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Health Watch USA

Transforming Healthcare Through Transparency

Information in this presentation is the opinion of Dr Kevin T Kavanagh.
• **Transparency:** Revealing to the public the cost and quality of the healthcare in their communities.
Public Reporting fosters the use of public oversight, public pressure and market forces to make change and to promote higher quality and lower cost of care.

It does not regulate how one runs a business and does not impose criminal sanctions for bad results.
Why Do We Need Transparency?

The Size of The Problem

• By 2020, our healthcare system will comprise 20% of our Gross National product. Much more than any other industrialized nation.

• The United States has a below average life expectancy rate, above average maternal and infant mortality rate than the average Industrialized Nation.

• The US has less hospital beds, nurses, and doctors than the average industrialized (OECD) Nation.

References: http://www.healthwatchusa.org/USA-Healthcare.htm
• 1 in 20 U.S. Hospital Patients Develops a HAI.
• 1.7 Million Infections, Nearly 100,000 Lives Lost Each Year
• Kentucky – An annual cost of almost 400 million dollars & almost 1400 Lives Lost from 23,000 HAI.

Nationally, deaths equal more than one Boeing 767 crashing every day.
## Size of the Problem

### HAI Burden

<table>
<thead>
<tr>
<th>Public Health Issue</th>
<th>Deaths Per Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAIs</td>
<td>100,000</td>
</tr>
<tr>
<td>Motor Vehicle Traffic Accidents</td>
<td>42,031*</td>
</tr>
<tr>
<td>Breast Cancer</td>
<td>40,598‡</td>
</tr>
<tr>
<td>HIV / AIDS</td>
<td>17,489†</td>
</tr>
</tbody>
</table>
Types of Public Reporting Initiatives

- Value Purchasing By Insurance Companies
- Value Purchasing By Patients (Consumer Driven Healthcare)
- Public Engagement
- Full Disclosure
Value = \frac{Quality}{Cost}
• What is Cost ??

1) Cost to the hospital (fixed and non-fixed costs).

2) Cost to the consumer or payer (PRICE)
   -- Asking or List Price
   -- Insurance Discount Price
Two Types of Incentives

• Payment schedules from third-party payers (insurance discount price).

• Market competition through consumer choices.
• Risk-Adjusted Data -- High degree of comparability, since payments by insurance companies (CMS) can be driven by performance.
Value Purchasing By Insurance Co.- Quality

- Non-Risk Adjusted Value Purchasing:

CMS has used this strategy to lower the incidence of expensive complications. Example: Catheter Associated Urinary Tract Infections.

“If you want more of something, pay more for it. If you want less of something, pay less for it.”

- Some Events should be close to zero:
  -- CLABSI (Central Line Associated Blood Stream Infections),
  -- VAP (Ventilator Associated Pneumonia),
  -- Post Surgery Chest Infections &
  -- Stage III & IV Pressure Ulcers.
Consumer Driven Healthcare

• Pioneered by Dr. Regina Herzlinger – Chair Harvard School of Business.
• The Consumer has a choice of Providers and Competition lowers cost and increases quality.
• Two issues
  – Cost
  – Quality
Value Purchasing By Patients

Hospital Compare

Where do you want to find a hospital?

Search Information

Location - ZIP Code or City, State

e.g. 10009 or New York, NY

Search type [?]

- General
- Medical Conditions
- Surgical Procedures

Find Hospitals

Hospital Spotlight

Click on the new Patient Safety Tab during your hospital search to see new information Hospital Acquired Conditions and Serious Complications and Deaths.

In January, Medicare will report new measures for heart attack care and surgical care. Also, for the first time, we will be reporting information on central line infections from the Centers for Disease Control’s National Healthcare Safety Network.

You can now visit Medicare’s Hospital Value Based Purchasing Program page and learn more about future measures.

You can now get information on Mortality and Readmission Measures for approximately 150 Veterans Administration Hospitals.
<table>
<thead>
<tr>
<th>Condition</th>
<th>Saint Joseph Hospital</th>
<th>U.S. National Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objects Accidentally Left in the Body After Surgery</td>
<td>0.000 per 1,000 patient discharges</td>
<td>0.026 per 1,000 patient discharges</td>
</tr>
<tr>
<td>Air Bubble in the Bloodstream</td>
<td>0.000 per 1,000 patient discharges</td>
<td>0.003 per 1,000 patient discharges</td>
</tr>
<tr>
<td>Mismatched blood types</td>
<td>0.000 per 1,000 patient discharges</td>
<td>0.001 per 1,000 patient discharges</td>
</tr>
<tr>
<td>Severe Pressure Sores (bad sores)</td>
<td>0.316 per 1,000 patient discharges</td>
<td>0.135 per 1,000 patient discharges</td>
</tr>
<tr>
<td>Falls and Injuries</td>
<td>0.568 per 1,000 patient discharges</td>
<td>0.564 per 1,000 patient discharges</td>
</tr>
<tr>
<td>Blood Infection from a Catheter in a large vein</td>
<td>0.063 per 1,000 patient discharges</td>
<td>0.367 per 1,000 patient discharges</td>
</tr>
<tr>
<td>Infection from a Urinary Catheter</td>
<td>0.379 per 1,000 patient discharges</td>
<td>0.316 per 1,000 patient discharges</td>
</tr>
<tr>
<td>Signs of Uncontrolled Blood Sugar</td>
<td>0.000 per 1,000 patient discharges</td>
<td>0.050 per 1,000 patient discharges</td>
</tr>
</tbody>
</table>

2011 Hospital Compare
-- Rates of Death
-- Rates of CLABSI
-- Rates of Bed Ulcers
-- Rates of Falls
-- Process Measures
Value Purchasing By Patients

Consumer Driven Healthcare

- Effectiveness of Consumer Driven Healthcare is expected to decrease with anti-competitive initiatives.
  - Certificate of Need
  - Healthcare Integration
Value Purchasing By Patients - Cost

Consumer Driven Healthcare

- Costs – Small differences will drive patients to other providers.
- Similar to the airline industry or the gasoline retail industry.
### Consumer Driven Healthcare

<table>
<thead>
<tr>
<th>Facility</th>
<th>T &amp; A Over 12 Asking Price</th>
<th>T &amp; A Over 12 Max Discount Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital #1</td>
<td>XX</td>
<td>XX</td>
</tr>
<tr>
<td>Hospital #2</td>
<td>$4100.00 (Including Anesthesia)</td>
<td>$3,280.00 (Including Anesthesia)</td>
</tr>
<tr>
<td>Hospital #3</td>
<td>$7,334 - $5013</td>
<td>$5500 - $3760</td>
</tr>
<tr>
<td>Hospital #4</td>
<td>$6,427.10</td>
<td>$3,020.74</td>
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<tr>
<td>Out Pt. Surgery Center #1</td>
<td>$1,886.00</td>
<td>$1,508.80</td>
</tr>
<tr>
<td>Out Pt. Surgery Center #2</td>
<td>$1,100.00</td>
<td>$825.00</td>
</tr>
<tr>
<td>Out Pt. Surgery Center #3</td>
<td>$2,373.00</td>
<td>$1,186.50</td>
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</table>
## Consumer Driven Healthcare

### T & A Insurance Discount Price

<table>
<thead>
<tr>
<th>Facility</th>
<th>Low</th>
<th>High</th>
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<tbody>
<tr>
<td>Hospital #1</td>
<td>$3463</td>
<td>$4092</td>
</tr>
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<td>Hospital #2</td>
<td>$5351</td>
<td>$5981</td>
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<tr>
<td>Hospital #3</td>
<td>$3463</td>
<td>$4092</td>
</tr>
<tr>
<td>Hospital #4</td>
<td>$2203</td>
<td>$2833</td>
</tr>
<tr>
<td>Out Pt. Surgery Center #1</td>
<td>$2203</td>
<td>$2833</td>
</tr>
<tr>
<td>Out Pt. Surgery Center #2</td>
<td>$1574</td>
<td>$2203</td>
</tr>
<tr>
<td>Out Pt. Surgery Center #3</td>
<td>$1574</td>
<td>$2203</td>
</tr>
</tbody>
</table>
Consumer Driven Healthcare - Quality

**Consumer Driven Healthcare**

- **Quality** – The measurement error in quality should be less than the observed deviation between facilities.

- **Patients** believe in their physician and believe that the problems lie in the other practitioners at a facility. Patients tend not to change facilities unless there are large variations in quality.
• **Quality** – Often for “Low Hanging Fruit”. The average person, does not know what a central line is. However, they all know what a dollar is. It takes large deviations in quality for a patient to seek another provider against his doctor’s recommendations.
Healthcare-Associated Infections Reporting Laws
as of January 2011

- Mandatory data reporting to the state; state reports publicly
- Voluntary data reporting to the state
- Mandatory data reporting to the state (by rule); voluntary public reporting by the state
- Voluntary data reporting to the state; mandatory public reporting by the state

Requires use of NHSN for reporting HAI data to the state (23 states and DC)
In 2009 -- Example to the right shows a greater than 50 fold increase in Central Line Blood Stream Infections (CLABSI) in a rural hospital compared to major medical centers.
In 2011—Marked Improvement.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Temp Hospital</th>
<th>Saint Joseph East</th>
<th>Saint Joseph Hospital</th>
<th>Saint Joseph London</th>
<th>Saint Joseph Martin</th>
<th>Saint Joseph Mount Sterling</th>
<th>Flaget Memorial Hospital</th>
<th>Kentucky</th>
<th>U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreign object retained after surgery</td>
<td>0 of 1175</td>
<td>2 of 10881 patients</td>
<td>1 of 17773 patients</td>
<td>0 of 8477 patients</td>
<td>0 of 833 patients</td>
<td>0 of 2185 patients</td>
<td>0 of 2602 patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Air embolism</td>
<td>0 of 1175</td>
<td>0 of 10881 patients</td>
<td>0 of 17773 patients</td>
<td>0 of 8477 patients</td>
<td>0 of 833 patients</td>
<td>0 of 2185 patients</td>
<td>0 of 2602 patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reaction to incompatible blood</td>
<td>0 of 1175</td>
<td>0 of 10881 patients</td>
<td>0 of 17773 patients</td>
<td>0 of 8477 patients</td>
<td>0 of 833 patients</td>
<td>0 of 2185 patients</td>
<td>0 of 2602 patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open skin wounds with deep tissue injury</td>
<td>0 of 1175</td>
<td>0 of 10881 patients</td>
<td>2 of 17773 patients</td>
<td>2 of 8477 patients</td>
<td>0 of 833 patients</td>
<td>0 of 2185 patients</td>
<td>0 of 2602 patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Falls and trauma</td>
<td>0 of 1175</td>
<td>3 of 10881 patients</td>
<td>10 of 17773 patients</td>
<td>3 of 8477 patients</td>
<td>0 of 833 patients</td>
<td>1 of 2185 patients</td>
<td>1 of 2602 patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catheter-associated urinary tract infection</td>
<td>0 of 1175</td>
<td>1 of 10881 patients</td>
<td>13 of 17773 patients</td>
<td>0 of 8477 patients</td>
<td>0 of 833 patients</td>
<td>0 of 2185 patients</td>
<td>2 of 2602 patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vascular catheter-associated infection</td>
<td>0 of 1175</td>
<td>0 of 10881 patients</td>
<td>2 of 17773 patients</td>
<td>1 of 8477 patients</td>
<td>0 of 833 patients</td>
<td>0 of 2185 patients</td>
<td>1 of 2602 patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor control of blood sugar</td>
<td>0 of 1175</td>
<td>0 of 10881 patients</td>
<td>0 of 17773 patients</td>
<td>1 of 8477 patients</td>
<td>0 of 833 patients</td>
<td>0 of 2185 patients</td>
<td>0 of 2602 patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Selected surgical site infections</td>
<td>0 of 350 patients</td>
<td>0 of 974 patients</td>
<td>0 of 139 patients</td>
<td>0 of 126 patients</td>
<td>0 of 833 patients</td>
<td>0 of 2185 patients</td>
<td>0 of 10 patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood clots after hip/knee replacement</td>
<td>1 of 15 patients</td>
<td>6 of 549 patients</td>
<td>1 of 98 patients</td>
<td>1 of 126 patients</td>
<td>0 of 833 patients</td>
<td>0 of 2185 patients</td>
<td>0 of 209 patients</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Saint Joseph Health System July 1, 2010 to June 30, 2011
Consumer Driven Healthcare - Utilization

Elective Angioplasty Rates of Utilization in California

Ask Questions.
For 10 you should know, go to ahrq.gov.

Billboard on East 80, Somerset Kentucky.
“You manage what you measure, you manage really well what you measure and publically report.”

-- Paraphrased from a number of speakers.
Public Engagement

• The Community has the right to know what the Hospital Acquired Conditions (HAC) and Healthcare Associated Infection (HAI) rates are in their facilities.

• Need baselines for grants.

• Need Data to change public behavior.
  – Handwashing, cleaning of public facilities, and children visiting healthcare facilities.
  – To identify problems which have roots in both the community and the healthcare facility.
Community response to an epidemic.

- Roger Wagner, Pike County, Ky, School Superintendent:
  “We need some way of reporting. Particularly our school system needs to know if this exists out there. For a parent to call me and say, ‘do we have an outbreak of MRSA in Pike County?’ If I can’t identify it. A couple of them have called me personally. My answer is, ‘Well I do not know.’ Parents don’t like you saying that to them, they want an answer. I can see that as being a big issue.”

-- Aug. 1, 2011 Education Subcommittee Meeting.
Community response to an epidemic.

• For example: If MRSA – Alcohol and Ammonia are used to clean surfaces. If C. Difficile one would use Bleach. Bleach however is very hard on surfaces and the fumes may not be good for asthmatic children.
Public Engagement – CLABSI Reporting

CLABSI Adult & Pediatric ICUs, Tennessee, 1/2008-12/2010

Draft Report

Public Report

<table>
<thead>
<tr>
<th>Year, Quarter</th>
<th>SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008-Q1</td>
<td>1.14</td>
</tr>
<tr>
<td>2008-Q2</td>
<td>1.10</td>
</tr>
<tr>
<td>2008-Q3</td>
<td>1.19</td>
</tr>
<tr>
<td>2008-Q4</td>
<td>1.35</td>
</tr>
<tr>
<td>2009-Q1</td>
<td>1.07</td>
</tr>
<tr>
<td>2009-Q2</td>
<td>1.23</td>
</tr>
<tr>
<td>2009-Q3</td>
<td>1.24</td>
</tr>
<tr>
<td>2009-Q4</td>
<td>1.09</td>
</tr>
<tr>
<td>2010-Q1</td>
<td>0.88</td>
</tr>
<tr>
<td>2010-Q2</td>
<td>0.88</td>
</tr>
<tr>
<td>2010-Q3</td>
<td>0.77</td>
</tr>
<tr>
<td>2010-Q4</td>
<td>0.55</td>
</tr>
</tbody>
</table>
• CLABSI – Very expensive and deadly infections.
• Current Federal Mandate.
  -- ICU’s only
  -- Does not include Critical Access Hospitals
Public Engagement is Important.

Over 90% of Constituents in Kentucky Senator Harper-Angel’s District wanted Hospital Acquired Infection rates reported to the Health Department.
NHSN Reporting System

- Alignment & Uniformity in what data is submitted. Align with CMS reporting requirements.
- One place to submit and the required information is the same.
Public Reporting Concerns

• Public Reporting Concerns.
  -- Report Verification
  -- Too Burdensome
  -- Differing Definitions of Infection
  -- Patient Confidentiality

• Joint Commission Accreditation Survey Data is prohibited by law from being distributed by the Federal Government to the public.
• Unless some identifiable information is reported the data cannot be verified.

“Trust, but verify.”  Ronald Reagan

• One of the reasons given by high-functioning institutions for not wanting public reporting is that they more accurately report adverse events than lower-functioning institutions.
December 2008 OIG Report by Levinson (OEI-06-07-0047) outlined problems with self-reporting and self-policing in facilities, including the reporting of only an estimated 0.1% of sentinel events to the Joint Commission.

A March 2010 Joint Commission Report stated that only 4,590 reports of sentinel events from general hospitals and 298 reports of sentinel events from emergency rooms had been received since January 1995. (63) Only 64.7% of these reports were identified by self-reporting.
A recent AHRQ survey (Sorras AHRQ March 2009) found 52% of the staff in 622 surveyed facilities did not report any adverse events (sentinel or otherwise) at their institution. The report concluded that, “It is likely events were underreported,” and identified this as an area for improvement.


The AMA News reported that as of 2007, approximately half of U.S. hospitals had never reported a physician to the National Practitioner Data Bank.

A March 8, 2010, OIG Report found that in surveyed hospitals, patient diagnosis codes were inaccurate or absent for 7 of the 11 Medicare Hospital Acquired Conditions identified by physician reviewers and reviewed hospitals did not generate incident reports for 93% of the 120 events. Two, out of the three events which caused death, did not have any reports.

http://oig.hhs.gov/oei/reports/oei-06-08-00221.pdf
A patient-reporting system designed to verify facility reports and flag absent reports for audit. AHRQ has just awarded a large grant to the Rand Corp for development of a Consumer Reporting System.

Recent AHRQ Report found 70% of patient reports were accurate.

• The healthcare industry will soon spend 20% of the USA’s GNP, far more than any other OECD nation.

• “It is not a problem of not having the resources to address one of the top 10 killers in the USA. It is a problem of allocation of these resources.” -- Kevin Kavanagh, MD, MS, FACS

In Lexington alone, approximately one billion dollars in Hospital construction is underway or planned.
• If reporting is burdensome, then reduce the infections and adverse events, so not so many reports will need to made.
What is an Infection?

• If the diagnosis of an infection is not standardized for reporting, it is also not standardized for treatment.

• If this exists, this is a huge problem and public reporting maybe one of the mechanisms for correction.
I hope the healthcare industry is not using a concern over inadequate data security and confidentiality to protect patients, as an excuse to not have their Healthcare Acquired Conditions reported to the government.
• Billings systems to CMS, NHSN, and local hospital online systems have shown this to be a secure system.
• The information reported is already online.
• Computers system use secure, password encrypted transmissions and servers.
• Any breach of confidentiality is a HIPPA violation with severe federal penalties.  
  http://www.cdc.gov/nhsn/FAQ_HIPPArules.html#A

• “All medical records and other individually identifiable health information used or disclosed by a covered entity in any form, whether electronically, on paper, or orally, are covered by the final rule.”

• “Fines up to $250K and/or imprisonment up to 10 years for knowing misuse of individually identifiable health information.”
‘Doug Leonard, President of the Indiana Hospital Association, said the industry needs to “embrace transparency. Sometimes we don't like the results of that, but I think transparency is good for us and good for the public.” Even if the data are off by 50 percent or more, Leonard said, “it really doesn't matter, because one injury or one error is wrong,” and hospitals should focus on preventing errors rather than disputing the numbers.’

-- Courier Journal June 12, 2011
John Santa, MD, Director of the Health Ratings Center for Consumer Reports.

Maryn McKenna bestselling author of SUPERBUG: The Fatal Menace of MRSA.

Frances A. Griffin, Senior Manager of Clinical Programs, BD Medical and Faculty at the Institute for Healthcare Improvement (IHI).

Dr. Joycelyn Elders, Past US Surgeon General on Transformational Leadership.

Rosemary Gibson award winning author of "The Treatment Trap".

Keith Sinclair, MD, Bluegrass Oakwood Community Center, Somerset, KY, presenting how Oakwood used transparency to virtuality eliminate pressure ulcers.

Ben Yandell, PhD, Norton Healthcare Systems, Louisville, KY, will present on Transparency.
Thank you!