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WILL JCAHO’s AGENDA AFFECT YOUR PRACTICE?
The mention of JCAHO’s Agenda for Change program provokes physician reactions ranging from enthusiasm over the intended goal of improved quality of care to grumbling over the potential for bureaucratic interference with clinical judgment.

TIME FOR A ‘CHANGE’: UPDATE ON JCAHO’s NEW AGENDA

By Jan Aylsworth

As early as May 1990, the obstetrics component of the Joint Commission on the Accreditation of Healthcare Organizations’ (JCAHO) new performance-oriented survey process, called the “Agenda for Change,” could become operational at all accredited hospitals in the country. At that time, the JCAHO-approved set of clinical indicators for monitoring the care of mothers and newborns should be integrated into the monitoring and evaluation activities in hospitals. In 1991, the hospitals will be expected to transmit these data to the JCAHO for feedback analyses. As part of the feedback system, the Commission will provide hospitals with comparison performance data to help each facility identify opportunities to improve their quality of care.

Those responsible for developing and testing the new system say that it should have the same impact on individual practitioners: Ob/Gyn clinicians will have a new tool for looking at their practices in a different way. Where changes in clinical practice may be warranted, peer review will be the mechanism for encouraging them.

PILOT TESTING COMPLETE

For the past 18 months, the JCAHO has been testing Agenda for Change at 17 hospitals around the country in the areas of obstetrics and anesthesia. These specialties were the first used to test the program because clinicians in both “have done a fair amount of monitoring themselves,” notes C. Irving Meeker, MD, an Ob/Gyn specialist who chairs the JCAHO Task Force for Clinical Indicators for Obstetrics. An added attraction with obstetrics, Dr Meeker says, is that “with OB, you usually don’t have the multiple medical problems that you have with other specialties—plus the complications of old age. The variables are small, and the outcomes and processes are more clear-cut.”

At the heart of Agenda for Change are “measurements” called clinical indicators. Each indicator, or clinical event, represents either an outcome (such as maternal mortality) or a specific occurrence that could point to a clinical deficiency (such as an inability to manage hemorrhage or anticipate prematurity).

“The clinical indicators aren’t in themselves measures of quality,” Meeker explains. “They’re simply a tool to monitor what’s happening.” For example, if perinatal mortality is much higher at one hospital than at a similar facility, that hospital would be asked to “take a look” at that particular item.

Careful scrutiny of the statistics to prevent misinterpretation of the numbers has been an important part of the testing phase. Data from pilot sites have so far shown that aberrations may show up for a brief period—such as a quarter—but then level off over the course of a year. “One physician may have had all of the hemorrhagic disasters one quarter, but he may have simply had the misfortune of being on call that particular day,” Meeker says. “If someone really doesn’t know how to manage hemorrhage, it will show up over a much longer period of time.”

IMPLEMENTING CHANGE

The timetable for implementation of the Agenda is on schedule so far, which means the JCAHO’s Board of Commissioners could approve final indicators as early as this December, with data gathering for obstetrics required by May 1990 (for a complete list of obstetric care clinical indicators currently under consideration, see page 13).

Although the indicator list could be shortened, the clinical circumstances the project is trying to identify shouldn’t change drastically, if at all. For instance, an indicator could be dropped if it proves ineffective or if the information it has been designed to detect becomes apparent through another indicator.

By 1992, indicator data will likely be linked to the accreditation process. Typically, survey teams will wait until accreditation visits to discuss indicator data, but statistics that may be cause for alarm could prompt an immediate visit, says David Bushelle, JCAHO’s Associate Director of Corporate Relations. However, Bushelle adds, “accreditation decisions will still be based on compliance with standards, not on indicator data.”

To date, most of the problems encountered at the pilot sites have been related to the logistics of data collection. One area
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of difficulty has been linking the charts of mothers and infants at discharge, a step necessary for properly abstracting data not yet routinely done at many hospitals. Without the linkage, OB/GYNs may not even be aware when the infants they deliver have suffered birth trauma, such as a fractured clavicle or Erb's palsy. "The pediatrician knows, and the mother knows; but the obstetrician may never know," Meeker points out.

The JCAHO won't require hospitals to break down indicator data by physician. Rather, that's something hospitals will find it necessary to do on their own to respond to JCAHO concerns. Many hospitals already have such quality assurance mechanisms in place, as well as peer review programs, which they'll take advantage of to reach individual practitioners.

"Peer review has to be the backbone for evaluating these data," Bushelle emphasizes. The JCAHO approach to quality assurance under the Agenda for Change is not intended to be punitive, he adds. "The fact that there may be a problem is not the most important thing; it's how you respond to it. The Commission has always believed that effective quality assurance is rooted in a positive attitude toward identifying opportunities for improvement and being continually ready to upgrade performance. This, in essence, is a process of continuous improvement."

THE PROFESSION'S REACTION

Dr Meeker, who has also served as Quality Control Officer at Maine Medical Center in Portland, one of the pilot test sites, says that OB/GYN physicians at his institution have accepted the clinical indicators as a means of enhancing awareness of their own practice patterns, and says he hopes that the profession in general will be just as receptive to the system.

"For OB/Gyns as a whole, I suspect most won't be doing much very differently. There's probably a minority who will find it an annoyance, but it's only going to impact their practice patterns if they're away from the norm and there's not a sufficiently good reason," Meeker says. "The onus to explain will be on the physicians."

Most of the additional work generated by the project is handled in medical records, so physicians shouldn't have to provide much more documentation than they're already doing, Meeker adds, but those whose charting is not as precise as it could be may have to make some changes. Physicians at another pilot site, Dixie Medical Center in St. George, Utah, seem to support Meeker's opinion about the Agenda for Change's anticipated enthusiastic reception by the majority of OB/Gyn practitioners. According to Craig Booth, MD, a family practice specialist who is Medical Director at the 105-bed rural hospital, "Most of the physicians at our hospital seem to welcome the idea because, in the past, they felt like the JCAHO's game was a game—with not enough substance to make it valid. What we have now is a realistic way of looking at quality objectively, in a way that's never been done before."

As past chairman of the hospital's Obstetrics Committee, Dr Booth has been one of the physicians responsible for bringing data that suggest room for clinical improvement to the attention of colleagues. "There haven't been any sticky meetings. We've mostly been sitting down and going through data," he says.

While physicians at pilot sites continue to work well with the new program, Booth concedes, acceptance might not be as willing if physicians felt their clinical judgment could be eclipsed by numbers.

John C. Nelson, MD, a Clinical Associ-
‘I’m afraid if everyone is compelled to practice the same way that no one will have the courage to innovate,’ says Dr John C. Nelson.

ready become apparent, Meeker notes, that some physicians do more cesareans for failure to progress/cephalopelvic disproportion than others. The challenge, he says, will be in encouraging more vaginal births after cesarean (VBACs).

C-sections are also an issue that illuminates Nelson’s point about deciding what is best for each patient. “I’ll do anything I can to reduce unnecessary cesareans,” Nelson says, “Just don’t tell me what my rate should be.”

CONCLUSION
Clinical issues aside, Meeker says he believes that most Ob/Gyns are aware that clinical indicators are forthcoming. Recently he worked with ACOG to revise the organization’s quality assurance manual for obstetrics. A complete revision of the publication’s 1981 version, it incorporates all of the clinical indicators that the JCAHO is using in the obstetrics component of Agenda for Change. (ACOG fellows automatically received a copy. Nonfellow may order Quality Assurance in Obstetrics and Gynecology for $40 by calling 1-800-762-ACOG.)

Although an adjustment period will probably be required before the new indicators are smoothly incorporated into existing data gathering and peer review systems, those involved with the project believe it stands a good chance of helping to improve quality of care—and that physicians, as a profession, will accept it.

“We’re being looked at in lots of ways these days,” Meeker says. “I think everybody is aware that it’s part of the world we live in.”

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**Agenda for Change Obstetrics Indicator Summary**

**The Items Now Under Consideration**

**OB-1.** Induction of labor, with and without C-section, for indications other than diabetes, premature rupture of membranes, pregnancy-induced hypertension, postterm gestation, intrauterine growth retardation, cardiac disease, I16:30; the number of cesareans.

**OB-2.** Primary C-section for failure to progress.

**OB-3.** Patient with attempted vaginal birth after cesarean (VBAC) subcategorized by success or failure.

**OB-4.** Delivery of an infant by planned repeat C-section weighing <2,500 gm or with hyaline membrane disease.

**OB-5.** Delivery of an infant following induction of labor weighing <2,500 gm or with hyaline membrane disease.

**OB-6.** Patient with eclampsia.

**OB-7.** In-hospital initiation of antibiotics 24 hours or more after a term vaginal delivery.

**OB-8.** Excessive maternal blood loss as defined by a red cell transfusion; hematocrit <22% or hemoglobin <7 gm/dL or a decrease in hematocrit of >11% or of hemoglobin >3.5 gm/dL, except with abruptio placenta or placenta previa.

**OB-9.** Maternal length of stay >7 days after a vaginal delivery or >7 days after a C-section.

**OB-10.** Maternal readmission within 14 days of delivery.

**OB-11.** Intrahospital maternal death up to and including 42 days postpartum during the primary stay or during readmission stay.

**OB-12.** Intrahospital intrapartum death of a fetus weighing 500 grams or more.

**OB-13.** The death of an infant weighing 500 grams or more at birth subcategorized by neonatal and stillborn.

**OB-14.** Neonatal death of an infant with a birthweight of 750 to 999 gm born in a hospital with a neonatal intensive care unit (NICU).

**OB-15.** Delivery of an infant weighing <1,800 gm in a hospital without a NICU.

**OB-16.** Transfer of a neonate born in a hospital without a NICU to a hospital with an NICU.

**OB-17.** Term infant admitted to an NICU either at the hospital of birth or by transfer to another hospital.

**OB-18.** Apgar score of 4 or less at 5 minutes.

**OB-19.** Discharge diagnosis of massive aspiration syndrome of neonate.

**OB-20.** Discharge diagnosis of birth trauma.

**OB-21.** Term infant with a clinically apparent seizure prior to discharge from the delivery hospital.

*SOURCE: Joint Commission on the Accreditation of Healthcare Organizations, April 28, 1986.*