Quality Assurance Requirements of the Joint Commission on Accreditation of Hospitals

(standards, utilization review, rehabilitation services, cost-effectiveness)

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In 1981, the Joint Commission on Accreditation of Hospitals instituted new quality assurance requirements. As occupational therapy departments plan for accreditation review, they must address these changes, which are markedly different from earlier standards. This article outlines the essentials. Official interpretations of the Joint Commission's quality assurance standard and its application to occupational therapy are presented. The focus of this paper is on one possible quality assurance system. The elements of an effective quality assurance plan for an occupational therapy department are defined, and a hypothetical quarterly report for a department is presented. The ongoing review and evaluation monitors required by the Joint Commission are described.

Hailed by proponents as a tool that would improve the impact of health care, quality assurance is still an enigma to many. Although required of occupational therapists by the Joint Commission on Accreditation of Hospitals (JCAH) and included in the Standards of Practice of the American Occupational Therapy Association (AOTA), it is still common for departments to avoid the issue, frantically developing the program only when a Joint Commission survey is pending.

Quality assurance (QA) is an objective form of patient care evaluation. It focuses on improving health care delivery so that achievable patient benefits are secured. It can be seen as boon or bane, depending on the understanding of the beholder.

Current State of the Art: The Joint Commission's QA Standards

The greatest impact on occupational therapists' performance of quality assurance has come from the Joint Commission, a private organization whose stamp of approval is used by most hospitals to demonstrate that they meet standards necessary for Medicare reimbursement. The Commission's standards for accreditation exert a powerful influence on health care delivery patterns. One of these numerous standards is a quality assurance requirement. It will be reviewed here to serve as a guide for therapists with an accreditation survey in their future, and to describe the current state-of-the-art.

This type of summary cannot
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Requirements for the treatment process 1 . patient evaluation 2 . development of treatment goals 3 . development of a treatment plan with input from physicians, staff, patients, and/or family 4 . progress assessment 5 . good documentation; and 6 . quality assurance. (It is interesting to note how these standards are imbed quality assurance in the treatment process. It is not isolated as a management function alone.)

Utilization review, which is included in quality assurance, considers such questions as: Is this level of care appropriate, i.e., could this care be offered at less expense but with equal quality elsewhere? Is this group of clients benefiting from the service? These and other quality assurance questions require predictive ability—a skill in judging who can benefit. Many therapists do not feel comfortable predicting, but this is a skill that can be sharpened. Quality assurance outcome studies contribute to this skill when therapists set goals for a group of patients and then assess outcomes to ascertain what percent of the group achieves the expectation.

Turning from the specific quality assurance requirements for rehabilitation services to the overall quality assurance standard for the facility provides further guidance. That standard requires "... evidence of a well-defined, organized program designed to enhance patient care through the ongoing objective assessment of important aspects of patient care and the correction of identified problems." (3, p 151) This standard is further described by a set of problem-solving steps: identification of problems in patient care; objective assessment of the cause and scope of the problems and determination of their priorities on the basis of the greatest potential patient benefit; implementation of improvement actions; monitoring of activities to assure that the desired change occurred and is maintained; and documentation showing that patient care improvement can be reasonably attributed to the quality assurance program.

Interpretation of the Standard

Based on the overall quality assurance standard, a surveyor could, during an accreditation survey, request to see the following: a quality assurance plan for the entire facility, minutes of committee meetings related to quality assurance, evidence of correction of patient care problems revealed in quality assurance activities, definitions of relevant terminology, and a list of specific changes in patient care effected through the hospital’s quality assurance program since the previous survey. (The list should “... not include changes relative to improved documentation or use of forms; to administrative changes that deal with patient satisfaction rather than patient care...; or to actions taken that, even with considerable monitoring, are known to have a low success rate in effecting change, such as verbal or written counseling, educational programs, and new or revised policies and procedures.”) (4, p 176) These overall guidelines refer to the entire facility, so applying them to the occupational therapy department of a rehabilitation unit requires some extrapolation and adaptation.

For clinical and support services,
The Joint Commission's quality assurance standards allow some flexibility in interpretation.

such as rehabilitation, the Joint Commission recommends that the review process begin with a regular monitoring of readily available data that may reveal patient care problems. The data can be found in medical records, patient complaints, observations of performance, utilization and financial data, department reports, and special studies. There is no longer a requirement for four special studies per year in rehabilitation services. The emphasis is on regular review and evaluation of patient care data, which are documented quarterly. No guideline exists about how many special studies other than the routine monitors are required (5). If an important problem cannot be resolved without a special study, then one should be conducted.

Application to Occupational Therapy

From these standards and interpretations, buttressed by personal contact with Joint Commission staff, a quality assurance program for an occupational therapy department in a rehabilitation facility can be devised. First, a written quality assurance plan for the department is desirable, but not required. It should describe both the quality assurance activities in occupational therapy and how they will be interrelated with the whole facility. The plan would need to relate the department's methods for monitoring patient care data.

The plan should state briefly how the data monitors will be regularly reviewed, with the review summarized and documented quarterly. Minutes of staff discussions on problem management and evidence of problem resolution might be a planned source of documentation regarding quality assurance actions, or the department might keep a list of the problems revealed and the data sources for them.

The plan should define any terminology used in the program. It also should relate how evidence of problem resolution will be documented by a count of specific changes in patient care or outcomes, and should specify how program results will be fed into the total quality assurance program for the facility.

Since problem discovery by ongoing review or monitoring of pertinent data is a radical departure from routine monitoring, this is a significant departure from traditional quality assurance practices. For example, "goals set" versus "goals reached" could be tallied for each patient, and the data clustered according to diagnosis or presenting problems. Such information could alert staff to possible problems in achievement of treatment goals in certain patient groups. Incorporating the collection of quality assurance data into the treatment process itself, as this assessment form does, is one solution to the oft-cited barrier to patient care evaluation—lack of time.

A routine patient-discharge questionnaire, asking how treatment might have been improved, is another possible source of data to monitor. A third possible monitor is a bi-annual meeting of the staff to identify patient-service problems through structured group decisions, a process explained elsewhere (7). A fourth monitor, utilization data, such as day of hospitalization when the first therapy session is ordered, also could be useful. Finally, overall program evaluation data are a good source of information about problem areas needing quality assurance action.

A hypothetical example of a quality assurance process follows: the problem—more patient referrals than staff can handle. This is revealed by monitoring the attendance log tally of referrals not accepted due to insufficient staff time. Staff set their standard for care: no patient should be denied care unless it is just as readily available on an outpatient basis, and the delay poses no complications to health or recov-
A number of ongoing review and evaluation monitors have been in operation this quarter, which is the fourth quarter since initiation of the quality assurance program. The monitors focus on indicators of quality care selected by the occupational therapy staff and the medical director. In addition, one special study is in process, and a care problem referred to the department has been addressed.

I. Indicators of Quality Care

A. Day of hospitalization when occupational therapy first ordered. Fifty percent of stroke rehabilitation patients failed to meet the standards for timely referral developed by the occupational therapy department based on research by Garraway et al. (9) and approved by the medical staff. A routine referral system, in which all patients meeting the criteria will automatically have a referral sent to the physician for approval, is in the planning phase.

B. Patient understanding of and identification with therapy goals. Staff felt at least 85 percent of the patients (or the families of those who cannot communicate) should be able to state their occupational therapy treatment goals. If they do not understand the purpose of therapy and feel that the goals are irrelevant to their needs, motivation may be seriously hampered. Patients (or family) were surveyed to see if they could verbalize their treatment goals and if the goals reflected their interests using a five-minute questionnaire during the second week of treatment. A survey to monitor this indication of quality care is being developed. Only 40 percent of the patients could state their therapy goals and only 55 percent of that group felt the goals had real relevance for them. To improve the situation, goals for occupational therapy will be placed on a card taped to the patient's bed. Therapists will be sure to use layman's terms to express the goals and repeat goals at each treatment period using the same phrasing each time. Patient and/or family will be given an extra consultation before they meet with the staff to determine treatment goals. The purpose of this initial consultation will be to reinforce the purpose of the upcoming team meeting, to enable the patient (and/or family) to think about their needs, and to help them be assertive about their ideas during the combined staff, patient, and family goal setting meeting.

C. Other monitors currently reviewed were evaluated as satisfactory. These monitors are based on the following indicators of quality care: 1. patient satisfaction with outcomes of treatment; 2. American Occupational Therapy Association's Standards of Practice; 3. accidents during treatment; 4. complications, and; 5. goals set compared with goals achieved.

II. Quality Assurance Study

In a staff committee meeting to identify and prioritize problems in care where significant achievable benefits are NOT being achieved, the following problem received the highest weighting and was approved for study by the Quality Assurance Committee: the unmotivated patient. Following the health accounting approach described by Williamson et al. (7), the problem of poor patient motivation was measured during the second week of treatment with a survey instrument administered as part of the therapy program. Forty-five percent of the patients were rated as lacking motivation regarding their treatment goals, whereas the highest acceptable standard for poor motivation was 20 percent. Improvement actions are currently under consideration and will be implemented in the next quarter.

III. Referred Problems

Nursing staff has occasionally mentioned that patients scheduled for occupational therapy treatments do not receive them. A temporary weekly monitor was established, using attendance records as the data source. Causes for missed treatments could be immediately ascertained and corrected.
quality assurance plan for an occupational therapy department, and the types of monitors one could put in place to review and evaluate care, a recommendation is now in order about the minimum essential items to show a surveyor. In a rehabilitation unit’s occupational therapy department in an acute-care hospital, a JCAH surveyor would probably want to see: 1) a quarterly report of a comprehensive, ongoing review and evaluation of the quality and appropriateness of care; 2) a method of tracking and summarizing quality assurance problems and their resolution; 3) minutes of any staff meetings related to quality assurance; and 4) evidence that significant quality assurance findings are reported to the chief executive officer, medical staff, or governing board, either directly or through the central quality assurance committee. Putting all quality assurance materials in a notebook would save time for both the surveyor and the occupational therapist. Therapists in other types of facilities would probably find the above four items suitable for their surveys, too.

The Joint Commission requires a quarterly report of a review and evaluation system from occupational therapy. The report should state indicators of quality care regularly monitored and list the data source(s) monitored for each indicator. A hypothetical report can be seen in Figure 1.

Along with the quarterly report of regular monitors, surveyors will want to see evidence of correction of patient problems revealed through quality assurance. A one-page presentation should suffice: statement of the problem, description of how the problem was identified and measured, improvement criteria to be met, probable causes of the problem, improvement action taken, and monitoring of results and description of how the problem resolution directly impacts to improve patient care. Back-up data should be available in case they are requested. A master sheet of problems—date identified, date resolved and continuous monitor dates—helps present the global quality assurance picture to the surveyor.

Summary and Discussion
Current Joint Commission quality assurance requirements can be summarized in four documents that describe the program for surveyors: a quarterly report of regular review and evaluation monitors and specific studies; a brief description of each quality assurance problem, its resolution, and subsequent effect on patient care; minutes of any staff meetings related to quality assurance; and evidence that quality assurance findings are reported to hospital officers. These definitive documents pin down quality assurance to specific tasks that can be phased into the occupational therapy program, hence, facilitate implementation of quality assurance.

Although objective and scientific in nature, quality assurance is also a straightforward and pragmatic problem-solving process that can be dovetailed into the patient’s treatment.

Tailored for use in the clinics, quality assurance takes research principles and applies them as a new practical and powerful tool to improve benefits of care for patients, and to show the effectiveness and accountability of occupational therapy in each facility.

The quality assurance process described here is best learned through practice, but guidance or consultation from a skilled individual can expedite skill acquisition.

Note: Joint Commission on Accreditation of Hospital Routine Number—(800) 621-8007; and The American Occupational Therapy Association telephone number for the Quality Assurance Division—(301) 948-9626. Seminars and manuals are available from both The American Occupational Therapy Association and the Joint Commission on Accreditation of Hospitals.

REFERENCES
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5. Quality assurance requirements for clinical and support service review: Perspectives, Joint Commission on Accreditation of Hospitals, Chicago, Illinois, September/October, 1980