Quality Assessment, Quality Improvement and Public Information: The Patient Care Ombudsman's Perspective

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When health-care providers go bankrupt, their patients need special protection. That is the underlying rationale to the Patient Care Ombudsman (PCO) provision found in Section 333(a)(1) of the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005, which provides as follows:

> If the debtor in a case under chapter 7, 9, or 11 [11 USCS §§ 701 et seq., 901 et seq., or 1101 et seq.] is a health care business, the court shall order, not later than 30 days after the commencement of the case, the appointment of an ombudsman to monitor the quality of patient care and to represent the interests of the patients of the health care business unless the court finds that the appointment of such ombudsman is not necessary for the protection of patients under the specific facts of the case.

Discussions in Congress about the need to monitor patient care during the bankruptcy process seems to have begun in the late 1990s. At that time, Senators Bob Torricelli (D-NJ) and Chuck Grassley (R-IA) expressed concerns triggered by a nursing home bankruptcy in California that occurred in 1997. 145 Cong. Rec. S28683-28684. A snippet from the Sept. 30, 1997, edition of the *L.A. Times* gives this account:

> WOODLAND HILLS — Sixty-three residents of the Reseda Care Center, some in wheelchairs, were ejected from the building and relatives were called to pick them up after 9 p.m. Friday. In one case, a family watching the eviction on late-night TV news realized that it was the same home where they had left a 106-year-old relative.

Once enacted, the new PCO law received significant attention. Within two years of its passage, numerous articles were published analyzing its pros and cons. (Lupinacci; Pruitt. "New Player at the Health Care Reorganization Table: Practical Implications of the Patient Care Ombudsman." *24-6 ABIJ 26,* July 2005; Lucian. "Does the Patient Care Ombudsman Statute Apply to Outpatient Facilities?" *25-7 ABIJ 20,* September 2006; Peterman; Koenig. "Patient Care Ombudsman: Why So Much Opposition?" *25-2 ABIJ 22,* March 2006; Maizel. "The First Year of the Patient Care Ombudsman in Review: Part I." *26-2 ABIJ 18,* March 2007; Peterman; Morissette; Koenig. "The Patient Care Ombudsman's New Reality: Top 10 Issues Relating to Appointment of an Ombudsman after BAPCPA." *26-6 ABIJ 22,* July 2007.)

Numerous cases have been reported involving challenges to the PCO appointment: *In re Valley Health Sys*., 381 BR 756, (Bankr. C.D. Cal. 2008); *In re Renaissance Hosp.—Grand Prairie, Inc*., 399 BR 442, (Bankr. N.D. Tex. 2008); *In re Synergy Hematology-Oncology Med. Assocs.,* 433 BR 316, (Bankr. C.D. Cal. 2009); *In re Total Woman Healthcare Ctr.,* 47 BCD 143 (Bankr. M.D. Ga. 2006); *In re Med. Assocs. of Pinellas,* 360 BR 356, (Bankr. M.D. Fla. 2007); *In re Saber,* 369 BR 631, (Bankr. C.D. Colo. 2007); *In re Alternate Family Care,* 377 BR 754, (Bankr. S.D. Fla. 2007); *In re Starmark Clinics*, 388 BR 729, (Bankr. S.D. Tex. 2008); *In re N. Shore Hematology-Oncology Assocs.*, 400 BR 7, (Bankr. E.D. NY 2008); *In re Genesis Hospice Care,* 51 BCD 104, (Bankr. N.D. Miss. 2009); *In re Denali Family Servs.,* 57 BCD 262 (Bankr. D.C. Alaska 2013); *In re Flagship Franchises of Minn.,* 484 BR 759, (Bankr. DC Minn. 2013); *In re Vartanian,* 2007 Bankr. LEXIS 4274 (Bankr. C.D. Vt. 2007).

Not surprisingly, the debate over appointing a PCO is usually about cost. Should creditors bear the brunt of further depletion of the debtor's resources to pay for the PCO? In a large and complex institution, those costs can be nontrivial. For example, the PCO may need to engage qualified professionals to assist him or her to ascertain whether patients are receiving appropriate care.

Challenging the PCO appointment, therefore, can pit the interest of patient care against the financial interest of the creditors. Nevertheless, courts have found that the PCO may not be necessary if sufficient monitoring and patient care oversight are in place and will remain in place during the bankruptcy process. See, e.g., *In re Valley Health Sys*., and *In re North Shore Hematology-Oncology Assocs.,* cited above.

The PCO Responsibilities and the PCO Report

Once a PCO is appointed, it has the following duties:

> (1) monitor the quality of patient care provided to patients of the debtor, to the extent necessary under the circumstances, including interviewing patients and physicians;
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> (2) not later than 60 days after the date of appointment, and not less frequently than at 60-day intervals thereafter, report to the court after notice to the parties in interest, at a hearing or in writing, regarding the quality of patient care provided to patients of the debtor; and
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> (3) if such ombudsman determines that the quality of patient care provided to patients of the debtor is declining significantly or is otherwise being materially compromised, file with the court a motion or a written report, with notice to the parties in interest immediately upon making such determination. 11 U.S.C. 333 (b)(1) - (3).

The PCO must act quickly and efficiently to assess the organization, its leadership, management and administrative infrastructure as it pertains to quality of care. Quality of care can be affected by a wide array of variables, such as financial ability to pay vendors, employee stability, information systems issues, etc. Therefore, establishing timely and effective contact with key individuals is essential in order to produce a valid and reliable assessment of patient care.

Validity and Reliability

An unspoken assumption is that the PCO's report will be both valid and reliable. But what exactly does that mean and how is it achieved?

Simply put, a PCO report is valid when its description of the status of patient care is accurate. That is, the narrative of the report matches the reality of the quality of patient care. Achieving this obvious objective can be elusive, however.

For example, the bankruptcy statute makes clear that the PCO must "monitor the quality of patient care … including interviewing patients and physicians." 11 U.S.C. 333 (b)(1). However, if the PCO limits its report to findings obtained exclusively from interviews with patients and physicians, any existing quality deficiencies beyond the scope of those interviews would go undetected, as would any looming threats to quality of care (e.g., employee defections, disruption of supplies, disruptions to information system, etc.). A PCO report that omits those undetected deficiencies would therefore lack validity.

The PCO report must also be reliable. For example, if the PCO were to prepare another report pertaining to the same 60-day period, both reports should reach the same conclusion. Accomplishing a reliable report requires that its underlying data be obtained in a manner that, if repeated, would yield the same result. Survey instruments, for example, must be constructed and worded in a manner that is clear, unambiguous, and avoids pitfalls of poor instrument design (e.g., includes no double-barreled questions, responses should be mutually exclusive, avoids leading questions, avoids unbalanced Likert scales, etc.). One option for the patient survey would be for the PCO to use already developed and tested survey instruments, such as the HCAHPS instrument (i.e., the Hospital Consumer Assessment of Healthcare Providers and Systems). This survey, created in collaboration with CMS and the Agency for Health Care Research and Quality, has been endorsed by the National Quality Forum and accordingly and can be used with confidence.

As suggested above, in addition to patient and physician interviews, the PCO must expand its scope of inquiry in order to capture quality of care concerns that may not be apparent to physicians or patients. The richest source of such information could be the debtor's existing quality improvement infrastructure. Accordingly, the PCO should

quickly assess the effectiveness of the debtor's existing quality improvement infrastructure and develop necessary contingency plans if existing quality improvement programming is deficient.

An observed downward trend in human resources can lead to declining quality of care even if those trends are unrelated to clinical employees. Accordingly, the PCO must inquire into current administrative initiatives that, if disrupted, could threaten patient care (e.g., information system upgrades pertaining to electronic health records). Financial stability during the bankruptcy process must also be measured. Will the health-care business be able to pay salaries to employed physicians? Will it be able to pay suppliers and maintain servicing of medical equipment? Failure to inquire into and assess the health-care business's administrative, financial and technical infrastructure can lead to an invalid assessment of current quality of care, and could entirely miss material threats to the quality of patient care.

Special Issues

Bankruptcy proceedings have a long tradition of openness and full disclosure of the debtor's condition. The debtor generally relinquishes its ability to protect otherwise confidential information from public view when it seeks bankruptcy protection (except for information supplied to the court under seal pursuant to court order). Full and complete disclosure of the debtor's assets and liabilities is clearly necessary. To the extent nonmonetary information would inform a potential purchaser at large, such information must also be made available. However, disclosure of certain types of health-care information out of context can indeed be a dysfunctional practice that contravenes quality improvement programming and therefore could frustrate the over-arching objective of providing quality health-care services.

Quality improvement programming is arguably the most important mechanism by which health-care institutions identify quality-of-care issues that require remediation. Would

those quality improvement programs be less effective if their findings would be readily available on the Internet? Would a health-care facility's self-critical analysis be compromised by the threat of disclosure of sensitive information? If so, quality improvement programming would be less effective and, thus, the disclosures of sensitive information would be potentially detrimental to the quality of patient care.

According to the American Medical Association, "In order to provide incentive for physicians and others to participate in medical peer review, federal and state law works to protect peer review participants and processes." "Medical Peer Review" from the AMA website. Indeed, certain types of information pertaining to the National Practitioners Data Bank is presumed confidential and can be released only in accordance with other mandates of the Health Care Quality Improvement Act. See *Medical Society of New Jersey v. Mattola*, 320 F. Supp. 2d 254, 259, (D.N.J. June 8, 2004), 42 U.S.C. 11137(b)(1). One of the primary reasons for these protections is obvious, i.e., to foster open communication about quality deficiencies.

The PCO report, however, is public information, available to news outlets and any other interested party. In scouring publicly available information regarding bankruptcy proceedings for newsworthy material, those news outlets would find the PCO report online and would have an interest in exploiting anything appearing newsworthy in it. What if the report included mortality reports showing preventable deaths that occurred at the debtor hospital? What if the report included incident reports showing surgical errors? Admittedly, there is a compelling interest in the public's right to know that information—regardless of quality improvement programming. However, what if the content is less dramatic, say, showing a 20 percent increase in surgical site infection rate? Would it matter if that rate of increase was lower than the state average? (The rate of increase for surgical site infection rate for NYSPFP member hospitals was indeed higher, i.e., 26 percent from 2010 through the third quarter of 2013. See "Special: NYS Partnership for Patients (NYPFP) A Look at Our Shared Progress Through 2013").

Undisciplined trumpeting of quality-of-care findings to the general public, therefore, can be misleading. By failing to provide a meaningful context within which to interpret statistical findings, a health-care provider's quality of care may be wrongly judged. The PCO, the U. S. Trustee and the Bankruptcy Court should be cognizant of this issue and keep in mind the criticality of quality improvement programming in health-care settings and the nexus between the health of those programs and the quality of patient care.