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The Accreditation of Hospitals— What Does It Promise?

Donald Rubin*

When Congress was fashioning the Medicare legislation of 1965, it met with great resistance from established provider groups, particularly the American Medical Association and hospital associations in a number of states. These groups felt that the federal government's plan to insure health care for the nation's elderly would mean undue government "policing" of health institutions and possible interference with the private practice of medicine. To placate these powerful interest groups, the government relinquished its responsibility to assure that public funds would be used to purchase decent quality of care. Instead, Congress literally wrote the Joint Commission on the Accreditation of Hospitals (JCAH) into the legislation, accepting the JCAH's private hospital accreditation program in lieu of a federal (public) inspection and certification program for Medicare-eligible hospitals. In other words, JCAH accreditation was a political price paid for Medicare. Thus it came about that any hospital good enough to be accredited by the JCAH was "deemed" to have met federal health and safety requirements. Subsequently, when the government insured health care for the poor, JCAH accreditation became the quality-of-care criterion for Medicaid reimbursement of hospitals as well.

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What Is the JCAH?

The Joint Commission on the Accreditation of Hospitals is a Chicago-based, non-profit agency controlled jointly by the American Medical Association, the American Hospital Association, the American College of Physicians, and the American College of Surgeons.[1/] Its hospital accreditation program differs from state licensure procedures in four important ways:

1) Unlike government licensure, JCAH accreditation was not intended to grant legal permission to operate; rather, JCAH accreditation was designed (originally at least) as a voluntary educational program for upgrading facilities, with hospitals paying JCAH a fee in order to participate.

2) JCAH accreditation standards and surveys emphasized hospital organization and the proper procedures for a hospital's administration, board, and medical committees; JCAH did not put the emphasis—as did the states—on strict compliance with the details of health and safety codes.

3) JCAH visits to hospitals, which are pre-announced, usually have the friendly quality of peer consultations and professional reviews and are less demanding than the inspections of local, state, or federal health departments.

4) The results of JCAH surveys, unlike the findings of governmental inspectors, need not be disclosed to the public.

JCAH alone assumed the role of guarding the door which led to Medicare monies in spite of the fact that it did not regard its own accreditation visits as "inspections," in spite of the fact that it extended the same broad "accredited" label to hospitals at very different points along the spectrum of quality, and in spite of the fact that its standards were in some cases less strict than the state codes being superseded.

Consumer Criticism

Eventually, the propriety of having the medical and hospital professions certifying the fitness of their facilities to receive federal funds began to be questioned by health consumers, especially as it became apparent that many hospitals could receive accreditation without necessarily giving good quality care. When asked, "Do you feel that accreditation is an assurance of high-quality care....?" JCAH Director John D. Porterfield, M.D., answered "No. Some people have complained recently that the certificate of accreditation in the hall of the hospital is taken as a guarantee that the quality of the care given in that institution will be excellent. That isn't true at all....When we accredit, we really are saying that there is nothing to prevent good medical care in this place...."[2/]

Porterfield's arguments notwithstanding, since Congress had provided no other means of quality assurance for the Medicare program, JCAH accreditation was meant to signify quality. Further, Congress' total capitulation to organized provider interests was clinched by the fact that, under Medicare legislation, the federal government could not question the accredited status of any hospital.[3/] Complaints about the quality of JCAH-accredited institutions received by federal officials could be forwarded to the JCAH to be checked, but there was no legal requirement that the JCAH take action in such instances. In other words, the JCAH may have made no claim to providing a quality warranty for general hospitals receiving Medicare funds, but it had effectively barred the government from doing so.

HEW Checks: JCAH Fails in New York

In 1972, Congress sought to restore a measure of public accountability to the process by which hospitals were declared to be eligible Medicare participants. Amendments to the Medicare legislation enabled the Secretary of HEW to make "validation surveys"—federally authorized quality inspections—of JCAH-accredited hospitals, either on a selective sample basis or in response to a substantial complaint.[4/] Thus the government was authorized to spot check JCAH reliability. Also, consumers, patients, and hospital staff were given the opportunity to appeal directly to the Secretary of HEW when accredited hospitals appeared to present serious dangers to patients. If significant deficiencies were found in a validation

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survey and the affected hospital failed to pass a subsequent follow-up check, its Medicare reimbursement could be cut off.[5] Since Medicare money often represents half or more of a hospital's operating revenues, the 1972 Medicare amendments put a few teeth in the otherwise undemanding quality assurance aspect of the Medicare program.

In 1974, suspecting that several JCAH-accredited hospitals were nonetheless seriously substandard, the Consumer Commission on the Accreditation of Health Services (an independent consumer health information and advocacy group in New York) asked HEW to step in and make a validation survey of eight New York City voluntary hospitals. In 1975, two additional requests to HEW for validation surveys of New York hospitals were made by other organizations. All of these requests were based on substantial evidence of violation of federal law. (Three hospitals, for instance, had only one exit, a clear violation of the Life Safety Code, with which Medicare-eligible hospitals must comply.)

JCAH ACCREDITATION WAS MEANT TO SIGNIFY QUALITY.

Madison and Wadsworth hospitals in New York City were two of the hospitals the Consumer Commission asked HEW to inspect. These two hospitals had been cited for repeated state hospital code violations, yet both were fully accredited by the JCAH and licensed by the state when the Consumer Commission asked HEW to intervene.

The federal survey found the hospitals to be in serious violation of federal health and safety standards and both lost their "deemed" status. No longer able to receive Medicare and Medicaid reimbursement (a great proportion of their operating revenue), Madison and Wadsworth closed. Five other New York City hospitals surveyed by the federal government at this time also lost their deemed status and closed voluntarily because they were unable or unwilling to make the changes and improvements which would bring them into compliance with health and safety standards.

Thus the action of the consumer group, in concert with federal authority, accomplished the closing of unsafe facilities—something that had not been achieved by the state health department and something which was apparently not thought necessary by the Joint Commission on the Accreditation of Hospitals.

...And Fails Nationally

At almost the same time, HEW decided to do a nationwide spot check on a sample group of 105 JCAH-accredited hospitals.

Of the 105 hospitals inspected, 68 were declared to be substandard because of significant health and safety violations. Many of the hospitals did not meet fire safety requirements, having inadequate exits, no fire detection system or sprinklers, or inadequate fireproofing. Other shortcomings included incomplete drug records, so that patients were in danger of receiving improper medications; insufficient nursing staff, so that it was impossible to care adequately for all patients; lack of controls in the dietary departments, so that patients were not necessarily being given prescribed foods (and in some cases were subject

to malnutrition); and poorly kept medical records, so that proper follow-up treatment could not be given.

JCAH Director Porterfield, in commenting on the results of the federal spot check, stated that the federally authorized inspection teams doing the validation surveys had "weighted" their inspections towards physical plant safety.[6] Federal officials concurred that the primary difference between the JCAH and the federal survey was that the JCAH cited fewer Life Safety Code deficiencies. By way of explanation, Dr. Porterfield stated that the JCAH downplayed the Life Safety Code because of what he termed its many "contradictory" requirements, and he added that the JCAH did not stress such things as fire safety because "we're not fire inspectors... we're doctors and nurses."[7]

Notion of Quality Must Be Broadened

While we criticize the JCAH accreditation process and compare it unfavorably with public licensing and inspection programs, it must be stressed that neither public nor private entities monitor the actual quality of health care provided by hospitals in terms of either medical excellence or patient care standards. Both the state health department and the JCAH stress physical plant and organizational and administrative structures of hospitals to varying degrees, and both ignore health outcomes at particular facilities. Until quality standards are expanded to include medical outcomes, consumers cannot afford to relax about the quality of the hospitals to which they are admitted.

Meanwhile, despite the fact that the federal validation surveys exposed the inability of the Joint Commission to adequately inspect hospitals, the JCAH remains the sole entity appointed by the government to certify hospitals for Medicare reimbursement.

How the JCAH Inspects a Hospital

The majority of JCAH surveys are conducted as friendly consultations. The hospital is assessed in two ways: 1) on its responses to a JCAH questionnaire, and 2) by the results of an on-site "inspection" of the premises. The accreditation visit occurs about once every two years. Hospitals receive from four to six weeks' notice of an impending accreditation survey and, given such advance warning, can prepare themselves for an inspection. When the JCAH team comes, it looks around the hospital for a day or two, meets with the administrator, and prepares a preliminary report of its findings for the JCAH Board of Commissioners. The final decision on accreditation rests with the Board.

Public Information Interviews

It is rare for the JCAH to make an unannounced visit to a hospital. During a hospital inspection, normally only

HOSPITALS RECEIVE FROM FOUR TO SIX WEEKS' NOTICE OF AN IMPENDING ACCREDITATION SURVEY.

JCAH surveyors and hospital officials are allowed to be present. The JCAH has never actively sought the input either of hospital workers or of the people who use the facility. Therefore, it is difficult to make surveyors aware of problems in hospital services which

may be conspicuous to those who use or work in the institution.

In the mid-1970's, in response to public pressure, the JCAH established new policies and procedures which allowed consumers and workers a limited role in accreditation surveys by creating an opportunity to bring hospital deficiencies to the attention of the surveyors. These new policies authorized members of the public to:

- learn, in answer to a written request, the exact date on which a hospital will be surveyed (in practice, consumers seldom get more than two weeks to prepare themselves);
- obtain, by written request, the past accreditation history of a hospital; and
- request and participate in—after formal written application—a public information interview (PII) at the hospital being surveyed.

The public information interview, if obtained, is held at the beginning of a JCAH survey, giving representatives of the community, patients, and hospital workers a chance to meet with JCAH surveyors and to lodge complaints, make recommendations, or present suggestions on all matters pertaining to hospital compliance with JCAH standards and/or the health, safety, and rights of patients. Data and supporting documentation about deficiencies in hospital services can be presented to surveyors at this time, thus alerting surveyors to problems prior to the actual inspection. The existence of the PII as a format for public input was an important breakthrough for consumers. Yet, the real value of this JCAH "concession" to the public is limited, since the community is rarely equipped to make organized and well-documented presentations to survey committees. It is even conceivable that the PII can merely dissipate public criticism without having a real impact on hospital conditions.

The JCAH visit to a hospital ends with an "exit interview" between JCAH surveyors and hospital officials. Consumers and workers who have made presentations at the PII cannot attend the exit interview without the express

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invitation of the hospital, and this is rarely extended. Consumers have had to rely on the occasional cooperation of concerned board members or medical staff to obtain any knowledge of JCAH findings and recommendations.[8]

Within 90 days after an accreditation survey, the JCAH will notify the hospital of its status in a summary letter. Any difficulties or problem areas will be noted in a separate attachment to the letter, along with specific recommendations for improvement. Copies of the summary JCAH letter and attachment are sent to the hospital's chief executive officer, the chairman of its board of directors, and the chief of its medical staff. Both the summary letter and the attachment are considered confidential, and their contents need not be disclosed to the public by the hospital or the JCAH (although on occasion a hospital will excerpt the favorable parts of the

HOUSE STAFF PARTICIPATION IN JCAH ACCREDITATION PROCEDURE

At those hospitals where the house staff is organized as part of the Committee of Interns and Residents (CIR), house staffs have been making presentations before JCAH surveyors at public information interviews (PIIs) since 1974. The first PII participation was at Lincoln Hospital on June 18, 1974. Since that time, interns and residents at both public and private hospitals have made over 25 such presentations, documenting key patient care deficiencies in their hospitals in order to obtain the Joint Commission's support in their efforts to improve the quality of care. Deficiencies attested to included shortages of nursing personnel, inadequate supplies, equipment and support services, unavailability of emergency lab tests, inadequate emergency room facilities, overcrowding, and lack of ICU beds.

Hospital administrators' responses to CIR efforts have been varied. Some administrators were quite receptive to house staff involvement in the survey process and the house staff's obvious concern for patient care. At those institutions, house staff began to meet with the administration on an ongoing basis in an effort to improve the various deficiencies. At other institutions, house staff met with a great deal of resistance, and in one instance a hospital employee was fired for assisting the house staff in its presentation.

In many cases, the JCAH responded to the problems presented by the house staff during the PII by citing the same deficiencies in their final report. The administration was then forced to deal with the problems. In other cases, JCAH was just the first step in the house staff's efforts to improve patient care conditions. Because participation by house staff in the survey process brought attention to the key patient care problems at the hospitals, it often resulted in increased involvement of the community and other hospital unions. Thus the JCAH survey served as a catalyst for bringing together all those interested in improving the quality of patient care provided in these hospitals.

CIR staff understand that improved patient care costs money. That is why hospitals would prefer to give 100 house staff each a $1,000 raise rather than upgrade equipment and add needed staff. Hospitals frequently take offense at the notion of house staff "meddling" in patient care considerations. Yet, hospital conditions are of vital concern to house staff from the point of view of giving the best care to the patient. This concern should be shared by the public and government—the public because it needs quality care when ill, the government because it pays for a large portion of the bills.

JCAH letter and release them to the press).

Violators Can Continue to Operate

Hospitals which the JCAH feels are adequately safe will receive full, two-year accreditation. If the JCAH survey team finds what it considers to be serious deficiencies in a hospital, it may issue a one-year (provisional) accreditation or—more rarely—it may disaccredit the hospital entirely. Each year about 20% of the hospitals visited are given a one-year accreditation in hopes that this "conditional" status will put pressure on the facility to correct deficiencies. Three consecutive one-year accreditations lead to automatic loss of JCAH accreditation.

From two to five percent of the hospitals surveyed are refused accreditation altogether, which is the first step in the process of losing the right to receive Medicare and Medicaid funds and reimbursement from a number of Blue Cross plans, and to conduct approved training programs for interns and residents. Upon learning that it has been disaccredited, a hospital can appeal the negative findings of the JCAH. Pending a review, the JCAH will consider the hospital "administratively accredited," thus effectively preserving the hospital's "deemed" status until the JCAH can resurvey the hospital.

A HOSPITAL WITH DANGEROUS AND IRREMEDIABLE VIOLATIONS CAN CONTINUE TO OPERATE AND RECEIVE FUNDS FOR SEVERAL YEARS AFTER IT HAS BEEN INITIALLY CITED AS DEFICIENT OR NONCOMPLIANT.

Should the hospital again be found deficient after a final survey review, the federal government will make an inspection (using state personnel following federal guidelines) before withdrawing Medicare eligibility. The protracted process of conditional and administrative accreditation means that a hospital with dangerous and irremediable violations can continue to operate and receive funds for several years after it has been initially cited as deficient or noncompliant. Linden General Hospital, one of the hospitals in New York City whose accredited status the federal government was asked to validate in 1975, continued to receive federal money to treat patients for more than two years after losing its full accreditation, in spite of fire safety violations, poor sanitation, and a host of other deficiencies.

Secrecy Versus Quality

The "confidentiality" of JCAH survey findings means that a veil is thrown over the whole issue of hospital quality. Health consumers literally cannot know whether they are being admitted to hospitals with a great many violations, whether a particular department within a hospital has been repeatedly found deficient, or whether the facility presents a danger to them in terms of inadequate fire and sanitary protection.

The Medicare law specifically exempts JCAH from any requirement to disclose its findings to the public.[9] However, the JCAH did release to HEW the summary reports on the 105 hospitals which were subject to the federal validation survey in 1975. Later, when the Consumer Commission filed for access to these

documents under the Freedom of Information Act, HEW released them. The JCAH promptly sued HEW over the disclosure. The legality of this disclosure was never fully tested in the courts because then-Secretary of HEW, F. David Mathews, settled out of court with the Joint Commission, agreeing that HEW would never again release JCAH "confidential" documents. Thus far, Freedom of Information legislation has made no difference in the ability of health consumers to learn about comparative hospital quality, and the public remains essentially blind to hospital conditions.

Curiously enough, the simple fact of JCAH accreditation was never the sole

It appears that one of the great failings at present is a lack of communication between those who are the first line providers of health care (interns and residents) and those who are its recipients (represented by community boards). All too often, important information, policies and findings of both groups are subverted by hospital administrative policies which are more divisive than productive. The health care crisis as we know it could be effectively confronted by a coalition between house staff officers, other hospital workers, both professional and non-professional, and hospital community board members, if a way were found for good communication between these groups.

Former President
Committee of Interns and Residents

The time has come for all people interested in improving health care to work together. Let's shed our own self-interest agendas and communicate on common grounds. Professionals, especially doctors, have been trained to view themselves as more than health workers, as the leaders of the system. With that approach, we cannot ever have a talking point to begin with. All of us must unite as a team to work together in resolving the problem. House staff (interns and residents) have many grievances (as do other health workers) on their working conditions. Consumers have many grievances about the care they receive. We have to be able to see and understand that patients' rights and workers' rights and working conditions are thoroughly interrelated and cannot be separated. Consumers welcome a joining with all health workers to work together towards improving the health delivery system.

Judy Wessler
New York City Coalition for Community Health
Member, Executive Committee, New York City HSA

One of the major needs of the health system is the establishment of a coalition of health care users and sympathetic providers. The Consumer Commission has found that community and professional representatives fail to work closely when their hospitals are being surveyed for accreditation. This failure to communicate with each other is typical in most health care activities of these groups.

The Commission hopes to open a dialogue between consumers and professionals around JCAH surveys so that a coalition of users and providers can be built to improve patient care.

basis for granting eligibility for Medicare and Medicaid reimbursements to nursing homes.[7] Unlike general hospitals, nursing homes still must be inspected by state or local governments acting as agents of HEW. Though the state and local governments have been far from perfect in performing their duties, the exposé of conditions in nursing homes which rocked the Northeast in the mid-1970's was possible only because state and federal inspection reports for nursing homes were available to the public and the press.

The JCAH defends confidentiality on the grounds that it promotes greater candor and openness on the part of hospital administrators vis-à-vis the JCAH inspectors. However, as the results of the validation surveys have shown, this greater candor has not translated into higher quality of hospitals. Rather, lack of disclosure is a convenient screen for substandard hospitals trying to conceal dangerous conditions. Until there is full disclosure of JCAH inspection reports, the public is left unprotected in the matter of hospital quality, and dangerous institutions can continue to collect tax-levied monies for the delivery of substandard care.

Footnotes

1. At its December 15, 1979, meeting, the JCAH Board of Commissioners granted board membership and one voting seat to the American Dental Association.

2. "JCAH Director Discusses New Standards," *Hospitals* 45:31 (July 1, 1971).

3. 42 U.S.C. §1395bb entitled any hospital which was accredited by the JCAH and which had a utilization review plan to receive reimbursement under the Medicare program. 42 U.S.C. §1395x(e)(8) declared that the Secretary of HEW could not impose on hospitals any standards higher than comparable JCAH standards.

4. Section 244 of P.L. 92-603.

5. 42 U.S.C. §1395x(e)(9) now requires that all hospitals, including those accredited by JCAH, meet "such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution." 42 U.S.C. §1395bb now permits the Secretary, through the appropriate state agency, to survey hospitals regardless of their accreditation status and to deny reimbursement to those plagued by serious deficiencies.

6. H. L. Lewis, "The Uncertain Future of JCAH," *Modern Healthcare* 4:20 (Aug. 1975).

7. *Health Perspectives* 2:1 (March-April 1975).

8. A more detailed (although somewhat dated) explanation of how a group can participate in the JCAH survey is given in "How to Participate in Your Hospital's Accreditation Procedure," The Community Advocates, Inc., Great Neck, NY, 1975. (This pamphlet is out of print, but the HLP will duplicate it for any readers who request it.)

9. 42 U.S.C. §1395bb(a)(2).

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