developmental efforts. Ultimately, the payoff still lies with effective problem analysis and peer review.

The JCAH Initiatives In Measuring Quality

The Joint Commission initiative will begin in 1987, with clinical profiling of the hospitals ready for re-survey. We will seek information, which the hospital should already be concerned about -- high volume services, high risk services, and the problem prone services; especially the multidisciplinary ones that require significant coordination. The clinical indicator initiative will move in parallel. We will start with generic criteria, but by 1990, we will have moved far beyond these crude measures. We will be developing what we talked about: Establishing meaningful differentiators of performance using a tracer approach.

In developing this new approach, it will be critical to have a normative data base to balance against professional criteria to provide a context of reality. We will adapt the best available severity of illness modifier. We will support the development of institutional data reporting capabilities, and we are going to come down very hard on promoting meaningful problem analysis. Finally, we will interact with health care organizations on an ongoing basis. In so doing, the Joint Commission's relationship with the organizations it accredits will change to a more facilitative and supportive role. The basis of the continual interaction will be a national data base against which you can compare your performance on a given measure with that of similar hospitals. If you have a problem area, you will be working on it, and we will be tracking your progress.

There is a parallel initiative to all of this, which the JCAH calls the organizational performance indicator initiative. We believe that the manner in which an organization functions affects patient care -- team function does make a difference. We have believed this for a long time, but tomorrow we will be looking for performance measures of organizations that demonstrably make a difference in the quality of care. All of this means a refocusing of the survey process -- a survey process that will look at the validity of the data going into your system, the validity of your problem analysis, whether the actions you take to resolve problems are effective, and it will have to look at organizational indicators as well.

On an accelerated timetable, and with lot of luck, all of this might be in place by 1990; but it is not going to be easy. We will be developing an entirely new conceptual model, and we are certain to face some inertia and resistance. We will probably run into some technical barriers, as there is still much we have to learn. Ultimately, tremendous benefits will emerge from this new approach.

You will have the opportunity to compare yourself meaningfully with related programs, and the JCAH will have the ability to obtain a more realistic appraisal of health care in this country. It is not what people think it is. Most hospitals and practitioners do not perform at 100 percent of perfection all of the time or even close to that. This new approach could have a positive effect in adjusting the context of public expectations. While that will not solve the liability crisis, perhaps we may ease it a bit.

So, the brave new world of health care has begat many new issues, not the least of which is the need to measure and evaluate quality of care in a way that is more meaningful to multiple audiences. It may seem like a burden, but I view it as a new challenge -- a tough one -- and an opportunity. This is an opportunity to demonstrate that what we are and what we have is still the best health care system in the world; it is just not perfect. It is an opportunity for the professions, in particular, to develop evaluation systems, which have true potential to improve the quality of care; and that is for what we all stand. ■

Presented at the ACCC's 1986 Fall Leadership Conference, "Oncology Economics and Alternative Delivery Systems," September 26, 1986, New Orleans, LA.

COMMITTEE BRIEFS

Ad Hoc Committee on Standards
Robert E. Enck, M.D.
Chairperson

Recently, the third draft of standards for community cancer programs was sent to each Delegate Representative for review and comment. These standards will be further discussed during two open forums at the ACCC annual meeting in March. The standards will then be presented to the House of Delegates for final approval by vote. *(NOTE: See pages 29 - 32 of JCPM for scheduled meeting times.)*

Administrator Special Interest Group
Marsha J. Fountain, R.N., M.N.
Chairperson

The Administrator Special Interest Group will meet on Thursday, March 12th, during the ACCC annual meeting. Anyone interested in giving a 10 - 15 minute presentation on reimbursement, product line management, or other topics of interest to cancer program administrators is asked to contact Marsha Fountain at (505) 848-8026.

Currently, the Administrator Special Interest Group, together with the Clinical Practice Committee and the ACCC Executive Office, is developing a survey on reimbursement. This survey will be mailed to each Delegate Representative for completion. The results will be available at the ACCC annual meeting in March.

Communications Committee
Diane Van Ostenberg
Chairperson

At the 1986 Fall Leadership Conference in New Orleans, the Communications Committee re-evaluated its role and responsibilities. The Committee agreed that its goal is to stimulate community cancer program growth; thus, the Committee agreed to assist the Membership Committee in recruiting new members. After some discussion, the Communications Committee presented to the ACCC Board of Trustees a recommendation that the Communications Committee be renamed the "Marketing Committee" to adequately reflect its new responsibilities. A proposal for this name change will be presented to the House of Delegates for approval by vote. ■