A Management Approach to Monitoring Quality Health Assurance Standards

J. D. FELSEN, MD, MPH

AN ALL-PERVASIVE phenomenon within the health bureaucracy centers around the setting, cataloging, and monitoring of quality assurance standards for health care services. For lack of a better definition, standards can be defined as agreed upon set values—the degree of compliance with these values is intended to influence and to assist in indirectly assessing progress towards (or away from) reaching stated objectives; that is, it is agreed that if the standards are met in a high proportion of cases, the probability is greater that the objectives will be reached. In the present context, the objective is usually couched in terms of providing health care of high quality, often through improving the efficiency or effectiveness of delivery of health services.

Attempting to define the "best," "most valid," "minimal," and "optimal" standards appears to consume the majority of the health bureaucrats' efforts. In an attempt to insure that the best or most valid standards are set, considerable discussion is often generated concerning the latest and best scientific or health evaluation studies. Although such an undertaking might well be justified, I must occasionally adjust my microscope from "high dry" to "scanning" in order to comprehend the relevance of such efforts as regards their applicability to the larger health system.

What follows is a discussion of the obvious but often forgotten —a summary of many tough management questions which must be resolved before application of even the most valid standard can have any real impact or utilitarian value within a health system. As the setting, cataloging, and monitoring of standards are being attempted, attention paid to such management considerations might well prevent the "best laid plans" from going agley.

Dr. Felsen is special assistant to the director, Division of Resource Coordination, Indian Health Service, Health Services Administration, Department of Health, Education, and Welfare. *The paper is based on a presentation at the Eighth Joint Meeting of the Professional Associations of the Public Health Service, held in Phoenix, Ariz., May 9–12, 1973.* *Tearsheet requests to J. D. Felsen, MD, Room 5A–35, Indian Health Service, Parklawn Building, 5600 Fishers Lane, Rockville, Md. 20852.*

Discussion

As an inventory of quality assurance standards for health care services is compiled, one quickly becomes cognizant of several important issues that must be resolved to avoid the quick demise of the inventory in the ubiquitous dust-covered caches of the bureaucratic structure.

ISSUE 1. Can such a document be kept simple enough to be functional? Many such inventories are lengthy and cumbersome, discouraging routine review, compilation, and updating. One must assess whether an inventory containing most of the quality assurance health standards in use can be formulated in a meaningful concise, uncomplicated format that will increase the probability of utilization.

ISSUE 2. Why are standards being developed? What is the specific purpose of compiling and monitoring various standards? Are the standards being employed to

—satisfy a program thrust or requirement of the Department of Health, Education, and Welfare (DHEW) or of another agency?

—provide data useful for budget justification and increased resources?

—monitor the quality of care provided directly to a particular population?

—manage more effectively and efficiently the health resources administered by a program?

—carry out research and development projects?

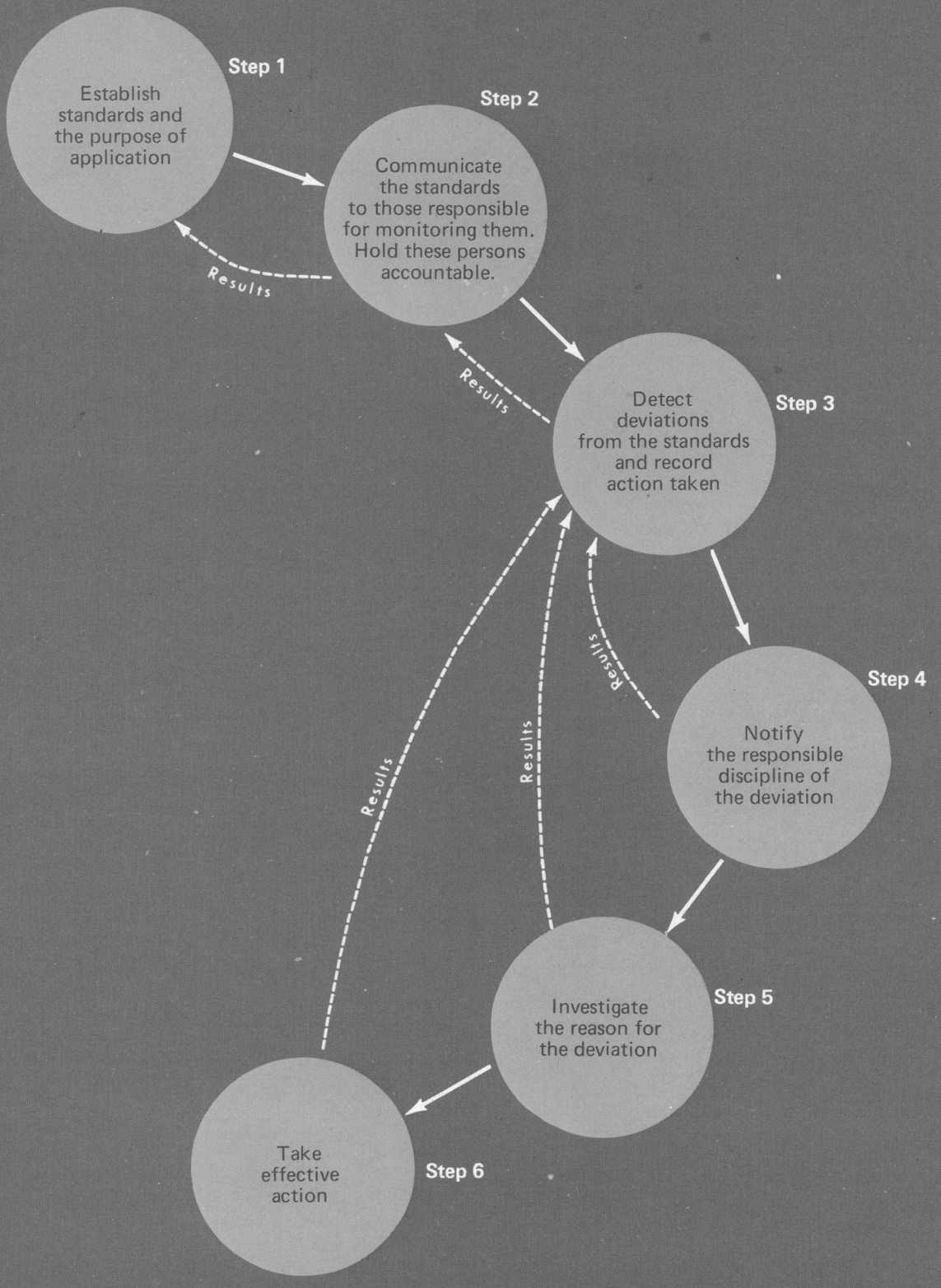
Obviously these purposes are not mutually exclusive, but the specific types of standards applied, the level at which—and the manner in which—they are monitored, and the format and frequency of the required reports might well differ, depending on the intended use.

ISSUE 3. Can specific standards honestly be effectively used to carry out the task for which they were intended? This issue ties in with issue 2 and emphasizes why it should be resolved. Essentially, it must be decided if applying the standards, within the constraints of the operating program's system, will promote constructive action or change. In other words, can the results of monitoring the standards be plugged back into the system to produce a useful result?

For example, let us suppose DHEW requires specific standards for medical care delivery that the Indian Health Service finds do not reflect the true quality of care the Service delivers. Furthermore, let us suppose that such standards do not effect

Operator gives instructions to the computer through the console typewriter at the Indian Health Service's Office of Research and Development in Tucson, Ariz.

Management process for monitoring quality assurance standards for health care services



changes in the quality of care rendered, the amount of resources appropriated, or the management of the system. Is such a standard useful? Yes. It provides DHEW with a piece of information the Department requires. However, the Indian Health Service is fully cognizant of why the standard is being applied and what it hopes to accomplish by applying the standard, that is, satisfying DHEW.

In another example, suppose a standard for wound and nursery infections in Indian Health Service facilities is being monitored. Although, remotely, such information might be useful in justifying construction of improved facilities or increasing the housekeeping staff, its primary purpose would be to affect immediately the quality of patient care. Facilities with abnormally high rates of infections should be inspected and prompt corrective action taken to assuage the situation. In this instance, action must commence at a local level within a short period.

Moreover, to apply such a standard in the hopes that it will fulfill a useful function, one must be assured that someone in an area office or local service unit will review regularly the results of monitoring. More important, it is essential that the reviewer can, and will, institute appropriate investigation and change when indicated. To apply such a standard without this assurance is a specious undertaking. One must be satisfied that the application of a standard can, and further, that it will, result in the desired feedback, input, and action at a predetermined level.

ISSUE 4. What standards can the staff of a program realistically monitor? Should priorities be set? A program has limited resources to carry out its mission. Funds for proper evaluation are always at a nadir. Hundreds of standards are presumably being monitored throughout most direct health programs. It is dubious that most direct service agencies can adequately monitor even a fraction of the standards that "exist." Although desultory monitoring is no doubt pervasive, the circumstances and situations in which monitoring such standards results in effective feedback, input, and appropriate action rings even more of serendipity. Such a situation is not tolerable. It tends to produce a false sense of accomplishment and security.

An agency must determine in which cases the monitoring of standards can result in useful impact. The staff must decide which standards, no matter how great their validity, can be realistically applied; that is, the men and resources exist to allow effective monitoring. Many excellent standards may exist—and superb methods of evaluating them might be available—but if the methods are too costly, it is far better not to implement the standards than to apply them incompletely.

A pragmatic analysis of the resources available must be completed and then priorities set to determine which standards will be monitored.

ISSUE 5. Does application of standards contribute to the realization of a program's objectives? Actually, this question should be the starting point for considering the application of review criteria. It should be clear how the standards contribute to assessing progress towards a program's objectives. If a connection cannot be shown, adopting a standard is of questionable value.

ISSUE 6. How often will selected standards be monitored? At what levels? Actually this issue is an extension of issues 2, 3, and 4. It must be decided how often and at what levels standard monitoring is necessary and results in effective action. These questions must be answered in advance to assure that only those who can, and will, use specific information actually receive it; the information must be in a form that can be used.

This is not an exclusive list of issues to be resolved, but I hope that it will supply a framework for beginning an investigation of this subject. It quickly becomes apparent that these issues overlap, and a clean separation is not possible. However, it is imperative that analysis of such issues be completed if one is ever going to comprehend meaningfully this area of concern.

Recommendations

The management process for effective monitoring of quality assurance standards for health care services is outlined in the chart. The probability of achieving a useful impact probably increases as one proceeds from step 1 to step 6. Merely establishing a standard might entice a few people to use it and generate action to assure compliance. However, as the standard is effectively communicated and monitored, the chances of expanding its impact no doubt increase. Thus, one could argue that the very establishment of a standard (step 1), without taking further steps, might be useful and justified. Perhaps, but the fallacy in this approach is that one never knows if the establishment of the standard has resulted in effective

action. If the action might have occurred anyway, why go through the difficulty of establishing standards? The same reasoning holds true for steps 2 through 5. Unless the whole process is established and monitored, one is never sure that all the intermediate efforts result in positive gain.

Thus, I feel that whenever one talks about establishing standards, he must also consider how such standards are to be applied. He must be fully assured that accountability exists at step 1 through step 6 and that resources exist at all these levels to assure successful application. Without these assurances, the process is a spurious undertaking.

At present, although there are notable exceptions, steps 2 through 6 are often carried out sporadically. In other instances it is unknown if they are carried out at all. Therefore, it is difficult to assess if any step makes a difference and if the standard should be retained and applied. This uncertainty generates frustration.

It is costly to assure that the process I have described is operating adequately. Arguments can be advanced to justify a standards and evaluation program based on broad validity assumptions and faith that some positive impact results merely from establishing standards. It is a relatively inexpensive undertaking; it often satisfies bureaucratic requirements; it does not necessitate the development and implementation of a complex cybernetic system which supposedly will contribute to rational decision making. Moreover, there is much evidence to suggest that present evaluative technology and models are so limited that establishment of a truly rational system is a pretentious undertaking.

However, if one decided that, despite technological limitations and resource constraints, a rational system of monitoring and evaluating standards should be implemented, then he should be fully cognizant of the structural components and dynamic functioning of the proposed system. Moreover, he should be aware that meaningful implementation of the system probably will necessitate severely limiting the scope of the program. Otherwise, the end product will be a magnificent, logical paper schema, but a desultory, unmanageable functioning entity.

Management Considerations

Following is a summary of management considerations regarding quality assurance standards for health care services.

1. What is the source of the standard? How valid is the assumption that compliance will result in progress toward reaching an objective?

2. Is the standard realistically approachable in a finite time period or is it a distant hope? Which type of standard (approachable or distant hope) should be applied? What is required to reach compliance with the standard; for example, management changes and small or large amounts of resources?

3. Will the standard have to be modified for use in the system under consideration? Why? Are there differences in the population base and in the population's morbidity experience, level of education, natality rates, age distribution, occupational exposure to disease, and genetic composition? Are there differences in geographic constraints, environmental factors, the size of settlements, cultural and socioeconomic factors, and the availability of community resources? Are there differences in the limitations in facilities or sophistication of care and in program economic constraints, the availability of supporting services, and the experience of the staff?

4. What is the real purpose of monitoring the standard? Is it limited to a real objective?

5. Who will monitor compliance with the standard? At what level? In an instance of deviation, what investigation and action will result? How soon after the deviation occurs should action result?

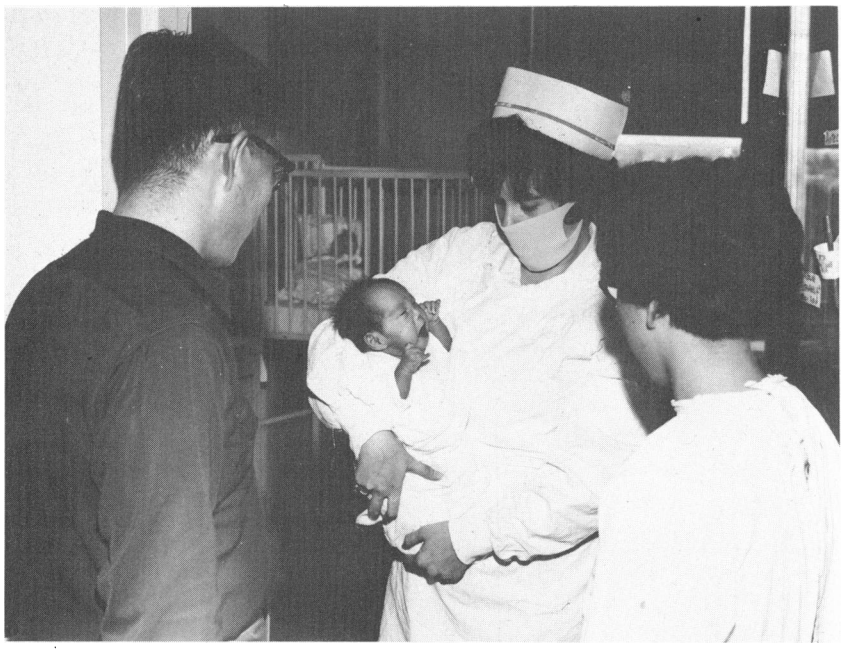
6. How will compliance or deviation be detected? Will there be standardized regular reporting, periodic reporting, or special investigation as deemed necessary?

7. How often will compliance or deviation be monitored?

8. How widespread will application of standards monitoring be? Will monitoring be applied to all professionals and institutions, selected professionals and institutions, or random professionals and institutions?

9. What resources are available or can be realistically made available to allow monitoring of a specific standard? What will satisfactory monitoring that includes reporting, review, analysis, investigation, and constructive action cost?

10. Despite the desirability or validity of particular standards, which standards (a priority listing) can be applied within the resource constraints of the system? If only certain standards can be pragmatically considered for monitoring, which ones will contribute most to providing an indirect means of assessing the influence upon approaching or deviating from objectives?



Father visits his newborn child at the Alaska Native Medical Center in Anchorage, a modern Indian Health Service facility. Below, *a young child is immunized by an Indian Health Service nurse at an outpatient facility.*