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INSIDE

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ORYX: What's Next?

Joint Commission jettisons ORYX Plus in favor of core measures reporting

Disgruntled hospitals, vendors warily await JCAHO's next move

If it's three strikes and you're out, the Joint Commission has got to be worried that it is perilously close to blowing its chances for convincing hospitals it is the organization to coordinate electronic reporting of outcomes data for quality assurance.

In late May, the Joint Commission's Executive Committee voted to pull the plug on ORYX Plus, the Cadillac version of its ORYX electronic outcomes reporting program. It will cease to be supported past May 31, 2000.

This marks the second major setback for the ORYX program, which was launched in late 1997 by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in Oakbrook Terrace, IL. In January, hundreds of hospitals protesting the basic ORYX program forced the Joint Commission to address complaints about the program's lack of standards, the Joint Commission's high-handed approach in imposing the program with little or no input from hospitals, and the program's mushrooming costs.

> ". . . the timing was awful. We spent a lot of money on programming to make this thing happen."

The result of those negotiations was that the Joint Commission is now busily retrofitting the program with a group of "core performance measures" that will have standard definitions and will be developed with input from hospitals. Just where this effort will go and what it will cost is the focus of current debate on ORYX.

But JCAHO has been on this ground before. In the early 1990s, it failed to get the industry to adopt a performance measurement system called the Indicators Measurement System. So, arguably, this is the Joint Commission's third embarrassing failure at setting up a central database of quality performance measures.

By any count, the industry's patience for JCAHO's failures is wearing thin, both among the hospitals it regulates and among health care

software vendors. The vendors now find themselves in the middle of another JCAHO about-face, which will require them to redesign existing packages or develop new software programs to accommodate the new initiative on core performance measures.

In an era of mergers, consolidation, hospital cutbacks, and strained budgets, the Joint Commission cannot afford another failure that wastes scarce hospital dollars while returning little or no benefit to the industry.

This latest retrenchment of the Plus program affected only a handful of hospitals and vendors, because no more than 25 hospitals ever signed on for the expansive program. ORYX Plus required its participating members to report electronically on 10 different outcomes. Once the data are risk-adjusted for comparison purposes, they are published for public consumption.

Costs for initiating ORYX Plus, depending on existing hardware and software, could easily run a hospital $100,000. This is substantially more ambitious, at least on paper, than the basic ORYX program, which is being phased in over a four-year period and requires hospitals to initially report only two or three outcomes (or 20% of its patient base) at a basic initiation cost of about $10,000.

"I think the Joint Commission just changed its thinking halfway through the process," says **Judy Finlan**, director of clinical consulting services at the New Jersey Hospital Association (NJHA) in Princeton. The New Jersey association was one of 17 state hospital associations that signed a letter of protest in January that resulted in the new core performance effort.

"Why is ORYX Plus dying?" Finlan asks rhetorically. "First, there wasn't a lot of interest in it. Not one New Jersey hospital participated, and there was not exactly a groundswell of interest nationwide — a very small number of hospitals signed on. Second, hospitals thought, if it's going to be replaced by core measures soon, why get into ORYX Plus?"

Jean Chenoweth, senior vice president at HCIA in Baltimore, a vendor of ORYX and ORYX Plus systems, agrees. "Hospitals saw that the work involved would be much more extensive than reporting a couple of items, and it would have been very difficult for them," she says. "There didn't seem to be much payback at all. It was not as though you were adding on another half-hour of effort to report a little more data. The data collection required a large effort."

Another vendor, **Leonard Rogers**, CEO of Health Care Data in Encinitas, CA, is critical of JCAHO's timing. "I'm not bashing the Joint Commission and saying what they did was wrong, but the timing was awful," he says. "We spent a lot of money on programming to make this thing happen. An entrepreneurial business like ours puts a lot of money into resources and program development. We put forth a lot of effort, and now it's stopping. It was our expectation that ORYX Plus would go on until the end of 2000 or at least until core measures were ready to be brought forward to the hospitals for consideration."

And Rogers voiced a common complaint from hospitals and vendors alike: "It's confusing to organizations when you start and stop programs. Hospitals no sooner put processes in place than they have to switch to something else."

Disgruntlement in many camps

A vendor who commented only on condition of anonymity for fear that his company might be blacklisted from future JCAHO-approved vendor lists says many ORYX Plus vendors are incensed. "Most say this move on the Joint Commission's part is awful after all the time and effort they put into it." He says many hospitals are upset as well because they had "the rug pulled out from under them." Although many hospitals like the ORYX Plus outcomes measures, they resent wasting that time and effort, he says, adding, "there's a lot of disgruntlement in many camps."

Another vendor, who also wanted anonymity, told *Hospital Peer Review*, "The American Hospital Association has been quiet over the past six months, but the membership has been critical of the Joint Commission and its ORYX initiative. Most people don't think the program is going to have much effect at all on what hospitals do."

It is this uncertainty regarding the Joint Commission's ability to accomplish what it proposes that most threatens its credibility in the industry. Taken alone, these failures might be overlooked, but over the past two years JCAHO also has been repeatedly and publicly criticized for its failures to do the basic jobs for which it exists.

In 1998, the Health Care Financing Administration questioned JCAHO's surveying techniques in light of ongoing quality problems, as well as huge Medicare/Medicaid fraud, estimated to be $23 billion that year. It sent Office of Inspector General auditors along on a number of JCAHO surveys to monitor surveyors' techniques.

Some questioned at the time whether HCFA

ORYX: What's Next?

Unhappy software vendors are leery of new effort

Many worry about wasted development

"A lot of vendors dropped out of the pool of those willing to develop ORYX Plus products even before they knew the initiative was going to end," says **Judy Finlan**, director of clinical consulting services at the New Jersey Hospital Association in Princeton. "Their numbers were in the low 20s to begin with, and out of that number, seven or eight remain. The vendors saw the demise of ORYX Plus coming a year ago if they were paying attention."

Jean Chenoweth, senior vice president at HCIA in Baltimore, says her company will not suffer as a result of ORYX Plus being pulled, but "companies that developed systems specifically for ORYX Plus reporting spent a lot of money doing so. It's most unfortunate that the Joint Commission would discontinue such an extensive reporting system at the expense of those vendors." She says such a move "will discourage vendors from developing new products for them in the future."

It seems that some hospitals using ORYX Plus measures will continue to use them even after the initiative has been discontinued. **Leonard Rogers**, CEO of Health Care Data in Encinitas, CA, says while not many actually signed on for the entire ORYX Plus program, his company has among its customers many facilities that use ORYX Plus measures anyway, even though they are not participants.

"They like the outcome measures," explains Rogers, "but don't want to participate fully in the initiative. They would select just two or three, where the agreement with the Joint Commission was to select 10 and report on those." He says some of his customer hospitals said they didn't want to do 10 measures because "that's too much data to collect right now. They said they wanted to get their organizations' cultures into the mode of collecting data before signing up. But they liked some of the Plus outcome measures, so they would select some with the idea of maybe signing up as a participant the following year."

Rogers says his company is suggesting that hospitals not stop when ORYX Plus terminates — that they continue to collect Plus measures. "It's a step in the right direction for core measures, but, in my opinion, a little premature." He says his company told hospitals that Health Care Data would risk-adjust the measures they send in. The Joint Commission gives vendors risk-adjustment factors, but will stop doing that at the end of this year.

"But we will have enough data by then that we will be able to continue to risk-adjust the measures," says Rogers. "So, our customers won't miss a beat. And when core measures are finalized, we will offer them." ■

might be threatening to pull the Joint Commission survey's "deemed status," which makes it possible for JCAHO-surveyed organizations to bypass a possible annual HCFA audit in order to participate in the Medicare and Medicaid programs.

"I think one can see where the dots are being connected," **Fay A. Rozovsky**, JD, MPH, DFASHRM, principal of the Rozovsky Group, Richmond, VA, told *Compliance Hotline*, a sister publication to *HPR*, in June 1998. "What the Joint Commission is concerned about, of course, is its own credibility and public trust in the whole accreditation process." HCFA's report on the audit of JCAHO surveyors has yet to be made public.

Should JCAHO lose deemed status privileges, its reason for existing would be severely compromised. Many hospitals undergo a Joint Commission survey primarily to avoid HCFA or state audits, which look at many of the same quality issues JCAHO does but open the hospital to government scrutiny anywhere in the hospital. If such an audit were no longer avoidable, there would be little justification for submitting to the costly Joint Commission survey.

Even as ORYX Plus slides into oblivion, many hospitals don't clearly understand just what the initiative tried to accomplish. It was expected that ORYX Plus hospitals would represent the top hospitals and become recognized by consumers, employers, payers, and government bodies for their commitment to self-evaluation and accountability through their willingness to share performance information with the public.

The Joint Commission also intended to develop a form of special recognition for ORYX Plus hospitals. But by the end of 1998, only 25

hospitals across 17 states participated in the project. These were primarily general medical-surgical facilities, but also included children's, teaching, and military hospitals. They range in size from 60 to 723 beds.

Although ORYX Plus did not have the problems of lack of standards and risk adjustments found in the basic ORYX program, the program was DOA anyway because of low participation. Recognizing this, the Joint Commission late last year proposed to retrofit basic ORYX with standard core performance measures.

That announcement was the last straw for many hospitals, which saw JCAHO-developed core measures as a bandaid measure that could cost individual hospitals thousands of dollars in customization of software. A groundswell of discontent and revolt surfaced in a letter sent in January by 17 hospital associations to JCAHO, expressing dissatisfaction and their intention to halt participation in ORYX unless the Joint Commission listened to their demands and took input from the hospitals themselves. **(See related story, *HPR*, March 1999, p. 37.)**

The Missouri Hospital Association in Jefferson City was one of the signatories. **Becky Miller**, director of performance measurement and quality at the association, told *HPR* that JCAHO president Dennis O'Leary's response to the letter has been generally positive. "We've gotten good feedback from our hospitals," she says. "We're especially interested in seeing what the finalized core measures will be and what they will mean for individual hospitals who participate in collecting and reporting them." She says Missouri hospitals have provided input to JCAHO on areas in which they would like to see core measures developed.

"We've only been involved from that perspective," she explains. "We haven't spent money to meet core measures so far."

The Alabama Hospital Association in Montgomery also signed the protest letter, and **Keith Young**, director of data and information services for the association, says hospitals in his state are not happy with the Joint Commission's performance on ORYX. "Hospitals here are concerned," Young says, "because they see JCAHO adding programs midstream without having evaluated them — without knowing if they're going to fly." He says JCAHO acts without knowing whether the programs it initiates will be a manageable load for the Joint Commission or for hospitals, and without knowing if hospitals can adequately implement the goals of a project.

"Then when the Commission added core measures, that raised questions," he says. People were concerned that the new process wasn't adequately spelled out, and they worried about having an additional burden, Young says. "It's one thing to decide that the current program doesn't work and isn't accomplishing a goal, but now they've recalled ORYX Plus and say we are moving to core measures. It's clouding the situation."

A third signer of the letter written to JCAHO in early January was the NJHA. **Ceil Stern**, director of accreditation and licensure for the association, says while no New Jersey hospitals were ORYX Plus participants, they have been transitioning to core measures over the past few months. "We support their use," she says, although her organization had concerns about how JCAHO was implementing the program.

"The problems were with the implementation of ORYX and its time frames, and how decisions were being made," Stern says. "We had no disagreement that core measures are a good idea, only with the manner in which the whole process of performance measurement reporting would be rolled out."

Like her counterparts elsewhere in the nation, Stern is worried about investing so heavily in programs with short life spans. "We were afraid that after investing a lot of money in ORYX, it would become obsolete," she says. "Then with the transition to core measures, we wondered if the vendors the Joint Commission selected would want to continue. The rules were changing too fast." ■

ORYX: What's Next?

JCAHO: Failed program taught useful lessons

Core measures made it easier to end program

The small number of participants opting for the ORYX Plus program was a "contributing factor" in the decision to end the program, "but, more importantly, it's part of our move toward core measures," says **Janet McIntyre**, a spokesperson for the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in Oakbrook Terrace, IL.

"The valuable lessons learned by the Joint Commission, hospitals, and performance measurement systems as the result of the ORYX Plus

ORYX: What's Next?

Core measures are being jointly developed

Task Force 'has active role in the process now'

Gary Carter, president and CEO of the Princeton-based New Jersey Hospital Association (NJHA), chairs a nationwide Core Measurement Implementation Task Force put in place by Joint Commission president Dennis O'Leary in response to a letter O'Leary received in January from 17 state hospital associations expressing concerns about the ORYX initiative and its feasibility. **(See the June issue of *Hospital Peer Review*, p. 96, for an article outlining the task force's goals.)** The group consists of representative associations from around the country and has input into decisions about how the core measures will be rolled out.

"We have an active role in the process now," says **Ceil Stern**, director of accreditation and licensure for the NJHA. The group met in late March for the first time and has met periodically after that, both in person and by phone.

"The implementation task force is making a great deal of progress," says **Judy Finlan**, director of clinical consulting services at NJHA. "That's because there's now a dialogue going on."

"People on the front lines, those who are actually implementing the process, now have input into making it successful," says Stern. There was a forum of state hospital associations in May that came on the heels of a notice from the Joint Commission asking for comments on content areas it was proposing for core measures. "We were asked to rank them, so we and other hospital associations sent out surveys to our members," says Stern.

As a result of those surveys and the discussions at the forum, the Joint Commission decided on five areas important enough to be included as core measures:

- acute myocardial infarction;
- congestive heart failure;
- pneumonia;
- surgical procedures and complications;
- pregnancy and related conditions.

"Now that those five areas have been identified," she continues, "the Joint Commission will convene clinical panels in each area and determine specific measures." The New Jersey association has nominated a member from that state to serve on one of those panels.

"We in the field bear the burden of implementing performance measures, so we need to be included when the Joint Commission develops policies that are going to impact us," she says. "I do think the Joint Commission has responded appropriately to our letter in terms of convening the task force." ■

experience will be used as we move toward core measures," says **Jerod M. Loeb**, PhD, JCAHO vice president in the department of research and evaluation and performance measures.

Hospitals currently participating in ORYX Plus will be issued full refunds of their fees, and performance measurement systems will be issued refunds for 50% of their annual fees. Despite the fact that the initiative is being phased out, the measures will continue to be available to measurement systems and hospitals to use, and participating hospitals still will be allowed to continue to collect data on all or some of the ORYX Plus measures if they choose.

The Joint Commission will provide limited support for the use of ORYX Plus measures through May 31 and will support the risk-adjustment methodology for measures through the end of fourth quarter 1999 data — those transmitted to the Joint Commission by April 30, 2000.

"ORYX Plus has given the Joint Commission good information about using the same measures across multiple systems," says **Chris McGreevey**, RN, MS, the performance measurement manager in the Joint Commission's ORYX department of performance measurement. "It also has given us input on how to help multiple measurement systems employ a single risk-adjustment methodology so that national comparisons can be made accurately. However, as ORYX Plus was underutilized by hospitals, and what with the Joint Commission movement towards core measures, the Board of Commissioners felt that the option would only need a limited time span."

"The Joint Commission embarked on the ORYX Plus initiative in good faith," says McIntyre. "We, too, committed a great deal to it in time and resources."

So what's ahead for ORYX? "Unlike ORYX Plus, which is a voluntary program, the ORYX initiative is a requirement for hospitals to be accredited," explains McIntyre. "The intention of ORYX is to integrate outcomes and performance measurement into the accreditation process so that the accreditation process becomes more continuous." Facilities will collect and report data on a quarterly basis rather than being surveyed every three years, giving the Joint Commission a complete, ongoing picture of how an organization is performing.

"The Joint Commission has more than 500 standards," McIntyre says. "If a hospital is following those standards, patients are more likely to receive good care, and it's less likely that bad things will happen." Performance measurement (PM) provides evidence for what is actually happening. "In order to improve, you have to measure and figure out where you are now and how to get to a future point," she continues. "We're living in an age of accountability, and performance measurement is about accountability."

'There are no firm costs'

To be a part of the ORYX program, you must select a PM system and collect information on a set number of measures. What does that cost? "There are no firm costs," says McIntyre. "Fees are worked out between the facility and the system it chooses." When JCAHO introduced ORYX in 1997, it ran a survey of hospitals. Most were already doing some type of PM then, and most reported costs of $10,000 or less to do so.

In the early 1990s, JCAHO developed the Indicators Measurement (IM) System with the intention of it being the vehicle for introducing PM. But many hospitals told JCAHO they were already measuring performance and using their own PM systems. They didn't want to be required to use the IM System; they wanted a choice.

In response, JCAHO backed off. The agency set up criteria for all PM systems and said, "If you can meet those criteria, you can use your own systems," says McIntyre. "We gave facilities some flexibility. We were in a beginning stage, and the idea was to get everyone on the measurement train. We said, 'You can choose a system that meets our criteria and also choose what measures you want to look at.'"

IM System was intermediate step

But, while being flexible was a good thing, that concept didn't allow for comparisons. If you have a number of hospitals measuring C-section rates, for example, unless all the hospitals are using the same PM system, they are probably not calculating their outcomes in the same way. And the multiple systems didn't adjust for risk, she explains.

"We knew that down the road there would be core measures — standardized measures that allow for comparison," says McIntyre. "And ORYX Plus was the first effort at core measures. ORYX Plus served as a basis for the evolution toward core measures that is now occurring in the ORYX initiative."

The Joint Commission has been working with the state hospital associations to come to an agreement on some initial focus areas for the core measures and to select measures for each of the focus areas. **(See article on core measures, p. 121.)** "The initial focus areas identified by the task force, however, do not necessarily correspond with those used as part of ORYX Plus," she says. ■

ORYX: What's Next?

Outcomes data help credential physicians

A major use of outcomes data is for credentialing doctors. Most systems produce not only clinical information, but also data on cost and length of stay.

"If a hospital's system is processing information the right way, at the individual patient level, you can compare one doctor and his patient's outcomes, costs, and length of stay to those of other doctors in the same department, and to every other doctor in the hospital," says **Judy Finlan**, director of clinical consulting services at the New Jersey Hospital Association in Princeton. "Depending on how sophisticated the system is, you can also benchmark with others in your state or even in other regions of the country. And all of that goes into credentialing decisions." ■

ORYX: What's Next?

Some hospitals are sorry ORYX Plus is dead

Program's premise was good, even if it lacked support

"It's a real disappointment that ORYX Plus is being phased out," says **Jenny Blair**, vice president for quality services at Prince William Hospital in Manassas, VA. "We were looking forward to working further within the initiative."

She says she believes the Joint Commission was taking a valuable stand with ORYX Plus because part of its requirement was to publish participating facilities' data and foster public accountability. "That's something we believe in," she says.

Potomac Hospital in Woodbridge was another ORYX Plus-participating organization in Virginia. "They were collecting data under the IM [Indicator Measurement] System," says Blair. "Like us, they regret the fact that the Joint Commission is withdrawing the program. It positively affected our competitive edge and helped our marketing because the Commission made information available for public display."

Elaine Vieira, manager of performance improvement and regulatory compliance at South County Hospital in Wakefield, RI, also is disappointed. "We've been pleased with the ORYX Plus project," she says. "We were enthusiastic about it from the start, and it's been a satisfying experience. We've been happy with our reports, and we've improved processes based on our data from one quarter to the next."

Vieira says the people at her facility understand JCAHO's dilemma: "there simply wasn't enough participation to continue. We look forward to moving ahead with core measures. Having had the experience with ORYX Plus positions us well to evolve into the core measures project. The categories are going to be similar. We have our processes down, and we know what we need to do to get through a lot of indicators."

Rhode Island has been selected to be one of two states in the Joint Commission's Early Bird project to come up with core measures. This will put the state a year ahead of others in implementing a core measures project. ■

Special Report: New Paradigms in Credentialing

Peer review process called into question

Two hospitals sued over credentialing issues

Pay close attention to the following cases, both projected to go to trial as this issue of *Hospital Peer Review* goes to press or shortly thereafter. These cases demonstrate that your credentialing efforts affect more than the good names, careers, psyches, and bankbooks of your medical staff; credentialing could seriously impact the reputation, coffers, and longevity of your very institution.

Two hospitals, one in North Carolina and one in Georgia, are being sued by patients after surgeries that went bad. If there's a lesson to convey, it is that credentialing procedures must be followed to the letter, documented, and reviewed often.

A North Carolina hospital is being sued by a patient who was injured following surgery by a doctor who was credentialed by the hospital but who wasn't board-certified.[1] The suit alleges that First Health Moore Regional Hospital in Pinehurst, NC, failed to follow its own credentialing procedures for granting a doctor privileges and did not "consider" the doctor's lack of board certification as required by standards promulgated by the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL.

Moore Regional inquired about certification status, not only in the original application, but also in every application for renewal of privileges,

Focus on credentialing

This issue of *Hospital Peer Review* is the third of three special issues concentrating on medical staff credentialing and privileging. This month we throw a hot spotlight on two hospitals that are being sued for allegedly allowing physicians to remain on their staffs while challenging their skills. Further on, we give you nuts-and-bolts information to make the credentialing facet of your job easier and more effective. ■

according to the hospital's defense attorney, **Sam Southern**, JD, of Raleigh, NC. On each occasion, the physician disclosed that he was not board-certified. The American Board of Neurological Surgery had never certified the doctor, and court records indicated that he had failed the certification exam three times.

Moore Regional first granted the doctor privileges in neurosurgery in 1975 and had renewed those privileges every two years since then, "based on the physician's training, experience, and demonstrated competence," Southern says. "He was grandfathered in." Such a practice of "grandfathering" physicians based on their experience, rather than on their test grades, is not uncommon in those hospitals that have transitioned to board certification as a requirement for medical staff membership, the attorney explains.

Where state law meets JCAHO

In 1992, Joint Commission standards stated that board certification of a physician in an area of practice is "an excellent benchmark and is [to be] considered when delineating clinical privileges."

In 1993, the doctor in question performed neck surgery on the plaintiff. When the patient became quadriplegic, he sued Moore Regional and the surgeon, alleging that the hospital negligently granted the surgeon privileges, failed to ascertain whether he was qualified to perform neurological surgery, and failed to enforce Joint Commission standards. The suit further alleged that those negligent acts caused his injuries. At trial, the patient's medical expert alleged that the hospital did not "consider" the doctor's lack of certification or his repeated failure of the certification exam. In response, Moore Regional's medical staff manager testified that board certification was not an issue in recredentialing. However, under North Carolina case law, a hospital's failure to comply with Joint Commission standards can be evidence of negligence.

When the case first came to trial in 1997, the trial judge entered judgment in favor of the hospital as a matter of law, finding insufficient evidence of hospital negligence to send the case to the jury. The case against the neurosurgeon proceeded, and the jury returned a $10 million verdict in favor of the plaintiff. After winning that case, the plaintiff appealed his loss to the hospital. The appellate court reversed and remanded the case against the hospital, which is now set for trial in October. The reversal hinged on whether the hospital had "considered" the doctor's lack of board certification and therefore whether it complied with Joint Commission standards. Although the application question revealed that Moore Regional was aware that the doctor was not board-certified, the court ruled that there was no conclusive evidence that, in deciding to recredential him, the hospital had "considered" his lack of certification and the fact that he had failed the exam three times, the court ruled.

"The appellate court reasoned that JCAHO standards require that board certification be 'considered' by a hospital when granting medical staff privileges, and that the board certification inquiry on the application for privileges is not conclusive on the issue," Southern says. "As a general proposition, the plaintiff's bar has been able to effectively use the Joint Commission as a weapon against hospitals in medical negligence cases, and the Joint Commission has not been as helpful as it might be in helping hospitals deal with the problem."

In deciding the issue, Southern points out, "the jury is not permitted to learn of the earlier verdict against the physician. Of course, they will be aware that the plaintiff is a quadriplegic with severe and irreversible spinal cord injuries. Sympathy often plays a significant role in these catastrophic injury cases."

The issue of the confidentiality of peer review will play an important role in the pending trial. The application itself is discoverable as evidence under North Carolina law, and is admissible in evidence. The credentialing process itself, however, is not subject to discovery and it may not be admitted into evidence. **(See next month's issue for more information on how the confidentiality of the peer review process is being eroded in hospitals across the country.)**

According to Southern, North Carolina has a strong peer review confidentiality statute, which trial courts have traditionally strictly enforced. "The credentialing process is sacrosanct. For policy reasons, plaintiffs cannot have access to it, even when it becomes relevant to issues in the lawsuit. The policy is to promote the public health by encouraging candor and objectivity in the credentialing process, a policy which I fully support."

But the immunity given to peer review materials can also work against health care providers. "How does a hospital defend itself in this kind of case?"

AMAP-JCAHO-NCQA co-op will ease data collection

While the American Medical Accreditation Program (AMAP), created by the American Medical Association (AMA) in Chicago, is beginning to define quality standards for individual physicians, last January it and the nation's other two leading health care quality oversight groups — the Joint Commission on Accreditation of Healthcare Organizations, which evaluates hospitals and other health care facilities and networks, and the National Committee for Quality Assurance (NCQA), the main accreditor of health plans — rolled out a plan to coordinate quality measures.

Performance measures currently vary from one type of organization to the next, but there is overlap. For example, patient satisfaction, immunization rates, and cervical cancer screening rates are used to assess physicians, facilities, and plans alike. Other broadly applied measures include cesarean section rates, mammography rates, measures of accessibility of care, cost measures, and utilization rates.

Last year, the three organizations established a 15-member Performance Measurement Coordinating Council (PMCC) to ensure that measurement-driven assessment processes are efficient, consistent, and useful for the many parties that rely on them to help make decisions about health care. (A list of Council members can be found on the Web at www.ncqa. org, www. jcaho.org, or www.ama-assn.org / amap.) Ostensibly, collaboration among the organizations is projected to significantly reduce the cost and effort required for collecting performance data.

AMAP, the Joint Commission, and NCQA currently define performance measurement at their respective levels of the health care system — the physician, the hospital or network, and the health plan. Consequently, each organization supports its own measure development efforts, often at great expense, and often drawing on the same pool of intellectual talent as the other organizations. Integration of development efforts not only streamlines the process and saves money, but also produces better, more broadly applicable measures that relate to each other and describe expectations for accountability at different levels of the system.

A common criticism of performance measurement activities is that costs for data collection and reporting can be high. The PMCC's efforts will help to reduce those costs by:

- coordinating identification or development of universal measures to assess physician, facility, or health plan performance in the same ways;
- standardizing data requirements for different measurement systems;
- devising means of coordinating measurement activities among physicians, organizational providers, facilities, and health plans;
- establishing more efficient verification and data quality assurance systems;
- developing guidelines for the appropriate use of performance data.

The PMCC also will address issues such as standardizing risk-adjustment techniques, a key issue for measuring performance at the physician, facility, and health plan levels. ■

asks Southern. "Our Court of Appeals has held that a plaintiff's expert can create an issue of fact as to whether a hospital 'really' considered an applicant's board certification status. But our Supreme Court has held recently in an unrelated case that peer review materials cannot be admitted into evidence, even if a party chooses to make them public records. Even if I wanted to disregard public policy and pull back the curtain, I probably cannot do so, even to defend the hospital. I could not use peer review minutes, data bank information, quality assurance materials, and the like to prove to the jury that the hospital, in fact, gave careful consideration to a particular physician's competence, including his or her board certification status.

"If peer review is going to work, it has to be sacred," Southern says. "It's unfortunate that, in North Carolina, any case involving the care of a non-board-certified physician — and that's half of them — where a hospital is the codefendant, there is what is called issue of fact with respect to credentialing. The issue of fact can be given to a jury."

Moore Regional is a 400-bed, acute care, not-for-profit facility that serves as the referral center

for a 14-county region in the Carolinas. Its medical staff includes 140 physicians.

In the Georgia case, the skills of another neurosurgeon were being called into question even as her hospital was recommending her services to patients who called its referral service. The Atlanta neurosurgeon performed a series of operations on a young male child, but the child became worse rather than better. The boy's parents sued the neurosurgeon in 1995, but it was after they learned about the hospital's longstanding concerns about the surgeon's performance that they filed suit in April against her hospital, Scottish Rite Children's Medical Center in Atlanta. In their suit, the parents accuse the hospital of fraud, deceit, and misrepresentation, alleging that the hospital recommended the physician even though hospital officers had serious concerns about her abilities.

The complaint alleges that credentialing committees at Scottish Rite were in the process of reviewing the surgeon's privileges at the time her services were recommended, and that administrators had "grave concerns" regarding the surgeon's ability to provide competent care as early as 1986. According to the complaint, various ad hoc committees were formed to review the surgeon's patient care from 1986 until her privileges were revoked in 1993.

The surgeon sued over her dismissal, claiming gender and age discrimination. A U.S. district judge in 1998 ruled in favor of the hospital, dismissing the surgeon's discrimination claim. The court records have subsequently been sealed. However, it was the peer review information disclosed at this trial that alerted the parents and triggered their suit against Scottish Rite.

"In Georgia, we don't have laws that make the physician credentialing records and peer review documents accessible to patients," **Karen Koser**, media relations director at Scottish Rite, tells *HPR*. "Patients can find out if doctors are board-certified, where they attended medical school, and where they practice, but not if there's anything outstanding against them, such as malpractice actions."

Glen Moffett, JD, the plaintiff's attorney in the parents' pending suit against Scottish Rite, acknowledges that peer review records are not discoverable in Georgia. He tells *HPR*, "This is a law that has confidentiality provisions connected with it, and that is one of the things that will be tested during the course of this litigation.

"There are good arguments to have these laws on the books," says Moffett. "We want peer review members to be able to talk forthrightly and honestly to try to correct problems. However, it's unfortunate that some of those committees abuse those rights, and it's that type of situation that brings those laws back into contest or review to see if they should be loosened or tightened."

Reference

1. *Hospital Litigation Reporter* 1998; X(1)January. *Carter v. Hucks-Folliss*, No. COA97-1530 (N.C. Ct. App. 1998) - DEx 61085, 3 pp. Tommy Carter and Tracy Carter, Administrator of the Estate of Phyllis Carter, Plaintiffs v. Anthony G. Hucks-Folliss; Pinehurst Surgical Clinic, P.A.; and Moore Regional Hospital, Inc., Defendants. ■

AMA's accrediting program up and running in 7 states

National process avoids duplicative credentialing

Physicians from Connecticut, Hawaii, Idaho, Massachusetts, Montana, New Jersey, and the District of Columbia have applied for accreditation by the American Medical Accreditation Program (AMAP), the program created by the American Medical Association (AMA) in Chicago. The new voluntary accreditation program measures and evaluates individual physicians against national standards, specific criteria, and peer performance. Meeting and maintaining AMAP's standards earns a physician the program's accreditation. Basically, it puts hospitals and the physicians they credential on the same page.

In operation since early this year, the program covers:

- **Credentials:** Primary source-verified information.
- **Personal qualifications:** Ethical behavior and documented participation in continuing medical education, peer reviews, and self-assessments. Fraud and abuse issues also will be included.
- **Environment of care:** Practice site review of office operations and medical records.
- **Clinical process:** Standardized measures of key patient care processes and comparative feedback to physicians on their performance.

If physicians have gone through a performance measurement system, they receive points for doing so in the same way they receive points for accumulating CME or going through a peer review program. In late spring, AMAP issued draft criteria for AMAP-compatible physician performance measurement systems. There was a one-month comment period on the criteria. Once implemented (which is projected to occur within a year or two), the criteria will identify AMAP-compatible performance measures from which physicians can choose and voluntarily participate in.

"AMAP's overall thrust is to improve the quality of medical care," says AMA spokesman **Robert J. Mills**. "In keeping with that, parts of the program deal with patient outcomes and satisfaction. That's where the criteria for AMAP-compatible physician performance measurement systems come in." AMAP is not creating a performance measurement system. Rather, it is accumulating lists of systems already in use and presents them to physicians with the understanding that they can voluntarily participate in those systems that gain AMAP approval and earn supplemental points toward their AMAP accreditation.

AMAP emphasizes peer review feedback

"No system will be listed with AMAP unless it contains a peer review feedback loop," he explains. "There are a lot of physician performance measurement systems out there, but most do not feed back to the physician. They don't provide credible evidence that physicians need to change practice attitudes." The AMAP team wants to influence the construction of any new performance measurement systems to include that feedback loop, and that is why the criteria are important.

AMAP does not now require physicians to go through performance measurement systems because, according to its definition, the state-of-the-art system does not yet exist. "Until some rock-solid criteria are available," says Mills, "AMAP won't make participation in performance measurement systems mandatory for physicians. We anticipate that in the future it will be mandatory, but not until the available systems are more credible."

Though accreditation has long been available as a quality standard for hospitals, payers, and managed care organizations, no single nationally recognized program has existed for individual physicians. Instead, physicians undergo fragmented and duplicative processes for credentialing and office site reviews, and they are evaluated against multiple, sometimes conflicting, performance criteria. Hospitals make their own decisions on granting privileges based on accreditation information purchased from AMAP.

Hospital Peer Review asked Mills how AMAP and the AMA's Physician Masterfile interact. "A physician's AMAP accreditation application is seeded with information from the Masterfile — information having to do with residency, medical school, and so on. But AMAP gathers more information than that on the Masterfile." How will a Joint Commission surveyor view AMAP accreditation? "AMAP meets or exceeds all Joint Commission requirements. All activities are in full compliance with its requirements as well as those of NCQA and other accrediting bodies. The Joint Commission, AMAP, and NCQA cooperate on the Performance Measurement Coordinating Committee." **(See article on AMAP-JCAHO-NCQA cooperation, p. 125.)**

To become a part of the AMAP system, a physician completes one application. The system verifies credentials information with primary sources and conducts office site reviews, Mills says.

"AMAP checks NPDB [National Practitioner Data Bank] for a physician's legal violations and licensing problems," he says. "If a physician defrauds Medicare, Health and Human Services reports that to NPDB, and the AMA Masterfile updates its information from there."

AMAP provides a report and certificate to each physician who meets its standards and provides a portfolio of verified credentials and office review information to each health plan, hospital, or other organization that uses the accreditation system. More information about AMAP can be obtained by calling (312) 464-5519. ■

Correction

Mark Kadzielski, Esq., contributed valuable comments to articles in *Hospital Peer Review*'s special series on credentialing, which ran in the June and July issues. Unfortunately, we attributed to him his former affiliation. Kadzielski's law firm since December 1998 is Akin Gump Strauss Hauer & Feld, Tower Plaza, Suite 2600, 2029 Century Park East, Los Angeles, CA 90067. Telephone: (310) 229-1011. E-mail: mkadzielski@akingump.com. Web site: www.akingump.com. ■

PostScript Picture
(Quality Cost Connection)

Are your plans in order?

By **Patrice Spath**, ART
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In the mid-1990s, the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, removed many of the prescriptive requirements from its standards. The standards currently outline general functions and activities that must be performed. Hospitals are expected to define how those requirements will be met within their organization.

For example, hospitals must perform functions related to risk management. The hospital's leaders must determine the scope of their risk management activities, definitions for reportable incidents, and how the function will be performed. The increased flexibility in the standards makes it easier for hospitals to meet their unique internal needs while still maintaining compliance with standards. However, this increased flexibility means hospitals must prepare numerous written plans or statements to meet the intent of the standards.

At the time of the survey, Joint Commission representatives compare what the plan describes vs. what the hospital is doing. That's why it's important to get your plans in order before your survey. Below are four of the written plans specifically required or implied by the Joint Commission's standards, a brief description of what the plan should include, and how they are evaluated by surveyors. All of these plans should be formally approved by the hospital's medical executive committee and the board of directors. In next month's column, the remaining plans will be discussed.

Strategic plan (LD.1, LD1.1): The responsibility for strategic planning lies with the hospital's senior leadership team. The team should develop a business plan that describes the organization's mission, vision, values, and strategic operational and programmatic objectives. The plan also should detail the mechanism for developing the annual operating budget and long-term capital expenditure strategy. Surveyors will interview the chief executive officer, chief operating officer, and leaders of the medical and nursing staffs to determine how strategic planning and resource allocation is carried out in the organization and how these plans are communicated to physicians and staff.

Recruitment, retention, staff development, continuing education (LD.1.9, HR.1-HR.5): The organization must have in place programs to promote recruitment, retention, and development of physicians and staff members. The description of these programs can be included as a section in the organization's overall strategic plan or developed as a separate plan.

Code of organizational ethics (RI.1 - RI.4.4): While not technically a plan, a written code of ethics must be developed by the organization. This may be in the form of a policy or general operational procedure issued by the hospital's governing board. The code of organizational ethics should describe how patients, employees, physicians, and visitors are to be treated with dignity, respect, and courtesy. It should address issues such as conflict resolution, recognition of potential conflicts of interest, billing practices, marketing practices, patients' rights to perform or refuse to perform tasks, confidentiality, and relationships with other health care providers and payers. The role of the hospital's Ethics Committee should be described. All other policies and procedures relevant to ethical conduct, such as policies on sexual harassment, advance directives, transfers, payer contracts, and so on, can be referenced in the ethics statement but do not need to be attached as appendices. The code of organizational ethics will be reviewed by surveyors during leadership conferences.

Plan for the provision of patient care (LD.1.3): The organization's plan for provision

Clarification

The *Quality-Co$t Connection* column in the June issue contained three figures, two of which should have been credited to **Patrice Spath**, ART, the column's regular author. The "Incident Screening Check List" on p. 98 and the "Form Used to Gather Additional Information about Incidents Being Considered for an RCA" in the insert were both devised by Spath. ■

Outline of Departmental Scope of Service

I. Goal of the service

II. Type of patients served — patients' ages, diagnostic categories

Note: Support services should describe departments/services served — customers, recipients of service

III. Scope and complexity of the patients' care needs — diagnosis, conditions

IV. Extent to which the level of care/services provided meets the patients' or customers' needs — direct patient care departments should consider treatments, treatment modalities, procedures, and/or activities provided; support services should consider the work, service, and/or activities provided

V. Appropriateness, clinical necessity, and timeliness of support services provided directly by the organization or through referral contracts

VI. Availability of necessary staff — staffing, hours of operation, specialties, credentials

VII. Standards or guidelines for practice, when available — professional standards, clinical paths, multidisciplinary plans of care, national guidelines, manufacturer's guidelines, service agreements, state requirements

VIII. Methods used to assess and meet patients' care needs — policies and procedures approved by the organization's administration and/or medical staff, case management, team rounds), customer surveys, environmental rounds

Source: Pelling M. *Hospital Manager's Guide to Joint Commission Standards*. Forest Grove, OR: Brown-Spath & Associates; 1997.

of patient care should include the following components:

- definition of patient care, distinguishing between those departments that provide direct patient care and patient support services delivered by individuals who may not have direct contact with patients;
- definition of the organization's continuum of care — a list of inpatient and outpatient departments that provide patient care according to the organization's definition of patient care;
- description of the community's role in the design of patient care services;
- the scope of services provided within the organization, to include:
  - — what services are provided and how patients are assigned to these services, for example, standards, practice guidelines, appropriateness, clinical necessity, and level of care;
  - — criteria for admission and discharge from specialty patient care units;
  - — methods used to assess and meet patients' needs;
  - — location(s) of each service;
  - — when (hours / days) services are provided;
  - — types of patients, ages of patients served,

and scope and complexity of patients' needs;

— who provides patient care (type / mix of staff members);

— how staffing is determined and how necessary staff is made available;

• functions performed within the organization and who performs them, what they do, and with whom they do them — a description of how each important function is delivered collaboratively through the coordinated efforts of each discipline;

• mechanism to support collaboration, coordination, and integration of patient care delivery — for example, monthly management meetings, staff meetings, interdisciplinary team rounds, and so on;

• performance improvement mechanism — how departments participate to improve patient care services in the organization;

• mechanism for annual review and update of the plan.

There must be evidence of uniform performance of patient care processes throughout the organization to ensure that patients with equivalent health care needs receive the same standard of care throughout the hospital.

Departments need individualized care plans

Each department should have a written patient care plan for its scope of responsibilities. The plan should include the same components as the organizationwide plan, but individualized for the department. These departmental plans can be included as appendices to the organizationwide plan; however, surveyors will expect managers and staff to have an understanding of their role in the overall provision of patient care services.

A model that organizations can use in developing their plan for the provision of patient care as required in the leadership standards is outlined below.

1. Develop the department and service "building blocks" for the plan. Each department and service should describe in writing the scope and goals of their services (LD.1.7). **(The outline shown in the chart on p. 129 can be used for this purpose.)** The outline differentiates between patient care and support service departments.

2. Each department and service should describe in writing how it performs each of the patient-focused functions found in the Joint Commission's *Comprehensive Accreditation Manual for Hospitals.* This task is best accomplished through the creation of a standard matrix to be completed by each department and service.

3. Once each department and service has completed the tasks in steps one and two, the organization can use these "building blocks" to create an overall plan that describes how the organization performs each of the patient-focused functions, what departments and services are involved, and what each group contributes to the provision of patient care. The matrix approach also allows the organization to identify areas where there is needless duplication of effort.

(Editor's note: Next month's Quality-Cost Connection *column will describe the remaining plans required by the Joint Commission's standards.)* ■

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NEWS BRIEFS

FDA recalls two sutures; sterility in question

There are two recently published FDA Class II recalls related to compromised suture sterility, according to the Health Devices Alerts Database of Plymouth Meeting, PA-based ECRI, an international nonprofit health services research agency. FDA Enforcement Report 1999 Jan. 13, recall # Z-349/354-9, relates to Zimmer Statpak suture kits, and FDA Enforcement Report 1999 Jan. 27, recall # Z-426/462-9, relates to a variety of United States Surgical sutures. The Health Devices Alerts Database is available on CD-ROM (updated quarterly), through weekly print notices, or through ECRI's Web site at www.healthcare.ecri.org. When there, search the site for "Health Devices Alerts Database." Contact ECRI at (610) 825-6000, ext. 5223. ▼

Specialized RNs more in demand, survey finds

A recent survey of 388 acute care hospitals, sponsored by the American Organization of Nurse Executives and the Department of Health and Human Services' Division of Nursing, reveals a shortage of neonatal, operating room, and intensive care nurses. Respondents also indicated that it takes longer to recruit qualified nurses than it did several months ago. The survey found:

- Urban hospitals have the most difficulty in filling vacancies.
- It takes longest in the Midwest to recruit qualified candidates.
- Small facilities have the most difficulty recruiting obstetrics nurses, and it takes longer.
- Larger and urban hospitals use agency and contract nurses now more than ever.

All of this seems due to the aging and retiring of Baby Boomers, as well as competition from managed care entities and pharmaceutical companies. Hospital leaders are dealing with the new dearth of nursing staff by offering incentives, including flexible hours, bonuses, and child care. ■

SourceKit

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- OSHA considers new anti-needlestick requirements
- Disenrolling and re-enrolling: HMO revolving doors
- Getting down to the wire: Ongoing Y2K information

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