HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

John E. Affeldt

JOHN E. AFFELDT

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

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CHRONOLOGY

1918	Born, Lansing, Michigan, May 26
1939	Andrews University, B.S.
1943-1944	Detroit General Hospital, Internship
1944	Loma Linda University, M.D.
1944-1946	U.S. Army
1946-1949	White Memorial Hospital, Los Angeles Residency in Internal Medicine
1949-1951	Harvard School of Public Health Fellow in Pulmonary Physiology
1951-1964	Rancho Los Amigos Hospital, Downey, CA Medical Director
1964-1972	Los Angeles County Department of Hospitals Medical Director
1972-1977	Los Angeles County Department of Health Services Medical Director
1977-1986	Joint Commission on Accreditation of Hospitals President

MEMBERSHIPS AND AFFILIATIONS

American College of Physicians

American Congress of Rehabilitation Medicine

American Medical Association

California State Department of Public Health,
Special Consultant in Rehabilitation

California State Governor's Committee on Employment of the Handicapped

California State health Facilities Board, Member

Chicago Medical Society, Member

Illinois Medical Association, Member

Institute of Medicine, Member

U.S. Department of HEW, Medical Assistance Advisory Council, Member

Western Society of Clinical Research, Member

BOOKS - CHAPTERS

Affeldt, John E., MD, and Regina M. Walczak, MPH. "The Role of JCAH in Assuring Quality Care," *Hospital Quality Assurance, Risk Management and Program Evaluation.* Editors: Jesus J. Pena, Alden N. Haffner, Bernard Rosen, and Donald W. Light. Aspen Systems Corporation. 1984. Rockville, MD. pp 49-62.

Affeldt, John E., MD. "Voluntary Accreditation," *Regulating Health Care: The Struggle for Control.* Editor: Arthur Levin, MD. The Academy of Political Science. New York, NY. Vol. 33, No. 4. 1980. pp 182-191.

Affeldt, John E., MD, James S. Roberts, MD, and Regina M. Walczak, MPH. "Quality Assurance: Its Origin, Status, and Future Direction--A JCAH Perspective," *Evaluation & The Health Professions.* Editor: R. Barker Bausel. Sage Publications. Beverly Hills, CA. Vol. 6, No. 2. June 1983. pp 245-255.

The Minimum Standard

1. That physicians and surgeons privileged to practice in the hospital be organized as a definite group or staff. Such organization has nothing to do with the question as to whether the hospital is "open" or "closed," nor need it affect the various existing types of staff organization. The word STAFF is here defined as the group of doctors who practice in the hospital inclusive of all groups such as the "regular staff," "the visiting staff," and the "associate staff."

2. That membership upon the staff be restricted to physicians and surgeons who are (a) full graduates of medicine in good standing and legally licensed to practice in their respective states or provinces, (b) competent in their respective fields, and (c) worthy in character and in matters of professional ethics; that in this latter connection the practice of the division of fees, under any guise whatever, be prohibited.

3. That the staff initiate and, with the approval of the governing board of the hospital, adopt rules, regulations, and policies governing the professional work of the hospital; that these rules, regulations, and policies specifically provide:

(a) That staff meetings be held at least once each month. (In large hospitals the departments may choose to meet separately.)

(b) That the staff review and analyze at regular intervals their clinical experience in the various departments of the hospital, such as medicine, surgery, obstetrics, and the other specialties; the clinical records of patients, free and pay, to be the basis for such review and analyses.

4. That accurate and complete records be written for all patients and filed in an accessible manner in the hospital—a complete case record being one which includes identification data; complaint; personal and family history; history of present illness; physical examination; special examinations, such as consultations, clinical laboratory, X-ray and other examinations; provisional or working diagnosis; medical or surgical treatment; gross and microscopical pathological findings; progress notes; final diagnosis; condition on discharge; follow-up and, in case of death, autopsy findings.

5. That diagnostic and therapeutic facilities under competent supervision be available for the study, diagnosis, and treatment of patients, these to include, at least (a) a clinical laboratory providing chemical, bacteriological, serological, and pathological services; (b) an X-ray department providing radiographic and fluoroscopic services.

WEEKS:

Dr. Affeldt, this oral history interview is to record some of the biographical events in your life, your professional life. I hope you will talk freely about those events and the individuals who played a part in your life, as well as some of the decisions you had to make yourself.

I might start off by saying that I have a few notes. I know that you were born in Lansing, Michigan in 1918. I know that you attended Andrews University in Berrien Springs, Michigan, and graduated in 1939. What was you major in undergraduate work?

AFFELDT:

That was pre-medical.

WEEKS:

How did you happen to decide to study medicine?

AFFELDT:

I would think that's probably my mother's influence. There were some physicians in her family, related family. She felt that she would like me to go to medical school. Because we were in the Seventh Day Adventist denomination as a church, there was quite a focus within that church on medical missionary work. So she influenced me to go into medicine and to go to Andrews, which was part of the denomination, and then to Loma Linda University in California, whose medical school is part of the denomination.

My father was in business in Lansing. He was owner of a grocery and meat store. He would like to have had me enter into the business with him. He wanted me to go to the University of Michigan to business school, but was perfectly willing, if I wished to go to medical school, which I chose.

WEEKS:

Is there more than one Adventist medical school?

AFFELDT:

No. Loma Linda is the only one.

WEEKS:

It has been in the news recently. It has a fine reputation as a school, doesn't it?

AFFELDT:

It's a good medical school, yes.

WEEKS:

Then you served your internship at Detroit General. Is that the same as the old Detroit Receiving?

AFFELDT:

Yes. The Detroit Receiving Hospital. That's correct.

WEEKS:

I lived in Detroit back in the 1930s and 1940s and I can remember hearing that medical students thought it was quite a plum to be granted a residency at the old Receiving Hospital because they saw every kind of case and every kind of condition.

AFFELDT:

It was good teaching hospital. Typical of the public hospital, city municipal hospital, they do receive all kinds. Lots of trauma, of course. In fact, it so happened -- if you remember the first race riots that occurred in Detroit -- I was an intern at that time and in the emergency admitting room at the time. That was quite an experience.

WEEKS:

This is a little beside the point, but I once attended a meeting, sort of a retreat up in Michigan, at which public health subjects were being discussed. There were two young men from the staff of Detroit Receiving or Detroit General, as you called it at that time, who were telling about the patients whose lives they saved, such as from gunshot wounds where the bullet would enter the heart.

AFFELDT:

There were enough of such patients that they could do a study.

WEEKS:

It must have been a wonderful experience for you to go there.

Inevitably, you were in the army.

AFFELDT:

Yes.

WEEKS:

Where were you stationed?

AFFEDLT:

I ended up in both theaters. I originally went to the European theater. I was a young physician at the time, a surgeon, with the combat engineers. Our mission was to cross the Rhine. We were trained for that. We were spared the crossing because of the bridgehead that occurred there at Remagen. We were east of the Rhine when the war ended. Because we were a combat engineer unit, we were tagged to go to the Pacific with the assignment to storm the beaches of Japan. So they took us down to Marseilles, put us on the Lourilene, and took us through the Panama Canal. We had just gotten through the canal when the A-bomb was dropped in Japan, which, of course, ended the

war. The decision was made that any troops that had passed through the Panama Canal would continue on. Those that had not reached it yet would be routed back to the United States. So I ended up in the Philippines. As a battalion surgeon near Clark Field I spent a year waiting to get back to the United States.

WEEKS:

That was the hard part of it, wasn't it?

AFFELDT:

That was.

WEEKS:

I have a note here that you served your residency at White Memorial Hospital in Los Angeles.

AFFELDT:

That's correct, in internal medicine.

WEEKS:

I have you down for being granted a fellowship in pulmonary physiology at Harvard School of Public Health.

AFFELDT:

That's correct. I spent two years there. The background is that during my residency in Los Angeles at the White Memorial — they split my residency and sent me over to the L.A. County General Hospital for half of it. I was over there in the communicable disease unit of the L.A. County Hospital and, if you may recall, that was the era of the polio epidemics. Los Angeles had more than its share of it, presumably because of the longer warm season. Because I was in communicable disease, which is where all of the polio patients were taken, I gained quite a bit of experience with it. As I was

finishing my residency, they asked me if I would be the chief resident of CD, which I accepted. So I was in the CD unit during the peak of the polio season. There were many cases of respiratory and bulbar polio. There were many patients in tank respirators, and many tracheotomies being done. Tracheotomy was being done in Los Angeles more than other parts of the country. The medical group in Boston was quite opposed to tracheotomy -- did not think it should be done. So a controversy arose. The polio foundation, the National Foundation for Infantile Paralysis, was brought into the question. Is trachetomy good or bad? What was this experience in Los Angeles which was being published and a lot of discussion. The polio foundation asked Dr. James Whittenberger, who was then Chairman of the Department of Physiology at the School of Public Health at Harvard, to put a team together to study the situation in Los Angeles. Being chief resident, I was assigned the task to take care of them -- to see that their needs were met.

It was a very stimulating experience. They said, "You're handling a lot of respiratory polio, but you don't know much about respiratory physiology." Which was true.

They invited me to come back for a fellowship at Harvard School of Public Health so that I could learn more about the respiratory aspects of polio, which I accepted. I ended up staying two years. It was a great experience for me, very enlightening. I learned a lot.

During that time, the polio patients continued to accumulate in Los Angeles. The issue of tracheotomy was resolved in favor of doing tracheotomy. In fact, Boston turned around and decided they should be doing it. It became accepted nationwide. Then there was a lot of controversy between Europe and the U.S. Denmark had a major polio epidemic which brought forth different

types of respirators. Now there was debate about what type of respirator is best.

Because the respirator patients were surviving and therefore accumulating in Los Angeles, to such a degree, they had to move them out of the acute disease unit to make room for the new ones coming in. They turned to their old county poor farm called Rancho Los Amigos, which is in a suburb of Los Angeles and part of the health services of the County of Los Angeles. They were sending their respirator patient there, in effect storing them. The number rose to a hundred or so. The families of the patients were quite perturbed, naturally, at the devastation and the lack of a treatment program. It turned out that the families reached a nationally known television commentator/reporter who was about to make a national scandal out of this. Los Angeles County turned to the polio foundation and asked if they could help. They in turn asked Harvard if they could provide a consultant who knew something about polio.

They said, "Yes." Then they suggested I go.

So I did. The National League of Nursing sent a nurse who was experienced with polio. The two of us did a two week study of the situation in Los Angeles, particularly focusing on Rancho Los Amigos.

I returned to Boston; gave my report to the folks in New York. There was a series of recommendations as to how they should develop a significant respiratory program, rehabilitation program, things they could and should do. The county negotiated with the polio foundation for some funds to assist in this. The polio foundation said, "Affeldt, you made the study, you made the report, why don't you go do it?" I agreed.

The county was pretty mad at me because my report was critical. They

said, "No, we won't accept him."

The foundation said, "You won't get any money if you don't accept him."

So they negotiated for me to go there, which I did. The county would not put me on the payroll for the first year because they were mad at me. After one year we got along just fine. The program developed very nicely. The county put me on the payroll. The first assignment that I received when I arrived was -- "We funded a new hospital for this program, you sit down with the architect and design it." Which we did.

The building was built. A good program was established. It became internationally recognized. It became the largest polio center in the United States, if not in the world. At that time the polio foundation decided to establish a series of respiratory centers. They did one at the University of Michigan -- Dave Dickinson was head of that one. They ended up creating eighteen such centers across the United States. This cadre of centers held a series of scientific meetings, comparing notes, and participated in an international meeting in Geneva, Switzerland.

As I looked back, I found that I was administering a program. No longer treating individual patients. I found I was doing medical administration. And I found that that did not distress me. I enjoyed it.

As the vaccines came along, Sabin and Salk, and proved to be effective, the acute polio load diminished. It became obvious to us, as to many others, that the rehabilitaion techniques being used on the polio patients were just as applicable to other disabilities -- stroke, heart disease, neurologic problems, spinal cord injury, arthritis, children's defects, any kinds of disabilities. The functioning teams -- including physical therapy, occupational therapy, prosthetics, orthotics, psychologists, vocational, just

the whole milieu of rehabiliation specialists were there. So we just gradually began shifting the resources to other disabilities.

The hospital continued to progress and, as I said, became internationally known. It still is.

WEEKS:

This is Los...

AFFELDT:

Ranchos Los Amigos Hospital. It was the old County poor farm. An amazing place. Many of those concepts are starting to come back now in terms of how to take care of the aged and the chronically disabled.

I was appointed medical director of Ranchos Los Amigos in 1956, the whole hospital not just the polio unit, which I was for about eight years. Then the headquarters of Health Services asked if I would become medical director for the Department of Hospitals, over all the hospitals in the system. I agreed to do that. Obviously I had moved into medical administration without having planned to. Just following your nose, I guess. And enjoyed it.

That continued on. Then there was a major merger of all county health services in Los Angeles which meant bringing together public health, mental health, drug, alcohol, the acute hospitals, chronic disease hospitals, and teaching affiliations for the three medical schools which were in Los Angeles. All of this came together and I was appointed medical director. All of that -- I think I'm defining about a twenty-five year history in Los Angeles going from the residency, to polio, the research, the rehabilitation and finally, medical director.

WEEKS:

The notes which I took out of Who's Who or someplace such as that, I have

you at Harvard from 1949 through 1951. Then I have you down for the Rancho Los Amigos Hospital from 1956 to 1964, so I have lost four or five years.

AFFELDT:

What is lost there is when I went into Rancho as head of the polio unit. That was in 1951, becoming Medical Director of Rancho in 1956. It was in 1964 that I went from Rancho to the Department of Hospitals as Medical Director.

WEEKS:

You were at Rancho Los Amigos...

AFFELDT:

...from 1951 to 1964.

WEEKS:

I was wondering whether you had been in private practice. Another thing I was wondering about in the notes I made is that I have you down from 1964 to 1972 at the Los Angeles County Department of Hospitals. Was there a change of name?

AFFELDT:

Yes. From 1972 to 1977 it was the Department of Health Services. That was when they merged all of these health functions into one major department.

WEEKS:

That will bring you up to the point where you went to the Joint Commission. Would you like to talk about the events that led up to your selection?

AFFELDT:

What happened was the Chairman of the Department of Surgery at UCLA, Dr. William Longmire was one of the commissioners at JCAH and John Porterfield was the Director of the JCAH at that time. They used the title of director

then, and later they changed it to president when I came in.

They had been searching for about a year and a half, or perhaps longer, for Dr. Porterfield's replacement. The search committee, which was headed by Jack Hahn, an administrator from Indiana, had selected a surgeon, a retiring Army general. They brought him to the board and presented him. Apparently he came across too strong in a military fashion and the board rejected the recommendation of the search committee. During that meeting, Dr. Joseph F. Boyle, who was a commissioner for the AMA on the JCAH board and from Los Angeles -- he and I had worked together many years -- spoke up and said, "I know a person who would be good for this position." He named me.

Apparently they said it sounded like a good idea so they asked Dr. William Longmire, Chairman of the Department of Surgery at UCLA and a member of the search committee to call me. He did. He asked if I would be willing to consider a position and come back to be interviewed by the search committee. I said, "Yes."

After I said that, I was quite surprised because over the years I had had a number of calls to consider this or that or whatnot and had always said no.

Anyhow, they were on a fast track at that point. They brought me back within a few weeks time. I met the search committee. Apparently the search committee liked the interview because they said they'd like to present me to the board which was a few weeks later. At the April board meeting in 1977, I met the board. The board agreed. We sat down and negotiated and I signed up. I began around the first of July of that year, officially taking over from Porterfield at the August board meeting of 1977.

WEEKS:

Possibly we can review the history of the founding of the Joint Commission. I'm sure many of our future readers will not be as familiar with it as they should be.

I read your paper on voluntary accreditation of hospitals. Being a writer somewhat myself, I thought your beginning with a discussion of Dr. Ernest Codman and Dr. Edward Martin riding in the hansom in England and discussing things that led up to the American College of Surgeons was very, very well done.

This did result in the College being formed in 1913?

AFFELDT:

Yes.

WEEKS:

And this eventually led to the idea of hospital standardization in 1917. I also read in this paper of yours, "The Minimum Standards for Hospitals"...

AFFELDT:

One page.

WEEKS:

I guess it had all of the basic things in it and from that you can go a great way.

Dr. MacEachern, was he the person in the American College of Surgeons who carried on the standardization program?

AFFELDT:

I think only in part. I believe it was really Dr. Babcock who was assigned -- I don't think I know that history that well.

WEEKS:

Dr. Babcock was one of the early directors of JCAH -- years before Porterfield, wasn't he?

AFFELDT:

Yes, he was. It probably was MacEachern and then Babcock and then Porterfield.

WEEKS:

George Bugbee has told me about the situation that came up when MacEachern, who was close to Bugbee -- they were good friends and knew each other well -- when the standardization program got to be a financial burden to the College and something had to be done, it no longer could support it. George Bugbee said that he was approached by MacEachern to see if the American Hospital Association would be interested. George said, "Yes, of course, we would be interested." Then the AMA heard about it and they wanted in, and then it turned out to be the four major sponsors.

You repeated the story of the burning of the first reports in the Waldorf Astoria Hotel. I wondered at the time what kind of fuel they used in the Waldorf Astoria. They must have used coal.

This Waldorf Astoria part of the story is based on the fact that in 1918, the first year they had the standardization program going, there were 700 hospitals of 100 beds or more inspected and only 89 passed the examination. So it becomes a horror story. But I think you brought out the point that within a year they turned this thing around and they had over a thousand.

AFFELDT:

I don't remember how long it took them to get up to a thousand. I don't think it was within a year, but over a period of years. I think it's also

significant that at that time there were no federal or state licensing laws. This is the only thing that really existed for hospitals at that time. It's really quite remarkable when you think about it.

WEEKS:

Yes, it is. I can remember going into a hospital when I was about fourteen years old for an appendectomy. When I look back at it, it was pretty primitive. But I survived as you well can see.

The American College standardization program, by 1950 when MacEachern must have been in, was too costly for them and so they wanted somebody to aid them. By that time, I have a note here that there were 3,000 hospitals that had met the minimum standards by 1951.

AFFELDT:

That's true. And that's before Medicare and Medicaid. By that time there were a number of states beginning to pick up licensing laws.

WEEKS:

So this improvement has been going on.

One thing I meant to ask you when we were talking about your military service. Maybe you don't mind my going back to that. When you came out of service, did you have any ideas about how the practice of medicine should be changed, or hospital operations should be changed?

AFFELDT:

I don't think so, no.

WEEKS:

I've had one or two persons say this had a dramatic effect on many physicians because they were operating under another system in the military and they saw different ways of doing things. They thought the solo practice

wasn't nearly as appealing as it had been before.

AFFELDT:

I think that's true, but that was not part of my thinking or experience. I was just focusing on -- at that time I felt that residency training, specialty training, was important.

WEEKS:

May I ask you if you did that under the GI Bill?

AFFELDT:

I think the answer is, no. Although at that time a couple of things were beginning to come.

WEEKS:

I don't know when the GI bill really was passed. Was that passed before Roosevelt died? I think it must have been.

AFFELDT:

I couldn't tell you. I don't believe I was under the GI Bill. I did get a few benefits, but they were so minor. I think they bought a stethoscope for me and a book or so.

WEEKS:

The reason I asked the question was that sometimes in discussing the growth of specialties, it has been said by some -- maybe this is just conjecture -- that it may have been caused by the GI Bill of Rights being available when some of these men came out of the service. They were able to go take up a residency with support under the GI Bill. And, thus, there were more specialists as a result of this. That may not be true.

AFFELDT:

I do not recall that I received any remuneration.

WEEKS:

Have you ever talked to anyone about the study commission that took about two years to formulate the Joint Commission after it had been agreed that there should be some sort of joint body? Did you ever meet a man by the name of Maurice Norby?

AFFELDT:

The name is familiar to me, but I don't believe I ever did.

WEEKS:

Well, he was in AHA, he was in Blue Cross back in the early days, and he, I understand, was the staff of the committee that studied the need for the Joint Commission. He has told about how the final meeting was here in the Drake Hotel. He was kind of a practical joker. This was on a Sunday, when most of the doctors could be available. So he said, "Let's have a pledge to this." He had the waiters bring in sparkling amber champagne glasses and they all took a taste. It turned out to be beer. It broke up the meeting and everybody started laughing and went away in good spirits. He thought he had found a way to start this off in a good fashion.

I interviewed him a couple of years ago.

The voluntary inspections began in 1952. Your manual, was that the standards for hospital accreditation? Was that a manual that was published?

AFFELDT:

Yes.

WEEKS:

Your organization is headed by a president and a board of commissioners. The commissioners are chosen by whom?

AFFELDT:

By the parent organizations. At that time four parents: the hospital association, the college of surgeons, the AMA, and the college of physicians. Remembering that Canada was part of it at one time, originally. They pulled out and created their own. Then later we added the dentists. So we have five parents.

The five parents -- they are known as the members and they meet once a year. The bylaws require that. Their sole function is to approve any changes in the bylaws or any new members. Those members, then, each have an allotted number of seats on the board -- AMA, seven; AHA, seven; ACP, three; ACS, three; the dentists, one; and then they later added a public member. So we have a total of twenty-two members on the board.

The members will appoint commissioners to the number of seats that they have. That's how the board is made up. The board then runs the organization, as any board is responsible for the organization.

WEEKS:

Do the member organizations contribute money to the support of this?

AFFELDT:

Yes. There is a $15,000 cost per seat, per year. That totals about $315,000 per year.

WEEKS:

I have often wondered why there was a difference in the number of seats.

AFFELDT:

That goes back to when the JCAH was created, the negotiations that occurred. That question has been raised a number of times. We have tried to go back. The best we could tell, it was the American College of Surgeons and

the American College of Physicians did not feel that they could afford more. There were some pretty heavy negotiations that went on between AMA and AHA over the numbers of seats at that time. The number, as it now stands, was a negotiated event.

WEEKS:

How is the public member chosen?

AFFELDT:

The board itself selects the public member and pays for him.

WEEKS:

The dentists are in this because the dental surgery in hospitals or what?

AFFELDT:

Yes. Primarily the fact that dentistry does have a role in quite a number of hospitals, as well as the fact that they had a dental accreditation program for their hospital part and really felt that they should be part of it. The discussion, which was controversial at the time, ended up agreeing and accepting them.

WEEKS:

This would have to be conjecture on your part, I suppose. The point has been raised by someone that the members seated, this group, some of them come instructed by their organization. Others are independent. Would that be a fair statement?

AFFELDT:

Yes. That's sort of a controversial statement, but I think the best way to look at it is to take a look at the American Medical Association. Their structure -- the House of Delegates is the real authority within the AMA. The House of Delegates will pass binding resolutions, binding on their board of

trustees and on staff. So they will take actions instructing their trustees and staff to do so-and-so at the JCAH. Those commissioners from the AMA, for example, feel instructed by virtue of the actions of the House of Delegates. It is in that sense -- they could defy it but they are in effect defying their electorate. It would have an effect at election time. They would not get re-elected to the board of trustees. The AMA is following a policy, an unwritten policy, that their commissioners are chosen from their board of trustees. The reason they do that is to create a very close link between the ruling structure of the AMA and the JCAH.

The AHA has been following that policy, not strictly but quite close to that same policy. So it is trustees from AHA that are appointed to the board. That is not true of the two colleges. They do not necessarily try to follow that pattern. So you could say there is a stronger link to being instructed on the AMA/AHA side than there is on the college side. But it is really for the reason that I cited.

WEEKS:

The board of commissioners is really the governing board of your organization, but you do have standing committees don't you?

AFFELDT:

Yes, committees from the board. Almost all action that goes to the board in the form of recommendations for their approval, come first from a committee. Very little, almost nothing, goes to the board for action that has not gone through a committee first.

WEEKS:

Then your standing committees operate like a house of delegates in a sense.

AFFELDT:

In that sense, yes.

WEEKS:

I was wondering about the committees, like the policy advisory committee to the board and the president. How are they selected?

AFFELDT:

The policy advisory committee does not exist any more. That was eliminated about one or two years ago. It was created when we did the reorganization in 1979. It was selected by the board. Organizations and names were floated up for their consideration and the board in effect appointed that committee. So it was a board created committee. It was eliminated because it was found that there were not enough issues that the board wished to have studied and evaluated by this group. I think it was apparent that the board preferred to deal with these questions themselves rather than another group. So it ended up that the committee was simply not productive enough to retain the interests of the caliber of people that were on it. We in effect recommended that they not retain it, but rather use ad hoc committees instead of a standing committee.

WEEKS:

That seems a reasonable way to do it. The political advisory committee, when it was in existence also had members on the accreditation committee and standard and survey procedure committee didn't they?

AFFELDT:

Yes. It was really an integration effort so that members from the policy advisory committee would be able to participate in the setting of standards and the accreditation committee. They did not participate in the

accreditation decision because that had to be a function of the board itself. But they could sit in on it and they could discuss. What it did was give them a feel of the organization. They could be in a better position to advise by functioning on these other committees. There would be only one member from the policy advisory committee to attend such a meeting.

WEEKS:

One of the other types of committees was the professional and technical advisory committee. Is that still in existence?

AFFELDT:

Yes. The history of that is, I think, quite interesting if you go back to prior to my arrival at JCAH and back to the onset of Medicare and Medicaid. JCAH recognized that there were other programs that should be brought in, such as the psychiatric program and the long-term care program, mental retardation, and ambulatory. These programs began to emerge by virtue of the professional groups that were involved like the field of mental health. Each of those fields came to the JCAH asking if and their programs could become part of the JCAH. As they would come -- again the mental health/psychiatric field is a good example. There was a group of fifteen or eighteen such major organizations in the country like the American Psychiatric Association, the American Psychological Association, the social workers, adolescent psychiatry. Each group had come together to create what became known as a council. So the JCAH developed a mechanism to relate to that council. The council was recognized by the board of JCAH. The council would create their standards, would select their surveyors, would train their surveyors, would carry out the survey, come back with the recommendations which would go to the board's accreditation committee. Policies that they would develop had to go to the

board to be ratified. Over the years, what emerged was four distinct councils. The JCAH at that point was in effect an umbrella organization with the board serving as an umbrella over these four councils, and their respective accreditation programs.

The original hospital accreditation program did not have a council. It was an integral part of the JCAH, whereas these others were not. As the health care industry, hospitals in particular, began changing during that period -- instead of being just acute hospitals they began adding psychiatric programs, long-term care programs, ambulatory programs -- these things started coming together as part of the hospital complex. The hospitals were perturbed to find five different groups from the JCAH coming to them, surveying them, with different standards, different policies, different procedures, no coordination. It was as if they were separate organizations. They were perturbed and began pressing, through their members like the AHA and the AMA, pressing for the JCAH to become better consolidated and integrated with more consistency in the standards and the survey process.

When I came on board that was the first assignment to me as the new president. To study the organization, come forth with a plan as to how to meet these problems. So I engaged Dr. Paul Sanazaro as a consultant to come in. He did a study. He ended up recommending that we eliminate the councils and replace them with the professional/technical advisory committees. In effect it was the same grouping of organizations and people, but changed from a semi-autonomous role to an advisory role. That was the real essence of it. So we retained them in an advisory form, the same organizations, the same people, and they are advisory to the accreditation program.

Yes, they still exist. They are very effective. They really bring a

breadth, of professional input to our standards-making process, to how we survey hospitals and health facilities and the philosophy of it. But the key thing that it allowed was, from an organizational structure, to consolidate the JCAH into an integral unit which has been most important over the past number of years to meet the change in the health scene.

WEEKS:

Would you care to talk about the five accreditation programs for which each has a PTAC committee?

AFFELDT:

Yes. Let's start with the hospital accreditation program because that is the original. It is the largest. We survey approximately 5,000 hospitals out of the slightly less than 7,000, about 75% of the acute hospitals in the United States. The military by policy, has us do all of their hospitals; the veterans, the VA has us do all of their hospitals; we do most of the state hospitals.

WEEKS:

I assume you also do for-profit as well as not-for-profit?

AFFELDT:

Just as many for-profit as not-for-profits. Really there is no distinction made there. We have a three year accreditation cycle. That's a change. A few years ago it was a two year. If they did not fully meet the standards, they might have gotten one year so they would be repeated every year or non-accredited. The experience is that about 2% of the hospitals receive a nonaccreditation. That's held fairly consistent. Some folks would say that must mean we are not doing a very good job. But you must remember that it's voluntary. So the hospitals that don't think they can make it,

don't apply. You've got about 1,500 hospitals out there that do not apply to the JCAH and are not accredited. And they are mostly small hospitals, mostly under 100 beds.

The three year accreditation, if they successfully meet the standards to a pretty good degree they will receive the full three years. If there are some noted deficiencies, they will receive a contingency. So you are accredited for three years contingent on correcting your medical staff procedures, credentialing procedures or your quality assurance program or your building may not be meeting standards. So the contingency may consist of a visit if we think it's serious enough and we need to have a physician go back, if it's something in the medical staff area, or a nurse if it's in the nursing area, or an engineer if it's in the building/safety area. Maybe a focus visit with the surveyor returning for one day to look that over. Or it may be that medical records are not being kept up to date properly and they can respond by writing. So it may be just a report coming into us. But it's a follow-up technique to make sure that they meet the correction.

We think this has worked out quite well because the thrust of the whole accreditation program is to help a facility to improve rather than trying to catch them in a deficiency and to penalize. There is a very distinct philosophic difference because government usually approaches it from the standpoint of you are not meeting the requirements and you will be penalized. It's the inspector versus the consultant philosophy. All of our actions, as much as possible, are designed to help a facility to improve.

For example, a fairly recent policy within the past two years is if it appears to staff that we are going to recommend a nonaccreditation to our accreditation committee, before that goes to committee for a decision, we will

notify the hospital. We will call the hospital administrator and say, "The staff is getting ready to recommend a nonaccreditation. Was there anything wrong with the survey? Did the surveyors not see things they should have seen? Was there some misinformation? Was there a personality conflict? Did something go wrong in the survey that has brought this result? If so, document that to us and we'll take that into consideration. Or is it something that you can correct quite readily? Is it something you are interested in correcting? Do you wish to try?"

We'll give them a little time. It's designed to help. So it is communication. Very effective. The hospitals respond quite readily. It has also eliminated at least half of the appeals. Where we have given a nonaccreditation and the hospital comes back and says, "You are wrong. Here's our evidence." And we reverse it. So it builds a better relationship and better results.

To move to the psychiatric program, there we have a number of sub parts such as the drug abuse program, alcohol abuse, child and adolescent program, adult psychiatry, and community mental health centers. Those are all distinct parts under the heading of the psychiatric program. We do most of the private psychiatric hospitals or psychiatric units within acute hospitals, most of the state hospitals -- not all, but most of them -- and, of course, military, if they have psychiatric units. That's a program dating back into the late 1960s. It's quite an effective program, always controversial because you get into the question of non-physicians providing care, credentialing of psychologists, psychiatric technicians, psychiatric nurses, the drug field and the alcohol field. There is always controversy of the philosophy of treatment, the approach, what type of discipline can have privileges. But it

is a successful program.

Ambulatory is a program that is effective, but has not penetrated the field very much. There is no particular incentive at the present time for an organized ambulatory clinic to seek accreditation in contrast to hospitals where for a facility to participate under Medicare or Medicaid, they either have to be certified by the government or accredited by the JCAH.

I should mention that so I will drop back to the hospital accreditation program. Under the Social Security Amendments of 1965, when Medicare and Medicaid was created, the federal government had no standards. So when they created the conditions of participation, they in effect adopted the JCAH standards. They modified them somewhat, but they are basically the standards that were in effect at that time. So they wrote into the law that if they are accredited by the JCAH, they are deemed to meet the conditions of participation. You have heard the term 'deemed status.' It stems from that concept. That was also applied to the psychiatric field, but not the other fields. It does not exist in ambulatory or in long-term care. So there is not the same incentive. In either ambulatory or in long-term care you do not find nearly as many facilities seeking accreditation. They just say, "What for? It doesn't mean anything to us." We believe that will change.

The ambulatory field is obviously expanding very rapidly, with your ambulatory surgical facilities, freestanding clinics, emergency rooms. So I do believe that there will be pressure for standards to be applied. Congress is pushing for PRO to get involved. PRO may be the vehicle. Or maybe there will be a day when they recognize the JCAH standards for it.

I should also mention, because it's pertinent here at this point, that going back to the council days -- there was a council for ambulatory care --

they did not like the proposal of the Professional and Technical Advisory Committee. They did not like the idea of going from a semi-autonomous council to an advisory body. So they declined to stay with the JCAH and created a competing organization, the AAAHC, the American Association of Ambulatory Health Care. So the two of us are competing in the field of ambulatory. Neither one has penetrated very deeply for the reasons I have given. But presumably that will change.

WEEKS:

May I interject here -- it would seem to me that ambulatory facilities with a hospital connection might naturally apply for a site visit. But those that are independent, the storefront, where two or three doctors open up a walk-in clinic I don't know whether any of those people would come to you.

AFFELDT:

Well, yes. Going back as this evolved. When you look at what is a hospital, here is St. Mary's Hospital or Riverfront Hospital, JCAH accredits the hospital. Hospitals have changed form. They are adding programs. They will have an ambulatory surgery program now. They will have an ambulatory emergency clinic. They will have a psychiatric program. JCAH had to face the problem if they accredit that hospital, they do not accredit just the acute portion, or just the psychiatric or just the ambulatory. So when you say that X hospital is accredited, does that cover all the programs? So we had to establish a policy that if we had standards and an accreditation program that would apply to that part of the hospital, for that hospital to be accredited they had to come under survey for all those programs. We did not accredit X hospital acute portion and ignore the long-term care portion or the ambulatory portion. Because the thing on the wall said that X hospital was accredited,

the public would assume that everything was covered. The policy meant that if they had an ambulatory program it had to be surveyed by JCAH.

WEEKS:

Did you want to say more about long-term care? I was interested in knowing what you encompassed in this long-term care.

AFFELDT:

We have standards for long-term care which are basically the nursing homes, extended care and skilled nursing care, they apply to both. We do not have standards for residential care under the long-term care part. There are some under psychiatric but not under long-term care. So it is basically the nursing home type that our long-term care applies to.

Again, just as in ambulatory, there is no incentive for them to seek accreditation except that it helps to raise their standards and prestige. But it has nothing to do with reimbursement or does not substitute for licensure. The long-term care field can't quite figure out whether it wants voluntary accreditation or is satisfied with the government certification, inspection licensing process. The field is controversial. The long-term care facilities do not have the history, the longstanding history of the struggle for excellence like hospitals have. It seems to be a different mix of ownership and approach. They are maturing, but they are not there as yet. So the public and the pressure groups do not feel that the long-term care facilities will respond to voluntary accreditation standards and must be regulated. They are insisting on greater regulation, more frequent inspections, greater penalties, financial penalties, possible imprisonment. It's a different approach than the voluntary. This became very evident about two years ago when HCFA proposed, as part of the current administration's deregulation

effort, to have the JCAH brought in and to give deemed status to long-term care. Local critics of voluntary accreditation went to Congress and objected.

Congress compromised by funding a study by the Institute of Medicine on licensing and certification and accreditation of nursing homes. That report has just come out. It's being studied by Congress now and in effect is advocating greater governmental control. So whether the long-term care field will ever evolve like hospitals did in terms of voluntary accreditation or not is hard to tell.

WEEKS:

Knowing you are from Lansing originally, have you seen the Burcham Hills Home in East Lansing?

AFFELDT:

No, I don't believe so.

WEEKS:

Hospital Corporation of America recently bought it. Originally it was one of those homes where you buy in for $25,000 or $30,000 and then have lifetime care. HCA is running it for profit. They are running it on a monthly fee. It may be $1,500 but you are guaranteed not only good care but lifetime care. They are segregating various strata of care, nursing home care, the chair-bound person is in one place, the ambulatory person who needs help is in another place, and then the fully ambulatory lives quite leisurely and nicely. In my mind there is going to be a great need for housing for the elderly where they have care under the same roof, even though they are quite well. I'm thinking of myself in another ten or fifteen years. It would be nice to be in a place where it was pleasant and the service was good. But everybody can't afford that.

AFFELDT:

True. But I do believe that that can become a trend. There is increasing interest in it. The only way that we could ever find a way to afford that would be if private insurance can come into play for the elderly. Obviously Medicare is not the answer. It does not provide that type of support. There is the feeling -- studies are showing -- that by virtue of various retirement provisions, Social Security, etc., that there is better financial support of the elderly today than some years ago. On the other hand, as the elderly are living longer, they are outliving their reserves. They built adequate retirement if they had lived to age eighty, but now they live to age ninety. Those reserves, those pension funds and whatnot weren't designed to carry them to age ninety. So that is a problem that is emerging.

All of which goes back to say that there needs to be some financing mechanism evolved. They are trying to look at private insurance for the elderly to cover what you just described.

WEEKS:

If they could build it into the pension plan some way so that you had a pension and security in addition for those extra years. In our local paper the other day they were discussing a nursing home which had been a former hospital in Ypsilanti. The owner was complaining because Medicaid paid only $40 a day. Forty dollars a day to the average working person would be almost impossible to bear for very long. The owner of this place said that he had private patients at $41 or $42 a day. Medicaid, although they didn't pay their way quite, would help increase the volume to the point where it would take care of some of the fixed overhead and thus they could make a little money on the one or two dollars a day extra that they were getting out of the

private patient. But that's figuring things pretty tight.

AFFELDT:

Well, the long-term field is on a very tight budget. They have to be very careful. I think that is part of the reason for some of the scandals we run into. It's pretty marginal.

WEEKS:

It would be nice if we could find some way to make living safe and secure because people, as they get older, have an insecure feeling, especially if prices are rising and the income is not rising. It's rather frightening to them.

In checking your list, the only one you haven't talked about it hospices.

AFFELDT:

Yes. The hospice program is new, relatively new. It came about -- the hospice movement started some few years ago. The W.K. Kellogg Foundation came to us a few years ago and asked if we would be willing to take on a project which they would fund to first of all survey the field to determine the status of hospice; how many facilities; what was their financial backing; what kind of programs do they have and of what size; and then create standards that could be applied. We agreed and I think successfully carried out that project and created standards. Our board at that time was ambivalent about whether the field would warrant accreditation, whether there would be sufficient volume that it could stand financially on its own, whether there would be interest in accreditation, how would the federal government look at it, how would the field look at it.

In the process of developing the standards and taking a measure of the field, it did evolve that it appeared appropriate for the JCAH to establish an

accreditation program. The board did approve that and we have such a program.

It is marginal in terms of sufficient volume to be financially viable but the hospice concept appears to be fairly solid. It appears that Congress is going to continue to fund and the insurance companies continue to fund hospice care. So there need to be standards and so far the federal government appears to be interested in JCAH carrying it on. They have not given deemed status. As I mentioned under the nursing home question, there are critics of the JCAH -- not just JCAH but voluntary accreditation. There are people who feel that only the government can regulate the health care industry. But the program, I would say, is successful and is continuing to grow.

What we are now looking at -- and I think it's appropriate to add this right now -- the home health care is likewise emerging. It has been around for quite some time but it is expanding now quite rapidly. Diversification of services, expanding the type of services that they provide under that heading. The field has expressed a strong desire to have JCAH get into the creation of standards and perhaps an accreditation program for home care. It would fit together with both long-term care and the hospice. So our board has approved our developing standards, studying it and developing standards. It has not yet approved that we proceed to the next stage of accreditation. That is two years down the road. But we are now in the process, with the backing of the field, to do that.

WEEKS:

It's a wonderful thing. I've observed the home care visiting nurse service and the therapy service and homemaker services which made it possible for people to be at home rather than in a hospital. It certainly was much cheaper and from the patient's standpoint it seemed to me that they were much

happier being home than they would be in the hospital.

We were doing a study at the University of Michigan of McPhearson Hospital in Howell which was one of the first small hospitals to have that service. I rode around with the visiting nurses for several days and visited patients with them. I could observe what was going on. It's marvelous. I came away very much in favor of it.

One point I have noted is that in speaking of the accreditation groups, some of them, like hospitals, are basically a facility and staff. When you are getting into some of these other areas you are getting into more tenuous groups it seems -- these services. You are not looking at a facility in the sense of a building and patients coming to one place but you are talking about other kinds of services, community services and this sort of thing. You must have difficulty setting standards for these site visits.

AFFELDT:

Yes. If you go back to the concept I expressed at one point where we accredit a hospital or a facility and now we are seeing services and programs that are not part of a building or facility, that is creating some problems for us in terms of how do you structure that. We are proceeding and we feel we will be able to find a solution to it.

Let's take these multi-institutional facilities where they are putting together all of these services, vertically integrated, so that guests have acute care, long-term care, hospice care, home health care. It's all there under some type of corporate management. We feel that we can survey all of that. One of the techniques that we use, because we have a separate manual for long-term care, separate manual for ambulatory, separate manual for hospice. What we do is that we will go into a facility like this with these

multiple programs and we use the appendix approach. Let's say it is primarily an acute hospital but with these subsidiary units. We will select those parts of the various manuals and we'll notify them that, "You will be surveyed against these standards and these appendices of these standards." And we will form a team to match the facility we are going into. The team may consist of the people who usually do an acute hospital, then we will add a long-term care person and we'll have a hospice person or an ambulatory person or a psychiatric person. So that the team that goes in will have the capability of looking at all of the facets of that place. We then bring that back and we integrate that into the accreditation decision so that again we are still able to accredit that facility with these programs.

WEEKS:

It seems like you have risen to the problem pretty well.

You mentioned your technique in telling a hospital which might not receive accreditation -- calling them and asking them if anything had been done to their dissatisfaction or so on. This brings up the point, what sort of appeals system do you have in case somebody really isn't satisfied after all and they want some kind of formal appeal process?

AFFELDT:

Yes. It's a several level of appeal. The first is, they come back to us by telephone or writing and express their dissatisfaction if they think there was a problem. So at that point we invite them to come into headquarters. They bring whomever they choose, usually the CEO of the hospital, the chief of the medical staff, maybe the chief nurse, maybe their lawyer will come along. They will meet with our staff. There will be a several hour sitdown session to go through the report, go through our findings and they can try to rebutt

and say, "Your surveyor said this, but that isn't true. Here's the evidence. We really did have our records up-to-date." Or, "All our physicians are licensed." Or, "Yes, we do have nurses around the clock." Whatever the problem.

If we find in that process that it appears that we have made some errors, we'll take that back to our committee and get a reversal of the same. If on the other hand it appears to us that our findings were valid and they have got these problems -- they may disagree -- but we feel our surveyor did a proper job, our decision is proper, we'll stand on it. We'll say, "We feel we did right."

They can still disagree and say, "No, we still think you are wrong." Now they can enter a formal appeal. We have defined in the manual the formal appeal process. We will bring in experts. We select people who have functioned as former commissioners or PTAC members, people who have been intimately involved with the JCAH process so they understand the organization, they understand the standards and what we do. We'll bring four or five of them together as an appeals body and let the facility come in and present their case to them. That will be a formal hearing. The results of that, will be a recommendation to our board.

WEEKS:

When you spoke of the lawyer being present, I was wondering if there is any civil action taken or could there be?

AFFELDT:

There certainly are lawsuits. We are sued periodically over these findings. So far, I think we have been upheld in all cases. The most recent case was a state hospital in Louisiana that sued us because their renal

dialysis unit was not checking their water properly. They ended up treating their water improperly. There was a lot of aluminum in it. It caused a number of deaths and neurologic damage. The state recognized that they were at fault. They settled. Then they turned around and sued us and said that if your surveyor had only told us of this problem we wouldn't be in this trouble. So it's the JCAH's fault. Well, we survived the suit and an appeal of the suit.

WEEKS:

Along this line, if you have accredited a hospital, or any institution as a fact, and before the period of accreditation runs out something happens which is unethical or something, do you have a mechanism for withdrawing that accreditation?

AFFELDT:

Yes. We can withdraw the accreditation at any time for cause. In the administrative part of the manual it describes the fact that if they request a survey and an accreditation by us, we have the right to go in unannounced, unexpected, anytime to take a look and withdraw our accreditation if appropriate. And we do this. There are instances where it may be that somebody phones us or a letter may come in or maybe newspaper or television publicity. Something has turned up. We'll send a surveyor or a team, whichever seems appropriate, in to take a look, come back and make a decision.

WEEKS:

That's good to know.

Another standing committee that I assume is still in existence is the advisory committee on education and publications.

AFFELDT:

Yes, that is in existence. It is one committee with two parts to it because we have our education programs, in-house training for our surveyors and seminars put on around the country in terms of our standards and how to meet our standards. Then we have our publications such as Perspectives which comes out bimonthly and is the official publication -- any new standards or changes in standards are published there so that hospitals get a preview of what is coming, policies of the board and all.

We have the journal, the Quality Review Bulletin, which is essentially a journal on quality assurance. We put out educational materials to help people understand the standards. So it's a fairly significant education and publication interest.

WEEKS:

You have quite a number of manuals that you publish also.

AFFELDT:

A manual for each program.

WEEKS:

Which have to be updated quite often, I assume?

AFFELDT:

The hospital accreditation manual is updated annually. The others are not necessarily annually, but probably at least every two years.

WEEKS:

There is a tremendous amount of work in your office when you look at it.

AFFELDT:

Yes, there is. It's a very busy place.

WEEKS:

Then also the standing committee on standards and survey procedures.

AFFELDT:

That is a committee of the board. That is the committee that any new standards or any changes in standards or changes in the survey process go through. From that committee they go to the board. I should inject here that in addition the committee will approve material to go out to the field for review. We may go out to the field on a standards change or a new standard three or four times. We send out about four thousand copies at a time -- widespread throughout the United States to the health care facilities, government agencies, professional associations -- so that they get a look at the language, the thrust of the language, and respond back. We go back and forth until we feel we can reach what we call a consensus on the current state-of-the-art. Then that will go to the Standard and Survey Procedures Committee for their review, modification, and recommendation to the board. The board becomes the final authority to appprove any of that. Once that is done then it is published in the manual.

WEEKS:

Once a process starts, it isn't cut off at any point?

AFFELDT:

No.

WEEKS:

It goes through with the final report going to the board and they make the final decision.

AFFELDT:

It may take a couple of years for that occur.

WEEKS:

The accreditation committee, how do they fit in with the standards committee and the others? The standards committee is on standards that might be added or changed. The accreditation committee, of course, considers the accreditation report of the survey and...

AFFELDT:

...and makes the decision.

WEEKS:

They make the final decision?

AFFELDT:

Yes, they do.

WEEKS:

This doesn't have to go to the board?

AFFELDT:

No. The committee consists of board members. We have twenty-two board members and the committee is about eighteen strong. They don't all come. It meets every month so that you may get anywhere from eight to eighteen members from one meeting to another, depending on their schedules.

The survey material comes in from the surveyor. We have a group of analysts who do nothing but analyze the report from the surveyor and check it against the standards to make sure the surveyor is making comment on something that's in the standards, not something personal. It's clear that it's in the standards. How does it relate to the standards? All of that is analyzed and put together into a report, reviewed several times by staff, ending up with a recommendation from staff to the accreditation committee.

The committee then takes those reports and staff recommendations, goes

through it, asks questions, will accept the recommendation, make that as a decision, or may modify it.

WEEKS:

I am impressed with all of these people who are contributing things. You must have a lot of volunteer help too, don't you? These people who serve on committees, are they paid?

AFFELDT:

No. The board members, those are all volunteers. No, they are not paid but their expenses are covered.

WEEKS:

No honorarium of any kind?

AFFELDT:

No.

WEEKS:

I think that this is quite marvelous that you can have an organization doing so much out of people volunteering their services. These people are all experts too.

AFFELDT:

Experts and very busy. When you stop and think -- let's take either AMA or AHA as an example, where they are requiring that their commissioner come from one of their trustees. So that that commissioner is not only busy at AHA on the board of AHA and all that that involves, added to that is the JCAH. When you figure that the board meets three times a year, each committee meets three times a year, the accreditation committee meets once a month, that is a very large load. There is a lot of material when we change standards and various policy changes.

WEEKS:

As a general statement can I say that you have some board members on each standing committee?

AFFELDT:

Yes. Each committee is composed of board members.

WEEKS:

Are there no outsiders?

AFFELDT:

The only outsiders -- there will be one PTAC member, there are five PTACs. There will be one from each sitting on the Accreditation Committee. One each sitting on the Standard and Survey Procedures Committee. That's it. The finance committee is entirely commissioners. The executive committee is entirely commissioners. So that makes up your four.

Non-commissioners are your PTACs and your education and publication advisory committee. Then we have one more committee, the plant technology/safety committee, which is your code, building, fire safety committee.

WEEKS:

But still, you have some very busy people doing a lot of hard work.

AFFELDT:

Oh, yes. It's really amazing the amount of time and effort. They are very dedicated.

WEEKS:

I think in our statements that we made previously, we stated that the five members were not able to contribute enough money to carry the whole program so that you now charge a fee to the institution that you are

surveying. Of course the team size varies with the kind of institution, I assume?

AFFELDT:

Yes.

WEEKS:

But you usually have a physician?

AFFELDT:

A physician, nurse, administrator and a medical technician is the standard team for an acute hospital unless the hospital may be using the College of American Pathologists for their laboratory. In that case we would not have the technician.

Then if you get into the psychiatric part, then there might be a psychiatrist, a social worker, a psychiatric nurse as part of the team.

WEEKS:

Do you charge a fee according to how many personnel and how many days?

AFFELDT:

We charge by surveyor day. A surveyor day is one surveyor, one day. So if the team is four and they are there one day that is four surveyor days. It's a known, fixed rate for one surveyor day. Then you just multiply that by the size team and number of days.

WEEKS:

This doesn't otherwise vary according to the size of the institution or...?

AFFELDT:

No. Now the surveyor fee is different from one program to another. The ambulatory and the long-term care has a lesser fee than the acute hospitals or

psychiatric hospitals. That's the only variation.

WEEKS:

That would seem reasonable.

I think that in your paper you mentioned that one of the big factors, one of the big benefits in your service is the fact that you not only survey but you also consult....

Somewhere I have seen the term summary report.

AFFELDT:

Oh, the summation conference?

WEEKS:

Yes.

AFFELDT:

That is a part of the process during the survey. When they have completed the survey, the survey team will meet with whomever the administrator chooses to have come. It may be many of his board, or many of his medical staff, nursing -- he may bring a crowd or maybe he'll bring only four or five people. Whatever he chooses to bring. The survey team will present their key findings. The things that they are going to be reporting -- not in detail -- but the key essentials. Particularly anything that is of an adverse nature. Again it's the effort to give the hospital a chance to rebutt. They say we found this and this wasn't right, we want the hospital to be able to say, "Hey, wait a minute. That isn't true. You didn't see it right."

We hope that there will be no surprises. That the hospital will have heard the essence of the findings and the essence of the report that's going back. It can't be complete because they've spent a couple of days there and

now the summary conference may last an hour.

WEEKS:

I can see where you are cutting down on the number of grievances that people might bring up by bringing it out in the open before the report is fornalized.

AFFELDT:

That's true.

WEEKS:

It seems like a very wise thing to be doing.

You also have pre=survey meetings sometimes, don't you?

AFFELDT:

Yes, we do. When we go into an area -- let's say the state of Indiana. We notify the hospital about three months ahead that they are going to be surveyed. Also the hospital association is alerted that we will be coming in. Then we offer a pre-survey conference, which is sort of a regional thing. The hospital association will bring the CEOs of those hospitals to be surveyed together in a meeting with the team. It will be a one day meeting. It gives them a chance to get acquainted with the team, to see what they look like, how they talk and act. It gives them a chance to ask what is emphasized, what is being looked at. Quality assurance? Outbuildings? Nursing? It establishes some rapport. They don't feel like strangers or antagonists.

WEEKS:

Some of these people who attend might never have been through the accreditation process.

AFFELDT:

Yes.

WEEKS:

Outside of the public member, is there any other way for public input into your operation?

AFFELDT:

The only other way is public interview which is a requirement of our standards. The hospital must post the fact that is a survey is going to be held. The question is where do they post that? Do they hide it somewhere? Our surveyors are trained to look for that to see where it has been placed. Sometimes it's effective, sometimes it isn't. But we try to establish to the public that we're coming and that if they wish to talk with our surveyors they can make such a request. We wish the hospital to know that they are coming so that they can be properly received, given hearing. Our surveyors are instructed to take that into account. Sometimes it gets used as a complaint session. It may be a disgruntled physician or a nurse, technician, trying to say something that they think is wrong with the hospital. Or the public in general.

WEEKS:

I think we mentioned that your staff analyzes the report that comes back from the survey and then submits it to the accreditation committee and they make the decision then?

AFFELDT:

Yes.

WEEKS:

We touched on how a new standard is developed. Maybe I could just run through this quickly and if you disagree, or if you have a comment, you could interrupt. This new standard may come out of the field somewhere. It may

come from anywhere, but it comes to your attention and somebody makes the observation that it's worth considering. Would that be at the board level?

AFFELDT:

It would probably start with the staff. It probably would be staff analyzing it in terms of: is this something that is going to improve the care in a hospital, not be unduly expensive, will it be cost effective? Is it practical? Could we survey it? All of those things are taken into consideration. Then that is put into a staff report and recommendations to -- the board. Right now the issue is risk management.

There is a lot of pressure being applied to the JCAH from a number of sources now saying that we should put some risk-management standards into our manual and survey process. So we will work that through the committee structure and eventually to the board to recommend that we should or we shouldn't.

WEEKS:

Then it goes through the process that you mentioned before through the standards and survey procedure committee and goes out for field review and you consider the feedback. The field comments, do they go to the PTACs?

AFFELDT:

They would go to the PTAC before they would go to the board committee.

WEEKS:

So you have a process here where it's considered by many levels and by many persons, but your actual final decision is made by the accreditation committee?

AFFELDT:

For an accreditation decision, but any change in standards is made by the

board.

WEEKS:

You have mentioned the fact that there are a very low percentage of surveys that do not lead to an accreditation.

AFFELDT:

Two percent.

WEEKS:

We talked about the complaints system for non-acceptance and so on. We talked about ethics.

What is looked for in a general survey?

AFFELDT:

The actual analysis report -- the report that is put together by staff, analysts and staff, and goes to the accreditation committee -- is broken into certain blocks. We congregate certain things like medical staff. That's an obvious focus to look at. Under the term medical staff are certain things such as credentialing, privileging, do they have any bylaws? Are they carrying out quality assurance mechanisms? There would be sufficient nursing staff? Do they assess the care of the patient? Do they have nursing plans for the patient? Do they have a quality assurance program? Is there a registered nurse always present on an intensive care unit? A number of things like this that are in the standards that are focused on as far as the accreditation system. The building, the safety of the structure, medical records, the quality assurance program. Those are the key elements.

We publish that so that the hospitals know what we focus on. Everything that a surveyor looks at and makes comment on has to be identifiable in the standard itself. He can make other remarks but we will not take those into

account in the analysis and decision process.

WEEKS:

So it is pretty well standardized then.

You take into consideration the reappointment of the staff?

AFFELDT:

Yes.

WEEKS:

How about the level of privileges?

AFFELDT:

Yes. Our surveyors are trained to go in and look at the surgical record and find that doctor so-and-so is doing thoracotomies. They will ask to see his credentials file. Has he been given the privilege to do thoracotomy? Have you checked his credentials? Does he have training and competence and experience to do thoracotomies? It's that type of checking that they will actually do.

WEEKS:

How about looking at the credential committee's report on new physicians on the staff? Every now and then you read some horror story about somebody practicing medicine who really doesn't have a license. Can you spot that kind of thing?

AFFELDT:

Actually, I don't think we can. All we can do is require that the hospital do it. So what we check on is is the hospital doing it? We pull X number of physician files. Have they documented that he has a license? Is the license correct? Have they documented that every two years they have considered his work? Have they reviewed his work? Has he been given more

privileges than he had before or have privileges been taken away? If so, why? It's that type. We are dependent upon the hospital. We do not do independent checking.

WEEKS:

But you have certain standards that you expect the hospital to adhere to.

You mentioned that you have a medical records expert in most hospital surveys.

AFFELDT:

We do not use an medical records librarian or records administrator.

WEEKS:

I'm sorry. You made the statement about the laboratory.

AFFELDT:

Yes. The laboratory technician. If the facility is not surveyed by the College of American Pathologists, we will send in a laboratory technician in addition to our physiciana who looks at the laboratory also. The technician will look more at the technical details of the laboratory that fit our standards.

WEEKS:

I was wondering if there was any standardized record format that you recommend?

AFFELDT:

No. There are certain things that we require, but we do not try to recommend any particular format.

WEEKS:

Because there is a varience in records as you well know.

Talking about the financial background now. You have the money from the

members and the revenue from the survey fees. You mentioned W.K. Kellogg. For special projects do you try to get outside support?

AFFELDT:

Outside support is really quite minimal. Our basic revenue is the survey fee, the educational income, publications income, the cost per seat. That's the bulk of it. We do get grants periodically, but that is a very small fraction. Or contracts. We have a contract right now in the state of Ohio to survey their HMOs that they contract with for Medicaid. We have a contract with HCFA right now to survey the hospice program.

WEEKS:

Does it seem likely that in a couple of years down the road that the commission will be surveying HMOs and other types?

AFFELDT:

We are doing that now.

WEEKS:

Capitation process all the way through?

AFFELDT:

Yes.

WEEKS:

What is the result of this survey? Are you giving them some kind of accreditation?

AFFELDT:

Yes. It comes under the ambulatory program.

WEEKS:

It looks like there will be a lot of work there in the next few years.

AFFELDT:

Yes.

WEEKS:

You just lightly touched on multi-hospital systems. Are they offering special problems?

AFFELDT:

I wouldn't say they are offering special problems. It's better to put it in the perspective -- here again, Kellogg came to us and asked if we would carry out a project on the multi-hospital systems and funded a three year project. We have just completed it. It became a pretty major study in which we did a pretty thorough study of the multi-hospital facilities, its corporate entities. There are so many variations of that now. We did it from the standpoint of one trying to understand them. What are the changes occurring? What impact do they have on our standards and our survey process? Particularly is quality assurance being established as a policy of the corporate headquarters, disseminated off to the multiple facilities that they have? Is it a centrally supervised program or is it independent in each hospital? What is the relationship of nursing from facility to facility or to headquarters? What is the medical staff relationship? The board of the individual hospital versus the corporate headquarters. All of that was part of the study. We have made changes in our standards and in our survey process based on our findings.

I think one of the most significant changes that we made and offered is that we will do a special type of survey for a multi-facility corporation. Meaning that, we will pick a team and we will use that same team in each hospital of that corporation and we will do it in sequence. We'll start with

corporate headquarters. The team goes to corporate headquarters, obtains the basic information needed there. They will then go in sequence to each of the hospitals so that corporate headquarters ends up receiving a consistent report and having the ability to compare one hospital with the other within their corporate complex. They like it.

WEEKS:

I should think that would be the best way of approaching it.

How is your relationship with PROs?

AFFELDT:

Tenuous.

WEEKS:

They haven't really developed as well as they should, as they were anticipated to do, have they?

AFFELDT:

No. And I think that's understandable because although Congress and HCFA says that one of the key efforts should be quality assurance, I think everybody knows that the prime effort is cost-containment. They are under a pretty tight budget for the workload demanded of them. Yet I don't think there is any question but what there will be continuing pressure from Congress and from the administration through HCFA to try to determine the quality level that's being used. There are the critics that say the cutback in funding, the DRGs, is going to threaten quality, discharges sooner than they should be, refusal for admissions. The incentives to provide services is not under the DRGs that there was under fee-for-service. So everybody feels that there will be a deterioration of quality and it is the PROs' job, that is the government's answer to make sure that there isn't the deterioration, or an

ability to detect it.

That's a tough job. PROs are obviously better funded than JCAH. We go in once in three years. They are in there every week. So obviously they can learn more about a hospital than we can. Whether that is a threat to the voluntary accreditation in the future is hard to say. It could be. It could be a serious threat. But at the present time, we do not feel that they can do the job any better, if as well, as the current approach of the JCAH.

WEEKS:

It seems that I have read that some of the PROs are finding it difficult to get reappointments.

AFFELDT:

Redesignation.

WEEKS:

And there seems to be delay at HCFA over even considering some of these cases or giving a decision on it let's say.

AFFELDT:

Yes.

WEEKS:

I made a list of questions, some of which you have already answered such as the medical staff monitoring. How about surgical care?

AFFELDT:

That all comes under the monitoring requirements of the quality assurance effort. That's where they are supposed to review each surgical case or surgical intervention. This is where we are speaking of technical procedures. Even though they may not be removing tissue necessarily. There may not be a tissue for a pathological examination, yet the procedure needs to be reviewed.

So we have that requirement for all such procedures.

We have recently introduced some modification of that, namely to the effect that you don't have to have pathological review of every specimen. For example, teeth. You don't have to look at every tooth. If they can document that there is an adequate spot review and a consistent practice going on there then we can do selective monitoring. It's cost consciousness.

WEEKS:

In pharmacy you would look at such things as the use of antibiotics and all of that sort of thing?

AFFELDT:

Yes. How is it reviewed? Which ones are they using? How is it monitored, not only from a cost effectiveness standpoint but the safety? Is there good control on antibiotic use?

WEEKS:

One thing that impressed me one time in a study that I was a part of in looking at medical records. There were many medications that had no cut-off. I think antibiotics there is an automatic cut-off after so many days. In this case there were a lot of probably harmless drugs that were being used without any cut-off date.

I was wondering how your quality resources center enters into your operation?

AFFELDT:

That is a unit that existed some years back. It does not exist any more. It was really subsumed under our shift from audit, which we did back in 1979 or 1980, from the audit requirements to a broader quality assurance program.

WEEKS:

Some of the material I have been reading predates your entrance. I was wondering if you have any kind of data bank? Is this available to research people?

AFFELDT:

Yes. It is fairly early into our development, but about four years ago we began accumulating our survey findings into the computer. It is a gradual process. We have just now reached the point where we are able to get the entire survey, standard by standard from the survey, entered into the computer for every facility that we survey. We just finally got to this point where when the surveyors report comes in the very first thing that is done is the technicians sit down and enter that into the computer. Now the computer begins to take over in terms of sorting things out and preparing the automatic part of it for the analyst. This is an efficiency effort. But that also begins to store all of the historical data, all of the geographical data, all of the survey data into the computer. As the analyst goes through the process of analysis he is using the computer. So the report is being prepared throughout this process. Every change is documented. The staff recommendations, the accreditation committee's decision, the report to the facility. It is all part of a computerized process now so that we can get the information in, we can get it out, and we can massage it.

WEEKS:

Do you have any connection with CPHA?

AFFELDT:

We have had a close association over the years with them. Not nearly as good as we would like. But we have just now, by virtue of having brought in

Dr. William Jesse to head up our education/publication effort. He came out of North Carolina with Cecil Sheps. He has been working with CPHA and just within the last month or so has been made a consultant to a project with CPHA. So we now have a connection far better than we ever had before.

WEEKS:

I'm glad to hear that. They had some rough times for a while but apparently they are coming back.

AFFELDT:

Yes.

WEEKS:

Also in your paper you spoke about the international voluntary hospital accreditation that was developing in some other countries. Has this been through the Commission's efforts?

AFFELDT:

Yes, I think so. A combination of Kellogg and JCAH. It really goes back to about 1981, if I remember, Kellogg provided us a small amount of money and we tied into the International Hospital Federation. They hold meetings every two years in different parts of the world. What we have done now is we put on a meeting, about a two day meeting, immediately prior to the IHF meeting wherever that occurs. It's pretty well focused on quality assurance efforts, not so much accreditation because other countries don't do accreditation, but quality assurance.

The first one was in Sydney, Australia in 1981. Two years later we did it in Geneva. This last year the IHF was in Puerto Rico, so we held the pre-meeting in Orlando, Florida. The fourth one will be in Helsinki in 1987. That's pretty well established now. We end up with about fifty countries

giving representation, from all over the world, showing a lot of interest. Various groups are beginning to organize in other countries. Spain, Italy, Belgium and a couple of others have developed organizations on quality assurance. They are trying to put together a publication so you get some international exchange of information. There is a definite interest there. You run into the cultural problems. The Oriental problem of face-saving. It's pretty hard to do peer review under that philosophy. One physician is very reluctant to criticize another physician, which shows up in peer review. But the idea is moving.

WEEKS:

It seems so whenever there can be an exchange of information about different systems. We are sort of hidebound in that we feel that our system is the system. But if we can hear from the other countries we may learn something that will be of help to all of us.

I don't suppose you have had anything to do with the right to die movement. You must run into it occasionally.

AFFELDT:

No, we have not been any instigators of it but there are pressures on us to consider developing some standards or guidelines to help out. The President's commission on ethics made reference to the JCAH indicating that they felt we should get into it. Right now what we are trying to do is gather sufficient data. What is the status of it? What would the proper role, if any, be of the JCAH? That's what we are studying.

WEEKS:

Dr. Affeldt, will you say something about the Seventh Day Adventists' hospital system, health care system?

AFFELDT:

Well, I'll start with the medical school, Loma Linda University, based in Loma Linda, California. It is a fine medical school. There is also a dental school there. Then they have affiliated colleges around the United States where the premedical courses can be taken as well as the regular general arts and other areas.

The hospital system, being church-oriented, religious-based hospitals, they really come out of the philosophy of the church. Namely, that you can help people spiritually through their illness to assist them to get well, preventive types of things, so that they lead a better life and that becomes sort of the philosophy of the hospitals themselves. The hospitals have been formed into systems. I don't think I know the details of their systems as much. I know they are regionalized. I don't think I know whether it is two, three or four regions. But they are following the pattern and in some cases really taking the lead of the multi-hospital system groups. They certainly are as far along in that as any of the multi-hospital systems. They certainly are staying modern with good teaching facilities. They provide good service. They attract good staff, good physicians, good nursing. They have nursing schools. They are strong on nutrition and life-style in terms of eating. They are opposed to drinking, smoking. They are strong on certain types of diet. It goes back to the Kellogg days, cereal and health foods. The Battle Creek sanatarium. All of which were based on the concept of healthful living. Strong, as you recall, in hydrotherapy, physical therapy. They still stress that. They have hospitals in other countries as well. It comes under their missionary system -- quite a few. They are pretty worldwide. I guess that's about as much as I know.

WEEKS:

That's interesting to hear.

The osteopaths. In Michigan, the osteopaths are fairly strong. This might not apply in every state, but do they have their own joint commission? Equivalent to a joint commission?

AFFELDT:

Yes. The headquarters is here in Chicago, just a few blocks down the street actually. They have their own standards and accreditation program. It is somewhat similar. I don't think it's nearly as extensive either in terms of the survey process or their standards, but there is a lot of similarity. Many of the osteopath hospitals ask for surveys by both. They like their own organization, like their own accreditation, but also they like to be part of the rest of the medical community, hospital community. So they ask for JCAH and have both accreditations. They do a good job as far as I know.

WEEKS:

At lunch we talked a bit about malpractice, or at least mentioned it. Has this any relationship to -- would your accreditation bear weight, let us say, in malpractice consideration, do you think?

AFFELDT:

I don't think it would. Not directly, it would not relate. The closest I think would be the fact that we have quality assurance requirements, monitoring requirements of physician performance and credentialing, privilege delineation. But I don't think that that would really have much influence on any particular case. It would have to stand on its own merits. We do know that our standards get called into question or are used by either the plaintiff or the defendant. Lawyers are calling us quite frequently for more

information on our standards or the survey. Questions are raised periodically in terms of the physician that's under suit. They would like to be able to get from us any information we have, which we will not release. We protect our confidentiality policy very strongly. We consider it the backbone of the voluntary approach to accreditation. But it is frequently sought.

WEEKS:

I have noticed for years your picture at the head of a column in Hospitals. Is that still continuing?

AFFELDT:

No. That was discontinued about a year ago.

WEEKS:

I had looked for it and hadn't seen it. It seemed to me that it hadn't been long before that.

AFFELDT:

Just about a year.

WEEKS:

You have written chapters in at least two or three books?

AFFELDT:

I don't remember exactly. Two, at least.

WEEKS:

You have a long bibliography of articles you have written.

AFFELDT:

Over the years, yes. Going back in my early stages, then in the polio days and rehabilitation days. Then, of course, since I've been at JCAH I have periodically put out some.

WEEKS:

Before we talk about the future, I might say that one of the questions that keeps coming up in these interviews is the pending oversupply of physicians. I understand that this is also true of the attorneys and the hospital administrators and many other professional people. Have you any feeling about how this may affect the quality of care or the type of care?

AFFELDT:

The oversupply, and I would agree that it does appear it's real. And we will probably see some increase over the next few years because of the lag time. I think that will have several effects. One, there will be more physicians who will get into a salaried or some relationship other than the independent private practice of medicine. We are seeing an increase of that already. I would project even more of that. Whether it's through the HMO process or the PPO process or just strict salaries in groups or in hospitals themselves.

I think that has an influence on the style of practice. I don't think that will impact quality so much as availability, accessibility and particularly, as we are into the disincentive side in terms of service versus the fee-for-service incentive side. We'll probably see fewer tests and fewer procedures done. But I don't consider that necessarily impacting quality.

WEEKS:

Is there any indication in your work of distribution among physician of their willingness to accept schedules of fees set up by insurance companies or Medicare or any other group that might now or in the future set up? Do you think physicians are willing to work under fee schedules if they are reasonably fair?

AFFELDT:

Oh, yes. I don't think physicians would object to fee scheduling. I think they would prefer fee schedules, in fact, to DRGs. I think they would like to see fee schedules established. It wouldn't surprise me but what we will see a revival of some form of the RVS system translating into a fee schedule more than we've seen for a long time. I think we will see that.

WEEKS:

It seems reasonable. In our own family, our son had serious surgery and I noticed that every one of the physicians who cared for him accepted the Blue Cross/Blue Shield fee schedule. It surprised me. I didn't expect that. I was under the impression that it wouldn't happen but it did.

AFFELDT:

They do not object to fee schedules. I think it's only a few of the more entrepreneurial motivated physicians. Particularly those who happen to get into a niche that is unique, where there isn't much competition and they can pretty well ask their own price that you see the exceptions. I think we hear about those exceptions more than the run of physicians.

WEEKS:

As to fees and malpractice. One day when I was looking at an article which was quoting insurance premiums for different specialties, particularly in the large urban areas, New York or Chicago. When I looked at a $100,000 a year premium for OB/GYN or neurosurgeon, I tried to divide that by the number of cases I imagined he might have in a year's time. It was amazing how much it's going to cost that poor patient for what the doctor has to add before he starts getting any economic return himself.

AFFELDT:

The surgeon could just as easily list his fee and then a surcharge for his insurance coverage because it's real, it's significant.

WEEKS:

It might impress the public. I don't think the public realizes. Some of the people who talk about it talk about the deep-pocket theory. This is some faceless, unknown entity that's paying this money and you are not really taking it away from anybody. They don't stop to think that they may be taking it away from themselves indirectly. To me it is one of our most serious problems that we have to face in some fair way. I don't think anybody should be above the guilt of doing something wrong or harming someone. But there has to be a fair way of considering this.

Have you had any experience with groups that have tried to self-insure or set up their own...

AFFELDT:

No. I know of these groups because hospitals have done it, the AMA has tried to do it, various professional societies. I don't think I have had any real personal experience with it. JCAH does not get into it.

WEEKS:

Insurance is not a factor?

AFFELDT:

No.

WEEKS:

We have spoken about the physicians and their changes that are taking place. In your work have you noticed any difference in the nurse's role over the years? What is the future of the nurse?

AFFELDT:

That's very controversial. We are certainly well aware that the overall organization of nursing, I am not speaking of the individual nurse now, but the organizational aspects of nursing, the American Nursing Association, for example, and some of the clinical specialties within nursing are certainly pushing hard to try to get deeper into the provision of health services. They want to get into the business of diagnosing, of prescribing. They want admitting privileges. They really would like to come closer to the practice of medicine than you usually think of in terms of nursing. Now it's certainly clear that nursing has skills, lots of skills, that are very important and valuable in the treatment of the patient. I think it's just a question of how independent can they and should they become in terms of prescribing, diagnosing, admitting, discharging, setting up therapeutic regimens. There is an awful lot that they can do and do do. I do not think it is wise for them to be pushing as hard as they are to take on greater clinical responsibilities. I don't think they have the training for it. I think they will leave a void in nursing that will have to be replaced by something else that will do what we used to think of nursing as doing.

WEEKS:

I didn't realize that they were going to that extent on clinical actions. I'm way back with their fight to get a baccalaureate degree as a requirement for an RN. This, in itself, is going to be difficult to bring about because women today, it seems, are getting into all the professions where a generation ago, nursing and teaching were two of the big outlets for women to express themselves. Now in medical schools sometimes 30% or 40% of the student admissions are women. Pharmacy, hospital administration -- I think

they could have 90% women if they could take them all. But they are thinking of can we place them when they have completed. It isn't a selfish motive on the part of schools. They have to think of what they can do with these graduates after they are through school. I am surprised to hear that some nurses, the nursing leaders let us say, are askng for all of these clinical privileges.

AFFELDT:

Yes, they are.

WEEKS:

It would seem to be too much.

AFFELDT:

Yes.

WEEKS:

What about such critical problems as AIDS in hospitals? Does this enter into your appraisal of the hospital?

AFFELDT:

Not so much in the appraisal as we did need to make a slight change in our standards. It's being made now. Namely, we have certain requirements for testing -- like for blood transfusions. We now have to modify the language slightly so that we are sure that there is proper testing for the antigen for the protection of the patient and donated blood. That is an example of a change. Otherwise, no. There are no changes required because the acute patient, the one that might be considered a danger to employees, staff, and other patients, are adequately protected under our current standards -- for isolation and handling of a communicable disease.

WEEKS:

Would you like to make some predictions on the future of health care?

AFFELDT:

Certainly I think the trend that we are seeing in terms of the corporatization of health care is real and, I believe, will continue. I am convinced that we'll find at least half of our providers of health care brought into the corporate fold or corporate structure in some means or another. I believe that that has significant impact on the role of the nurse, the physician, the administrator. Certainly we are seeing anxiety on the part of physicians in terms of their traditional independence. I don't know that that anxiety is warranted, but it is there. At a time when we need close cooperation between hospital administration and medical staffs, we are seeing an awful lot of antagonism and efforts to separate. Current efforts of the medical staff to consider themselves completely independent and wanting to be fully self-governing with no relationship to the hospital or the governing body is not a good trend, as I see it. I hope that does not occur, but I can't be sure that it won't.

WEEKS:

Do you have any comments you would like to add?

AFFELDT:

Yes. I will say that my eight to nine years experience at the JCAH has certainly convinced me that those who serve on our board and our member organizations are truly dedicated to finding ways to improve health care. Although there are critics who would say that it's the profession protecting itself more than it is the higher motivation of improving care, certainly that potential is there but my observations have been that when the tough decisions

are made and the chips are down that they have always ended up on the side of a decision in favor of improving care rather than self-motivation.

That has been a very heartwarming observation and experience on my part. To see that they truly do set aside their own personal prejudices and try to find a way to accommodate to the common good.

WEEKS:

I think that tribute to these people is certainly one that should be made. Too often people who contribute a great deal of their time and effort, at the expense of personal pleasures, aren't recognized. I'm sure this is good for that purpose.

Interview with John E. Affeldt

Chicago, Illinois

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The Voluntary Accreditation of Hospitals*

John E. Affeldt, MD

Former JCAH President

* A chapter of a forthcoming book. Used with permission of Jesus J. Pena.

Introduction

The voluntary accreditation program for hospitals has been aptly called American Surgery's noblest experiment[1] because of the salutary influence it has had on the progress of hospitals and patient care in this country. The central tenet of the program has always been that patients in hospitals should receive the best care that modern medicine has to offer.[2,3]

Since the program began in 1917, physicians, hospital administrators, and other health professionals have been striving to achieve this goal by monitoring and assessing conditions in the hospital environment, by setting and refining national standards designed to guide the provision of quality care to patients in that environment, by visiting hospitals to evaluate their compliance with the standards and to encourage improvement in patient care through education and consultation, and by awarding accreditation as recognition for substantial compliance with the standards.

This is the system developed by the American College of Surgeons (ACS) in establishing its Hospital Standardization Program at the beginning of this century, and this is the system being carried on today by the Joint Commission on Accreditation of Hospitals (JCAH), which was founded to continue and improve the College's program.

Origins of Hospital Accreditation

One day in the summer of 1910, two surgeons, Dr. Ernest Codman of Boston and Dr. Edward Martin of Philadelphia, were riding in a hansom through the English countryside. They were in England with other members of the Society of Clinical Surgery and had recently talked with members of the Royal College of Surgeons about the possibility of founding an American College of Surgeons.

in the hansom, Dr. Codman was explaining what he called his "End Result System of Hospital Organization" to Dr. Martin. He described it as "merely the common sense notion that every hospital should follow every patient it treats, long enough to determine whether or not the treatment has been successful, and then to inquire 'if not, why not?' with a view of preventing similar failures in the future."[4] As Dr. Codman tells it, Dr. Martin seized his idea "as the catalyst to crystallize the College idea. An American College would be a fine thing if it could be the instrument with which to introduce the End Result Idea into the hospitals; in other words to standardize them on the basis of service to the individual patient, as demonstrated by available records."[5] Thus were wed two ideas that were destined to be realized and have a positive and enduring influence on the quality of hospital care available to citizens of the United States.

To understand the potential that standardization had to revolutionize hospital care you must have some sense of what conditions were like in hospitals about this time. Many were merely inferior hotels for the poor and sick; in most others conditions were considerably less than adequate. In 1917, John Hornsby, MD, editor of The Modern Hospital, estimated that in 75% of the hospitals, patients were not examined on admission, no history was taken or diagnosis made, and no follow-up work was done to determine the results of treatment. As a result, medical records were useless. Furthermore, no attempt was made to determine a physician's competence to practice in a hospital, and because most medical staffs were not organized, responsibility for patient care could not be fixed.[6] Most hospitals also lacked clinical laboratory, x-ray, and other services necessary for conducting proper preoperative and postoperative studies of surgical patients.[7]

Although these conditions were discouraging, leading physicians in the country were optimistic about the future of medicine and hospital care. During the end of the nineteenth and the beginning of the twentieth century, more progress was made in technology and in the practice of medicine -- particularly the introduction of antiseptic surgery -- than ever before. These advances set the stage for the transition of hospitals from charitable institutions providing primarily custodial care to the poor and sick to institutions of medical science providing orderly care and treatment for the cure of acute illness and the restoration of health. Although physicians looked forward to the day when all acutely ill people would go to hospitals to receive the benefits of the latest advances in medical science, they also knew that some measure of hospital standardization had to be achieved to hasten the attainment of this objective.

It seems unlikely that anyone who was present at the Third Clinical Congress of Surgeons of North America on November 15, 1912, realized it was a milestone in the history of hospital care when Dr. Martin's idea received its first official expression in a resolution made by Dr. Allen Kanavel. This resolution, which was instigated by Dr. Martin and which followed a resolution that was to result in the establishment of the American College of Surgeons, stated in part:

> that some system of standardization of hospital equipment and hospital work should be developed, to the end that these (sic) institutions having the highest ideals may have proper recognition before the profession, and that those of inferior equipment and standards should be stimulated to raise the quality of their work. In this way patients will receive the best type of treatment, and the public will have some means of recognizing those institutions devoted to the highest ideals of medicine.[8]

After this resolution passed, Dr. Martin, who was President of the Congress, established a Committee on the Standardization of Hospitals and appointed Dr. Codman its chairman.

During the next few years, this committee and others made various efforts to find a way of initiating a national hospital standardization program, and although progress was made, success was not achieved. What was needed was a national organization that was willing to undertake the project and could support it.

With the founding of the American College of Surgeons in 1913, the ideas discussed by Codman and Martin in 1910 came closer to realization because one of the stated purposes of the College was to set standards for hospitals. Although the College initially had to address several projects vital to its survival, the need for hospital standards plagued the College and was one of its most pressing concerns. During the first three years of its existence, for example, the College had to reject 60% of the applicants for fellowship because the information in the medical records they submitted for consideration was insufficient to determine their surgical skills and technical ability.[9]

Development of the Voluntary Accreditation System

Finally, in 1916, with the help of a gift of $30,000 from the Carnegie Foundation, the ACS appointed state and, for Canada, provincial Committees on Standards to establish criteria for the program. The 300 members of these committees and 60 hospital superintendents met on October 19th and 20th, 1917, in Chicago. During this conference, participants described and analyzed conditions that existed in hospitals throughout the country and identified and discussed those conditions they believed should exist in hospitals for the

proper care of patients. The importance of the conference, as the proceedings, which were published in the first issue of volume three of the *Bulletin of the American College of Surgeons* in 1917, make clear, is that it presaged the first step in the voluntary accreditation system that is practiced today: the assessment of conditions in hospitals by knowledgeable health care professionals and the unanimous agreement that those problems that most directly affect patient care should be addressed first.

Although this conference culminated the preliminary work in establishing the program, it is important to realize that hundreds of physicians were working throughout the country to build enthusiasm and support for the program. Beginning in 1913, these physicians would meet at national conventions and other professional gatherings, discuss the prospect of hospital standardization, and then return to their state, county, and local medical societies to establish committees on hospital efficiency. These committees urged local hospitals to support a national hospital standardization program and encouraged them to use their facilities "efficiently and cooperatively and to standardize records in order to study end results."[10] In addition to this growing support for the program, a steadily increasing optimism was spreading that the program could succeed and succeed quickly. This optimism was heightened by the success that had recently been achieved in standardizing medical schools and in implementing hospital standardization in Pennsylvania and New Jersey.

This explains the great expectations the ACS had when it officially established the Hospital Standardization Program in December 1917, with the hope of approving 1,000 hospitals during the program's first year. The first field trials of hospital evaluations began in April 1918. Hospitals

participating in the trials were evaluated by ACS staff for compliance with a "Standard of Efficiency" that was published in the College's March 1918 Bulletin.

The results of these surveys were announced by John Bowman, Director of the College, at a conference on hospital standardization in New York on October 24, 1919. Bowman told the audience that 671 hospitals of 100 beds or more had been surveyed during the past 18 months and that in the first twelve of those months only 89 hospitals met the standards. However, 109 hospitals corrected deficiencies after their initial surveys and subsequently were approved. Although these results are not surprising when you consider hospital conditions in 1919, they were so embarrassing to the College that the names of the hospitals were burned at midnight in the furnace of the Waldorf Astoria Hotel to keep them from the press. Even though the results of the first surveys were disappointing, they did dramatize the need for national standards and for a national hospital accreditation program.

Consequently, at its December 1919 meeting, the Board of Regents of the College formally adopted the five official standards of the program (see Table I), which were collectively called the Minimum Standard because they defined those factors considered essential to the proper care of patients in any hospital. These standards, like Codman's "End Result Idea," are based on management principles that were developed during the industrial revolution and that were being applied in all types of institutions throughout the country. Codman's idea, for example, was simply a translation of the principle that the products of an industry are the measure of its quality. For hospitals, that product was the health of the patient. That these standards are as essential to the provision of quality care in hospitals today as they were in 1919 is no

small tribute to the genius of the men who contributed to their development.

With the adoption of the Minimum Standard, the accreditation process that continues today was set. The elements of this process include an analysis of conditions in a particular health care setting, in this case, hospitals; the development of reasonable standards that every hospital can meet and that address those issues most directly related to patient care; the survey of hospitals by health care professionals to assess compliance with these standards and to provide consultation and education on how to enhance compliance; and the subsequent efforts of hospitals to use this process to improve. It is important to note that the Minimum Standard as well as the accreditation process were intended to be a beginning from which further progress would be made as hospitals achieved the standards and reached for higher levels of excellence. This evolutionary nature of the voluntary accreditation process persists today.

Progress of the Program

Although the program did not have the immediate dramatic success envisioned by the ACS, the 109 hospitals that corrected deficiencies after their initial surveys and achieved accreditation proved that the system worked. The College persevered with the program and gradually its value became apparent. The quality of care provided in hospitals that participated in the program improved noticeably, and the medical records submitted to ACS by physicians in approved hospitals were acceptable. As the program gained prestige, more and more hospitals sought approval. The number of approved hospitals rose from 89 during the program's first year of operations to more than 3,000 in 1951.

By 1950, the size of the program had increased to such an extent that the

costs of operations were becoming prohibitive. In addition, the increasing sophistication of medical knowledge and technology, the rapid emergence of nonsurgical specialties after World War II, and the increasing complexity of hospitals dictated more timely standards review and revisions as well as an increasingly pervasive survey. These and other factors made it clear that if voluntary accreditation were to fully realize its potential, it needed the support of the entire medical and hospital field.

Consequently, in late 1950, the ACS invited representatives from the American College of Physicians, the American Hospital Association, and the American Medical Association to discuss the possibility of forming a joint hospital accreditation program. A committee, referred to as the Interim Committee, was established to work out a plan for the program. This committee met repeatedly between October 1950 and March 1951 to discuss the best way to expand and improve the program. The committee agreed that physicians and hospital administrators should continue to play an important role in hospital accreditation and that future accreditation surveys should encompass a wider range of hospital activities. The committee also agreed that the future success of voluntary accreditation would depend on the leadership of experienced surveyors whose encouraging attitude and constructive criticism would promote high-quality patient care services in hospitals. In early March of 1951, the committee recommended an organizational structure that it believed would provide for a more effective hospital accreditation program than had existed in the past.

The JCAH: Its Creation and Development

As a result of the work of the Interim Committee, the American College of Physicians, the American Hospital Association, the American Medical

Association, and the Canadian Medical Association joined with the American College of Surgeons on December 15, 1951, and formed the Joint Commission on Accreditation of Hospitals as an independent, nonprofit organization for voluntary accreditation. Preparations for initiating accreditation activities were completed by the end of 1952, and on December 6, 1952, ACS officially conveyed its Hospital Standardization Program to JCAH, which began offering accreditation to hospitals in January 1953.

The Canadian Medical Association withdrew from JCAH in 1959 to participate in its own program, the Canadian Council on Hospital Accreditation; and on December 17, 1979, the American Dental Association accepted an invitation to become the fifth member of JCAH.

The JCAH is directed by a 22-member Board of Commissioners (BOC). Twenty-one are appointed by the five corporate members and the other is a private citizen appointed by the BOC to provide a perspective on consumer concerns.

Since the JCAH began, it has preserved the principles of hospital accreditation set by the ACS Hospital Standardization Program. The JCAH places great value in the fact that the accreditation process is voluntary, that the standards reflect what health professionals agree is most conducive to the provision of quality care to patients, that the accreditation survey is a peer evaluation that achieves its most beneficial effects through education and consultation, and that information obtained in the survey process is held in confidence between JCAH and the hospital.

Under the direction of the Board of Commissioners, JCAH began a continuing effort to track and mirror the evolution of hospitals and other health care organizations. As these organizations evolved and proliferated,

JCAH worked with increasing numbers of national health care organizations, as well as with federal and state agencies that operated and regulated health care organization, to develop standards and survey procedures designed to enhance quality of care.

The first results of these efforts were published in 1953 in Standards for Hospital Accreditation, an update of the standards of the ACS Hospital Standardization Program. This manual included standards that addressed, for the first time, a hospital's governing body, bylaws, buildings, food preparation, dietary services, drug control, and nursing services. This manual was updated periodically until the BOC, in August 1966, voted to review and rewrite the standards so they would guide hospital staff in the provision of an optimal achievable, rather than a minimal essential level of care.

The Board decided to completely rewrite the standards for several reasons. Most hospitals in the country had achieved and were maintaining the minimum standards, and because of this, the standards no longer provided the significant inducement to improvement that the Board thought JCAH standards should provide. The Board also received a most convincing incentive to change from government. John Porterfield, then Director of JCAH, described this turn of events as follows:

> In the mid 1960s the Joint Commission found itself no longer the advanced and lonely leader. The Federal government wrote its conditions for participation in Medicare. State after state with new and refurbished licensing authority wrote regulatory codes, where there has been few or none before. They did have some premise on which to build and it is more than coincidence that the federal conditions and, more particularly, the state codes bore a strong family resemblance to the Joint Commission's accreditation standards. From advanced leader, the Joint Commission seemed almost overnight to be struggling to stay even in the vanguard of progress. And it was challenged, most seriously, as being no longer necessary because now everybody was beginning to do what

it had once done alone....[11]

With the emergence of government into the hospital regulatory arena as the definer of the minimum acceptable level of hospital care, it was both timely and appropriate for JCAH to reach higher. In making the leap from minimum to optimal standards, JCAH was also realizing the intentions of the founders of voluntary hospital accreditation. The Minimum Standards of the College was always considered a beginning from which the health professions would prompt hospitals to continuously strive for higher levels of quality in patient care. That the JCAH should assume the role of definer of the higher levels of hospital care was also more compatible with the aspirations of the health professions and the principles of voluntary accreditation.

The publication of the completely revised standards in the 1970 edition of the Accreditation Manual for Hospitals was a landmark in the history of voluntary accreditation. In little more than fifty years, the one-page set of standards that specified a minimal essential level of performance had developed into a 152-page manual of optimal achievable standards. As used to describe these standards, the term "optimal achievable" must not be understood to mean the ideal. It means the best that could be achieved at the time, given realistic, practical, legal and other concerns that must be incorporated into national standards to make them as effective as possible.[12] Nevertheless, the publication of these standards in 1970 was a clear indication of the progress hospitals had made since 1919 and of the positive impact of the support of the health care professions for voluntary accreditation.

Expansion of Voluntary Accreditation

In the early 1960s, concerns for the quality of care provided in other health care organizations, which were proliferating throughout the country,

led the JCAH and other national professional organizations to discuss the value of expanding the scope of JCAH accreditation services. The advantages of centralizing accreditation services at JCAH were considerable. The JCAH had experience, expertise, and other important resources, and it had national scope, acceptance, and prestige. Centralization would also give unity and strength to new accreditation efforts and would assure coordination of efforts and consistency among standards and approaches to accreditation. Given sufficient time, centralization also promised important reciprocal benefits, benefits that might one day lead to the development of a completely integrated approach to the accreditation of health care services, an approach that would effectively enhance the quality of those services regardless of the setting in which they were provided. These actual and potential benefits were potent arguments for centralization and cooperation.

Convinced by such considerations, the JCAH began to formally expand the scope of its accreditation activities in the mid 1960s by setting standards for excellence in other types of health care organizations and programs. Working with relevant national organizations, the JCAH developed and published standards for long term care facilities in 1965, for residential facilities serving the developmentally disabled in 1971, and for psychiatric facilities in 1972. In 1973, the JCAH published standards for community agencies serving the developmentally disabled, and in 1974, standards were published for psychiatric facilities serving children and adolescents. Standards for alcoholism programs were also published in 1974, and in 1975, the JCAH published standards for drug abuse treatment and rehabilitation programs. Standards for community mental health service delivery systems were published in 1976, for ambulatory health care programs in 1976, and for hospices in

1983.

In developing these standards as well as accreditation procedures for these various health care programs, what were then called Accreditation Councils and are now called Professional and Technical Advisory Committees (PTACs) were established to advise JCAH on specific standards and survey procedures. Each of these five committees is composed of approximately 15 individuals who are appointed as individuals or as representatives of national organizations concerned with the provision of quality health care. One committee advises JCAH on hospitals. A second offers advice on psychiatric, substance abuse, and mental health facilities and programs, as well as on services for developmentally disabled persons. The third committee advises JCAH on long term care, and the fourth PTAC advises JCAH on ambulatory health care. The fifth committee advises JCAH on hospice care. In addition, 15 experts on education and publications and 15 on health care safety serve on national committees that advise JCAH in these areas. All JCAH accreditation services are supported by research, education, publication, and marketing activities.

JCAH Standards Development Process

One of JCAH's most important functions is to set national standards that reflect the consensus of health professionals on the state of the art in the provision of quality care to patients in organized health care settings. To achieve consensus, JCAH works cooperatively with experts in the field and relevant national organizations, both public and private. Each draft of proposed standards undergoes extensive review: as many as 4,000 copies of a proposed standard have been sent to the field for comment.

After a proposed standard is approved for field review by relevant PTACs and by the JCAH's Standards and Survey Procedures Committee (S-SP) of the BOC, it is sent to national professional organization, including specialty groups; government organizations concerned with health care standards; all types of user facilities; numerous experts; and anyone who requests a copy for review. Each of these individuals and groups often further disseminates the standard for additional review and comment. All comments received by JCAH are studied, and the proposed standards are considered in light of such comments by JCAH staff, by relevant PTACs, by the S-SP Committee, and, finally, by the JCAH Board of Commissioners, which formally adopts all JCAH standards. When approved, new or revised standards are announced and published in _JCAH Perspectives_, the official JCAH newsletter, and in the appropriate accreditation manuals. New standards usually become effective for accreditation-decision purposes six months following publication (see Table 2).

Using the process outlined in Table 2, the JCAH is constantly updating its standards, and this process has accelerated to address the rapidly evolving state of the art and the powerful forces that are changing the structure and character of the health care delivery system. The most powerful of these forces are the national efforts being made by government and business to reduce their outlays for health care. To survive and maximize revenues, health care organizations are modifying their organizations internally by restructuring and diversifying, and externally by developing corporate relationships with other organizations. These changes have produced a concentration on the financial aspects of health care delivery that is so overwhelming as to threaten the quality of care that has been achieved in the

past.

While health care organization are providing an ever expanding range of services in nontraditional settings, the number and type of practitioners, particularly nonphysician groups, are growing and the scope of their practice is expanding. Because of these changes, hospitals and other health care facilities are being petitioned by an increasing number and broader array of practitioners to provide a greater range of services than they have in the past. These petitioners frequently point out that the law is supporting competition through the application of antitrust provisions to the health professions and through changes in state practice acts and licensure laws.

All these changes in the health care delivery system, including emerging ethical issues associated with the provision and termination of health care services and the challenges that will soon be presented by the rapidly increasing elderly population, have significant implications for the JCAH. In an era of increasingly limited resources, the JCAH must intensify its efforts to keep the voluntary accreditation process as efficient and effective as possible in enhancing quality of care. New standards must focus on essential indices of quality, and the costs involved in implementing proposed standards must be carefully weighed against the standards' potential effect on quality of care. Because of the very real possibility of fragmentation in the delivery of health care services, the JCAH is looking for ways to develop comparable standards for similar health care services provided in various settings and to assure continuity of care by encouraging the coordinated delivery of health care services throughout the system.

TABLE 2

Steps in Developing a Standard

Suggestions for new standards can come from any source. If the suggestion is reasonable and relates to the state of the art in the delivery of health care services or to the environment in which those services are provided, the standards development process is initiated. New standards are adopted only after extensive review by the field and only after national consensus is achieved.

1. Developments in health care create the need for new standards.

2. JCAH staff develop a draft of standard after reviewing the state of the art as contained in the literature and working with committees of experts in the area and related areas being considered.

3. Appropriate PTACs review standards and make recommendation to the S-SP Committee.

4. S-SP reviews proposed standards and PTAC recommendations.

5. If approved by S-SP, the proposed standard goes to field for review.

6. Field comments and opinions reported to PTACs.

7. Results of field review and PTAC recommendations reported to S-SP.

8. S-SP considers issues, makes appropriate changes, repeats steps five through eight as often as necessary to achieve consensus, and then submits standard to the Board of Commissioners for approval.

9. Board approves standard.

10. Standard is published in appropriate standards manual, and the field is usually given six months to learn and implement new standard.

The meeting of these challenges is not only vital to the continuing provision of qulaity health care services in the U.S., but also to the very survival of professionally-based voluntary accreditation efforts. The value and integrity of these efforts are being increasingly challenged as the public and its representatives in government, business, and law challenge the system to further reduce costs and maintain quality.

The JCAH has begun to address these issues in its standards by encouraging accredited facilities to make significant advances in quality assurance. JCAH's most recent quality assurance standards emphasize the systematic monitoring and evaluation of important aspects of patient care provided throughout health care organizations and the implementation of mechanisms designed to assure that health care professionals are competent to provide the patient care services the facility allows them to provide. Particular emphasis is being placed on the use of the results of quality assurance activities in the medical staff reappraisal and reappointment process.

The Evolution of Quality Assurance

Quality assurance activities have always been key requirements in the standards of voluntary accreditation. The very first national requirements calling for the review and evaluation of the quality of patient care provided in hospitals were contained in the *Minimum Standard*. This standard required the medical staff to review and analyze its clinical experience in the various departments of the hospital at regular intervals. The history of quality assurance in organized health care settings is essentially the story of the evolution of these seminal ideas.

When JCAH assumed responsibility for accreditation and began to track and reflect the development of health care organizations, quality assurance continued to be the key aspect of new standards. As JCAH developed standards covering the various departments and services in modern hospitals as well as the new types of health professionals practicing in them, it developed standards that paralleled the minimum standard in their concern for the qualifications and competence of these health professionals and for the review and evaluation of the quality of care they provided. During these years, however, the vast majority of efforts to review care were based on relatively informal and subjective review processes that relied on an individual practitioner's knowledge and experience in evaluating records and other documentation and in observing the performance of others.

While the JCAH was developing these standards, researchers in quality assurance were searching for ways to make the review and evaluation process formal and objective. These researchers developed various ways of doing this, and although the methods they developed varied in focus and approach, two elements were common to all of them. One was the implementation of systematic review procedures and the other was the use of objective, valid criteria for measuring the actual quality of care being provided.

In the early 1970s, JCAH began emphasizing medical audit, a methodology that incorporated these two elements, as a mechanism for reviewing quality of care and published what became known as the audit standard. As a result of these actions, retrospective outcome-oriented audits were conducted throughout the country. They were even incorporated into the requirements of Professional Standards Review Organizations (PSROs) that were legislated in 1972 in Public Law 92-603.

While JCAH was introducing medical audit requirements, it was also strengthening other significant quality assurance standards. During this period, for example, JCAH consolidated its standards on medical staff monitoring functions and defined them as surgical case, pharmacy and therapeutics, medical records, blood usage, and antibiotic usage review. JCAH also adopted broad, relatively uniform requirements calling for review and evaluation of the quality as well as the appropriateness of care provided by medical and support service departments. Standards that addressed such hospitalwide quality assurance functions as safety management, infection control, and utilization review were significantly strengthened during this period. Finally, JCAH adopted standards requiring consideration of relevant findings from quality assurance activities in reviewing credentials and delineating clinical privileges for medical staff members. These requirements were the first explicit references in JCAH standards to the important relationship between quality assurance and the delineation of medical staff privileges.

In spite of this range of quality assurance standards, by the mid 1970s most hospitals in the country were focusing almost all their quality assurance efforts on conducting formal audit studies. At the same time, several limitations of this focus became obvious. All too often, these audits were merely paper exercises conducted to complete the number of annual audits required by JCAH or PSROs. By focusing on the process of audit, hospitals failed to adequately address problems in patient care and clinical performance that were identified during the process. It was also apparent that the audit requirements were limiting both the amount and the scope of care being evaluated. The most serious problem with the audit standard, however, was

that it did not provide for linkages between audit and other quality assurance activities being conducted throughout the hospital, activities such as the delineation of clinical privileges. As a result, hospital quality assurance activities were fragmented, often duplicated each other, and generally failed to realize their full potential for effecting sustained improvement in the overall quality of patient care being provided by the hospital.

In a major effort to address these problems and enhance hospital quality assurance activities, JCAH developed and in 1979 introduced a new quality assurance standard and eliminated numerical audit requirements. The new standard asks hospitals to develop a hospitalwide quality assurance program that encompasses and integrates all quality assessment activities required by JCAH standards. The overall purpose of the program is to improve patient care through an ongoing systematic and objective process that focuses on important aspects of patient care for the purpose of identifying and correcting any problems or of taking identified opportunities to improve patient care.

There are several important characteristics of the program. One is that all clinical components of a hospital are involved, and all major aspects of care are monitored and evaluated. This monitoring and evaluation process involves the routine collection of information about important aspects of care provided throughout the hospital and the periodic evaluation of that information. The evaluation must be guided by explicitly stated criteria and should result in the identification of problems in patient care or of opportunities for improving patient care. These problems should be corrected and the opportunities to improve care taken. JCAH has purposely not specified the mechanism by which care should be monitored and evaluated in order to give hospitals flexibility to adapt the program to their particular needs and to

encourage innovation in the identification, assessment, and resolution of problems.

Another significant characteristic of the program is that it encourages the use of findings from quality assurance activities in the reappraisal process for medical staff membership and hospital privileges as well as in other processes hospitals use to measure and assess the competence of their professional staff.

Since the new quality assurance standard was adopted for hospitals in 1979, JCAH has adopted it for all other types of health care organizations it accredits. Through this standard, the JCAH intends to encourage health care organizations to integrate quality assurance mechanisms into the very fabric of their management systems. In this way, health care organizations will give the same formal and careful attention to quality of care issues that they give to planning, budgeting, and tracking the use and cost of facility resources.

Hospital Accreditation Surveys

The purpose of a JCAH accreditation survey is to provide health care organizations and programs with a thorough, objective evaluation of their facility's compliance with JCAH standards and to help facilities achieve higher levels of compliance through the education and consultation that JCAH surveyors provide during the survey.

A JCAH hospital accreditation survey generally takes from 1 to 4 days, depending on the size of the hospital. The survey team consists of a physician, nurse, hospital administrator, and medical technologist. The surveyors evaluate the hospital for compliance with the 24 chapters of standards in the *Accreditation Manual for Hospitals*. Each surveyor evaluates

areas relevant to his or her discipline or training as a surveyor.

Although the evaluation takes a considerable amount of time, JCAH surveyors also try to provide as much advice and consultation on the standards as possible. Special conferences are held during each survey for this specific purpose. These meetings include a nursing, governing body, and medical staff conference, as well as a survye summation conference during which JCAH surveyors review all major recommendations and key staff of the hospital are given an opportunity to respond. During each survey, the public is also given an opportunity to provide JCAH surveyors with any information they have concerning the hospital's performance.

After the completion of a survey, JCAH surveyors send their report and recommendations to JCAH headquarters in Chicago. JCAH professional staff analyze the report and recommendations and submit them to the JCAH Accreditation Committee for an accreditation decision.

Facilities are either accredited for three years or not at all. Accreditation for some facilities is made contingent upon the correction of deficiencies. The correction of such deficiencies is determined either through a written progress report that the facility is asked to send to the JCAH or through a focused on-site survey. Usually, this is a one-day visit by a JCAH surveyor.

Recognition

In the last 20 years, the value of the JCAH voluntary accreditation process has been recognized by the government, and in recent years, other nations have exhibited an increasing interest in the philosophy, policies, and procedures associated with the movement. The U.S. Congress first gave formal

recognition to JCAH in 1965 when it passed Public Law 89-97, the Medicare Act. Written into this law is a provision that hospitals accredited by JCAH are considered to be in compliance with the Medicare Conditions of Participation for Hospitals and, as a result, are eligible for participation in Medicare. Because a hospital that is certified for Medicare is also considered certified for Medicaid, hospitals accredited by JCAH are also eligible to participate in Medicaid. This means that hospitals that want to participate in either of these programs may pass either a certification inspection by a state agency or an accreditation survey by JCAH. Government oversight and responsibility for the program is maintained through a validation process. The Secretary of the Department of Health and Human Services validates JCAH survey findings either on a selective sample basis or when the Secretary receives a substantial complaint. The Secretary includes an evaluation of the JCAH accreditation process in the department's annual report to Congress on Medicare.

In addition to this recognition by the Federal government, 40 states and the District of Columbia, in one way or another, also recognize JCAH accreditation for hospital licensure purposes. in most of these states, licensure is not granted merely on the basis of accreditation, but on the basis of an acceptable review of JCAH findings by the state licensing agency. It should be noted that all 40 states have retained the enforcement powers that accompany responsibility for licensing hospitals. Even though a hospital may be considered licensable if it is accredited, the hospital must still comply with licensing laws and regulations and may have its license revoked if found in noncompliance with these laws and regulations as a result of a complaint investigation or a random sample evaluation. This recognition of JCAH accreditation by government is of considerable benefit to hospitals

because it reduces the number of surveys hospitals must undergo and consequently the significant expenses involved in staff time and facility resources in preparing for survey.

That the government's trust in voluntary accreditation was well placed was evident in a 1979 report of the U.S. General Accounting Office (GAO). The report, "The Medicare Hospital Certification System Needs Reform," described the results of a two-year study the GAO conducted to evaluate Medicare's hospital certification system as well as the JCAH's voluntary accreditation system. The report praised JCAH for the consistency, effectiveness, and economy of its standards-setting, surveyor-training, and accreditation-survey and decision-making processes.

Since JCAH began, voluntary hospital accreditation has spread to Canada and Australia, and since 1980, interest in the program has spread rapidly to other countries. In 1981, the Catalonia province of Spain implemented the first hospital accreditation program in Europe, and although the program is publicly administered, its standards and survey processes are based on the JCAH voluntary system. In addition, in the past 5 years, the JCAH cosponsored three international conferences concerned with hospital accreditation and quality assurance. As many as 70 health care leaders representing 28 countries have attended one or more of these conferences.

The history of voluntary hospital accreditation though brief in time, is significant in growth and accomplishments. Beginning with only the support of the American College of Surgeons, it has gained the support of the entire hospital and medical field, has spread to Canada, Australia, and Europe, and is being considered with increasing interest by other nations. The accomplishments of voluntary accreditation in improving conditions and

services in hospitals have been considerable, far-reaching, and lasting. The future is challenging, but, as in the past, meeting these challenges will afford proof of the merits of voluntarism and will constitute an important contribution to a free society.

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INDEX

A-Bomb 3

AIDS 64

American Association of Ambulatory Health Care 26

American College of Physicians 16,17,75

American College of Surgeons 11,12,68,75,91

- Committee on Standards 71
- founding 70,71
- Hospitals Standards Program 13,72,74,76
- regents 73
- "Standard of Efficiency" 73

American Dental Association 16,76

American Hospital Association 12,15,16,75

- JCAH commissioner 39
- JCAH program 21

American Medical Association 10,12,16,25

- House of Delegates 17-18
- JCAH program 21

American Psychological Association 20

Andrews University 1

Australia 91

Babcock, Kenneth B. 11-12

Battle Creek Sanitarium 57

Belgium 56

Berrien Springs, MI 1

Blue Cross 15

Blue Cross/ Blue Shield 61

Boston, MA 5,6,68

Bowman, John 73

Boyle, Joseph F. 10

Bugbee, George 12

Bulletin of the American College of Surgeons 72,73

Burcham Hills Home, East Lansing MI 28

Canada 71,91

Canadian Council on Hospital Accreditation 76

Canadian Medical Association 76

Carnegie Foundation 71

Chicago 61

Clark Field, Philippines 4

Codman, Ernest 11,68,69,71,73

College of American Pathologists 48

Commission on Professional and Hospital Activities 54

Committee on the Standardization of Hospitals 71

Communical disease unit 5

Corporatization of health care 65

Denmark

 polio epidemic 5-6

Detroit, MI

 race riots 2

Detroit General Hospital 2,3

Detroit Receiving Hospital 2,3

Dickinson, David 7

District of Columbia 90

DRGs 51,61

East Lansing, MI 28

Elderly

 financing care 29

 pension funds 29

End Result System of Hospital Organization 69,73

England 11,68

Europe 91

Fee for service 60

Fee schedule 60

Geneva, Switzerland 55

GI bill 14

Hahn, Jack 10

Harvard University 4,5,9

Health Care Financing Administration (HCFA) 51

 JCAH and deemed status 28

Health Maintenance Organization (HMO) 49,60
Home health care 31-32
Hornsby, John 69
Hospice 30-31
Hospital Corporation of America (HCA) 28
Hospital standardization 11,12,68,70
<u>Hospitals</u> 59
Hospitals
    ancillary services 69
    licensing 13
Howell, MI 32
Indiana 10
Interim committee 75
International Hospital Federation 55-56
Italy 56
Japan 3
Jesse, William 55
Joint Commission on Accreditation of Hospitals (JCAH) 9-18,55,68
    accreditation 23
    accreditation committee 19-20,38,40
    accreditation councils 80
    accreditation decision 45
    <u>Accreditation Manual for Hospitals</u> 78,88
    accreditation for Medicaid 25
    accreditation percentage 46
    accreditation program 21
    accreditation withdrawal 35
    Advisory Committee on Education and Publications 35-36
    Affeldt arrival 20
    ambulatory care 26
    ambulatory program 25
    ambulatory surgery program 26
    Board of Commissioners 39-40, 76
    bylaws 16
    Canada 16

Joint Commission on Accreditation of Hospitals (JCAH) continued
Committee on Standards and Survey Procedures 37-38,40
committee structure 18
commissioners 16
councils 20-29
creation and development 75-92
data bank 54
dental affiliation 16
differences in hospitals 26
executive committee 40
expansion of accreditation 78-79
extended care program 27
finance committee 40
financial support 16
hospice program 30,31
hospital accreditation program 25
hospital accreditation surveys 88-89
hospital credentials committee 47-48
hospitals surveyed 22
inhouse training 36
lawsuits 34
long-term care 26-27,31
manuals 16,32,36-37
mental field 20
Minimum Standards 78
multihospital systems 50-51
new standards 44-45
nonaccreditation appeal 33-34
nonaccreditation procedure 23-24
nursing homes 27
osteopathic accreditation 58
outside support 49
physician staff privileges 47
plant technology/safety committee 40
presurvey meetings 43
Professional Technical Advisory Committee 21,22,26,40,45

Joint Commission on Accreditation of Hospitals (JCAH) continued
provider deemed status 25
psychiatric program 24-25,26
public input 44
public member of commission 17
quality assurance 52-53
renal dialysis unit check 35
reorganization, 1979 19,21
risk management 45
social workers 20
staff analysis of survey report 44
standards change 45-46
standards development 80-81
Standards for Hospital Accreditation 77
Standards and Survey Procedure Committee 19-20,45
"Steps in Developing a Standard" 83
study committee before founding 15
summation conference 42-43
survey fee 40-41
survey parameters 46
survey review 24
survey team 41-42
surveyor 38-39
Veterans Administration hospital 22
voluntary accreditation 89-92
Kanavel, Allen 70
Kellogg (W.K.) Foundation 49,50,55
hospice program 30-31
Lansing, MI 1
Loma Linda University
dental school 57
medical school 1,2,57
Longmire, William 9,10
Los Angeles, CA 5,10
Los Angeles County, CA 6-7
Los Angeles County Department of Health Services 8,9

Los Angeles County Department of Hospitals 8,9
Los Angeles General Hospital 4
Louisiana 34
Lourilene steamship 3
MacEachern, Malcolm 11,12,13
McPherson Community Health Center 32
Malpractice 58
    insurance premium 61
Marseilles, France 3
Martin, Edward 11,68,69,70,71
Medicaid 13,20,90
    nursing home payments 29
Medical audit 85-87
Medical staff
    independence 65
Medicare 13,20,29,90
    accreditation 25,91
Medicare Condition of Participation for Hospitals 90
Michigan, University of 1,32
    respiratory center 7
"Minimum Standards for Hospitals" 11,73,74,84
Modern Hospital 69
Multi-institutional facilities 32
National Foundation for Infantile Paralysis 5,6
National League for Nursing 6
New York 61
Norby, Maurice 15
North Carolina 55
Nurses
    role 62-64
Nursing 50
Nursing homes
    costs and charges 29
Occupational therapy 7
Orlando, FL 55
Orthotics 7

Osteopaths
    standards and accreditation 58
Pacific area 3
Panama Canal 3,4
Pena, Jesus A. 67
Perspectives 36,81
Philadelphia 68
Philippines 4
Physical therapy 7
Physicians
    oversupply 60
    solo practice 15-16
Polio 4,5
Porterfield, John 9,10,12,77
Preferred Provider Organization (PPO) 60
Professional Review Organization (PRO) 25,51,52
Professional Standards Review Organization (PSRO) 85
Prosthetics 7
Psychologists 7
Public Law 89-97 90
Public Law 92-603 85
Puerto Rico 55
Quality assurance
    evolution 84-89
Quality Review Bulletin 36
Race riots 2
Rancho Los Amigos 6,8,9
Rehabilitation program 6
Rehabilitation techniques 7-8
Remagen, Germany 3
Respirator 6
Respiratory center 7
Retirement living 28-29
Rhine river 3
Right to die 56
Royal College of Surgeons 68

Sabin vaccine 7

Salk vaccine 7

Sanazaro, Paul 21

Self insurance 62

Seventh Day Adventists 1

    hospital system 56-57

Sheps, Cecil 55

Social Security 29

    amendments, 1965 25

Society of Clinical Surgery 68

Spain 56

    Catalonia Province 91

Sydney, Australia 55

Tank respirators 5

Third Clinical Congress of Surgeons of North America 70

Tracheotomy 5

U.S. Army 3

U.S. Congress 28,51,89-90

U.S. Department of Health and Human Services 90

U.S. General Accounting Office 91

University of California, Los Angeles

    Department of Surgery 9,10

Vertical integration 32

Visiting nurses 32

Vocational specialists 8

Voluntary accreditation 11,21,68,72

Voluntary hospital accreditation

    international 55

Waldorf Astoria Hotel 12,73

White Memorial Hospital 4

Whittenberger, James 5

<u>Who's Who</u> 8

Women in health professions 63-64

World War II 75

Ypsilanti, MI 29