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Human Resources  
Division

B-199186

JULY 2, 1980

The Honorable Herman E. Talmadge, Chairman  
The Honorable Robert J. Dole  
The Honorable Sam Nunn  
Subcommittee on Health  
Committee on Finance  
United States Senate

SEN04105

DG04662

Subject: [Information on hospital inspections,  
reporting requirements, and Life Safety  
Code enforcement] (HRD-80-94)

Pursuant to your request, we reviewed the impact of regulatory requirements being imposed on hospitals. As agreed with your office, we studied three separate areas of hospital regulatory requirements--inspections, reports, and Life Safety Code enforcement.

Although hospitals are subjected to many inspections and are requested to complete many forms and reports, our work indicates that the degree to which they are duplicative or similar is not as great as other studies on this subject have reported. Further, we believe that efforts by Federal, State, and private organizations currently underway to reduce the existing duplication and similarity of inspections and information requests are improving the situation, and should be continued.

Our work on Life Safety Code enforcement showed that most deficiencies in our sample of hospitals have been or are in the process of being corrected, and they cost hospitals an average of at least \$31,000 to correct.

HOSPITAL INSPECTIONS

Hospitals are subjected to inspections by Federal, State, and local governments, and by private sources. The three hospitals where we conducted a detailed analysis identified a total of 101 different inspections. About



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45 percent of these were performed by private organizations, and most were made every 2 to 4 years by the American Medical Association in departments having medical education programs. Federal inspections accounted for 20 percent of the total.

Of the 101 inspections, 38 were identified by hospital officials as duplicative or similar to others. Licensure inspections by State agencies and accreditation surveys by the Joint Commission on Accreditation of Hospitals--which are similar in nature and scope--were considered the most burdensome because both generally involved all departments in the hospital. Efforts are underway to reduce this burden. Twenty States currently accept Joint Commission accreditation, either in whole or in part, for licensure or participate in cooperative inspection activities with the Joint Commission. Sixteen States and the District of Columbia are considering such arrangements.

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The Department of Health and Human Services' 1/ Health Care Financing Administration has been working with States and the Joint Commission to reduce duplicative or similar hospital inspections. Continued success in getting more States to participate in Joint Commission surveys or accept its survey findings should minimize the problem associated with these inspections. Cooperative inspection programs can be sufficiently flexible to adequately meet the requirements of both Joint Commission accreditation and State licensure.

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#### REPORTS AND FORMS

Hospitals are required to prepare reports and complete forms on various aspects of their operations. Many forms and reports request data similar to that requested by other organizations. However, no forms or reports at the four hospitals we visited were identical, and most of the similar requests contained data that were used internally by the hospital.

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1/On May 4, 1980, a separate Department of Education commenced operating. Before that date, activities discussed in this report were the responsibility of the Department of Health, Education, and Welfare.

Of the 202 forms and reports we identified at the four hospitals, only 29 resulted from requests for information that were directed at hospitals only, and contained duplicative or similar information that was not used by the hospital itself for internal management purposes.

Duplicative and similar data collection problems have been reduced through implementation of the Federal Paperwork Commission's recommendations and continued efforts within the executive branch to review agency reporting requirements and reduce the public reporting burden under the President's Reporting Burden Reduction Program. Continued emphasis on these efforts should further minimize requests for duplicative or similar data.

#### LIFE SAFETY CODE ENFORCEMENT

Generally, hospitals are one of the safest places in terms of risk of death by fire. Our review of Life Safety Code enforcement included sending a questionnaire to 313 hospitals and visiting 15. Our work showed that most Life Safety Code deficiencies at the 275 hospitals that responded to our questionnaire had been corrected or were being corrected. Hospital officials indicated that only about 2 percent of the deficiencies would not be corrected.

The cost of correcting deficiencies was difficult to determine primarily because hospital accounting records did not specifically identify the costs, and in some cases, corrections were made as part of major renovation projects and could not be separately identified. The cost data we were able to develop suggested that correction costs were considerably lower than other studies have reported (see p. 26 of enclosure I). Only 1 of 275 hospitals responding to our questionnaire claimed correction costs exceeding \$1 million.

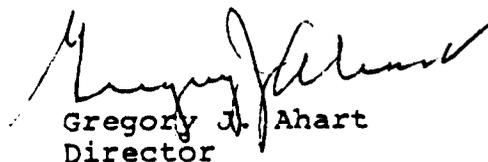
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Detailed information on these matters is included in enclosure I, and the status of arrangements between States and the Joint Commission on Accreditation of Hospitals for conducting cooperative inspections is included in enclosure II.

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As requested by your office, we did not obtain written comments from the Department of Health and Human Services on this report, but the contents were discussed with Department officials.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from the date of the report. At that time we will send copies to interested parties and make copies available to others upon request.



Gregory J. Ahart  
Director

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## ABBREVIATIONS

AHA	American Hospital Association
AHR	Annual Hospital Report
AMA	American Medical Association
CHHS	Cooperative Health Statistics System
FSES	Fire Safety Evaluation System
HCFA	Health Care Financing Administration
HSA	Health Systems Agency
HSS	Department of Health and Human Services
JCAH	Joint Commission on Accreditation of Hospitals
NBS	National Bureau of Standards
NFPA	National Fire Protection Association
OMB	Office of Management and Budget
SHUR	Standard Hospital Uniform Reporting

INFORMATION ON REGULATORY  
REQUIREMENTS IMPOSED ON HOSPITALS

INTRODUCTION

Three separate areas of hospital regulatory requirements-- inspections, reports, and Life Safety Code enforcement--have been cited in recent years as some of the causes for the rapid increase in hospital costs. At the request of the Chairman, Subcommittee on Health, Senate Committee on Finance, we reviewed the impact of these regulatory requirements on hospitals.

SCOPE

Our work on hospital inspections and reporting requirements was conducted at three and four hospitals, respectively, in the Washington Metropolitan area. The hospitals were of varying sizes, and included public, private, and teaching facilities. At each of the hospitals visited, officials were asked to provide data on either all inspections made of the facility or all reports and forms completed by the facility, and to make judgments regarding the extent of duplication or similarity. We analyzed the data provided and met with hospital officials to discuss and clarify the information.

We also met with officials of the Office of Management and Budget (OMB), the Federal Paperwork Commission, and 20 Federal, State, local, and private agencies who requested information from hospitals. In addition, we discussed our findings with Department of Health and Human Services (HHS) <sup>1/</sup> officials and representatives of six State hospital associations across the country as well as the American Hospital Association.

As agreed with the Senate Committee on Finance, Subcommittee on Health staff, we did not expand our work on inspections and reporting requirements beyond the hospitals originally selected for review, because the extent of the problems identified, in our opinion, did not warrant such expansion.

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<sup>1/</sup>On May 4, 1980, a separate Department of Education commenced operating. Before that date, activities discussed in this report were the responsibility of the Department of Health, Education, and Welfare.

Our work on Life Safety Code enforcement included sending a questionnaire to a statistical sample of 313 hospitals throughout the United States inquiring about various aspects of Life Safety Code enforcement--including the correction status of Life Safety Code deficiencies and the costs to correct them. In addition, we visited 14 hospitals to develop information on Life Safety Code enforcement and the incidence of fires at those hospitals.

We also did work at HHS headquarters, regional offices, and State organizations. We interviewed officials of the Joint Commission on Accreditation of Hospitals (JCAH), the American Hospital Association (AHA), the National Fire Prevention and Control Administration, the National Bureau of Standards (NBS), and the National Fire Protection Association (NFPA).

### HOSPITAL INSPECTIONS

Hospital inspections are performed for a variety of reasons. Some cover the entire hospital while others cover only a portion, such as the laboratory or dietary departments. Federal and State agencies require inspections (1) for licensure, (2) to certify a facility for participation in a program, such as Medicare, and (3) to assure that services are provided in a prescribed manner. Private groups, such as JCAH and the American Medical Association (AMA), generally conduct inspections for the purpose of accrediting the entire hospital or specific departments in accordance with voluntary standards or guidelines. Generally, these latter inspections are solicited by the hospital and are designed to improve hospital operations or the delivery of health care.

HHS' Health Care Financing Administration (HCFA) has been working with States and JCAH to reduce duplicative and similar hospital inspections by establishing cooperative survey agreements where States accept JCAH survey results or participate with JCAH during surveys.

### Information on inspections at three hospitals

As shown in the following table, the three hospitals we visited for purposes of assessing the impact of duplicative inspections received a total of 101 different inspections from Federal, State, local, and private organizations. The three hospitals reported 24, 45, and 65 inspections, respectively.

	<u>Every 2 to 4 years</u>	<u>Annual</u>	<u>Quar- terly</u>	<u>Unscheduled (note a)</u>	<u>Other (note b)</u>	<u>Total</u>
Federal	3	5	0	9	3	20
State	0	7	2	15	3	27
Local	0	3	2	4	0	9
Private	<u>27</u>	<u>7</u>	<u>1</u>	<u>2</u>	<u>8</u>	<u>45</u>
Total	<u>30</u>	<u>22</u>	<u>5</u>	<u>30</u>	<u>14</u>	<u>101</u>

a/Includes unannounced inspections and other inspections done on an irregular basis.

b/Includes inspections conducted monthly, bimonthly, semi-annually and one time only.

About 45 percent of the inspections were performed by private organizations. Most of these were conducted every 2 to 4 years and were carried out by AMA in departments having medical education programs. About 27 percent of the inspections were made by States, and many were unannounced inspections in connection with complaints and new construction.

Of the 101 inspections, 38 were identified by hospital officials as duplicative or similar to others. Inspections for State licensure and JCAH accreditation--which are similar in nature and scope--were considered particularly burdensome because both generally involved all departments in the hospital. Notwithstanding the duplication or similarity, hospital officials ranked the problems associated with inspections far below those associated with other regulatory related requirements.

#### JCAH accreditation and State cooperative surveys

The purpose of these surveys is generally to assess the capability of a hospital to deliver health care. JCAH measures a hospital's capability against a set of optimum standards which cover most hospital operations. JCAH accreditation is voluntary, and about 75 percent of all hospitals participating in Medicare are accredited.

State licensure surveys also assess a hospital's capability to deliver health care. While State licensing standards vary, they generally represent a minimum set of standards for health care.

While there are variances, the focus of the JCAH and State surveys is similar in that both generally examine the entire hospital to arrive at accreditation and licensure decisions. Hospital officials expressed the belief that it was unnecessary to have two inspections which cover essentially the same areas and differ only in depth. They pointed to successful programs in several States that involve cooperative inspections between JCAH and State licensure authorities. According to JCAH, 20 States currently accept JCAH accreditation, either in whole or in part, for licensure or participate in cooperative inspection activities with JCAH. An additional 16 States and the District of Columbia are considering similar programs. HHS has been working with the various States and JCAH to promote the establishment of cooperative inspection arrangements.

There are two basic types of JCAH-State cooperative programs. The first is called a "deemed status" arrangement, under which a State accepts JCAH accreditation for licensure purposes. This is similar to the arrangement between the Federal Government and JCAH for certifying hospitals for participation in Medicare. Variations of this basic arrangement range from no State intervention in hospital inspection activities to spot checks by State health departments to confirm that JCAH recommendations are being followed. For example, according to JCAH, some States have elected to conduct surveys of JCAH accredited hospitals on a sample basis to confirm JCAH results, thereby minimizing State inspection activity while at the same time assuring compliance with State standards.

The second type of JCAH-State cooperative program involves conducting the JCAH and State licensure inspections simultaneously. Variations range from two distinct inspection teams conducting their own surveys to State and JCAH inspectors performing different parts of an inspection with each accepting the other's findings. (See appendix II for a list of the status of JCAH-State joint inspection programs.)

Hospitals, States, and JCAH benefit from the cooperative survey programs. Hospitals benefit because they only have to prepare for one inspection instead of two. States benefit because it gives them the flexibility to either reduce or redirect inspection efforts to other health areas, such as nursing homes or problem hospitals. Basically, States can have as little or as much involvement as desired provided the needs of both organizations are satisfied. JCAH could also benefit since it (1) would need fewer inspectors to the extent it and the States perform joint inspections and accept each

others findings and (2) can make better use of personnel and reduce costs to the hospitals being inspected. Whatever method is chosen, using JCAH survey findings reduces duplicate inspections while providing a means of assessing the capability of hospitals to provide quality health care.

There are, however, some drawbacks to JCAH-State cooperative programs. JCAH reports of survey findings are normally confidential and, in most cases, they become public information as a result of State involvement in the inspection process. Some State officials also believed that involving JCAH could reduce their budget and possibly their authority over hospitals. However, hospital association officials we interviewed in four States having cooperative surveys generally believed the drawbacks were minor and favored a cooperative survey program.

JCAH strongly favors the elimination of duplicative hospital inspections. In addition to its cooperative survey programs, it has supported participation in several pilot projects with the objective of developing a single survey for multiple purposes--accreditation, licensure, and certification. JCAH believes that these cooperative activities contribute to health care cost containment while providing a strong review program directed at the provision of quality patient care in hospitals.

HCFA has been working with States and JCAH to reduce duplicative or similar hospital inspections. Continued success in getting more States to participate in JCAH surveys or accept its survey findings should further reduce problems associated with duplicative or similar hospital inspections. Cooperative survey programs can be sufficiently flexible to adequately meet the requirements of both JCAH accreditation and State licensure.

#### HOSPITAL REPORTING REQUIREMENTS

We visited four hospitals to assess the burden of reporting requirements. Hospitals are completing many reports and forms at various time intervals ranging from one time only to monthly for Federal, State, and local governments as well as private organizations. Many of the forms and reports (requests for information) asked for similar information. No forms or reports we analyzed were identical, and where similar data were requested they were readily available. In addition, most of the reports and forms requesting similar information contained data that were used internally by the

hospital. Continued efforts resulting from the Federal Paperwork Commission recommendations and the President's Reporting Burden Reduction Program can help diminish problems associated with requests for duplicate or similar data.

The four hospitals we surveyed identified a total of 202 different reports and forms that had to be completed for Federal, State, and local governments and private organizations. The highest number of reports and forms identified by a single hospital was 85.

As shown in the following table, the Federal Government made the greatest number of requests (44 percent) and private organizations had the second highest number.

	One time only	Annual	Quarterly	Monthly	Other (note a)	Total
Federal	13	45	8	6	16	88
State	1	19	7	11	11	49
Local	2	4	0	8	0	14
Private	<u>9</u>	<u>26</u>	<u>6</u>	<u>4</u>	<u>6</u>	<u>51</u>
Total	<u>25</u>	<u>94</u>	<u>21</u>	<u>29</u>	<u>33</u>	<u>202</u>

a/Other includes forms or reports used less frequently than annually--other than monthly or quarterly--or as needed.

The 202 reports and forms represented requests for information from 59 organizations; 49 (83 percent) were State and local government or private organizations. There were 10 Federal organizations which included departments and agencies or subordinate organizations and health systems agencies and Professional Standards Review Organizations, which are federally funded.

About one-half of the 202 requests were annual forms and reports, and most of these came from the Federal Government and private organizations. Of the 139 Federal and private requests, about one-half were made annually. Most of the one time only Federal requests were from the Department of Labor requesting information on employee benefit plans.

Although the information requested applied to all phases of hospital operations, the most frequent requests involved employee benefits, taxes, facility services and utilization, medical education, equipment and treatment using radioactive

materials, and alcohol and drug controls. Of the 202 requests identified by the hospitals, 76 were required of all businesses, not just hospitals.

	<u>Federal</u>	<u>State</u>	<u>Local</u>	<u>Private</u>	<u>Total</u>
All forms and reports	<u>88</u>	<u>49</u>	<u>14</u>	<u>51</u>	<u>202</u>
All businesses	45	22	4	4	76
Hospitals only	43	27	9	47	126

Most of the requests directed at all businesses were from the Internal Revenue Service and the Department of Labor.

#### Use of data requested

Our survey included interviews with data requestors to determine the use made of information collected. Governmental requestors used the hospital data to (1) reimburse hospitals for services provided, (2) prepare reports to the Congress, (3) publish other reports, (4) make agency decisions, and (5) monitor patient treatment. For example, HCFA collects data from kidney dialysis facilities pursuant to title 18 of the Social Security Act (42 U.S.C. 426). A variety of information is required that is used to manage HCFA's program and to report to the Congress on program effectiveness.

Also, federally supported health systems agencies (HSAs) need hospital data to carry out health planning responsibilities within their respective health service areas. One HSA we visited collected data on the use of cardiac surgery facilities to determine whether there was a need for additional or fewer services in its health service area. The information was ultimately used in developing part of the health systems plan for the HSA service area.

Private requestors we spoke with were using the data to evaluate hospital services, costs, or trends within the industry. In two cases, data were published in industry journals or agency reports. For example, AHA's Guide to the Health Care Field is a compilation of statistics on individual hospitals responding to an annual questionnaire. The guide is used both within and outside the industry as a reference to general statistics on U.S. hospitals.

We also found that information was being collected under HHS' Cooperative Health Statistics Program. Contractors under this program coordinate data requests between users and share

information they collect with other users. These data include statistics from hospitals on births and deaths, hospital facilities and services, and data on their health care personnel. The Cooperative Health Statistics System (CHSS) has contractors in 44 States, the District of Columbia, New York City, and Puerto Rico which collect these types of data and make them available to other groups that would otherwise request such data from hospitals. One CHSS contractor in Virginia was sharing its data with numerous groups throughout the State in an attempt to reduce duplicative requests.

Many data requests are duplicative or similar

In addition to the volume of forms and reports completed by hospitals, requests for duplicate or similar data were one of the most frequent concerns of hospital officials. Although the number and type of requests for similar data varied at the four hospitals we visited, officials were able to identify forms which requested similar data. Hospital officials told us that a similar data request often requires them to retabulate and present information in a different format.

As shown below, of the 202 reports and forms hospital officials identified, 90 (45 percent) were considered by the officials to be requests for duplicative or similar data.

Analysis of All Data Requests

	<u>Federal</u>	<u>State</u>	<u>Local</u>	<u>Private</u>	<u>Total</u>
Total data requests identified	<u>88</u>	<u>49</u>	<u>14</u>	<u>51</u>	<u>202</u>
Duplicative or similar	34	21	7	28	90
Not duplicative or similar	54	28	7	23	112

Many of the duplicative or similar requests emanated from the Federal and private organizations. Also, half of the 90 duplicative or similar requests were made annually. Private groups, such as AHA and JCAH, asked hospitals to respond to a total of 51 requests. The percentage of these requests that hospitals identified as duplicative or similar was higher than for any other group--28 of 51 forms (55 percent).

Of the 126 reports and forms that applied to hospitals only, 69 (55 percent) were duplicative or similar, as shown below.

	<u>Federal</u>	<u>State</u>	<u>Local</u>	<u>Private</u>	<u>Total</u>
Hospital only	<u>43</u>	<u>27</u>	<u>9</u>	<u>47</u>	<u>126</u>
Duplicative or similar	24	13	5	27	69
Not duplicative or similar	19	14	4	20	57

We examined and compared most of the forms identified by hospital officials as duplicative or similar and generally agreed with their characterization. This, as well as other aspects of our survey, seemed to confirm the belief among hospital officials that there are many forms and reports that request data similar to that already requested by other organizations. However:

- No two forms which we examined were exactly alike; in most cases, only some of the data requested were similar to another request.
- Duplicative data were, for the most part, basic (number of physicians, beds, types of services, etc.) and readily available.
- Of the 90 duplicative or similar requests, 48 asked for information normally collected by the hospitals for internal purposes (see p. 11).

#### Reasons for similar requests

We interviewed officials from Federal, State, and local governments and private organizations that requested information from hospitals. Of 20 officials, 11 agreed that some of the information they requested was similar to information requested and collected by others, but most officials indicated that the information collected by others could not always be readily used. Reasons given for collecting duplicative or similar data included

- different requirements for reimbursement,
- timeliness of data,

- data needed from different geographic areas, and
- data not specific enough from the sources or in aggregate forms and therefore not readily usable.

Federal, State, and local government organizations independently collect information to manage their programs. As a result, hospitals receive multiple requests for the same or similar data from these sources. Some of the requests are the result of legislation enacted by the Congress. However, for cases where statutory requirements would not preclude their elimination, agency officials believe that such things as questions concerning the reliability and timeliness of data, differing requirements, and scope of data collected by other sources contribute to the large number of forms and reports used to collect duplicative or similar data.

During our survey, hospital officials cited billing as a primary area in which paperwork costs could be reduced. This was also noted by some State hospital association officials. Experiments on uniform billing, sponsored by HHS, are currently underway in five States. Hospital officials said an increased paperwork burden is anticipated if HHS implements the requirement of its proposed Annual Hospital Report (AHR). They said that, at least initially, they would also continue to maintain records using their current system so that management decisions could be made. They also expressed concern about the substantial detailed data required by AHR, and they were not optimistic about being able to use these data internally. As a result, they believed that the AHR could require additional staff and increase costs related to Federal reporting.

We testified before the Senate Finance Committee and the Subcommittee on Health of the House Committee on Ways and Means in July 1979 on the HHS proposed system. <sup>1/</sup> The testimony provided information on (1) the amount of additional data the SHUR would require, (2) HHS' intended use of the data, (3) comparability of the SHUR with AHA's Chart of Accounts and Reporting System, and (4) steps HHS has taken to determine additional hospital costs. The testimony also provided suggestions for simplifying the proposed SHUR system.

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<sup>1/</sup>The proposed system was called Standard Hospital Uniform Reporting (SHUR). Subsequent to our testimony and after modifications were made to the system reducing the data requirements, the name of the system was changed to Annual Hospital Report.

Hospitals use much of the requested data for their own internal purposes

Hospital officials provided us information which showed that much of the data requested by others would be tabulated and used for internal purposes even if the information was not required by others. The following tables illustrate the extent to which the information contained in the 202 reports and forms is used internally by the hospitals.

Analysis of All 202 Reports and Forms

	<u>Federal</u>	<u>State</u>	<u>Local</u>	<u>Private</u>	<u>Total</u>
Data request identified	<u>88</u>	<u>49</u>	<u>14</u>	<u>51</u>	<u>202</u>
Used internally	32	22	6	31	91
Not used internally	56	27	8	20	111

Analysis of the 90 Duplicative or Similar Reports and Forms

	<u>Federal</u>	<u>State</u>	<u>Local</u>	<u>Private</u>	<u>Total</u>
Duplicative or similar	<u>34</u>	<u>21</u>	<u>7</u>	<u>28</u>	<u>90</u>
Used internally	14	10	3	21	48
Not used internally	20	11	4	7	42

Analysis of the 69 Duplicative or Similar Forms and Reports Applying Only to Hospitals

	<u>Federal</u>	<u>State</u>	<u>Local</u>	<u>Private</u>	<u>Total</u>
Hospital only duplicative or similar	<u>24</u>	<u>13</u>	<u>5</u>	<u>27</u>	<u>69</u>
Used internally	10	8	2	20	40
Not used internally	14	5	3	7	29

As shown above, only 29 of the 202 reports and forms identified by the four hospitals we visited related to requests that were directed at hospitals only, and requested duplicative or similar information that was not used internally by the hospital.

#### Experiences at the hospital level

The following example illustrates the nature of the data requests received by one hospital we visited and shows the extent to which data requested are also used for internal hospital purposes.

We asked hospital officials to provide information on all forms and reports completed 1/ by hospital personnel. We asked these officials to

- identify the forms or reports,
- identify the sources of the requests,
- show the frequency,
- show the amount of time required for completion,
- tell us whether the requests were duplicative or similar to other requests for information, and
- tell us whether most of the information would have been collected for internal use if it had not been requested by a governmental or private organization.

Hospital officials told us that they prepared 85 forms and reports. As shown in the following chart, the majority (53 percent) were forms and reports that had to be prepared by all businesses--not only hospitals.

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1/No specific time period was provided hospitals so that they could identify and include all reports and forms regardless of their frequency of request (see table on p. 6).

	<u>Hospitals only</u>	<u>All businesses</u>	<u>Total</u>
Federal	15	33	48
State	12	11	23
Local	-	-	-
Private	<u>13</u>	<u>1</u>	<u>14</u>
Total	<u>40</u>	<u>45</u>	<u>85</u>

Of the 85 reports and forms prepared at this hospital, 71 (84 percent) were for Federal and State governments, and 14 (16 percent) were completed voluntarily for private organizations. Half of the private requests came from AHA and JCAH.

Of the 71 Federal and State government data requests, 44 were directed to all businesses. The other 27 were directed to hospitals only. Hospital officials told us that 13 of these 27 governmental forms contained information used by the hospital and that the information would have been tabulated anyway for internal use.

According to the hospital staff, the total estimated time required to complete all 85 reports and forms was between 1,800 and 2,400 staff hours. Of the 85 data requests, 26 contained information normally collected for internal use of the hospital, and hospital officials said that the time required to complete data requests for information not normally compiled for internal use was between 970 to 1,250 staff hours or between one-half and three-fourths of a staff year. While the overall reporting burden on this hospital may be substantial, the burden specifically associated with Federal and State forms and reports directed at hospitals only which are not used internally was only a small portion of the total. Only 14 requests that came from Federal and State governments were directed at hospitals only, and were not used internally.

#### Efforts to reduce duplication

A number of efforts, both governmental and private, are underway to reduce duplicative reporting requirements. Federal requestors have been directed to implement (1) the procedures set forth in the President's Reporting Burden Reduction Program, (Executive Order 12044) issued by the President on March 23, 1978, and (2) the recommendations of the Commission on Federal Paperwork. Private efforts include those of AHA and Blue Cross/Blue Shield.

Progress in implementing Commission  
on Federal Paperwork recommendations

In April 1977 the Commission on Federal Paperwork made recommendations to the President and the Congress that would reduce information demands of Federal programs, including health programs. These recommendations called for "immediate reduction in paperwork in certain programs, followed by fundamental changes in the way Federal health data needs are identified and met." Agencies, however, have been slow to implement the recommendations.

The Commission's report included 39 recommendations, 15 of which would reduce hospital paperwork and duplicative requests. As of January 1980, HHS had implemented four of these recommendations and had rejected one. The other 10 recommendations were in the process of being implemented by HHS and OMB or they required congressional action. These recommendations can be categorized into four areas:

- Uniform billing.
- A mandatory health data inventory to be used by all agencies.
- Coordination of data requests.
- Implementation of legislative procedures which would reduce public reporting burdens.

We believe that the Commission's recommendations, if implemented, could reduce the existing reporting burden of hospitals. The recommendations relating to uniform billing, for example, are likely to help because they would consolidate many reimbursement forms into one. As discussed on page 8, hospital officials said that billing was a primary area in which paperwork costs could be reduced. There are five States which are testing a uniform billing system.

The Commission's recommendations are not specifically directed at private groups or State and local governments. Therefore, the impact of the recommendations on hospital reporting burdens which emanate from State and local governments may be limited. As shown previously (see p. 6), about 56 percent of all requests for data come from State, local, and private sources.

Impact of President's Reporting  
Burden Reduction Program

In March 1976, prior to the Federal Paperwork Commission's recommendations, the President announced the results of the Reporting Burden Reduction Program which directed each department and agency head to (1) reduce the number of reports used to collect information from the public by at least 10 percent by June 30, 1976, and (2) undertake a continuing effort to reduce the public burden of Government reporting. By July 1976, the number of regularly used reports had been reduced by 12.5 percent but, according to OMB, the overall reporting burden on the public had increased. <sup>1/</sup> Therefore, OMB announced the President's initiation of a second phase Government-wide effort. The goal was to reduce the public reporting burden by 5 percent by September 30, 1977. OMB had overall oversight responsibility for the program, including preparation of an overall assessment report. Each executive agency, however, prepares individual progress reports on program related activities.

In June 1978, HHS announced that it had reduced the paperwork burden associated with Public Health Service and HCFA forms for health care providers by 10 percent. Although we did not evaluate HHS' reduction in paperwork, a previous GAO report on efforts to reduce paperwork (GGD-77-38, May 25, 1977) concluded that statistics on paperwork burden and the Reporting Burden Reduction Program are subject to error, primarily because the estimates are made by the agency that developed the report and there are disagreements between agencies and respondents on their validity. Nevertheless, it appears that HHS is making a concerted effort to reduce the number of reports required of health care providers.

Private efforts

Both AHA and Blue Cross/Blue Shield have taken actions to reduce the reporting requirement burden on hospitals. AHA has two efforts under development. The first is to identify all data hospitals are requested to provide in order to develop ways in which hospitals can respond more

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<sup>1/</sup>The increase in burden was attributed to increased reporting requirements for the (1) Department of Housing and Urban Development and (2) Department of Labor and Internal Revenue Service Under the Employee Retirement Income Security Act of 1974.

efficiently. The second involves inventorying all data sources available for use by requestors instead of them directly requesting data from hospitals.

Blue Cross/Blue Shield attempts to use data developed by hospitals for other requestors. This has been done in Maryland where Blue Cross/Blue Shield accepts data that are provided by hospitals to the State rate review commission.

#### LIFE SAFETY CODE ENFORCEMENT

The National Fire Protection Association (NFPA) estimated that 16,000 fires occurred in the Nation's 7,000 hospitals during 1975. Of the more than 7,100 fires reported each day in the United States, less than 1 percent are in hospitals, which are also one of the safest places in terms of risk of death from fire. Fires that cause extensive property damage to hospitals or multiple deaths (three or more) are rare. In the past 30 years, there have been only three multiple death fires in community hospitals. The last one was in Missouri in 1974 where eight people died. Because many hospital fires are minor, they often are not reported to Federal or State authorities. Sometimes the local fire department will be notified.

Of the 14 hospitals we visited, 6 did not have any fires during 1977 and 1978. Data on 63 fires that occurred in the other eight hospitals showed they were generally small, with no deaths or injuries and only minor property damage. With the exception of two incidents, hospital officials did not believe Life Safety Code deficiencies contributed to a fire. The first incident involved the burning of a patient's bed linen which should have been fire resistant. The second involved the use of a flammable liquid for cleaning purposes. Many of the fires in the hospitals we visited were extinguished by hospital employees. Although reports were prepared on these fires, they were not provided to any authorities other than local fire departments. As a result, it is difficult to obtain reliable data on the number of fires occurring in hospitals.

#### Life Safety Code requirements

The Life Safety Code, developed by NFPA, is a compilation of standards designed to provide the degree of public safety from fire which can be reasonably required. Chapter 10 of the code entitled "Health Care and Penal Occupancies" contains fire safety standards for hospitals and nursing homes.

The code is revised periodically, and the most recent editions of the code were adopted in 1967, 1970, 1973, and 1976. NFPA anticipates that a new version will be adopted by November 1980.

The Social Security Amendments of 1965 (Public Law 89-97) require that hospitals receiving Medicare funds meet certain conditions of participation. One of these conditions as described in the Code of Federal Regulations--life safety from fire--requires that all participating hospitals meet appropriate provisions of the 1967 Life Safety Code of NFPA.

Life Safety Code deficiencies are identified through (1) Medicare certification surveys performed by States under contract with HHS, (2) JCAH accreditation surveys, (3) validation surveys of JCAH accredited hospitals performed by States for HHS, (4) inspections conducted by State and local government agencies for licensure, occupancy permits, or other reasons, and (5) inspections conducted by the hospital itself.

The Secretary of HHS may waive adherence to specific requirements of the Life Safety Code which, if rigidly applied, would result in an unreasonable financial hardship upon a particular hospital. However, a waiver will only be granted if it will not adversely affect the health and safety of the patients. In addition, because Medicare certification for unaccredited hospitals must be renewed annually, HHS waivers must also be renewed each year. The majority of waivers are renewals or redeterminations with few new waivers being granted.

The National Bureau of Standards (NBS) under contract to HHS, has developed a system called the Fire Safety Evaluation System (FSES) for health care facilities. The objective of FSES is to (1) evaluate the level of fire safety in existing buildings relative to the level prescribed by the Life Safety Code and (2) determine the equivalency of alternative systems for safety from fire for new designs, construction, or modifications to existing buildings.

A basic principle of the Life Safety Code is to require a redundancy of protection so that the failure of a single protection device will not result in a failure of the entire system. This is the underlying concept of FSES. Using FSES allows a hospital to avoid incurring unnecessary correction costs. The hospital's cost of correcting Life Safety Code violations often can be reduced because FSES allows an equivalent measure of safety. Also, the need for HHS to grant waivers could be significantly reduced by using FSES.

HHS is in the initial stages of implementing FSES in the field, and only a few hospitals have been evaluated using the system.

Types of Life Safety Code  
deficiencies found

Many Life Safety Code deficiencies have been identified in both accredited and unaccredited hospitals. The severity of deficiencies ranges from minor easily corrected problems, such as the absence of exit signs, to major structural deficiencies, such as the absence of automatic fire protection devices or appropriate construction safeguards in hazardous areas.

We sent a questionnaire to a sample of 313 hospitals nationwide that had been cited by State inspectors for violation of 1 or more of 19 Life Safety Code standards violation of which is common, expensive to correct, or considered to be serious (i.e., life threatening). Following is a general description of the 19 standards and the number of hospitals cited for violation of the standard out of the 275 hospitals (87.5 percent) who responded to our questionnaire.

General description of standard	Number of hospitals cited for violating standards (note a)
HAZARDOUS AREAS--Every hazardous area must have automatic fire protection or be separated by construction having at least a 1-hour fire resistance rating.	167
CORRIDOR WALLS--Corridors must be separated from sleeping rooms and treatment areas by construction having at least a 1-hour fire resistance rating.	119
CORRIDOR DOORS--Doors to patient rooms and diagnostic and treatment areas must be solid wood bonded core doors or the equivalent.	126
ANESTHETIZING AREAS--Rooms and areas used for storage of flammable anesthetic agents must be designed, operated, and maintained in accordance with NFPA standards.	100
SMOKE BARRIERS--Partitions must have at least a 1/2-hour fire rating and be continuous from exterior wall to exterior wall and floor to floor.	98
DOORS IN FIRE AND SMOKE PARTITIONS--These must be self-closing upon actuation of the fire alarm system.	75
CONSTRUCTION TYPE--Generally, building must be of fire resistant construction.	74
SPRINKLER COVERAGE--Automatic sprinkler protection must exist throughout with adequate water supply and pressure where the construction type standard is not met.	60
STAIRWAY ENCLOSURES--Each stairway between stories must be enclosed with partitions having at least a 1-hour fire resistance rating.	60
SMOKE BARRIER--Smoke partitions must divide corridors in sections of not more than 150 feet in length.	53
EXITS--There must be at least two exits, remote from each other, for each floor or fire section with at least one leading outside the building.	52
ACCESS--Every aisle, passageway, corridor exit, must lead to the outside.	49
SPRINKLER SYSTEM MAINTENANCE--The system must be maintained, inspected, and tested in accordance with NFPA standards.	48
INTERIOR FINISH--Finish of walls and ceilings must restrict fire.	42
VERTICAL SHAFTS--Elevator, and ventilation shafts and other vertical openings must have partitions with at least a 1-hour fire resistance rating or other features.	41
COMMON WALL--Certain common walls must have at least a 2-hour fire rated partition with openings protected by self-closing fire doors.	35
LINEN AND TRASH CHUTES--Any linen or trash chute which opens directly on to a corridor must be sealed by fire resistant construction.	27
CENTRAL ELECTRICAL SYSTEMS--These must be designed, installed, and maintained to assure continuity of electrical power in accordance with NFPA standards.	26
WINDOWS--Generally, every patient's bedroom must have at least one outside window which can be opened from the inside without the use of tools.	24
a/Hospitals were counted once as having a deficiency regardless of the number of times the violation was found in the hospital.	

The following table shows the total and average number of deficiencies for the 275 hospitals that responded to our questionnaire arranged in five bed-size groups. The table shows that smaller hospitals generally had fewer Life Safety Code deficiencies than larger hospitals.

<u>Beds</u>	<u>Number of hospitals</u>	<u>Total deficiencies</u>	<u>Average number of deficiencies</u>
Less than 50	126	391	3.1
51-100	72	394	5.5
101-200	35	226	6.5
201-400	28	308	11.0
Over 400	<u>14</u>	<u>130</u>	9.3
Total	<u>275</u>	<u>1,449</u>	5.3

#### Correction of deficiencies

According to our questionnaire results and our visits to 14 hospitals, most Life Safety Code deficiencies in the 19 standards have been corrected or are being corrected. Responses to our questionnaire showed that 60 percent of the identified deficiencies in the 19 standards had either been corrected or were in the process of being corrected. At the 14 hospitals we visited, 86 percent of all Life Safety Code deficiencies had been corrected or were being corrected.

The questionnaire responses also showed that:

- Hospital officials agreed with 74 percent of the deficiencies cited.
- Hospital officials believed that about 61 percent of the deficiencies cited did not present an unreasonable risk to patient safety.
- Generally less expensive deficiencies are more likely to be corrected.
- Many corrections that cost over \$5,000 are included in broader renovation or modernization projects.
- Hospital officials indicated that about 43 percent of the deficiencies would most likely be corrected without regulatory pressure.

--Hospital officials indicated that they had no plans to correct about 2 percent of the deficiencies cited.

The following table shows the correction status as of late 1979 of the Life Safety Code deficiencies at the 275 hospitals who responded to our questionnaire.

Status of Deficiencies

	<u>Accredited</u> (113 hospitals)		<u>Unaccredited</u> (162 hospitals)		<u>Total</u>	
	<u>Number</u>	<u>Per- cent</u>	<u>Number</u>	<u>Per- cent</u>	<u>Number</u>	<u>Per- cent</u>
Corrected	423	44.5	295	59.1	718	49.6
Corrections in progress	138	14.5	10	2.0	148	10.2
Plan to correct	117	12.3	29	5.8	146	10.1
Waived	53	5.6	59	11.8	112	7.7
Waiver pending	28	2.9	10	2.0	38	2.6
Equivalent protection	30	3.2	9	1.8	39	2.7
No correction planned	20	2.1	9	1.8	29	2.0
Other	33	3.5	5	1.0	38	2.6
Unknown	108	11.4	73	14.6	181	12.5
	<u>950</u>	<u>100.0</u>	<u>499</u>	<u>100.0</u>	<u>1,449</u>	<u>100.0</u>

Deficiencies that are less costly to correct are more likely to be corrected, as shown by the following table compiled from our questionnaire responses.

<u>Cost</u>	<u>Percent of deficiencies corrected or being corrected</u>
Less than \$100	85
\$100 - \$500	92
\$501 - \$1,000	86
\$1,001 - \$5,000	73
\$5,001 - \$10,000	60
\$10,001 - \$50,000	58
\$50,001 - \$100,000	58
Greater than \$100,000	33

Many deficiencies at the hospitals we visited were corrected as part of a renovation or modernization project. Respondents to our questionnaire indicated that about 29 percent of the deficiencies corrected were done as part of a modernization or renovation project.

The following table shows--for each of the 19 standards we inquired about--the correction rate, cost ranking, and percentage of deficiencies which, according to hospital officials who provided data on these items, presented a risk to patient safety.

<u>Standard</u>	<u>Percent corrected (note a)</u>	<u>Percent presenting a risk to patient safety</u>	<u>Cost ranking (note b)</u>
Sprinkler maintenance	95	27	12
Linen and trash chutes	86	46	5
Doors in fire and smoke partitions	83	35	7
Smoke barriers (1/2 hr)	81	28	16
Corridor doors	78	21	11
Anesthetizing areas	76	21	15
Hazardous areas	74	23	4
Smoke barriers (150')	71	33	2
Stairway enclosures	69	25	6
Vertical shafts	68	24	19
Interior finish	66	5	17
Exits--number and type	65	27	10
Corridor walls	63	14	9
Common wall	59	18	13
Access to exits	48	31	14
Electrical systems	47	19	1
Sprinkler coverage	46	12	3
Windows	42	0	18
Construction type	38	13	8

a/Consists of corrections completed and in progress.

b/Most expensive is ranked 1. See chart on page 25.

Risk to patient safety

The reduction of risk to patient safety is one of the main purposes in enforcing compliance with the Life Safety Code in hospitals. Many hospital administrators, however, do not believe that most fire safety deficiencies in hospitals present an unreasonable risk to patient safety.

As shown by the table on page 22, hospital officials said that deficiencies associated with sprinkler maintenance, fire doors, linen and trash chutes, access to exits, and smoke barriers posed the greatest risk to patient safety.

Hospital officials and inspecting authorities sometimes differ on the issue of risk to patient safety. For example, a hospital official at one of the hospitals we visited told us that as long as a deficiency is not in a patient area or if the patient is under constant supervision by hospital staff, the deficiency does not present an unreasonable risk to patient safety. On the other hand, an official of the State Fire Marshall's office stated that any deficiency which affects the containment or extinguishment of fire and smoke poses an unreasonable risk, regardless of where the deficiency is located.

Costs to correct Life Safety Code deficiencies

It is difficult to obtain accurate data on the cost to correct Life Safety Code deficiencies. For example, many hospitals do not maintain accurate records of cost data associated with correcting Life Safety Code deficiencies. Our questionnaire responses indicated that hospitals did not have cost data for about 17 percent of the cited deficiencies and could not separate the cost data by deficiency cited for an additional 23 percent.

Costs for expansion or renovation projects are sometimes included with Life Safety Code compliance costs. Hospitals often decide to correct cited deficiencies as part of these projects and, as a result, costs become commingled or are otherwise difficult to link to Life Safety Code compliance. For example, a 198-bed hospital complex in the Northeast had a \$10.6 million modernization project underway. A hospital official estimated that 75 percent (\$7.95 million) of the cost of the project represented the cost to comply with various building regulations (but not specifically fire

safety regulations). Costs associated with correcting Life Safety Code deficiencies could not be identified from the hospital's accounting system.

In addition, hospitals sometimes correct deficiencies by using their own maintenance staffs. Costs associated with these activities are often not separated from the costs of normal maintenance activities.

Our questionnaire respondents provided correction cost estimates for only about 67 percent of the violations in the 19 deficiency categories (correction completed, in process, or planned). Seventy-eight percent of the respondents (214 hospitals) provided cost data.

Based on these data, individual hospital costs to correct deficiencies in the 19 categories ranged up to \$1,024,000, with the average cost per hospital at least \$31,000. The table below groups into four categories the 214 hospitals that provided cost data in their questionnaire responses.

<u>Cost to correct deficiencies</u>	<u>Number of hospitals</u>
0-\$10,000	137
\$10,000-\$50,000	38
\$50,000-\$100,000	14
Over \$100,000	25

The following table lists the 10 hospitals 1/ claiming the highest costs to comply with the Life Safety Code.

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1/A total of 20 deficiencies each having correction costs over \$100,000 were reported by 15 hospitals. We contacted these hospitals to determine the actual amounts spent or planned for correcting the 20 deficiencies. We were unable to obtain additional estimates from nine hospitals for 11 of the 20 deficiencies, other than that the costs exceeded \$100,000. Therefore, the nine hospitals are not included in the table. Some of the 9 hospitals probably have incurred or will incur correction costs in excess of some of the 10 hospitals listed in the table.

<u>Hospital</u>	<u>Total cost to correct deficiencies</u>
#1	\$1,024,000
2	577,000
3	257,000
4	225,000
5	211,000
6	189,000
7	179,000
8	153,000
9	150,000
10	138,000

Costs to correct 19 common  
deficiencies

Based on questionnaire responses providing cost data, the most expensive Life Safety Code deficiencies to correct are electrical systems, smoke barriers (150'), and sprinkler coverage, as the table below indicates:

<u>Deficiencies</u>	<u>Average cost to correct</u>
1. Electrical systems	\$23,500
2. Smoke barriers (150')	12,700
3. Sprinkler coverage	11,300
4. Hazardous areas	7,800
5. Linen and trash chutes	7,200
6. Stairway enclosures	6,500
7. Firedoors	6,000
8. Construction type	5,600
9. Corridor walls	5,000
10. Exits	4,700
11. Corridor doors	4,100
12. Sprinkler maintenance	4,000
13. Common wall	3,900
14. Access to exits	3,600
15. Anesthetizing areas	3,400
16. Smoke barriers	3,300
17. Interior finish	2,900
18. Windows	1,600
19. Vertical shafts	1,000

RELATIONSHIP OF OUR WORK  
TO OTHER STUDIES

The information we developed in our work on inspections and reports was generally consistent with the detailed results contained in the report entitled "Cost of Regulation" issued in 1978, by the Hospital Association of New York State. That report 1/ estimated that, of the total costs attributable to areas of regulated activity in hospitals, 1 percent and about 11.5 percent were attributable to inspections and reports/forms, respectively.

The result of our work on Life Safety Code enforcement was not consistent with the results of other published studies. AHA and the Hospital Association of Pennsylvania published studies in 1975 and 1976, respectively, which indicated that it would cost about \$1 million per hospital to comply with the Life Safety Code. Our sample of hospitals cited for Life Safety Code deficiencies in the standard categories suggested a much lower compliance cost than AHA and the Pennsylvania studies. According to data provided by hospitals responding to our questionnaire, it would cost an average of at least \$31,000 for each hospital to comply with Life Safety Code requirements in the 19 deficiency categories. Only one hospital claimed a compliance cost of \$1 million. While our data include costs associated with deficiencies in only 19 standard categories, they include the most costly deficiencies to correct. (See pp. 18 and 25.)

The AHA study was based on data received from 84 of 107 hospitals that lost their Medicare certification "deemed status" 2/ as a result of deficiencies identified during HHS

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1/It should be noted that about 65 percent of the total "regulatory costs" identified in the New York report were attributable to legally required hospital functions, such as preparing patient charts and developing annual budgets which would be performed as a part of good hospital practice whether or not they were required. The report went on to say that these functions were unlike inspections or reports which were required only because regulatory bodies exist.

2/According to the Social Security Act, hospitals surveyed and accredited by JCAH are automatically certified for Medicare.

validation surveys. The study states that "an average \$1.2 million per hospital" would be needed to comply with the Life Safety Code. This was based on overall estimates provided by hospitals and included substantial amounts for replacement of buildings or major equipment. As a result, these estimates could include costs not specifically associated with correcting Life Safety Code deficiencies. Detailed data submitted to AHA by 76 hospitals indicated that correction costs would be an average of \$685,921--substantially less than the \$1.2 million estimate.

The Pennsylvania study provided no detailed data supporting its estimated \$1 million expenditure per hospital to correct deficiencies. It did state that costs were estimated assuming that no waivers would be granted by HHS. As mentioned on page 17, HHS often grants waivers in situations of financial hardship. Therefore, including estimated expenditures for deficiencies that would likely be granted, waivers could inflate correction cost estimates.

STATUS OF COOPERATIVE JCAH-STATEINSPECTION PROGRAMS(as of 1/31/80)

1. Legislation Grants "Deemed Status"
 

Tennessee	Texas
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2. Legislation Enables State Agency to Grant "Deemed Status"
 

New Mexico	Oregon	Arizona
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3. State Agency Accords "Deemed Status" in Whole or in Part
 

Washington	Louisiana	Mississippi
Nevada	Colorado	Illinois
  
4. Joint Survey in Place
 

California	New York	Maryland
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5. State Agency Grants "Deemed Status" Without Legislation or Regulation
 

Iowa	Utah	Virginia
Idaho	Kentucky	Delaware
  
6. Legislation Under Consideration
 

Maine	Minnesota	Ohio
Pennsylvania	West Virginia	
Wisconsin	District of Columbia	
  
7. Initial Discussion Stage
 

Wyoming	Indiana	South Carolina
Hawaii	Michigan	Connecticut
Rhode Island	Massachusetts	New Hampshire
Puerto Rico		