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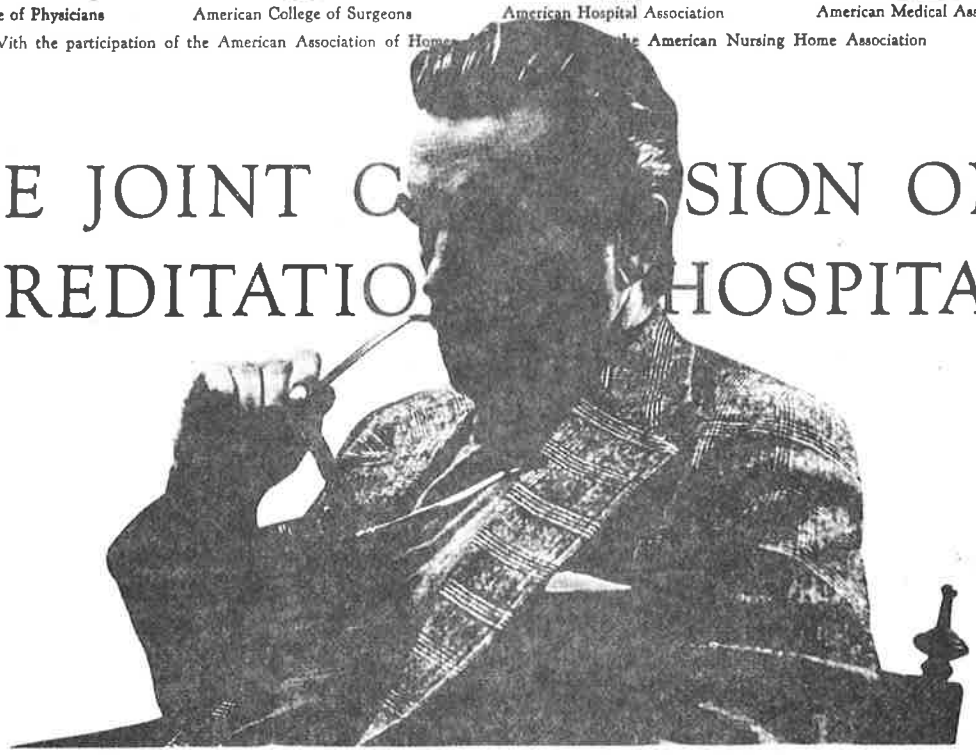

The uncertain future of JCAH

Appropriateness of certification and confidentiality of data are the points of contention between federal and state authorities and the Joint Commission

Howard L. Lewis

One of the pillars of the healthcare establishment, the Joint Commission on Accreditation of Hospitals, may be in danger of toppling. At the very least, its base is being eroded as a series of federal actions and regulations chip away at the commission's independence.

Despite denials by some federal officials, John D. Porterfield, M.D., JCAH director, believes there may be a move afoot to bring down the commission. "There appears to be some feeling, expressed by state agencies and federal spokesmen, that we have no business in the field (of institutional accreditation) at all," he says. "Their view is that this is purely a federal determination of where to put federal funds for federal beneficiaries and it should be done by government instead of a voluntary agency. If this is their view, I assume that they would like to see us out of the business."

The commission's foes have drawn their weapons from Public Law 92-603, that hydra-headed act which seems to keep the healthcare field in a constant state of agitation and litigation. Sec. 1865 of the original Medicare law lists eight requirements hospitals must meet to be reimbursed through Medicare, but institutions are "deemed to be in compliance" with seven of the requirements (the exception is peer review) if they hold JCAH accreditation. That's the carrot. The stick is contained in Sec. 1864 (c), one of 1972 Social Security Amendments, which requires the Secretary of HEW to conduct validation surveys of JCAH inspections and to determine if the deemed status concept is valid. In 1974, HEW conducted crosschecks on 105 hospitals in 33 states and the District of Columbia and that's when the stick started beating.

In its report, which by law must be delivered to the Senate Finance Committee, HEW declares that state inspectors, working at its behest, found 3,854 deficiencies while JCAH had found only 2,745. Most of this discrepancy can be accounted for in the inspectors' view of the 1967 Life Safety Code: JCAH teams found 256 violations, while HEW representatives found 1,633. The HEW report was expected to say that 68 of the 105 hospitals were out of compliance and 65 of those were cited for LSC violations.

Stanley Rosenfeld, the Bureau of Health Insurance official in charge of coordinating the validation program, summarized the findings: "Essentially, we say that Medicare found more life safety deficiencies than JCAH did. In other areas, however, our findings were comparable." Dr. Porterfield maintains that JCAH turned up more deficiencies in areas other than life safety.

While both sides were busily checking the scoreboard, HEW took a step which is probably destined to lead to a courtroom confrontation. JCAH had supplied to HEW's Bureau of Health Insurance summary copies of its inspection reports on the 105 hospitals to be cross-checked. In April, answering a request under provisions of the Freedom of Information Act, James B. Cardwell, commissioner of Social Security, released those reports to a New York consumer organization, the Consumer Commission on the Accreditation of Health Services (see page 23).

Dr. Porterfield: "There appears to be some feeling . . . that we have no business in the field of institutional accreditation at all."

JCAH and the American Hospital Association registered instant and strenuous objections with HEW Sec. Caspar W. Weinberger. And on May 30, the commission filed suit in U.S. District Court, Chicago, against the Secretary asking "injunctive and declaratory relief." HEW had 60 days to respond.

In its brief, the Joint Commission stated that its policy is not to release any information obtained during accreditation surveys except as required by law and that this procedure is central to the commission's purpose. "The improvement of healthcare is furthered by this agreement of confidentiality," the brief argues, "since the Joint Commission can make informed comments, criticisms and recommendations to the hospitals which it surveys only if a hospital feels free to be open and honest with the Joint Commission . . . concerning conditions at the hospital."

The brief also contends that hospitals may be injured by public disclosure of the reports since, "in the interest of inducing the hospital to achieve optimal achievable standards, the Joint Commission's recommendations and comments are purposely critical. This in turn is likely to lead to a proliferation of lawsuits, thus exacerbating the current malpractice insurance crisis and increasing the cost of healthcare." Hospitals would be less likely to be open and frank with JCAH surveyors if they knew the information would be made public, the statement argues, a situation which

would result in fewer improvements in healthcare. The brief also contends that Congress recognized the need for privacy by providing for "the release of the Joint Commission's most current survey of a hospital (with the hospital's authorization) only 'on a confidential basis.' " That provision covers the release of the documents to HEW, but not to any other group, the brief contends.

The harm caused by such a breach of confidentiality could be widespread, the JCAH suit states, because many hospitals might "cease to utilize" the commission's services if they thought accreditation information would be made public. "The withdrawal of large numbers of hospitals from . . . the accreditation process will irreparably injure the Joint Commission because its accreditation survey fees are its principal source of revenue," says the brief. "Such injury is likely to result in poorer care for the public. Thus, the harm to the Joint Commission, the hospitals, and the public is continuing, immeasurable and irreparable. . . ."

Using more direct language, Dr. Porterfield says the reason for confidentiality is not to hide problems but is "because many, if not most, of the problems we deal with in hospitals cannot be readily understood and interpreted by nonprofessional people. It would be just as apt to say that no physician should take out the appendix of a patient until he has publicized the basis of his decision."

Asked how far the commission would go to protect the confidentiality of its information, Dr. Porterfield responded: "All the way, if we have to. If we don't have confidentiality, that will be another step toward getting out of the business."

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It is ironic that the Life Safety Code should become the battleground over which JCAH's effectiveness will be fought. The commission has downplayed the LSC for several reasons, one of which is what Dr. Porterfield calls confusing and contradictory requirements. "If under the 1967 code you built two-wall or fire-resistant walls," he notes, "in 1973 they tell you it wasn't really necessary." More important perhaps, he continues, "fire in the hospital was not what we considered to be a major problem. The last multiple death hospital fire was in Osceola, Mo., in late 1974. The one before that was in 1954 in Hartford, Conn. How many billion patient days have there been per death?

"We have to put dimensions on the amount of work we do and the amount of time we spent in the hospital. And we ought to spend it on the things that have the greatest impact."

Dr. Porterfield charges that state inspection teams were weighted toward physical plant safety and the LSC, and that "apparently BHI asked its state teams to concentrate on 1967 Life Safety Code violations." He also suggested that some variations between the JCAH and HEW reports are to be expected since an average of 60 days separated the two inspections.

Mr. Rosenfeld of BHI vehemently denies the implication that life safety experts not normally present were specially added to validation teams. He says that in all but one or two validations, which attracted special interest because they were being conducted for the first time, only the normal teams of state inspectors were used.

Nevertheless, JCAH and HEW have been arguing over the appropriateness of the techniques used by some inspectors. Dr. Porterfield said one hospital complained to him that a state inspection team marked down a loose door knob and a burned out light in an exit sign as deficiencies. The JCAH approach is to have those things fixed on the spot, he said.

In June, this difference in interpretation became a point of legal contention as six Illinois hospitals whose deemed status was threatened by the validation surveys filed suit against HEW in the same U.S. District Court where JCAH had brought suit on the confidentiality issue. A key section of the hospitals' brief contends that due process was not afforded and that the standards used in the inspection were too vague to be enforceable: "The determination to remove deemed status in each case was made without notice to the respective hospitals, and without an opportunity for hearing."

Despite his misgivings, Dr. Porterfield did admit that JCAH is beefing up its fire safety standards by requiring more information on the

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statement of construction required before an accreditation visit. At present, the Joint Commission requires a state fire marshal's report — if it exists. A fire safety consultant will examine the new reports to spot potential violations and a fire expert will be added to the JCAH staff.

The crucial issue in this war of words is whether the deemed status/validation approach to Medicare certification is appropriate. That will be decided by the Senate Finance Committee, acting for the Congress. HEW and JCAH versions of their first year's experience under the program were scheduled to go to the committee in late June.

According to one source, HEW's report will be brief. It will fault the Joint Commission for not stressing the Life Safety Code and will suggest that JCAH raise its fire safety standards and have surveyors get tougher with hospitals on the LSC. A JCAH source said: "We could say it is a friendly report, but it makes me suspicious that they expect it to be overturned by the Senate Finance Committee as the result of pressure from activist consumer groups." The HEW report also will include reaction from the Joint Commission.

Dr. Porterfield said two separate JCAH reports will be filed directly with the finance committee. An interim report will fault the BHI and HEW for premature leaks of information to the press, he said, and argue strongly about the harm this does to hospitals in general and to the 68 hospitals that lost their deemed status in particular. This report also repeats the commission's objection to emphasis on the Life Safety Code, "particularly since there is confusion within government as to the appropriateness of the LSC," he said.

Also, Dr. Porterfield said, "We will voice our opinion that the validation survey is not what it purports to be at all — validation of our program — since there are so many variables. We don't believe the report answers the question either way."

The second, more detailed JCAH report will be sent to the finance committee later. Dr. Porterfield said the report could come to one of three conclusions: "(1) that the validation program is sufficient and that JCAH is not useful for federal purposes — we would have no hesitation about reaching that conclusion; (2) that the data are valid and we are useful, or (3) that the data are not valid and don't tell us anything — which is what I suspect."

"Representatives of the organizations that founded JCAH still make up the board of governors."

Like wines, certain years are better for surveys than others, and Dr. Porterfield is unhappy that the validations occurred in one of JCAH's off-years.

The commission had considerable turnover on its surveyor staff in 1974, he says, with some surveyors who didn't "measure up" being let go and others leaving because of personal or health problems. In addition, the commission had difficulty competing for top-quality people with such U.S. agencies as the Air Force, he adds. This situation has improved in recent months, he reports, but the finance committee will be tasting the fruits of a bad year.

What would happen to JCAH if the Congress decided to eliminate the deemed status provision? The commission now has about 5,000 hospitals as "clients" and Dr. Porterfield anticipates losing a fair number of them, although "I could not begin to estimate what percentage." The loss might be severe since all hospitals would prefer to save the money a duplicate inspection would cost; if they were going to be surveyed by an HEW-designated agency, the voluntary check would be the one to be eliminated.

Even without that impetus, the JCAH director sees some trouble ahead for self-regulation. "There has been some dissatisfaction in the field with our surveys as not being completely applicable," he explained. JCAH adopted new standards in 1970 that are more comprehensive, detailed and demanding than the old criteria, "but we have not yet been able to bring our survey process up to the same level of sophistication as the standards." This has led to some debate over the meaning of a standard and the way a surveyor interprets it.

Obviously, though, the end of deemed status would have a far greater impact on the commission than any internal problem. But Dr.

Porterfield does not believe that even that cataclysmic event would necessarily spell the end of JCAH. "We would still be in the business of education and consultation," he notes. "We have developed a competence in the last five years for technical aid and methodologies that might prove quite useful."

Nevertheless, full-scale contingency plans have not been drawn, he admits. "We have conceptual, alternative courses, and these are now being presented to the board to see which ones they want a lot of staff time devoted to."

One direction JCAH would like to take is toward intermediary status, for example as the certifying agency for utilization review programs under PSRO. JCAH was written into the Medicare law because government "needed a bridge to the professions and to reassure them that the program would be on terms relatively familiar to them," Dr. Porterfield says. "I still think there is something to be said for the Joint Commission as an intermediary with the health professions because there appears to be a growing gulf between government and the professions."

That may be easier to propose than to sell. "I have been told," Dr. Porterfield admits, "that neither of the reasons for folding the Joint Commission into Medicare obtains for PSRO because the professions are hooked, for better or worse, and it isn't important that you make them happy. Second, I was told the federal government has put money and help into the states and the states have geared up and are now competent to do the job."

At the least, that latter assumption requires some testing, and Dr. Porterfield is confident that the state agencies are not now competent to do what the Joint Commission is doing. "They are very meticulous and precise data collectors when they are put to it," he admits. "But we are not impressed that the training that is given by the federal government through training center contracts is any better, if as good, as what we do for our people. And we are not satisfied with what we are doing."

Does HEW want to assume exclusive authority over hospital accreditation? To put it another way, does the department want to put JCAH out of business?

Mr. Rosenfeld, of the Bureau of Health Insurance, denies it. "I've had contact with JCAH over the years and have found the people there quite cooperative," he says. "Their requirements are essentially the same as ours. Their philosophy is a little different in that they don't feel theirs is an inspection program, whereas ours, obviously, is. They are out to upgrade the quality of care in hospitals, and they don't feel they are in the business of taking punitive action. We have to. I think on the whole JCAH has done a good job."

Responding to reports that he

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"The health professions are always fighting us, always arguing, consider us too tough and too demanding."

What a consumer group wants to know

The Consumer Commission of the Accreditation of Health Services, Inc., is a nonprofit corporation organized two years ago with headquarters at 381 Park Avenue South, New York, N.Y. Its president is Donald Rubin, a health consultant to trade unions. The organization has an all-volunteer staff, Mr. Rubin said in an interview, and a board of about 20 members including a former president of the American Public Health Association, an executive of an aircraft company, several labor representatives, and "some grassroots people." The organization produces a periodical called "Health Perspectives."

Why did his organization, with a name that sounds so much like the Joint Commission on Accreditation of Hospitals, get involved in this area of healthcare? "We felt consumers should have the same access to data as professionals," Mr. Rubin said, "and consumers didn't have anyone working for them."

The Consumer Commission began asking for accreditation reports from the Social Security Administration about a year ago, Mr. Rubin said, after personal inspections of some JCAH-accredited hospitals in the New York area. He termed JCAH inspections "a whitewash" when it comes to fire safety.

Mr. Rubin says the work of his organization has already helped lead to the elimination of HEW's Medicare support to the 78 bed Linden General Hospital, Brooklyn, N.Y. (HEW's regional office in New York City made an announcement to this effect on May 23.) The American Hospital Association's 1974 Guide Book shows Linden General as an AHA member but not as a facility accredited by the JCAH.

"The Joint Commission should not be used for certification," Mr. Rubin said. "HEW should do it . . . government agencies. The public should rely on government." If the public had not been able to gain access to state reports on nursing home inspections, he said, "there wouldn't have been an investigation of the nursing home industry in New York City."

The release by SSA of 105 deficiency letters to his organization is only the beginning, Mr. Rubin believes. "We have asked the SSA for the full reports on all hospitals."

has been behind a move to eliminate the Joint Commission from the certification process, Mr. Rosenfeld says, "There was no directive from anybody to 'Get JCAH!' That report is completely erroneous. That was never the intent, and it still isn't as far as I know.

"There are several reasons why we would not want to get JCAH out of the process, and first and foremost among them is the cost factor."

Dr. Porterfield also has received some reassurances. "We do give them an awful lot of work, something like 4,500 surveys a year which the states would have to do if we did not."

But he still feels like the baseball manager who receives 100 per cent support from his superiors — the day before he is fired. JCAH is receiving "mixed signals," he says. Noting that the signals come from both Washington and the various state capitals, he suggested that "federal government people, even when they change faces over the generations, develop a feeling that they see the problem clearly from the national point of view. And the state and local people perceive ways in which the national blanket doesn't exactly fit local circumstances."

One reason for skepticism regarding JCAH, Dr. Porterfield recognizes, is that many people believe the commission is a creature of the providers it evaluates. (JCAH was formed by the American Medical Association, the American Hospital Association, the American College of Surgeons, and the American College of Physicians, whose representatives still make up the governing board.) In addition, the commission's principal funding comes from payment for its surveys, in other words from those who it is supposed to criticize. "There is an attitude on the part of the general public, certain representatives of government, and certain elected officials who say, 'No good could possibly come of this. You're a creature of those interests.' "

That view conflicts with experience, however. "The health professions are always fighting us, always arguing with us . . . consider us too tough and too demanding," Dr. Porterfield declares. "We think we are doing an honest job. All we can say is that the record appears to show that we have kept hospitals moving in the right direction through the years, and the quality of care in hospitals today is better — not exclusively because of the Joint Commission, but we were one of the forces that caused things to improve."

Whether JCAH will continue as a prime mover now seems to be up to the courts and the Congress. □