
Chapter 9

Scope of Hospital Services: External Standards and Guidelines

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Scope of Hospital Services: External Standards and Guidelines

INTRODUCTION

Scope of hospital services is a structural measure that reflects whether a hospital has the resources—facilities, staff, and equipment—to provide care for the medical conditions it professes to treat or to care for the medical conditions affecting potential patients. There are several potential sources of information on the scope of a hospital's services, including hospital advertising, media reports about the existence of special equipment or specially trained staff, consumer guidelines for selecting medical providers, and organizations that accredit or certify hospitals.¹ Identifying whether a hospital complies with external standards such as those used for accreditation or certification by an external body, however, is likely to be the most valid means of ascertaining a hospital's scope of services. Accreditations and cer-

¹Hospital certification typically refers to approval by governmental bodies; accreditation usually indicates approval by a private organization, most often a professional organization of peers. The term "guidelines" refers to standards proposed by professional organizations and voluntarily applied by providers.

tifications for scope of hospital services are distinct from some of the other indicators evaluated in this report in at least one sense. As currently constructed, they measure only the capability of a hospital to deliver good quality care, not the quality of care actually delivered or its outcome.

This chapter briefly describes two national methods of overall accreditation/certification of hospitals, that of the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and that of the Health Care Financing Administration (HCFA). It then describes external standards and guidelines for neonatal intensive care units, cancer care, and hospital-based emergency and trauma services. The next sections of the chapter analyze the reliability, validity, and feasibility of using external standards and guidelines related to the scope of hospital services as indicators of the potential of a hospital to deliver good quality care. The final section draws conclusions and discusses policy implications.

EXTERNAL STANDARDS AND GUIDELINES

Standards for Overall Hospital Accreditation/Certification

JCAHO Accreditation

The most well-known and widely applied hospital accreditation standards are those of JCAHO. Of the approximately 6,800 hospitals of all types in the United States, about 5,000 (70 percent) are surveyed by JCAHO. Submitting to JCAHO evaluation is voluntary, but not all hospitals are eligible for JCAHO surveys (325). One reason that JCAHO accreditation is important is that such ac-

creditation, along with certain additional criteria, is a condition of participation in the Medicare and Medicaid programs (Section 1865 of the Social Security Act).² Medicare and Medicaid pay for

²In addition to being accredited by JCAHO, hospitals must meet requirements for utilization review (Section 1861(e)(6) of the Social Security Act (42 CFR Subpart S, 405.1901(d)(1) and 482.30)) and discharge planning (Public Law 99-190). In practice, the require-

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about 38 percent of the hospital care provided in this country (715). JCAHO accreditation is also woven through the hospital licensure requirements of 41 States (323) and is a condition of participation for an unknown number of insurance companies (48).

JCAHO conducts a complete survey of each eligible hospital once every 3 years and assesses each hospital's compliance with over 2,000 standards. The purpose of the JCAHO hospital accreditation process is to evaluate each hospital's overall capability of providing medical care. Thus, particular attention is paid to functions affecting the entire hospital, such as the governing body, the medical staff, nursing services, infection control, and quality assurance, and the way these and other functions are integrated across the hospital. Throughout this chapter, and for purposes of evaluating JCAHO accreditation as a potential indicator of the quality of care, it is important to keep in mind that it *is* not JCAHO'S purpose to separately accredit individual hospital departments such as those that provide emergency services or neonatal intensive care. Because JCAHO does survey and evaluate those services as part of its overall accreditation process, however, JCAHO standards for these separate departments are discussed in this chapter as having the potential to evaluate whether hospital scope of services is appropriate.

JCAHO standards are developed by panels of experts, sometimes with the aid of scientific literature, and are evaluated by interested hospitals and other experts before their adoption. JCAHO standards and required characteristics focus on

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ments for utilization review are met by the existence of utilization and quality control peer review organizations.

In general, to meet the Medicare and Medicaid conditions of participation, hospitals must meet "any requirement under section 1861(e) of the [Social Security] Act and implementing regulations which the Secretary [of Health and Human Services], after consulting with [the Joint Commission] and [the American Osteopathic Association], identifies as being higher or more precise than the requirements for accreditation (section 1865(a)(4) of the Act)" (42 CFR Subpart S, 405.1901(d)(3)). Psychiatric hospitals must meet "the additional special staffing requirements that are considered necessary for the provision of active treatment in psychiatric hospitals (section 1861(f) of the Act) and implementing regulations" (42 CFR Subpart S, 405.1901(d)(2)).

certain key functions across the hospital: quality assurance, privilege delineation, existence of policies and procedures, and infection control.

A hospital's failure to comply with key JCAHO standards sometimes results in "accreditation with contingencies." JCAHO gives each hospital a contingency score (which may be *zero*) that determines in part whether the hospital is accredited. The actual accreditation decision is made by JCAHO'S Accreditation Committee, following a recommendation by JCAHO staff, using a set of weighting procedures and objective rules to ensure consistency across hospitals. If a hospital receives a contingency, it must satisfy JCAHO within a specified period of time that it is in compliance with the problem standards. Depending on the nature of the contingencies, hospitals may have to submit to a focused resurvey, usually within 6 to 9 months from the date they receive the report. From 1982, when the current JCAHO accreditation procedure was implemented, until 1987, the percentage of surveyed hospitals with JCAHO contingencies of any type increased from about 65 percent to 90 percent (387,388,524).

About 7s hospitals (s percent of JCAHO-surveyed hospitals) each year receive enough contingencies of a serious nature that a formal nonaccreditation decision from JCAHO looks probable; the hospitals are informed of this possibility by JCAHO staff before the staff recommendation goes to the JCAHO Accreditation Committee. Among the s percent, 3 to 4 percent of the JCAHO-surveyed hospitals correct their deficiencies to the satisfaction of JCAHO and avoid a formal nonaccreditation decision. Each year, about 1 to 2 percent of all JCAHO hospitals surveyed, or 15 to 30 hospitals, are formally judged by JCAHO to be nonaccredited. Some of the 1 to 2 percent of hospitals that are formally nonaccredited work on correcting deficiencies while they are appealing the JCAHO decision and then request a resurvey; others drop their quest for JCAHO accreditation, sometimes permanently. Some hospitals do, however, request HCFA inspection following nonaccreditation by JCAHO.

HCFA Certification

Hospitals that desire Medicare and Medicaid reimbursement but choose not to be surveyed by



Photo credit: Joint Commission on the Accreditation of Healthcare Organizations

A JCAHO surveyor examines hospital records. JCAHO's accreditation process is intended to evaluate the overall capability of a hospital to provide medical care, rather than to evaluate particular services.

JCAHO or cannot meet JCAHO'S eligibility or accreditation criteria may opt to be certified by HCFA. About 1,400 hospitals per year routinely choose to be surveyed by HCFA. Because for every day that a hospital is not certified by HCFA, it loses Medicare and Medicaid reimbursement, not being accredited by JCAHO or certified by HCFA is very costly for a hospital.³

Most HCFA-certified hospitals are small, rural community hospitals (438). Texas has the largest number of HCFA-certified hospitals (157 hospitals), followed by Kansas (83), Minnesota (63), Georgia (59), Nebraska (56), Mississippi (55), California (53), Oklahoma (51), Louisiana (50), Florida (48), and Iowa (46) (438). Those 11 States have half the non-JCAHO-accredited, HCFA-certified hospitals in the United States and its possessions.

³Accreditation by the American Osteopathic Association enjoys the same status with respect to Medicare and Medicaid payment as JCAHO accreditation.

HCFA uses survey methods that are somewhat different from JCAHO'S. HCFA'S hospital surveys are conducted annually, whereas JCAHO'S are conducted every 3 years. HCFA/State surveyors have the force of law and the threat of noncertification to ensure compliance, while the JCAHO organization does not. HCFA surveyors are State personnel, and although the teams receive some training from HCFA, their composition is determined by the States (399). JCAHO surveyors are hired and trained by JCAHO. JCAHO provides 2 weeks of didactic training, a 3- to 4-week preceptorship, and an annual 3-day conference for surveyors.

JCAHO has stricter criteria for surveyors than does HCFA. JCAHO requires each survey team to include one physician, one nurse, and one hospital administrator. In addition, JCAHO requires the nurse and hospital administrator surveyors to have had administrative experience in a hospital. The qualifications of HCFA/State surveyors are more diverse, and many of these surveyors are not as highly trained as JCAHO surveyors. Of

the 2,786 surveyors (of a total of about 3,400) who responded to a HCFA questionnaire, for example, only 10 (less than one-half of 1 percent) were medical doctors (646). Finally, HCFA has substantially fewer standards than does JCAHO, and HCFA'S conditions of participation are much less detailed than JCAHO'S standards. Generally, 1 percent or less of the hospitals surveyed by HCFA each year are terminated from the program involuntarily (249).⁴

Overall Hospital Accreditation/Certification and Scope of Services

Neither JCAHO accreditation nor HCFA certification is designed to assess whether particular hospital departments are capable of providing specific services. Nevertheless, JCAHO accreditation or HCFA certification does ensure that a certain scope of services exists in a hospital. In order to qualify for the survey on which JCAHO accreditation is based, a hospital must meet certain eligibility criteria. The hospital must maintain facilities, beds, and services that are available over a continuous 24-hour period, 7 days a week. Unless a hospital is a psychiatric or substance abuse facility, it must also provide diagnostic radiology, dietetic, emergency, rehabilitation, and respiratory care services, among others. In addition, it must provide at least one of the following acute-care clinical services: medical, obstetric-gynecological, pediatric, surgical, psychiatric, or alcohol- or drug-abuse services. If the hospital provides obstetric-gynecological or surgical services, it must also provide anesthesia services.

A hospital is also required to supply far fewer hospital services for HCFA certification than for JCAHO accreditation. Services required by JCAHO that are not required by HCFA include emergency services, nuclear medicine services, some type of special care services, professional library services, and social work services. For both JCAHO accreditation and HCFA certification, surgical services are optional.⁵ Although both

HCFA and JCAHO rate a number of specific departments or services (e.g., diagnostic radiologic services, outpatient services, surgical and anesthesia services), for the most part, neither rates condition-specific services such as heart disease or cancer services.

Standards and Guidelines for Specific Services

Neonatal Intensive Care Services

In 1976, in the face of a proliferation of neonatal intensive care units, the Committee on Perinatal Health' proposed guidelines for the regionalization of U.S. maternal and perinatal health services (142). Underlying the concept of regionalization of these services is the idea that high-risk mothers and infants will be screened and referred or transported to the appropriate level of care. The Committee on Perinatal Health proposed three levels of hospital care for perinatal services. Hospitals that served as regional centers and provided the most sophisticated neonatal intensive care were to be designated Level III facilities. Hospitals that provided neonatal intensive care but lacked some services provided in Level III facilities were to be called Level II facilities; and hospitals that provided normal newborn care with no special units for the care of seriously ill infants were to be called Level I facilities.

In 1983, the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists more fully explicated the responsibilities and requirements of the three levels of hospitals in the regional system of maternal and perinatal services. A document issued by these organizations specified guidelines for minimum number of beds, square footage per bed, personnel, hospital structure, equipment, ancillary support, and educational services for parents (15).

A recent analysis by OTA concluded that neonatal intensive care has been in large part responsible for the remarkable decline in U.S. neonatal

⁴In fiscal year 1987, 9 hospitals were terminated involuntarily, in fiscal year 1986, 20 hospitals were terminated involuntarily, and in fiscal year 1985, 8 hospitals were terminated involuntarily for not meeting HCFA'S conditions of participation.

⁵The reason surgical services are optional for JCAHO is to make it possible for psychiatric hospitals to be accredited. In most other

respects, psychiatric hospitals are held to the same standards as all other accredited hospitals.

⁶The Committee on Perinatal Health was a joint effort by the American Medical Association, the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, and the American Academy of Pediatrics.

mortality rates over the past 25 years and has contributed to improved long-term developmental outcomes for premature infants; the improved survival of premature infants has not been accompanied by an increase in the proportion of babies with serious long-term disability (194).⁷ According to OTA's analysis, however, "an extremely premature baby's chances for survival and normal development are in large part determined by where the baby is born" (194). The evidence strongly suggests that the likelihood of survival among very low birthweight babies (babies weighing under 1,500 grams at birth) is highest if the baby is born in a hospital designated a Level III neonatal facility. When considering these conclusions, however, one should keep in mind that they are based on some studies that were not methodologically rigorous (i.e., studies that did not use random assignment of newborns to compare Level I, II, or III facilities). Some studies have found that very low birthweight infants in Level III units had lower mortality rates than those in Level II units.

The concept of regionalization for perinatal services has not been so well accepted by hospitals and physicians, however (194). Despite the existing guidelines, there is no standard national application of what constitutes Level II or Level III perinatal care (106). Ohio and some other States use the American Academy of Pediatrics/American College of Obstetricians and Gynecologists guidelines to evaluate each hospital's perinatal services and assign levels accordingly (73,106). In California and most other States, however, the regional system of perinatal services is informal, and each hospital classifies its own services (344).

JCAHO applies standards for neonatal intensive care units in its overall hospital accreditation process (325), but these JCAHO standards are much less detailed and specific than the guidelines of the American Academy of Pediatrics and American College of Obstetricians and Gynecologists. Table 9-1 illustrates some of the differences between them in terms of staffing. JCAHO'S standards do not differentiate between Level II and

III neonatal intensive care. Even though JCAHO evaluates neonatal or other specific services as part of its overall hospital accreditation process, consumers may want to go beyond JCAHO accreditation to approvals by the appropriate specialty organization.

Cancer Care

Being stricken with cancer creates great fear among patients, and patients with cancer are intensely interested in finding the appropriate place for treatment. At least three organizations of independent observers have devised systems of approval for cancer treatment centers:

- the American College of Surgeons,
- the Association of Community Cancer Centers, and
- the National Cancer Institute.

There are substantial differences among them.

Cancer program approval by the American College of Surgeons is granted following an application and a survey by three members of the Commission on Cancer. The four basic requirements for American College of Surgeons approval are as follows:

1. the existence of an established multidisciplinary cancer committee that meets quarterly and provides the overall leadership of the cancer program;
2. an established tumor registry with 2 years of patient data and 1 year of successful (minimum 90 percent) patient followup;
3. patient-oriented, multidisciplinary cancer conferences conducted weekly or monthly; and
4. completion of two patient care evaluation studies each year (27,28).

Failure to comply with any one of these requirements results in either a 1-year approval (versus the usual 3-year approval) or, if there are other significant deficiencies, nonapproval. When a hospital first applies for approval, approval is not granted if there are any deficiencies. The American College of Surgeons has approved about 1,200 cancer programs (356), and an additional 400 to 500 are awaiting approval (469a). Centers approved by the American College of Surgeons'

⁷OTA did find, however, that there has been an increase in the absolute number of survivors with serious long-term disability (194).

Table 9-1.—Various Organizations' Standards and Guidelines for Staffing Neonatal Care Facilities

JCAHO Standards for Staffing Neonatal Intensive Care Units		
S. P.7.4.2. The director or other qualified physician designee in charge of the unit has at least 1 year of recognized special training and experience, as well as demonstrated competence, in neonatology.		
S. P.7.4.3. Pediatric surgery is provided in the hospital, as required.		
S. P.7.4.4. Nursing care is supervised by a registered nurse who has training, experience, and documented current competence in the nursing care of high-risk infants.		
S. P.7.4.5. The nursing staff is proficient in teaching parents how to care for their infants at home.		
S. P.7.4.9. Radiologic technologists are familiar with X-ray techniques to be used with newborn infants so that repetitive exposures are not necessary.		
American Academy of Pediatrics and American College of Obstetricians and Gynecologists' Guidelines for Staffing Level I, Level H, and Level III Neonatal Facilities		
<u>Level /</u>	<u>Level //</u>	<u>Level III</u>
Chief of service One physician responsible for perinatal care (or codirectors from obstetrics and pediatrics)	Personnel Joint Planning: Ob: Board-certified obstetrician with certification, special interest, experience, or training in maternal-fetal medicine; Peals: Board-certified pediatrician with certification, special interest, experience or training in neonatology	Codirectors: Ob: Full-time board-certified obstetrician with special competence in maternal-fetal medicine. Peals: Full-time board-certified pediatrician with special competence in neonatal medicine
Other physicians: Physician (or certified nurse-midwife) at all deliveries Anesthesia services Physician care for neonates	Level I plus: Board-certified director of anesthesia services Medical, surgical, radiology, pathology consultation	Levels I and II plus: Anesthesiologists with special training or experience in perinatal and pediatric anesthesia Obstetric and pediatric subspecialists
Supervisory nurse Registered nurse in charge of perinatal facilities	Ob: RN with education and experience in normal and high-risk pregnancy only responsible Peals: RN with education and experience in treatment of sick neonates only responsible	Supervisor of perinatal services with advanced skills Separate head nurses for maternal, fetal, and neonatal services
Staff nurse/patient ratio		
Normal labor	1:2	
Delivery in second stage	1:1	
Oxytocin inductions	1:2	
Cesarean delivery	2:1	
Normal delivery	1:6-8	
Other personnel Licensed practical nurse, assistants under direction of head nurse	Level I plus: Social service, biomedical, respirator therapy, laboratory as needed	Level I plus: Designated and often full-time social service, respiratory therapy, biomedical engineering, laboratory technician Nurse clinician and specialists Nurse program and education coordinators

SOURCES: JCAHO standards: Joint Commission on the Accreditation of Healthcare Organizations, *AMI/BB: Accreditation Manual for Hospitals* (Chicago, IL: 1985); **AAP/ACOG guidelines:** American Academy of Pediatrics and American College of Obstetricians and Gynecologists *Guidelines for Perinatal Care* (Evanston, IL: 1983).

Commission on Cancer are listed in the American Hospital Association's *Guide to the Health Care Field* (29), and a list of approved programs is available from the American College of Surgeons. The American College of Surgeons does not disclose how many programs have been refused approval, except to say that the number is small.

The American College of Surgeons' patient care evaluation studies are similar to JCAHO'S monitoring and evaluation requirements,⁸ except that

⁸A key aspect of hospital quality assurance activities required by JCAHO, the monitoring and evaluation process includes identifying important aspects of care, identifying indicators related to these

established American College of Surgeons-approved programs are required to complete one study to measure process and one study to measure outcome, and new programs may complete two process studies each year until sufficient data are available to participate in the outcome studies. The specifics of both JCAHO'S and the American College of Surgeons' monitoring/evaluation programs are determined internally at the hospital.⁹ Unlike JCAHO, however, the American College of Surgeons requires that the outcome study compare the hospital's experience with national or regional results (27). The American College of Surgeons does have a voluntary program of cancer patient care evaluation, in which results are compared across hospitals.

In comparison to the American College of Surgeons' program, the accreditation program of the Association of Community Cancer Centers is just beginning. Membership in the Association of Community Cancer Centers is granted if a cancer center has the following:

1. a multidisciplinary cancer program;
2. supervision by a multidisciplinary cancer committee, group, or team; and
3. direct or indirect involvement with care for cancer patients.

Membership is open to freestanding cancer centers, health maintenance organizations, physician group practices, home health agencies, hospital-based cancer programs and individual providers (45). The Association of Community Cancer Centers has standards, but they operate primarily as guidelines to be used as self-assessment tools by the association's organizational members (46). The Association of Community Cancer Centers has about 30 hospital members and plans to begin a survey process in the near future (179).

The National Cancer Institute has several programs to designate cancer centers: the Compre-

aspects of care, establishing thresholds for evaluation related to the indicators, collecting and organizing data, evaluating care when thresholds are reached, taking actions to improve care, assessing the effectiveness of the actions and documenting improvement, and communicating relevant information to the organizationwide quality assurance program (326).

⁹JCAHO recently modified its requirements to encourage the use of indicators from the clinical literature (326).

hensive Cancer Centers program, the Community Clinical Oncology Program, and the Cooperative Group Outreach Program. Such designations are a requirement for receiving support grants and are based primarily on research capability (118, 580, 668).

Emergency and Trauma Services

Emergency and trauma services involve situations in which life or death may be at stake, and are therefore of extreme importance to consumers. In addition, consumers seem more likely to choose an emergency department than other hospital departments, although they may consult their physicians for advice or direction. 10

There are several sources of standards and guidelines for the scope of emergency services that may potentially be of use to consumers. JCAHO, HCFA, the American College of Emergency Physicians and Emergency Nurses Association (ACEP/ENA), and the American Medical Association (AMA) all have or are planning guidelines for emergency services (23,36,38,325,642).¹¹ The American College of Surgeons has a set of guidelines for trauma care (26). In addition, many States and other localities have requirements that hospitals must meet to provide emergency services and/or to be designated as trauma centers.

Here as in other sections of this chapter, the distinction must be kept in mind between standards and guidelines. Only the requirements for emergency services and trauma care of JCAHO, HCFA, and States and localities are required for accreditation or certification by those organizations and can strictly be considered standards. Specialty organizations provide guidelines for emergency services and trauma centers, but their use by hospitals is optional. The ACEP/ENA guidelines, for example, are a "statement of suggested capability . . . not designed to be interpreted as mandatory by legislative, judicial, or

¹⁰Their physicians may be on the medical staff of a particular hospital and may direct the patient to that hospital so they may care for the patient there.

¹¹The Accreditation Association for Ambulatory Health Care also has standards for emergency services, but their standards are oriented primarily toward freestanding emergency service centers (4). The ACEP/ENA guidelines apply to both hospital and freestanding emergency facilities (23).

regulatory bodies” (23). Similarly, AMA guidelines for emergency services, currently under revision, are to be considered guidelines for use by hospitals, rather than standards (36,38,178). Neither ACEP/ENA nor the AMA has any plans to survey for compliance with the guidelines they have devised. ACEP/ENA, American College of Surgeons, and AMA guidelines have, however, been adopted or adapted by some State bodies for regulatory use.

The following discussion makes a distinction between emergency services and trauma centers, but in practice, the distinction is not always clear. The medical services being evaluated in the trauma literature are not always restricted to trauma care (543), and there is some overlap in the guidelines for emergency services and trauma centers, as there is in the services themselves. Some trauma centers have their own admitting areas and staff (621), while others are a “concept” within the emergency department (153). In general, however, emergency medical services focus on prehospital care and care within the emergency department; trauma care includes in-hospital and rehabilitative care.

Standards and Guidelines for Emergency Services.—Standards and guidelines for emergency services and standards can be distinguished along at least three dimensions: 1) whether they are standards or guidelines, 2) their breadth or depth, and 3) whether they distinguish among levels of services. Table 9-2 shows how various organizations’ standards and guidelines for emergency services can be characterized along these dimensions.

The proposed AMA guidelines for emergency services will have perhaps the largest breadth, because they will be a compilation of guidelines from about 10 specialty organizations. The list of specialty organizations consulted in the development of the proposed AMA guidelines is shown in table 9-3.

Because the AMA guidelines for emergency services will incorporate the standards of specialty organizations, they will also have the greatest depth. The guidelines for emergency services of specialty organizations such as the ACEP/ENA, for example, designate administrative and managerial responsibilities, staffing levels, equipment, drugs, and relationships among the emergency service and other hospital departments (23). The ACEP/ENA guidelines do not specify guidelines for care of specific conditions such as burns or poisonings. Although the ACEP/ENA guidelines do not require that emergency departments operate continuously and do not stipulate levels of emergency care, they state that the emergency department should be staffed by a physician during all hours of operation. Optimally, according to the ACEP/ENA guidelines, the medical staff should be board certified in emergency medicine and the nursing staff should practice in accordance with the Standards of Emergency Nursing Practice.

Like the other organizations, JCAHO lists various aspects of hospital emergency services: organization, direction and staffing; integration, training and education, policies and procedures; and facility design and equipment. JCAHO standards for emergency services are more specific than

Table 9-2.—Characteristics of Various Organizations’ Standards and Guidelines for Emergency Services

Organization	Standards or guidelines	Breadth v. depth	Levels of care
JCAHO	Standards ^a	Breadth	Levels I (highest) to IV (lowest)
HCFA	Standards ^a	Breadth	None specified
ACEP/ENA	Guidelines ^b	Breadth	None specified
AMA	Guidelines ^b	Breadth and depth	To be specified

Abbreviations: ACEP/ENA = American College of Emergency Physicians and Emergency Nurses Association; AMA = American Medical Association; HCFA = Health Care Financing Administration; JCAHO = Joint Commission for the Accreditation of Healthcare Organizations.

^aThese guidelines apply to hospitals only.

^bThese guidelines apply to freestanding emergency facilities as well as hospitals.

SOURCE: Office of Technology Assessment, 19S8.

Table 9-3.—Specialty Organizations To Be Consulted in Developing the American Medical Association's "Guidelines for Classification of Hospital Emergency Capabilities," January 1988

Type of emergency	Organization providing guidelines or guidance
General medical	American College of Emergency Physicians'
Behavioral and psychiatric	American Psychiatric Association
Burn	American Burn Association
Cardiac	American College of Cardiology and American Hospital Association
Pediatric	American Academy of Pediatrics
Perinatal	American College of Obstetrics and Gynecology and American Academy of Pediatrics
Poisoning or drug	American Association of Poison Control
Spinal cord	American Spinal Cord Injury Association
Trauma	American College of Surgeons
Pediatric trauma	American Pediatric Surgery Association; American College of Surgeons

-entative.

SOURCE: P. Dietz, Program Administrator, Commission on Emergency Medical Services, American Medical Association, Chicago, IL, personal communication, Jan 28, 1988.

ACEP/ENA guidelines with respect to the components of medical records for emergency patients and include requirements for quality control and monitoring and evaluation. In addition, JCAHO hospital-wide standards (e.g., medical staff requirements) apply to emergency services. Unlike the ACEP/ENA guidelines, JCAHO standards require that a hospital's emergency service be classified according to four levels of services provided, ranging from a "comprehensive" level of care (Level I) to a "first aid/referral" level of care (Level IV). The primary distinguishing feature among the four levels of emergency services is physician availability, although there also are differences with respect to nursing staff and equipment.

HCFA'S condition of participation governing emergency services is rather broad (see table 9-4). They do, however, contain some of the same basic requirements as do the standards and guidelines of other groups. These requirements pertain to organization and direction and the qualifications of personnel. HCFA does not require specific staff coverage, equipment, or drugs.

Table 9-4.—HCFA'S Condition of Participation Governing Emergency Services

482.55 Emergency Services

The hospital must meet the emergency needs of patients in accordance with acceptable standards of practice.

a. *Standard: Organization and direction.*

If emergency services are provided at the hospital:

1. The services must be organized under the direction of a qualified member of the medical staff; and
2. The services must be integrated with other departments of the hospital.
3. The policies and procedures governing medical care provided in the emergency service or department are established by and are a continuing responsibility of the medical staff.

b. *Standard: Personnel.*

1. The emergency services must be supervised by a qualified member of the medical staff.
2. There must be adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility.

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration, "Appendix A: Interpretive Guidelines and Survey Procedures—Hospitals," *State Operations Manual, Provider Certification*, HCFA-Pub. 7 (Baltimore, MD: September 1988).

Standards and guidelines for emergency services differ in their requirements regarding physician services. ACEP/ENA guidelines for emergency care recommend that emergency facilities be staffed during all hours of operation by a physician "trained and experienced in emergency medicine. According to ACEP/ENA, unless there is physician staffing, a hospital should not be regarded as able to provide emergency services (709). This is a somewhat controversial recommendation. Not all of the 77 million visits to emergency facilities in a year (506) require a physician trained and certified in the specialty of emergency medicine, or even a physician. The basis of this ACEP/ENA guideline, however, is that "emergency health care exists for the individual benefit of the patient or family who perceives a need for emergency care, and for society's benefit in most casualty accidents" and that "the American public justifiably expects an emergency facility to be staffed by medical, nursing, and ancillary personnel who are trained and experienced in the treatment of emergencies" (23).

JCAHO'S standards for emergency services do not require the presence of a physician at all times. JCAHO'S standard for Level IV, the least com-



Photo credit: American College of Emergency Physicians

External standards and guidelines for emergency services differ on whether a physician must be available at all times in hospital emergency rooms.

prehensive level of care, for example, is that the "emergency service offers reasonable care in determining whether an emergency exists, renders lifesaving first aid, and makes appropriate referral to the nearest facilities that are capable of providing needed services." There must be some mechanism for providing physician coverage at all times in Level IV emergency facilities, but the mechanism is to be defined by the medical staff of the hospital. That the standard does not require immediate availability is reflected in JCAHO standards for Level III and higher emergency facilities. Level III facilities, for example, are required to have at least one physician available to the emergency care area within approximately 30 minutes.¹² The impact of having a trained and experienced physician available in an emergency department at all times has not been evaluated, so the relative validity of these standards cannot be judged.

In addition, it is noteworthy that only one set of standards or guidelines for emergency services—JCAHO's—requires that a hospital have a provision for providing emergency care 24 hours a day, 7 days a week (325).

¹²Level I and 11 hospitals are required to have at least one physician experienced in emergency care on duty in the emergency care area at all times. In addition, in Level I hospitals, there must be in-hospital physician coverage by members of the *medical* staff or by senior-level residents for at least medical, surgical, orthopedic, obstetric/gynecological, pediatric, and anesthesiology services.

Trauma Center Designations.—A review by the Centers for Disease Control of mortality data for 1984 shows that unintentional injuries were the leading cause of "years of potential life lost" before the age of 65 (440). A large proportion of efforts to decrease the number of deaths caused by injury have focused on injury prevention, but considerable attention has also been directed to the designation and implementation of emergency medical service systems (e.g., 454, 455; the Federal Emergency Medical Services Systems Act of 1973 [revised in 1975, repealed in 1981¹³]). In an organized emergency system, some hospitals are designated as regional trauma centers, to which severely multiply injured individuals are brought for treatment.

Intuitively, one expects that treatment and outcome in trauma centers will be better than elsewhere because of the immediate availability of rapid transportation, highly trained field personnel and emergency physicians, modern diagnostic tools, and experienced trauma surgeons (543). The only current national guidelines for trauma centers have been devised by the American College of Surgeons' Committee on Trauma (26). The American College of Surgeons' guidelines incorporate resources for both prehospital and hospital care. For hospitals, the guidelines specify the desired characteristics for three levels of trauma care. The two highest levels (Levels I and 11) have similar requirements for patient care; the highest level (Level I) has additional requirements for education and research in trauma. Level III trauma center hospitals serve communities that do not have all the resources usually associated with Level I or 11 institutions; Level 11 facilities must have a "maximum commitment to trauma care commensurate with resources." Thus, for example, a Level 11 hospital might have a surgeon and other personnel on call rather than in-house. Nonetheless, a Level 11 facility would be called a trauma center by the American College of Surgeons.

According to a recent survey by the American College of Surgeons, approximately 177 hospitals

¹³The Federal Government devolved much of its leadership responsibilities to States by folding the Emergency Medical Services Systems Act program into the Preventive Health and Health Services block grant.

have Level I trauma centers, 138 of which are designated as Level I by some external body; the remainder are self-designations by hospitals themselves. About 157 hospitals have Level II trauma centers, 124 of which are so designated by some external body (127). Table 9-5 indicates that only 19 States designate trauma centers using either the guidelines of the American College of Surgeons or a modified version of those guidelines.

The availability of various surgical, as opposed to medical, personnel is a major requirement for meeting the American College of Surgeons' guidelines, although there are numerous other require-

ments as well (26). For example, the American College of Surgeons recommends that a trauma team be organized and directed by a surgeon. The surgeon-directed trauma team is to evaluate the patient initially, and a surgeon is to be responsible for the patient's overall care. A physician with special competence in care of the critically injured is to be a designated "member" of the trauma team, and is to continuously staff the overall emergency department, but not be the head of the trauma team. Although the need for surgeons to deliver most trauma care is generally acknowledged, there is some controversy about who should design and manage the overall service (44).

RELIABILITY OF THE INDICATOR

Accreditation schemes for hospitals overall and for particular services are, it is clear, highly variable. To a consumer interested in neonatal intensive care, certification by the State of Ohio for a particular level of neonatal intensive care would convey much more information than the fact that a hospital with a neonatal intensive care unit had received JCAHO accreditation. Similarly, to a person interested in cancer care, a hospital's membership in the Association of Community Cancer Centers or designation as a Comprehensive Cancer Center by the National Cancer Institute would not convey the same type of approval as would approval by the Cancer Commission of the American College of Surgeons. Overall, HCFA'S certification process is not as rigorous as JCAHO'S accreditation process.

Some States have developed specific requirements for hospitals to offer specific services, but

the types of services under these regulations and the specific requirements differ across States. In California, for example, emergency services are considered a supplemental service and appear as such on hospital licenses and published information for consumers (113,345); New York is about to change a similar regulation to make emergency services a basic requirement (472).

At the level of the individual State standard, there is considerable variation, because States develop their standards through statute and regulation, and statutes vary across States. The reliability of the surveyors and the survey process may vary as well. Hospitals surveyed by JCAHO, for example, have complained that judgments regarding their compliance with the same standard may vary considerably between survey periods. In part, the variation is due to periodic revision by JCAHO of its standards, a necessity.

VALIDITY OF THE INDICATOR

Accreditation for scope of hospital services is not a single entity, and individual standards themselves may vary in the extent to which they have been validated. Optimally, perhaps, standards and guidelines for scope of services would be based on medical practice with systematically demonstrated efficacy. The problem, however, is

that much of medical practice is not based on evidence from scientific studies (628). Decisions about the "best" staff, equipment, and organization for a particular service or a particular problem are often the result of clinical judgment. Thus, most standards have been developed through expert consensus.

Table 9-5.—Characteristics of Trauma Center Designations by State^a

	Categorization of facilities				COMMITMENTS OF STATE LAWS AND REGULATIONS			
	Categorize trauma centers by level	Categorize emergency services by AMA guidelines	Categorize specialized centers	System designated to bypass nontrauma centers	Legal authority embedded in legislation or regulation	Use survey team from outside the State	American College of Surgeons (ACS) guidelines	Modified 1981 ACS guidelines
Alabama								
Alaska								
Arizona								
Arkansas								
California	CA	CA	CA	CA	CA	CA	CA	CA
Colorado								
Connecticut	CT	CT	CT					
Delaware	DE	DE	DE	DE	DE	DE	DE	DE
District of Columbia	DC			DC	DC	DC		DC
Florida	FL			FL	GA	GA		GA
Georgia								
Hawaii		HI		ID	HI			HI
Idaho								
Illinois								
Indiana		IN		IA		A		
Iowa								
Kansas				KY				
Kentucky								
Louisiana								
Maine								
Maryland	MD	MD	M	MD	MD	MD	MA	MD
Massachusetts		MI		MA				
Michigan								
Minnesota			MS	MS	MO	MS	MS	MO
Mississippi								
Missouri								
Montana								
Nebraska								
Nevada								
New Hampshire								
New Jersey	NJ			NH		NH	NH	NM
New Mexico	NM		NM	NJ		NJ	NJ	
New York	NY			NM		NM		
North Carolina	NC	NC	NC	NC		NC		NC
North Dakota								
Ohio								
Oklahoma								
Oregon	OR	OR	OR					
Pennsylvania	PA		PA	PA	PA	PA	RI	PA
Rhode Island			RI	RI	RI	RI	RI	SC
South Carolina	SC	SC	SC	SC	SC	SC		
South Dakota								
Tennessee								
Texas								
Utah	UT	UT	UT	UT	UT	UT	VA	UT
Vermont				VT	VT	VA	VA	
Virginia				VA	VA			
Washington								
West Virginia	WV							
Wisconsin								
Wyoming								

^aExcludes trauma center designations by counties and cities, or which were not reviewed.
^bSpecialized centers include such facilities as spinal cord injury centers and burn centers.
^cSome States, for example, use survey teams from or suggested by the American College of Surgeons.
 SOURCE: H. Champion (Chief Director, Critical Surgical Care Services, Medstar, Washington Hospital Center), and H. Bricker (Attorney at Law, Bricker Eckler, and Regulations), Washington, DC, 1988.

Expert consensus may be an appropriate basis for establishing standards and guidelines for hospitals overall and for particular conditions, services, and departments. For some services, however, groups of experts disagree with one another, either on the need to establish standards or on the content of the standards themselves. The consumer is then left with the puzzling question of which group of standards or guidelines is more valid.

The validity of particular standards and guidelines could be demonstrated with studies of relationships between standards or guidelines and good process and outcomes, determined post hoc. Some standards and guidelines, such as those for neonatal intensive care and trauma centers, have been subjected to some such study, but most have not. JCAHO'S hospital accreditation standards for hospitals have been subjected to very little study, and HCFA'S hospital certification standards subjected to none. The studies that have been conducted have had methodological problems. For the most part, they have relied on retrospective analysis and outcomes as criteria and have not been conducted by independent observers.

One significant problem, applicable to all standards and guidelines, is that the standards or guidelines may change over time, sometimes significantly (388), a situation that makes the results of studies conducted at one point in time not applicable to subsequent standards. Frequent changes in standards may, of course, be necessary to reflect changes in technology and medical practice.

Validity of Overall Hospital Accreditation

There has been little attempt to validate overall JCAHO accreditation as an indicator of the quality of care. An important factor limiting studies seeking to validate JCAHO accreditation is that accreditation is refused or withdrawn for so few hospitals that the mere fact of accreditation may not be very sensitive to variations in quality. The few studies of the validity of JCAHO

accreditation as an indicator of the quality of care have yielded inconclusive or noncomparable results.

Hyman obtained the results of JCAHO surveys for New York City hospitals (312). Unexpectedly, Hyman found that publicly supported hospitals had better JCAHO contingency scores¹⁴ than voluntary not-for-profit hospitals on 9 of 11 functions. Friedman analyzed the relationships between numbers of JCAHO contingencies and HCFA'S 1984 hospital mortality data (237). The result was a very low, statistically insignificant correlation, but this result is not surprising given the problems with HCFA'S measure of hospital mortality (see ch. 4). One internal JCAHO study found a high level of agreement among JCAHO senior clinical and administrative staff as to the significance of several categories of standards for ensuring quality patient outcomes, but actual outcomes or process criteria were not used as validation standards (572).

Because JCAHO accreditation means that hospitals will be certified by HCFA, HCFA is required by law to validate JCAHO'S results (Subsection 1864(c) of the Social Security Act). Every year, HCFA requests that State surveyors survey a small sample of JCAHO-accredited hospitals, stratified to be representative of hospitals nationally. HCFA also asks State surveyors to investigate patient complaints that seem to have substance. The State surveyors perform JCAHO validation surveys for HCFA using the Medicare conditions of participation. If a State surveyor finds that a hospital has significant deficiencies that could affect the health and safety of patients, the hospital is placed under State surveillance until the deficiencies are corrected. The hospital is no longer deemed to meet the Medicare conditions of participation, and the State monitors the correction of any deficiency.

HCFA conducted the last published JCAHO validation survey in fiscal year 1983, and transmitted it to Congress in 1986 (639). In general, JCAHO hospitals were found to be in compliance with HCFA'S requirements. Any conclusion that JCAHO standards are valid because of their compliance with HCFA'S requirements, however, depends on the validity of HCFA'S survey process,

¹⁴At the time Hyman collected his data, JCAHO was using the terminology "recommendations" rather than "contingencies."

and that process has not been validated. In addition, the discrepancy rates that HCFA found between HCFA'S deficiencies and JCAHO'S contingencies would mean that 276 hospitals in any single year, and as many as 750 hospitals overall¹⁵ would be out of compliance on some condition of participation.

One future source of information for developing and validating JCAHO (and HCFA) standards is JCAHO'S Agenda for Change project (see app. D). This project is attempting to develop more valid and condition-specific standards, including clinical process and outcome indicators. A potential JCAHO clinical indicator for obstetrics, for example, is birthweight-specific hospital mortality rates; hospitals designating themselves as high level neonatal intensive care units may have to meet a minimum birthweight-specific mortality rate. This project is being pilot-tested now with a small sample (324). In addition, JCAHO is progressing with plans to revamp its structural indicators so that they reflect the characteristics of effective health care organizations.

Validity of Standards and Guidelines for Specific Services

Many of the available studies of the validity of trauma center designations as indicators of the quality of care are methodologically flawed. Those that rely in whole or in part on autopsy

¹⁵ H(3A)'s 1983 validation surveys found that Up to 15 percent of hospitals surveyed were not in compliance with HCFA standards, although they had been in compliance with JCAHO's standards. If the 15 percent noncompliance rate is multiplied by the total number of JCAHO-surveyed hospitals (5,000), the number of hospitals not in compliance with HCFA standards would be 750.

studies, for example, are biased in that not all deaths result in autopsies. Some studies use different sources of information to determine causes of death. In one study of the San Diego County Regional Trauma System, for example, the causes of deaths in trauma centers were taken from a trauma registry, but the causes of death in comparison hospitals were taken from autopsies (564).

Perhaps more important, most studies of trauma center designations tend to be uncontrolled; that is, they merely compare patient outcomes before and after implementation of a trauma system. Studies that merely compare outcomes before and after implementation of a trauma system do not take into account factors other than medical care that may be responsible for reducing death rates from trauma (543). These factors may include simultaneous changes, such as reductions in speed limits and enhanced enforcement of drunk driving laws. In studies of standards and guidelines for neonatal intensive care, most of the research has been done only on Level III neonatal intensive care units (194), and the validation standards have been outcome measures, primarily mortality. Plans are underway to conduct studies of neonatal intensive care units using process criteria for validation.

Standards for emergency services have not been subject to the same amount of study that trauma center designations have, perhaps because the scope of services in emergency rooms is so broad. A knowledgeable observer concluded that there is no dependable knowledge about interhospital differences in emergency department performance or about the sources and correlates of such differences; there is also no dependable knowledge about the factors and conditions that facilitate or hinder emergency department effectiveness (245, 246).

FEASIBILITY OF USING THE INDICATOR

If validated, compliance with external standards for scope of hospital services is potentially an extremely valuable and easily accessible indicator of the quality of care for consumers. Currently, JCAHO and the American College of Surgeons both provide hospitals with a certificate to

post. JCAHO'S certificate addresses overall hospital accreditation, not individual services. Detailed reports on the results of JCAHO surveys of hospitals would be more informative; but these results are for the most part not easily obtained.

JCAHO releases to the public, on request, information about whether a hospital is accredited, is involved in an appeal of its accreditation, is nonaccredited, or holds no accreditation status. JCAHO also releases a hospital's accreditation history. It does not, however, reveal a hospital's contingency score or copies of the survey reports. The JCAHO survey reports may be available on request from individual hospitals and from those States that require hospitals to submit the detailed survey reports as a requirement for licensure. Some States make the survey reports available; New York, Pennsylvania, and Arizona are among them. Other States, including California and Illinois, do not release copies of the JCAHO survey reports. States that recognize JCAHO accreditation for State hospital licensure purposes and require a copy of the accreditation report from the hospital are listed in table 9-6. JCAHO survey reports are long and technical, and consumers may face problems in interpreting the information they contain. One problem is that the survey reports focus on what is wrong with the surveyed hospitals. Without reviewing survey reports of several hospitals, consumers would not be aware of how a particular hospital compared with other hospitals.

Results of HCFA'S hospital surveys exist in several forms. HCFA constructs individual hospital facility profiles that indicate the types of deficiencies a hospital has had for past survey years, and the services and personnel available at the hospital, among other information (649). In addition, HCFA constructs a table comparing State, regional, and national deficiency patterns for each Medicare condition of participation (650). A table constructed in January showed that (27 percent) of the 18 HCFA-inspected hospitals in one State had deficiencies in the area of licensure of personnel; this rate compares to 19 percent for the U. S. Department of Health and Human Services Region 111 and 13 percent for the Nation (650). Some of the information from HCFA is not easy to use, however. The individual facility profiles report deficiencies by code numbers. These code numbers are not the same as the information on the report for the State, region and Nation, which does include written descriptions of the HCFA conditions of participation. It is, however, easy

to glean from the individual facility profiles the services available at the hospital, which could be an important source of information for consumers. Both HCFA reports are intended as internal management tools for HCFA, but must be made available to the public on request (249). As for the individual survey reports, copies of a report (form 2567) that includes both the surveyors' recording of deficiencies and the hospital's plan of correction, and copies of the original survey reports from which the deficiency portion of form 2567 is drawn, are available from State survey offices, which are required to release them to the public (249).

Some States publish information about hospital accreditation and certification overall, licensure for particular services, and other information. California, for example, will send consumers who request it a summary report on hospitals. Hospitals in California and New York State must post in a conspicuous place their licenses, which note the services that the hospital is permitted to provide (34s,414).

The feasibility of using scope of service designations to indicate quality of care is affected by the tendency of hospitals to self-designate themselves as specialists in particular areas. Even some State approval of trauma centers is based on hospital self-designation. Consumers would have to be careful that a designation is based at least on the stipulation of independent observers that the hospital adheres to a set of standards; otherwise such a designation may not be a valid indicator of quality. The American Hospital Association

Table 9-6.—States That Require Copies of JCAHO Accreditation Reports From Hospitals

Arizona	Massachusetts
California	Minnesota
Connecticut	Mississippi
District of Columbia	Montana
Florida	Nebraska
Georgia	New Hampshire
Idaho	New York
Illinois	North Carolina
Iowa	Pennsylvania
Kansas	South Carolina
Louisiana	Utah
Maine	Wyoming

SOURCE: Joint Commission on the Accreditation of Healthcare Organizations, "State Project Status Report," Chicago, IL, Sept. 21, 1957.

currently publishes a guide indicating the facilities and services available at hospitals that participate in the association's survey, but these designations are based largely on hospital self-reports. The American Trauma Society also publishes a list of trauma centers based on self-designation.

Consumers also face the problem of conflicting sets of standards for the same service. For cancer care, for example, there will soon be standards from two organizations (the American College of Surgeons and the Association of Community Cancer Centers). Although these stand-

ards build on each other to some extent, their relative validity remains to be established.

Even if available and reasonably validated, however, accreditation and standards for scope of services rely on the ability of patients to "match" their condition with the service as described by the accrediting body. When a patient requires more than one service, the problem becomes even more complex. Even accreditations that seem relatively condition-specific may not be useful to a particular patient. Hospitals whose cancer programs are approved, for example, may be more successful with some types of cancer than others.

CONCLUSIONS AND POLICY IMPLICATIONS

The external standards and guidelines that have been promulgated for hospital services overall and for scope of hospital services have not been rigorously validated as indicators of quality of care. Clearly, however, it seems worthwhile for consumers to seek out hospitals that have been judged by independent experts to have the appropriate resources to provide care, either overall or for specific conditions.

Some accreditation/certification information is readily available to consumers (see box 9-A). Information on a hospital's JCAHO accreditation history, for example, is available from JCAHO. HCFA will provide information on the certification status of any of the approximately 1,400 hospitals it inspects, and the American College of Surgeons will provide a list of the cancer programs it has approved. HCFA-inspected hospitals' actual survey reports are available from State agencies that conduct the surveys on behalf of HCFA. Some States require that hospitals post a notice stating which services they are allowed to perform and others provide consumers with reports supplying such information.

Other information is in existence but is more difficult for consumers to obtain or interpret. JCAHO survey reports, which form the basis of JCAHO accreditation decisions, are an example. Such reports can provide more detailed information to consumers than the mere fact of JCAHO

accreditation. To see the reports, consumers may have to approach the hospitals themselves and ask for the reports, although some States will provide consumers copies of JCAHO survey reports for individual hospitals. Some consumers may have trouble interpreting and comparing detailed survey reports, and may prefer to see summary judgments that compare hospitals along a range of scores. Although JCAHO computes overall contingency scores for hospitals and also evaluates whether hospital emergency services meet requirements for four levels of care, this information is not readily available to the public.

There are considerably more guidelines available for the internal, optional use of hospitals than there are standards applied by independent groups of observers. Although hospitals may diligently conform to such guidelines, consumers should be wary of hospitals that say they adhere to the principles of one group or another, when there is no independent evaluation of such compliance.

Several steps could be taken to address the existing problems of external standards for overall hospital accreditation and scope of hospital services as quality-of-care indicators, to make existing information available, to improve existing standards, and to develop new standards. Table 9-7 shows the status of existing standards and guidelines in terms of their validity and feasibility of use as indicators of quality.

Box 9-A.—Selected Sources of Information About Scope of Hospital Services

Type of information

JCAHO hospital accreditation history

JCAHO hospital survey reports

HCFA hospital survey reports

List of hospital cancer programs approved by
the American College of Surgeons

Organization, address, or telephone number

Joint Commission on Accreditation of
Healthcare Organizations
1-800-621-8007 (nationwide except Illinois)
1-800-572-8089 (Illinois)

Available from States of New York,
Pennsylvania, and Arizona
May be available from individual hospitals

Available from State agencies that conduct
surveys on behalf of HCFA

Cancer Department
American College of Surgeons
515 East Erie
Chicago, IL 60611

With some effort, existing information about compliance with existing standards could be made available to consumers. It seems ironic, for example, that survey reports for the 1,000 predominantly small and rural hospitals surveyed by HCFA are available to the public, while survey reports for the 5,000 hospitals surveyed by JCAHO on HCFA'S behalf are not. Hospitals accredited by JCAHO are paid on the same basis as those certified more directly by HCFA. HCFA could improve its individual facility profiles, so that the reasons for deficiencies are intelligible to consumers and comparable to the reasons in HCFA'S State, regional and national reports. As another example, JCAHO could include as part of its accreditation certificate the level of emergency services provided at a hospital, so that consumers could know whether a physician was likely to be on site. JCAHO and HCFA could develop summaries of their hospital survey reports that are meaningful to consumers (e.g., they could devise summary scores for specific services). Such information could be made available at hospitals themselves and in public places, such as libraries, local government offices, Social Security offices, and the offices of utilization and quality control peer review organizations. Similar information about the approvals by professional specialty organizations could also be made available.

Research to validate existing standards and help develop new standards is essential if consumers and providers are to be able to have confidence in the standards. Research is needed on all the standards and guidelines for scope of hospital services discussed in this chapter: JCAHO hospital accreditation standards; HCFA hospital certification standards; and various organizations' standards and guidelines for neonatal intensive care units, cancer care, emergency services and trauma units. Undoubtedly, research is needed on other condition-specific services. As some of the organizations that have developed standards begin to gather data about the process and outcome of care in organizations in compliance with the standards, the opportunities to conduct such research will increase.

Even as standards are being validated, the Federal Government, State governments, and private organizations could take more interest in developing and encouraging the use of consistent sets of standards for specific services and conditions. This step could increase consumers' access to scope of services information, as well as to hospitals with at least a minimal level of resources for conditions affecting them. Some consumers do not have access to scope of services information, because available guidelines are not applied

Table 9-7.—Characteristics of External Standards and Guidelines for Hospitals:
Overall Accreditation/Certification and Specific Services

	Validated	Voluntary or mandatory	Survey by independent observers	Publicly available	Ease of access to information
Overall hospital accreditation/certification:					
JCAHO	Some studies; generally not	Voluntary	Yes	Accreditation history	Accreditation his- tory easy; other information difficult
HCFA ^a		Mandatory for participating hospitals	Yes	Yes	Difficult
Standards and guidelines for specific services:					
<i>Neonatal/ intensive care services:</i>					
AAPIACOG	Level III/outcome studies	Voluntary	No	No	Difficult
States	Results differ by State	Varies	Ohio, some other States; not by AAPIACOG	Ohio, some others	Difficult
<i>Cancer care:</i>					
ACS	No	Voluntary	Yes	Yes ^a	Fact of approval relatively easy; more detailed information difficult
ACCC	No	Voluntary	To begin	Yes ^b	Fact of membership relatively easy; actual adherence to standards difficult
<i>Emergency services:</i>					
JCAHO	No	Mandatory for participating hospitals	Yes	No, except through some States and willing hospitals	Difficult
ACEP/ENA	No	Voluntary	No	No	NA
AMA ^a		Voluntary	No	No	NA
States	No	Both	?	Some	Varies
<i>Trauma:</i>					
ACS ^b		Voluntary	Under consideration	No	NA
States	Some studies but poor methodologically	Both	Some	Probably	Varies

Abbreviations: AAP/ACOG = American Academy of Pediatrics and American College of Obstetricians and Gynecologists; ACCC = Association of Community Cancer Centers; ACEP/ENA = American College of Emergency Physicians and Emergency Nurses Association; ACS = American College of Surgeons; AMA = American Medical Association; HCFA = Health Care Financing Administration; JCAHO = Joint Commission on the Accreditation of Healthcare Organizations.

^aList of approved hospitals.

^bList of member hospitals, who may or may not follow ACCC guidelines.

SOURCE: Office of Technology Assessment, 1958.

by the organizations that developed them or by regulatory bodies. The development of standards has been slowed by professional rivalries, as well as by financial concerns (194,627), and lack of evidence about which requirements are valid. Less than half of all States have designated a State trauma center program, for example. Concerted efforts to develop consistent standards will be needed to overcome these problems.

In conclusion, considerable research is needed to validate accreditations/certifications for hos-

pitals overall and external standards for specific hospital services. At present, accreditations, certifications, and approvals by independent bodies of experts seem to be a necessary, but not sufficient, indicator of a minimum standard of quality for hospitals overall and for some specific services. At the same time that research to develop more valid standards is being conducted, State and Federal governments could encourage the use and dissemination of information about hospitals' compliance with existing standards.