from the state's health care providers.
- Began promulgation of regulations to effect the collection and dissemination of health care cost and quality data.

## 1988

- Presented state's General Assembly with report on the medically indigent in Pennsylvania. The series of options presented helped pave the way for incremental solutions to the uninsured problem, such as the Children's Health Insurance Program.
- Regulations guiding the Council's data collection and reporting went into effect.
- Released first public reports: the first quarterly *Hospital Effectiveness Report* – the precursor to PHC4's annual *Hospital Performance Report* – and the first quarterly *Hospital Utilization and Financial Summary,* which looked at key utilization measures, such as discharges, patient days and gross patient revenues.

## 1989

- Expanded the *Hospital Effectiveness Report* – the first time in U.S. history that hospital-specific information about charges and patient outcomes became available to the public.

## 1990

- Released the first annual report on the financial performance of Pennsylvania hospitals.

## 1991

- Released the first full-year *Hospital Effectiveness Report.*
- Issued the first small-area analysis reports specific to defined health markets in the state; they highlighted potential access-to-care problems, health problems or overutilization of services in communities.

***"By gathering valuable data on health care cost and quality, the Council increased public scrutiny of the health system."***
U.S. News and World Report (11-18-91)

## 1992

- Began public reporting on heart bypass surgery outcomes, becoming the second state in the nation to report physician-specific performance data.
- A 1992 performance audit conducted by the Legislative Budget and Finance Committee revealed that the Council's mandated benefits reviews may have contributed to a $30 million savings in health insurance costs.

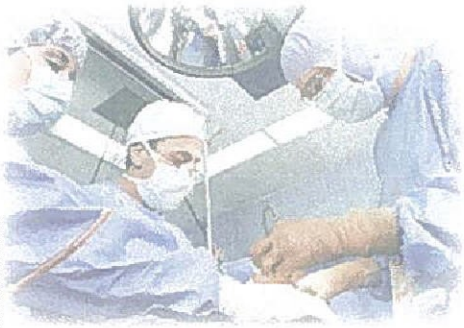
***"Due to the Council, Pennsylvanians can get far more information about their hospitals than can most Americans."***
The Wall Street Journal (1-22-92)

***"When it comes to choosing a heart surgeon, Pennsylvania is on the cutting edge in helping consumers pick the right one."***
Dan Rather, The CBS Evening News with Dan Rather (11-19-92)

## 1993

- Act 89 amended by Act 34; PHC4 reauthorized for an additional ten years.
- Council heart bypass surgery reports are the subject of documentaries produced by the British Broadcasting Corporation (BBC) and Japanese Public Television Corporation.

***"...the Health Care Cost Containment Council remains the definitive source on hospital quality and costs..."***
Lancaster Intelligencer Journal (7-27-93)



## 1994

- Released new report studying the utilization of experimental and non-experimental organ transplant procedures.

## 1995

- Issued *Hospital Utilization Patterns: Comparisons of Inpatient Service Utilization by Medicaid Recipients and Other Patients* – the first in a series of hospital utilization reports intended to provide information to better inform policymakers about the state's Medicaid program.
- Held the *National Symposium on Outcomes and Quality Assessment* which featured 21 workshops and was attended by over 300 health care leaders.
- Issued a joint report on C-section deliveries in the state with the Pennsylvania Department of Health.
- Began implementation of a system to collect, analyze and report outpatient data.
- Launched its Web site (www.phc4.org).

## 1996

- Published *Focus on Heart Attack* – a report covering approximately 200 hospitals and 5,000 cardiologists, internists, general and family practitioners. It reported the only physician-specific data available anywhere in the United States aside from that on coronary bypass surgery, and it was the first public outcomes report to track patients through episodes of care, not just their initial hospitalization.
- By its ten-year anniversary, the Council had created 80 different health care reports for the general public, distributing tens of thousands of copies. It also produced more than 300 customized reports for data users from 1991 to 1996.

***"The Council's decision will fill a clear need for factual and objective information as the practice of medicine moves into new and uncharted waters."***
Harrisburg Patriot-News (6-30-96)

## 1998

- Released the first report on outpatient procedures in Pennsylvania.
- Included health-plan specific outcomes data in the CABG report – marking the first time that such data was reported in the nation.
- Issued the first report on diabetes hospitalizations in Pennsylvania.
- Completed a record number (12) of mandated benefits reviews in a year's time.

## 1999

- Began posting all public reports on the PHC4 Web site.
- Published *The Role of HMOs in Managing Diabetes* to increase public understanding of the disease management role of HMOs.
- Began collaborating with the Pittsburgh Regional Health Initiative to provide community leaders with data and analysis needed to improve the quality of care in Southwest Pennsylvania.

## 2000

- Issued a new commercial HMO report – the first report of its kind to combine clinical results, preventive measures and member satisfaction information to give purchasers, policymakers and consumers a more complete picture of how well HMOs serve their members.

## 2001

- In conjunction with the Pennsylvania Department of Aging, released a new publication to assist older Pennsylvanians in selecting a Medicare HMO.
- Started "purchaser" meetings to provide health care purchasers with the opportunity to learn more about PHC4's capabilities, discuss current health care topics and network with other purchasers.

- Began *PHC4 FYI* – a series of white papers geared toward the health care purchaser community.

## 2002

- Worked with the state's Tobacco Settlement Committee to implement Act 77, the Tobacco Settlement Act, which established the Hospital Uncompensated Care Program and the Hospital Extraordinary Expense Program.
- Created PHC4's Electronic Data Submission (EDS) system – a confidential, efficient and cost-effective method of data submission. This online system replaced hospitals' submitting bulky mainframe tapes and paper documentation.

## 2003

- Reauthorized until June 30, 2008 under Act 14.
- Required all general acute care hospitals in the state to collect and submit data on hospital-acquired infections – a decision that placed Pennsylvania in an elite group of only two states (Illinois being the other) to decide to collect this important information.
- Received the prestigious Ellwood Award presented by the nationally-recognized FACCT – Foundation for Accountability.

## 2004

- Hospitals began submitting hospital-acquired infection data to PHC4, making Pennsylvania the first state to *actually* collect such data.
- Introduced PHC4's Research Briefs, which are periodic web-based publications that examine health care topics relevant to public policy and public interest.

## 2005

- Released the nation's first physician-specific report on total hip and knee replacement surgeries. No other state has produced a physician-specific report on any treatment category other than cardiac care and heart bypass surgery.
- Released the nation's first statewide report on hospital-acquired infections, highlighting both the quality of care and financial consequences.

***"The Commonwealth has become the first in the nation to report the number of people stricken by infections they picked up at a hospital."***
Philadelphia Daily News (7-15-2005)

## 2006

- Began reporting actual third-party payment data (distinct from hospital charges) provided by commercial insurers to further quantify the financial toll of hospital-acquired infections.
- Released the nation's first hospital-specific report on hospital-acquired infections.

## 2007

- In its 2007 report, *Cardiac Surgery in Pennsylvania 2005*, PHC4 showed how much commercial insurers and Medicare actually *paid* hospitals for cardiac surgery – a significant step forward in pricing transparency.
- PHC4's groundbreaking work on publicly reporting hospital-acquired infections was the catalyst for the Governor and General Assembly to enact Act 52 of 2007 – the most comprehensive and progressive approach to preventing, tracking and reducing these infections in the nation.

## 2008

- Released the second hospital-specific report on hospital-acquired infections.