Appendix 2

Hospital Comment Letters

SUMMARY

Each of the hospitals included in this report was provided with a preliminary copy of the report and encouraged, but not required, to formally submit comments to OSHPD. The 29 letters[21] received are reproduced in this appendix.

Hospitals' comments acknowledged many limitations of the present report and also reiterated its strengths and potential usefulness. Eleven of the 32 hospitals rated "significantly worse than average" are represented by letters, and two of the 27 hospitals rated "significantly better than average" submitted a letter. Six hospitals indicated that they are using this report to develop improved methods of care, including clinical practice guidelines and protocols for treating community-acquired pneumonia.

Most of the concerns raised by the letters have been summarized below in six areas.

1. CODING ACCURACY

Hospital Comments: Ten letters expressed concern that, after hospitals linked data from this report with their own medical records, coding inaccuracies were discovered. Such inaccuracies included representing source of admission as "home" when in fact it was either "long-term care" or "residential care," under-reporting "DNR (do not resuscitate) order present within 24 hours of admission," and failing to code all of the diagnosis fields used to measure the clinical risk factors.

Response: Incorrectly coded admissions from "long-term" or "residential" care as admissions from "home" resulted in inappropriately including some institutional pneumonia patients in the report as community-acquired pneumonia patients. Three of the hospitals affected by this type of reporting error indicated that their risk-adjusted mortality rates markedly improved (i.e. decreased) after the error was corrected. Improved reporting by the hospital of the DNR and the diagnosis fields would also likely improve the risk-adjusted outcomes of affected hospitals.

OSHPD staff continues to work closely with hospitals, both directly and through the California Health Information Association,[22] to improve the uniformity and validity of hospital discharge data. Many hospitals have improved their coding practices since the first report of the California Hospital Outcomes Program was published in 1993. By law, hospitals must report to OSHPD all diagnoses that "affect the treatment received and/or the length of stay."[23] Specifically, reportable diagnoses include "conditions that affect patient care in terms of requiring: clinical evaluation... therapeutic treatment... diagnostic procedures... extended length of hospital stay...

[21] The letter from the Northern California Kaiser Foundation Hospitals represents all of its Northern California hospitals, and the letter from the Kaiser Foundation Hospitals/Health Plan in Southern California represents all of its Southern California hospitals.

[22] See: Steven Lubeck, "*Improving Data for Measuring Hospital Outcomes,*" *CHIA Journal*, California Health Information Association, 51, 2, (May, 2001): 6.

[23] *The California Hospital Discharge Data Reporting Manual,* January 1985. Title 22, California Code of Regulations, Division 7, Chapter 10, §97212(e)(11).

increased nursing care and/or monitoring."[24] According to these guidelines, conditions that require inpatient evaluation or treatment (e.g., laboratory tests, medications) should always be reported. Hypertension, shock, diabetes, and congestive heart failure are clear examples of such conditions.

2. ADDITIONAL RISK FACTORS

Hospital Comments: Nine letters claimed that the risk-adjustment models used in this report did not include important predictors of mortality: They pointed out that such predictors might have explained some of the observed variation in mortality across hospitals. Unmeasured risk factors mentioned in the letters included: key clinical prognostic factors that can influence mortality (e.g. vital signs, lab results, and X-ray findings at admission); lower socioeconomic status; lack of medical insurance; abuse of drugs, alcohol, or tobacco; mental impairment; dementia; illness severity; terminally ill patient status that results in declining further treatment; DNR orders that take place later than 24 hours after admission; and indicators of which patients are "immunocompromised."

Response: Every CHOP report assesses the need to redevelop its risk–adjustment model. The risk-adjustment model used in this report was developed and validated under the guidance of a clinical advisory panel, using patient discharge data reported during 1996. It may be in need of future updating to reflect advances in medical care, as well as demographic patterns that have changed. Thus, future reports will consider hospitals' suggestions to add new risk factors, or might omit some of the risk factors that were used in the present report.

The CAP validation study published in 1996 (presently available on OSHPD's Web site) identified five clinical risk factors that are not available from discharge abstracts but that would significantly improve the risk-adjustment models used in this report. They are: heart rate, systolic blood pressure at presentation, temperature, sodium <130 mEq/l; and Multi-lobar pneumonia. Future regulatory changes to the Patient Discharge Data Set might allow for the inclusion of these and other factors, resulting in the improved measurement of risks.

Unmeasured risk factors bias the results in this report only if they are distributed unevenly across hospitals. In fact, the CAP validation study found no evidence that patients at high-mortality hospitals possess significantly higher risk, based on physiologic factors, than patients at low mortality hospitals.

3. OLD DATA

Hospital Comments: Eight letters commented that the data used in this report are too old to be useful. Two of these letters pointed out that the report does not fairly reflect recent improvements in how their organizations treat CAP patients.

Response: Recent data are clearly more useful than older data in comparing hospital outcomes. However, the timeliness of the present report was limited by two factors. First, most hospitals have too few cases in one year to provide reliable results. When a hospital has very few cases in a given period, the relatively higher likelihood of chance variations reduces confidence in its outcome statistics. By combining three years of data, hospital outcome statistics become more reliable and more useful. Year 2001 was the third year during which OSHPD collected information on the new DNR field, and thus it defined one boundary of the first three-year period that could be used as a basis for this report: Work on this report could not begin until data for 2001 became available.

[24] *Coding Clinic*, Second Quarter 1990, 12-13; *ICD-9-CM Coding Handbook*, 1991 Revised Edition, 24.

A second factor affecting the timeliness of this report was that it took 15 months for hospitals to submit data for 2001, and for OSHPD to edit and compile, patient discharge abstracts for year 2001. Because of this, the patient discharge data required for this report was not available until March of 2003. It is not unusual for first-time reports to take more time to produce than established reports. Another 6 months was needed to estimate the coefficients in the risk-adjustment models, to calculate outcome rates and to finalize the preliminary draft of this first report. This was followed by the 60-day period needed to solicit comments from hospitals, and then by additional time to prepare and disseminate the final version of the report. For this reason, patient discharge data submitted to OSHPD after December 31, 2001 could not be used.

OSHPD has recently implemented data reporting and editing procedures to accelerate this entire process, which will provide a basis for faster publication. The next report cycle will benefit from the precedents (i.e. computer programs, production templates, improvements suggested in hospital letters, etc.) established by this first report. The next CAP report should be produced faster than the present report.

4. METHODOLOGY

Hospital Comments: Four letters expressed dissatisfaction with the underlying methodology of this report, including the following concerns: it was claimed that the validation study did not demonstrate an association between processes of care and 30-day mortality that would justify the categorization of hospitals as "better than," "worse than" or "as expected." Furthermore, the results of the report may mislead the public to conclude that mortality outcomes are due solely to interventions initiated by hospitals, when in fact patients' health maintenance behaviors and compliance with treatment regimens are key to 30-day survival. Concern was also expressed that if the range of values (i.e. the confidence interval) for Hospital A overlapped the range for Hospital B, then it could not be concluded that either hospital had a better performance in terms of 30-day mortality. For example, many hospitals that were labeled "better than expected" exhibited a range of values that overlapped hospitals labeled "as expected." Finally, it was pointed out that the mix of different types of patients receiving care at each of the different hospitals is not the same. Because of this, inter-hospital comparisons of risk-adjusted outcomes should not be viewed as participants in a controlled study where identical patients with identical conditions are admitted to the hospitals being compared.

Response: In response to the claim that the validation study did not demonstrate an association between any of the processes of care in the "better than," "worse than" or "as expected" hospitals, readers are again referred to the 1996 CAP validation study. It found a trend towards greater "use of sputum cultures" in "better than" hospitals compared with the other two mortality categories. Although this trend was not statistically significant, analysis indicated that odds of dying within 30 days of admission[25] were about 40 percent lower for patients receiving a sputum culture than they were for patients who did not receive a sputum culture. Further, among patients who did not have DNR orders within 24 hours of admission, those admitted to "worse than" hospitals were significantly less likely to have received a sputum culture than patients admitted to "better than" hospitals (44.5% vs. 56.9%, $p<.05$). However, the validation study pointed out that while the performance of a sputum culture may result directly in better care through a more tailored choice of antibiotics, this variable was most likely a proxy for "more conscientious care" (that was not directly measured). Pneumonia, like many medical conditions, does not have a clearly defined set of interventions that represent "best care" practices. The validation study did not find a significant association between "mechanical

[25] Instead of measuring outcomes with inpatient mortality, OSHPD based its measure on mortality within 30-days of admission. This is because in its earlier outcomes reports on AMI it was found that this removed any bias due to variation in average lengths of stay across hospitals. Accordingly, in this report a hospital's early discharge of CAP patients cannot reduce its risk-adjusted mortality.

ventilation," "admission to an ICU," or "time to the administration of antibiotics" and mortality. The possible impact of patients' post-discharge health maintenance behaviors and compliance with treatment regimens were not measured by the validation study or by this report.

In response to the concern that many hospitals labeled "better than expected" exhibited a range of values that overlapped hospitals labeled "as expected," it should be noted that the categorization of a hospital as significantly "better than," "worse than," or "no different than" average was not based on the presence or absence of overlap between pairs of hospital's confidence intervals, but on the difference between any hospital's risk-adjusted 30-day mortality rate and the state's overall mortality rate for CAP admissions. This tripartite categorization was based on a cutting point that separated statistically significant differences from non-significant differences. Two hospitals with similar risk-adjusted rates, but on different sides of the cutting point, were assigned to different categories even if their confidence intervals overlapped.

Anyone concerned that this report might be confused with a controlled study is reminded that, at best, risk-adjusted comparisons represent a reasonable, albeit imperfect, use of multivariate statistics to create a level playing field where different hospitals can be meaningfully compared. As was discussed under issue #2 above, in spite of the best efforts to create such a level field, there will always be unmeasured risk factors that might account for variations in observed mortality across hospitals. Accordingly, this report should not be elevated to the "gold standard" status of a controlled study: Individual patients were not randomly assigned to hospitals, nor were identical cohorts of patients systematically matched to different hospitals.

5. MEASUREMENT OF CAP

Hospital Comments: Three letters claimed that this report did not accurately measure community-acquired pneumonia, and therefore misrepresented their organizations. (This issue is separate from hospitals' miscoding of "source of admission," discussed above).

Two of the letters claimed that the report included patients who did not have community-acquired pneumonia. One organization's review of a sample of 143 medical records led it to conclude that one-third of its (approximately 11,000) community acquired pneumonia patients represented by the report did not have CAP at all. However, it did not specify what illness these patients did have. A second organization indicated that only 25% of the deaths recorded for its facility met criteria for a principal diagnosis of community-acquired pneumonia. It claimed that 75 percent of its patients were admitted for cancers, pulmonary emboli, congestive heart failure, tuberculosis, AIDs, and a variety of other conditions.

A third letter asserted that, in measuring pneumonia, the report relied on diagnosis codes from administrative data that were found to be inaccurate by the 1996 CAP validation study.

Response: Hospital datasets from the two organizations claiming that this report included patients who did not have community-acquired pneumonia were re-examined to determine if any patients other than CAP admissions were mistakenly included. Results showed that all patients included from the two organizations had CAP as measured by the criteria specified in Table A.1 of the Technical Appendix. These criteria are consistent with prior work using administrative data to examine CAP.

In response to the third letter's assertion that the measurement of pneumonia using administrative data was inaccurate, note that the 1996 CAP validation study found that 9.5 percent of its sample had "no CAP." Of the 98 discharges without CAP, 59 had insufficient documentation of pneumonia of any type, 34 had pneumonia with insufficient documentation to determine whether it was present on admission, and 5 had pneumonia that clearly developed after admission. (Whether or not improved coding practices during 1999-2001 lowered these figures cannot be determined in the absence of further validation research.) The 9.5 percent

figure representing “no CAP” was considered an acceptable margin of error by OSHPD’s Technical Advisory Committee.

At the same time, 90.5 percent of the 1996 validation sample was found to have definite or possible CAP at admission. Definite CAP was considered present if the patient had a diagnosis of CAP and there was a documented radiographic infiltrate that was not known to be old. These data had to be confirmed by at least one of the following: the documented presence of a new onset of cough or sputum production; fever; and a white blood cell count of >15,000 or greater than 15 percent band forms on differential. Possible CAP was considered present if the treating physician or radiologists noted pneumonia or the presence of a radiographic infiltrate that was not known to be old. A physician’s diagnosis of CAP with confirmatory signs (listed above) was considered possible CAP in the absence of a documented radiographic infiltrate. For the pneumonia to be considered present at admission, the clinical signs had to be documented within 24 hours of admission, and the confirming chest x-ray had to be taken within a 48-hour time period immediately before or after admission.

6. DEATHS MAY BE UNRELATED TO CAP OR TO HOSPITAL CARE

Hospital Comments: One letter expressed concern that the report charged hospitals with all deaths that occurred within 30 days after admission regardless of the immediate cause or location. Some of these deaths may not have been related to patients' CAP, or to the quality of care received during the index hospitalization.

Response: Deaths unrelated to CAP cannot be excluded, for three reasons: (1) without detailed information about the date, severity, and treatment of each diagnosis, we cannot identify which diagnosis led to death; (2) the true cause of death can often be established only by autopsy, yet relatively few CAP fatalities are autopsied; and (3) even if CAP is not the primary underlying cause of death, it is probably a contributing cause in many cases. Previous studies have shown substantial error in the attribution of "cause of death" on death certificates, especially among patients with multiple contributing factors.

HOSPITAL LETTERS

The Law that created the *California Hospital Outcomes* program specified that hospitals and their medical staff be given 60 days to review a draft of this report, along with the patient data on which it is based. Hospitals and their chiefs of staff were encouraged, but not required, to submit written comments. These comments have been published as part of this report, so that readers can better appreciate this report's strengths and limitations. Enclosed are all letters received in response to this report.

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Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

November 25, 2003

Joseph Parker, Ph.D
Acting Deputy Director
Health Care Quality and Analysis Division
Office of Statewide Health Planning & Development
818 K Street, Suite 200
Sacramento, CA 95814

Re: City of Alameda Health Care District Response to California Hospital Outcomes Report on Community Acquired Pneumonia (CAP)

Dear Dr. Parker:

Alameda Hospital appreciates the opportunity to review and respond to the CAP data provided for years 1999 through 2001.

As indicated by the report, only one aspect of the quality of care, that being death, was provided. Although the CAP statistics table for Risk Adjusted Death Rate (RADR) for patients without Do Not Resuscitate (DNR) status was above the Statewide Death Rate, DNR status is a strong predictor of 30-day mortality in this aged island community population. The CAP detail for RADR in patients with DNR status was not significantly different from the state average.

There were 42 deaths reported in the 250 cases reviewed. Of those, only 18 were reported to not have a DNR in place. After reviewing those 18 cases, seven (7) actually were DNR status; one (1) had metastatic lung cancer; one (1) was conserved by Alameda County, which prohibited DNR at the time, even though it was indicated; three (3) arrived in the emergency room code blue with a grave prognosis; two (2) had multiple severe co-morbidities with notes from the MD that the prognosis was poor/grave; and in one (1) case the MD requested a DNR of the family but was denied.

There appears to have been a significant under-reporting of DNR status and possibly other risk factors that could have significantly changed the Expected Death & RADR rates for patients with and without DNR status. It also should be noted that outcomes in this limited value improved over the course of the review even though Alameda Hospital performed as expected in the patients with DNR status category.

Alameda Hospital prides itself in the quality care it provides to all of its patients. Our statistics have historically demonstrated a better than average result in local and national benchmarks. To better enable us to take a more current, intensive look at the care in the CAP patient, we will add CAP to our 2004 JCAHO core measures data reporting. This will afford us the opportunity to involve the medical staff in root cause analysis and review of all core measures' indicators. The outcomes and analysis of the data will be reviewed by the Medical Executive Committee and process improvement activities implemented which will be reported to the Board of Directors.

We thank you for the opportunity to participate in this important aspect of patient care.

Sincerely,

David D. O'Neill
Chief Executive Officer

DDO/ll

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December 10, 2003

Joseph Parker, Ph.D.
Acting Deputy Director, Healthcare Quality and Analysis Division
Office of Statewide Health Planning and Development
818 K Street, Room 200
Sacramento, California 95814

Dear Dr. Parker:

We, at Children's Hospital Central California, appreciate the opportunity to review and comment on the 1999-2001 Community-acquired Pneumonia (CAP) report published by the Office of Statewide Health Planning and Development (OSHPD). While sharing OSHPD's commitment to improving quality through the measurement of care outcomes, we feel that the inclusion of children's hospitals in a study that was designed to analyze adult patients exhibits a significant bias.

Children's Hospital Central California is an acute care facility that primarily serves neonate and pediatric populations. However, a very select number of adults with serious congenital diseases are treated at our facility. Unfortunately, in this study, the risk factors used that attributed to mortality were developed with adult-related medical conditions in mind and do not take into consideration some other factors that contribute to mortality in adult patients with serious diseases present from birth. That being noted, the specific patients included in this study suffered from severe medical conditions, which led their families to decline resuscitation efforts. In honoring their wishes, all three patients were placed on "do not resuscitate" (DNR) status. Although DNR status was considered in the study, the specification that DNR status is assigned within 24 hours of admission is a limitation which distorts the analysis. Additionally, we offer the following observations for the noted mortalities:

- The first patient was admitted from a skilled facility where they had lived for the past 17 years. This patient's coexisting medical conditions included spastic quadriplegia (inability to control all four limbs along with abnormal muscular tone), obstructive hydrocephalus (an abnormal increase in the amount of cerebrospinal fluid within the skull, that causes pressure on the brain that leads to deterioration of the brain) which was treated with a ventriculoperitoneal shunt (this drains cerebrospinal fluid from the brain into the peritoneal cavity), agranulocytosis (absence of a type of blood cell involved in the immune system), scoliosis (unnatural curvature of the

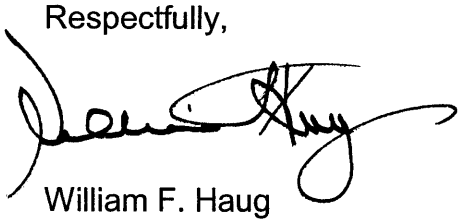
spine), dysphagia (difficulty swallowing), autosomal deletion syndrome (genetic disorder involving the deletion of chromosomes), recurrent urinary tract infections secondary to vesicoureteral reflux (reflux of urine from the bladder back into the kidney), bilateral hydronephrosis of the kidneys (dilation of the structure that collects urine in the kidney), anemia, cerebral palsy and severe mental retardation. This patient was placed on a DNR on the fourth day of admission.

- The second patient had several previous admissions for pneumonia and was placed on a DNR status on admission. This patient's related medical conditions included cerebral palsy, spastic quadriplegia, intractable seizures, severe scoliosis, swallowing dysfunction, and chronic lung disease.

- The third patient was placed on a DNR status within 30 hours of admission. This patient suffered from thrombocytopenia (persistent decrease in number of blood platelets, often associated with hemorrhagic conditions), cerebral palsy, and esophageal reflux (backward flow of gastric contents into the esophagus), swallowing dysfunction, scoliosis and asthma.

The care we provide to our patients is based on best practice, and our outcomes demonstrate exceptional performance based on the Pediatric Health Information System (PHIS) and the Pediatric Intensive Care Unit Evaluation (PRISM) national databases. By utilizing both external and internal benchmarking and performance improvement strategies, we continuously strive to provide the best possible care to our patients. Again, thank you for the opportunity to submit these comments for publication.

Respectfully,



William F. Haug
President & Chief Executive Officer

Community Hospital of the Monterey Peninsula®

Innovative healthcare with a human touch

December 1, 2003

Joseph Parker, Ph.D., Acting Deputy Director
Health Care Quality and Analysis Division
Office of Statewide Health Planning and Development
818 K Street, Room 200
Sacramento, CA 95814

Dear Dr. Parker:

Community Hospital of the Monterey Peninsula strives to be the healthcare organization in our region most concerned for those we serve, most chosen for the quality and value of our services, and most respected for the integrity, competency, and commitment of our employees, medical staff, and volunteers.

To accomplish that vision, employees and medical staff set aggressive targets for clinical improvements, and we are committed to achieving those targets year after year. We have formed a team of physicians, nurses, pharmacists, and other caregivers who are working to improve the care we provide for patients with community-acquired pneumonia. Since this data was collected, we have already reduced the average time it takes us to give the first dose of antibiotics and we have also improved immunization rates for pneumonia.

We strongly support your right to receive information that will assist you in making informed decisions about your healthcare. We also believe it is important for you to understand the limitations and complexity of this type of data. We encourage you to discuss this information with your own physician, so that together you can make the best possible choices for your healthcare.

Although we are pleased with our overall results in this study, we are confident that we will do even better in the future. At Community Hospital, we know that providing quality care requires vigilance and continuous effort. We're never satisfied. We always strive to do better for our community.

Sincerely,

Steven J. Packer, M. D.
President/CEO

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Doctors Hospital
Of Manteca

Tenet California

Administration
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Katherine A. Medeiros, CEO
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November 18, 2003

Office of Statewide Health Planning and Development
Healthcare Quality and Analysis Division
Healthcare Outcomes Center
818 K Street, Room 200
Sacramento, California 95814

Doctors Hospital of Manteca has received and reviewed the California Hospital Outcomes Report on Community Acquired Pneumonia for 1999-2001. Our Medical Staff has also reviewed the content and has approved the information provided. Please publish the Doctors Hospital of Manteca data as presented.

Sincerely,

Kathy Medeiros, CEO

Carmen Silva, CNO/COO

Katy Marconi, Director Clinical Quality Improvement

Stephen Lin MD., Chief of Medical Staff

Michael Davis MD., Chief of Pulmonary Care

DOS PALOS MEMORIAL HOSPITAL
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December 8, 2003

Joseph Parker, Ph.D.
Acting Deputy
Office of Statewide Health Planning and Development
Healthcare Quality and Analysis Division
818 K Street, Room 2000
Sacramento, CA 95814

Dear Dr. Parker,

Thank you for sharing an early copy of the California Hospital Outcomes Report on Community-Acquired Pneumonia, 1999-2001. This gives us an opportunity to respond to certain data points.

The single case which seems to produce a glaring statistic of one death in four cases in 2000 was investigated closely. This was a patient (M..... P.....) presented with possible pneumonia and was admitted. She was a 69 year old smoker. The background issue was that the patient had had a cardiac bypass surgery in 1995.

The chest x-ray here (attached) was not typical but was read as some sort of interstitial process, perhaps pulmonary edema. She did not get better on pneumonia treatment and was transferred to what is now Mercy Medical Center of Merced for ICU care under a cardiologist and pulmonologist.

Although she improved enough to leave the ICU, the lung problem was so unusual that it did not get better. At one time it was called "bronchiolitis obliterans organizing pneumonia" (attached "Expiration Summary"). Then she had a cardiac rhythm event causing death.

The physicians were still not sure of the diagnosis in the chest and made the case a coroner's case. We do not have any autopsy report but would be interested.

This patient does not fall into the simple Community-Acquired Pneumonia category and should be removed from that category. There should be an attempt by the State to get the autopsy report from Merced County and find out the real diagnosis if the case is kept in.

We believe that our care was excellent and that our referral to a high center was timely when the problem proved to be more complex than pneumonia. Her sudden death on the medical ward of the referral hospital could easily have been a myocardial infarction with ventricular fibrillation.

Sincerely,

Charles Phillips MD

Dr. Charles Phillips
Chief Clinic Physician

Robert Hill

Robert Hill
Administrator

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November 26, 2003

Joseph Parker, Ph.D., Acting Deputy Director
Health Care Quality and Analysis Division
Office of Statewide Health Planning and Development
818 K Street, Room 200
Sacramento, CA 95814

Dear Dr. Parker:

Enloe Medical Center is committed to the delivery of high quality health care for patients through out the North Valley. Thus, Enloe commends the Office of Statewide Health Planning and Development (OSHPD) for the work it is doing to help track and trend the provision of quality care at California hospitals. The most recent reporting of statistical data regarding community-acquired pneumonia is an important step toward helping hospitals meet their quality improvement goals.

The medical staff and administration of Enloe Medical Center have reviewed the data, and concur that the hospital's results fall within the expected range with no statistically significant variance. Since this report is based on data that is two years old, it does not reflect current practice and the efforts that have been taken to improve pneumonia patient outcomes. One example is the addition of a Hospitalist Program at our facility, which provides patients with immediate access to an onsite physician seven days a week. We have also initiated free, community wide flu shot vaccinations, and are working with our medical community to overcome barriers that may limit vulnerable populations from receiving pneumococcal vaccinations. We believe these initiatives will reduce the occurrence, severity and mortality resulting from pneumonia within our region.

Additionally, and as reflected by our comparatively high volume, Enloe Medical Center is a tertiary referral center for rural hospitals and skilled nursing facilities in the North Valley. Accordingly, the number of patients we receive from convalescent homes, skilled nursing facilities, and other hospitals may be disproportionately higher than other facilities, and the risk adjustment model does not account for this variable.

Enloe Medical Center appreciates the contributions made by the OSHPD study. The study is one of a number of tools that is being used by our physicians and clinical staff to monitor, assess and improve the quality of care at our hospital.

Sincerely,

Dan Neumeister
Senior Vice President & Chief Operations Officer

THE
FREMONT-RIDEOUT
HEALTH GROUP

December 4, 2003

Joseph Parker, PhD.
Acting Deputy Director, Healthcare Quality and Analysis Division
Office of Statewide Health Planning and Development
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Dr. Parker:

Thank you for the opportunity to review and comment on the preliminary draft of the first report on Care of Community Acquired Pneumonia (CAP) patients 1999-2001. This data has been shared with key physicians on the Fremont-Rideout Health Group Medical Staff, the Director of Quality / Risk Management, the Director of Inpatient Nursing, the Assistant Administrator for Patient Care Services, the Director of Medical Records, the Chief Medical Officer and the Chief of Staff.

Our commitment is to provide high quality care to citizens of our region and strive to improve patient outcomes on an on-going basis. This data is helpful to us; however, it is unfortunate that the data to be published will be 3-5 years old before it is ever published. Community Acquired Pneumonia is the most common admitting diagnosis at Rideout Memorial Hospital and therefore has been a focus of our on-going performance improvement initiatives for many years. In fact, in 2002, we elected to participate in the Joint Commission on Accreditation of Healthcare Organizations' (JCAHO) Core Measures on Community Acquired Pneumonia. In doing so we will be able to continually monitor several process and outcome indicators associated with CAP and benchmark our performance with other participating hospitals.

While the actual 30-day mortality rate during the study period was within one standard deviation of the statewide median, our efforts have been directed at improving the outcomes for patients admitted with CAP. In collaboration with key members of the medical staff we have recently revised our pre-printed order set for CAP. The revisions are based on best practices and will standardize the care and treatment of these patients. Research has shown that when standardized order sets (based on current

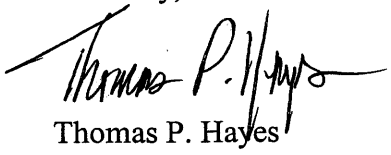
December 4, 2003
Page 2
Joseph Parker, PhD.
Acting Deputy Director, Healthcare Quality and Analysis Division
Office of Statewide Health Planning and Development

clinical research and best practices) are utilized, outcomes such as 30-day mortality improve dramatically. Through various mechanisms, the use of these order sets by all physicians who admit patients with CAP will be encouraged. On-going review, both retrospective and concurrent will assist our efforts to continually monitor for improvement. We have also revised our admission data collection to include history of immunizations for influenza and pneumoccus – this enables us to assure that these patients are immunized prior to discharge. In addition, we provide information to patients and access to education on smoking cessation. We believe that both of these measures will improve outcomes for patients with CAP.

We have reviewed published data from Yuba County's Health Status Profile which shows that residents of Yuba County have higher mortality rates for other conditions such as cancer and heart disease compared to other California counties. We believe this to be due, at least in part to lower socioeconomic status, a high percentage of uninsured patients and a significant rate of abuse of drugs, alcohol and tobacco. Many patients in Yuba County do not seek routine or preventative medical care, therefore have lower rates of immunizations against influenza and pneumoccus than other counties. Yuba County residents who do not have a primary care provider may also delay seeking care, resulting in complications and comorbidities that result in poorer outcomes. Fremont-Rideout Health Group works closely with and supports the efforts of the Yuba County Health Department and two federally qualified healthcare clinics to improve access to primary care services. We are also working with local officials to educate the community on smoking cessation, health maintenance and the importance of establishing regular care with a primary care provider. We believe all these efforts collectively will have a positive effect on patient outcomes.

In summary, Rideout Memorial Hospital is committed to improving care for all residents of the Yuba-Sutter area and are confident that our performance improvement efforts will help us to achieve this goal. We look forward to receiving data on an on-going basis to determine if our efforts have been successful in decreasing mortality for patients with Community Acquired Pneumonia.

Sincerely,



Thomas P. Hayes
Chief Executive Officer
Rideout Memorial Hospital

THE
FREMONT-RIDEOUT
HEALTH GROUP

December 4, 2003

Joseph Parker, PhD.
Acting Deputy Director, Healthcare Quality and Analysis Division
Office of Statewide Health Planning and Development
818 K. Street, Room 200
Sacramento, CA 95814

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Yuba City, CA 95991
530/751-4010

RIDEOUT MEMORIAL HOSPITAL
726 Fourth Street
Marysville, CA 95901
530/749-4300

FREMONT MEDICAL CENTER
970 Plumas Street
Yuba City, CA 95991
530/751-4000

THE FOUNTAINS
1260 Williams Way
Yuba City, CA 95991
530/751-4888

FREMONT-RIDEOUT FOUNDATION
989 Plumas Street
Yuba City, CA 95991
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FREMONT-RIDEOUT HOMECARE
319 G Street
Marysville, CA 95901
530/749-4386

VALLEY HOSPICE
319 G Street
Marysville, CA 95901
530/749-4368

Dr. Parker:

Thank you for the opportunity to review and comment on the preliminary draft of the first report on Care of Community Acquired Pneumonia (CAP) patients 1999-2001. This data has been shared with key physicians on the Fremont-Rideout Health Group Medical Staff, the Director of Quality / Risk Management, the Director of Inpatient Nursing, the Assistant Administrator for Patient Care Services, the Director of Medical Records, the Chief Medical Officer and the Chief of Staff.

Our commitment is to provide high quality care to citizens of our region and strive to improve patient outcomes on an on-going basis. This data is helpful to us; however, it is unfortunate that the data to be published will be 3-5 years old before it is ever published. Community Acquired Pneumonia is one of the most common admitting diagnoses at Fremont Medical Center and therefore has been a focus of our on-going performance improvement initiatives for many years. In fact, in 2002, we elected to participate in the Joint Commission on Accreditation of Healthcare Organizations' (JCAHO) Core Measures on Community Acquired Pneumonia. In doing so we will be able to continually monitor several process and outcome indicators associated with CAP and benchmark our performance with other participating hospitals.

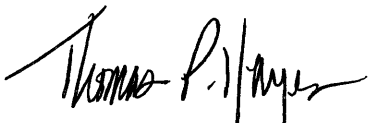
While the actual 30-day mortality rate during the study period was within the expected range, our efforts have been directed at improving the outcomes for patients admitted with CAP. In collaboration with key members of the medical staff we have recently revised our pre-printed order set for CAP. The revisions are based on best practices and will standardize the care and treatment of these patients. Research has shown that when standardized order sets (based on current clinical research and

best practices) are utilized, outcomes such as 30-day mortality improve dramatically. Through various mechanisms, the use of these order sets by all physicians who admit patients with CAP will be encouraged. On-going review, both retrospective and concurrent will assist our efforts to continually monitor for improvement. We have also revised our admission data collection to include history of immunizations for influenza and pneumoccus – this enables us to assure that these patients are immunized prior to discharge. In addition, we provide information to patients and access to education on smoking cessation. We believe that both of these measures will improve outcomes for patients with CAP.

Fremont-Rideout Health Group works closely with and supports the efforts of the Sutter County Health Department and two federally qualified healthcare clinics in our area to improve access to primary care services. We are also working with local officials to educate the community on smoking cessation, health maintenance and the importance of establishing regular care with a primary care provider. We believe all these efforts collectively will have a positive effect on patient outcomes.

In summary, Fremont Medical Center is committed to improving care for all residents of the Yuba-Sutter area and are confident that our performance improvement efforts will help us to achieve this goal. We look forward to receiving data on an on-going basis to determine if our efforts have been successful in decreasing mortality for patients with Community Acquired Pneumonia.

Sincerely,



Thomas P. Hayes
Chief Executive Officer
Fremont Medical Center

1950 Franklin Street, 20st Floor
Oakland, CA 94612-3434

December 9, 2003

Joseph Parker, Ph.D.
Acting Deputy Director
Health Care Quality and Analysis Division
Office of Statewide Health Planning and Development
818 K Street, Room 200
Sacramento, CA 95814

Dear Mr. Parker:

Thank you for the opportunity to review and respond to the California Hospital Report on Community-Acquired Pneumonia (CAP). We appreciate OSHPD's effort to provide the public outcome-based reports. We strongly support continuous improvements in health care outcomes and public reporting of valid information to help facilitate accountability and inform consumer decision-making. However, it is important to point out that we believe this report misrepresents the implied quality of care at the Kaiser-Permanente Northern California medical centers because of two underlying flaws in the reporting: 1) because of its reliance on billing codes and administrative data sets, the report significantly under-reports patient risk at Kaiser-Permanente and 2) the methodology does not take into account clinical factors that impact the risk for mortality. It is essential that readers of this report consider these reporting flaws and not accept the premise that the outcomes reflect better or worse quality.

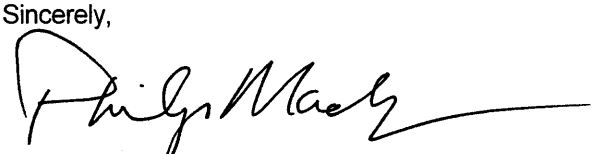
As the largest pre-paid, integrated health care system in California, Kaiser-Permanente does not use the same kind of billing systems commonly seen in other hospitals. Hospital billing codes are known to be inaccurate as the foundation for outcomes reporting for CAP, yet they are relied on in this study. The validation study recognized a 40% error rate for properly categorizing patient admissions as having Community Acquired Pneumonia. In other words, potentially 40% of the patients in this study may not have had Community Acquired Pneumonia. Electronic outpatient clinical information is readily available to clinicians treating patients in the hospital, decreasing the utility of coding co-morbidities upon admission. The study model relied on admission diagnosis (and previous admissions) but because of our coding practices, we are certain that the risk of our population is underreported. As recognized in the validation study, there is a significant level of under-reporting of Do-Not-Resuscitate orders when comparing the medical record to the administrative data. We also found that to be true thereby greatly underreporting this critical risk factor.

The validation study did not show an association between any of the processes of care in the "worse than" or "better than" hospitals. Additionally, key prognosticating clinical factors which can influence mortality were not taken into account (vital signs, lab results, specific x-ray findings on admission and more). More rigorous and predictive study methods have been utilized to assess outcomes for patients with CAP, but it is recognized that such studies involve resource intensive medical record data abstraction.

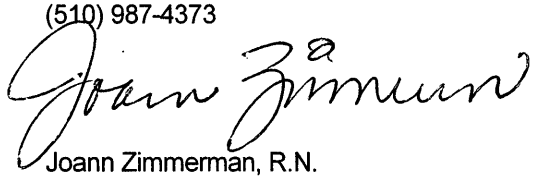
Kaiser-Permanente is a strong proponent of evidence based practices in medical care to promulgate superior quality. We developed a clinical practice guideline for CAP in 1998. Several changes have occurred since this data was extracted for this report, including the development of new clinical tools for physician and nursing staff to support the evidence-based principles. We are in the process of implementing a one-of-a-kind sophisticated electronic medical record that will span the continuum of care and significantly enhance communication and the transfer of information between the care team. We are investing in this system to recognize the goal of obtaining optimal health outcomes.

Overall, we commend OSHPD for reporting on CAP and other conditions and we recognize the maturation in methodology over time. However, this report is not reflective of the quality of care provided by Kaiser-Permanente. We believe that the next round of reports should continue to evolve and consider critical clinical parameters and not rely so heavily on primary and secondary billing codes. The people of Kaiser-Permanente are committed to improving quality of care and maximizing health outcomes for our patients. We look forward to participation in future outcome reports and eagerly await the next publication on Community-Acquired Pneumonia.

Sincerely,



Philip Madvig, M.D.
Associate Executive Director
The Permanente Medical Group, Inc.
(510) 987-4373



Joann Zimmerman, R.N.
Senior Vice President Operations
Northern California
Kaiser Foundation Hospitals
(510) 987-3189

Joseph Parker, Ph.D.
Acting Deputy Director
Health Care Quality and Analysis Division
Office of Statewide Health Planning and Development
818 K Street, Room 200
Sacramento, CA 95814

Dear Dr. Parker:

The Kaiser Permanente Medical Care Program in Southern California would like to thank the Office of Statewide Health Planning and Development (OSHPD) and its contractors for giving us an opportunity to review and comment on the release of OSHPD's *Report on Hospital Outcomes for Community-Acquired Pneumonia in California*". Kaiser Permanente welcomes carefully planned and thoughtfully executed strategies to measure and improve quality of health care. We applaud OSHPD's attempt to measure and report hospital outcomes for pneumonia, and accept the accountability that comes with public reporting. We reviewed the Report very carefully, and attempted to validate the Report's findings by reviewing a sample of medical records of patients who were part of this study. Regrettably, our findings indicate that the assessment and hospital rankings are flawed. Our concerns are outlined below.

Unsubstantiated diagnosis: This outcomes assessment was meant to apply to patients with pneumonia. If patients do not have the diagnosis in question – pneumonia – then the hospital ratings are meaningless. In our review of 143 records of Kaiser Foundation Hospital patients in the OSHPD study, we found that one third did not actually have community-acquired pneumonia at all. These patients should never have been included in the study. Our own findings are entirely consistent with OSHPD's 1996 validation study, when OSHPD itself found that fewer than 59% of cases in its sample had a definitive diagnosis of pneumonia. Accuracy of diagnosis is crucial in research on the outcomes in patients with that diagnosis, and fundamental for public policy. When the State itself cannot confirm the diagnosis in four out of ten cases, the validity of the rating of hospital outcomes for patients with the diagnosis is dubious.

Inaccurate or incomplete diagnostic coding: The validity of the model depends on accurately coding co-morbidities that were present at hospital admission, as it is these co-morbidities that drive the risk-adjustment. In our chart review, we found that documented co-morbidities were uncoded or miscoded over 20% of the time. In other words, several of our hospitals were systematically undercoding during the study period. In the Kaiser system, hospital care – like ambulatory care – is prepaid. In such systems, there is little or no financial incentive for complete diagnostic coding, as reimbursement is not linked to coded data. With incomplete coding, patients who were seriously ill and had a greater risk of mortality were unable to be risk-adjusted, and were assigned an inappropriately low risk of death, yielding a skewed (inaccurately elevated) risk-adjusted mortality. We have been aware of sub-optimal coding practices for a number of years, and have implemented a re-examination and systematic improvement of coding practices at Kaiser Foundation Hospitals. Here, we can be very blunt: our coding practices during the study period were sub-optimal, opportunities for improvement have been identified, and improving medical record coding is a top priority of Kaiser Permanente senior leadership. However, the distinction between quality of *medical care* and quality of *medical record coding* is important, and readers of the Report should keep that distinction in mind.

Designation of pneumonia as community acquired: Although this category is related to both unsubstantiated diagnosis and inaccurate coding, it is worth identifying as a distinct concern. In our chart validation review, we found numerous cases of admission from skilled nursing facilities, as well as of aspiration pneumonia acquired in the patient's home. These should not be classified as "community-acquired pneumonia" per the OSHPD inclusion criteria, and these patients should have been removed from the study. Similarly, we found a number of cases of hospital-acquired pneumonia misclassified as community-acquired, reflecting coding inaccuracies. Although this misclassification is entirely our responsibility, the inclusion of these patients in the study cohort calls into question the validity of the results.

DNR policies and practices: In OSHPD's model, the presence of a DNR order is second only to respiratory failure as a predictor of death. Yet in its 1996 validation study, OSHPD itself found that fewer than half of chart-documented DNR's were recorded in the administrative data set used to construct risk-adjusted mortality rates and hospital ratings. For a variable of such prognostic significance, 50% underreporting is unacceptable. The under-recording of DNR orders in administrative data again calls into question the validity of the rating of hospital performance. We question whether it is possible to develop a model of outcomes of community acquired pneumonia that adequately take into account the contribution of patient and family preferences for management of pneumonia, a condition that is common in chronically ill patients making end of life decisions.

Unmeasured risk/inherently limited administrative data: OSHPD's assessment relies solely on administrative data. However, OSHPD itself acknowledges the limitations of administrative data, and that "clinical variables [temperature, systolic blood pressure, heart rate, sodium < 130 mEq/l, presence of multi-lobar infiltrate] substantially improve the risk-adjustment models". Administrative data are admittedly convenient, but if clinical variables not routinely recorded on datasets "substantially" improve the model's prognostic value, the public is not well-served by a report that highlights hospital ratings from incomplete data.

In sum, unsubstantiated diagnoses, incomplete coding, and incomplete documentation of DNR orders, combined with the model's use of administrative data that do not include key prognostic variables, strongly suggest that the outcome assessment is not a valid indicator of the quality of hospital performance in the management of pneumonia.

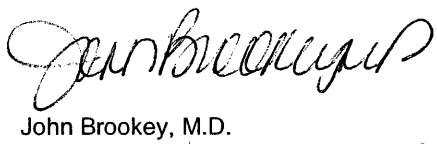
We would like to emphasize that *processes* of care are as important as clinical outcomes. Indeed, outcomes cannot reliably be measured until their antecedent processes are identified, understood, and implemented as a routine part of care. In electing to limit its assessment to outcomes based on administrative data, the *Report on Hospital Outcomes for Community-Acquired Pneumonia in California* is unable to measure and compare hospital performance on key aspects of pneumonia management that the clinical literature has demonstrated truly make a difference in outcomes.

Given the inherent limitations of OSHPD's administrative dataset, it is essential to explore alternative approaches to measuring and reporting hospital performance on management of pneumonia. We would like to point to three specific areas where Kaiser Permanente is actively working to improve the documentation, coding, and most importantly *delivery* of care to improve health outcomes, including pneumonia outcomes.

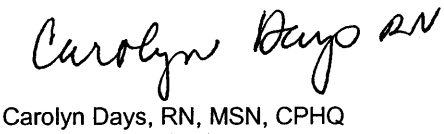
1. We are routinely auditing a random sample of medical records from each of our medical centers for accuracy of diagnosis and adequacy of coding. Findings from the audits are reviewed at least three times a year, with hospital leadership directly accountable for maintaining high levels of performance.
2. All of Kaiser Permanente's hospitals participate in the Joint Commission on Accreditation of Healthcare Organization's (JCAHO's) ORYX/core measure initiative. As part of this initiative, each of our hospitals will be measuring and reporting its performance on important aspects of pneumonia care, including timing of antibiotic administration, initial selection of antibiotic agent, and oxygenation assessment. Because these and other measures in the JCAHO pneumonia dataset are incontrovertibly linked to improved outcomes – and because they are more "real-time" than the OSHPD data, some of which are as much as five years old – the ORYX/JCAHO process of care data are likely to have a more direct and "actionable" impact on hospital performance than risk-adjusted outcomes.
3. Kaiser Permanente is in the process of implementing an electronic medical record at all its facilities. The scope of this project is enormous, but the long-term benefits to our patients will be incalculable for documenting and delivering medical care, as well as for studying and improving health outcomes.

Once again, although we believe that the OSHPD Community-Acquired Pneumonia hospital ratings do not accurately reflect quality of care (either good or bad), the Report is nonethless helpful in identifying pneumonia as one of the conditions we should focus on to improve chart documentation and coding, and we acknowledge and appreciate the considerable work that OSHPD has done to bring this opportunity to our attention.

Sincerely,



John Brookey, M.D.
Assistant Associate Medical Director for
Clinical Services/Operations
Southern California Permanente Medical Group



Carolyn Days, RN, MSN, CPHQ
Vice President for Quality
Kaiser Foundation Hospitals/Health Plan
in Southern California

November 25, 2003

Joseph Parker, Ph.D
Acting Deputy Director
Health Care Quality and Analysis Division
Office of Statewide Health Planning and Development
818 K Street
Room 200
Sacramento, CA 95814

Dear Mr. Parker:

Kaweah Delta Health Care District Community Acquired Pneumonia patients have an acceptable risk adjusted mortality rate only when DNR status is included in the calculation of risk. Analysis of other conditions associated with mortality reveal that Kaweah Delta has much higher rates than the statewide prevalence for chronic renal failure, acute CVA, and CHF. Surprisingly, for high-risk patients, for those with predicted mortality rates of greater than 40%, our observed mortality rate is better than predicted. Future efforts to improve outcomes at KDDH will include emphasis on rapid treatment with antibiotics according to IDSA and ATS guidelines, assessment and documentation of oxygen saturation, documentation of immunization status, and attention to the accuracy of diagnosis and coding in the lower risk populations who seem to be the source of our excess mortality.

Sincerely,

Lindsay K. Mann

Lindsay K. Mann
Chief Executive Officer

400 West Mineral King • Visalia, CA 93291-6263 • 559 624-2000 • FAX 559 635-4021

KERN MEDICAL CENTER

AFFILIATED WITH UNIVERSITY OF CALIFORNIA SCHOOLS
OF MEDICINE AT LOS ANGELES, SAN DIEGO, AND IRVINE

December 10, 2003

Joseph Parker, Ph.D.
Acting Deputy Director
Health Care Quality and Analysis Division
Office of Statewide Health Planning and Development
818 K Street, Room 200
Sacramento, CA 95814

Dear Dr. Parker:

Thank you for the opportunity to respond to the data reported in your Community-Acquired Pneumonia Project. We appreciated your ongoing efforts to improve care by providing outcome-based data. In conjunction with the study we submit the following comments.

The risk adjustment models utilized for the study has no consideration for the patients with the co-morbidities of alcoholism, drug abuse, mental impairment, or dementia. In the population Kern Medical Center serves, we feel these co-morbidities impact the incidence of both community-acquired pneumonia and aspiration pneumonia. Using these co-morbidities may have had an impact on Kern Medical Center's incidence of CAP because over 30% of the patients involved had those conditions. For Kern Medical Center it raises the question about the adequacy of our documentation and coding practices. Your study highlighted this shortcoming and we are strengthening our educational efforts regarding appropriate documentation and awareness of clinical data that supports patient diagnosis. We do ask, however, that you consider these additional co-morbidities in your outcome study results.

Lastly, in 2002 we selected CAP as one of our core measures for Joint Commission because we recognized our need to improve treatment protocols. Modifications have already been made initially focusing on the timely administration of medications. We continue to actively pursue process improvement that will enhance the care for those we serve.

We look forward to continuing to work with OSHPD to improve care provided in Kern County and ask that you give consideration to our comments for your final report.

Sincerely,

Peter K. Bryan
Chief Executive Officer
Kern Medical Center

PKB:abra
O:\Letters\121003OSHPD.doc

Marian Medical Center
CHW

1400 East Church Street
P.O. Box 1238
Santa Maria, CA 93456
805 739 3000 Telephone

December 9, 2003

Joseph Parker, Ph.D.
Acting Deputy Director
Health Care Quality and Analysis Division
Office of Statewide Health Planning and Development
818 K Street, Room 200
Sacramento, CA 95814

Dear Dr. Parker,

The Office of Statewide Health Planning and Development recently completed the preliminary draft of its first report on the care of Community-Acquired Pneumonia at California Hospitals between 1999 and 2001. Please accept this letter as an official response from Marian Medical Center.

The data for Marian Medical Center does not appear to correlate with the severity of illness for CAP patients. Because the expected mortality rate is based on the acuity of patients, understating patient acuity can, and most likely will, result in a higher than expected mortality rate.

In order for hospitals to have the greatest impact on improving the quality of care for patients, information and data must be made available quickly. Marian Medical Center appreciates recent improvement in the effort by OSHPD to gather and report data to California hospitals in a timely manner.

Sincerely,

Charles J. Cova,
President
Marian Medical Center

MARSHALL MEDICAL

December 2, 2003

Joseph Parker, Ph.D.
Acting Deputy Director
Health Care Quality and Analysis Division
Office of Statewide Health Planning and Development
818 K Street, Room 200
Sacramento, CA 95814

Subject: California Hospital Outcomes Report on Community-Acquired Pneumonia, 1999-2001

Dear Mr. Parker;

Marshall Medical Center is committed to providing patients and their families with the latest in scientific medicine delivered in a healing environment. This report, as well as our internal performance audit, shows that we are performing well. For example, our 2003 pneumonia data indicates a significantly lower than expected mortality rate.

Although the Hospital Outcomes Report is interesting, the limitations of the Mortality Prediction Model make it difficult to draw conclusions about the quality of care in hospitals. In the spirit of continuous performance improvement, we want to express our concerns about Hospital Report Cards and note that the American Hospital Association shares these concerns.

Limitations of the Mortality Prediction Model:

1. Your risk adjustment model does not consider patients who are terminally ill and have declined further treatment. Patient wishes for "Palliative-Comfort Care Only" were found in 26% of our deaths.

2. It is difficult for a model based solely on computer-generated data to identify all of the risk factors of a patient. Because hospitals have a variety of types of personnel reviewing and entering clinical data, the quality of the data varies. Therefore, computer data alone cannot be reliably used to evaluate outcomes. As one example, when we reviewed the medical records of the patients in this study who died, we found that they were much sicker than indicated in our computer-generated data.

Thank you for the opportunity to review and comment on the draft of this report. We can appreciate the difficulty of developing a reliable mortality prediction model and encourage you to work with the American Hospital Association to develop a more reliable approach to help consumers judge the quality of hospital care.

Sincerely,

James Whipple
CEO
Cc: American Hospital Association

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Mercy San Juan Medical Center
CHW

6501 Coyle Avenue
Carmichael, CA 95608
Telephone (916) 537-5000

November 5, 2003

Joseph Parker, PhD
Acting Deputy Director
Health Care Quality and Analysis Division
Office of Statewide Health Planning and Development
818 K Street
Room 200
Sacramento, CA 95814

Dear Dr. Parker:

Thank you for the opportunity to respond to the California Hospital Outcomes Report on Community-Acquired Pneumonia 1999-2001on behalf of Mercy San Juan Medical Center prior to its release to the media and general public.

The findings for Mercy San Juan Medical Center indicate risk-adjusted mortality rates close to, and not statistically significantly different from, the statewide average in both groups (DNR YES and DNR NO). We fully acknowledge the tremendous work put forth by the OSHPD in developing and executing a risk-adjusted evaluation in such a complex patient population and in the preparation of a public report. Although the size of the data set and the sophistication of the risk adjustment methodology provide valuable comparative information, the utility of the findings are limited by the timeliness of data and failure to include or account for potentially important risk factors in the process of risk adjustment. In addition, factors beyond the control of the hospital may bias findings when 30-day mortality is selected for study as the outcome variable.

We support the State's efforts to inform the public about the quality of healthcare provided by California hospitals.

Sincerely,

Michael J. Uboldi
Hospital President

Mission Community Hospital™
Compassionate Healthcare. Quality Healthcare.

November 13, 2003

Joseph Parker, Ph.D.
Action Deputy Director
Health Care Quality and Analysis Division
Office of Statewide Health Planning and Development
818 K Street, Room 200
Sacramento, CA 95184

Dear Dr. Parker,

Mission Community Hospital is committed to delivering high quality healthcare in the San Fernando Valley. Our patients and their families look to us to deliver on that promise.

Our results published in OSHPD's "California Hospital Outcomes Report on Community-Acquired Pneumonia, 1999 – 2001" indicated that Mission Community Hospital's Community-Acquired Pneumonia (CAP) mortality rate is "not significantly different from the state average." However, the 1999 outcome, with only 17 cases, skews the overall results since that outcome had a very high probability that the rate occurred by chance.

We established and have continued a performance improvement process to examine the care of the pneumonia patient and we monitor the JCAHO Core ORYX measures for CAP. Further we developed a clinical pathway and patient education tools directed at improving our treatment protocols. It is important to note that a significant number of our pneumonia patients enter Mission Community Hospital through the Emergency Department where timely assessment and treatment is implemented. Our outcomes for patient assessment and implementation of antibiotic therapy in less than 8 hours have been outstanding.

While we are not taking exception to the data provided, we are disappointed that the age of the data makes it difficult for organizations to respond.

Thank you for the opportunity to respond to the outcomes report.

Sincerely,

Bill Daniel
Chief Executive Officer

14850 Roscoe Boulevard • Panorama City, CA 91402 • (818) 787-2222
www.MCHonline.org

Peter F. Bastone
President & Chief Executive Officer

Mission Hospital
ST. JOSEPH HEALTH SYSTEM

27700 Medical Center Road
Mission Viejo, CA 92691

Tel 949.365.2248
Fax 949.364.2056
www.mission4health.com

November 25, 2003

Joseph Parker, Ph.D.
Acting Deputy Director
Health Care Quality and Analysis Division
Office of Statewide Health and Planning and Development
818 K Street, Room 200
Sacramento, California 95814

Dear Dr. Parker,

Thank you for the preliminary report on the care of Community-Acquired Pneumonia (CAP) at California hospitals between 1999 and 2001. We appreciate the comparison data on CAP mortality.

We have reviewed the hospital specific outcome measures for our facility. Mission Hospital physicians and staff are pleased with the outcomes reported for its patient population of CAP/mortality. For the third year, Mission Hospital remains on the low end of the expected mortality range for both the observed and the risk adjusted death rates for CAP.

Mission Hospital is very proud of the care we deliver. We very much appreciate your interest in our comments regarding this study and thank you for the opportunity to participate. The study feedback will be used as a part of our internal systems for our continuous performance improvement.

Sincerely,

Peter F. Bastone
President and Chief Executive Officer

NORTHBAY HEALTHCARE
A Non-Profit NorthBay Healthcare System Affiliate

1 December 2003

Joseph Parker, Ph.D.
Acting Deputy Director
Health Care Quality and Analysis Division
Office of Statewide Health Planning and Development
818 K Street, Room 220
Sacramento, CA 95814

Dear Dr. Parker:

The NorthBay Healthcare Group (NorthBay Medical Center and VacaValley Hospital) appreciates the opportunity to review and respond to the draft California Hospital Outcomes Report on Community Acquired Pneumonia, 1999-2001. Our organization is committed to continuous quality improvement and we consider the findings of reports such as this very seriously, using it as a tool to initiate a process of self-evaluation and consequent performance improvement.

Once we received the comparative data that you sent to us, a Quality Improvement (QI) team of four medical staff physicians and two QI Department staff was empanelled to analyze the findings of the OSHPD study and to design interventions aimed at lowering the mortality rate of patients admitted with community acquired pneumonia. Our findings and plans are detailed below:

1. The first activity of the QI team was to evaluate the veracity of the data submitted to OSHPD and to evaluate whether there were any trends in patient care that could have explained the observed mortality rate. During the 3 years between 1999-2001, there were 134 cases identified as meeting criteria for mortality from community acquired pneumonia. The medical records of 132 patients were successfully retrieved and abstracted. In a significant number of cases at both NorthBay Medical Center and VacaValley Hospital, the data contained in the OSHPD report was different from that found in our review of the hospital medical records. The findings from each site are as follows:

<u>NorthBay Medical Center</u>

CAP deaths in OSHPD study		75
Deaths with incorrect admission source	20	
Did not die of community acquired pneumonia	1	
Corrected deaths		54
Corrected death rate (prior=19.8%)		15.08%
Corrected risk adjusted death rate, without DNR		17.98%
Corrected risk adjusted death rate, with DNR		17.33%

<u>VacaValley Hospital</u>

CAP deaths in OSHPD study		59
Deaths with incorrect admission source	12	
Did not die of community acquired pneumonia	1	
Had hospital acquired pneumonia	1	
Corrected deaths		45
Corrected death rate (prior=22.1%)		17.13%
Corrected risk adjusted death rate, without DNR		18.56%
Corrected risk adjusted death rate, with DNR		16.45%

From this re-analysis of deaths from community acquired pneumonia, it is clear that incorrect coding data previously submitted by NorthBay to OSHPD explains in part the high degree of disparity between observed and expected mortality rates from community acquired pneumonia. The corrected mortality rates significantly reduce our overall mortality rate and the degree to which the performance of the NorthBay hospitals varies from other hospitals.

1200 B. Gale Wilson Boulevard
Fairfield, CA 94533-3587
Telephone 707/429-3600

2. NorthBay Healthcare recently has installed Midas DataVision software as a method to track process and outcomes of care provided in our hospitals, as compared to hospitals of similar size. In order to determine whether there has been improvement in pneumonia mortality after the time interval contained in the OSHPD study, we evaluated pneumonia mortality using JCAHO Core Measure definitions for 2002 and the first quarter of 2003. The findings are as follows:

	2002	1stQ 2003
NorthBay Medical Center	6.67%	6.42%
VacaValley Hospital	7.77%	9.48%
DataVision benchmark for similar hospitals	6.23%	5.96%

While the JCAHO Core Measures have different criteria than the OSHPD community acquired pneumonia study, it is reassuring to us that in a more recent time frame, the performance of our two hospitals is closer to expected mortality rates than in the OSHPD study. Whether this is due to actual improvements in outcomes over time or differences in selection criteria is not known at this point, but will be further evaluated.

3. By any measure, it is a matter of concern to us that the corrected mortality rates for community acquired pneumonia are higher at the NorthBay hospitals than they are at comparable community hospitals, as it is our goal to perform well above average in the care that we provide. As a consequence, the Quality Improvement team has embarked upon the following activities in an effort to substantially reduce the rate of pneumonia mortality in our patients:

- With the data abstracted from the medical records of patients in the OSHPD report, we are searching for trends that may explain the observed deaths during this period, thereby providing opportunities for system improvements or educational interventions with individual staff members.

- In an effort to improve the veracity of data submitted by NorthBay Healthcare to OSHPD, a detailed review of hospital coding practices and data submission will be performed.

- The Quality Improvement team is working on the development of an evidence-based Community Acquired Pneumonia Care Pathway, which once approved by the Medical Staff, will be implemented in both hospitals. This will include the development of clinical practice guidelines, use of pre-printed order sets, and daily concurrent review of care provided to patients with pneumonia to ensure that the pathway is being followed.

- Systems of care (involving physicians, nursing staff, pharmacists, respiratory therapists, etc.) within each of the hospitals will be evaluated and redesigned. This is especially critical in regard to coordination of care between the Emergency Department, where medical care for pneumonia patients typically is initiated, and the in-patient units where on-going treatment of pneumonia is provided.

- We will continue to utilize the Midas DataVision information to monitor our progress in reducing pneumonia deaths so that performance data is analyzed and acted upon at a time that is more proximate to when care is given.

We look forward to participation in future OSHPD outcome projects and other quality measurement efforts.

Sincerely,

Deborah Sugiyama
President
NorthBay Healthcare Group

Michael S. Policar, MD, MPH
Vice President for Medical Affairs
NorthBay Healthcare Group

Northridge Hospital Medical Center
CHW

Roscoe Boulevard Campus
18300 Roscoe Boulevard
Northridge, California 91328
(818) 885-8500 Telephone

Sherman Way Campus
14500 Sherman Circle
Van Nuys, California 91405
(818) 997-0101 Telephone

Date: December 3, 2003

To: Joseph Parker, Ph.D.
Acting Deputy Director, Health Care Quality and Analysis Division
Office of Statewide Health Planning and Development
818 K Street, Room 200
Sacramento, CA. 95814

Dear Dr. Parker,
Thank you for the opportunity to review the California Hospital Outcomes Report on Community-Acquired Pneumonia (CAP). Northridge Hospital is committed to delivering high quality heath care. Our patients have high expectations and we strive to exceed them. Patients can be assured that each case involving CAP is individually reviewed.

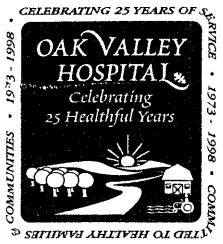
We have carefully reviewed our hospital's results in OSHPD's Report on CAP mortality. Our risk adjusted 30 day outcomes are rated better than expected on both models (with and without DNR, P value <0.01). In addition, our mortality rate is significantly lower than the statewide rate (P value <0.01).

Northridge Hospital physicians and other clinical team members are trained in state of the art treatment and strive for the highest quality outcomes. They welcome any opportunity to improve the quality of care that is given. In keeping with their intent, any patient death or complication that results from CAP is reviewed in depth by the medical staff via their peer review mechanism.

Our outcomes related to CAP will continue to be closely monitored internally. Thank you for the opportunity to gain perspective on our performance as it relates to the larger healthcare community.

Sincerely,

Michael L. Wall
President



Oak Valley Hospital
A Division of Oak Valley Hospital District

October 16, 2003

Joseph Parker, Ph.D.
Office of Statewide Health Planning & Development
Healthcare Quality and Analysis Division
818 K Street, Room 200
Sacramento, CA 95814

RE: California Outcomes Report on Community-Acquired Pneumonia, 1999-2001

Dear Mr. Parker,

Oak Valley Hospital District (OVHD) is a 35 acute-bed rural facility located in the San Joaquin Valley. As a rural facility, the number of cases seen at the facility is limited. Despite the relative low incidence of patients with a diagnosis of pneumonia, Oak Valley Hospital District is committed to ongoing clinical quality improvement not only for patients with pneumonia, but all patients.

We support the analytic approach undertaken by the Office of Statewide Health Planning and Development with this project. The California Hospital Outcomes Project on Community-Acquired Pneumonia provides a unique opportunity to evaluate our performance in relationship to hospitals across the state. While we applaud the efforts to obtain information of this nature from hospitals, one of the limitations is that this data reflects patient care rendered from 1999-2001.

Over the last several years, OVHD has moved to a focus on continuous quality improvement. Data is now assessed on a continual basis and strategies are implemented and modified continuously to improve processes and outcomes. This focus on CQI is a change from the focus of quality assurance, which was in place at the time data collection began. Another hallmark change during the data collection period was initiation of Core Measures by the Joint Commission on Hospital Accreditation (JCAHO). JCAHO has identified Community-Acquired Pneumonia as one of the core measures hospitals can chose to provide comparative data. As the outcomes for Oak Valley Hospital District demonstrate, improvements in care have come to the forefront, ultimately improving outcomes. Overall, OVHD realized an observed death rate less than expected. The rate was slightly higher in 1999, but as identified earlier, our commitment to continuous

350 South Oak Avenue • Oakdale, CA 95361 • (209) 847-3011

quality improvement lead to the observed death rate being significantly lower than expected. One area of concern is related to the number of cases included in the patient category "with a Do Not Resuscitate (DNR) in place". We found that during the study period there were 7 patients with DNR, and not 30, as identified.

An additional concern with release of this information to the lay public relates to the implication that patient outcomes, such as mortality, are solely due to the interventions initiated by the treating facility, when in fact the patient's own health maintenance and willingness to comply with the treatment regime is key to long term survival. Despite these few identified concerns, we feel that the information presented to the public from this project will be favorable. Our participation in the California Hospital Outcomes Report on Community-Acquired Pneumonia demonstrates our commitment to the residents of our community to provide optimum care.

Sincerely,

John Friel
Chief Executive Officer

Ojai Valley
Community Hospital

December 5, 2003

Office of Statewide Health Planning and Development
Health Care Quality and Analysis Division
818 K Street, Room 200
Sacramento, CA 95814

Attn: Joseph Parker, Ph.D, Acting Deputy Director

RE: California Hospital Outcomes Report on Community-Acquired Pneumonia, 1999-2001

Dear Dr. Parker:

Ojai Valley Community Hospital is committed to delivering high quality healthcare. Our patients have very high expectations and we strive to exceed them.

Our results on OSHPD's Community-Acquired Pneumonia Outcomes in California demonstrated a lower than expected mortality rate. We are committed to quality healthcare as well as our commitment to honor our patients' wishes. Our patients have the final say in their treatment decisions. As evidenced by our participation in the Patients Evaluation of Performance-California (PEP-C), our survey showed an above average rating by our patients.

Ojai Valley Community Hospital appreciates the contributions presented in the OSHPD study. This report gives us the opportunity to continually improve protocols, which in turn help us to better serve our patients.

Sincerely,

Victoria A. Alexander
Chief Executive Officer

1306 Maricopa Highway, Ojai, California 93023 Telephone (805) 646-1401 Facsimile (805) 640-2204

ADMINISTRATION

November 14, 2003

Joseph Parker, PhD.
Acting Deputy Director
Health Care Quality and Analysis Division
Office of Statewide Health and Planning and Development
818 K Street, Room 200
Sacramento CA 95814

Re: California Hospital Outcomes Report On Community-acquired Pneumonia

Dear Dr. Parker:

We have reviewed our results and find, unfortunately, that our mortality rates appear to be higher than they actually were because of an error our hospitals made in sending OSHPD our data. Patients admitted via our emergency rooms from skilled nursing facilities have erroneously been included in the study.

The reported mortality rates for this category of patients, excluding, as it is supposed to do, patients admitted from skilled nursing (SNFs) and residential care facilities, is substantially higher than the rates that we have been tracking internally for the past several years. On reviewing the material that was sent to us on disc, we discovered that large numbers of patients not admitted from "home" were mistakenly included in the study. During the period of the report, 1999-2001, we did not have a specific identifier for patients admitted to our hospitals via the emergency departments who were residents of skilled nursing or residential care facilities. The data that we submitted to OSHPD only indicated that these patients were admitted via our emergency department, with the result that these patients appear in OSHPD's database and this study as having been admitted from "home." Obviously residents of long-term care facilities who contract pneumonia will have a higher mortality rate than those living at "home", and this falsely inflated our mortality rates.

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A California Health Care District

It would not be practical to go back and manually review some 1500 charts to determine which patients were admitted from SNFs, nor for OSHPD to alter our data on such short notice based upon this review. We established new internal codes allowing the identification of patients admitted from SNFs in 2002. We have now examined our data for our fiscal year 2003, and we hope this can shed light on the magnitude of the error introduced by inappropriate inclusion of SNF patients in OSHPD's study results.

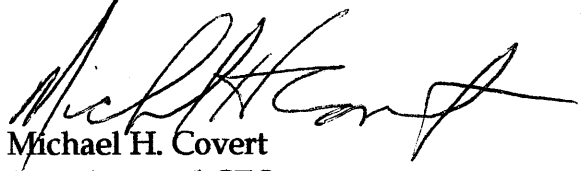
The mortality rate for all patients meeting OSHPD's criteria for the study, but including patients admitted from SNFs, was 11.4%. When these patients were excluded, the rate fell to 10.8%. We believe that these figures would closely approximate those during the 1999-2001 period.

We would be grateful if you could arrange to refer the reader of OSHPD's published report to this letter of comment.

We appreciate the opportunity to review our data. Thank you in advance for your cooperation.

Respectfully yours,

PALOMAR POMERADO HEALTH



Michael H. Covert
President and CEO

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Redlands, CA 92373-0742
909-335-5500
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December 16, 2003

Joseph Parker, Ph.D
Acting Deputy Director
Health Care Quality and Analysis Division
Office of Statewide Health Planning and Development
818 K Street, Room 200
Sacramento, CA 95814

Dear Dr. Parker:

This is in response OSHPD's Draft Community Acquired Pneumonia (CAP) report, which we recently received. Thank you for providing us a copy of the data we gave OSHPD for this study and for answering our questions over the past few weeks. After careful review of Redlands Community Hospital (RCH) data and current CAP literature and practice guidelines, we respectfully request that this study not be published in its current form.

RCH Data

The CAP study population included patients admitted to hospitals from home. Due to abstracting errors, RCH unintentionally provided OSHPD incorrect "admission source" data for about half of the patients included in the study. The abstracting error incorrectly assigned skilled nursing and board and care patients to the admit source category "home," rather than to the appropriate category "long term care." These patients should have been excluded from the study. When we adjust our data and consider only the patients truly admitted to RCH from home, our actual mortality rate is reduced from 17.8% to an estimated 9.0%, significantly below the average expected statewide mortality rate of 12.2%. We brought this important correction to the attention of OSHPD, but we were told that OSHPD would not accept the corrected data.

It is surprising to us that OSHPD would intentionally publish a report that OSHPD knows contains incorrect data. Further, it is reasonable to assume that other hospitals may also have had problems with data quality, so the extent of error may well be larger than the relatively small number of discharges reported in RCH data.

Current CAP Literature and Practice Guidelines

OSHPD indicates the methodology used to produce this report is based on a 1996 model that includes a literature review through June 2000. While OSHPD is apparently aware of published critical risk factors that are associated with an increased rate of CAP mortality, they were rejected for this study.

OSHPD's methodology does not include the widely accepted study published by the Infectious Diseases Society of America (IDSA) in September 2000. The IDSA study includes clinical management guidelines approved by the Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) for CAP patients. The IDSA report defines community acquired pneumonia as community-acquired pneumonia in immuno-*competent* adults, which is consistent with what most practitioners think of as community-acquired pneumonia. Unfortunately, the OSHPD definition of CAP includes immuno-*compromised* adults, i.e., individuals who were admitted with respiratory failure and requiring ventilatory support, or septicemia, abscess of the lung, pulmonary collapse, and pleurisy, among other conditions.

The IDSA report also provides a comprehensive list of risk factors associated with a higher likelihood for mortality in CAP patients. Unfortunately, only a few of these risk factors were included in the OSHPD methodology, while 49 of these published risk factors were excluded from the OSHPD methodology.

As an example of the significance of excluding or including risk factors, RCH compared the clinical severity of the RCH CAP patients who died against the excluded risk factors. All (100%) of the RCH CAP patients who died had at least one of these risk factors. In most cases, the patients had multiple risk factors identified on the exclusion list, and over half of these patients had at least five excluded risk factors. The presence of these risk factors clearly indicates all of these patients were in an immuno-compromised state, and they should not have been included in the study universe. The true clinical picture and conclusions about quality for these patients are considerably different from what the draft OSHPD report suggests.

Another Perspective

RCH also compares its CAP data with published Joint Commission on Accreditation of Healthcare Organizations (JCAHO) benchmark data. Only immuno-competent patients are included in this CAP data base. The results of this ongoing study are remarkably different from the draft OSHPD CAP study.

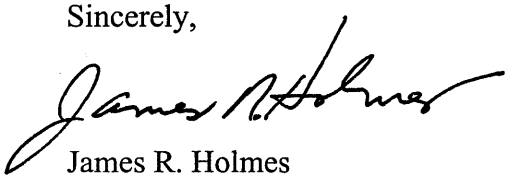
Since 2002, Redlands Community Hospital has routinely measured the CAP mortality rates of our patients and compared them against the JCAHO published CAP National Mortality Rates. The findings of this comparison reveal an average RCH CAP mortality rate of 7% during a 30 month period. This unadjusted-risk mortality rate is well below the reported national CAP mortality rate of 9% as published March 2002 by the JCAHO in their CAP core measure overview.

Recommendation

We support OSHPD's desire to assist the public in making informed healthcare decisions. As all of us in the healthcare industry are aware, identifying and agreeing to definitions of quality and providing the data to measure and compare against these definitions is difficult, at best. To further complicate matters, medical practice continues to evolve and improve. OSHPD has an important but difficult responsibility to identify, report, and measure standards of practice that represent the current state of the art of medicine, rather than to compare current outcomes to dated concepts, as in the draft CAP report.

OSHPD should not publish the draft CAP study without further review and modification, and we believe that OSHPD's presentation of the CAP data as it now exists will mislead the public. Contrary to OSHPD's intent, this report misrepresents hospitals and their medical staffs and does a disservice to the general public. Rather than assisting individuals in making more informed decisions about healthcare, this report is inaccurate, out of date, and not in keeping with the level of service and quality the public expects from its government officials.

Sincerely,



James R. Holmes
President/CEO

OFFICE OF THE DIRECTOR

REGIONAL MEDICAL CENTER

December 4, 2003

Office of Statewide Health Planning & Development
Healthcare Quality and Analysis Division
818 K Street, Room 200
Sacramento, CA 95814

Subject: California Outcomes Report on Community Acquired Pneumonia, 1999 – 2001 OSHPD Data

We are submitting comments regarding the above referenced study, which was sent to us for review and comment. We would like to alert you to concerns we have about significant problems with this study.

Upon receiving the draft report, we undertook a thorough review of our own practices in providing for community acquired pneumonia. Our objective was to look for opportunities to improve our processes of patient care and improve outcomes. We looked at every one of the deaths in the study that occurred at our facility. In this review, we were quite shocked to see that only 25% met criteria for a principal diagnosis of community acquired pneumonia. Cancers, pulmonary emboli, congestive heart failure, tuberculosis, AIDS, and a variety of other conditions accounted for the other 75%.

Furthermore, we then looked at our coding and found the coding was substantially correct.

We therefore conclude that there is a problem with the methodology to identify community acquired pneumonia cases and that, in fact, the codes chosen to represent community acquired pneumonia do not accurately represent such cases.

Additionally, we identified another problem with one of the exclusion criteria, namely DNR within 24 hours. We do not believe that is an appropriate time frame to use to identify DNR in facilities such as ours. The majority of our patients do not have an existing continuity-of-care arrangement with a physician in practice, and often arrive with medical history and family matters not known. Consequently, we often do not write DNR orders within that short a time frame. We may need a longer period of time to assess the overall patient and family situation in an ethical and responsible manner, and feel 24 hours is not a wide enough time frame for capturing DNR orders. Of our 53 deaths, CHOP only identified 13 DNRs, whereas in fact there were 22.

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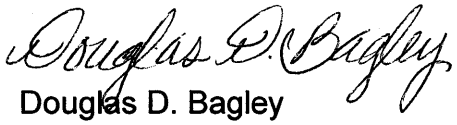
Phone: 909-486-4470 • FAX: 909-486-4475 • TDD: 909-486-4397

Because these issues are probably systemic to the study, we feel that the results cannot be accepted with confidence as to their accuracy. Therefore, we strongly urge OSHPD not to release the study until these issues can be examined and resolved. To release the study as it presently stands, without addressing these issues, could seriously mislead the public.

We are available to discuss these issues further. Please contact Dr. W. Benson Harer, Medical Director, at 909-486-4474.

Sincerely,



Douglas D. Bagley
Chief Executive Officer

DB:sg

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26520 Cactus Avenue, Moreno Valley, California 92555
Phone: 909-486-4470 • FAX: 909-486-4475 • TDD: 909-486-4397

San Joaquin General Hospital / A Division of San Joaquin County Health Care Services

December 20, 2003

Joseph Parker, Ph.D., Acting Deputy Director
Health Care Quality and Analysis division
Office of Statewide Health Planning and Development
818 K Street, Room 200
Sacramento, CA 95814

Dear Dr. Parker:

Thank you for providing San Joaquin General Hospital the opportunity to review the community-acquired pneumonia data for 1999-2001 associated with our facility and for providing us the opportunity to respond to the findings published in your report. We have gone through an extensive review of the data and our patient records to determine whether the data upon which our mortality rate is based is accurate, especially because it was so far outside the statewide norm. The data and the patient records have been reviewed by the Chief of Pulmonary Medicine, the Chief of our Internal Medicine Department, Performance Improvement staff, as well as the Directors of Nursing and Information Management.

Our process given the time allowed for response was to review the 60 cases listed as mortalities within 30 days. We found that a full thirty-two (32) of the cases should have been excluded from the report based on OSHPD's exclusion criteria. Twenty-one (21) of the patients were admissions from nursing homes, so should not have been a part of the study. In addition, eleven (11) cases met the clinical exclusion criteria based on such factors as co-morbidities which were the actual cause of death and therefore should not have been included as deaths from community-acquired pneumonia.

Our review has revealed to us that we need to make improvements in our processes here for accurately coding patients upon arrival, particularly those from nursing homes, and to improve our discharge coding so that correct information is transmitted as part of the statewide database. We have instituted correction plans with the Admitting Department, the Information Management Department, and the medical staff to enhance communication which will result in improved data and more accurate risk adjustments.

Based on our review, we believe that our mortality rate is likely in line with the statewide average and not at the level conveyed in the report. We are committed to working with your agency to ensure that our data accurately reflects our patient care in future reports.

Sincerely,

Steve Ebert
Hospital Director

SE:DH

Cc: Dr. Deepak Shrivastava, Pulmunologist
Dr. Sheela Kapre, Internal Medicine Chief
Dr. Lee Adams, Medical Director
Dr. Christopher Flores, President of the Medical Staff

Post Office Box 1020 / Stockton / California 95201 / 209 468-6000

Scripps Green Hospital
10666 North Torrey Pines Road
La Jolla, CA 92037-1092
Tel 858-455-9100

October 21, 2003

Joseph Parker, Ph.D.
Acting Deputy Director
Health Care Quality and Analysis Division
Office of Statewide Health Planning and Development
818 K Street, Room 200
Sacramento, CA 95814

Dear Dr. Parker,

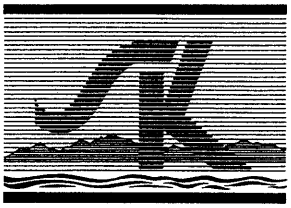
After reviewing the Scripps Green Hospital specific data and the preliminary draft in general in the **Community-Acquired Pneumonia: Hospital Outcomes in California, 1999-2001,** I would like further clarification on the RADR.

How many ICD 9 codes for co-morbidities do you use for each patient medical record when calculating RADR? Do you believe that each patient record includes a complete list of co-morbidities or is there a limit to the number that are utilized. For example, if one of the patients has 15 comorbidities and the record does not have them ranked in an order of severity for CAP, would some of them not show up on your risk adjustment calculation?

I am pleased with our rating, but wonder if you can provide any more clarification on this issue.

Sincerely,

Robin Brown
Administrator



SIERRA KINGS
DISTRICT HOSPITAL

December 3, 2003

Joseph Parker, Ph.D.
Acting Deputy Director
Health Care Quality and Analysis Division
Office of Statewide Health Planning and Development
818 K Street, Room 200
Sacramento, California 95814

Dear Dr. Parker:

Thank you for the opportunity to respond to the preliminary report of the care of Community Acquired Pneumonia for California hospitals between 1999 – 2001. The preliminary report for Sierra Kings District Hospital CAP without DNR and with DNR, rates us significantly under the risk adjusted death rate percent.

Sierra Kings District Hospital physicians and staff assure each patient individual treatment and strive to give the highest quality of care.

Sierra Kings appreciates the contributions made by the OSHPD study. The report on Community Acquired Pneumonia outcomes in California gives us the opportunity to re-evaluate and improve our pneumonia protocols.

Thank you for helping us to better serve our patients.

Sincerely,

Melvyn Patashnick
Chief Executive Officer

372 West Cypress Avenue, Reedley, CA 93654 (559) 638-8155 FAX (559) 637-7555

465 W Putnam Ave
Porterville, Ca 93257

November 10, 2003

Dear Mr. Parker,

Thank you for the opportunity to respond to the release of data on our hospital's outcomes for community acquired pneumonia. Sierra View District Hospital is a 157-bed, acute care facility that serves a population of over 100,000 people. The second largest hospital in Tulare County, Sierra View has 190 births per month and our Emergency Room serves over 38,000 patients annually. Our 29-bed Subacute Unit provides for short or long term 24-hour nursing care and the Cancer Treatment Center offers a full range of radiation and oncology services under one roof.

We at SVDH are committed to analyzing our patterns of care and patient outcomes to provide the highest quality of care possible. One hundred percent of unexpected death cases are screened by the Quality Management Department to ensure that they are not related to a quality of care issue.

OSHPD's CAP data for 1999-2001 has been analyzed carefully by our hospital's Medical Director of Quality, CEO, CNO and Director of Quality Management. The results of the study shows our observed risk –adjusted mortality rate for the No code patient's to be just above the California State average of 12.23% with the confidence interval width crossing the state average and the full code patient's rate to be significantly higher than statewide rate.

Joining the ORYX study for CAP patients in July of 2002 and CMRI in 2003 has identified opportunities to improve care and has prompted education for patient's and their families, hospital staff, and physicians. We also established a performance improvement team to examine the processes around the care of the CAP patient. This multi-disciplinary team is concentrating on the amount of time it takes to administer first dose antibiotics from admission, Pneumococcal screen and vaccinating and Smoking cessation advise/counseling. In addition, the Health Information Management department will be conducting an audit to ensure accuracy of our coding practices for CAP patients here at Sierra District Hospital.

In reviewing our statistics from January 2002 through 2003 to date we found our in house mortality rate to be <5% for those admitted with a primary diagnosis of pneumonia.

We look forward to opportunities to participate in improving the OSHPD CAP outcomes project as well as continuing with other benchmark efforts such as CMRI and ORYX. This report affirms our already noted dedication to improving care for the community acquired pneumonia patient's in our community.

Sincerely,

Kelly Morgan,
President and CEO

Simi Valley Hospital

Adventist Health

Mailing Address
2975 N. Sycamore Drive
Simi Valley, CA 93065
Tel 805-955-6000

December 22, 2003

Joseph Parker, PhD
Acting Deputy Director
Health Care Quality and Analysis Division
Office of Statewide Planning and Development
818 K Street, Room 200
Sacramento, CA 95814

Dear Mr. Parker,

Simi Valley Hospital is in receipt of the California Hospital Outcomes report released to us in October 2003. We have reviewed the hospital specific measures of outcome for our facility and are pleased that we are below the statewide average for overall risk adjusted mortality rates for Community–Acquired Pneumonia.

We are currently participating in JCAHO's ORYX Core Measure reporting and CMS Hospital Quality Incentives involving Community-Acquired Pneumonia as a part of our quality improvement for the care of pneumonia patients.

Thank you for the opportunity to respond to the study results.

Sincerely,

Margaret R. Peterson

Margaret R. Peterson, PhD
President & Chief Executive Officer

MRP/blc

STANFORD
HOSPITAL & CLINICS
Stanford University Medical Center

ADMINISTRATION

November 25, 2003

Joseph Parker
Acting Deputy Director
800 18th K Street
Room 200
Sacramento, CA 94814

Dear Mr. Parker,

Stanford Hospital and Clinics is committed to providing the highest quality of patient care to all of its patients. In that endeavor, Stanford Hospital and Clinics is continuously seeking opportunities to further improve and validate the quality of care it provides. The OSHPD Community Acquired Pneumonia (CAP) study provided Stanford Hospital and Clinics an opportunity to participate in and utilize the findings from the study to direct improvement efforts.

Stanford Hospital and Clinics supports the OSHPD evaluation of the study and believes the study data support the excellent quality of care provided.

No study, however well-designed and executed, can answer all questions. All studies necessarily make compromises in gathering and summarizing data, especially when the information comes from dissimilar hospitals. As a result, there are limitations on conclusions that can be drawn from this report. We draw your attention to two particular points which are supported in the detail of the report itself.

(1) Comparing two or more healthcare facilities may yield conflicting or unreliable results because:

- The number of relevant patients (sample sizes) are too few to reach firm estimates of a healthcare organization's performance. Such a comparison would be similar to comparing two baseball player's batting performance based on their results from a few games rather than the entire season. A typical approach in estimating true differences in performance is to attach a "margin of error" to each estimate as is done with public opinion and election polls. By adding and subtracting the "margin of error" to the estimate a range of values is formed. If, after accounting for sampling error in this way, the range of values for one organization overlaps with the range for another then we cannot conclude which organization has better performance. It should be noted the "margin of error" is quite large in this study and that, in many cases organizations that were labeled "better than expected" have a range of values that overlaps with organizations that were labeled to be performing "as expected."

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- The mix of different patient types and condition of patients receiving care at each of these organizations are not the same. Healthcare organizations providing care to the sickest and most complicated patients may then display only average performance compared to organizations with more routine and uncomplicated patients. Returning to the baseball analogy, one would resist comparing two baseball teams if they each played in dissimilar leagues with strong pitching in one league and weaker pitching in the other. The report uses a "risk adjustment model" to try to correct for such differences but usually cannot eliminate the impact of differences in patient mix and patient condition:

  "A principal weakness of this report is its reliance on a small set of 'administrative' data elements that hospitals are required to report to the State's Patient Discharge Data Program. Such administrative data provide limited information about demographic and clinical variables. Accordingly, it is possible that some of the deaths predicted by the model used in this report were the result of unmeasured risk rather than poor hospital quality."

  This "risk adjustment model" comparison should not be viewed in the same light as, say a controlled study on automobile safety. In such a study, similar cars from different manufactures can be put through performance tests under the same circumstances, such as the car's breaking distance when traveling 30 mph. Since each car is tested under the same circumstances, differences in performance can be determined without need for a "risk adjustment model." Such controlled studies are not possible in healthcare since that would require an identical patients with identical conditions to be admitted to each healthcare facility we would like to compare. The "risk adjustment model" is an attempt mathematically create a "typical" patient.

(2) The risk-adjusted mortality rate alone does not portray an organization's performance. As noted in the report, aspects of patient care other than 30-day mortality are not being measured here:

"This report focuses on 30-day mortality, but does not assess other outcomes such as a patient's quality of life after discharge, or subsequent hospital readmissions."

Stanford Hospital and Clinics is devoted to three goals: to care, to educate, and to discover. Stanford Hospital and Clinics will continue to seek opportunities to improve patient care, even while validating all measures of its performance.

The data provided by OSHPD to Stanford Hospital and Clinics will form part of the Community Acquired Pneumonia Core Measurement Program. The program is focused on both improving care delivery to the individual patient, regardless of how sick he/she may be, and improving the group's overall rates of successful outcomes.

Martha H. Marsh
President & CEO
Stanford Hospital & Clinics

Larry Shuer, MD
Chief of Staff
Stanford University Medical Center

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NL:dd

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November 20, 2003

David M. Carlisle, M.D., Ph.D., Director
Office of Statewide Health Planning and Development
818 K Street, Suite 200
Sacramento, CA 95814

Dear Dr. Carlisle,

Thank you for the opportunity to review and comment on the preliminary draft of OSHPD's 1999-2001 Community-Acquired Pneumonia Mortality outcomes report.

We appreciate the magnitude and scope of compiling, analyzing and publishing this data. However, we are concerned that consumers and other users of this report will view this data as the current state of quality in California hospitals, when in fact; the data is 3-5 years old. Hospitals strive to improve the quality of care they provide continuously. Data that is 3-5 years old does not reflect the positive effects of these efforts.

We agree with most aspects of the risk adjustment methodology utilized. We recognize that death within 30 days of admission is an important data point; however, we have significant concerns that a death from any cause or location is linked to the initial hospitalization. Reporting of thirty-day mortality introduces many variables beyond the control of the hospital. Some patient deaths occurring after discharge may not relate to the patient's pneumonia, or to the quality of care during the patient's hospitalization. Extraneous factors such as the patient's quality of life after discharge, adherence to medical treatment or follow-up post discharge are not considered.

Another area of concern with this report is its reliance on a limited set of "administrative" data elements that hospitals are required to report to the State's Patient Discharge Data Program. As stated in the outcomes report, such administrative data provides limited information about demographic and clinical risk factors that may increase the risk of death. Additionally, only risk factors found by the validation study to be reliably coded were included in the risk-adjustment model. Some risk factors that were significantly correlated with 30-day mortality were excluded from the model due to unreliable coding.

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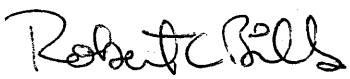
We are pleased to see that we are slightly below the statewide average for overall risk-adjusted mortality. Enhancing the level of care to our patients remains a top priority at Valley Presbyterian Hospital. The data from the OSHPD California Outcomes Project is only one of many reports that we utilize to assist us in our performance improvement efforts. Despite the concerns listed above, we do take this data seriously and have shared the information with the members of our medical staff, nursing leadership and administrative staff for the purpose of continuing to improve outcomes for our patients.

Again, thank you for the opportunity to submit these comments for publication with the final draft of the "Community-Acquired Pneumonia Outcomes Report". As always, Valley Presbyterian Hospital remains dedicated to providing the utmost in quality patient care to the communities we serve.

Sincerely,



Robert C. Bills
Chief Executive Officer

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December 19, 2003

Joseph Parker, Ph.D.
Acting Deputy Director
Office of Statewide Health Planning and Development
Healthcare Quality and Analysis Division
Healthcare Outcomes Center
818 K Street, Room 200
Sacramento, CA 95814

Re: California Hospital Outcomes Report on Community-Acquired Pneumonia, 1999-2001

Dear Mr. Parker:

Western Medical Center Santa Ana appreciates the opportunity to respond to the Annual Report of the California Hospital Outcomes Project published by the Office of Statewide Health Planning and Development (OSHPD). We support the State's efforts to better inform the public regarding the quality of health care being delivered in California hospitals. Unfortunately, the usefulness of the 1999-2001 Community-Acquired Pneumonia Study does not recognize the severity of the patient's illness.

Western Medical Center Santa Ana conducts reviews of all mortalities and patient resuscitations as part of our continuous quality improvement process. The medical staff has taken opportunities to identify and improve patient outcomes. We believe our review processes provide a continuous feedback that allows us to meet quality standards of care and identify opportunities to improve. Additionally, Western Medical Center Santa Ana has a Commitment to Quality program which addresses evidence-based medicine for pneumonia patients.

Thank you again for the opportunity to respond prior to publication. If you have any questions, feel free to contact me at 714.953.3610.

Sincerely,

Dan Brothman
Chief Executive Officer

DB:lm