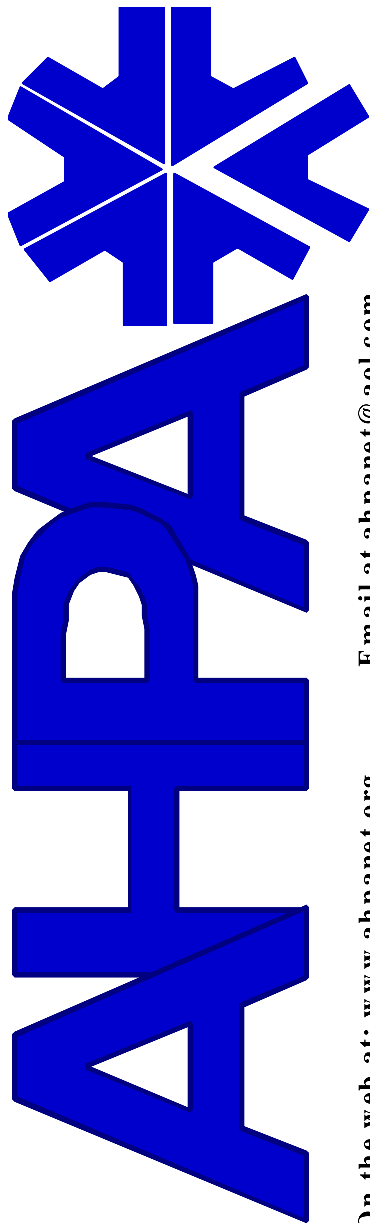

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4th Quarter, 2006

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President's Message

Again, Asking the Right Questions

by John Steen

In the last issue, I wrote about asking the right questions. A report has just been published in which some of those questions are implicit. It is the Commonwealth Fund Commission on a High Performance Health Care System's *Why Not the Best? Results from a National Scorecard on U.S. Health System Performance*, which is described on page 7 of this issue along with an associated article, "U.S. Health System Performance: A National Scorecard."

The questions I raised were about the health care system that would provide optimal benefits for the American people. And I was led to editorialize about it because, although I was pleased to see so many articles and commentaries on the subject, none of them addressed it as a question of good governance. Their writers implicitly accepted the economic and political "upstream conditions" that are most responsible for the mess we're in! Perhaps I need to ask whether we're still the "can-do" nation we've always been, or if we've become so disillusioned over political stalemate and mendacity that we no longer believe in the values we thought defined us. I think that those of us who speak or write owe it to our fellow Americans to be

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Health Planning Today

an American Health Planning Association publication
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Again, Asking the Right Questions

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uncompromising in attempting to dispel the ignorance of all the great civic lessons that now retards our progress as a nation. I suggested that the way to begin answering the health care questions is by asking ourselves what sort of a society we wish to be.

Ask a health planner what is wrong with our health care system, and you're likely to hear that we don't have one. That is precisely the right answer, for it avoids blindly making a multitude of assumptions. If we all looked at our nation in relation to comparable ones that way, we could better understand the situation. What we have is like a patchwork quilt where the pieces don't fit together, leaving large gaps, and where groups continually conduct a tug of war with it, as it becomes ever more expensive to try to rent access to it. And so it gets ever more expensive in human terms.

If we were actually to plan and design a health care system, might we not wish to see what works well elsewhere and why? Would we want to make the profit motive the genie that runs it, or would we prefer to encourage public service with compassion, the ethos of public health? And would we breathe life back into the mantra of "government by the people, and for the people?"

Only if we are **asking the right questions**.

[1]September 2006 [http://www.cmwf.org/publications/publications_show.htm?doc_id=401577]

[2] By Cathy Schoen, Karen Davis, Sabrina K. H. How, and Stephen C. Schoenbaum, *Health Affairs* 25 (2006): W457 – W475.

Noteworthy . . .

Health Affairs announced the publication on December 19 of an article by Jonathan Oberlander dissecting the rise and fall of the Oregon Health Plan (OHP), addressing the questions of what went wrong with it and what does that say about the prospects for coverage expansion initiatives in other states.

As the announcement states:

> "When it was first enacted in 1989, and approved by the federal government as a Section 1115 Medicaid demonstration project in 1993, OHP represented a leading state policy innovation that sparked a national debate on rationing health care. OHP was 'intended to expand Medicaid to more people by covering fewer services,' says Oberlander. But now the plan is 'covering both fewer services and fewer people, and the elimination of entire benefit categories and rollback in enrolled beneficiaries looks more like the arbitrary cuts common in other states than the rational and equitable model of prioritization to which Oregon aspired.'

Read the article at http://content.healthaffairs.org/cgi/content/abstract/hlthaff.26.1.w96

CON Metaphysics I

By Dean Montgomery

Earlier this year, *JAMA* carried an article reporting research on the question of whether certificate of need (CON) regulation affects the rate of coronary revascularization (PCI and CABG surgery) and risk-adjusted mortality from acute myocardial infarction (heart attack). The investigators reported that in conducting the study they examined the "relationship between the stringency of certificate of need regulations in individual states and these end points [revascularization and AMI mortality]."[1] Puzzled readers likely consulted their dictionary. Stringency? Whatever it is, what does it have to do with planning and CON regulation?

The investigators concluded that, of the 27 states with CON regulation of open-heart surgery during the study period (2000 – 2003), 3 states had high stringency, 8 had moderate stringency, and 16 had low stringency. The results of the study were generally favorable to planning and regulation of interventional cardiovascular services and supportive of greater stringency. But the states in each category were not identified and no definitions or meaningful descriptions of high, moderate, and low stringency were offered.[2]

So, the curious were left to investigating the history of the term as it has been used in assessing planning and CON regulation. The authors of the *JAMA* article acknowledge borrowing the classification scheme from Conover and Sloan, the dynamic Duke University duo who have been rather critical of regulation generally, and of CON regulation in particular. Under their scheme, states that regulate acute care services were categorized as having high stringency, moderate stringency, or limited stringency. Conover-Sloan have used the categorization in their CON consulting work in several states (e.g., Michigan, Delaware).[3] That work and associated recommendations have not been favorable to planning or CON regulation.

According to the authors of the *JAMA* article, the stringency classification scheme is based on several considerations, including:

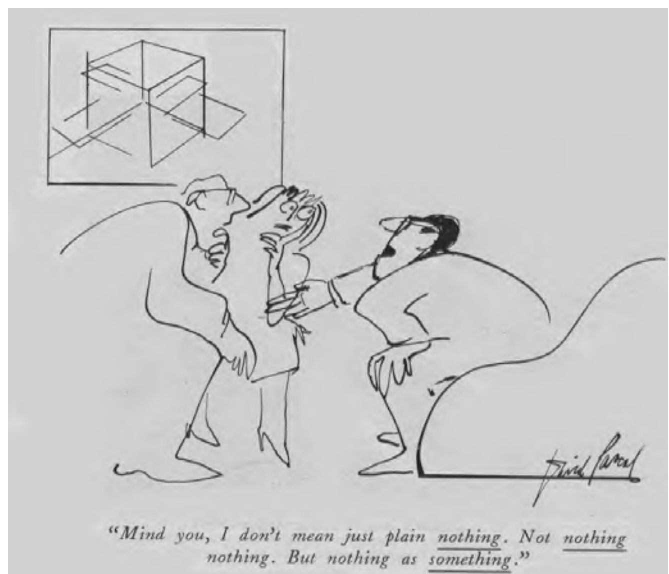
- Facility capital expenditure thresholds;
- Equipment and service expenditure review thresholds;
- Number and scope of services covered; and
- Expert opinion to assign weights to each of the factors.

Inspection of the Conover-Sloan Michigan and Delaware reports gives additional insight into the nature and limitations of the stringency classifications. First, Conover-Sloan borrowed, and perhaps "tweaked," the classification scheme from Lewin-VHI, another consultant with an interest in establishing itself as an authority on CON and, thereby, advisory to states on whether, and if so how, they should modify or terminate their regulatory programs. In their Delaware report, Conover-Sloan state:

> "… we rely on definitions of CON stringency developed by Lewin-ICF (1992, 1995). These are based on taking into account the dollar thresholds used to determine whether a project is subject to CON review, as well as the scope of CON review in terms of specific categories of services subject to review."[4]

This elliptical reference to the factors and considerations underlying the stringency categorization scheme was amplified seven years later in the Conover-Sloan report on the Michigan CON program. In an explanatory note to a table with the quixotic title "Trends in Acute Care CON Stringency, by State, 1980-1994," they write:

Continued on page 4



"Mind you, I don't mean just plain nothing. Not nothing nothing. But nothing as something."

CON Metaphysics I
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> "… [T]he methodology for deriving stringency scores was not described in sufficient detail to replicate exactly. Therefore, stringency scores were projected from 1993-2000 based on a manual comparison of CON general capital threshold index . . . and the CON equipment threshold index . . . in each state in a given year relative to the index in 1992. Stringency was adjusted up or down based on changes in the index."[5]

In other words, an opaque scheme developed by an outside entity that was not understood well enough to "replicate exactly" was replicated (presumably) inexactly, transported backward 12 years, and applied forward nine years in order to establish a stringency "trend." This is magisterial finagling and hubris. One can only smile admiringly.

The logical question arises as to whether Lewin-VHI, the apparent originator of the stringency scheme in the assessment of CON regulation, has offered an understandable explanation of the idea and its value. Alas, there is no evidence the secret has been revealed. It appears as safely guarded as Colonel Sanders' eleven herbs and spices. Lewin used the categorization scheme in several studies in the 1990s, but did not deign to explain the component parts or the rationale for them.[6] None of the consultants, scholars, scholar-consultants, or consultant-scholars that report using this analytical device has bothered to explain, much less justify, it.

Marginal differentiation, an analytical tool of precision and utility in biology and mathematics, and of some value and considerable fun when used artfully in the social sciences,[7] becomes a source of much pretense and folly in the hands of some certificate of need consultants and scholars. Planners should be appropriately skeptical of their "analyses" and advice.

Setting aside the infelicitous use of a term with inherently negative connotations when used in association with planning and regulation, the idea of CON stringency has a superficial plausibility. Some states have stronger, and presumably more effective, planning and CON programs than others. Staff and data resources, analytical capabilities, political environments, and community orientation and support vary widely. If so, and if these and other relevant factors could be taken into account, it is conceivable that CON programs in states characterized as having greater "stringency" would have noticeably different, and presumably better, results than states with less stringent programs.

Identifying, documenting and explaining these differences and their implications, of course, is a difficult, if worthy, undertaking. There is little evidence, and no reason to believe, that the stringency classifications and analyses discussed here have been useful in this regard. In addition to questionable methods and results, analytically and politically, this approach has spawned imitators, including some who would improve upon the concept by applying yet more precise classifications and analyses. That question, and the underlying logic and implications of the stringency categorization scheme, will be addressed in future editions of *Health Planning Today.*

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[1] I. Popescu, M. Vaughan-Sarrazin, and G. Rosenthal, "Certificate of Need Regulations and Use of Coronary Revascularization After Acute Myocardial Infarction," *JAMA*. 2006; 295: 2141-2147, p. 21423.

[2] Although not identified, it is likely that states were categorized as follows: High Stringency (CN, MD, NJ); Moderate Stringency (GA, MA, ME, MI, NC, RI, SC, WV); Low Stringency (AL, AK, DC, FL, HI, IL, IA, KY, MI, MO, NH, NY, TN, VT, VA, WA).

[3] C. Conover and F. Sloan, *Evaluation of Certificate of Need in Michigan*, May 2003 and *Evaluation of Certificate of Need and Other Heath Planning Mechanisms*. Delaware Health Care Commission, May 1996. See especially volume 2 of both studies.

[4] C. Conover and F. Sloan, *Evaluation of Certificate of Need and Other Heath Planning Mechanisms*. Vol. 1, p. 8.

[5] C. Conover and F. Sloan, *Evaluation of Certificate of Need in Michigan*, May 2003, Vol. II, Table B-2, p. 58.

[6] See B. Manard, *et al*., *The Georgia Certificate of Need Program*. Lewin-VHI, December 1995; J. Arnold and D. Mendelson, *Certificate of Need: A Synthesis for Policymakers*. Lewin-VHI, March 1993; Lewin-ICF, *Econometric Analysis of CON in Pennsylvania*, 1992; Lewin-ICF, *Evaluation of Ohio CON Program*, 1991.

[7] See Thorstein Veblen's discussion of conspicuous consumption in *The Theory of the Leisure Class: An Economic Study of Institutions* (New York: Macmillan, 1902), pp. 68-101.

Is This Any Way To Do Health Planning?

By John Steen

When a state is spending $45 billion per year on its Medicaid budget, it needs to do something radical, and New York State is doing it now. In 2004, New York's generous Medicaid program paid $10,349 per enrollee, while California's paid $4,793. According to the federal Agency for Healthcare Research and Quality, New York's Medicaid program paid 21 percent of doctors' bills, hospital bills and other expenses in that state in 2003, compared to Medicaid's U.S. average of 9.2 percent of medical expenses. By comparison, Pennsylvania's Medicaid program paid 4.4 percent. New York State relies so heavily on hospitals rather than private physicians to serve Medicaid clients that it paid $530 per capita for hospital expenses, while the U.S. average was $185 in 2003. And long-term care, including nursing home services and home health and personal care, consumed $16 billion in 2004, or about 36 percent of the Medicaid budget, two-and-a-half times the U.S. average. In fact, according to the Centers for Medicare and Medicaid Services, about one-third of the Medicaid dollars spent on personal care in the United States in 2004 were spent in New York.

Not all of the questions raised in an article in this newsletter one year ago[1] have yet been answered, but the 18-member Commission on Health Care Facilities in the 21st Century issued its long-awaited report on November 28, 2006.[2] On November 2, a headline in *The New York Times* read, "Plan Could Close 20 or More Hospitals."

The Commission's report includes the following recommendations:

- Nine hospitals should totally close, including five in New York City;
- Several other hospitals should cease to exist through mergers or conversion to new uses;
- Throughout the state, 4,200 beds should be eliminated, representing 7 percent of hospital capacity, and beds should be reassigned to different uses or to other institutions at scores of hospitals; and
- About 3,000 nursing home beds, representing 2.6 percent of capacity, should be eliminated and several nursing homes should be closed and others downsized.

If adopted, the Commission's recommendations will have their greatest impact in shaping a new system out of the surviving resources, with 48 reconfigurations and restructurings. Among its most controversial is the merger of public institutions — two hospitals in Buffalo and Syracuse, and several upstate nursing homes — with private ones, a form of privatization that would remove them from government control. The report does not recommend reductions in New York City's municipal hospitals or closings of academic medical centers. This and adherence to the prime goal of protecting health care for the poor result in most of the hospitals recommended for closure being located in middle-income neighborhoods. Geographically, the greatest impact from the plan's reductions would be felt in the Buffalo/Niagara Falls area and in New York City.

A Failure of State Policy

Over the past eight years, New York State's more than 200 hospitals have been losing money and are more fragile financially than those in any other state. About two dozen have closed, and most of those that remain have lost money and gone deeply into debt.

This year, the state has made a commitment to fund the industry in transition with $1 billion, and the Bush Administration has confirmed its commitment of $1.5 billion over five years. This funding will be needed to pay off outstanding debts, pay severance to workers, and convert acute care buildings to outpatient clinics. In addition, the state's plans call for heavy investment in computer technology for the surviving hospitals. It will be far harder for officials to preserve and enhance access to primary care, given the state's extreme underpayment of physicians in Medicaid.

Governor George Pataki and Governor-elect Eliot Spitzer have each endorsed the plan. For Pataki, the endorsement represents a reversal of policy on health care regulation. New York State once had the most robust regulation of hospitals in the nation, but he began to change all that when he took office in 1995, saying that "free market competition" would control health care spending. He eliminated his Department of Health's hospital rate-setting function and compromised its

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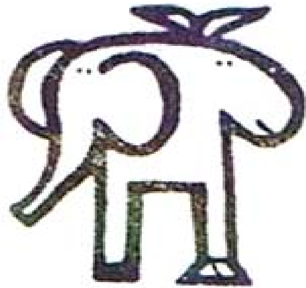
certificate of need regulatory program, laying off every one of the policy-level officials that had long been devoted to serving the public interest. And in 1996, he cut off state funding to the eight health systems agencies that carried out planning and review functions on the regional level. Without state funding, only two, in Rochester and Syracuse, have survived, but at a reduced size.

The Republican-led State Senate and the Democratic-led Assembly will hold hearings on the plan in December, and they have until December 31 to accept or reject it, unless they pass a new law extending their deadline or negating the existing law. In its report, the Commission states that its



> "… work should be considered a beginning, rather than an end, of a broader reform effort. We need to build on this effort to address an ongoing need for structured decision-making regarding health care resource allocations. The speed of change in health care, driven by changing technology, populations and finance, makes it essential that the work of reforming the system and the regulatory framework be continuous. New York State should implement an ongoing process to sustain the efforts initiated by this Commission."

The Moral

Can this scenario be viewed from a policy context as anything but the state and federal governments bailing out a massive policy failure, and performing emergency surgery with further operations to come, to make up for a decade of neglecting the public interest in health care? Intelligent regulation of health care is no oxymoron; but free market competition in health care surely is. The more the state freed its hospitals to compete, the more they ran up costs by acquiring every service and piece of equipment any other hospital had, and excess capacity developed like never before. Inner city hospitals were less successful in that "medical arms race," so they began closing, eroding the state's safety net. Perhaps the ultimate irony is hearing the governor explain his support for the Commission by saying, "we wanted to rationalize the downsizing."

New Jersey Studies Hospital Closings Too

On July 31, Governor Jon Corzine announced the formation of a panel to determine if New Jersey needs all of its hospitals, if they are properly located, and whether state funding is being distributed rationally. The New Jersey Hospital Association says that the state's hospitals averaged a 1.6 percent average operating margin last year, and that almost 40 percent lost money.[3] Corzine claims that state hospital officials have told him privately that the state has 25 hospitals more than it needs, but he is also concerned that the most financially distressed hospitals are those in urban centers with the greatest needs. The state has 81 acute care hospitals and 34 psychiatric, rehabilitation and specialized-care facilities.

In October, Corzine signed an executive order creating an 11-member Commission on Rationalizing Health Care Resources, which is headed by Professor Uwe E. Reinhardt, the world-renowned Princeton University political economist. The Commission will study hospitals' finances and viability, map existing services, project future demands, and develop oversight criteria for financially distressed hospitals. Its report is due by June 1, 2007, and reassessment of the hospital system every three years is mandated.

The moral here? Well, New Jersey experienced a remarkably similar series of policy failures to and in parallel with New York's….

[1]"A Fiscal Crisis Revives Health Planning in New York State," *Health Planning Today,* Winter 2005.

[2]To view, go to: http://www.nyhealthcarecommission.org/finalreport.htm.

[3]According to the American Hospital Association, the average operating margin for hospitals nationwide was 3.7% in 2005.

U.S. Rankings on an International Report Card

Why Not the Best? Results from a National Scorecard on U.S. Health System Performance,[1] and an associated article, "U.S. Health System Performance: A National Scorecard,."[2] measure how well we're doing by looking at what works well anywhere. By comparing scores from up to two dozen countries, the report places American health care in a global perspective.

The Scorecard contains 37 scored indicators, although many of these are composites. The way its measurement of performance is organized is based in large part on the framework used by the Institute of Medicine (IOM) in its series of reports on quality and insurance coverage, but the new report's specific indicators draw on those developed by the U.S. Department of Health and Human Services, the Agency for Healthcare Research and Quality, the National Committee for Quality Assurance, and experts elsewhere. The report also includes many new indicators developed for the Scorecard, including efficiency indicators, and it is the first to combine indicators for quality, access, efficiency, and equity in one scorecard.

The indicators are grouped into five broad "domains": health outcomes, quality, access, efficiency, and equity. A score of 100 on a given indicator represents not perfection, but rather benchmarks set by top-performing countries or the top 10 percent of U.S. states, hospitals, health plans, or other providers.

The report's Overview begins:

> "Once upon a time, it was taken as an article of faith among most Americans that the U.S. health care system was simply the best in the world."

Its principal finding about our nation is summed up as follows:

> "For the 16 percent of its gross domestic product that the United States spends on health care … it achieves neither the best outcomes nor the best quality of care when compared to other nations. Wide variations within the United States in quality, access, and costs pull national averages down to well below benchmarks achieved by top-performing states, hospitals, or other providers."

U.S. ratio scores to benchmarks for the five domains range from 51 to 71 percent. Across the 37 indicators of performance, the U.S. achieves an overall score of 66 out of a possible 100 when comparing actual national performance to achievable benchmarks. Scores on efficiency are particularly low, just as they were in the World Health Organization's *World Health Report 2000*.

The Scorecard findings show that if the U.S. improved performance in key areas, the nation could save an estimated 100,000 to 150,000 lives and $50 billion to $100 billion annually.

Outcomes -- U.S. Score 69

The Scorecard includes five system-level indicators of health outcomes: two on potentially preventable mortality, one on life expectancy, and two on the prevalence of health conditions that limit the capacity of adults to work or children to learn. Among 19 industrialized countries, the U.S. ranked 15th on "mortality from conditions amenable to health care," or deaths before age 75 that are potentially preventable with timely, effective care – 115 per 100,000 people, compared with 75 per 100,000 in France. Out of 23 industrialized countries, the U.S. was lowest in life expectancy at birth and tied for last with Portugal, Ireland, Denmark, and the Czech Republic on healthy life expectancy at age 60. The most damaging finding: the U.S. ranked last on infant mortality as of 2002, with rates 259 percent of the average of the three leading countries (Iceland, Japan, and Finland).

Quality – U.S. Score 71

This domain includes getting the right care (71) that is well-coordinated (70), safe (69), patient-centered, and timely (72). Lowest scores[3]:

- 58 - ability to see doctor on same/next day when sick or needed medical attention
- 53 - very/somewhat easy to get care after hours without going to the emergency room

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U.S. Rankings on an International Report Card

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Access – U.S. Score 67

This domain includes participation in the health system (65), and affordability of care (69). In 2003, 35 percent of adults under 65 (61 million) were either underinsured or were uninsured at some time during the year. And 34 percent of all adults under 65 have problems paying their medical bills or have medical debt they are paying off over time.

Efficiency – U.S. Score 51

Scores for these indicators tell the story:

48 - Potential overuse or waste (indicator for multiple related measures
23[3] - Went to emergency room for condition that could have been treated by regular doctor
57 - Hospital admissions for ambulatory-care-sensitive conditions

Equity – U.S. Score 71

The report's authors state that, "Having an equal opportunity to lead a healthy and productive life is consistent with the founding principles of this country. In fact, the elimination of disparities in health and health care has for years been a national policy priority." Belying that is our performance on the four indicators:

66 - Uninsured	76 - African American
62 - Low-Income	80 - Hispanic

Many of the scores for the above areas reflect variations in performance among the 50 states that are even greater than found among all the nations studied. For example, with respect to potentially preventable deaths, the five lowest scoring states were all below Portugal, the lowest scoring of the 19 industrialized countries, while the highest scoring states were equal to the highest scoring countries.

Future editions of the Scorecard are to assess changes in performance on this initial set of indicators and will also include new indicators as data become available.

The report concludes with this prediction:

> "In the future, transformative change within the U.S. health care system will likely come from innovations in the way care is organized and delivered, and from better research in support of evidence based medicine."

[1] Commonwealth Fund Commission on a High Performance Health Care System, September 2006 [http://www.cmwf.org/publications/publications_show.htm?doc_id=401577]

[2] Cathy Schoen, Karen Davis, Sabrina K. H. How, and Stephen C. Schoenbaum, *Health Affairs* 25 (2006): W457 – W475.

[3] Benchmark is best of six countries.

POLICY PERSPECTIVE

by John Steen

Angioplasty Controversy Continues in PA

Pennsylvania has ten hospitals performing elective angioplasties – also known as percutaneous coronary intervention (PCI) – without open heart surgery programs to provide back-up. The issue is improved access for rural areas vs. better safety and quality of care. In the absence of CON, the state's licensure regulations currently require on-site cardiac surgical back-up, but hospital administrative appeals created two-year waivers during which time elective PCIs could be performed without on-site open heart surgery. And legislators sympathetic to their local suburban and rural hospitals' arguments for greater revenue to compete with major urban medical centers introduced legislation that passed both houses of the legislature, but was not supported by the Governor. It could have extended waivers indefinitely without any volume requirements.

In reaction, by way of compromise, the State Department of Health now proposes to provide waiver extensions to hospitals that do one of three things:

- join the CPORT trial being conducted by Thomas Aversano, M.D., of the Johns Hopkins School of Medicine;
- join an in-state registry that collects and studies quality outcomes; or
- agree to a supervisory and cross-training arrangement with a tertiary hospital to oversee quality.

The last option is controversial in that it carries no minimum annual procedure volume requirement. The other two require at least 200 (elective and emergency) PCIs per year, and at least 75 PCIs (including at least 11 emergency PCIs) per year by each interventional cardiologist, while the American College of Cardiology and the American Heart Association recommend 400 per year *with* surgical back-up. Dr. Aversano maintains that there is adequate evidence demonstrating that outcomes suffer below 200. About the legislation, he said that "this law is a paradigm of the problems that occur when politics stands in the stead of sound health care policy."

And doesn't that judgment apply to what precipitated this issue in the first place: the state's loss of its certificate of need program ten years ago? As the State awaits the results of the CPORT study, it has at least used its licensure authority to uphold a 200-procedure volume requirement for several of the waiver hospitals.

Need for State Health Planning to Regionalize Emergency Care

The Institute of Medicine's (IOM's) Committee on the Future of Emergency Care in the U.S. Health System issued a report in June that found that emergency rooms are understaffed, overwhelmed and not prepared for a major emergency, and there is a growing need for them to become more efficient at coordinating care and referring patients to the right hospital. The Committee believes that the federal government should support the development of national standards for emergency care performance measurement, categorization of all emergency care facilities, and protocols for the treatment, triage, and transport of prehospital patients. Health experts who attended a recent IOM workshop in Chicago urged hospital emergency departments to adopt a regionalized approach to care similar to that used by trauma centers that allows one trauma center's specialists to treat patients across a broad geographic area to maximize scarce resources. Regional collaboration would also mean that not every hospital has to maintain on-call services for every specialty, which would help address shortages caused by the dwindling number of specialists willing to take emergency calls. The nation's 1000 designated trauma centers coordinate care using criteria established by the American College of Surgeons for surgical coverage, equipment, and training.

Noting that the various parts of the emergency care system have received very little of the funds that Congress has dispensed for disaster preparedness, the IOM committee identifies this as its top priority for greater funding and specifically calls for enhancing emergency deparment, trauma center, and inpatient surge capacity. In addition to asking for more preparedness funding, the IOM committee says Congress should establish a pool of $50 million to reimburse hospitals that provide large amounts of uncompensated emergency and trauma care. It says the Veterans Health Administra-

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Policy Perspective

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tion (VHA) is "well positioned to enhance regional response, particularly since its hospitals are required by law to maintain excess capacity," and federal organizations should work with states to integrate the VHA into regional disaster planning.

The IOM has produced three new reports that together provide a comprehensive view of the emergency medical services system and hospital emergency departments.[1] The third volume addresses the difficulty of balancing the roles of hospital-based emergency and trauma care – not simply urgent and lifesaving care, but also safety-net care for uninsured patients, public health surveillance, disaster preparation, adjunct care in the face of increasing patient volume and limited resources, and the challenges of providing emergency care in rural settings.

NY State Hospital & Health Care Report Cards

A brief history of report cards provided in the last issue of this newsletter[2] noted New York State's achievements in reporting on and improving outcomes for open-heart surgery. But the New York State Department of Health has never issued a report card for other hospital services. For the past four years, however, the Niagara Health Quality Coalition, a not-for-profit corporation, has issued one annually.. It is the New York State Hospital Report Card, and it is published in partnership with the Alliance for Quality Health Care, a coalition of more than 2,000 businesses and more than 30 health plans across the state. Data have been provided for hospital-specific death rates for open-heart surgery and stroke, prevalence of Cesarean sections and other procedures, safety of patients undergoing angioplasty, and infection rates.

The Coalition also has a Health Care Advisory Committee charged with recommending additions of medical technology in Western New York. It reviews plans for purchases of new devices and decides if they will be used appropriately, by the right personnel, in an area that needs the devices. The Advisory Committee's recommendations, which are included in the Coalition's Report Card,[3] are nonbinding and are taken into consideration by insurers in deciding whether to cover certain services..

For the past seven years, the State Accountability Foundation, a private-public partnership of health care and business leaders, has also issued a report card on health plan performance, and for the first time this year, it included hospitals. It is the New York State Health Care Report Card,[4] and it reports hospital performance for 18 measures, across the categories of care for heart attacks, heart failure, pneumonia and surgical infection prevention.

Massachusetts Adds to Its Report Cards

The State of Massachusetts has decided to add risk-adjusted mortality data for individual cardiac surgeons to its CABG report cards, thereby becoming the fourth state to do so. (New York State first did so 15 years ago.) The first report, to be issued on December 18, 2006, covers data for the three years 2002-2004, during which time 55 surgeons operated on about 4000 patients at the 14 hospitals licensed for CABG. The state's first hospital report was issued three years ago. Last year, the University of Massachusetts Memorial Medical Center, in Worcester, temporarily suspended its cardiac surgery program because of a higher-than-average mortality rate, and this year, Caritas St. Elizabeth's Medical Center, a tertiary teaching hospital in Boston affiliated with Tufts University School of Medicine, suspended a surgeon.

PA First State To Report on Nosocomial Infection Rates

In November 2006, the Pennsylvania Health Care Cost Containment Council (PHC4) issued the nation's first statewide report on nosocomial infections, detailing the rates for all of the state's hospitals. The state's overall rate for 2005 was 12.2 per 1,000 cases, and such infections generated $3.5 billion in additional hospital charges and resulted in 2,478 patient deaths. The death rate for patients who got a hospital-acquired infection was 12.9 percent (average charge: $185,260), compared to 2.3 percent (average charge: $31,389) for patients without such infections.

The rates of infection in Pennsylvania, if applied to other states, suggest that nationally 400,000 cases of hospital-acquired infection occur each year, resulting in 50,000 deaths and $20 billion in payments for treatment. Reporters seeking comments on this from the CDC were referred to a CDC press release dated February 28, 2005, in which Dr. Denise Cardo, director of CDC's Division of Healthcare Quality Promotion, said:

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Policy Perspective

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> "The goal of mandatory reporting is to provide consumers with information they can use to make informed healthcare choices."

These days, I guess, one has to attribute such a statement to political influence[6] rather than rank incompetence, and then ponder which is worse.

The same reporters were told by an official with the American Hospital Association that that lobby is focusing its disclosure efforts on data hospitals are reporting for Medicare's Hospital Compare web site.

Hospitals are reporting data for the site on three measures relating to preventing surgical infections, but all three are process measures, not outcome measures, placing Medicare's reporting far behind Pennsylvania's in its usefulness.[6] And that's usefulness for the hospitals themselves – to be prodded into being more accountable for determining what they are doing wrong.

Meanwhile, states like Pennsylvania are properly using public reporting as a mild form of regulation toward assuring consumers that, regardless of which hospital they wind up in, they can expect to be safe.

[1] Pre-publication copies of The Future of Emergency Care series, which includes *Emergency Care Services at the Crossroads* (http://www.nap.edu/catalog/11629.html.), *Emergency Care for Children: Growing Pains* (http://www.nap.edu/catalog/11655.html), and *Hospital-Based Emergency Care: At the Breaking Point* (http://www.nap.edu/catalog/11621.html), are available from the National Academies Press.

[2] "A Brief History of Report Cards," by John Steen, *Health Planning Today,* 3rd Quarter, 2006, p.4

[3] Available at www.myHealthFinder.com

[4] Available at www.AboutHealthQuality.org.

[5] Mass-Dac, the Harvard Medical School center that collects and analyzes the heart patient data for the state, posts them at hcp.med.harvard.edu/massdac/index.htm.

[6] Though the Bush Administration devotes lip service to informing consumers' choices, it does nothing to support such state reporting.

State Certificate of Need Coverage

Home Health Agencies

Regulated | Not Regulated

Job Opening

DIRECTOR OF STRATEGIC PLANNING

Position	• Director of Strategic Planning, Durham Regional Hospital Durham Regional Hospital delivers world-class care in a hometown environment of warmth and comfort. We seek a long-range planner to design, coordinate, implement and direct our strategic and operational planning process. You'll report directly to our CEO and to the chief planning officer for the Duke University Health System. Your key responsibilities will include: -Assessing long-term goals and objectives and short-term operating objectives of the hospital and health system -Updating our strategic and operational plan annually or as needed -Providing consulting services, reports and recommendations on services under consideration by the hospital and health system -Coordinating and ensuring the inclusion and participation of our management team, medical staff and board of trustees in strategic and operational planning issues Consistently ranked as one of the best places in the nation to live and work, Durham, "The City of Medicine," is a dynamic community with many cultural and recreational opportunities. We offer a competitive compensation package and ample opportunity for professional growth.
Requirements	Qualifications include: -Master's degree in health administration, health planning, public health or business administration -5 years' experience in healthcare planning, or a combination of relevant education and experience
Contact	You may send resumes, indicating position of interest, to: Recruitment Department, Durham Regional Hospital, 3643 N. Roxboro Road, Durham NC 27704. Email: stacy.connoley@duke.edu. Fax: 919-470-7376. Job Line: 800-233-3313. EOE/AA