SHEA Newsletter

Edited by Robert A. Weinstein, MD

Editor's note: Peter A. Gross, MD, Hackensack Medical Center, Hackensack, New Jersey, sent us the following two reports. His work with the Joint Commission on Accreditation of Healthcare Organizations and his Working Group on Severity of Illness Indicators are two very important, current activities of SHEA. Dr. Gross and the SHEA Newsletter editor are interested in receiving comments from readers on these reports.

Review of the Joint Commission's Hospital-wide Clinical Indicators Task Force

In early 1987, the Joint Commission on Accreditation of Healthcare Organizations organized a task force to develop hospital-wide clinical indicators. Peter Gross, MD, was appointed as the SHEA representative. This task force is one of three organized to help implement the Joint Commission's "Agenda for Change." (The two other task forces were created to develop indicators for anesthesia and obstetrical care.) The three initiatives on the "Agenda" are:

1. An accreditation and surveys initiative to enhance the Joint Commission's ability to evaluate quality of care and promote improvement in the delivery of health care services.

2. A communication initiative to maintain and enhance Joint Commission relationships with provider organizations and health care professionals while fostering broader relationships with government, business, labor, insurance, and consumer communities.

3. An education initiative to expand and enhance Joint Commission education and consultation services.

The Hospital-wide Clinical Indicators Task Force will work with the first initiative. The task force will design hospital-wide indicators to answer on an ongoing basis this question: *'Does* the hospital provide quality health care?" Now the Joint Commission's triennial on-site survey process addresses the question *"Can* the hospital provide quality health care?' The Joint Commission consequently will be interested in *outcomes* as well as *structure* and *process.* The Joint Commission proposes that a key aspect of assessing outcomes is ongoing data collection with continuous communication from the hospital to the Joint Commission and feedback from the Joint Commission to the hospital.

The indicators themselves are considered to be flags or screens to highlight a problem and a need for peer review. The indicators will not directly show the quality of clinical performance.

The need to adjust for differences in severity when making comparisons between hospitals is acknowledged. The confounding effects of these differences will be considered. Controls for patient severity of illness (see following report) will be part of the final methodology.

Full implementation of the outcome assessment program is scheduled for the early 1990s. Hospitals will be the first to implement the program and will be followed by other health care facilities including ambulatory service sites. Initially the program will be studied at pilot test sites. Then, broader field trials will be conducted, and finally full implementation will occur.

To approach its goals, the Clinical Indicators Task Force met three times between May and August 1987. The members of the task force represent academic and private practice physicians, internists and surgeons, hospital administrators, statisticians, and a medical records librarian. Both large and small, urban and rural hospitals are represented. The work of the task force is supported by a large research team made up of the Joint Commission's Division of Research and Planning, Division of Accreditation Surveys, and Division of Education. Numerous clinical indicators were initially considered for measuring appropriateness of care, complications, errors, outcomes, and quality of documentation.

A major interest in evaluating nosocomial infections existed from the outset. Factors considered were type of infections, service or location in the hospital, and how to define the selected infections.

The potential hospital-wide clinical indicators chosen for study will focus on problems such as development of wound infections, decubiti, pneumo-

nia, and intravascular device infections in selected patient populations; medication side effects and complications; timing of antibiotic surgical prophylaxis; and appropriate use of antibiotic susceptibilities. These and the other potential hospital-wide clinical indicators will be evaluated at a number of hospitals that have already been selected as pilot test sites.

Incidentally, the new name Joint Commission on Accreditation of Healthcare Organizations replaces the name Joint Commission on Accreditation of Hospitals, reflecting the organization's broadening scope of interests.

Review of Severity of Illness Working Group Meetings

The members of the working group are Peter Gross, MD; B. Eugene Beyt, MD; Michael Decker, MD, MPH; Walter Hierholzer, Jr., MD; William Jarvis, MD; Richard Garibaldi, MD; Bryan Simmons, MD; Elaine Larson, PhD; William Scheckler, MD; and Lorraine Harkavy, RN (liaison from APIC).

The need for a severity of illness indicator to supplement the DRG (diagnosis related group) system is being reviewed. It is readily acknowledged that DRGs may be inaccurate in predicting costs for an individual case. However, does this problem persist when all patients in a hospital are considered together? If the problem does persist, can a DRG severity adjuster significantly improve accuracy!

We have begun to examine the major severity of illness indices. 'These are:

1. APACHE II (acute physiology and chronic health evaluation score, second generation)
2. CSI (computerized severity index)
3. Disease staging: clinical and coded versions
4. MEDISGROUPS (medical illness severity grouping system)
5. PMC (patient management categories)

After our first meeting, it became apparent that the various indices have been neither sufficiently studied individually nor compared with each other to permit us to make specific recommendations. However, we thought potential uses of these indices would include predicting risk of nosocomial infections and assessing utilization review, quality of care, appropriateness of care, and cost reimbursement.

Expansion of the role of the hospital epidemiologist was also discussed. The committee thought that we should expand our traditional role in infection control and infectious diseases to actively pursue involvement in quality assurance (QA) programs; we should apply our epidemiologic training and experience to the evaluation of data collected in QA studies.

The group considered undertaking a multicenter study to compare the value of the severity indices for the potential uses discussed above. After further discussion, it became clear that such studies were already underway at several institutions. We thought it would be more appropriate to try to set up a liaison with the Joint Commission on Accreditation of Healthcare Organizations. They have developed several clinical indicators for screening for the quality, appropriateness, and outcome of the care of patients in hospitals.

Dr. Gross, as a member of the Joint Commission's Hospital-wide Clinical Indicators Task Force, spoke with the Joint Commission's project managers for severity adjustment and for the clinical indicators. It was agreed to have SHEA's Severity of Illness Index Working Group members meet with representatives of the Joint Commission. At that December 198'7 meeting the plans of the Joint Commission were presented to the SHEA working group. We discussed the proposed clinical indicators and the need for severity adjustment. Some indicators will require severity adjustment while others may not. The meeting was fruitful. Representatives of the Joint Commission have subsequently requested that our working group meet with them again to help with the evolution of' their data dictionary and plans for data analysis. These tasks will be the major focus of our committee in 1988.

The working group's interest in severity indices naturally led to the proposal to expand the role of the hospital epidemiologist to all QA activities and to work with the Joint Commission in evolving the proposed clinical indicators. These are exciting proposals that we hope will develop into concrete programs over the next two years.

Brief items of interest for the SHEA Newsletter may be sent to Robert A. Weinstein, MD, SHEA Newsletter Editor, Division of Infectious Diseases, Michael Reese Hospital, Lake Shore Drive at 31st St., Chicago, IL 60616. Copy must be typed, double-spaced, and may not exceed five pages.