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Pennsylvania Health Care Cost Containment Council
Attn.: Marc P. Volavka, Executive Director
225 Market Street, Suite 400
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October 23, 2006

RE: PHC4 Hospital Acquired Infection Report (2005 Data). Comments for inclusion in the public report and for posting on the PHC4 website.

To Whom It May Concern:

Grand View Hospital strongly supports the publication of appropriately collected and defined patient morbidity and mortality information – including hospital-specific information relating to hospital-acquired infections. Our organization sincerely believes that PHC4 has an opportunity to be of tremendous benefit to the citizens of Pennsylvania through its timely issuance of complete, accurate and informative reports in a well-explained and balanced manner.

Efforts to eliminate infection have been among the highest priorities of every hospital with which it's been my privilege to be affiliated. However, totally eliminating infections is no simple task. As was once stated by H. L. Mencken, *"For every problem, there is a well recognized solution that is simple, neat and wrong..."* Inasmuch as hospitals care for individual patients having individual circumstances and conditions, each case of infection warrants individual review.

By way of example, if we dissect the details of actual case examples from Grand View Hospital that are addressed as mortalities within PHC4's Hospital Acquired-Infections report, we learn of facts and circumstances that will likely give us pause as we review the report in context. Because of the limitations that are understandably placed by PHC4 on the length of "letters of comment," I'll discuss the cases of just two representative patients – both of whom acquired infections while in the hospital.

The first representative case, as I understand its details, involved a 93 year old gentleman with uncontrolled diabetes and advanced peripheral vascular disease who was admitted to our hospital with a severely gangrenous limb. At the request of the patient, three major surgeries were performed in an effort to extend this

gentleman's life. After four weeks in the hospital, the patient's life was fading and his situation was becoming more and more dire. The gentleman experienced difficulty eating and swallowing and most likely because of the difficulty with swallowing contracted pneumonia. In the end, after 36 days in the hospital, the patient succumbed. Our staff's attempt to save the life of this 93 year old gentleman may have proven unsuccessful, but it is in spite of, and not because of our staff's Herculean efforts on behalf of this gentleman that he is no longer alive.

Another representative example, as I understand its details, involved a 63 year old lady who was admitted to our hospital for treatment of a bowel perforation that was experienced secondary to a colonoscopy procedure that had been performed at another facility. At the time of her admission, this lady was on the "waiting list" for a liver transplant because of liver failure that she had suffered as a consequence of having contracted hepatitis years earlier. Because of the gross contamination caused by the bowel perforation, the patient arrived at the hospital with a severe infection brewing in the lining of her abdominal cavity. This lady was in serious condition upon arrival at our hospital. Following life saving surgery, the patient's course soon became even more complicated. Because she could not speak for herself, her family assumed responsibility for making decisions on the patient's behalf concerning her care. The patient's physicians recommended to the family that nature be permitted to take its course and that the patient be provided only comfort measures. However, the family felt strongly that it was their obligation to call for the use of every possible means of extending the patient's life – an effort that they pursued over a period of *months.* The patient could no longer breathe on her own, so her life was supported by a mechanical ventilator. The patient's sepsis worsened. Along the way, a urinary tract infection developed and was treated. The patient's chronic liver failure worsened. She went into kidney failure. *During the fifth month of her hospital course,* the patient developed a ventilator-associated pneumonia. Soon thereafter, the family agreed to discontinue aggressive care. The patient succumbed three days later – 163 days after being admitted with sepsis, a perforated bowel, and a failed liver for which transplant was being awaited. A reader of this report who is not aware of the particulars of this case, however, could understandably believe that the patient's death resulted from the aforementioned pneumonia or urinary tract infection.

As has been discussed with PHC4 leadership, I remain concerned that this report by PHC4 may lead less informed readers to conclude that direct "cause and effect" relationships exist consistently tying together occurrences of infection with lapses in care, the lengthening of a patient's hospital stay and the amount paid for the involved patient's care. However, as I hope is evident through the examples that have been provided (and with apologies to Mr. Mencken), things are often not as simple as they may first appear.

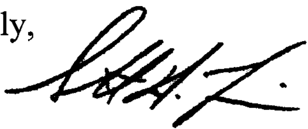
A secondary concern that is inherent to reports that include calculations that are based upon small sample sizes is what is known in statistics as "the tyranny of small numbers." By way of example, in Grand View Hospital's case, there is one category of infection for which a mortality rate of "0%" is reflected based on 8 cases in which infections developed. In another category, a mortality rate of "37.5%" is reflected based on 8 cases from which 3 patients died. Had 1 patient out of 8 passed away in the first category, that would have changed the mortality rate from "0%" to "12.5%", while had 1 less patient from the second category have died, that would have changed the mortality rate from "37.5%" to "25%". Such sizeable shifts reflect "the tyranny of small numbers," and reduce dramatically the value and validity of the percentage rates reflected in the report.

As noted in my opening paragraph, Grand View Hospital supports the publication of appropriately collected and defined morbidity and mortality, including hospital-specific information relating to hospital-acquired infections. We are not attempting to "make perfect the enemy of good" by calling attention to the difficulties that must be considered in evaluating a report such as the one to which this letter relates. We do, however, respectfully call upon PHC4 to continue to refine, clarify and improve its efforts at publishing complete and accurate information in a well-explained and balanced manner.

Grand View Hospital is pleased to be a part of this important effort at advancing transparency in the area of hospital-acquired infections. Concurrently, we remain very concerned that oversimplifying the details of complex medical cases may serve to mislead the public and to cause patients to make inappropriate decisions based upon information that is reviewed without context or adequate explanation. Grand View believes that a tremendous opportunity exists for the development of collaborative efforts at improving care through positive modeling and data sharing. We are hopeful that efforts such as that which led to the issuance of this report will, through refinement, yield constructive outcomes benefiting the public.

Thank you very much for this opportunity to provide comment concerning this work of The Pennsylvania Health Care Cost Containment Council.

Sincerely,



Stuart H. Fine
Chief Executive Officer