UNIVERSITY OF
PENNSYLVANIA
MEDICAL CENTER

Hospital of the University of Pennsylvania
Administration

December 9, 2002

Mr. Marc P. Volavka
Executive Director
Pennsylvania Health Care Cost Containment Council
225 Market Street, Suite 400
Harrisburg, PA 17101

Dear Mr. Volavka:

The Hospital of the University of Pennsylvania appreciates the commitment and effort of the Pennsylvania Health Care Cost Containment Council in the publication of the 2001 Hospital Performance Report. We would like to acknowledge the Council's work on identifying the specific 16 "code-based conditions" which focuses on disease conditions rather than diagnostic related groups. We appreciate the opportunity to comment on the performance report.

Comments to "Code-based Conditions" for the published report:

Condition - Septicemia
The patients assigned a diagnosis code for septicemia as a primary diagnosis at the Hospital of the University of Pennsylvania generally have additional co-morbid conditions. Almost half (47%) of the patients assigned this diagnosis have metastatic cancer and are generally in the terminal phase. In addition 21% of the patients who died in this disease group had end stage major organ failure. A few patients had both conditions. Over a third of the patients that died were immunocompromised. Ninety-five percent of the patient deaths in this disease group either had terminal cancer, major organ failure, immunocompromised, or a combination of all three conditions. Of the patients who died, 80% were admitted through the Emergency Department while the remaining 20% were transferred to the Hospital of the University of Pennsylvania from other hospitals. Since the majority of patients (68%) had terminal co-morbid conditions (cancer and major organ failure), as discussed above, 77% of these terminal patients had a DNR status (do not resuscitate) or the patient families requested that only supportive measures be maintained during this admission.

Comments to DRG on the Web Report

DRG 395 - Anemia & Transfusion Reaction
While mortality for this DRG is higher at the Hospital of the University of Pennsylvania than expected for the Pennsylvania database, 50% of the patients that died were transferred from other hospitals due to the extreme nature of the clinical aspect of the patient. These patients were transferred due to co-morbid complications prior to admission, such as major organ failure, to the Hospital of University of Pennsylvania. Most of the patients (75%) were immunosuppressed and 50% of the patients had DNR (do not resuscitate measures) plan of care. Two patients' deaths in this DRG were related to the end-stage effects of the complications of sickle cell anemia.

DRG 478 - Vascular Operations except Heart, Complicated
Within this Diagnosis Related Group many other disease conditions occur concurrently. At the Hospital of the University of Pennsylvania most of the patients included in this category did not, in fact, have vascular surgery. Only 45% of the patients who died in this DRG had vascular procedures, such as, arterial re-vascularization and these patients had other co-morbid conditions The remaining 55% of the patient deaths involved complex clinical interventions, such as interventional radiology procedures to assess, maintain, and attempt to improve major organ function. None of the deaths were due to the interventional radiology procedures but rather to the effects of their co-morbid conditions such as end stage organ failure including renal failure, heart/lung failure, or cardiogenic shock. We note that among patients at our Hospital who underwent Abdominal Aortic Aneurysm repair (which is included in the public report) the mortality rate was much better than expected. This procedure code is a more accurate reflection of our performance in Vascular Surgery.

In summary, the data indicates that patients admitted to the HUP have multiple disease diagnosis codes due to complex and complicated co-morbid disease processes. Many patients are transferred emergently to the Hospital of the University of Pennsylvania from multiple primary hospitals after attempts to resolve the patient condition have not been successful. Such patients have a much higher expected mortality. Our careful review of these outliers does not identify systematic quality issues as an explanation for the outlier status. Rather, the complexity of our patient mix in these categories and the terminal nature of many of the presentations account for the differences in our performance compared to other hospitals.

Sincerely,

Garry D. Scheib
Executive Director
Hospital of the University of Pennsylvania