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Concerning the HHS Inspector General Reports on *The External Review of Hospital Quality*
(OEI-01-97-00050; -00051; -00052; & OEI-01-97-00053)

If you announce well in advance that you are going to do a survey, allow the hospital to hand-pick most of the medical records which are going to be reviewed, make no significant efforts to uncover systemic problems by eliciting criticism of hospital practices from employees (with anonymity guaranteed) or patients and their families, and view the hospital as your "customer" rather than an institution which must be regulated, it is not likely you will discover the serious, often life-threatening problems which exist in many hospitals. If you behave that way, you are probably called the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). We advocate legislation to repeal the authority for JCAHO to act as the government-deemed regulator of America's hospitals. Too many people have been killed or injured because of its negligent reviews.

The Most Alarming Findings of the Inspector General's Reports Are:

1. Joint Commission surveys are unlikely to detect patterns, systems, or incidents of substandard care.

According to the Inspector General's reports, Joint Commission's surveys, the *primary* source of external review for approximately 80 percent of the hospitals in this country, are unlikely to reveal problems "such as inappropriate surgeries, high complication rates, or poor or unexpected outcomes." The Joint Commission's approach is characterized as "educational" and "collegial," rather than regulatory, and hospitals are not only notified far in advance of survey dates, but often are allowed to select the records to be reviewed by the Joint Commission. As a result, the survey process may not reveal any problems when in fact systemic problems exist. One example noted in the Inspector General's reports included a hospital where a Joint Commission survey failed to uncover what a State agency subsequently identified as deep-rooted problems: "[I]n the Spring of 1996, the Joint Commission awarded one hospital its highest level of accreditation: accreditation with commendation. That Fall, the hospital experienced an unexpected death, triggering the State agency to investigate. In the Spring of 1997, more unexpected deaths occurred, and the agency returned. After a 3-week investigation, that agency found systemic problems in both quality assurance and medical staffing." Detecting patterns of substandard care before injury or death occurs should be a central goal for a system of hospital review; the Inspector General's finding that the current system does not adequately perform this

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role is highly disturbing.

2. Joint Commission surveys are unlikely to identify individual practitioners whose judgment or skills to practice medicine are questionable.

Although a Joint Commission survey includes a review of the hospital's method for ensuring the competence of its practitioners, the Inspector General's reports found that the Joint Commission's review is "a preliminary and superficial assessment," and is unlikely to identify individual practitioners who pose risks to their patients. The collegial nature of the process, the limited time, an approach to medical records that includes allowing the hospital to choose the files for review, and lack of background information combine to create a process that "falls short of identifying individuals whose skills may be questionable." The Inspector General's investigation also found little evidence that the Joint Commission examines how the hospital identifies or deals with physicians whose skills are marginal. Indeed, the Joint Commission standards do not even reference the federal law that requires hospitals to report to the National Practitioner Data Bank any practitioner the hospital has disciplined with a restriction on privileges lasting more than 30 days, even though an earlier Inspector General report found widespread failure of hospitals to comply with this federal law. As of December 1998, more than eight years after the National Practitioner Data Bank started, only 38.3% of American hospitals had reported taking a disciplinary action against even one physician. This means that 3,914 American hospitals, most of which have dozens if not hundreds of physicians with admitting privileges, either have not disciplined even one physician sufficiently to trigger reporting to the Data Bank, or, if they have disciplined some physicians, have failed to report the physicians as required by federal law.

3. For the 20 percent of the hospitals in the country that are not accredited by the Joint Commission, external review is infrequent and tends to be triggered by a serious incident involving patient harm rather than as part of a routine review intended to prevent such incidents.

There are more than 1,400 hospitals across the country that do not participate in the Joint Commission accreditation process, and instead are surveyed by State agencies in order to be certified for Medicare participation. Because of the low priority given to routine hospital surveys by the Health Care Financing Administration (HCFA), however, half of these hospitals have not been surveyed within the 3-year industry standard, and some hospitals have gone for as long as eight years without a survey. In addition, in all but a few states, the length of time between surveys is growing.

4. In spite of the fact that the present system of hospital review is already heavily tilted towards a collegial, industry-friendly approach, the current trend is towards even more of a collegial mode of oversight and away from a regulatory mode.

As the Inspector General's reports point out, the Joint Commission is the dominant force in the external review of hospitals, surveying approximately 80 percent of hospitals, and its approach is grounded in the collegial mode. "Notwithstanding the presence of non-industry members on its board or of various advisory bodies or of certain public purposes it may fulfill, it is primarily responsive to the interests of entities it accredits." Given this large imbalance between collegial and regulatory modes of oversight, we are greatly alarmed by the Inspector General's conclusion that the movement in the field is towards an even greater use of the

collegial mode. The Inspector General's reports note the danger of relying too heavily upon the collegial mode as the basis for external oversight, and state that "[t]he emerging dominance of the collegial mode may undermine the existing system of patient protections afforded by accreditation and certification practices." The Inspector General's reports cited the conclusion reached by the National Roundtable on Health Care Quality that "as the overall system of quality oversight becomes increasingly oriented to the collegial side of the continuum, the risks begin to mount, with potentially significant consequences to patients."

*5. The Joint Commission and State agencies are only **minimally** accountable to HCFA for their performance in reviewing hospitals.*

In surveying hospitals for accreditation or certification, the Joint Commission and State agencies are performing what is essentially a regulatory function--ensuring that hospitals can provide the quality care necessary in order to participate in Medicare. Yet according to the Inspector General's reports, HCFA provides only slight oversight of their performance: HCFA asks for little in the way of routine performance reports; provides little feedback; and makes little information available to the public on the performance of hospitals or external reviewers.

Recommendations Beyond Those Made by the Inspector General

After reading these reports, we are all the more convinced that the external review of hospitals should be conducted by a publicly accountable body. As the reports make clear, the failure of our current system to adequately detect patterns of substandard care or to identify marginal practitioners--*before* harm to patients occurs-- is a critical failure. While some of the tragedies that have occurred in our hospitals in recent years have initially seemed to be horrible, unpredictable accidents, subsequent investigations often reveal a series of mistakes, patterns of substandard practices, and inattention to mounting problems. Clearly a vital component of any system of external review, therefore, would be to detect such problems before harm occurs.

We recommend that the Department of Health and Human Services propose legislation to repeal the federal law that "deems" Joint Commission-accredited hospitals to satisfy Medicare requirements.

Let the Joint Commission, with its close ties to the hospital industry, focus on an educational approach to promoting hospital improvement, but locate the regulatory role of insuring that our hospitals are safe, quality institutions in a publicly accountable body. If, however, this legislative change does not happen, then we believe that the Inspector General's recommendations, while a step in the right direction, are not strong enough in light of the disturbing findings contained in these reports, and should be strengthened by setting specific, numerical targets for improvement, and establishing time limits for change including those listed below.

1. Increase the number of unannounced surveys. At least 50% of Joint Commission routine surveys should be unannounced, with no prior notice given to the hospitals. Only through unannounced surveys can the Joint Commission be sure that it is seeing the hospital as it functions from day to day, rather than what it looks like after an extensive "clean-up" and cosmetic improvement program.

2. Records reviewed during Joint Commission surveys should be randomly selected, and when any randomly selected record in a sample indicates a problem or raises questions, the sample size should be increased, and more records reviewed. The Inspector General reported on one Joint Commission survey where the credentials review in a hospital with more than 500 active staff consisted of a review of only three practitioners' files. Even when the surveyor found a problem with one of the three, he did not review any additional files of that practitioner. Clearly it does little good to detect what may be a problem if the matter is not explored further; the Joint Commission should establish a rule that questionable records will automatically trigger further review.

3. The Joint Commission should formally incorporate additional sources of information into its survey process, particularly information gathered from hospital employees, and complaints from patients, and should be required to submit summaries of such information to HCFA, along with a statement of the Joint Commission's findings. It is very likely that hospital employees and patients can provide the Joint Commission with information different from that obtained through the rest of the survey process, especially information about substandard practices that could lead to patient harm.

4. There should be greatly increased public disclosure of the results of hospital surveys. With the advent of the Internet, it is now possible to vastly improve public disclosure in a meaningful way. Disclosure should include not only scores and simplified charts that might facilitate comparison among hospitals, but should also provide detailed hospital-specific information about complaints and problems.

5. HCFA should establish a minimum 3-year cycle for conducting certification surveys in non-accredited hospitals, with immediate attention paid to those non-accredited hospitals that have gone the longest without a survey.

6. HCFA should establish a 5-year time limit for changes in the Joint Commission process, and at the end of five years, if the problems identified by the Inspector General's reports have not been eliminated, and the above recommendations as well of those of the Inspector General been implemented, then the Department of Health and Human Services should seek legislation to repeal "deemed" status for Joint Commission accreditation.

We recommend that HCFA use the findings of these Inspector General reports to make extensive changes in the system of external review. HCFA should especially note the Inspector General's warning about the dangers of a system overly tilted towards a collegial approach, and set a time frame for changes with the Joint Commission process to reduce the problems associated with its current "collegial" approach. We are not optimistic, however, of the ability of the Joint Commission to reform its process enough to become the independent body needed for the task of external review, because of the Joint Commission's inherent conflict of interest between its role as hospital inspector and its role as "educator" to its paying clients--the hospitals it inspects. At the end of five years, HCFA should examine the state of external hospital review, and if the problems identified by the Inspector General's reports have not been eliminated, then the Department of Health and Human Services should seek legislation to repeal "deemed" status for Joint Commission accreditation.