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I. INTRODUCTION

Performance matters in a healthcare economy. Data collection and its analysis provide effective ways to help end the taboo of medical mistakes while promoting enhanced quality care outcomes. Dr. Paul M. Schyve, M.D., Senior Vice President of the Joint Commission (formerly Joint Commission on Accreditation of Healthcare Organizations), spoke about performance measurement in improvement and accreditation, primarily as it relates to hospitals, while addressing the Sixth Annual Health Law and Policy Colloquium at Loyola University Chicago School of Law. He provided an insider's viewpoint from a private accreditation body, illustrating the role of data collection and its surrounding issues.

Dr. Schyve is responsible for working with professional, patient, consumer, and government organizations to enhance the quality of care provided to the public. He has worked for the Joint Commission since 1986 and has dedicated most of his professional life to enhancing the quality of health care in this country. Dr. Schyve is certified in psychiatry by the American Board of Psychiatry and Neurology and is a Distinguished Life Fellow of the American Psychiatric Association. He is a member of the Board of Directors of the National Alliance for Health Information Technology and a Founding Advisor of Consumers Advancing Patient Safety. In addition, Dr. Schyve has served on multiple advisory panels for the Centers for Medicare and Medicaid Services, the Agency for Healthcare Research and Quality, and the Institute of Medicine. Dr. Schyve is well published in the areas of psychiatric treatment and research, psychopharmacology, quality assurance, continuous quality improvement, healthcare accreditation, patient safety, and healthcare ethics.

The Joint Commission is a private accreditation body that is granted authority by federal and state governments to accredit hospitals.[1] It accredits more than 15,000 healthcare facilities in the United States.[2] The

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1. Barry R. Furrow, *Medical Mistakes: Tiptoeing Toward Safety*, 3 HOUS. J. HEALTH L. & POL'Y 181, 207 (2003).

2. Maxine M. Harrington, *Revisiting Medical Error: Five Years After the IOM Report,*

Joint Commission inspects hospitals every two to three years to ascertain their compliance with structural and process-oriented quality measures.[3] Further, the Joint Commission's Office of Quality Monitoring receives, assesses, and monitors complaints affecting healthcare quality.[4] While hospitals are not required to follow the non-profit organization's guidelines,[5] most hospitals seek compliance with Joint Commission standards because Joint Commission accreditation is necessary to qualify for Medicare payments and some licensure requirements.[6]

The Joint Commission's quality improvement surveillance system continues to evolve. In 1996, the Joint Commission's Sentinel Event Policy required health organizations to conduct root cause analysis for all serious adverse events, while additionally requiring the organizations to establish measures to decrease the likelihood that such events would occur again.[7] The Sentinel Event Policy encourages the self-reporting of "an unexpected occurrence involving death or severe physical or psychological injury, or the risk thereof."[8]

In 2002, the Joint Commission established six National Patient Safety Goals.[9] The goals include improved accuracy of patient identification, enhanced medication safety, reduced risk of healthcare-associated infections, reduced risk of patient falls, prevention of pressure ulcers, and identification of safety risks inherent in the organization's patient population.[10] If an organization fails to implement the recommendations associated with these goals, it can affect the organization's accreditation status.[11]

Some express doubts that the Joint Commission has enhanced hospital quality and argue that the Joint Commission's undersized sentinel event

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Have Reporting Systems Made a Measurable Difference?, 15 HEALTH MATRIX 329, 359 (2005).

3. Michelle M. Mello et al., *Fostering Rational Regulation of Patient Safety*, 30 J. HEALTH POL. POL'Y & L. 375, 381-82 (2005).

4. *Id.* at 382.

5. Katharine Van Tassel, *Hospital Peer Review Standards and Due Process: Moving From Tort Doctrine Toward Contract Principles Based on Clinical Practice Guidelines*, 36 SETON HALL L. REV. 1179, 1188 (2006).

6. *Id.*

7. Mello et al., *supra* note 3, at 382.

8. The Joint Commission, Sentinel Event Policy and Procedures, http://www.jointcommission.org/SentinelEvents/PolicyandProcedures.org (last visited Jan. 16, 2007).

9. Mello et al., *supra* note 3, at 382.

10. The Joint Commission, 2007 National Patient Safety Goals, http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals.org (last visited Jan. 16, 2007).

11. *Id.*

database points to significant underreporting.[12] However, the Joint Commission continues to play a key role in this country's movement for increased healthcare quality. Notably, the Joint Commission's data collection in performance measurement continues to challenge healthcare facilities to provide the most optimal care possible.

This introduction will briefly address the benefits of provider performance transparency, including discovery of medical errors, empowerment of individuals as consumers, promotion of providers' internal learning, ability of government to focus regulation, and payors' use in pay-for-performance. It will also discuss the conflict in tort law, which seeks punishment of providers as a means to effect quality care, versus the movement for sanction-free environments to promote better performance.

II. THE NEED FOR DATA COLLECTION TO MEASURE PERFORMANCE

Electronic data gathering is arguably one of the most important ways to improve quality of care. It can be used to evaluate processes and outcomes.[13] Without electronic surveillance systems, the compilation and interpretation of large amounts of data would be realistically impossible.[14] When used appropriately, data collection of provider performance will increase the quality of health care achieved and still allow for patient and physician privacy.[15] Indeed, some argue that as both positive and negative patient outcomes are collected, our society may be less attracted to using the legal system to force discovery of provider performance.[16]

A. Collecting Data Discovers Medical Errors

The collection of electronic data for the use of improving the quality of our nation's healthcare system allows for the discovery of unknown errors, risks, and trends.[17] It thereby allocates to providers focal areas of quality improvement needs. The Institute of Medicine's 1999 report, *To Err Is Human*, attributed between 44,000 and 98,000 deaths to avoidable medical errors in hospitals.[18] The importance of analyzing hospital performance

12. Mello et al., *supra* note 3, at 383.

13. Gerald M. Eisenberg, *The Medical Staff Structure—Its role in the 21st Century*, 12 ANNALS HEALTH L. 249, 250 (2003).

14. *Id.*

15. Barry R. Furrow, *Data Mining and Substandard Medical Practice: The Difference Between Privacy, Secrets and Hidden Defects*, 51 VILL. L. REV. 803, 804 (2006).

16. *Id.*

17. Harrington, *supra* note 2, at 330.

18. INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 26 (Linda T. Kohn et al. eds., 2000), *available at* http://www.nap.edu/books/0309068371/html/index.html.

data is even more significant considering that medical errors, if ranked as a disease, would be the sixth leading cause of death in this country—ahead of pneumonia and diabetes.[19]

Importantly, medical errors could be significantly decreased when these incidences are realized and when unsafe, unknown trends are discovered by the collection of performance data.[20] The collection of information into databases can find hidden patterns, which may previously have remained dormant in a case-by-case analysis.[21] Specifically, large-scale data analysis can solve a variety of needs: (1) predicting—learning a pattern from examples and using the model to predict future values of the target variable; (2) classification—finding a function that groups records into discrete classes; (3) detection of relations—searching for the independent variables for a selected target of variables; (4) explicit modeling—finding explicit formulae describing dependencies between various variables; (5) clustering—identifying groups of records that are similar between themselves but different from the rest of the data; and (6) deviation detection—determining the most significant changes in some key measures of data from previous or expected values.[22]

Thus, adverse patient outcomes, as well as poor provider performances, may be realized by the collection of data on performance measures.[23] Significantly, the Joint Commission's and government agencies' increased focus on quality improvement measures forces providers to acknowledge, resolve, and prevent adverse outcomes and risk factors, thereby enhancing quality improvement.[24]

B. Patients are Empowered as Consumers

The competition theory foresees individuals as buyers and sellers in health care where selection of providers is based on performance results.[25] Moreover, such exposure of performance outcomes reveals variations among providers, thereby enhancing provider competition.[26] A provider's performance record that reports safety, cost, and overall quality may empower individuals to choose health plans or hospitals based on their

19. Furrow, *supra* note 15, at 811.
20. *See id.* at 812.
21. *Id.* at 816.
22. *Id.* at 817.
23. *Id.* at 821-22.
24. *Id.* at 823.
25. William M. Sage et al., *Bridging the Relational-Regulatory Gap: A Pragmatic Information Policy for Patient Safety and Medical Malpractice*, 59 VAND. L. REV. 1263, 1274 (2006).
26. Furrow, *supra* note 1, at 204.

performance.[27] Patients are currently limited in their ability to access reliable and specific performance results of providers.[28] Instead, they must rely almost solely on provider reputation.[29] Essentially, public disclosure of performance will force providers to compete on a results basis like they presently compete via reputation.[30]

Further, public disclosure of provider success rates, like the Joint Commission's public reporting of data via their website, may lead to increased demands for provider performance information.[31] Ideally, this enhanced competition among providers enables patients to select higher performing providers and disregard poor performers, resulting in better performance generated across providers.[32] Thus, transparency of provider performance will allow consumers to "vote with their feet"[33] and empower patients in a consumer-driven healthcare marketplace.[34]

C. Usefulness in Provider Education

Data transparency also affects providers' internal practices. Hospitals are able to screen for poor performing medical staff with the advent of performance data analysis.[35] Hospitals use the data in order to reduce risk and improve the organization's quality of care.[36] In effect, hospitals are able to refuse staff privileges to providers who exhibit poor performance.[37] Alternatively, providers can use performance results as an educational tool to implement changes in the organization.[38] In one published example, a physician, surprised by his patients' abnormally high incidents of infection, was able to drop the infection rate to zero.[39]

D. Government Ability to Elevate Quality of Care Received

Governments can regulate and promote specific objectives for providers in response to the information that performance data provides. They can do this through contractual provisions, financial incentives, and continual

27. Sage et al., *supra* note 25, at 1274-75.
28. *Id.* at 1280.
29. *Id.*
30. *Id.* at 1274.
31. *See id.* at 1280.
32. *Id.* at 1274.
33. Sage et al., *supra* note 25, at 1274.
34. Mello et al., *supra* note 3, at 392.
35. Furrow, *supra* note 15, at 819.
36. *Id.* at 819-20.
37. *Id.* at 819.
38. *Id.* at 821.
39. *Id.*

quality surveillance.[40] For example, the patient safety organizations (PSOs) governed by the Agency for Healthcare Research and Quality (AHRQ) collect voluntary reports of medical errors and establish recommendations and protocols illustrating "best practices."[41]

According to AHRQ, its research and reports have affected healthcare quality in a variety of different ways.[42] These include improving patient outcomes, increasing the value of healthcare services, establishing a foundation for evidence-based medicine, developing tools that improve the quality of care, and further, by assisting patients to become involved in making health decisions.[43] Specifically, based on AHRQ's research, Quality Improvement Organizations implemented projects to increase anticoagulation therapy for Medicare beneficiaries who suffered a stroke.[44] As a result of this project, the Centers for Medicare and Medicaid Services estimated that this improvement prevented up to 1,300 strokes.[45]

E. Payors Can Link Provider Compensation to Performance

Pay-for-performance programs offer a market justification for the comparative use of performance results.[46] A payor that is unhappy with a provider's performance can use individual performance results to terminate a provider's contract.[47] Alternatively, a payor can implement an incentive program in response to provider performance.[48] Similar to pay-for-performance programs, transparency in provider performance may influence provider liability.[49]

III. TORT LAW'S RELATIONSHIP WITH PERFORMANCE DATA DISCLOSURE

The dispute between medical malpractice litigation and performance measurement disclosure as modes to improve the quality of our nation's healthcare industry is not likely to be quickly resolved. This country's tort

40. Mello et al., *supra* note 3, at 392.

41. Furrow, *supra* note 15, at 824.

42. Agency for Healthcare Research and Quality, Impact of AHRQ Research 1 (2002), *available at* http://www.ahrq.gov/news/impactfact.pdf.

43. *Id.* at 1-4.

44. *Id.* at 1.

45. *Id.*

46. Sage et al., *supra* note 25, at 1277; *see generally* Stacy L. Cook, *Will Pay for Performance be Worth the Price to Medical Providers? A Look at Pay for Performance and its Legal Implications for Providers*, 16 ANNALS HEALTH L. 163 (2007) (discussing pay for performance as a means to control healthcare costs while improving quality).

47. Sage et al., *supra* note 25, at 1281.

48. Cook, *supra* note 46, at 167.

49. *Id.* at 177.

system assumes that retribution through monetary judgments is the best approach to deterrence of poor performance.[50] In contrast, states and organizations like the Joint Commission, which seek to enhance providers' quality of care, rely on provider commitment and a sanction-free environment to encourage improved performance.[51]

A. Tort Law is Not a Sufficient Mechanism to Regulate Providers

The effectiveness of tort law in protecting and promoting patient safety and healthcare quality is inadequate.[52] First, judges lack the specific education and experience necessary to make determinations about healthcare quality.[53] They must instead rely on parties bringing the lawsuit to provide evidence regarding appropriate standards of care.[54] Conversely, government agencies and accreditors typically possess vast healthcare experience and can investigate their own facts.[55] Second, courts cannot be proactive in their regulation of providers, as they must wait for already-wronged litigants to file suit.[56] Additionally, courts are restricted in the remedies they may provide.[57] Compare this to agencies, which can conduct increased on-site inspections, implement new rules for all providers, require sanctions, and revoke provider accreditation.[58]

Further, no significant evidence supports the assumption that providers see tort law litigation as a deterrent.[59] Rather, providers view malpractice suits as random and often unwarranted.[60] One researcher found support in this view: "Contributing to the perception of haphazardness are findings from the California, New York, and Utah/Colorado studies showing that most patients who are injured due to negligence never bring claims,

50. Mello et al., *supra* note 3, at 391.
51. *Id.* at 391-92.
52. *See id.* at 389.
53. *Id.* at 387.
54. *Id.*
55. *Id.*
56. Mello et al., *supra* note 3, at 387.
57. *Id.*
58. *Id.*
59. *Id.* at 388.
60. *Id.* at 388.

whereas a large proportion of malpractice claims do not actually involve a negligent injury."[61]

Also, providers carry professional liability insurance, which further weakens tort litigation's effect as a deterrent. So, while some providers are forced to pay high premiums, most are still protected from the possibly devastating economic consequences of an adverse verdict.[62] Thus, while malpractice litigation is a concern of providers, its effectiveness as a deterrent and ability to improve quality is arguable.

B. Performance Data Transparency May Decrease Reliance on the Tort System

Proponents of performance data disclosure believe if patients and families have open communication with healthcare providers, they will be less inclined to litigate.[63] Providers that exhibit honesty and apologize for mistakes are less likely to be sued by the harmed patient.[64] Researchers emphasize that the main way to improve quality is to recognize that systems, not individual providers, are responsible for the majority of medical errors.[65] It follows that attributing errors and poor performance to individuals through public disclosure is likely not enough to prevent recurrences.[66]

The Joint Commission, and agencies like it, wish to foster an atmosphere of greater transparency in error reporting and provider performance.[67] Currently, the Joint Commission has a voluntary sentinel event database for providers.[68] After a report is made, the facility must conduct a root cause analysis of the incident.[69] Further, if the Joint Commission discovers such an event was not reported, it can conduct an on-site visit at the provider's cost or potentially rescind accreditation.[70] This is one of the reasons providers may prefer to report to state agencies versus private accreditors.

Similar to the Joint Commission, many states believe increased performance disclosure will enhance healthcare quality.[71] Moreover, these states have passed laws that make patient safety data contained in reporting

61. *Id.*
62. Mello et al., *supra* note 3, at 388.
63. Sage et al., *supra* note 25, at 1273.
64. Furrow, *supra* note 1, at 205.
65. Sage et al., *supra* note 25, at 1277.
66. *Id.*
67. Furrow, *supra* note 1, at 215.
68. Mello et al., *supra* note 3, at 382.
69. Furrow, *supra* note 1, at 208.
70. Harrington, *supra* note 2, at 365.
71. Sage et al., *supra* note 25, at 1278.

systems confidential, further acting to protect such disclosed information from discovery in litigation.[72] In addition, those states that grant public access to information primarily provide only aggregate data that is de-identified (the Joint Commission also de-identifies data).[73] The belief is that by creating a confidential database, more providers are likely to report and less likely to hide poor performances.[74] Experts believe the origin of under-reporting is directly linked to providers' fear of admissibility in litigation or disciplinary actions by their employer.[75] Thereby, agencies, not litigation, are able to develop more specific and appropriate recommendations for improving the quality of care provided.[76]

Nevertheless, there is still much debate over the appropriateness of maintaining the confidentiality of healthcare performance. The American Association for Justice (AAJ, formerly American Trial Lawyers Association) desires provider performance information to be available to the public and thus not subjected to confidentiality laws.[77] The conflict between the AAJ's retributive position and confidential reporting databases that promote disclosure is that they likely work against one another as ways to enhance quality of care.[78] Moreover, evidence concerning the impact of performance databases on providers and the tort system is only beginning to emerge.[79]

IV. CONCLUSION

Governments, providers, payors, and private accreditors all seek and potentially benefit from the collection and analysis of performance data. Likewise, such transparency of performance allows individual consumers to make informed decisions. In the following transcript, Dr. Schyve addresses performance measurement in improvement and accreditation. He focuses specifically on the role of performance measurement in hospitals, including accreditation requirements, public reporting, and the ability to compare performance measures across providers.

72. Mello et al., *supra* note 3, at 385.
73. Harrington, *supra* note 2, at 355.
74. *Id.* at 351-52.
75. *Id.* at 332, 360.
76. *See* Mello et al., *supra* note 3, at 387.
77. *See* American Association for Justice, http://www.atla.org/pressroom/FACTS/secrecy/index.aspx (last visited Jan. 17, 2007).
78. *See* Mello et al., *supra* note 3, at 391.
79. *Id.* at 389.