The Historical Precedents for Quality Assurance in Health Care

(peer review, patient care evaluation, utilization review, outcome and process assessment, data-based management)

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The evolution of quality assurance as an essential component of a scientific, objective approach to health care delivery, and its implications for the profession of occupational therapy are presented. A review is made of the economic, ethical, psychological, and legislative forces that have influenced the development of quality assurance over the past century, a development that has seen times of strong emphasis on quality assurance functions, as well as periods of minimal support and, even, obstacles to any activity.

Quality assurance standards established by both The American Occupational Therapy Association and the Joint Commission on Accreditation of Hospitals (JCAH) are discussed. Results of commitment to these standards include improved effectiveness and efficiency of health care, better coverage and reimbursement from third-party payors, and greater professional growth. The need for commitment by occupational therapists to the most effective forms of quality assurance is recommended.

The profession strives for quality in many ways: accreditation of occupational therapy curricula, certification of therapists via a national examination, licensure, continuing education, research, standards of practice, and ethical standards. These activities focus almost exclusively on the therapist's credentials and behavior. Quality assurance provides a unique contribution to the quest for quality because it focuses on the health care interaction itself, the problems at hand in the particular facility, and on patient outcomes.

Three major elements comprise the quality assurance program:

1. Assessment of patient care problems that have a substantial effect on treatment outcomes.
2. Use of objective criteria and/or standards developed by peer-professionals as the measure of quality care.
3. Elimination of impediments that restrict the benefits of care.

The goal is measurable improvement in patient care that can be reasonably attributed to the quality assurance improvement action.

The Professional Mandate

Assessing and improving the quality of occupational therapy services for aggregates of patients with similar problems is as important to patient treatment as evaluation of individual patients before devising the care plan. Support for this statement is found in the Standards of Practice (1). Here, quality assurance shares equal rank with each of the major elements of care: Standard I pertains to patient referrals; Standard II, evaluation of clients; III, development of the treatment plan; IV, treatment implementation; V, discharge plan; VI, re-evaluation for chronic conditions; and VII, quality assurance. The quality assurance standard emphasizes consideration of patient outcomes: "The occupational therapist shall systematically review the quality, including outcomes, of their services, using predetermined criteria reflecting professional consensus and recent developments in research and theory." (1, p 4)

After a review of the Standards of Practice, it is reasonable to deduce that the Association considers quality assurance an essential element of practice. This opinion is not restricted to our profession and our era. In fact, quality assurance efforts to measure and enhance health care have a long history that encompasses many pseudonyms: end-result assessment, peer review, audit, chart review, and medical care evaluation. An understanding of its infancy and development helps clarify the current conceptual and technical aspects of quality assessment, making it easier to learn and apply.

The Roots of Quality Assurance

In ancient history, quality of care was achieved with the "eye for an eye, tooth for a tooth" philosophy. An extreme example of this is ancient Egypt, where the life span of the Pharaoh's physician depended on the Pharaoh's continued good health! Similar attitudes were recorded in Biblical times. In the
more recent—and more relevant—past, Florence Nightingale assessed and improved quality of care in Army hospitals. Fatality and length of stay statistics showed the effectiveness of her efforts (2).

In 1912, about 50 years after Ms. Nightingale's activities, E. A. Codman, a physician and a professor of surgery at Massachusetts General Hospital, founded his own hospital and began his "end-result" assessment to improve health care. Codman abstracted each case history and re-evaluated every patient a year or more after hospitalization, relying on objective measures of outcome whenever possible. He then classified the results as satisfactory or unsatisfactory, and analyzed the latter to ascertain causes. The causes of the poor results fell into various categories: diagnostic error, inadequate technical skill, poor surgical judgment, inadequate equipment or care, the disease process, and patient noncompliance (3).

Codman's published results were highly influential in the health care community, which was suffering at that time from seriously inadequate hospitals. The famous "Flexner Report," a scathing, detailed analysis of hospital conditions, had made everyone painfully aware of the problems (4). Codman's end-result analysis looked like one very useful solution.

In 1918, the American College of Surgeons inaugurated their own first effort to improve hospital care throughout the United States. But, they turned from Codman's exacting end-result evaluation of a hospital's care and wrote general standards instead. Their voluntary accreditation program was based on a one-page set of minimum standards including the stipulation that physicians and surgeons "review and analyze at regular intervals their clinical experience in the various departments of the hospital . . . ; the clinical record of patients, free and pay, to be the basis for review and analysis." (5, p 3)

The first accreditation survey was shocking: only 89 of 692 hospitals passed (6). Although review of patient care was included in these first standards, a systematic, objective review was not required. The main thrust of the accreditation standards encompassed physicians' credentials, the characteristics of good medical records, and the necessity for laboratory and X-ray facilities. In the 1950s, Paul A. Lembcke developed what he called medical auditing by scientific methods. He emphasized the need for explicit and objective measures of quality. He also stressed the importance of profound impact on the delivery of health care in the United States.

**Quality Assurance Requirements Proliferate**

In the 1960s—with the advent of Medicare and Medicaid signaling the government's entry into health care reimbursement for the elderly, the poor, and the handicapped—the impact of JCAH standards grew. JCAH's program was still a private, voluntary accreditation process; however, it became the preferred route for hospitals to demonstrate that they met standards for quality service and thus were eligible for reimbursement from the government for services provided to recipients of Medicare, Medicaid, and Maternal and Child Health Programs.

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**In 1918, the first JCAH Standards included review and analysis of patient care.**

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To exercise some control on the expenditures of public money, Medicare legislation required that hospitals have utilization review boards. These boards were composed primarily of physicians. They were responsible for preventing misuse of funds by assuring that the services rendered were necessary. Nonetheless, in the next 10 years incidents of abuse of Medicare grew. For example, patients were frequently admitted to the hospital just for X-ray and laboratory tests because such tests were not covered by Medicare on an outpatient basis. Many other severe insurance abuse cases also came to the public's awareness; several involved billing for extensive services never provided.

In 1972, Congress replaced utili-
ation review boards with Professional Standards Review Organizations (PSROs), again made up of local physicians. The PSROs' responsibility encompassed both quality review via chart audit and admission review through length of stay and admission screening. Health care services of all practitioners were to be used only when necessary and to be provided at the most economical level of care consistent with appropriate service (i.e., skilled nursing home vs. acute care, or outpatient vs. inpatient). Along with these economy measures, the professional standards of quality care were still to be met.

Fiscal intermediaries such as Blue Cross would not pay for services PSROs identified as medically unnecessary, and substandard care was monitored until it improved. Although some argued that PSROs would never be effective—claiming it was like having the fox guard the hen house—elaborate regulations governing every aspect of PSRO activities were developed between 1972 and 1980.

The 1970s provided an atmosphere of rapid growth for various types of objective medical care evaluation. Originally, physicians and nurses were the most active, professionally, in assessing patient care. In 1973, the AOTA Representative Assembly launched a nationwide chart audit training program (8). Since PSRO legislation applied to all health care practitioners, the occupational therapy profession authorized funds for seminars to prepare members to fulfill these requirements.

As a result of skills learned in the audit seminars, occupational therapists at national and state levels developed objective descriptors of quality care called screening criteria. The criteria addressed referral, essential treatment, and outcomes for patients with a specific diagnosis or a special problem. In 1978, the profession—clearly committed to health care evaluation—added the requirement for quality assurance studies to the basic Standards of Practice (1). The screening criteria served the profession not only as a basis for quality assurance studies, but as guidelines for improved reimbursement from Medicare companies (9).

While occupational therapy voluntarily embraced the idea of quality assurance and conducted demonstration projects to test its feasibility (10), physicians were rejecting the mandatory PSRO requirements for review of their patients' care. The PSROs represented a major change in health care and governmental intrusion was bitterly resented by many in the medical field. The American Medical Association (AMA) brought a suit against the government to repeal the PSRO legislation. Although the AMA lost the case, their opposition retarded PSRO development.

In the late 1970s, the requirement of both JCAH and PSROs requiring that hospitals perform a minimum number of medical care evaluation studies per year spurred a rush of activity. Critics complained that the efforts were superficial and meaningless, done only to fulfill paper requirements; proponents found that the efforts produced significant results.

### In 1972, quality and utilization review were mandated by a Congress hoping to curb health costs.

**Revisions in Quality Assurance Requirements**

By the late 1970s, Congress became concerned that PSROs were spending more than they were saving. Broad-scale evaluations of the PSROs yielded different verdicts, depending on who did the evaluations and what was measured. Although a Department of Health and Human Services study in the 1970s showed that PSROs saved $1.27 in Medicare reimbursement for every $1.00 spent in concurrent review, the Congressional Budget Office (CBO) added hospital costs for private patients to government expenditures and found that every PSRO dollar spent saved only $.40 in the cost of hospital care. CBO assumed that fixed hospital costs were being shifted from the hospital bills of the government-reimbursed patients to the privately insured and out-of-pocket payors (11).

PSRO denial of payments was further complicated because frequently there were no skilled nursing facilities available for patients ready to be discharged from the more expensive acute-care facilities.

With all these problems and despite the debates about PSRO's efficiency, the JCAH continued to emphasize and refine their requirements for quality assurance studies. In January 1981, a new quality assurance standard went into effect for JCAH accreditation.

No longer would a minimum number of studies be required per year; instead, an on-going efficient
Health care budget cuts call for increased efforts to maintain quality.

Over the past century, quality assurance occurs as a strong component of health care in some periods, only to suffer neglect in others—Codman's end-result thesis was hailed, then disregarded. Medicare legislation spawned a spurt of rapid growth in both the extent to which quality assurance was employed and the usefulness of the procedures. Now, deregulation is paring back the PSRO program. The time required to collect quality assurance data has been an inhibiting factor for many, but practitioners skilled in quality assurance learn to blend it into the ongoing treatment process.

There also appears to be a strong emotional need to avoid formal assessment of patient outcomes. The time required to collect quality assurance data has been an inhibiting factor for many, but practitioners skilled in quality assurance learn to blend it into the ongoing treatment process.

At this time of potential radical revolution in the health care benefit-reimbursement systems, the legislative support for quality assurance is in jeopardy as the mandate to save money receives primary consideration. Nevertheless, the ethical mandate for quality assurance will increase. This will occur because ongoing professional requirements to continually assess and improve care must be augmented to prevent serious loss in patient outcomes due to cuts in programs. History shows that quality assurance can solve major problems in productivity and health care outcomes, but an increase in commitment to quality assurance will be needed if its benefits to the patient and the profession are to survive.

REFERENCES
1. The American Occupational Therapy Association; Standards of Practice for Occupational Therapy Services for the Developmentally Disabled Client, Standards of Practice for Occupational Therapy Services for Clients with Physical Disabilities, Standards of Practice for Occupational Therapy Services in a Home Health Program, and Standards of Practice for Occupational Therapy Services in a Mental Health Program, Rockville, MD, The American Occupational Therapy Association, 1976.