1 **Transparency in Healthcare**

Kevin T. Kavanagh, MD, MS

2 **Transparency in Healthcare**

- Regardless of type of healthcare system, transparency is needed. Transparency should be present in either consumer driven healthcare or a single payer system

- Transparency – You know what you are buying.
  - -- Quality
  - -- Costs

Value = Cost + Quality

3 **Transparency in Healthcare**

In the US:

- Below Average Life Expectancy for industrialized nations. (Ranked 22ed out of 30 OECD Nations)

- Above Average Infant Mortality for industrialized nations. (Ranked OECD)

- Ranked 41st out of 171 world nations for Maternal Mortality – A rate 3.3 times higher than the top 10 industrialized nations (Reuters & Lancet Oct 13, 2007)

- Spends more in healthcare per capita than any other nation. 238% more than the average OECD Nation.

4 **Transparency in Healthcare**

- Both unions and business organizations support Healthcare Transparency. Excessive healthcare costs is becoming the number one issue in contract negotiations.

5 **Transparency in Healthcare**

- Transparency needed in all aspects of healthcare
  - ➢Healthcare Facilities
  - ➢Physicians
  - ➢Pharmacy

6 **Transparency -- Quality**

- Facilities – Most Important Parameters

  ➢Registered Nursing Staff -- The Nurse is the Hospital. ICU means Intensive (Nursing) Care Unit.

  ➢Infection Rates (Pennsylvania & Florida).

  ➢Bed ulcer formation – In both high and low risk patients. This can be monitored by nursing homes and hospitals. Disease classification codes are being changed to distinguish “Acquired” vs “Preexisting” skin lesions.

  ➢Mortality Rates

7 **Transparency – Nursing Staff**

- Aiken, L.H., et. al. (JAMA, 2002) if a nurse is responsible for four patients and the care load is doubled, there is a 31% increase in the patient death rate. In patients who had complications, this rate is even higher.
- Joint Commission – Aug 2002, Inadequate nursing care was a factor in 24% of all

sentinel (severe) events and that “care is literally being left undone”. -- Aug. 2002.

- Needleman J., et. al. (NEJM, 2002) found that the higher the proportion of care provided by registered nurses the shorter the length of stay in the hospital, the lower the rate of urinary tract infections and upper gastrointestinal bleeding, and the lower the rate of pneumonia, shock, cardiac arrest and "failure to rescue".

- Leape, JAMA, 1995, Nurses are responsible for 86% of all interceptions of medical errors.

8 **Transparency – Nursing Staff**

- Importance – Costs
  - ➢Patients are charged different levels of care (ICU, Stepdown, General Floors.)
  - ➢Patients should know what they are paying for.

9 **Transparency – Nursing Staff**

- If in the ICU, you are receiving nursing staffing of one nurse to four patients, one of two things should be strongly considered.

  ➢Possibly you are not getting the nursing staffing you need OR

  ➢Possibly you are paying for an ICU charge when you should be on the stepdown unit or general floor.

- Remember the “intensive care” in Intensive Care Units is mainly given by the nurse, not housekeeping or security. The nurse is the one at the bedside monitoring the patient. The doctor also cares for the patient but he submits a separate bill.

10 **Transparency – Nursing Staff**

- Staffing Data is Available for Nursing Homes at http://www.medicare.gov/NHCompare/

11 **Transparency – Nursing Staff**

- However, consumer choices are limited.
- In Kentucky, the number of beds available is strictly controlled by the Certificate of Need process.

12 **Transparency – Infection Rates**

- Very important parameter. Currently publically reported by Pennsylvania and Florida.
- This parameter is affected by the numbers of nursing and housekeeping staff, and adherence to hospital protocols.
- This parameter may also have major impact on the community. Facility outliers may be responsible for the development and spread of antibiotic resistant Staphylococcus (MRSA) and resistant Strep Pneumonia.
-

13 **Transparency – Skin Sores & Bed Ulcers**

- Nursing Homes: Skin Ulcer Data can be obtained on http://www.medicare.gov/NHCompare/

- Hospitals: Florida (www.floridahealthfinder.gov) has public access to this data. However, high risk patients (those from nursing homes) are not included.
  -- Diagnostic codes do not discriminate between acquired and preexisting bed sores. New codes to differentiate these two groups will soon be available.

14 **Transparency – Mortality Rates**

- Available on-line at: www.hospitalcompare.hhs.gov

- For Kentucky, is available on-line at: https://publicreports.chfs.ky.gov/healthdata/

15 **Kentucky - Quality Transparency**

- the KY State Website -- Mortality Data & Measurement of the Quality of Prevention Services. http://chfs.ky.gov/ohp/healthdata/

- KY OIG Reports released under Freedom of Information. Few state regulations for hospitals to guide investigations. Investigations, should be posted on website similar to KY Medical Board.

- Joint Commission – Summary information posted after 90 days on their website. Initial findings may be expunged from the final report.

- Healthgrades: www.healthgrades.com

- DHHS website: www.hospitalcompare.hhs.gov
  (Treatment Protocols for Heart Disease, Pneumonia and Surgical Infection Prevention Protocols.)

16 **Kentucky - OIG**

- Investigation reports can be obtained by filing a Freedom of Information Act request.

- In 2004 and 2005 the number of citations dropped to ½ to ¼ that under the previous administration.

17 **Joint Commission**

- Main resource that the State of KY uses to assure quality of healthcare facilities.

- Little Transparency – KY Senator Request Letter.

- The ANA is suing the US DHHS in June of 2006 for lack of quality oversight and allegations of inadequate Joint Commission quality safeguards in assuring adequate nursing staffing in hospitals.

- Salisbury, NC, Veterans Administration Incident.

18 **Joint Commission**

Used in Kentucky to accredit acute care hospitals.

- The State is prevented from accrediting Hospitals that have had full accreditation on or before 7/15/2002 – KRS 216B.185(1).

- ..... An annual on-site licensing inspection of a hospital shall not be conducted if the Office of the Inspector General receives from the hospital:
- (a) A copy of the accreditation report within thirty (30) days of the initial accreditation and all subsequent reports; or
- (b) Documentation from a hospital that holds full accreditation from an approved accrediting organization on or before July 15, 2002.

19 **Joint Commission - Transparency**

- Response for CMS: "Also, in addition you would like to request the initial find(ing)s from the Joint Commission on Accreditation of Healthcare Organizations (JACHO)

survey which took place in late September 2005, including the narrative of the initial findings of the survey. There were no documents located in the file that pertains to the initial findings from the J(A)CH(O) survey which took place in September 2005."

20 **Joint Commission - Transparency**

- As Reported By SUSAN ELZEY
  Danville, VA
  Register & Bee staff writer
  Thursday, May 31, 2007.

- Portions of Danville Regional Medical Center's Joint Commission evaluation were unveiled to area business leaders Wednesday, but the complete results have not been made public. The hospital received a "preliminary denial of accreditation" from the national health care accreditation organization in March.
- Art Doloresco, CEO of Danville Regional Medical Center, presented the results of the survey Wednesday morning at a Chamber of Commerce breakfast. ..... "This is only the second time in the United States that a hospital has revealed a Joint Commission decision," he said. "This is a unique opportunity for businesses to take a look."

21 **Joint Commission – ANA Lawsuit**

- Joint Commission is paid by the organizations it accredits.

22 **Joint Commission – Quality Assurance**

- Salisbury, NC – Veterans Administration Hospital. http://www.charlotte.com/va/v-print/story/78072.html

23 **Quality -- Physicians**

- KY Medical Board. Make sure license has no actions against it. If actions were taken find out what they are.

- National Board of Medical Examiners. Find out if your doctor is board certified.

- Google: Pull up news reports which may disclose civil legal actions.

24 **Quality -- Physicians**

- Medicare tracks a number of hospital parameters for quality. Many of these are physician dependent. Such as administration of antibiotics within one hour of surgery.

- Data for hospitals is currently available online. Physician data may also soon be available. www.hospitalcompare.hhs.gov

25 **Quality -- Physicians**

- Do not rely upon online patient ratings of physicians.

- These are not randomized surveys and can be manipulated by the provider and his competitors.

26 **Quality -- Transparency**

- This information supports the assertion that the State of Kentucky should also take an active role in assuring quality of healthcare facilities.

- Statues KRS 216B.155 – Facility Quality Assurance
  KRS 216B.160 – Patient Care Needs
  KRS 216B.165 – Whistleblower Protection

There should be regulations and penalties to make these statues effective.

27 **Costs -- Physicians**

- Ask about costs when you schedule an appointment. How much will the visit cost and any expected tests or services.

- Physician billing is complicated, since there are three types of visits; Consult, New and Return, each with five levels.

- Thus, one physician may charge more for each level but charge a lower level for the service.

28 **Transparency - Costs**

- Facilities:
  - Insurance costs are posted on web by BC/BS and Humana.
  - Charge data posted by the KHA.
  - Modified Cost to Charge ratios are posted by the KY Dept of Labor -- Suggest a link to this site from http://chfs.ky.gov/ohp/healthdata/ to http://www.labor.ky.gov/workersclaims/medicalservices/hospitalcost/

29 **Transparency - Costs**

- Cost to charge ratios are often used to describe a hospital's finances. A low cost to charge ratio can be caused by excessive charges or lower costs.

- The lower the cost to charge ratio, the larger the profit margin on the charges. Similar to buying a car, this information is useful in negotiating a price.

- It is Health Watch USA's opinion that the costs of supplies and pharmaceuticals in most hospitals are similar due to cooperative purchasing organizations. That one of the ways a health care facility can cut costs is to cut the staff, a practice which may lower the quality of service.

30 **http://www.floridahealthfinder.gov/ 1**

31 **http://www.floridahealthfinder.gov/ 2**

32 **http://www.floridahealthfinder.gov/ 3**

33 **http://www.floridahealthfinder.gov/ 4**

34 **http://www.floridahealthfinder.gov/ 5**

35 **KY Healthcare – One could argue**

- Monopolies granted with the Certificate of Need.

- No “Public Service Commission” to oversee charges or quality.

- Little state oversight of quality. The accrediting agency used by most facilities is paid for by the facilities it accredits.

Charlotte.com

Posted on Sun, Apr. 08, 2007

Sunday, Nov 4, 2007

Veterans hospitals received gold seal

STELLA M. HOPKINS

The Salisbury veterans hospital can boast a "Gold Seal of Approval" from the premier overseer of U.S. health care quality.

But the Joint Commission awarded its highly sought certification without any knowledge that the VA had investigated suspicious deaths at the hospital and found it provided poor care.

Now the commission, which accredits about 80 percent of U.S. hospitals, wants to know why Veterans Affairs kept it in the dark, and plans changes to avoid a repeat.

"That has given us a lot of fodder for discussion with the VA," said Joe Cappiello, the commission vice president who heads inspection operations. "The public should be able to rely on the accreditation certificate to have value and meaning."

VA officials aren't required to advise the commission of their reports, and they didn't. The commission -- one of few independent monitors of VA care -- didn't ask. Its officials learned from the Observer about negative reports for the Salisbury and Asheville veterans hospitals, both gold seal holders.

The lack of required disclosure is an example of oversight shortfalls for the nation's largest health care system, serving millions of veterans. The Observer has found that even within the VA, investigators don't share reports that could uncover persistent problems.

At the Salisbury hospital, the Joint Commission has signed off for several years without knowing that officials had been told of problems endangering patients. Private consultants, hired by the VA in 2001, found serious shortcomings. In 2005 and again last year, VA investigators found problems with patient care.

The commission's failure to ask about internal investigations casts doubt on the rigor of its inspections and the credibility of an important certification. For civilian hospitals, commission accreditation can fulfill state licensing requirements and also allows reimbursement from Medicare and other programs.

Consumer advocates are pleased that the commission last year stopped telling hospitals in advance of the dates for routine inspections. But advocates say that health care generally needs a stronger watchdog.

"Everyone in the industry knows, you scramble when (the commission) is coming, make yourself look great and then go back to normal," said Lisa McGiffert, a Consumers Union patient advocate. "Who's there to make sure hospitals are safe?"

The Salisbury veterans hospital is the focus of congressional hearings set for April 19 on VA health care. The hearings were called after Observer stories.

Hospitals are asked to respond

The commission has asked both hospitals to respond to issues raised by Observer stories. Cappiello said management is considering policy changes, including asking for reports such as those withheld. The group also could conduct impromptu inspections, but Cappiello wouldn't say whether that will happen. Routine accreditation inspections are conducted every three years. In off years, renewal is typically granted following self-evaluation.

The commission inspects hospitals for compliance with nationally recognized patient-care standards and accredits about 15,000 health care groups. The group is not a regulatory agency, but it can deny certification if a facility ignores problems.

VA hospitals have sought accreditation for decades even though they don't need it in the same way as civilian hospitals.

The federal VA system isn't subject to state licensing and doesn't get Medicare or similar payments. But accreditation bestows credibility, indicating VA hospitals are held to the same standards as civilian facilities.

"Accreditation provides independent, external confirmation that a hospital is meeting high performance standards," said Adrien Creecy-Starks, a VA spokeswoman in Washington. "It is an important part of VA's commitment to quality."

Consultants gave a low score

In 2001, the VA wanted to know how its hospitals might fare in upcoming commission inspections. Salisbury, the Charlotte area's main veterans hospital, was among those that underwent a "mock" inspection by outside consultants.

At the time, the commission used a grading system with 100 as the top score. The Salisbury hospital scored a 59 in the consultants' report, obtained by the Observer. The private firm's grading system could not duplicate that of the commission but clearly indicated care problems.

Cappiello, with the commission for 10 years, couldn't recall the organization scoring a hospital that low. Such a low score would have meant a hospital "most certainly would not be accredited."

In 2002, the hospital fared much better with the official inspection, receiving a score of 91 and notice of problems that needed attention. As of June 20, 2003, the commission said the hospital had acted and been granted "accreditation with full standards compliance."

Coincidentally, that was the day Robert Lashmit died at the hospital. His death was one of two detailed in a 2005 report by VA investigators, who also reviewed other cases. They concluded his care was "substandard," and that other care reviewed was "marginal at best, and in some cases, substandard."

The hospital has disputed some findings and said problems were corrected.

Two months after the 2005 VA report, the commission again awarded accreditation following a routine inspection. They renewed it last year, as VA investigators were finalizing another report that included patient care problems.

Commission VP is surprised

In December 2004, VA officials told the Asheville veterans hospital to stop admitting patients to its nursing home.

Agency investigators found a patient had died following a procedure performed by an inadequately trained and supervised physician assistant. They also concluded the nursing home staff didn't understand how to care for dying patients and didn't provide enough pain medication for seriously ill men.

The hospital wasn't cleared to fully resume admissions until August 2005. That month, the commission granted accreditation following an earlier routine inspection. Cappiello said the commission didn't know

about the suspended admissions.

The VA has said that it took action and fixed problems identified at the two hospitals. Still, Cappiello was surprised that the VA didn't reveal the reports. He also acknowledged that the commission could have done more to ask about negative inspections.

And he expressed personal concern. "I'm a veteran," he said. "It may very well be me in that bed at some time."

Joint Commission
on Accreditation of Healthcare Organizations

November 18, 2005

The Honorable

Dear Senator

I am in receipt of your letter dated October 19, 2005 to Marlene Korso at the Joint Commission on Accreditation of Healthcare Organizations regarding _ Hospital in , Kentucky.

It is my understanding from your correspondence that you seek a copy of the accreditation report for Hospital. Unfortunately, the Joint Commission is unable to provide you with a copy of the accreditation report. The Joint Commission has an obligation to its accredited organizations to keep accreditation related information confidential, including the accreditation report.

I urge you to consult *Quality Check*® on the Joint Commission's website. *Quality Check*® is an on-line tool whereby third parties may access information about a particular health care organization. The Quality Report contains the following information: the date of the most recent survey; an organization's current accreditation decision; the date of the most recent evaluation activity for the organization; the standards area with requirements for improvement; subsequent satisfaction of requirements for improvement and the date(s) of resolution for specific standards areas; and Joint Commission policy and/or rules that led to a decision of Preliminary Denial of Accreditation or Denial of Accreditation. *Quality Check*® can be accessed by the following link: http://www.jcaho.org/quality+check/index.htm.

One Renaissance Boulevard
Oakbrook Terrace, IL 60181
708/916-5600

Please do not hesitate to contact me for any assistance as you utilize this information.

Very truly yours,

Karen A. Ryan
Associate Director, State Relations
Joint Commission on Accreditation of Healthcare Organizations
One Renaissance Boulevard
Oakbrook Terrace, Illinois 60181
630-792-5261
kryan@jcaho.org

cc: Mark Crafton, Executive Director, State and External Relations, JCAHO
Marlene Korso, Account Representative, Corporate Region, JCAHO

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop N2-20-16
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Office of Strategic Operations and Regulatory Affairs/ Freedom of Information Group

Refer to: C06FOI1449 (DJH)

JUL 19 2007

[redacted]
[redacted]
Attorneys At Law
[redacted]
Somerset, KY 42502

I am responding to your April 5, 2006, Freedom of Information Act (FOIA) request submitted to this office for a copy of the Kentucky State Investigation ARO [redacted] for [redacted] [redacted] Hospital located at [redacted] Kentucky, provider number [redacted]. The investigation took place in 1998 and dealt with inadequate staffing levels at [redacted]. Also, in addition you would like to request the initial finds from the Joint Commission on Accreditation of Healthcare Organizations (JACHO) survey which took place in late September 2005, including the narrative of the initial findings of the survey.

There were no documents located in the file that pertains to the initial findings from the JOCHP survey which took place in September 2005.

After careful review of the pages submitted to me twenty-six (26), I am releasing these pages to you in their entirety without deletions.

There is no charge for processing this request.

If you have reason to disagree with this decision, you may appeal. Your appeal should be mailed within 30 days of the date of this letter to: The Deputy Administrator, Centers for Medicare and Medicaid Services, Room C5-16-03, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. Please mark your envelope "Freedom of Information Act Appeal" and enclose a copy of this letter with your letter

Sincerely yours,

Michael S. Marquis
Director
Freedom of Information Group

Enclosure

JAMA. 2002 Mar 13;287(10):1277-87. FREE text at JAMA Links

Comment in:

JAMA. 2002 Jun 26;287(24):3206-7; author reply 3207-8.
JAMA. 2002 Jun 26;287(24):3206; author reply 3207-8.
JAMA. 2002 Jun 26;287(24):3207; author reply 3207-8.
JAMA. 2002 Mar 13;287(10):1323-5.

Evaluation of a consumer-oriented internet health care report card: the risk of quality ratings based on mortality data.

Krumholz HM, **Rathore SS**, **Chen J**, **Wang Y**, **Radford MJ**.

Yale University School of Medicine, 333 Cedar St, PO Box 208025, New Haven, CT 06520-8025, USA.

CONTEXT: Health care "report cards" have attracted significant consumer interest, particularly publicly available Internet health care quality rating systems. However, the ability of these ratings to discriminate between hospitals is not known. OBJECTIVE: To determine whether hospital ratings for acute myocardial infarction (AMI) mortality from a prominent Internet hospital rating system accurately discriminate between hospitals' performance based on process of care and outcomes. DESIGN, SETTING, AND PATIENTS: Data from the Cooperative Cardiovascular Project, a retrospective systematic medical record review of 141 914 Medicare fee-for-service beneficiaries 65 years or older hospitalized with AMI at 3363 US acute care hospitals during a 4- to 8-month period between January 1994 and February 1996 were compared with ratings obtained from HealthGrades.com (1-star: worse outcomes than predicted, 5-star: better outcomes than predicted) based on 1994-1997 Medicare data. MAIN OUTCOME MEASURES: Quality indicators of AMI care, including use of acute reperfusion therapy, aspirin, beta-blockers, angiotensin-converting enzyme inhibitors; 30-day mortality. RESULTS: Patients treated at higher-rated hospitals were significantly more likely to receive aspirin (admission: 75.4% 5-star vs 66.4% 1-star, P for trend =.001; discharge: 79.7% 5-star vs 68.0% 1-star, P =.001) and beta-blockers (admission: 54.8% 5-star vs 35.7% 1-star, P =.001; discharge: 63.3% 5-star vs 52.1% 1-star, P =.001), but not angiotensin-converting enzyme inhibitors (59.6% 5-star vs 57.4% 1-star, P =.40). Acute reperfusion therapy rates were highest for patients treated at 2-star hospitals (60.6%) and lowest for 5-star hospitals (53.6% 5-star, P =.008). Risk-standardized 30-day mortality rates were lower for patients treated at higher-rated than lower-rated hospitals (21.9% 1-star vs 15.9% 5-star, P =.001). However, there was marked heterogeneity within rating groups and substantial overlap of individual hospitals across rating strata for mortality and process of care; only 3.1% of

comparisons between 1-star and 5-star hospitals had statistically lower risk-standardized 30-day mortality rates in 5-star hospitals. Similar findings were observed in comparisons of 30-day mortality rates between individual hospitals in all other rating groups and when comparisons were restricted to hospitals with a minimum of 30 cases during the study period. CONCLUSION: Hospital ratings published by a prominent Internet health care quality rating system identified groups of hospitals that, in the aggregate, differed in their quality of care and outcomes. However, the ratings poorly discriminated between any 2 individual hospitals' process of care or mortality rates during the study period. Limitations in discrimination may undermine the value of health care quality ratings for patients or payers and may lead to misperceptions of hospitals' performance.

PMID: 11886319 [PubMed - indexed for MEDLINE]

216B.185 Accreditation as evidence of compliance with licensing requirements -- Exemption from inspection -- Fees -- Submission of building plans -- Standards for licensure.

(1) The Office of the Inspector General shall accept accreditation by the Joint Commission on Accreditation of Healthcare Organizations or another nationally recognized accrediting organization with comparable standards and survey processes, that has been approved by the United States Centers on Medicare and Medicaid Services, as evidence that a hospital demonstrates compliance with all licensure requirements under this chapter. An annual on-site licensing inspection of a hospital shall not be conducted if the Office of the Inspector General receives from the hospital:

(a) A copy of the accreditation report within thirty (30) days of the initial accreditation and all subsequent reports; or

(b) Documentation from a hospital that holds full accreditation from an approved accrediting organization on or before July 15, 2002.

(2) Nothing in this section shall prevent the Office of the Inspector General from making licensing validation inspections and investigations as it deems necessary related to any complaints. The cabinet shall promulgate the necessary administrative regulations to implement the licensing validation process. Any administrative regulations shall reflect the validation procedures for accredited hospitals participating in the Medicare program.

(3) A hospital shall pay any licensing fees required by the cabinet in order to maintain a license.

(4) A new hospital shall not be exempt from the on-site inspection until meeting the requirements of subsection (1) of this section and administrative regulations promulgated under KRS 216B.040, 216B.042, and 216B.105 for acute, critical access, psychiatric, and rehabilitation facility requirements.

(5) Before beginning construction for the erection of a new building, the alteration of an existing building, or a change in facilities for a hospital, the hospital shall submit plans to the Office of Inspector General for approval.

(6) To the extent possible, the cabinet shall consider all national standards when promulgating administrative regulations for hospital licensure.

Effective: July 15, 2002

History: Created 2002 Ky. Acts ch. 159, sec. 1, effective July 15, 2002.