The Case for Public Reporting:

“Making the DATA real…”

Presentation before the Legislative Committee on Health Care,
Las Vegas, Nevada
Marc P. Volavka
Executive Director
Pennsylvania Health Care Cost Containment Council (PHC4)
Finger pointers can't settle on who's to blame for health costs

Whether it's insurers, drugmakers or consumers, the fact remains that costs are going to keep rising.
Hospital bills spin out of control

By Julie Appleby, USA TODAY

Hospital sticker shock is hitting the USA.

It isn't just $5-a-pill aspirin. Daily room charges exceed $5,000 in some New Jersey hospitals. An appendectomy in California, including about two days in the hospital, has an average list charge of $18,000. Nationally, federal data show the median charge for treating a heart attack is more than $20,000.

Rapidly rising hospital charges have placed hospitals in the spotlight. Critics say hospitals are unfairly using their growing clout in many markets and charging far more than it costs to provide services. Spending on hospital care is the fastest-growing segment of the nation's health care tab.

"It's a national crisis," says Sean Harrigan, head of the board that oversees the California Public Employees Retirement System (CalPers), which is considering dropping 45 of the states' most expensive hospitals from its network. Doing so could save $72 million annually.
Increases in Health Insurance Premiums Compared to Overall Inflation

<table>
<thead>
<tr>
<th>Year</th>
<th>Health Insurance Premiums</th>
<th>Overall Inflation</th>
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<tbody>
<tr>
<td>1999</td>
<td>2.3%</td>
<td>5.3%</td>
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<td>2000</td>
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</tr>
<tr>
<td>2001</td>
<td>10.9%</td>
<td>10.9%</td>
</tr>
<tr>
<td>2002</td>
<td>12.9%</td>
<td>12.9%</td>
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<tr>
<td>2003</td>
<td>13.9%</td>
<td>13.9%</td>
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</table>
FIRST: Understand Who’s who?
Who’s who?
Purchaser; Consumer; Provider?

Talk about a “clash of cultures”??

“Hospitals” buying physician practices and running managed care companies

“Physicians” owning free standing ambi-surg facilities and imagining centers

“Insurers” owning providers or offering 3rd party administrative services

Government: The single largest purchaser and payer of health care!
Purchaser; Consumer; Provider?

It’s no wonder the “consumer” is confused:

Who’s the “purchaser” and who’s the “payer”??
The Blues “Divorce”...Good for You???
The first in an occasional series of articles from an interested observer - PHC4

Recent articles in the New York Times (May 25) and The Journal of the American Medical Association (May 23-30) have suggested that managed care is dying. In the last decade, the health insurance marketplace has been in turmoil, with health systems consolidating, and price pressure escalating. Commercial insurers spin, and PHC4's recently issued Financial Analysis 2000 demonstrates that hospitals are now reprinting the driver's seat.

Events in Central Pennsylvania offer support to the view that the marketplace is changing. Central Pennsylvania's health care has been dominated by a partnership between Capitol Blue Cross (CBC) and Highmark Pennsylvania Blue Shield (PBS), but recently these entities have announced they will be ending their partnership. Each company apparently plans to offer its own package of health insurance products.

The proposed “divorce” between CBC and PBS is likely to result in major health insurance changes. Purchasers in central Pennsylvania will have to make new decisions regarding health care coverage. PHC4 would like to assist you in these actions. This paper, written primarily for health care purchasers, outlines what is known to date about this proposed divorce. We also invite you to share your questions and concerns.

CBC is one of four regional Blue Cross entities in the Commonwealth. It has customers across Central PA, in the Susquehanna Valley and the Lehigh Valley. This market provides CBC with about 1.45 million customers in Central PA.

Highmark was created in 1990 by consolidating Blue Cross of Western Pennsylvania and PBS. The resulting company is among the ten largest health insurers in the United States, with a substantial market share, including about two-thirds of all Pennsylvania residents in some form of its insurance products.

CBC is a non-profit company (no shareholders, owners or investors) that typically contracts with hospitals, while PBS is a profit that historically contracts with doctors and other medical service providers. CBC has contracts with 25 hospitals and dozens of smaller medical facilities. PBS has contracts with 28,000 physicians in the state.

Last year CBC had revenues of $3.5 billion and reserves of $587 million. Highmark had revenues of $3 billion and reserves of $2.2 billion. Reserves are assets that insurance companies must maintain to ensure they have sufficient funds to pay all claims.

Historically, the Blue Cross and Blue Shield Plans in Pennsylvania have offered health care benefits worth 30 cents of every dollar they receive in premiums. About 10 cents of your premium dollar is used to cover administrative expenses such as salaries, claims.

You’re a PURCHASER!
And that is why PHC4 was created...
PHC4 Mission

The collection, analysis and dissemination of data and information that identifies differences in the quality and cost of health care services and that allows purchasers to make informed decisions regarding their health care purchasing options.
What is PHC4?

- An independent state agency, established in 1986, by Act 89; amended and reauthorized in 1993 and 2003 (Act 14)

- 25 member Council; members nominated by the various stakeholders and appointed by the Governor, Speaker and President Pro Tem
Council Members

- **Purchasers**
  - 6 Business
  - 6 Labor
  - 1 Consumer

- **Providers**
  - 2 Hospital
  - 2 Physician
  - 1 Nurse
  - 1 Health Care Quality Improvement Expert

- **Insurers**
  - 1 Commercial
  - 1 Non-Profit (Blues)
  - 1 HMO

- **State Government**
  - Secretary of Health
  - Secretary of Welfare
  - Insurance Commissioner
Staffing and Operations:

- Annual operating budget of just over $5 million:
  - $4.2 million in general fund appropriations
  - $600,000 from sales of data
  - Carryover from non-lapsing line item
Staffing and Operations

- Staff compliment of 60 full time
- Including nurses; medical record coders; Ph.D and Masters level health policy researchers; epidemiologist and Md. consultants
Organizational Structure

4 Departments:
- Administration and Finance
- Data Collection and Information Tech
- Health Policy and Research
- Communications and Special Requests
Revenue from Data Sales

We have increased the sales of our data and our special request custom analysis and reports each year (we will go over $650,000 this fy)

We currently have over 150 clients:
- Commercial
- Non-Commercial
- Research
- State Government
What makes PHC4 different?

- All the stakeholders are at the table, but PURCHASERS dominate
- The unique alliance of the business and labor community
- The requirement to report publicly
- The focus on hospital, physician and HMO "outcomes"...not just process measures or aggregate analysis
What makes PHC4 different?

- The importance of collaboration with ALL the stakeholders is balanced by the desire of the purchaser community to have actionable, value based, data.
Severity Adjusted Outcome Data

Takes into account differences in patient risk factors and illness levels

Those hospitals treating a higher % of very sick patients and/or complex cases are not penalized for doing so.
PHC4 Data Sources:

- 186 Acute Care Hospitals representing about 1.8 million inpatient admissions
- 153 Surgery Centers representing about 1.7 million visits
- Third party insurers, including Medicare and Medicaid
Pennsylvania’s GAC Hospitals
Fiscal Year 2003

- Total charges for all PA hospitals: $72,599,386,428
- Total Payments (net patient revenue) for all PA hospitals: $22,099,360,825
To put this in perspective:

Nevada (FY03 estimate):

$8.622 Billion in charges

$2.588 Billion in PAYMENTS (NPR)

(even for Las Vegas, that’s REAL money!)
Is there already data in place?

What data do you already collect?
Nevada

- Hospitals required to submit UB Hospital Inpatient Data pursuant to NRS 449.485, NAC 449.951-449.969
- Responsible entity is the Nevada Department of Human Resources’ Division of Health Care Financing and Policy (DHCFP)
- DHCFP contracts with the Center for Health Information Analysis (CHIA) at the University of Nevada, Las Vegas to handle collection and analysis of data
Information available for purchase

- Hospital UB Discharge Data Sets (partial and complete field formats)
- Standard reports (e.g., Hospital Census and Charge Comparison, Payer Census and Charge Comparison by Hospital, DRG Analysis by Hospital)
- Custom reports
## 2002

<table>
<thead>
<tr>
<th></th>
<th>Nevada</th>
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<tr>
<td>Source</td>
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<td>PHC4</td>
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<tr>
<td>Number of Hospitals</td>
<td>26</td>
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<tr>
<td>Total Charges</td>
<td>$7.1 billion</td>
<td>$59.5 billion</td>
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<td>Days</td>
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<td>Outpatient Visits</td>
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PHC4 Public Reports

- Hospital Performance Report
- Coronary Artery Bypass Surgery
- Hospital Financial Report
- The Role of HMOs in Managing Diabetes
- Measuring the Quality of Pennsylvania’s HMOs
- Mandated Benefit Reviews
Hospital Performance Report
22 Common Medical Procedures and Treatments

Report Period: January 1, 2008 through December 31, 2008

PHC4
Pennsylvania Health Care Cost Containment Council
December 2008
### Congestive Heart Failure (CHF)

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*Note: The data includes admission and readmission rates for various hospitals. See page 4 for more details.*

Information about hospitals and cardiothoracic surgeons

Pennsylvania Health Care Cost Containment Council
May 2002
# Surgeon Data

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<th>Surgeon/Hospital</th>
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<td>Proneal Health</td>
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</tbody>
</table>

* Most cases at other hospitals not shown for privacy reasons. This information can be found at www.phc4.org.

** Lengths of stay are the average number of days spent in the hospital following the CABG surgery per surgeon by hospital and procedure.

- ○: Below expected
- □: Close to expected
- ●: Higher than expected
Pennsylvania Health Care Cost Containment Council (PHC4)

HMO Report

- May 2002 PHC4 released its third HMO report.
- Combines clinical outcomes, prevention measures and member satisfaction information.
What’s unique about this report?

This is the only report of its kind to combine clinical results, preventive measures and member satisfaction information.
## Treatment Measures

### HYSTERECTOMY - Abdominal

<table>
<thead>
<tr>
<th>HMO</th>
<th>TOTAL Hospital Admissions</th>
<th>ABDOMINAL Hospitalization Rate per 10,000 women</th>
<th>Statistical Rating</th>
<th>Length of Stay (Days) Risk-Adjusted</th>
<th>Complication Rate Actual (%)</th>
<th>Complication Rate Expected (%)</th>
<th>Statistical Rating</th>
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<td>17.7</td>
<td>12.4</td>
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**HMO Total/Average** 6,091 4,156 29.1 2.9 13.6 12.6

**Fee-For-Service Sample** 5,220 3,414 NA 3.0 12.1 11.9

**State Total/Average** 18,888 12,831 34.8 3.0 13.6 12.5

○ Less than Expected
● Same as Expected
● Greater than Expected
NR Not Rated
NA Not Available

Source: PHC4
Act 77 – Tobacco Distribution

PHC4 data is an integral part
Pennsylvania’s GAC Hospitals
Fiscal Year 2003

- Total charges for all PA hospitals: $72,599,386,428
- Total Payments (net patient revenue) for all PA hospitals: $22,099,360,825
## Inpatient Revenue Index and Case Mix Index by Payor, FY03

<table>
<thead>
<tr>
<th>Payor</th>
<th>Average Inpatient Revenue per Discharge</th>
<th>Inpatient payment</th>
<th>Cost of care</th>
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<td>0.91</td>
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Pennsylvania Health Care Cost Containment Council (PHC4)
TOTAL HIP AND KNEE REPLACEMENT SURGERY
IN SOUTHWEST PENNSYLVANIA

Prepared by:
The Pennsylvania Health Care Cost Containment Council.
Under contract with:
The Jewish Healthcare Foundation.
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December 1999

Pennsylvania Health Care Cost Containment Council (PHC4)
Maternity Length of Stay Legislation
October 1999

Minimum Maternity Stay Legislation:
Changes in Hospital Length-of-Stay for Childbirth

OCTOBER 1999
REPORTING NUMBER: 99-10005-03

THE PENNSYLVANIA HEALTH CARE COST CONTAINMENT COUNCIL
Breast Cancer and Mastectomy – Facts and Figures
Special Legislative Reports – October 2002

Hospital Admissions for Older Residents of Adams County

Health care is an important issue for many people, but particularly so for those who are older. While poor health is not necessarily an inevitable part of aging, the likelihood of developing chronic conditions such as cardiovascular disease, diabetes, arthritis, and stroke increases as people get older. Further, as the number of older Pennsylvanians grows, so too will the demand placed on the health care delivery system.

18.5% of older residents in Adams County were hospitalized in 2001. The main reason for these admissions related to the circulatory system.

To better understand the challenges facing both older Pennsylvanians and the health care delivery system, the Pennsylvania Health Care Cost Containment Council (PHC4) has conducted the following analysis of older residents (age 65 and over) who were admitted to a Pennsylvania hospital during 2001.

How many older residents were hospitalized last year?

In 2001, 18.5% of Adams County residents age 65 and over were hospitalized in Pennsylvania, resulting in 3,671 hospital admissions. These admissions resulted in 20,231 hospital days and $18.5 million in hospital charges. Compared to the statewide figures, Adams County residents generally had a lower rate of hospitalization, spent less time in the hospital, and incurred lower average charges.

<table>
<thead>
<tr>
<th></th>
<th>Adams County</th>
<th>Pennsylvania</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of older residents hospitalized</td>
<td>2,340</td>
<td>496,115</td>
</tr>
<tr>
<td>Percent of older residents hospitalized</td>
<td>18.5%</td>
<td>22.8%</td>
</tr>
<tr>
<td>Number of hospital admissions</td>
<td>3,671*</td>
<td>726,866*</td>
</tr>
<tr>
<td>Average hospital charges</td>
<td>$11,773</td>
<td>$11,205</td>
</tr>
<tr>
<td>Total hospital charges</td>
<td>$18.5 million</td>
<td>$18.5 million</td>
</tr>
<tr>
<td>Average length of stay</td>
<td>5.5 days</td>
<td>5.7 days</td>
</tr>
<tr>
<td>Total number of days</td>
<td>20,523</td>
<td>4,290,234</td>
</tr>
</tbody>
</table>

* Some residents were hospitalized more than once

This report is the first in a series to provide information to members of the General Assembly. PHC4 hopes this report will give you additional information about the health issues confronting your constituents.
Does Quality Matter??

Just a few examples of the relationship between cost and quality:
Purchasers say, “We’re not paying based on quality, just price.”

But, you are paying for quality; and, in some cases, Poor quality.
The Case for Quality
There were 73,527 readmissions to PA hospitals for 38 conditions studied in the HPR.

Had ONLY those hospitals that had HIGHER than statewide average readmission rates, reduced the rate to Only the statewide average:

- 7,331 less hospitalizations
- $191,470,421 LESS in Charges

2002 Printed Report
Here’s what Nevada might look like (Readmissions)

- 8820 readmissions to NV hospitals for 38 conditions studied in the HPR.
- Had ONLY those hospitals that had HIGHER than statewide average readmission rates, reduced the rate to Only the statewide average:
  - 880 less hospitalizations
  - $22,970,000 LESS in Charges

2002 Printed Report
FFY 2002 HPR

(Readmissions for Complication/infection)

- There were 16,134 readmissions to PA hospitals with a principal cause of complication/infection for 38 conditions studied in the HPR. (36.4%)

- Had ONLY those hospitals that had HIGHER than statewide average rates, reduced the rate to Only the statewide average:

  - 3,170 less hospitalizations
  - $115,032,626 LESS in Charges

2002 Printed Report
2004 CABG Report Readmissions

- 30-day readmissions in rates for hospitals ranged from 7% to 25.7%

- 30-day readmission rates for surgeons ranged from 2.4% to 26.7%

- Over 32.5% of the readmissions were to a different facility than where the surgery was done!
30-day readmissions in 2002 resulted in -

$55 Million in Charges

11,654 Hospital Days
Compromised Care Can Be Costly

- 2002 - about 6,747 “misadventures in surgical care or medical care” in Pennsylvania hospitals

- 3.6 of every 1,000 admissions had a coded “misadventure”; Cases with a misadventure stayed, on average, 3.6 days longer.

- These “misadventures” accounted for over $254 million in additional charges and more than 24,289 additional hospital days.

<table>
<thead>
<tr>
<th></th>
<th>Death Rate</th>
<th>Probability of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Misadventure</td>
<td>4.7%</td>
<td>2.7%</td>
</tr>
<tr>
<td>W/O Misadventure</td>
<td>2.4%</td>
<td>2.8%</td>
</tr>
</tbody>
</table>

Pennsylvania Health Care Cost Containment Council (PHC4)
What might Nevada look like?

- 2002 - about 212,000 admissions

- IF the NV hospitals look similar to PA:
  - 763 “misadventures”; accounting for almost $5 million in additional charges and more than 2800 additional hospital days.
  - Average payment per day in Nevada is $1400
  - Potential of $3,845,000 in PAYMENTS for misadventures in Nevada.
For a company with 100 employees:

What kind of questions would you ask of your insurance company if your renewal premium was required to carry the following line item:

**MEDICAL ERROR SURCHARGE: $1300.00**

*There IS a direct relationship between the quality of care you are provided and the cost of that care!*
Hospital Acquired Infection

The average payment for hospital day in Pennsylvania (FY03) is $1,350

Patients with UTI stayed 149,796 additional days than those without UTI

The Cost: This translates to $202,226,625 in additional payments to hospitals.
Hospital Acquired Infection: What might Nevada look like?

The average payment for hospital day in Nevada (FY02) was $1400

Patients with UTI stayed 17,553 additional days

The Cost: This translates to $24.6 MILLION in additional payments to hospitals.
Hospital Acquired Infection

Best is not Good Enough

If collecting data in isolated hospital areas represents “best practice,” when 2 million Americans develop a hospital–acquired infection, resulting in 90,000 deaths, and $5 billion in cost, then best is just not good enough.

Hospital Acquired Infection

PHC4 will initially collect data on 4 categories

These data will constitute approximately 50% of infections

CDC lists 13 categories of infection data
We will complete hospital wide collection efforts in 2006
Have you asked:

- How many readmissions I’m paying for?
- How many infections I’m paying for?
- How many complications I’m paying for?
In what other industry...

Do you get paid MORE for a mistake?

Do you get paid MORE for a complication?

Do you get paid MORE for a “do over”?
To be blunt:

The Elephant in the middle of the room is an upside down payment system!

We have first rate medicine, and a third rate payment system!
Public Accountability? Has it made a difference?
Pennsylvania’s in-hospital mortality rate decreased faster than the nationwide rate between 1991 and 2002. This represents about 28,000 fewer mortalities during that time period.

Sources: (1) CDC NCHS National Hospital Discharge Survey 1991-2002; (2) PHC4 Inpatient Data, 1991-2002
Savings = $470 million ($47 million per year)

Expected Total Charges for those 19,000 discharges if they had died in the hospital:
$765,000,000

Actual Total Charges for those 19,000 live discharges:
$295,000,000

Source: HCFA inpatient data 1994-2000
CABG Mortality declining faster than the country; from 3.4% in 1992 to 2.0% in 2002

Poor performers DO increase their quality

CABG readmissions DECREASED by over 14% between 2000 and 2002 reports
And…the Press and the Public pay attention:
Deaths and data
Hospital of University of Pennsylvania must reconcile report on mortality rates.

This is why noting that two other major Philadelphia teaching hospitals that handle as many critically ill patients as does HUP - Thomas Jefferson University Hospital and Temple University Hospital - did not have higher than expected mortality rates in the new report.

HUP officials argue that the new assessment may not adequately measure underlying factors contributing to HUP's mortality rate. For instance, while a HUP patient died of death occurring after vascular surgery, that patient may have already been dying from terminal cancer or another disease.

And, as HUP officials note, many patients who died at HUP had been transferred there from other hospitals. Those hospitals, in effect, succeeded in shifting a likely mortality onto another hospital's record.

But there is no denying that HUP and its parent organization, the University of Pennsylvania Health System, have been going through tumultuous times.

After a $70 million loss in 2010, the Penn system cut nonessential staff by 20 percent, went through three chief executives in short order. The hospital was good financial position for the Penn system, which made $18.5 million in the last half of 2009. But answers are needed for whether there is a relationship between the cutbacks, turnover at the top, and the now-higher mortality rates at HUP.

The Hospital of the University of Pennsylvania "must show a willingness to scrutinize its own operations - first fact, correct the report's figures - in hopes of determining how to reduce mortality rates."

Patrick J. Brennan, head of health care quality and patient safety for the University of Pennsylvania Health System, promised last week that "we will take a very careful look at the report. "Was it telling us there really was a problem or an issue with the data?"

The region - and thousands of HUP patients - need an answer.
Recent PHC4 Web Downloads:

HPR: 10,500 for FY03 report
CABG: 10,000 within one month
Commercial HMO: 4500 within 1 month
Blue Cross to reward hospitals for quality

John George  Staff Writer

Independence Blue Cross is dangling new financial rewards for hospitals that can deliver specific performance quality standards and, as a result, keep costs down.

For health systems with multiple hospitals, the
“We want to use indicators that are fairly well accepted.” (Independence Blue Cross)

Among those sources are statistics gathered by Pennsylvania Health Care Cost Containment Council, a state agency that collects and analyzes information related to the performance of hospitals in the state.
**Pennsylvania Health Care Cost Containment Council (PHC4)**
Patient Safety Report  
01/01/2003 - 03/31/2003

**Hospital Specific Report**

**Possible In-Hospital Complications/Infections**

**PAF0000 - Hospital A**

<table>
<thead>
<tr>
<th>Possible In-hospital Complications / Infections</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of Discharges</td>
<td>4,406</td>
</tr>
<tr>
<td>Total Number of Cases with Possible Complications/Infections *</td>
<td>203</td>
</tr>
<tr>
<td>Complications/Infections Rate (%)</td>
<td>4.6</td>
</tr>
<tr>
<td>Peer Group Complications/Infections Rate (%)</td>
<td>6.1</td>
</tr>
<tr>
<td>Peer Group Complications/Infections Rate Range (%)</td>
<td>3.3 - 9.0</td>
</tr>
</tbody>
</table>

* If a record contains multiple codes for complications/infections, it is only counted once.
Pennsylvania Health Care Cost Containment Council (PHC4)
Patient Safety Report
01/01/2003 - 03/31/2003
Hospital Specific Report
Misadventures to Patients
During Surgical and Medical Care
PAF0000 - Hospital A

<table>
<thead>
<tr>
<th>Misadventures to Patients During Surgical and Medical Care</th>
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</thead>
<tbody>
<tr>
<td>Total Number of Discharges</td>
</tr>
<tr>
<td>Total Number of Cases with Misadventures *</td>
</tr>
<tr>
<td>Misadventure Rate (per 1,000 Discharges)</td>
</tr>
<tr>
<td>Peer Group Misadventure Rate</td>
</tr>
<tr>
<td>Peer Group Misadventure Rate Range</td>
</tr>
</tbody>
</table>

* If a record contains multiple codes for misadventures, it is only counted once.
When you peel back the layers of an onion...
Some will start to cry!
NO MEASUREMENT

NO MARGIN

NO MISSION
Personal Health Choices

- Public Report
- All Nevada General Acute Hospitals
- 39 DRGs – most common
- Total discharges, avg. length of stay, avg. charges
- Age and gender breakdowns
- Statewide and hospital-specific
Poor Quality Care Costs More

What price are you willing to Pay?
Don’t let the perfect be the enemy of the good!
For more information on PHC4:

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