

Future Trends in Evaluating Quality of Care

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Chicago, Illinois

*The 1988
Michael M. Davis Lecture*

CENTER FOR HEALTH
ADMINISTRATION STUDIES
GRADUATE SCHOOL OF BUSINESS
DIVISION OF BIOLOGICAL SCIENCES
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THE SPEAKER

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THE OCCASION

Dr. O'Leary delivered this lecture at the McCormick Center Hotel, Chicago, on May 13, 1988.

INTRODUCTION

It is a pleasure to be here to present the Michael M. Davis lecture during this symposium on quality of care. Just a few years ago, it would have been hard to imagine that anyone would have given this amount of time to quality of care. Even more encouraging, is that the tenor of the presentations suggest a practical orientation to this whole issue. Interestingly, the Davis Lecture, over the years, has seemed to return, again and again, to the quality of care issue. Having read some of those lectures, I note that we have moved now from a somewhat theoretical and, at times, obscure framework to a much more pragmatic view of the issue of quality of care evaluation. My remarks this afternoon are going to be of a pragmatic nature because it is not enough today to say that quality of care evaluation is good. It is, rather, something we must do. The questions are how do we do this, and when will we develop a real capability to do it effectively and with some real credibility?

I would like to walk you through a little bit of history and current environment, because I think that is important in understanding the pressures that we face and why we are where we are. The history of quality in health care is a bit peculiar. We have a long history in medicine of giving lip service to quality. I do not intend that as a pejorative comment in any sense. In fact, it simply is a reflection of a highly rational posture. Very simply, for years and years in medicine, we have known that there was quality in the system. Physicians knew it. Health care administrators knew it. Other purchasers of care knew it. If there was quality in the system, why in the world would you want to invest enormous energies and resources trying to prove what you already know? So we made essentially no investment in this process. If our world had not changed very significantly, if we had gone on with business as usual, we would probably be in exactly the same place today.

However, our world changed, and it has changed a great deal. It has been driven largely by a serious and increasing concern about health care costs. The 1980s have seen major restructuring of the health care delivery system and significant alteration in incentives, grouped around reimbursement. For the past several years, we have had incentives to provide less care as opposed to more care. The swirl of change befuddled many people

for a long time, before they figured out what was going on. It was really the consumer groups who picked up on this issue: apparently awakening one morning and saying to themselves, "Incentives to provide less care may have some quality of care implications." That point in time—now approximately three-and-a-half years ago, led to the explosion of quality of care as a public policy issue in Washington and, subsequently, across the country. This issue was red hot during the 1986 elections. There were people who ran for the House and the Senate on the quality of care issue, and they won—an occurrence that should not be lost upon us. The manner in which we in health care have been affected varies, but certainly a major result is that the quality of care public policy issue has created a goldfish bowl for medical practice and health care delivery. Indeed, today we find ourselves more publicly accountable than we have ever been before in our lives. I would like to suggest that this is not a passing fancy. It is a situation that we will probably live with for the balance of our professional lifetime. The reason for this, I think, is fairly understandable.

INCENTIVES FOR QUALITY MEASUREMENT

Those of you familiar with Washington know that the lifetime of an average public policy issue is about two or three years, if it is a really hot issue. But this issue will last longer than that. Why? Despite all the fairly major system changes that we are undertaking in the name of controlling health care costs, the fact is, today, that almost now to the end of this decade, health care costs are not under control at all, by anyone's wild stretch of the imagination. Back in Washington, and probably beyond it, the schemers are back at the drawing board. They have new ideas about containing health care costs, and these will make whatever has already occurred look pretty tame. These are fairly radical kinds of changes. Not all of these changes will eventually see reality but some of them will and, importantly, all of these contemplated changes will have major quality of care implications. That is why this issue is going to be with us for a long time, and that is why we in health care will enjoy some visibility whether we like it or not for a long time.

That is not the only dimension of quality in this current area. We continue to be in the middle of the 1980's professional liability crisis. It is a much stickier liability crisis than the one we encountered in the 1970s. This crisis is characterized by an increasing volume of lawsuits and very significant, if not astounding, increases in the size of awards. Almost the only realistic way of beating back this crisis has been through tort reform. Because the legal nature of tort reform is peculiar, it is not a problem that can be readily attacked at the federal level. So we are looking at state-based solutions, which means that we will have at least 50 different solutions to the problem. That is liable to lead to a potpourri of inadequate solutions.

Indeed, if you look across this country in the past few years, that is exactly what is happening. We have such a potpourri that it is hard to make sense out of what has gone on, but if you look more closely now, you will see the evolution of a fairly steady trend. In about ten or twelve states—that number is growing—the following scenario has played out. Physicians and hospitals, either separately or collectively have approached the state legislatures with a request for tort reform, only to find to their surprise that there are some pretty receptive ears there. The legislature, realizing that liability is a broader problem than in just health care, has said, in essence, to the professional community, "We'll give you three or four of your favorite tort reform measures—pick them off your wish list—and by the way, you physicians and hospitals are doing a reasonably poor job of professional self-regulation, you really wouldn't know risk management if it came up and bit you on the leg. We, the friendly state legislature, are going to help you."

The state legislatures have been of various degrees of "help." In states like New York, Massachusetts, Maryland, and my very favorite one, Florida, the legislation has reached extremes. In Florida, for instance, there is now detailed—and has been for a couple of years—legislation addressing risk management and establishing fairly detailed requirements for hospitals in this arena. Not only must hospitals have these programs in place, they also must be overseen and run by certified risk managers of which there are none in the country. In fact, there are not very many certifying programs, except in Florida, where there are now two certi-

fyng programs. We have reached ridiculous extremes.

What does risk management have to do with this whole issue? Risk management, in this context, is not the broad loss control function that we commonly have known throughout hospitals. Rather, in the lexicon of a state legislator, risk management is a much more narrowly-defined term. It is all revolving around patient safety and patient risk issues. We can get into our little semantic debates, but, in my world, when we talk about patient safety and patient risk issues we use the term quality assurance. What you really have now in about a dozen states is detailed quality assurance legislation. That is something new and different.

And, finally, the last phase of quality I will comment on briefly is competition. They said competition would never come to health care, and of course, it is now here. Like any new competitive market, this one has been driven, at least at the outset, largely by price. The price differences I do not believe will be sufficient alone to sustain the separation of the market. Pretty soon, everybody gets to know everybody else's price, and at least the band of prices gets narrower and narrower. Pretty soon, people will start looking for something substantive to separate the market. And that substantive something by almost everybody's reckoning now is going to be quality of care. I hasten to add that quality of care does not mean your own individual proclamations of excellence, which we are given to, nor does it mean all the glossy advertisements that we are given also to invest in these days. Rather, in this context, we are talking about the ability of health care providers to prove or to demonstrate—not only to their own satisfaction but the satisfaction of others—that they really are providing high quality care. Therein really lies our challenge for the future.

If you step back from these three faces of quality, with public accountability, professional liability crisis, or just some good old American competition, what should be very striking is that these are self-interest issues for providers of health care. That is very different from what it was ten years ago. Then the reason you undertook quality assurance activities was out of professional altruism, or because somebody such as the Joint Commission or the government told you that you had to do it. In 1988, it is fair to say that the Joint Commission is essentially moot. We will go prop our

feet up and take a siesta. Health care providers are still faced with the need to deal with these issues. I am a great believer in professional altruism. I think it is wonderful, but I am also very pragmatic, and in the end, I believe, as I am sure you would agree, self-interest is what makes Johnny run. And Johnny will have to run or at least walk briskly to another place. That other place, in a sense, is a process: a process of self-examination. A re-examination of who we, in health care, really are—a hard look at our values, our attitudes and our behaviors. And through self-examination, we will emerge into a different professional environment, a different culture. An environment in which we instinctively have a heightened sensitivity to all the things that we do for patients—an environment in which we place value upon identifying problems. We identify problems, not for the purpose of punishing individual practitioners or organizations, but for the purpose of identifying problems to solve.

There are problems in the delivery of health care. Health care today is enormously complex, particularly that care delivered in health care organizations and especially hospitals. All of that complex care is delivered by human beings who make mistakes. We know that there are problems; we just do not know how widespread they are, exactly what they are and how serious those problems are. If we develop a culture where we instinctively desire to find those problems for the purpose of fixing them, and we indeed do fix those problems, the quality of care will improve. That's the environment we are being asked to create for ourselves.

While we are examining our professional culture, we need to bear in mind that back in Washington and elsewhere, now across the country, quality of care evaluation is a hot issue. There are strident and urgent calls for the development of sophisticated methods for measuring and monitoring quality of care. Those calls are coming largely from consumer groups and from purchasers, principally the government. The concerns on the part of purchasers have to do with the fact that the purchasers are basically those responsible for altering the system and creating what some would call perverse incentives. Now, they are worrying that they really may have had an adverse effect on quality care, and that they are going to get blamed for this in some fashion. In fact, they already do get blamed, even in the absence of any data. So, there is a call for method-

ology on the part of consumer groups; this is the most natural issue in the whole world. This is the high ground. This is apple pie, mother and the flag all rolled into one, and a consumer group will grab onto that and shake it. Don't necessarily believe that the consumer groups consult their constituency. It is a little hard to believe that AARP, for instance, would have time to chat individually with each of its 29 million members. You will notice, as you move out in casual conversations at cocktail parties—as I do occasionally—and engage people in a discussion about the quality of care crisis, they are not overly concerned. The demand is coming from a more narrow base. However, it is so strident and heated that eventually this issue will spill over in a significant fashion into the public arena.

Now, recognizing the force of the concern, the question really becomes, how well prepared are we to meet the demand? Unfortunately, we are not terribly well prepared. Any meaningful investigation up until this time would lead you to the conclusion that our methods today are fairly crude. In fact, crude is a charitable description. Our problem is, in fact, even deeper than that. We are being asked to develop methods to measure and monitor the quality of care, as if we even knew what that is. But we don't really. Quality in health care has many dimensions, many facets, and is also a moving target changing from day to day. There is no broad-based, comprehensive definition of quality. You can get any two health care professionals together and assign them the task of developing a definition, and the likelihood is that they will destroy each other, arguing over this issue. As you add to the debate consumer groups, insurers, business and government, you have compounded the problem by adding ignorance to confusion.

This is not a minor, academic exercise that we are talking about; neither is it an impossible task to complete. We will have a definition of quality that is broad-based, comprehensive and widely accepted. The difficulty is that we needed that definition yesterday, while methods development has far to go. The train has left the station. And, the limited methods are going to end up doing what they inevitably would. They are going to end up addressing only certain dimensions of quality, but not in a broad context of a wider understanding. It

is a given, I think, that as a definition evolves and the methods evolve, we will have to come back and fix the methods at some future point in time.

CURRENT METHODS OF EVALUATION

Now, we have not been totally remiss in our work. There are quality of care evaluation methods in place. Very simply, we have three methods in place. One is a set of methods that is derived from the old PSRO program: it is called Case Based Review. You sit down and look at medical records, absent of any explicit standards. It is just the doctor looking at the record and making a judgment as to whether the care rendered was outstanding, pretty good or maybe not so good. And your interrater reliability, in fact, is pretty good too. A crude method but certainly a valid kind of method as far as it goes.

The problem in today's world is that this method has been taken beyond its base of validity. It is now used principally by the PROs, who have been assigned federal responsibility for quality of care review, at least for Medicare patients. The PROs are, in essence, being asked to use this methodology with the addition of a few bells and whistles for generic screening. They are asked to use this methodology to determine who is a pretty good provider and who is—more importantly—not a good provider or a dangerous kind of provider.

This is done on a basis of finding one, two, or, maybe at most, three cases of substandard care of an individual practitioner and declaring that practitioner inept. That is statistically dangerous and not valid. It is dangerous to do that, because the PRO, in fact, has no idea as to what the denominator of the equation is. How many total patients has this doctor seen or managed? They don't even have a pretty good idea as to how many Medicare patients he has seen or managed. And the numerator of the equation is kind of pathetic. This may be a bad doctor, but the basis of proving that is invalid. He also may be a pretty good doctor when all is said and done. What is going on here, I think, illustrates the frustrations that people have. The need to determine who is good, average or poor is so strong that a method will be taken beyond its validity. This strategy is supposed to be better than nothing at all. I'm not sure

that it's true. Nothing at all may be better.

The other end of the spectrum of our methodology is something the Joint Commission has done for years. We call it structure and function review, but, in essence, it is based upon the development of standards. While PSROs and PROs, in essence, had no standards at all, the case-based review really doesn't require that. The Joint Commission writes standards almost for a hobby. Our accreditation manual for hospitals is 301 pages. We will send a survey team into a hospital and evaluate the hospital against that set of standards. Once we have done that, we have succeeded in determining the capacity or the capability of that organization to provide high quality care. That is a very important thing to know. At the same time, in all candor, and particularly in this era, that is not enough. We have two big questions beyond capacity. The first is, when the patient came into the hospital, did the hospital do all the wonderful things it was capable of doing? And two, when it did those things, what happened to the patient? What was the outcome of care? We are not currently addressing those questions in any meaningful fashion. Those questions more than anything else are driving us to develop a whole new methodology for review.

Into this void of the older methods, case-based review and structure and function review, now comes a new player, called statistical profiling. Statistical profiling is really a numbers game—a legal numbers game, unfortunately. The prototype for this is hospital mortality data released by the Health Care Financing Administration last December, as your pre-Christmas present. However, it is not an isolated activity. In fact, what HCFA has done so far is fairly small scale compared to what is contemplated for 1988 and 1989 and some of the odd years. We see a lot of the same mentality and drive for statistical profiling in the private sector as well. We have seen this activity in states as they look to expand their state data pools. Pennsylvania is now collecting quality of care data, analyzing it, and they are going to publish this data. Colorado and Iowa are just a couple of steps behind Pennsylvania. This will spread like wildfire across the country. The mentality that is driving this is as follows: One, we live in an information-intensive age. Two, we believe in numbers. We think you can look at numbers and get a lot of information out of them. And three, there is a general realization, at

least among sophisticated people in the field, that the development of really good quality of care evaluation is going to take some time. Wouldn't it be nice if you could just do statistical profiles and that would be the silver bullet to answer the problem? In fact, by late Friday afternoon of any given week, I wish that it were the silver bullet to answer the problem. But it's not.

It's not because of an ever-present confounding variable, called the patient. Patients are constantly getting in the way of our methods. The patients vary a great deal from each other. We don't even have a system that remotely takes into account a significant proportion of those variables. When you are looking at health care, you cannot look at numbers and read quality.

Each of these three methodological approaches have their very strong champions and advocates in this current environment. Make no mistake about that. The Joint Commission is moving forward and hard with this initiative, but there are people working on statistical profiling and case-based review with as much vigor. In fact, in Washington, it is very much in doubt as to which methodology will prevail. It's hard to believe that all three can retain currency over time. Probably the methodology that best incorporates the critical elements of the other two methodologies will be the one to prevail. We have a lot of hope at the Joint Commission that our methodology will prevail, because, at least on the surface now, it looks like we have the best crack at that.

CURRENT CONCERNS OF THE JOINT COMMISSION

Let me tell you a little bit about some of the work the Joint Commission has been doing over the past couple of years. We entered into a set of activities, now known as the agenda for change, following a major Board of Commissioners Retreat in the fall of 1985. The agenda for change initiatives are largely developmental in nature and are thought of as centerpieces for the three following elements.

First of all, we believe that it is absolutely feasible to identify clinical indicators of care. Clinical indicators—nothing terribly profound—are simply a dimension of care that is discrete and measurable and,

therefore, produces data. As you monitor that data, you are pretty close to the pulse of the quality of whatever that dimension of care is. You can develop clinical indicators for any one of 35 or 40 different clinical disciplines. You can develop clinical indicators relative to a variety of procedures that are done on patients. Or you can do it generically and develop clinical indicators across an organized health care setting, like a hospital, an HMO or a long-term care facility. Basically, these are data generators. They are measures of clinical performance. As you gather, simulate and analyze this data, you gain the ability to do trend analyses relative to the clinical performance. Never before have we had that capability. We will also have the capacity to identify "funny numbers" or outliers. The purpose of following trend analysis or finding outliers is to find potential problems. It comes to a focused kind of problem identification process.

The second developmental piece has to do with the development of the organization and management indicators. No one gets very excited about this piece—at least up to the present time. In fact, examination of organization and management is every bit as important as looking at clinical care. In health care, the organization is not an inert element. The organization is an alive kind of place. And doctor/patient relationships do not occur in a vacuum. Complex care, in fact, occurs in a hospital. Anybody who has practiced medicine will tell you that the organization matters. There are days when the organization actually facilitates or helps the physician provide high quality care to patients. But there are other days when the organization hinders the delivery of high quality care. In fact, organizations are fairly clever at doing this. So, what we are really saying is that there is some sort of dynamic between the organization on the one hand and that doctor/patient relationship on the other. I will not tell you that we know or have crystallized this dynamic, but we know it exists, and we know it's important, and we absolutely believe it can be characterized—and eventually measured and monitored. What we are really saying is that, although we have our 301 pages of standards, we never looked carefully at management within an organization. We can no longer walk away from that issue. Management and health care organizations make a lot of difference. It is a quality issue, we all know and understand that,

and if we are not willing to look at management, we really ought to get out of the business.

The third developmental piece is one that, all things being considered, we'd rather not be in at all. It has to do with risk adjustment. You may know it by its narrower terminology as severity of illness adjustment. In very simple terms it says, the patient is a variable. Some patients come in very sick. You do everything imaginable in the best possible way for that patient, and the patient dies. Why did this patient die? Because everyone dies at some point, no matter what you do. On the other hand, you may have a patient who comes in fairly healthy, and you do various things to the patient, and now this patient becomes very sick. So you have had some negative impact on this patient. The point is that you need to have some adjustment to take the patient into account. Particularly, when you are looking at clinical performance data, that kind of modification becomes extremely important.

An even more important purpose of risk adjustment today is to compare one hospital with another, and one doctor with another. Without valid risk adjustment there is no basis for comparison. Many audiences I speak to in health care—physicians and hospital administrators—say, "It's okay, we're not terribly interested in being compared. What is all the excitement about?" The excitement is coming from other sectors, from consumer groups and from purchasers, who are urgently interested in these kinds of comparisons. They are so urgently interested that they have not threatened but rather promised to develop their own formula and methodologies, which will generally be lousy. And they will use these lousy methods to collect lousy data, upon which they will base lousy decisions. That to me, and I think to others, is frightening and has raised the ante for the need for investment in this area.

We are already doing some work at the Joint Commission. One thing that becomes increasingly apparent is that despite a lot of antecedent research there probably isn't a single magic formula. In the end, probably the very best you're going to be able to do is build a formula or identify co-variables around closely-related diseases or closely-related procedures. We will identify co-variables for one set of diseases; when we go to the next set of diseases, the important co-variables will change. When we go to the next set, there will be still

additional and different co-variates. We are building into our clinical indicator development process the association of co-variates with clinical indicators. We will be able to test some of these hypotheses and develop risk formula adjustments parallel with the indicator development.

Let me just describe to you how this system functions operationally. What we are really talking about is a development of data-driven quality assurance systems. We are taking the old Joint Commission stamped quality assurance standards, and we're marrying them with data. Now the old Joint Commission standards—old in the sense that they have been around since 1979—are not complicated. The standards manual makes them complicated, but when you translate them into English, they are pretty straight-forward. They say fairly simply that you must have a systematic process for identifying problems. When you find those problems, whatever they are, you should analyze them, and you should undertake peer review if that's appropriate. Then, you should take an action to make the problem go away, and you monitor the problem and make sure the action worked. That is just common sense.

The only problem is it hasn't worked. It hasn't worked, I think, for some fairly simple reasons. First of all, it hasn't worked because the system lacked focus. When all is said and done, we in health care are no different from anyone else. If we are given half a chance not to look at the sensitive areas, where the action really is, then we won't. We will count stars, watch the grass grow and do anything that is irrelevant. We came out of an era where we could get away with that. We are not going to be able to get away with that tomorrow.

There is another reason why we have had a problem. Although you can listen to me explain what quality assurance is the way I understand it, or read about it and say, that is really pretty simple, try to take that very simple construct and make it operational in a hospital. It is very hard to do. We are still looking for one four-star hospital that has really done it right. If you are out there, please see me after the program. We would like to visit you, and we won't charge you anything.

This problem set changes radically when you marry it with data. Imagine for a minute that the Joint Commission has been successful in developing a full menu of clinical indicators: kidney disease, obstetrics, general

surgery, emergency medicine, etc. You, as a hospital, should now ask yourselves, Who are we, clinically? That can be determined through three straight-forward questions: (1) What is it that we do here in high volume? What do we do a lot of? (2) What do we do here that is kind of dangerous to patients? Perfectly good procedures; helps out a lot of patients, but sometimes patients get into trouble. It is inherent in the procedure. And (3) What do we do here that we've had trouble with before? What is problem prone around here? If you look at your high-volume, high-risk, problem-prone areas, you are on your way to doing a lot. And if you base a functional quality assurance program around those three questions, I think you are in business with a pretty good quality assurance program.

Now, take your high-volume, high-risk and problem-prone areas over to your indicator menu and pull off the relevant clinical indicators. If you deliver 4,000 babies a year, for example, you better take those obstetric indicators. Start monitoring those data elements, and you are in business.

It is very important to emphasize here, in this system, that the numbers are not an end in themselves. They are a means to an end. They are a mechanism for problem identification through trend analysis or through outlier identification. What the numbers are saying is that here may be a problem, but in the end you have to look behind the numbers to determine whether there really is one, what is the problem, how serious is it and, most importantly, what are you going to do about it. The end product of this system is called problem analysis, and timely and demonstrable action. That really is your quality assurance system. It carries you beyond assessment.

INDICATOR DEVELOPMENT

In our indicator development work, we have had an interesting experience. I will abbreviate my comments here, but note that we have been in this business for a year. We have done indicator development work for obstetrics care, anesthesia care and for hospital-wide care. We found, first of all, that when we brought experts together from around the country, they understood what we were saying. We didn't know for sure that when we said clinical indicators they would

understand. They did. Our problem is that there are too many indicators, and it is difficult building some discipline into these groups to focus on the things that are really important. What is going to get you the greatest yield in useful data? That is the question. These groups have done a good job. We started with a total load in the first three task forces of more than 250 indicators. Those were eventually boiled down to 49 indicators that are now out in the field in 17 pilot hospitals to answer a large number of important technical questions.

One of the interesting things that surfaced out of this whole experience was when the task forces had boiled their indicators down to the final list, 13 in anesthesia care, 22 in obstetrics and 14 for hospital-wide services, we asked the task forces, "You have given us a bunch of indicators from which we will derive data and numbers. Would you mind sharing with us the significance of the numbers? What should we worry about when we see a given number? Let's take gall bladder mortality. Do we get worried when the mortality rate is 1, 4 or 9 percent, or what?" The task force rejoinder was, "That is a very good question but we don't know the answer. Why don't you go to the clinical literature?" And so, we did. We took our 49 indicators to the clinical literature and combed through it. When we had completed our review of the clinical literature, we found nothing. There is no clinical literature on this. You may well wonder why what we've been writing about this past 100 years, is only marginally related to patient care—certainly to bread and butter care. In retrospect, we knew this. We knew there had not been big, database studies of bread and butter care. I can go to the literature and look for this very same data relative to heart transplants, and it's there. However, breast lumps, hernias, hangnails, broken ankles, sore throats, sorry, that's not there. In fact, if you had done the research and submitted a paper to the *Journal of Medical Association* or the *New England Journal of Medicine*, it probably would have been turned down. The base that we are starting from in this new science of quality assurance—because that is where we are headed—is zero.

We desperately need a rigorous science; however, even under the most fast-track of conditions, it will probably take a decade or a decade-and-a-half to build. We are quite mindful of the fact that 10 or 15 years of

building a science, laid against these strident concerns expressed by government and consumer groups, doesn't fit very well. At least in our developmental work, whether we like it or not, we are going to have to move these indicators out for practical application as soon as we can. In the pragmatic world that we live in, we expect that once the pilot testing is completed this year and some further refinements have taken place, you are going to see clinical indicators in use—that is to say, they count—probably in the last half of 1989. That is not fairly far down the stream. Indeed, if we continue to develop new groups of indicators over time, they will keep coming forward in waves for application, and those waves will probably keep coming all the way up to the turn of the century and, quite possibly, beyond that point in time. The urgency of the situation has also told us that it is time to move into some big areas that have impact. Visibility will make a difference. So, the indicator development work we are moving into in 1988 will cover areas like cardiovascular care, trauma care, cancer care, long-term care, mental health, to name most of them. That is where we are in the indicator development area.

CONCLUSION

Let me wrap up by telling you very briefly about the organization and management indicator initiative, because in a sense that has been more fascinating in its evolution. We, after a lot of difficult, hard work and also arm-twisting and consensus-building, secured from our expert task force a set of principles now used to characterize the excellent health care organization. This is a very unusual document in my view; one that I would not have in any fashion associated with the Joint Commission. It is so different. This set of principles is now moving through the approval process, and it will become public some time in the summer of 1988.

I won't go through the principles, but I will share with you the lead principle. I will paraphrase it. Basically, it says that quality is explicitly part of the organization mission. I notice that no one fell off his chair in listening to that. It is a little more profound than it sounds. If you go to your typical hospital and a quality problem has been encountered, I will guarantee you that it has been sent to the quality assurance office, which is

probably in the basement. There, it will disappear. This principle says something different. This principle says that quality is everybody's business in the hospital. Quality is part of the fabric of the organization. That maybe if everything is going well, you don't need a quality assurance office. This theme plays itself out through these 14 principles. I think it sets a very different cast and tone to this. What do you use principles for? Outside the inner warmth and glow that they give you, the practical applications are that they will serve as a basis for indicator development. Things that you can measure. We started this whole process by saying that measuring management organization performance is too touchy; you will never find anything. That is nonsense. There are things that are very measurable that have a lot to do with quality within an organization. Our task force is moving fairly briskly downstream, having some very good arguments about what is important and not. We will have indicators to pilot-test by the end of this year, as well.

The other thing you use principles for is as a template for recasting the standards manual. That is a terribly important exercise. Our standards manual, which I have alluded to, is 301 pages—corpulent, bordering on disgusting. You can't even sort out the standards in this manual. This is a manual that was basically developed from the traditional organization chart. There is a chapter for each box on the organization chart. There is a chapter for the peer governing body. There is a chapter for the medical staff, etc. That's not what the world will be about tomorrow. The question tomorrow is, "Does this organization get its jobs done?" Are clinical outcomes important? Yes. Is management outcome important? You bet it is. And, that will bring you to a function-orientated manual. It is a very different kind of manual.

The first stone has already been cast. We are now moving to begin the drafting of a chapter called hospital leadership and another field of study will be something else—managed care organization leadership. There is a chapter that talks about the governing body, management and the medical staff. And, how they integrate and/or coordinate their functions to get jobs done. Almost all of which says, none can get done all by itself. It will talk about communication, coordination, conflict resolution and all the things that grease a complex piece

of machinery. That chapter reaches maturity, hopefully, not very far downstream. The three existing chapters, separate ones on governing body, medical staff and management and administration, will disappear. That is what I mean by function.

The other problem we have with the current manual is that it contains a lot of irrelevant material. Very simply this manual is replete with protectionism—there is always a downside when the professions develop standards. They seem to look after themselves first and quality second. That was a nice game for as long as it lasted, but we can't afford it anymore. We can probably cut the new standards manual in half, or maybe even a little more than that, simply by taking out those protectionistic standards that don't have anything demonstrable to do with quality at all. The fact of the matter is that this manual must be patient-centered. For that matter, anything the government or anyone else writes has to be free of the kinds of perversions that enter our developmental systems. It is the patient who ultimately counts.

What I have tried to do is give you a little snapshot of our methods development work, thus far. There are other efforts going on, in addition to ours. The Joint Commission is certainly not the only organization invested in this kind of activity, I want to comment that when all is said and done methods are only part of the story. If all we do is develop methods, and we pay no attention to our professional culture, if we are unwilling to undergo self-examination, to take a look at our values, our attitudes and our behaviors, there will be no fertile climate in which these methods will be able to thrive. These are high stakes now. Quality of care matters. When you are in a goldfish bowl, you can't afford to make big mistakes. Professional liability suits are in seven or eight figures today. There is competition based on quality of care: somebody is going to get patients and somebody is not. These are strong incentives to change. I think that professional culture change has everything to do with whether we're really going to make it tomorrow. It will have a great deal to do with whether organized medicine and organized health care can continue to maintain the professional influence on behalf of the patients that we have held to for so many decades. I, for one, believe that we must do that, and we cannot take a passive role. This is one of those times

when we in the profession, who have been so reactionary over the years, must take a leadership role. The time is now.