“Sunshine Is the Best Disinfectant”

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Just last year, the Pennsylvania Health Care Cost Containment Council, known as PHC4, celebrated its 30th anniversary. This watershed event went largely unnoticed at the national level, because PHC4 is a relatively unheralded organization. Yet its impact, and its 3 decades of accomplishments, are increasingly apparent during this transition period in healthcare reform. In short, the public accountability for outcomes will continue to be central to the pending changes in the care delivery system. I had the privilege of addressing many past and current leaders of PHC4, along with members of the state legislature and other dignitaries, at a celebratory conference in Harrisburg, PA, to publicly recognize this important anniversary.

What follows is an abbreviated version of my celebratory comments, with a special emphasis on the role of public accountability on the quality and safety of the care that we deliver. For nearly 20 years, I have chaired the Technical Advisory Group (TAG) for PHC4. The TAG is comprised of statewide experts who perform an important function by giving advice to the staff and leadership at PHC4, and whose guidance has been central to the success of the agency in its mission to promote “sunshine as the best disinfectant.”

Drawing on the work of Steven D. Findlay in a 2016 article in Health Affairs, I mirrored the 3-decade timeline of public reporting that he created.1 The history of PHC4 aligns in an uncanny, positive way with the timeline created by Mr Findlay. Please let me explain.

PHC4 was created in 1986 by an Act of the Pennsylvania State Legislature. The year 1986 stands as the veritable beginning of the accountability movement. Barely a year later, Medicare, known then as the Health Care Financing Administration, released the first-ever hospital-specific mortality data. By 1991, the New York State Department of Health published the first-ever hospital-specific, surgeon-specific mortality report for coronary artery bypass graft (CABG) surgery. In August of that year, my former colleague, the late Marvin Bentley, and I researched the impact of the public report of CABG outcomes, and the response of hospitals to CABG outcomes, and the response of hospitals across Pennsylvania. Not surprisingly, our results showed that the hospitals paid close attention to the report, whereas the public and employers, as well as multiple insurance companies, paid slight-to-no attention at that time. We were among the first to argue that although report cards, regrettable, may not influence public opinion, hospitals surely were paying avid attention to them.

In 1991, the New England Journal of Medicine refused to publish our findings, because the editor thought that the public disclosure of mortality rates on an individual hospital level (although the hospitals were labeled A-E) was potentially libelous. George Lundberg, the courageous editor of JAMA at that time, thought differently and published our article, along with an article from O'Connor and colleagues at the Northern New England Cooperative Cardiovascular Disease Study Group at Dartmouth2—yes, a bit of almost ancient history reaching back to 1991 as the jumping-off point for the movement toward public accountability. By 1995, PHC4 joined New York State in publishing only the second publicly available CABG outcomes report. Yours truly was selected to be the local hospital spokesperson at a raucous press conference, wherein the hospitals simply were unprepared to deal with an unprecedented level of interest in the data by the lay press.

For an article in the Joint Commission Journal on Quality Improvement,3 my former colleague, the late Marvin Bentley, and I researched the impact of the public reporting of CABG outcomes, and the response of hospitals across Pennsylvania. Not surprising, our results showed that the hospitals paid close attention to the report, whereas the public and employers, as well as multiple insurance companies, paid slight-to-no attention at that time. We were among the first to argue that although report cards, regrettable, may not influence public opinion, hospitals surely were paying avid attention to them.

In 2006, PHC4 played a central role in a nationally evolving story. At a press conference at the venerable National Press Club in Washington, DC, PHC4 debuted the first-ever statewide hospital-acquired infection report. Mind you, no state had ever assembled the data regarding hospital-acquired infection, and in fact, that lexicon was not yet in regular use. In other words, most informed individuals had never heard of the term “hospital-acquired infection” or “hospital-acquired condition” back then. A November 2006 press conference resulted in a front-page breakthrough story in USA TODAY, which was, in turn, widely cited.4 I’m proud to say that we, in turn, published the results of the press conference and several key investigations in a special issue of the American Journal of...
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Medical Quality in November 2006. Thus began the 15-year conversation on the role of hospital-acquired conditions and their deep connection to the quality and safety of care that we deliver at the bedside. Sunshine is indeed the best disinfectant.

From 2010 through late 2016, 3 teams of investigators have attempted to assess the true impact of public report cards and the role that these report cards may play in improving the quality and safety of care. Space prohibits a deep dive into these 3 articles, but teams led by well-known investigators such as Jon B. Christianson, PhD, Karen E. Joynt, MD, MPH, and Brent Sandmeyer, MPH, all reached generally the same conclusion, that the public reporting of outcomes certainly influences the work done at the individual hospital level by shining a bright light on areas that need improvement. Public reporting plays a modest role from a managed care perspective, as payers seek the most efficient and effective providers with whom to contract services; yet, disappointingly, the public still is not fully engaged in the reporting of outcomes.

What about future directions for PHC4? As I noted in my celebratory plenary talk, the movement from volume to value is inexorable. As a result, in my view, one must ask: Does public accountability, such as Yelp11 and other review systems, to provide information about the patient experience of care?

Do you believe that public reporting of outcomes improves the quality and safety of the care that we deliver? As always, I am interested in your views, and you can reach me via e-mail at david.nash@jefferson.edu.

References