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HOSPITAL LICENSURE BY PRIVATE ACCREDITATION

This issue will explore hospital licensure in New York State. It will present the history and explain the importance of the fact that for all intents and purposes, public licensing of hospitals in New York State has ended; government recently gave away its enforcement powers to a private, industry-controlled accrediting agency -- the Joint Commission on the Accreditation of Hospitals (JCAH).

WHAT LICENSING IS ALL ABOUT

The responsibility to assure the provision of quality health care to citizens is a cornerstone of the philosophical foundation on which government regulation of hospitals rests. The primary mechanism to guarantee the quality of hospital-based health care in New York is the licensing activity of the State Health Department. State law mandates broad regulatory and inspection powers to the State Health Department. Article 28 of the Public Health Law states:

> Hospital and related services including health-related service of the highest quality, efficiently provided and properly utilized at a reasonable cost, are of vital concern to the public health. In order to provide for the protection and promotion of health of the inhabitants of the state... the department of health shall have the central, comprehensive responsibility for the development and administration of the state's policy with respect to hospital and related services...

The Commissioner of Health is given the:

> power to inquire into the operations of hospitals and home health agencies and to conduct periodic inspections of facilities with respect to, (among other things) the fitness and adequacy of the premises, equipment, personnel, rules and by-laws (and) standards of medical care.

Specific inspection and monitoring duties of the State include:

(1) preparation of regulations setting forth standards for facilities and activities of hospitals;

(2) periodic review and recommendation for changes of specific regulations as well as the basic Public Health Law;

(3) development of procedures for inspection of facilities covered by the law;

(4) inspection, either directly or through delegation, of facilities covered by the law;

(5) issuance of operating certificates to facilities found to be in substantial compliance with the law and regulations;

(6) when there is found to be substantial noncompliance:

(a) informing the violator of the minimum requirements which must be met;
(b) supplying expert consultant services to assist the violator in identifying the problems involved and the remedies necessary to achieve compliance;
(c) closing the facility if there is no attempt to comply; and

(7) provision of educational and consultant services, particularly on matters in which licensed institutions have considerable difficulty in meeting standards and on matters covered by governmental regulations.

To obtain a license to operate in the State, a health facility must be in substantial compliance with the standards set forth in the New York State Hospital Code. Based on continued compliance with the Code -- as determined by on-site inspections -- hospital operating certificates are renewed every two years.

The standards and the process by which substantial compliance is determined is a highly complicated and technical process. Health care consumers and medical practitioners alike often have insufficient information to make these determinations. It takes, and in the past New York State has used, a multi-disciplined team of expert inspectors to monitor and judge hospital performance. As an outcome of government performing the inspections, the full inspection reports concerning the degree of Code compliance of individual hospitals were made available to the public under State and federal Freedom of Information laws.

NEW YORK STATE: IN ITS HEYDAY

In 1969 New York was considered to have the best hospital regulation and inspection program. Anne Somers' book Hospital Regulation: The Dilemma of Public Policy states:

> New York provides a conspicuous exception to the generalizations... (that) licensing agencies in most states are characterized by weak, poorly paid, and often divided administration and have had very little impact on actual hospital operations...(New York State Health)Department officials claim that their State Medical Handbook, a compendium of requirements, is much more detailed than the Medicare Conditions of Participation.
> Probably more significant than the proliferation of laws and regulations is the fact that New York inspections are carried out by five-man interdisciplinary teams, each of which includes a hospital administrator as well as a nurse and other health professionals. The physicians are full-time, well paid... and mostly board-certified.

In 1969, Ms. Somers believed that the hospital licensure and inspection programs in "New York and Michigan clearly mark significant steps forward in hospital licensing and could serve as pace-setters for other states."

New York State's regulatory program was considered a model for the nation, better organized and more comprehensive than those of most other states. The New York State Department of Health was better staffed and funded.

CRITICISM AND ITS OUTCOME

Nevertheless there was, and has continued to be, strong criticism of the administration of New York State's inspection and licensure program. The Code itself has been censured for emphasizing the structure of hospital plants and the organization of institutional administration; while largely ignoring the processes and outcomes of medical care. Hospitals have also been dissatisfied with the regulatory process. The Task Force Report of the Hospital Association of New York, an outcome of a two-year examination of regulation in New York, found duplication and contradiction in overlapping sets of regulations, as well as fragmentation of functions and authority among numerous regulatory agencies. This document was used to rationalize their call for the weakening of hospital regulation in the State. Although many of its conclusions were factual, they could equally well have been used to argue for consolidating and strengthening the government's role as protector of the health of the public.

There have been two major schools of thought on how best to approach the weaknesses in the State program: 1) strengthen the State Code and the State's ability to administer and enforce it, or 2) accept certification by a private professional association in lieu of State Health Department inspections. (A third alternative -- incorporate all health institution inspection into a national health service -- is being discussed by the Consumer Commission on the Accreditation of Health Services in its HEALTH PERSPECTIVES.) Without attempting the former, New York State through a series of steps has arrived at the latter solution. With its final step the New York regulatory process has been substantially dismantled; standards have been lowered and the public has been shut out of the decision-making process. A private agency (the JCAH) -- accountable to no public body -- now sets standards, conducts surveys and determines code-compliance. The JCAH full reports, unlike those of the State, are kept from the public. Apparently this situation, created with the full support of the State, reflects the beliefs and goals of Health Department officials.

GOVERNMENT AND THE JCAH

When Congress established the Medicare program in 1965, it retained limited responsibility to ensure that public funds spent on hospital care for covered persons would be used to purchase acceptable and needed care. But there was great pressure applied at that time to prohibit the government from policing and interfering with the "private practice of medicine". Thus the federal government accepted the principle that any hospital accredited by the Joint Commission on the Accreditation of Hospitals (for a detailed study on the JCAH see HEALTH PERSPECTIVES Mar.-Apr. 1975, Vol. II No.2) was good enough to receive Medicare money. Hospitals accredited by the JCAH were deemed to meet federal health and safety requirements.

Under the original legislation, the federal government could not question the accreditation of any hospital. If federal officials received complaints about a hospital, they could forward them to the JCAH, but there was no requirement that the JCAH take any action.

In 1972, however, Congress passed amendments to the Social Security Act (PL 92-603) which authorized the Secretary of HEW to make validation surveys of

accredited hospitals, either on a selective sample basis or in response to a substantial complaint. This legislation gave the federal government the right to check the reliability of JCAH surveys. In 1974, 67% of the hospitals surveyed through the validation process failed to meet federal standards!

With so many official and non-official agencies relying on the JCAH as the guardian of quality care and on its decisions as the basis for spending billions of public dollars, it could reasonably be expected that the JCAH would be strictly monitored -- with methods established and enforced to assure the validity and reliability of its standards and procedures. In fact few things could be less true.

JCAH: THE FRIENDLY INSPECTORS

The JCAH determines whether or not a hospital should be accredited on the basis of the hospital's answers to a questionnaire, and the outcome of an inspection of the hospital by a JCAH survey team. JCAH surveys are conducted as friendly consultations; hospitals receive a minimum of four weeks' notice concerning an impending survey, and only JCAH surveyors and hospital officials are present for the inspection. The team -- entirely made up of health care professionals, e.g. doctors, nurses and administrators -- comes, looks around (usually for two days), meets with the administrator, and prepares a preliminary report, including its recommendations about continued accreditation, to the JCAH Board of Commissioners which makes the final decision. The JCAH Board of Commissioners is composed of representatives of the American Medical Association, the American Hospital Association, the American College of Physicians and the American College of Surgeons.

JCAH surveys are purportedly voluntary, i.e. a hospital may choose government inspection instead. Obviously most hospitals prefer the friendly JCAH teams to the publicly accountable government ones. Additionally, hospitals pay the JCAH for their services; like all employees or private consultants, the JCAH is thus beholden to the hospitals. After all, the JCAH has to do a good job to stay in business, and what employer would voluntarily pay a consultant to survey his facilities if he thought he wasn't likely to pass. Would you?

JCAH survey reports are kept completely confidential. Even hospitals do not receive a copy of the report. Instead they receive a letter summarizing deficiencies. Under certain circumstances, HEW may receive a copy of this letter, but even the government lacks the right to see the full report. The federal Freedom of Information Act specifically excludes JCAH survey reports from those materials which are available to the public.

GOVERNOR CAREY'S SECRET

In July of this year, without public hearings and without the benefit of objective and independent evaluation of the effect of its decision, the New York State Health Department and the State Hospital Review and Planning Council approved changes in the hospital code and inspection procedure which radically alter both the nature and the method of hospital inspection and subsequent licensure. JCAH standards and criteria were adopted in place of the State's maximum code. Health Department inspection responsibilities were delegated to the JCAH; for purposes of licensure, state inspection requirements are now considered satisfied if a hospital receives two-year JCAH accreditation. The Department of Health will limit its own survey activities to abbreviated follow-up visits to institutions not fully accredited by the JCAH. The standards for these back-up surveys will be the less rigorous set of

regulations referred to as the "mini-code" which are equivalent to the federal Conditions of Participation in Medicare. This administrative decision was the final step in the erosion of the regulatory process which Ms. Somers lauded in 1969.

STEP BY STEP: THE STAR FALLS

Since 1969 there has been a steady erosion of the New York State hospital inspection program. In the Winter 1974 CCAHS QUARTERLY, "A Comparison of Hospital Surveyors in New York State," and in the September-October 1974 HEALTH PERSPECTIVES, "Hospital Inspection: Its Importance to the Consumer," the Commission outlined the failure of the New York State Health Department to carry out its biennial hospital inspections. Between 1970 and 1974 no voluntary hospital in New York City was inspected. To date, 80-90% of the city's voluntary hospitals have still not been inspected.

In July 1976, the State Hospital Code was weakened by the creation of the "Medical Facilities - Minimum Standards" (Part 400) or the "mini-code". Although the "State Hospital Code" (Part 700), or the "maxi-code", continued to exist, hospitals no longer had to maintain operations to meet these higher standards. The political rationale for the promulgation of these new mini-standards was based on the 3.9% increase in Blue Cross and Medicaid reimbursement rates. It was successfully argued that since hospitals had to provide service with a minimal increase in income, they could no longer meet the old (high) standards. The State, it can be implied, accepted the proposition that without continuing to pump huge increases of funds into hospitals those hospitals cannot, in fact should not, be required to meet previously accepted (minimum) standards. There is no data to show that these hospitals met "maxi-code" standards prior to the 3.9% increase!

In recent months the New York State Health Department decided to discontinue any guise of performing regular state inspections of hospitals. Two-year accreditation from the Joint Commission on the Accreditation of Hospitals (JCAH) will now be accepted in lieu of state inspection. Hospitals receiving less than two-year accreditation will be inspected only in those areas found deficient by the Joint Commission. The standards used will be the mini-code. This capitulation to the hospital industry endangers patients. This is borne out by the fact that in the past many proprietary hospitals which had received two-year accreditation from the JCAH and were subsequently surveyed on behalf of the Department of Health, Education and Welfare (DHEW), were found to be so substandard that they lost their right to continued Medicare and Medicaid funding and were forced to close. In the past, several major voluntary teaching hospitals in New York City received only a one-year accreditation, while totally inadequate facilities somehow managed to be fully accredited. The JCAH yardstick has too few inches to measure compliance with realistic standards.

The JCAH full inspection report is not, and will continue not to be, publicly available -- even to government! Hospitals will only receive the JCAH summary letter; these letters will be made available to the public on request after being sent to the State Department of Health by the hospitals.

New York State has ceded its legal obligation to monitor hospitals. In turn New York patients have lost government assurance of quality, while the State's citizens have lost their right to review survey reports. This strikes to the heart of the ability of patients to select hospitals based on government quality inspection

programs. This latest action by the State Health Department calls for a full investigation and review.

OTHER STATES MAY FOLLOW THE LEADER

New York State is the first in the nation to accept JCAH accreditation in lieu of its own licensure procedures. In this decision to delegate inspection functions to an industry-dominated private association the New York State Health Department fails to carry out its legislated mandate to assure "hospital and related services...of the highest quality, efficiently provided and properly utilized at a reasonable cost..."

The record of the JCAH does not substantiate the belief that the JCAH -- a private organization -- will do a better job of assuring the quality of medical care than the New York State Department of Health. Indeed, the thoroughness, appropriateness, and comprehensiveness of JCAH standards and survey procedures have been demonstrated to be significantly less than ideal. The fact that the full hospital report is unavailable raises serious questions about what is being covered up or hidden from the public.

The decision to accept JCAH accreditation was made without public notice or input. Similar decisions are currently under consideration in other states. It is imperative to analyze the possible adverse impact of this administrative decision on the quality of health services in New York State.

Serious consideration must also be given to the following issues:

(1) the advisability of establishing, or reinforcing, the precedent of delegating important public health regulatory functions -- which have traditionally been state government responsibilities -- to a private, self-interested and unaccountable group;

(2) the overall appropriateness of the administrative delegation of legislatively mandated responsibilities; and

(3) specifically, the legality of such a decision being made without public notice or input.

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