The fastest growing concept for providing quality healthcare while containing costs is the preferred provider organization. PPOs bring together providers, purchasers and patients with incentives for all of them to hold down healthcare expenditures, while preserving what they want most from the system: freedom of choice. PPOs have virtually exploded onto the healthcare scene in the last few years and are growing at a faster rate than HMOs and other types of plans. The growth of PPOs has essentially doubled each year since 1984. There are approximately 700 PPOs operating today.

What distinguishes PPOs from other managed care plans?

1.) PPOs retain fee-for-service medicine. Until providers learn to reduce costs without reducing services, PPOs will not reimburse providers on a capitation basis.

2.) The free choice of physicians and hospitals is retained in PPOs. Although there are strong financial incentives to motivate patients to use preferred providers, i.e., lower deductibles and co-payments, patients may still go outside the PPO group to other physicians and hospitals.

3.) PPO providers accept strict management control such as utilization review and other techniques which are designed to contain costs.

4.) Preferred Providers render care at agreed-upon prices, generally discounted from their usual charges.

5.) PPOs provide efficient claims payment as well as comprehensive data systems that track utilization and costs for purchasers.

PPOs don't provide less care or lower quality care to hold down costs.

Providers negotiate lower fees and agree to utilization review in anticipation of a greater volume of patients.

Physicians and hospitals tend to think of PPOs as organizations, that is, a separately created unit through which they can negotiate with buyers or middlemen to provide healthcare services to a defined group of patients.

Payors and purchasers more often view PPOs as a healthcare product, that is, healthcare services purchased at a competitive price through negotiations with providers. Of course, in the past, providers and buyers often viewed themselves as adversaries. Insurance executives and healthcare professionals tend to speak a different language and exist in separate cultures. Their tendency to view PPOs as organizations or as product lines, increases the confusion. PPOs are both.

Complicating this fact is the incredible variety of PPO plan sponsors: hospitals and physicians start PPOs, commercial insurance companies and the Blues have PPOs, entrepreneurs start PPOs, many third party administrators (TPAs) sponsor PPOs, even employers and business coalitions are forming PPOs. To be a PPO, there must be a network of providers, someone to underwrite the risk, and someone to market and/or distribute the product.

Two elements critical to the success of PPOs are utilization management and the selection of preferred providers.

Utilization management generally includes the following:

1.) Prior authorization procedures: i.e., to determine the need for a hospital admission, the appropriateness of the intended procedure, and the appropriateness of the site or type of facility.

2.) Pre-admission certification: to obtain approval for a given admission on the basis of sound medical criteria and to establish an expected length of stay.

3.) Second-opinion programs: to verify a legitimate need for surgery and to prevent unnecessary operations.

4.) Concurrent review of care: to monitor a patient's care while admitted and undergoing treatment.

5.) Discharge planning: to determine the appropriate time when a patient is ready to leave the hospital and the next level of appropriate care for the patient, i.e., skilled nursing facility, rehab facility or home.

6.) Retrospective review of care: to monitor claims after a patient is discharged for indications of unnecessary use of services or procedures.

Some PPOs use retrospective review to develop a profile of the practice patterns of individual physicians and hospitals. The information is then used to educate providers whose treatment patterns are outside the norm or patients who are using the system improperly.

In the future, retrospective review of care will expand further to include review of services in the ambulatory setting, that is, doctor's offices.

Utilization management is a delicate balancing of appropriateness, efficacy and effectiveness of care with
ongoing efforts to hold down the costs of that care. It is at the heart of every successful PPO.

The process of utilization management begins with the careful selection and credentialing of good providers. This concept is based on the fact that good providers practice good medicine and operate good, efficient facilities. These physicians perform no unnecessary surgeries, monitor patients’ conditions carefully to avoid complications, use tests and diagnostic tools judiciously and are not profligate with costly resources.

PPOs select providers through a process of credentialing and accreditation. Peer review, continued monitoring of performance, demonstrated concern for cost-effectiveness, reputation for excellence, are just a few of the necessary objective and subjective criteria for choosing PPO providers.

Even the Federal Government has recognized PPOs growth and progress in the last several years and is funding demonstration projects to test the PPO concept for Medicare beneficiaries. The Healthcare Financing Administration (HCFA) indicates it will use existing private sector PPOs instead of organizing its own PPO system.

The nation’s healthcare system, under competitive pressures, will continue to evolve rapidly. All who are associated with healthcare and the health insurance field must understand the changing economics and regulatory climate of managed care systems.

Through national conferences, regional meetings, its monthly Newsletter and other publications, the AAPPO helps PPOs and their partners find answers to their critical market questions, and guidance on the direction of federal and state policymakers.

For more information, please contact the AAPPO: AAPPO, 111 East Wacker Drive, Suite 600, Chicago, IL 60601 (312) 644-6610 ext. 270.

The Joint Commission: Tradition and Innovation in Its 37th Year

David Bushelle
Associate Director of Corporate Relations
The Joint Commission

America’s daily healthcare bill: over $1 billion. For most of the decade colossal figures such as this one have been the impetus behind an economic face-lift of our healthcare system. The healthcare industry has plunged into the quest for more efficient provision of patient care, and consumers are starting to shop and compare using cost data. But cost is only one consideration. What about the quality of a healthcare organization?

The Joint Commission on Accreditation of Healthcare Organizations is a private, nonprofit corporation dedicated solely to promoting high quality care. The Joint commission sets healthcare standards, evaluates healthcare organizations, and provides voluntary accreditation for a variety of healthcare settings. Today, the Joint Commission accredits approximately 5,100 hospitals. In addition, the Commission evaluates and accredits 3,200 other health care programs, including mental health and substance abuse organizations, ambulatory care centers, nursing homes, hospices, and home care and managed care organizations that are either sponsored by hospitals or are free standing organizations.

Founded in 1951, the Joint Commission traces its roots back to the early years of this century when Dr. Ernest Codman of the Massachusetts General Hospital pioneered a new concept: setting standards for, and evaluating, the nation’s burgeoning number of hospitals. His dream came to fruition in 1917 when the American College of Surgeons created the first hospital standards, which formed the basis for a voluntary accreditation program initiated one year later. By 1951, the accreditation program had grown too large for the College to manage by itself. That year, the College, the American Medical Association, the American Hospital Association, the American College of Physicians, and the Canadian Medical Association became the founding members of the Joint Commission on Accreditation of Hospitals. The Canadian Medical Association withdrew in 1959 to help establish the Canadian Council on Hospital Accreditation. In 1979, the American Dental Association became the fifth corporate member, and in 1982 one public member was added to the board of commissioners.

Meanwhile, the Joint Commission had begun accreditation programs for mental health, ambulatory, hospice, and long term care organizations, and in 1987, to reflect the scope of its mission, changed its name to the Joint Commission on Accreditation of Healthcare Organizations.

In 1988, the Joint Commission continued its efforts to ensure meaningful public involvement in its work by adding two more public members to the board of commissioners. Public representatives already serve on each of the seven accreditation program advisory committees.

The board of commissioners also established two new accreditation programs in 1988: one for the full spectrum of home care organizations and another for managed care. The accreditation program for managed care is an outgrowth of extensive Joint Commission experience in reviewing HMOs for state health departments and major insurance companies.

Keeping in step with industry changes — and now responding to the need for better measures of clinical and organizational performance — has led the Joint Commission to its most ambitious undertaking in its history, called the "Agenda for Change."

The central objective of the Agenda for Change is to develop a new accreditation system that incorporates the use of better information on the processes and outcomes of care to improve quality. New Joint Commission standards will
emphasize the use of clinical and organizational indicators of quality in gathering and developing this information. Using an indicator, such as surgical wound infection rate, would prompt detailed evaluation of care by the organization’s managerial and clinical reviewers.

Uniform sets of these indicators will also provide a format for data submission to the Joint Commission. The indicator data processed by the Joint Commission will enable healthcare facilities to compare their performance with aggregate groups of like organizations.

In addition to the periodic on-site accreditation survey and special, focused surveys for problem resolution, the Joint Commission will be evaluating the healthcare organization’s indicator data through a continuous monitoring and feedback system as part of the accreditation decision making process.

The new outcome-oriented monitoring and evaluation process will enable healthcare managers to base their efforts to improve quality on concrete performance data. With help from the Joint Commission, accredited organizations will develop data systems and methods to document the actual results they are achieving.

The new accreditation systems for hospitals is due to be implemented in 1992, and for other healthcare organizations in the years that follow.

Creating such a system has and will continue to require a tremendous amount of developmental work. Ground-breaking studies conducted in the past two years have taught us an important lesson: there is a paucity of the research necessary to guide clinical decisions. Joint Commission task forces developing indicators of quality, then, found that the clinical literature provided little assistance in their efforts to develop clinical indicators. The development of organizational indicators also represents work that had to begin from the ground up. These indicators will help managers look in objective, measurable terms at how organizational processes and structure affect quality. Finally, each component of the Agenda for Change will be vigorously tested to ensure that when the new accreditation system is put in place, valuable healthcare resources invested in quality control will pay off.

Demands for efficiency and effectiveness of care will continue to trigger a shake-up of traditional healthcare delivery systems. Much more care is being provided in settings in which nationally-recognized standards and state-of-the-art assessment technology are not used — settings which have no history or weak commitment to meeting such standards. America’s employers and other payers of healthcare need to rely on a system that objectively addresses their concerns about quality of care. The Joint Commission’s Agenda for Change builds on a historic, professional commitment to quality.

American Liver Foundation
A Missing Link in Employee Assistance Programs

Although one out of every ten Americans suffers from a liver, biliary tract or gallbladder disease, employee assistance programs often omit this important area of health concern. In spite of the impact that liver diseases have on virtually every family in the country, they are still poorly understood and frequently overlooked in health education efforts.

The American Liver Foundation, a national voluntary health agency dedicated to fighting liver diseases, offers important resources that can help medical directors in improving employee wellness and in aiding employees faced with liver disease in themselves or their families.

“Education is one of our top priorities, since experts have estimated that more than 60-65 percent of liver diseases could be prevented,” said Thelma King Thiel, president and chief operating officer.

Within the 25-59 year old group, liver diseases are the third leading cause of deaths from illness. More than 27,000 Americans die each year from liver disease, while many others are unable to work because of illness, or are less productive at their jobs. The national economic toll exacted is formidable — estimated at a total of more than $14 billion a year for lost productivity and increased medical expenses. A substantial reduction in liver disease would be highly beneficial to corporate employers, as well as to individual employees.

The Foundation’s most popular pamphlet, "I'm Your Liver," uses an amiable liver character to explain why the liver is so important and what the individual can do to protect it. It points out that simple lifestyle adjustments can prevent many cases of liver diseases and stresses moderation in drinking alcoholic beverages (or not at all), avoiding illicit drugs, carefulness in using prescribed and over-the-counter medication, and taking protective measures when handling common household chemicals, such as pesticides and solvents.

A "Love Your Liver" coloring book can be used by parents to help develop good health habits in their children at an early age. Designed for children in the 5-8 year old age range, it gives basic facts on the liver and how it is harmed by tobacco, alcohol and drugs. Taking a positive approach to wellness, it emphasizes the value of a balanced diet and regular exercise. Parents who have used it with their children have reported learning some facts themselves.

Another important element in the Foundation’s preventive efforts is making the public aware of the availability of the hepatitis B vaccine. A special educational campaign has been aimed at encouraging pregnant women to be tested for hepatitis B so that if they are found to be carriers, their newborn infants can be protected at birth. On a long-range basis, this means fewer cases of chronic liver disease, cirrhosis and liver cancer.
An attractive fact sheet, "Breaking the Cycle," helps women to understand what it means to be a carrier, how to find out if they are, and the need to protect their infants from the possibility of contracting hepatitis B at birth.

One of the Foundation’s new pamphlets, "Alcohol and the Liver: Myths vs. Facts," has been found to be helpful in substance abuse prevention programs, as well as health programs focused on the liver.

A wide range of fact sheets and brochures on specific liver diseases make available information that is difficult for a lay person to obtain. Among the diseases included are biliary atresia, hemochromatosis, primary biliary cirrhosis, sclerosing cholangitis, alpha 1 antitrypsin deficiency, galactosemia and glycogen storage disease.

The Foundation also operates a patient hot line, 1-800-223-0179, (except in New Jersey: 1-201-857-2626) that provides answers to many questions about liver disease and gives referrals to medical specialists in the patient’s area.

"People who call us are often frightened and confused," said Thiel. "It’s an enormous shock to be diagnosed as having a serious disease you’ve never heard of. Even if you’re given considerable information at the time, it’s difficult to absorb it right away." She added that many physicians find it difficult to communicate medical information in language patients can understand. On their side, patients cannot immediately think of all the questions to ask and are concerned about emotional and lifestyle factors, as well as medical ones.

While the hotline at national headquarters in Cedar Grove, New Jersey, provides immediate help, local chapters and support groups around the country give invaluable continuing assistance to patients and their families in coping with all the ramifications of chronic and life-threatening illness. Those who face the possibility of a liver transplant in the future are encouraged by the success stories of those who are living with transplants.

"Just knowing that you’re not alone can bring tremendous relief," said Thiel. "Chapters also enable people to stop being passive victims of their disease and take an active role in fighting it by learning more and by helping to raise funds for research. Sharing information and feelings makes it possible for members to improve their own physical and emotional well-being while helping each other."

In addition to the educational meetings held by chapters, the American Liver Foundation sponsors a national "Meet the Researchers" Day, at which attendees have a chance to ask questions of some of the foremost liver researchers in the world.

A quarterly newsletter, Progress, brings reports of the latest developments in liver research to all American Liver Foundation members.

Sharing Cares and Hopes links a national network of parents of children with liver diseases. Some of the members live in small, isolated communities, so that networking by mail and phone provides their only contact with other parents confronted by similar problems.

The Foundation is happy to work with medical directors in providing articles tailored to the needs of employee publications and in supplying materials for health fairs.

Samples of literature and additional information on the Foundation’s programs may be obtained by writing to the American Liver Foundation, Cedar Grove, N.J. 07009 or calling 1-201-857-2626.