



# association of american medical colleges

## MEETING SCHEDULE COUNCIL OF TEACHING HOSPITALS ADMINISTRATIVE BOARD

September 7-8, 1988  
Washington Hilton Hotel  
Washington, DC

### WEDNESDAY, September 7, 1988

- |       |   |
|-------|---|
| 6:00p | JOINT ADMINISTRATIVE BOARDS SESSION<br>with Guest Speaker (TBA)<br>Conservatory Room                            |
| 7:00p | COTH ADMINISTRATIVE BOARD RECEPTION/DINNER<br>with Representatives of the<br>Nursing Tri-Council<br>Caucus Room |

### THURSDAY, September 8, 1988

- |        |   |
|--------|---|
| 8:00a  | COTH ADMINISTRATIVE BOARD MEETING<br>Caucus Room          |
| 12:30p | JOINT ADMINISTRATIVE BOARDS LUNCHEON<br>Conservatory Room |
| 1:30p  | EXECUTIVE COUNCIL BUSINESS MEETING<br>Jefferson West Room |

## A G E N D A

### COUNCIL OF TEACHING HOSPITALS ADMINISTRATIVE BOARD

WASHINGTON HILTON HOTEL

Caucus Room

September 8, 1988

8:00a-12:30p

- |       |  |                                       |
|-------|--|---------------------------------------|
| I.    | CALL TO ORDER  |                                       |
| II.   | CHAIRMAN'S REPORT  | Dr. Buchanan                          |
| III.  | CONSIDERATION OF THE MINUTES   | Page 1                                |
| IV.   | COTH AGENDA ITEMS  |                                       |
|       | A. NURSING SHORTAGE FOLLOWUP   | Discussion                            |
| V.    | B. JCAHO MEETING ON ACCREDITATION OF ACADEMIC MEDICAL CENTERS (Memorandum)                     | Page 14                               |
|       | C. SELECTION OF 1991 COTH SPRING MEETING SITE  | Page 36                               |
|       | D. AAMC DIVISION OF CLINICAL SERVICES STAFF  | Page 37                               |
| VI.   | EXECUTIVE COUNCIL AGENDA-ACTION ITEMS  |                                       |
|       | A. MEDICARE POLICY ISSUES FOR 1989   | Executive Council<br>Agenda - Page 44 |
|       | B. COMMITTEE ON AIDS: REPORT ON INSTITUTIONAL POLICIES   | Executive Council<br>Agenda - Page 19 |
|       | C. REVISION OF THE GENERAL REQUIREMENTS SECTION OF THE ESSENTIALS OF OF ACCREDITED RESIDENCIES | Executive Council<br>Agenda - Page 60 |
|       | D. REVISION OF THE ACGME BYLAWS  | Executive Council<br>Agenda - Page 62 |
| VII.  | EXECUTIVE COUNCIL AGENDA-INFORMATION ITEMS   |                                       |
|       | A. GROUP PROGRESS REPORTS<br>GBA/GFP/GME/GPA/GSA   | Executive Council<br>Agenda - Page 71 |
|       | B. LEGISLATIVE REPORT  | Handout                               |
| VIII. | OLD BUSINESS/NEW BUSINESS  |                                       |
| IX.   | ADJOURNMENT  |                                       |

ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
COTH ADMINISTRATIVE BOARD MEETING  
June 23, 1988

PRESENT

J. Robert Buchanan, MD, Chair  
Spencer Foreman, MD, Immediate Past Chair  
Gary Gambuti, Chair-Elect  
Leo M. Henikoff, MD  
John E. Ives  
William H. Johnson, Jr.  
Larry L. Mathis  
James J. Mongan, MD  
Max Poll  
Raymond G. Schultze, MD  
Barbara A. Small

ABSENT

Jerome H. Grossman, MD  
Charles M. O'Brien, Jr.  
C. Edward Schwartz  
Alexander H. Williams

GUESTS

John W. Colloton  
Monica Dreuth, AHA Representative  
Sarah Johnson, OSR Representative

STAFF

Ivy Baer  
James D. Bentley, PhD  
Catherine Cahill  
Edwin Crocker  
Joyce V. Kelly, PhD  
Elizabeth M. Martin  
Robert G. Petersdorf, MD  
John F. Sherman, PhD  
Kathleen S. Turner  
Melissa H. Wubbold

COUNCIL OF TEACHING HOSPITALS  
ADMINISTRATIVE BOARD  
MEETING MINUTES

June 23, 1988

I. CALL TO ORDER

Dr. Buchanan called the meeting to order at 8:00a in the Caucus Room of the Washington Hilton Hotel. Dr. Petersdorf opened the meeting with a discussion of the proposed COTH membership dues increase. A copy of Dr. Petersdorf's presentation on the proposed dues increase from the 1988 COTH Spring Meeting had been made available to Board members with their June Board meeting agendas, and was used as the basis of this discussion. Additionally, a staff paper in the form of a memorandum on the Executive Session Agenda was distributed as a handout (included in these minutes as Appendix A). This memorandum outlined the history and proposed implementation of the proposed dues increase, including discussion of the topic at the February Administrative Board meetings and again at the COTH Spring Meeting in New York. Dr. Petersdorf acknowledged that the hospitals are facing a very significant increase from \$2,745 to \$10,000 per institution, but noted that is a very modest sum compared to dues the majority of COTH members pay to the American Hospital Association. Lest there be concern that the hospitals would be shouldering the brunt of the burden, he noted each medical school will now be paying 3 1/4 times what each hospital will pay. He added that the suggestion to phase in these dues in increments was considered but it was determined that this approach would result in loss of so much revenue that it would negate moving the association into new headquarters, which is important because the owners of One Dupont are considering selling the building altogether, putting all current tenants at risk. Dr. Petersdorf then reiterated the plan to put the proposal to a formal vote at the AAMC Assembly at the Annual Meeting in November, and asked the Administrative Board to reaffirm their commitment to the financial objectives of the Association.

The floor was opened to discussion on the proposal and Dr. Bentley asked Dr. Schultze to share the discussion he had had with other hospitals in his area on the subject. Dr. Schultze reported that the representatives of some of the smaller member hospitals in the Los Angeles area do not feel as enfranchised as they perceive the larger hospitals to be, and that they do not feel they should be paying to the same degree as these larger hospitals. Further discussion ensued on the greater involvement of the academic medical centers and the benefits that result. Dr. Bentley went on to point out the more significant problems in differential dues, noting that a sliding scale could easily place the public general municipal hospitals at the highest paying end of the scale, and adding that other organizations he had spoken with indicated that they were trying to work away from such a dues structure. Dr. Foreman praised the membership dues increase presentation and dissemination of pertinent information to constituents. He suggested that in the absence of any legitimate objection, the Board approve the proposal, adding that protracted discussion of the topic could be misconstrued by the membership. Mr. Colloton agreed and proposed that a document be prepared that would

describe the services provided by the AAMC to COTH.

ACTION: It was moved, seconded, and carried unanimously to recommend to the Executive Council support of the proposed dues increase and to implement whatever process necessary to put this proposal before the AAMC Assembly at the 1988 Annual Meeting in November.

## II. CHAIRMAN'S REPORT

Dr. Buchanan then took the opportunity to introduce new Board member, Leo Henikoff, MD, President, Rush Presbyterian-St. Luke's Medical Center in Chicago, and Joyce V. Kelly, PhD, the new Associate Vice President in the AAMC Division of Clinical Services. Dr. Bentley distributed copies of Dr. Kelly's curriculum vitae and briefly reviewed her career and outlined her anticipated duties within the Division as associate director, and emphasized her involvement in forwarding the division's fledgling research efforts to better serve the membership. Dr. Kelly's duties will officially commence July 18. Dr. Buchanan also introduced Sarah Johnson, the Organization of Student Representatives (OSR) representative to this meeting.

Dr. Buchanan then noted the 1988 COTH Nominating Committee was in place and consists of Dr. Foreman as Chair, Earl Frederick of the Children's Memorial Hospital in Chicago, and himself. He outlined the duties of the Committee, and noted that the Committee would be responsible for nominations of an AAMC Chair-Elect, a COTH Chair-Elect, three administrative board members and 21 COTH Assembly delegates. He indicated that the Committee would welcome suggestions from the Board. He then congratulated Mr. Mathis on his recent election as Chairman of the Texas Hospital Association. Lastly, Dr. Buchanan briefly outlined the planned format for the upcoming AAMC Annual Meeting in the fall. He noted that Dr. Carol McCarthy, President of the American Hospital Association, will be addressing the COTH Business Meeting on Monday, November 14, in an effort to update COTH members on the AHA concerns and interests. He then asked Mr. Gambuti to outline the program for the COTH General Session on that same day.

Mr. Gambuti noted that the topic for the General Session is to be "Profits and Hospital Spending Decisions: Findings and Implications," and that Steven H. Sheingold, PhD, of the Battelle Human Affairs Research Center, and Michael J. Kalison, of the law firm Manger, Kalison, Murphy & McBride will address this forum.

Dr. Buchanan closed his report with special thanks to Dr. Foreman, Mr. Gambuti, and Dr. Schultze for their involvement in the recent 1988 COTH Spring Meeting in New York.

III. CONSIDERATION OF THE MINUTES

ACTION: It was moved, seconded, and carried to approve the minutes of the February 25, 1988 COTH Administrative Board Meeting.

IV. MEMBERSHIP APPLICATIONS

ACTION: It was moved, seconded, and carried to approve the following institutions for membership in the Council of Teaching Hospitals:

CHILDREN'S HOSPITAL OF THE KING'S  
DAUGHTERS, Norfolk, Virginia for  
full membership;

INGHAM MEDICAL CENTER, Lansing, Michigan  
for full membership;

TULANE MEDICAL CENTER HOSPITAL,  
New Orleans, Louisiana for full  
membership.

V. UPDATE ON 1988 COTH SPRING MEETING

A. Criteria for Spring Meeting

Dr. Bentley gave a brief review of the past 11 years of the Spring Meeting's history, crediting Mr. David Everhart with its inception. He suggested that the Board give some thought to what they would like that meeting to be as it continues to evolve. He also stated that he felt that the meeting was an important event in creating a community of interest in academic medicine among hospitals.

Mr. Gambuti stated that he would like to put forth the premise that the meeting should continue. He then went on to discuss the difficulties in selecting topics for this meeting, indicating that "timing" is a distinct problem when attempting to establish a program six months in advance. Dr. Buchanan suggested that a partial solution to this problem might be the promotion of transcendental issues, "big trends" in the environment that do not necessarily affect only hospitals or the health care field. He felt that addressing long term issues that will have a large impact on hospitals in the future will relieve the pressure of timely programs. Mr. Poll agreed with addressing the less pragmatic and suggested topics such as long term employment projections. Dr. Foreman felt that the catholic aspect and diverse topics of the Administrative Board agendas could serve as an example of alternatives to the "how to" approach frequently seen at the Spring Meeting. He recommended putting together a program that would reflect the broader concerns of the organization, and suggested that the program strive to avoid duplicating hospital association level efforts. Mr. Mathis indicated that he would consider a meeting that would provide him with a current update/overview of academic medicine extremely useful;

i.e., "Where we are in academic medicine today." There was a general consensus that CEO's are not interested in attending a meeting to hear a prepared speech that they could read elsewhere as an article.

Dr. Buchanan was concerned that the meeting might be losing the chief executive officer, and that a smaller re-focused meeting might be a future direction worth considering. Dr. Schultze re-emphasized his point that CEO's prefer to participate in a meeting rather than be lectured to, and that the breakout sessions at the 1988 Spring Meeting attested to the success of such a format. He added that the smaller sessions provided an atmosphere of intellectual and professional interchange.

Dr. Foreman noted that The Hotel del Coronado, San Diego, site of the 1989 COTH Spring Meeting, would provide a unique opportunity to restructure the meeting along more social lines, making use of the resort setting. Mr. Poll cautioned on "stretching" the meeting, noting that many CEO's feel that they cannot spare the extra time devoted to a social program.

Dr. Mongan summed up the discussion by indicating his support for identifying various interests particular to the group, looking to an annual assessment as described by Mr. Mathis, and continuing the smaller discussion group format. He noted that accommodation of those three points could obviate the need for a Planning Committee. Dr. Foreman suggested that the Board consider a trial, abolishing the use of a Planning Committee for one year and using the Administrative Board in this capacity. The Board agreed to this suggestion.

#### B. JCAHO Followup

At the COTH Spring Meeting, a presentation was made by Joint Commission staff on the pilot study of a modified quality assurance survey project for academic medical centers. Because the proposal had originated in response to COTH concerns but was poorly received by members at the COTH Spring Meeting, the Board was asked to discuss possible courses of action with the JCAHO.

Dr. Schultze opened the discussion by expressing his concerns with the lack of an objective standard for JCAHO requirements, the inconsistencies between JCAHO reviews and HCFA "death rate" data for medical center hospitals, and Dr. O'Leary's repeated statement that hospitals should spend 2% of expenses on quality assurance.

Mr. Poll and Dr. Buchanan then discussed the very burdensome record keeping requirements that the modified survey process would require.

Mr. Gambuti, a new JCAHO Commissioner, noted the Board of Commissioners would not allow separate standards for individual hospital types. Thus, any special project will involve an addition to, rather than a replacement for, existing JCAHO activities. Pointing out that some JCAHO Commissioners find academic medical centers to be arrogant and unwilling to be studied, he urged the Board to maintain a dialogue with the JCAHO if a discussion is made to halt the modified survey process. In response to Mr. Gambuti's observations, Drs. Mongan and Foreman suggested the AAMC should attempt to engage the JCAHO in an ongoing discussion of quality assurance issues while recognizing that the process of clinical teaching

does not fit the present JCAHO requirements for a process to monitor and evaluate care.

After further discussion, the consensus of the Board was that AAMC staff should meet with JCAHO staff in an effort to halt further development and testing of the modified survey process. During the meeting, AAMC staff should express appreciation to the JCAHO staff for their work on the project and indicate continuing COTH interest in maintaining an open dialogue with the JCAHO.

#### C. Nursing Shortage Followup

Following Dr. Petersdorf's dues increase presentation, a discussion arose around the recent American Medical Association's (AMA) proposal for the creation of the position of Registered Care Technician (RCT) as a possible solution to the national and ongoing nursing shortage. Dr. Buchanan had reviewed the paper and generally outlined the description, requirements, and proposed training described for the RCT, noting its very similarity to the traditional nursing model but emphasizing the fact that this position would be under the physician and out of the hands and control of the nursing realm. Dr. Buchanan noted that the major nursing concern at this time is the cohort of population from which new nursing recruits must be drawn. In many urban settings, the interested recruits are individuals who traditionally would not satisfy the basic entry level requirements, and nursing consequently feels that the alternative of an RCT will not remedy this situation. He then suggested that the Board consider whether in fact the Association would wish to align itself with what professional nursing is proposing in response to the AMA RCT model rather than identifying with the AMA proposal which "shoots right across their (nursing) bow."

Much discussion ensued on the origin of the nursing difficulties and the ongoing shortage, alternate working models, the need to look at "hands on" care, the effect of the introduction of PPS on nursing, the nursing coalition and lack of nursing leadership, unrealistic salary projections, and the AAHC's responsibility to serve as a facilitator in the conflict. Monica Dreuth, serving as AHA representative to the Administrative Board, was asked to describe the American Hospital Association's stance on the issue. She noted that the AHA has been invited to serve and are participating on a task force committee of organizations created to investigate the situation, adding that the AHA's participation on that committee has been characterized by trying to facilitate discussions between the involved parties. She stated there is concern that the RCT proposal threatens to be a major issue at the upcoming AMA Annual Meeting and there are rumors of proposed nurse pickets and other dissenting activity. Dr. Foreman concluded the discussion by re-emphasizing the diminishing pool of nursing applicants and the need to take a hard look at the reasons for this, including financial disincentives and the rigid career ladder.

No action was taken: staff was requested to continue to research the issue, monitor ongoing related activity, and arrange a dinner with the nursing leadership for the September Administrative Board meetings.

## VI.

STAFF REPORT

Dr. Bentley reported that the preliminary data on the 1988 COTH Survey of Housestaff Stipends, Benefits, and Funding was available and had been mailed that week. He noted that the increase in housestaff stipends was once again running at about 3.3-3.4%, and that this rate has been steady for the past four years. He indicated that breakout by region showed the largest rate of increase to be in the west and the smallest in the midwestern states, and that breakout by ownership seemed to denote the largest rate of increase in state university owned hospitals, and specifically the western state university hospitals. He mentioned, however, that it was unclear as to how much of that increase was in fact due to legislative involvement in the rate of increase for all employees on state payrolls across the board. Dr. Bentley felt that the response rate on this survey had generally been good.

He went on to explain that results of the Survey of Academic Medical Center Hospitals' Financial and General Operating Data, which he described as the key piece to the AAMC database on teaching hospitals, had not been forthcoming to date due to the very mixed quality of data received from the responding institutions. He proceeded to give examples of the discrepancies in the data, and went on to note that the effort will be facilitated by Dr. Kelly's arrival and the creating of a research assistant position to assist Linda Fishman in her efforts as study coordinator. He also reported he anticipated this survey would most likely be reported in separate segments in the future, enabling staff to report processed data while giving appropriate attention to more problematic areas.

Dr. Bentley then described the current staffing situation in the Division of Clinical Services noting that three division staff persons had recently left the Association. He reported that Nancy Seline was to be married that week and was relocating to Philadelphia. Judy Teich had taken another position as a study project director at the Institute of Medicine (IOM), and Sonia Kohan had left in May also to marry and relocate. Additionally, he noted that Jim Terwilliger in the Office of Governmental Relations who was very much involved in the VA Liaison Committee and budget as well as the unrelated business income tax issue, was leaving that week to take a position as Washington staff person for the Association of the Professors of Medicine (APM).

Dr. Bentley assured the Board that divisional efforts would be ongoing and procedures to recruit appropriate replacements were in place. Dr. Buchanan assured him of the Board's confidence and wished him well in finding the needed talent.

## VII.

AAMC MISSION STATEMENT

While a draft AAMC mission statement had been included in the Executive Council agenda, the discussion of this item began with the distribution of an amended draft which had been prepared by the Executive Committee on the prior day. After reading the Executive Committee's amended version, Board members offered two suggestions: revising the first sentence to state "the Association of American Medical Colleges has as its purpose the

improvement of the nation's health through the advancement of academic medicine" and removing the word cost from the final clause "to integrate education and research into the provision of cost-effective health care."

ACTION: It was moved, seconded, and carried to recommend that the Executive Council adopt the amended AAMC Mission Statement with these modifications.

#### VIII. REVISION OF ACGME GENERAL REQUIREMENTS

Because revisions of the general requirements for the ACGME must be modified by each sponsoring organization, the Board considered a minor revision in section 3.5, paragraph 2. The Board did not object to replacing the original wording "are strongly encouraged to participate in the NRMP" with new language "should participate in the NRMP," and the Board recommended that the AAMC Executive Council ratify the revision.

#### IX. PHYSICIAN RECREDENTIALING

Catherine Cahill from the Office of Governmental Relations opened the discussion of the physician recredentialing issue by reviewing the material contained on pages 18-21 of the Executive Council agenda. As an organization interested in academics and education, Board members found it difficult to oppose a requirement that physicians demonstrate their continuing competence. However, several Board members felt that it would be very difficult to use a standardized test to appropriately evaluate clinicians in practice. While a standardized test may be appropriate for testing competence at the end of a formal education program and upon introduction into the profession, Board members felt that the wide spectrum of professional careers and experiences would make it difficult to prepare an appropriate test for practicing physicians. Secondly, Board members felt that the licensing of physicians is a state responsibility and that the Federal government should continue to leave licensing at that level. Noting that there are numerous existing professional controls such as hospital privileges and peer review and that many cases of incompetence result from drug or alcohol abuse rather than the absence of basic knowledge, the Board concluded that the AAMC should not support the concept of standardized testing at a periodic basis to determine physician competence.

ACTION: It was moved, seconded, and carried to recommend to the Executive Council that the AAMC should not support a Federal statute to assess physician competence through periodic examinations.

#### X. SCIENTIFIC FRAUD

Since the last Board meeting, the issue of scientific fraud had received considerable attention in Washington. In opening the Board discussion of actions AAMC might take, Dr. Buchanan noted that Anthony McCann's comments the previous evening cast a new light on the subject, particularly Mr. McCann's observation that procedures which are deemed acceptable in the presence of trust are often viewed with question if that trust is

diminished. Dr. Buchanan expressed his concern that the current interest in scientific fraud may lead to the development of a rigid set of procedures which do not fit all situations and which require scientists and institutions to provide justification for any deviation from the so-called model procedure. In further discussion, Dr. Foreman noted that our society is not tolerant of "whistle-blowers" and he observed that institutions must have procedures in place to protect individuals who raise legitimate concerns about the scientific authenticity of the work of others. Dr. Henikoff then raised the question of what "triggering level" must be reached before an investigation or incident should be reported to the funding organization. He observed that there were few, if any, guidelines on this issue and that the AAMC could render a service if it met with funding organizations to develop some informal guidelines in this question. Without taking a formal vote, it was the consensus of the Board that the AAMC should continue to work on and continue prototype guidelines which institutions could use in adopting policies for the investigation of questions of scientific fraud. Board members felt that the AAMC should encourage members to develop guidelines for the investigation of scientific fraud prior to any incident. A number of institutions have found it very difficult to try to develop broad guidelines when confronted with a specific incident.

#### XI. INTRAMURAL RESEARCH AT THE NATIONAL INSTITUTES OF HEALTH (NIH)

At its February meeting, the Board discussed an Office of Management and Budget (OMB) proposal which suggested that the intramural program of the NIH be "privatized" by setting NIH up as an independent research organization. While the OMB proposal had addressed a number of problems faced by the NIH, it raised many significant issues and the Board supported a thorough study of the "privatization option" before recommending AAMC action. Since the February Board meeting, an Institute of Medicine (IOM) committee to study intramural research at NIH has been appointed with Harold Shapiro, President of Princeton University, as its Chairman and with Robert Petersdorf as one of the Committee members. After a brief Board discussion of the new agenda item which described the IOM study and a series of NIH characteristics believed to be important by AAMC staff, the Board asked Dr. Sherman to join them for a further discussion of the issue. Dr. Sherman noted that the establishment of an IOM committee had led to the need for a formal Association position on the issues before the Committee. Observing that the NIH did have problems paying competitive salaries, providing adequate research support, and recruiting supporting personnel, Dr. Sherman noted that each of these problems could be addressed without privatization and that any move to reconfigure the NIH should assure that key characteristics of the NIH are not destroyed. In taking action on the agenda item, the Board recommended that the AAMC endorse a comprehensive examination and evaluation of all aspects of the NIH intramural program and that the AAMC support the five specific positions listed in the agenda book.

#### XII. ANIMALS IN EDUCATION

The Administrative Board reviewed a 1985 AAMC statement on animal research and a 1987 AAMC memorandum encouraging members to develop an institutional policy on the participation of students in educational experiences involving animals. In light of these statements, the Board was asked if

there was further action that the AAMC should take on this issue. Board members agreed that the AAMC had certainly made the membership aware of the need for a policy; however, they believed that the AAMC should regularly communicate this concern to both medical schools and hospitals so that institutions which have not developed an up-to-date policy are encouraged to do so.

XIII. ADJOURNMENT

There being no further business. the meeting was adjourned at 12:30p.



**association of american  
medical colleges**

ROBERT G. PETERSDORF, M.D.  
PRESIDENT

June 10, 1988

(202) 828-0460

MEMORANDUM

TO: Members of the Administrative Boards and  
Executive Council

FROM: Robert G. Petersdorf

SUBJECT: Executive Session Agenda

The attached item on the Association's proposed dues increase will be considered during an executive session of each of the Administrative Boards as well as the Executive Council.

In February the Executive Committee reviewed the Association's financial status and projected budget and established a series of financial objectives for the Association. It was recognized that a dues increase would be necessary to achieve these goals, and each of the Administrative Boards was briefed on the proposed dues increase. The dues proposal was discussed at each of the Council spring meetings, and the original plan had been to ask for a vote of the Executive Council at the June meeting. However, since many member institutions and societies were not represented at the spring meetings, it is in the interest of the Association to delay Executive Council action until the September meeting and to communicate with all constituents about the dues proposal and its underlying rationale.

There are three characteristics of the Association's current financial status that must be kept in mind as the dues proposal is considered:

--The revenue curve has flattened, primarily because demand for Association services, particularly the MCAT and American Medical College Application System, has lessened;

--A budget deficit has been accepted in anticipation of a dues increase;

--Reserves and investment income are being used to support general operations.

The financial objectives articulated at the February meeting were:

1. Not to use reserves for operations
2. Not to use investment income for operations; future investment income should be designated for a capital fund to allow a long-term solution to the Association's space requirements
3. Replace declining services income with dues
4. Cover projected program growth.

The cost of implementing this financial plan is \$4,600,000:

\$ 700,000	To move ongoing expenditures from reserves to operating budget
1,200,000	To replace investment income
1,300,000	To meet deficit
1,400,000	For inflation and new programs

The dues proposal presented to the spring meetings would meet these cost by increasing dues for FY 90 in the following manner:

	FY89	FY90
Medical Schools (127)	18,900	32,500
Teaching Hospitals (450)	2,745	
General (375)		10,000
Federal (75)		4,800
Corresponding & Canadian (35)	930	2,400
Academic Societies		
LT 300 members (32)	930	1,300
301 - 999 members (25)	1,890	2,600
1,000 - 4,999 members (20)	3,735	5,200
5,000 and over (8)	5,600	6,300
Total Revenues (thousands)	3,903	8,624

After FY90 the dues would continue to increase annually based on the Higher Education Price Index. The following changes in how dues are calculated are implicit in this proposal:

1. Nominally, medical schools currently have a sliding scale dues structure, based on the size of the school's operating budget, with total dues payment capped. In fact, all but one medical school pay the maximum amount. The new proposal abandons the concept of a sliding fee for medical schools on the basis that all schools get the same services and benefits from AAMC membership.

2. Currently teaching hospitals dues are differentiated only between full COTH and corresponding members. The new proposal would add a third level of dues for federal hospitals, recognizing that much of the Association's work related to reimbursement and payment for all other members is peripheral to the needs of these institutions.

3. Academic societies would continue to have a sliding fee system based on size of membership, but the differential between the largest and smaller societies would not be as great in order to encourage continued membership by those large societies.

During the spring meetings some members were concerned that:

--the single rate for medical schools does not recognize differences in the size of medical schools and their ability to pay this level of dues;

--the single rate for full, non-federal hospitals does not reflect differences in hospital size, budget, number of residents or affiliation relationship;

--the dues increase is too large an amount for a single step and should be phased over time.

In July the Association plans to communicate with each of its members sending the following information:

1. A copy of Dr. Petersdorf's presentation to the spring

council meetings, outlining the Association's financial history and current status, the reasons for the dues increase, and the financial objectives that would be met by the increase

2. A description of programs and services that members receive from AAMC

3. A list of the appropriate Administrative Board and an invitation to call any of the members to discuss the dues proposal.

#### RECOMMENDATION


The Executive Council is asked to reaffirm its commitment to the financial objectives and to approve the plan for communicating with the members about the dues increase prior to a September vote to recommend the dues proposal to the Assembly.

The Administrative Boards are asked to consider how they can work with their Council members to assure support for the dues proposal.

July 28, 1988

MEMORANDUM

TO: COTH Administrative Board  
AAMC Executive Staff  
DCS Staff

FROM: James D. Bentley, Ph.D.   
Vice President for Clinical Services

SUBJECT: Joint Commission Meeting on Accreditation of Academic  
Medical Centers

You will recall that several years ago, the COTH Administrative Board met with senior officials of the Joint Commission to discuss problems academic medical center hospitals were having with their hospital accreditation. In response to the COTH concerns, the JCAHO established a special project to determine if it would be possible to modify the survey process to meet some of the concerns of academic medical center hospitals. At the 1988 COTH Spring Meeting, Joint Commission officials and COTH members discussed the first pilot test of the Joint Commission's effort to develop a modified survey process for some of the quality assurance components of the present accreditation process.

On July 20, I attended a meeting, hosted by the Hospital of the University of Pennsylvania which brought together Joint Commission officials, five COTH member medical center hospitals, and myself to discuss the progress of the Joint Commission special effort. Attachment 1 is a list of the individuals who attended and the institution with which they are affiliated. Don Avant opened the meeting by setting forth three objectives: first, JCAHO staff and consultants would set forth the basic components of the monitoring and evaluation standards of the Joint Commission and explain the proposed modified survey process; secondly, the Joint Commission staff and the member hospitals wanted to understand the position on the pilot study that had been taken by the COTH Administrative Board at its most recent June meeting; and finally, in recognition of the substantial investment the JCAHO has made in this pilot project, the JCAHO wish to gain a consensus (i) on the wisdom of continuing the project with an understanding that it would require outside funds or (ii) on terminating the project. After Don Avant had summarized the purpose of the meeting, he called on me to review the history of

the COTH request for a modified survey process which would provide recognition of medical center educational and research activities as a means of meeting quality assurance standards. I provided a history of the late 70s accreditation concerns with facilities and university governance and the mid-80s concern with quality assurance. I concluded by stating that I would review the board's position on the present effort at a separate time after everyone had become conversant with the Joint Commission project.

Don Avant provided the historical background from the Joint Commission's view. He indicated that the project was developed to create a survey process capable of using information on teaching and research activities which had not previously been recognized. He also stated that the JCAHO did not envision the new approach as a replacement for its existing requirements. He then gave the group a brief history of the concept pilot which was conducted last year at hospitals at the Universities of Alabama, Utah, and Vanderbilt and at Grady Memorial Hospital. Finally, he presented a series of slides which compared university teaching hospitals and their percentage of low ratings with the percentage of low ratings by all accredited hospitals and the percentage of low ratings by hospitals having 400 or more beds regardless of their teaching status. I have enclosed a copy as Attachment 2. The first page of that attachment shows that the university teaching hospitals scored significantly poorer in the areas of blood review, medical record review, and pharmacy and therapeutics review. The second page shows university hospitals continue to show less governing body support or involvement in the quality assurance program. On the third page the only significant difference shows the university hospitals perform poorer on the monitoring and evaluation segment which focuses on surgery and anesthesia care. The fourth page shows that university hospitals tend to be cited for delinquent medical records more often, and the final page shows that university hospitals have more difficulty in meeting the life safety/facility requirements. This final page also shows that in the areas of safety management, equipment management and utilities management, university hospitals perform significantly better than either all hospitals or hospitals over 400 beds. Don Avant suggested that one reason for this is the high technology orientation of the university hospital leads these facilities to establish regular and ongoing maintenance and safety programs unlike the community institutions.

After Don's introduction, Jean Carroll, who is the Director of Standards Development at the JCAHO, distributed a draft report to the Commission's Board of Commissioners which will be considered at their August 27 meeting. She used the draft report, which is enclosed as Attachment 3, to lead a presentation describing the monitoring and evaluation standards applies to all hospitals. Prior to the meeting, each attendee had been sent a report on

monitoring and evaluating the quality and appropriateness of care, and that report, outlining the mandatory steps, is enclosed as Attachment 4. The Joint Commission presentation ended with Paul Sanazaro, M.D., describing the pilot project which the JCAHO had developed. His presentation was essentially a much condensed version of his remarks at the COTH meeting.

After Dr. Sanazaro's presentation, I reviewed the COTH Administrative Board discussion held last month. I indicated that the Board continues to provide strong support for a voluntary accreditation program and understands it will be politically impossible for the Joint Commission to establish a different set of standards or procedures for any category of hospital. As a result, developments like the modified survey process for academic medical centers become added requirements not substitutes for existing requirements. Moreover, I noted that it was the impression of the hospitals which had participated in the pilot and of a number of the special surveyors who were added to the Joint Commission's teams, that the amount of staff and data efforts required to complete the survey pilot were significantly in excess of the benefit likely to be realized from the modified survey process. Finally, I indicated that the Board had reached two conclusions: first, that the proposed modified survey process either should be substantially modified or discontinued; secondly, that the AAMC and the Joint Commission should find ways to help academic medical center hospitals understand and comply with the monitoring and evaluation standards which apply to all hospitals.

The meeting then turned to a discussion of what, if anything, should be done to modify the Joint Commission's present pilot project. There was a wide ranging and sometimes heated discussion with medical center representatives concerned that the JCAHO could not validate the approach or standards it imposed on all hospitals, and similarly, could not validate the special modified survey process for academic medical centers. The discussion considered topics of how many monitoring and evaluation projects a hospital must have ongoing at any one time in order to be in compliance, the absence of a scientific standard for many of the criteria which hospitals across the country are using in conducting monitoring and evaluation, the tendency of the modified survey process to give credit to hospitals which developed new procedures, the heavy data requirement that would be imposed by the modified survey process, and the general short-comings of Joint Commission surveyors. The final portion of the meeting then became a brainstorming session with everyone attempting to suggest modifications that could be developed for a new pilot project. While there were a number of ideas, there was a consistent level of frustration with the recommendation that any criteria suggested would involve substantial documentation in order to be accepted by the JCAHO.

At the conclusion of the meeting, Don Avant on behalf of the Joint Commission suggested that a consensus had been reached with the following elements:

- o Both the COTH Board and the five hospitals attending the July 20 meeting shared the view that no effort should be made to proceed with any further pilot studies using the modified survey process.
- o Because the five hospitals which were present had been candidates for pilot studies, their otherwise scheduled JCAHO review this year had been postponed. Don assured each of the hospitals that the JCAHO would allow them ample time after the conclusion of this meeting to prepare for a routine survey.
- o While academic medical center hospitals have been unhappy with the JCAHO survey, the Joint Commission has now tested its best idea. As a result, the ball is in the court of academic medicine.
- o The COTH Administrative Board should conduct a further discussion of whether it wishes to pursue additional activity in this area. The activities could include special seminars with the JCAHO helping to educate academic medical center hospitals on the current medical monitoring and evaluation standards. They could also include a seminar for JCAHO surveyors in which AAMC members would help provide an orientation on university hospital governance and organization.
- o There was considerable interest among the five institutions in helping the JCAHO recruit specialized physician surveyors from among the medical staff of medical center hospitals who could participate in one or two surveys a year to help the Joint Commission staff surveyors understand and evaluate academic medical center hospitals.

My sense of the meeting is that each of the persons present would still like to see the Joint Commission develop a recognition of ways in which academic procedures contribute to peer review. We discussed the two concepts imbedded in the term peer review. First the involvement of multiple independent physicians participation in a case, and secondly, a rigorous evaluation which would consider the appropriateness of the clinical decisions made and the alternatives which could have been considered. If the COTH Administrative Board wishes to pursue this matter further, I believe it will be necessary to appoint an AAMC committee which could convene to consider a yet-to-be written staff paper and recommendations. If the committee was

favorable to the staff paper, then we could use that paper to pursue the matter with the Joint Commission.

While the consensus of the meeting was that the present JCAHO effort should be stopped, the meeting did not end on a negative tone. JCAHO staff were very appreciative of the participation and candor of the medical center representatives who had participated. They were, I believe, also pleased to be out of the "no man's land" of pilot studies even if that meant taking no further action in an area where they have worked diligently. In a similar manner, the hospital representatives were pleased that JCAHO staff were willing to accept the legitimacy of hospital objections and take no further action on the project. Hospital representatives were also stimulated by the discussion of trying to think through a more appropriate solution to measuring educational contributions to peer review.

In light of this meeting, I plan to include a Joint Commission item in the agenda of the COTH Administrative Board at its next meeting. The Board will be asked to determine the level of interest in sponsoring seminars for medical center hospitals, seminars for the education of Joint Commission surveyors, and the priority they would attach to staff efforts to develop a concept paper on educational activities as an alternative means of meeting peer review criteria.

JDB/mrl

Attachments



**Joint Commission**  
*on Accreditation of Healthcare Organizations*

MEETING WITH ACADEMIC HEALTH CENTERS

PARTICIPANTS

JULY 20, 1988

10:00 A.M.

PRESBYTERIAN UNIVERSITY HOSPITAL

Maureen Rusnock  
Carol Colabrese  
Ralph Schmeltz, M.D.  
Brian Jegasothy, M.D.

UNIVERSITY OF TEXAS

Ann Smith  
Frank H. Gardner M.D.

MASSACHUSETTS GENERAL

Stephen Kauffmann  
Maryanne Spicer  
Daniel Ellis, M.D.

UNIVERSITY HOSPITALS, STONYBROOK, NY

William T. Newell  
Thomas Cottrell, M.D.

AMERICAN ASSOCIATION OF MEDICAL COLLEGES

James D. Bentley

JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS

Donald W. Advant  
Jean Carroll  
Paul Sanazaro, M.D.  
Tracy L. Schalk

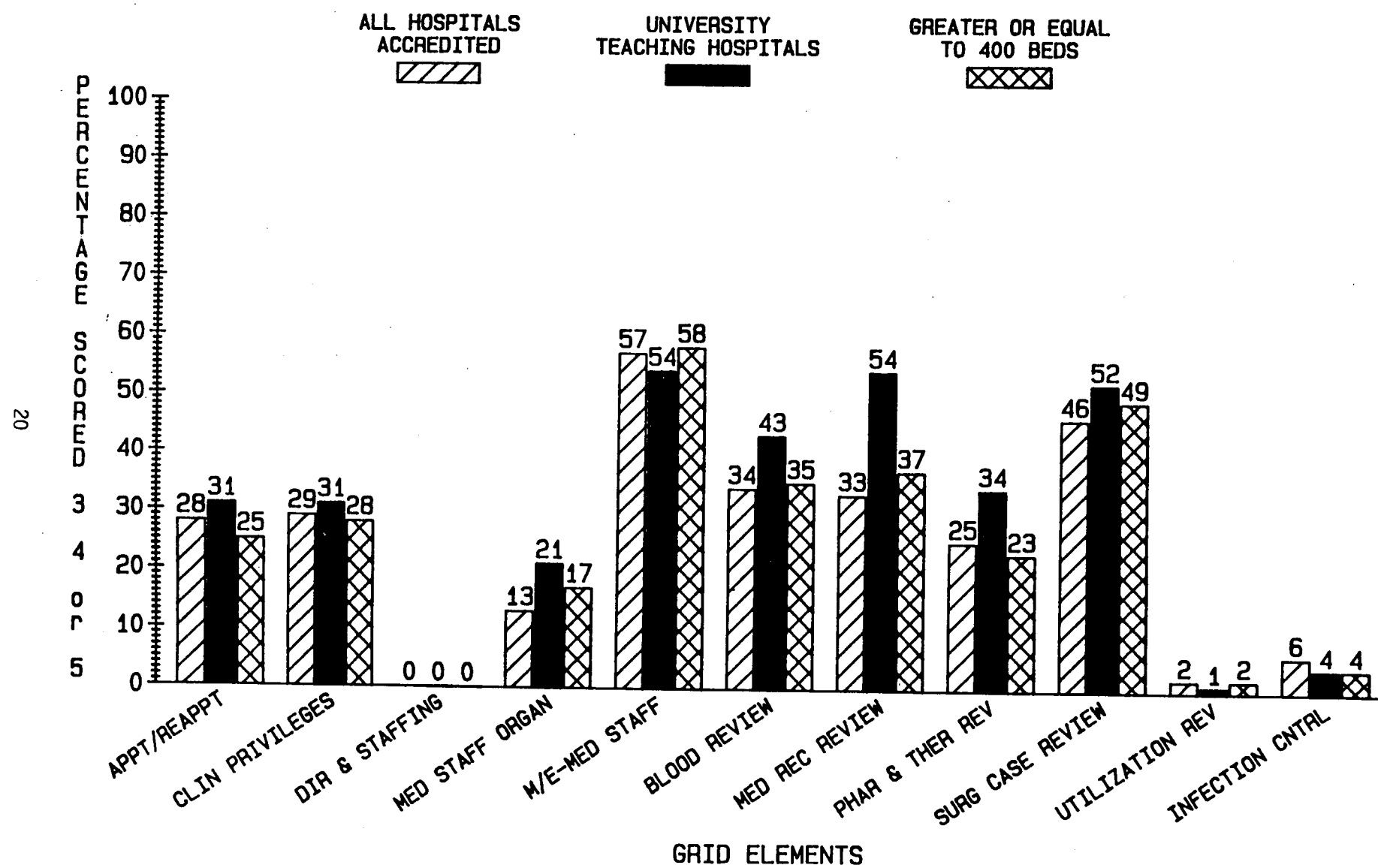
HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA

James Stinnett, M.D.  
Ronald Arenson, M.D.  
Manfred Goldwein, M.D.  
Donald Martin, M.D.  
Leonard Miller, M.D.  
Fred Burg, M.D.  
Marvin Steinberg, M.D.  
Arnold Cohen, M.D.  
Frances Katz

# HOSPITAL ACCREDITATION PROGRAM

## COMPARISON OF HOSPITALS / UNIVERSITY HOSPITALS / > OR = 400 BEDS

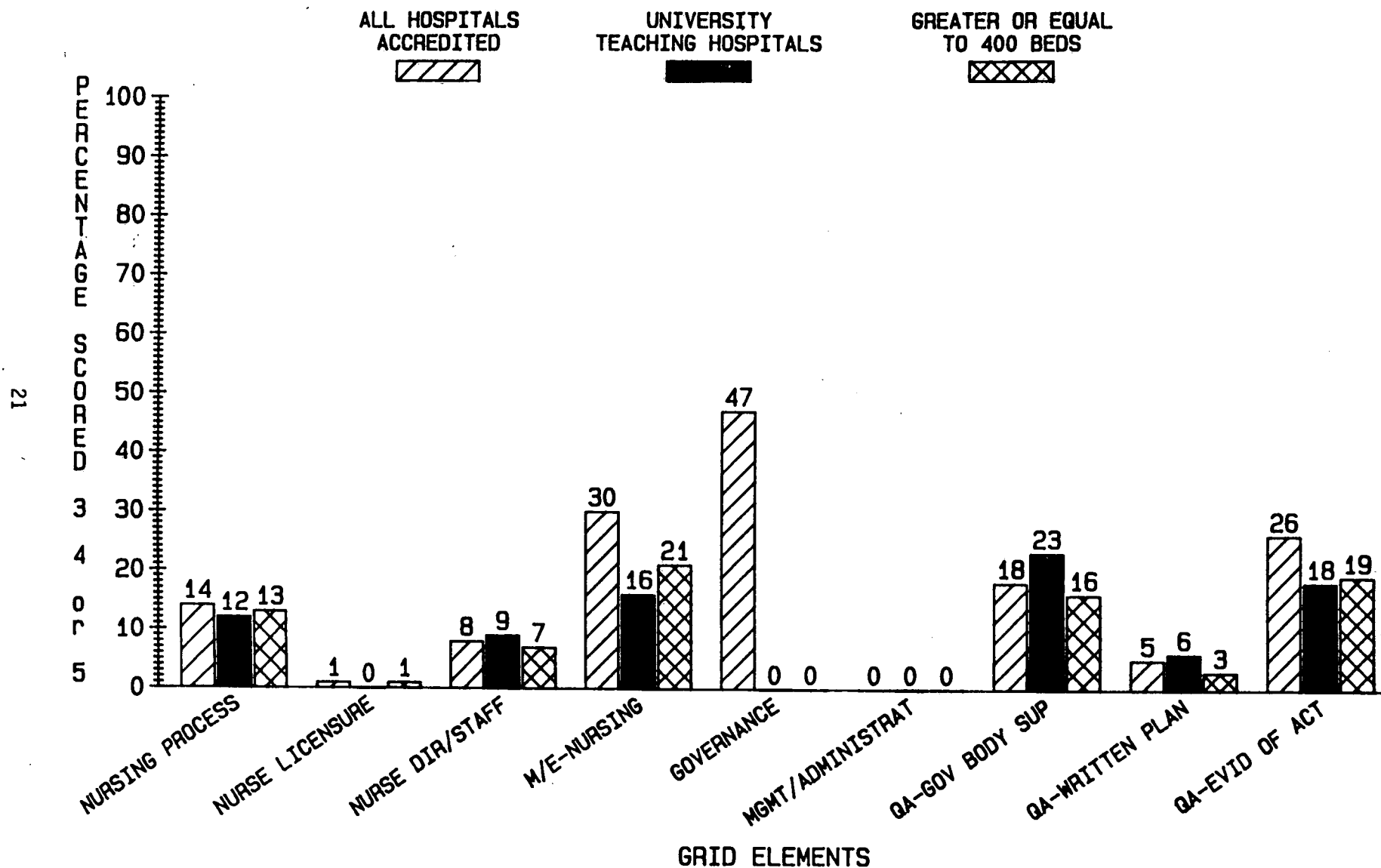
January 1, 1986 through July 6, 1988



# HOSPITAL ACCREDITATION PROGRAM

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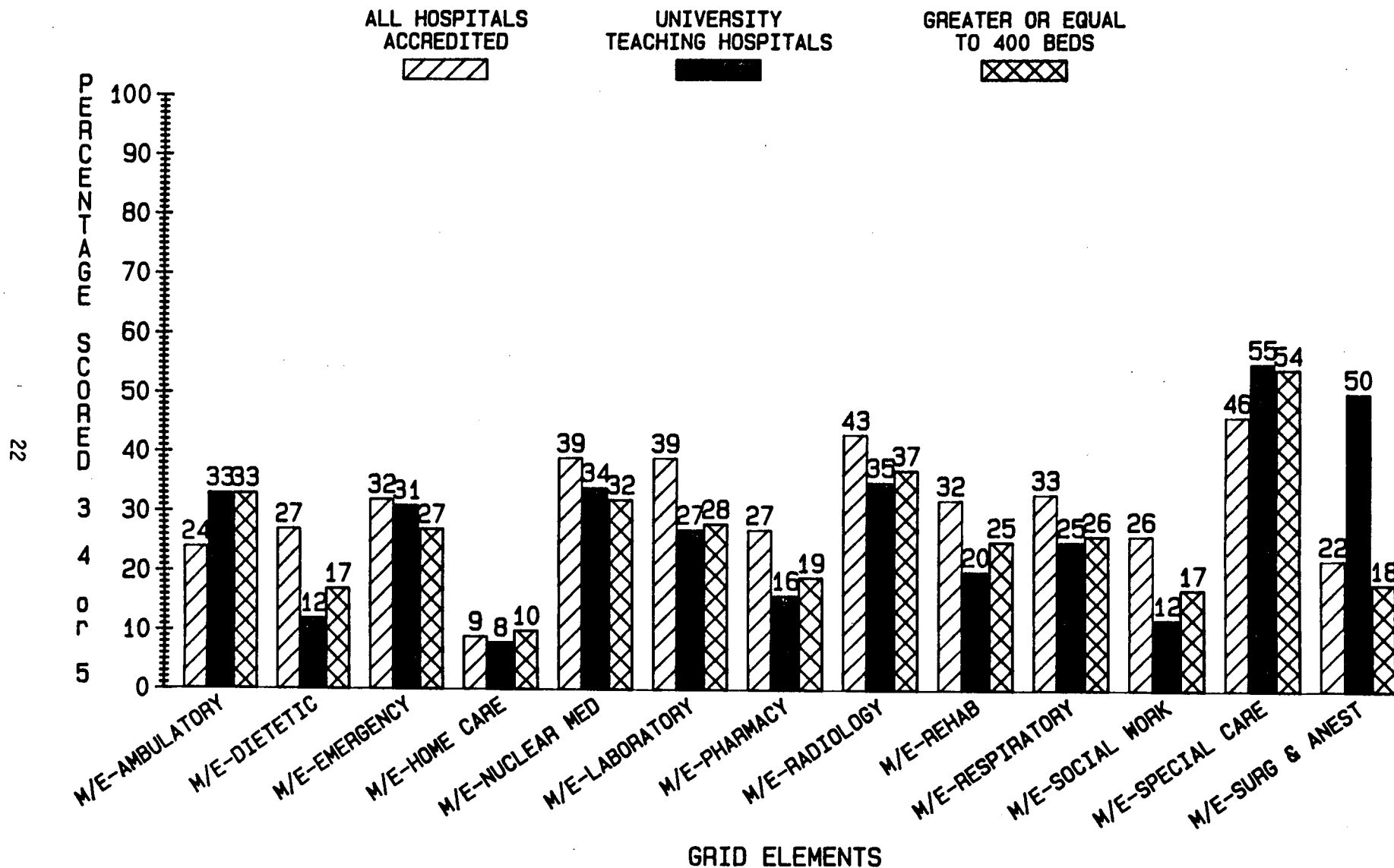
January 1, 1986 through July 6, 1988



# HOSPITAL ACCREDITATION PROGRAM

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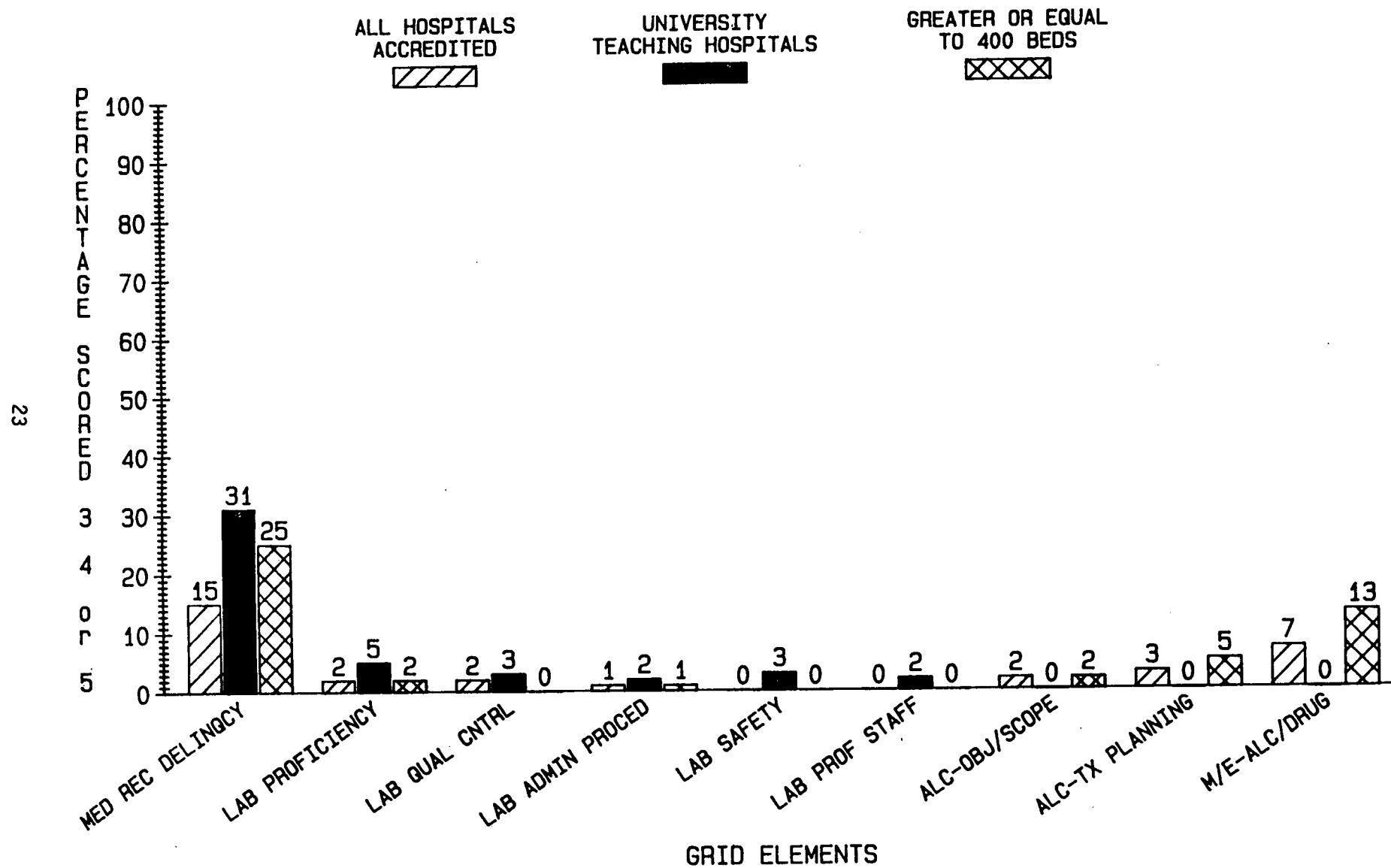
January 1, 1986 through July 6, 1988



# HOSPITAL ACCREDITATION PROGRAM

## COMPARISON OF HOSPITALS / UNIVERSITY HOSPITALS / > OR = 400 BEDS

January 1, 1986 through July 6, 1988



# HOSPITAL ACCREDITATION PROGRAM

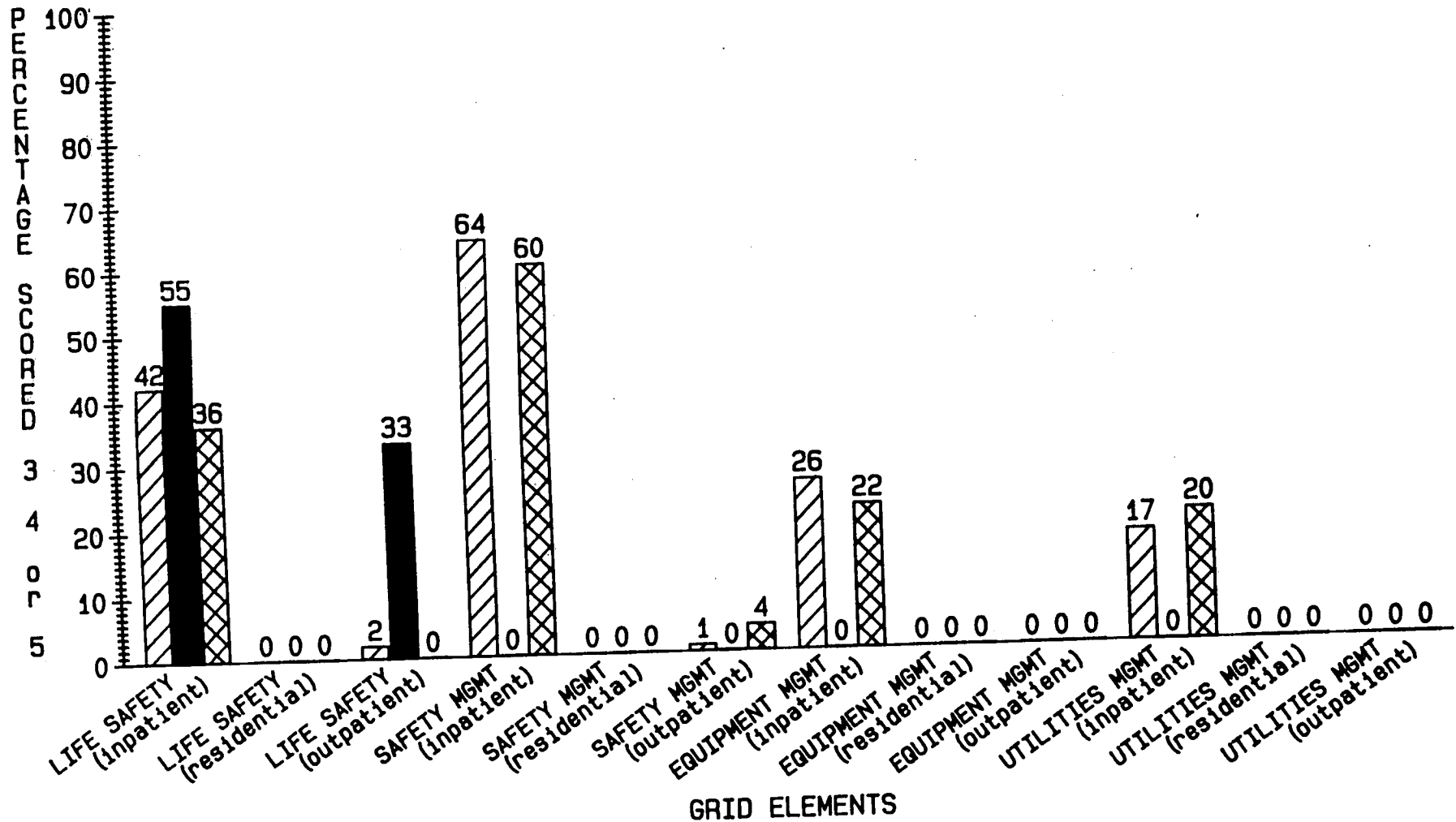
## COMPARISON OF HOSPITALS / UNIVERSITY HOSPITALS / > OR = 400 BEDS

January 1, 1986 through July 6, 1988

ALL HOSPITALS  
ACCREDITED  


UNIVERSITY  
TEACHING HOSPITALS  


GREATER OR EQUAL  
TO 400 BEDS  

**DRAFT**

TO BE SUBMITTED TO BOARD OF COMMISSIONERS  
FOR ADOPTION AUGUST 27, 1988

**"Quality Assurance" Chapter**  
**Accreditation Manual for Hospitals**  
**Proposed Standards**

Preamble

The monitoring and evaluation process is designed to help health care organizations effectively use their quality assurance resources by focusing on high priority quality of care issues. In order to accomplish this, the process involves:

- The identification of the most important aspects of the care (e.g., procedures, treatments) the organization (or department or service) provides;
- The use of "indicators" to systematically monitor these aspects of care in an ongoing way;
- The evaluation of the care when monitoring raises suspicions about its quality or appropriateness, in order to identify problems in the care or opportunities to further improve the care;
- The taking of actions to resolve problems or improve the care, and evaluation of their effectiveness.

Because the use of indicators to monitor important aspects of care involves the collection and aggregation of data about a series of events or activities over time, the monitoring and evaluation process can be used to identify trends or patterns of care that may not be evident when only case-by-case review is performed. Indicators can also be used to identify single events which may represent poor quality care. Whether focused on patterns or single events, the use of indicators helps to efficiently identify situations in which case review (e.g., peer review) is most likely to identify correctable deficiencies in care or opportunities to improve care. Although the monitoring and evaluation process will not identify every case of substandard care, it does help the organization identify situations on which the organization's attention could be most productively focused.

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The process is composed of ten steps:

1. Assigning responsibility for the monitoring and evaluation activities;
2. Delineating the scope of care provided by the organization;
3. Identifying the most important aspects of the care the organization provides;
4. Identifying indicators (and appropriate clinical criteria) that can be used to monitor these important aspects of care;
5. Establishing thresholds for the indicators at which further evaluation of the care is triggered;
6. Collecting and organizing the data for each indicator;
7. Evaluating the care when the thresholds are reached in order to identify problems or opportunities to improve the care;
8. Taking actions to correct identified problems or to improve care;
9. Assessing the effectiveness of the actions and documenting the improvement in care; and
10. Communicating relevant information to other individuals, departments, or services, and to the organizationwide quality assurance program.

The following standards address the second through tenth steps of this process.

**QA.3** Monitoring and evaluation activities, including those described in Standard QA.2, Required Characteristics QA.2.1 through QA.2.4, reflect the activities described in this standard, Required Characteristics QA.3.1 through QA.3.2.8.

QA.3.1 There is a planned, systematic, and ongoing process for monitoring, evaluating, and improving the quality and appropriateness of care provided to patients.

QA.3.1.1 The process is designed to effectively utilize quality assurance resources to:

QA.3.1.1.1 identify and correct problems that have the greatest (or an important) impact on patient care; and

QA.3.1.1.2 identify and take opportunities to make important improvements in patient care;

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QA.3.1.2 The monitoring process is designed to identify

QA.3.1.2.1 patterns or trends in care that warrant further evaluation, and/or

QA.3.1.2.2 important single clinical events in the process or outcome of care that also warrant further evaluation.

QA.3.1.3 The evaluation is designed to:

QA.3.1.3.1 determine the presence or absence of a problem in or opportunity to improve the quality and/or appropriateness of care, and

QA.3.1.3.2 design a plan for correction of an identified problem or for improvement in care.

QA.3.2 The monitoring and evaluation process has the characteristics described in Required Characteristic QA.3.2.1 through QA.3.2.8.

QA.3.2.1 Those aspects of care that are most important to the health and safety of the patients served are identified.

QA.3.2.1.1 These important aspects of care are those that

QA.3.2.1.1.1 occur frequently or affect large numbers of patients;

QA.3.2.1.1.2 place patients at risk of serious consequences or of deprivation of substantial benefit when:

QA.3.2.1.1.2.1 the care is not provided correctly, or

QA.3.2.1.1.2.2 the care is not provided when it is indicated, or

QA.3.2.1.1.2.3 the care is provided when it is not indicated; and/or

QA.3.2.1.1.3 tend to produce problems for patients or for staff.

QA.3.2.2 Indicators are identified to monitor the quality and appropriateness of important aspects of care.

QA.3.2.2.1 The indicators are related to the quality and/or appropriateness of care, and may include clinical criteria (sometimes called "standards of care or practice").

QA.3.2.2.1.1 The indicators are\_

QA.3.2.2.1.1.1 objective,

QA.3.2.2.1.1.2 measurable, and

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QA.3.2.2.1.1.3 based on current knowledge and clinical experience.

QA.3.2.2.1.2 The indicators are structures of care (e.g., resources), processes of care (e.g., procedures, techniques), or outcomes of care (e.g., complication rates).

QA.3.2.3 Data are collected for each indicator.

QA.3.2.3.1 The frequency of data collection for each indicator and the sampling of events or activities is related to:

QA.3.2.3.1.1 the frequency of the event or activity monitored,

QA.3.2.3.1.2 the significance of the event or activity monitored, and

QA.3.2.2.1.3 the extent to which the important aspect of care monitored by the indicator has been demonstrated to be problem-free.

QA.3.2.4 The data collected for each indicator are organized in a manner that identifies situations in which a more detailed evaluation of the quality or appropriateness of care is indicated.

QA.3.2.4.1 Such evaluations are prompted by:

QA.3.2.4.1.1 single clinical events, and

QA.3.2.4.1.2 patterns of care or outcomes that are at variance with predetermined levels of care or outcomes (sometimes called "thresholds for evaluation").

QA.3.2.5 When initiated, the evaluation of an important aspect of care

QA.3.2.5.1 includes analysis of trends and patterns in the cumulative data for the indicators,

QA.3.2.5.2 employs review by peers when analysis of the care provided by an individual practitioner(s) is undertaken, and

QA.3.2.5.3 identifies problems in or opportunities to improve the quality and/or appropriateness of care.

QA.3.2.6 When an important problem in or opportunity to improve the quality and/or appropriateness of care is identified,

QA.3.2.6.1 action is taken to correct the problem or improve the care, and

QA.3.2.6.2 the effectiveness of the action taken is assessed through continued monitoring of the care.

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QA.3.2.7 The findings, conclusions, recommendation, actions taken, and results of the actions taken

QA.3.2.7.1 are documented, and

QA.3.2.7.2 are reported through established channels.

QA.3.2.8 As part of the annual reappraisal of the hospital's quality assurance program, the effectiveness of the monitoring and evaluation process is assessed.

In the "Medical Staff" and service chapters (e.g., "Radiation Oncology Services," "Surgical and Anesthesia Services") of the AMH, the following revisions are proposed to the existing standards addressing departmental or service monitoring and evaluation. New language proposed for addition is underlined.

As part of the hospital's quality assurance program, the quality and appropriateness of \*\*\*\*\* patient care services are monitored and evaluated, in accordance with "Quality Assurance" Standard QA.3 and Required Characteristics QA.3.1 through QA.3.2.8.

RC.1.1 The director or chairman of the \*\*\*\*\* department/service is responsible for implementing the monitoring and evaluation process.

RC.1.2 When an outside source(s) provides \*\*\*\*\* patient care services, or when there is no designated \*\*\*\*\* department/service, the medical staff is responsible for implementing the monitoring and evaluation process.

## MONITORING AND EVALUATING THE QUALITY AND APPROPRIATENESS OF CARE

Over the past year, four factors have led the Joint Commission to increase its efforts to help health care organizations better understand the process used to monitor and evaluate the quality and appropriateness of care. First, the accreditation surveys have shown that many organizations have not effectively implemented this central component of quality assurance. Second, as the Joint Commission has worked with surveyed organizations and provided educational programs, it has become increasingly clear that different individuals and organizations use terms such as "criteria" differently. Third, the actual use of the monitoring and evaluation process has raised new questions, the answers to which have helped clarify the steps of the process. And fourth, the development of clinical and organizational indicators as part of the Joint Commission's Agenda for Change has increased understanding of the uses and limits of indicators in monitoring and evaluation.

In response to these factors, the Joint Commission has clarified its description of the monitoring and evaluation process. A copy of this clarified description is attached. Although the process itself has not changed, the steps in the process have been more explicitly identified, and the language used in the description has been modified to more clearly explain the process. This monitoring and evaluation process is consistent with the Joint Commission's current standards. New standards that reflect the clarified description will be developed; until those standards are in effect, the Joint Commission will evaluate and score compliance based on current standards. For educational purposes, the Joint Commission will teach the clarified description of the monitoring and evaluation process.

## MONITORING AND EVALUATING THE QUALITY AND APPROPRIATENESS OF CARE

The monitoring and evaluation process is designed to help health care organizations effectively use their resources to manage the quality of the care or service they provide. Monitoring and evaluation activities involve the ongoing examination of care provided, identification of deficiencies in that care, and improvement, as necessary, of the quality of care. Appropriate monitoring and evaluation activities are ongoing and integrated with other monitoring and evaluation activities throughout the organization.

The monitoring and evaluation process assists both in identifying patterns of care that may not be evident when only case by case review is performed and in identifying situations in which case review is likely to be most useful in identifying correctable deficiencies in care and opportunities to improve care. Although this process will not identify every case of substandard care, monitoring and evaluation does help the organization identify situations on which its attention could be most productively focused.

### The Ten-Step Monitoring and Evaluation Process

The following ten steps are necessary for effective monitoring and evaluation in an organization, department, or service.

1. Assign responsibility;
2. Delineate scope of care;
3. Identify important aspects of care;
4. Identify indicators related to these aspects of care;
5. Establish thresholds for evaluation related to the indicators;
6. Collect and organize data;
7. Evaluate care when thresholds are reached;
8. Take actions to improve care;
9. Assess the effectiveness of the actions and document improvement; and
10. Communicate relevant information to the organizationwide quality assurance program.

The following pages describe the concept of this process and the activities involved in each of the ten steps.

#### Step 1: Assign Responsibility

Overall responsibility for monitoring and evaluation in a given department should be assigned to its chairperson or director. In turn, this individual designates the responsibilities of other personnel in performing monitoring and evaluation activities (eg, identifying indicators, collecting data, evaluating care, and taking actions).

### Step 2: Delineate Scope of Care

To delineate the scope of care for a given department, its personnel should simply ask themselves the following question: "What is done in this department?" The answer to this question is an inventory including the types of patients served, the conditions and diagnoses treated, the treatments or activities performed, the types of practitioners providing care, and even the sites where care is provided and the times it is provided. This inventory provides a basis for subsequent steps in the monitoring and evaluation process.

### Step 3: Identify Important Aspects of Care

After the scope of care is delineated, department personnel should ask themselves a more specific question: "Which of the things we do are most important?" The answer to this question should lead to identifying important aspects of care--the aspects on which monitoring and evaluation will be focused. To effectively use the organization's resources (including professionals' time) in quality assurance, the activities chosen should be those with the greatest impact on patient care. Therefore, priority should be given to those aspects of care for which one or more of the following is true:

- o The aspect of care occurs frequently or affects large numbers of patients;
- o Patients are at risk of serious consequences or are deprived of substantial benefit if the care is not provided correctly (including providing care that is not indicated, and failure to provide care that is indicated); and
- o The aspect of care has tended in the past to produce problems for staff or patients.

That is, high-volume, high-risk, or problem-prone aspects of care should be the highest priority for monitoring and evaluation.

### Step 4: Identify Indicators

In order to efficiently monitor the important things being done in the department, indicators should be identified for each important aspect of care. An indicator is a measurable variable relating to the structure, process, or outcome of care. Structures are inputs into care such as resources, equipment, or numbers and qualifications of staff. Processes of care are those functions carried out by practitioners, including assessment, planning of treatment, indications for procedures and treatments, technical aspects of performing treatment, management of complications, etc. Outcomes include complications, adverse events, short-term results of specific procedures and treatments, and longer-term status of patients' health and functioning. To monitor the important aspects of care, data is collected for each indicator.

Therefore, an indicator should be measurable and well-defined for ease and reliability of data collection. Indicators of the process of care are often standards of care or practice, such as the indications that justify a specific surgical procedure or the steps that are to be followed in assessing a specific condition. Such indicators of process often include objective clinical criteria established by the medical staff, based upon authoritative sources such as the clinical literature and consensus panels. The following is an example of an indicator of the process of care: Each patient with a systolic blood pressure on admission greater than 150 mm Hg or diastolic blood pressure greater than

95 mm Hg has his or her blood pressure measured and recorded in the medical record at least twice during the 24 hours following admission to the inpatient unit. As this example shows, an accepted standard of care may serve as an indicator if it can be accurately determined to be present or absent, or can be otherwise measured. An example of an indicator pertaining to outcome of care is the rate of development of wound infections after clean or clean-contaminated surgical procedures. Other examples of possible indicators (which would need to be further defined) include hospital-acquired infections, severe adverse drug reactions, the correlation of final surgical pathology diagnoses with patients' previous diagnoses, and the need to transfer patients from post-surgical care units to operating rooms.

#### Step 5: Establish Thresholds for Evaluation

The data collected for each indicator cannot alone lead to conclusions about the quality and/or appropriateness of care. The indicator can, however, direct attention to those areas in which a problem or other opportunity to improve care may be found. To conclude that there is an actual problem requires intensive evaluation of the care provided. As data is collected over a series of cases or events being monitored, there should be a preestablished level or point in the cumulative data that will trigger this intensive evaluation. When reached, this threshold for evaluation initiates the evaluation to determine whether an actual problem or opportunity to improve care exists.

For the indicator related to measuring blood pressure of potentially hypertensive patients, the threshold for evaluation might be set at 98%. That is, intensive evaluation of the quality and appropriateness of this aspect of care would be undertaken if this indicator is not fulfilled for over 2% of such patients. The indicator in this example is an established standard of care whose clinical criteria individual practitioners would expect to meet 100% of the time. Rare instances of noncompliance, however, either may not indicate a systematic or continuing problem or may be justified as an appropriate exception to the standard of care. Therefore, a department may deem the investment of professional resources in intensive evaluation unnecessary for only rare instances of noncompliance (in this case, under 2%).

Using another example, the threshold for evaluation relating to the wound infection rate indicator may be set at 2.5%. Because a certain percentage of wound infections are not preventable even with the best of care, professionals may find it unproductive to intensively evaluate through the quality assurance program the quality of care received in each instance of such infection.

Although many thresholds may be set at levels other than 0% or 100%, some events or occurrences are so serious that every such case must be evaluated or are so rare that it is not appropriate to accumulate a series before evaluating. A possible example of such an indicator is failure to type a patient's blood before a transfusion. The thresholds for evaluation pertaining to such indicators would be 0% or 100%.

When the threshold for evaluation is other than 0% or 100%, it may be necessary not only to apply the threshold for evaluation to the data collected for the department as a whole, but also to apply the threshold to the data collected for each practitioner separately. In this way, patterns of care for individual practitioners can help identify the need to initiate peer review.

### Step 6: Collect and Organize Data

To collect and organize data, appropriate staff members must determine the following for each indicator: the data sources, data-collection method, appropriateness of sampling, frequency of data collection, and process for comparing cumulative data with the thresholds for evaluation.

Data sources. Rather than create all new data sources and data-collection methods for monitoring and evaluation, staff should first attempt to use existing sources and methods. Existing sources of potentially useful data include patient records, laboratory reports, medication sheets, incident reports, and department logs. The specific indicator will help determine the appropriate data sources.

Data collection. The individual responsible for the monitoring and evaluation activities must determine the data-collection method and who will collect the data. In some organizations, the department staff, either clinical or clerical, collect data. Other organizations may have an individual or group from outside the department (such as medical records or quality assurance personnel) collect data.

Sampling. For each indicator, appropriate staff members should decide whether sampling is appropriate for data collection. Sampling would not likely be appropriate for an indicator that describes an infrequent but serious complication. It may be appropriate to use sampling in data collection for an indicator pertaining to a high-volume occurrence.

Frequency. The frequency with which data will be collected and tabulated should be sufficient to accumulate the necessary data to compare with thresholds for evaluation. The frequency should be based on the number of patients affected by the care being monitored, the risk involved in the care, the regularity with which the aspect of care is performed, and the extent to which the aspect of care has been demonstrated to be problem free.

Comparing cumulative data with thresholds for evaluation. As data is tabulated, the cumulative data for each indicator should be continuously or periodically compared with its corresponding threshold for evaluation. This comparison is used to determine whether further evaluation is necessary.

### Step 7: Evaluate Care

When the cumulative data reaches the threshold for evaluation, staff members qualified in the particular area should evaluate the care provided to determine if a problem is present. This evaluation may include an analysis of patterns or trends in the care suggested by the cumulative data. When it is appropriate to conduct an intensive review of care provided by an individual practitioner and/or to an individual patient, peer review is undertaken. This peer review is a critical element in the monitoring and evaluation process, but the productivity of this intensive use of professionals' time can be increased through the identification of cases for review by the indicators and thresholds for evaluation.

#### Step 8: Take Actions To Solve Identified Problems

The evaluation may conclude that the care is acceptable and that no further action is necessary. If the evaluation identifies a problem, department staff should decide what action is necessary to solve the problem. A plan of corrective action identifies who or what is expected to change; who is responsible for implementing action; what action is appropriate in view of the problem's cause, scope, and severity; and when change is expected to occur. If a needed action exceeds the department's authority, recommendations are forwarded to the body that has the authority to act.

To be effective, corrective action must be appropriate to the problem's cause. Three common causes of problems are insufficient knowledge, defects in systems, and deficient behavior or performance. Insufficient knowledge often is addressed by adding or developing classes or other training activities, by providing additional reference sources, or by restructuring existing educational procedures. Defects in systems often are addressed by changing policies and procedures, redistributing staff, altering use of equipment and supplies, and correcting any communication problems. Behavior or performance deficiencies often are addressed by counseling, increasing supervision, changing duties, transferring, or withdrawing certain privileges of the individuals involved.

#### Step 9: Assess the Actions and Document Improvement

Staff next must ask themselves whether the action was successful. Continuing monitoring and evaluation should provide the information to answer this question. If, for example, the level of performance for the given indicator is unchanged, the problem likely persists. If the level of performance improves notably, the action was probably successful in solving the problem. Even if the problem appears to be solved, monitoring and evaluation is continued to assure that care remains at a high level of quality and that any other problems are identified and solved.

#### Step 10: Communicate Relevant Information to the Organizationwide Quality Assurance Program

It is essential that monitoring and evaluation information be communicated to the necessary individuals and departments throughout the organization. Such integration of information should begin with each department's regular reporting of monitoring and evaluation activities and findings to the organizationwide quality assurance program. Integrating quality assurance information contributes to the detection of trends, performance patterns, or potential problems that affect more than one department or service. Monitoring and evaluation findings are also important in granting or reassessing privileges and in conducting other performance evaluations.

1-21-88

## SELECTION OF 1991 COTH SPRING MEETING SITE

Keeping in mind the June Board Meeting discussion of the COTH Spring Meeting, and with an eye to competitive hotel rates, staff asks of the Board that consideration be given at this time to a timely meeting site for the 1991 COTH Spring Meeting Site.

Listed below are the past COTH Spring Meeting sites.

1978	St. Louis, MO
1979	Kansas City, MO
1980	Denver, CO
1981	Atlanta, GA
1982	Boston, MA
1983	New Orleans, LA
1984	Baltimore, MD
1985	San Francisco, CA
1986	Philadelphia, PA
1987	Dallas, TX
1988	New York, NY

The 1989 Spring Meeting is scheduled for San Diego, May 10-12 and the 1990 meeting is scheduled for Boston, May 9-11. Though a good turn out for these two meetings is anticipated, given the shift in attendance patterns raised at the June meeting, staff recommends that consideration be given to the following cities for the 1991 COTH Spring Meeting; other suggestions are welcome.

Chicago, IL

New Orleans, LA

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