

## QUALITY ASSURANCE AND UTILIZATION REVIEW

Position Paper

of the

AMERICAN COLLEGE OF PHYSICIANS

13 September 1984

### INTRODUCTION

Effective quality assurance activities that improve the delivery of health services to the public are of particular concern to the American College of Physicians. The College is committed to maintaining high standards of quality in the delivery of health services and believes that quality assurance mechanisms can be an effective means for achieving this goal. Some of the College's efforts to ensure high quality medical care are its continuing medical education programs, including postgraduate courses, regional meetings, the Annual Session, and the Medical Knowledge Self-Assessment Program (MKSAP); and the Clinical Efficacy Assessment Project (CEAP), to name a few.

Congressional concerns over rapidly rising costs of the Medicare and Medicaid programs, coupled with concerns regarding the quality of care delivered to patients, led to enactment of legislation in 1972 that provided for the creation of Professional Standards Review Organizations (PSROs). This program relied on peer review by physicians at the local level to evaluate the medical necessity, appropriateness, and quality of medical care provided to patients. Cost containment was always a primary goal of the program, and the issue of quality received less focus. As part of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (PL 97-248), the PSRO program was repealed and replaced with a new utilization and quality control peer review program. The review organizations in that program are now referred to as Peer Review Organizations (PROs). The new law attempts to place increased emphasis on the review of quality of care. In addition, it places a greater emphasis on private sector involvement while retaining the principle of physician peer review. The new PROs also will be heavily involved in monitoring and validating classification of diagnoses under the new Medicare prospective payment system.

As the costs of medical care continue to be of major concern to the nation and expanding efforts are made to control the rate of increase in costs, the College believes it is essential that there be both quality assurance and utilization review mechanisms in place to ensure that both quality and costs of care are appropriate.

### SUMMARY OF POSITIONS

1. There should be effective mechanisms of quality assurance that improve the delivery of health services to the public.
2. Utilization review is a mechanism of ensuring appropriate use of health care resources.
3. There should be national guidelines to ensure the provision of high quality care to the public.
4. Physicians should be encouraged to participate in the conduct of quality assurance and utilization review activities.
5. The federal government must continue to support both quality assurance and utilization review programs.
6. The transition from a retrospective to a prospective payment system for Medicare reenforces the need for effective quality assurance and utilization review mechanisms.
7. Research efforts must continue in the continually evolving areas of quality assurance and utilization review.

### POSITION

1. There should be effective mechanisms of quality assurance that improve the delivery of health services to the public.

### RATIONALE

Quality assurance mechanisms are activities aimed at improving the quality of care and the delivery of health services to patients. The purpose of these activities is to improve the quality of care through a systematic process designed (1) to identify deficiencies in the quality and delivery of health care, (2) to correct such deficiencies through education and administrative change, and (3) to reassess performance periodically to ensure that improvements have been maintained.

The goals of an effective quality assurance program are to ensure high quality care through a coordinated system of reviewing, monitoring, and assessing care; to modify practices that do not meet professional standards of quality; and to modify practices that inflate costs unnecessarily.

The complexities of quality assurance are many, making it difficult to arrive at a single acceptable definition. Many factors in the health care system influence the quality of care, and there is no unanimity of opinion how best to measure quality of care. System changes that have an impact on the availability of facilities and medical services (e.g., capital construction, changes in rules and regulations, reimbursement policies, etc.) are key factors related to the quality of care, but are often beyond the control of the individual physician and are outside the realm of most quality assurance programs.

The American College of Physicians believes that effective mechanisms of quality assurance are essential for good patient care. The College, therefore, supports the peer and quality review activities embodied in the PRO program.

Worthwhile elements of quality assurance programs are standards, reliable and valid data, peer review, and means to effectuate behavioral change.

#### Standards

Standards development can be a worthwhile activity in the quality assurance process. Standards serve as measures against which the quality of services may be compared. They are developed by professionals relying on their expertise and prior experience, and involve the task of defining the critical required elements of quality care. Further, standards encompass professionally developed expressions of the range of acceptable medical practice and may be adjusted to reflect regional patterns of care and even local variations in practice. Internists must be actively involved in the setting of standards by which their medical practice is judged.

#### Data

The foundation of any quality assurance program rests on comprehensive and accurate data. Data-based systems are essential for identifying variations in medical practice. Types of data collected may include: (1) structure data, which describe a variety of characteristics of the facility (e.g., size, equipment available, credentials of practitioners, patient mix); (2) process data, which describe what physicians and other health care professionals do for a patient; and (3) outcome data, which describe the results to the patient. Data should be collected areawide to allow comparison with regional and national data. These data can be used to identify patterns of health care delivery and unusual practice patterns related to a specific institutional or individual provider.

The College is concerned, however, that a major factor in attempting to utilize "outcome" in an objective manner and trying to establish demonstrable criteria is the factor of "caring" -- which results in patient satisfaction (e.g., sense of well being and/or "happiness"). Physician "caring" may be especially important in the area of management of chronic and/or incurable disease. This introduces an intangible factor that cannot be quantified, yet there are few elements of physician performance that are more important to patients. This is one of the major stumbling blocks in using objective "outcome" criteria in the assessment of quality of care.

Dr. Walsh McDermott addressed the issue of the role of the physician in the delivery of personal health care and the problem of developing appropriate health indicators for measuring the impact of physician care (which he referred to as "the personal physician system") on patient outcomes. He determined that there are no established indicators for measuring the influence of physicians' personal services on health outcomes.

Data serve as a basis for the establishment of standards against which the assessment of quality of care can be made and for monitoring patient care activities. One means of assessing and evaluating quality is through determination of patient outcomes. As concerns for the costs of care mount, health outcomes may be used with increasing frequency to measure the cost/benefits of medical care. However, the assessment of the quality of care solely by evaluating patient outcomes is most problematic because of the multiple factors that figure in both successful and non-successful outcomes. Although there are many effective mechanisms for the assessment of quality of care, what is lacking are appropriate standards against which actual patterns of care can be measured.

Confidentiality of medical data must be preserved to obtain patient and physician cooperation. Access must be limited only to those fulfilling specific legitimate tasks on a need to know basis. Protection of individual privacy must be a primary concern behind any data disclosure policy.

#### Peer Review

Peer review is evaluation by fellow professionals of health care services. Its purposes are determining appropriateness of care, identifying medical practice that does not meet acceptable medical standards, and correcting deficiencies through effectuating change (e.g., education or administrative change). For peer review to be practical and effective it should be performed on a local level by physicians whose expertise is known and respected in the area. Internists -- by their education, training, and hands-on experience -- can perform a significant role in this process.

#### Means of Effectuating Behavioral Change

Changing physician behavior that does not meet acceptable standards of care is a desired result of any effective peer review activity. However, the best approach to achieve this goal is unclear. To ensure cooperation, physicians must participate in the design and operation of a system created to achieve behavioral change in physicians.

Involvement in setting local standards for quality care can, by itself, be a step toward achieving desirable behavioral changes and could result in improvements in patient care. Where the peer review process identifies substandard care, advisory counseling from physician reviewers could facilitate corrective action. In other instances a more formal educational process may be necessary. Changes in physician behavior can best be accomplished if physicians take responsibility for managing the change themselves.

Medical audits are another mechanism for evaluating patient care performed according to preestablished standards. Audit can be an effective mechanism for concurrent or retrospective review of care. Audits are used to assess the quality of health care with the goal of improving health care delivery through an educational process. The development of standards,

the analysis of variations, and the correction of deficiencies are essential components of the audit process. Benefits derived from audit activities remain controversial. However, the College advocates continued development of the process and views these activities as potentially worthwhile quality assurance devices.

## POSITION

### 2. Utilization review is a means of ensuring appropriate use of health care resources.

Utilization review (UR) is an activity aimed at determining the appropriate use of health care resources and whether such resources are provided in the most cost-effective manner. It relies heavily upon statistical analysis of hospital patient care data to identify unwarranted use of diagnostic and procedural services, unnecessary admissions, and excessively long hospital stays. In the past UR has been required under the Medicare and Medicaid programs to ensure that public funds are spent only for appropriate care. Now and in the future under Medicare prospective payment, there are different needs for a form of utilization review. For example, in order for hospitals to deliver services most efficiently, it will be necessary for hospitals to review the service delivery, and for PROs to monitor both over- and under-utilization. An additional difference between PSRO review and PRO review is that PSROs focused on individual patients and hospitals; under the PRO Scope of Work, PRO review is focused on the population within the PRO. The PRO is responsible for setting across the board standards for reducing the volume of admissions. In addition, for those patients not covered by Medicare and continue to be covered by cost- or charge-based reimbursement, the reimbursers themselves will wish to be assured that service utilization is as efficient as possible. The College supports UR mechanisms as a means of controlling health care costs and believes that greater efficiency in the use of resources is an appropriate means of reducing costs.

Worthwhile elements of utilization review are standards development, data gathering and analysis, prospective review, concurrent review, and discharge planning.

#### Standards

As in any effective review process, a fundamental activity of utilization review involves standards development by professionals. These serve as measures for determining appropriate utilization of resources.

#### Data

Data-based systems also are essential for the conduct of effective utilization review activities. Institutional or individual provider profiles can be generated from UR activities to identify such areas as inappropriate admissions, variations in length of stay, over- and under-utilization of ancillary services, and aberrations related to a specific provider or institution.

### Prospective Review

Prospective review is an activity that occurs prior to delivery of service to ensure that the service is appropriate. A specific form of prospective review is preadmission review, which is an activity conducted to ensure that patients seeking admission are placed in a facility most appropriate for their medical, nursing, and other health service needs. It is useful for determining appropriate use of beds, curtailing inappropriate admissions, assuring appropriateness of elective surgery, and identifying procedures that can be performed on an ambulatory basis. Preadmission review should not be done routinely, but should be focused on admissions involving procedures that have been found often to be inappropriate or unnecessary.

The College favors systems of UR that involve prospective review that prevent unnecessary services from being provided, as opposed to denying reimbursement of services retrospectively.

### Concurrent Review

Concurrent review is review at the time of the provision of the service. One form of concurrent review is that in which assessments are made at the time of admission and during the patient's stay. Admission reviews are conducted to ensure appropriate placement at the most economical level. Duration of stay reviews are performed on an ongoing basis to ensure the efficient and economical use of resources. These activities focus on making determinations of inappropriate admissions, use of ancillary services (e.g., x-ray, drug, or laboratory services), and variations in length of stay. It should be noted that under the prospective payment system, the hospital itself has the economic incentive to ensure that the patient's continued stay in the institution is medically appropriate.

### Discharge Planning

Discharge planning is a process for ensuring that patients are discharged to the most appropriate settings and that their medically-related and resource needs continue to be met. It should not be just a system for getting patients out of a facility but should entail a community oriented approach for caring for the patient. It is a tool for determining that a full continuum of patient care is provided. It is also a mechanism for discouraging prolonged hospital stays for lack of availability of more suitable long term care facilities. Discharge planning should be initiated as soon as possible after admission. Physicians must be actively involved in the process. The College believes that every hospital and long term care facility should have an organized system for discharge planning to ensure that all patients continue to receive any required post-institutional care.

POSITION

3. There should be national guidelines to ensure the provision of high quality care to the public.

RATIONALE

The establishment of national guidelines continues to be controversial. Some question their use at all; others object on the basis that they are cookbook medicine. Still others question the application of national guidelines at local levels on the basis that they may be inappropriate and even counterproductive.

Although the provision of health care is predominantly a local matter and decisions concerning effective care are most often made at the local level, these decisions can be enhanced by national guidelines. Quality of medical care is of concern to the entire medical profession, and it is the responsibility of the profession to establish guidelines that encourage optimal quality care. National guidelines can assist in determining whether local care is within an acceptable range or represents substandard care.

National guidelines for quality care could prove effective in ensuring minimal levels of quality and in achieving a more effective allocation of health resources. Guidelines should be formulated in the form of ranges of acceptable standards and allow for local variations while advancing toward a uniform optimal national level of care and for prudent utilization of health resources. Medical care is a dynamic and evolutionary process, and national guidelines will need to be flexible, responsive to change, and constantly updated.

Indeed, the medical profession acting alone or in concert with government has developed, and practicing physicians have utilized, national guidelines for clinical care in numerous instances. For example, each year the profession participates with the Centers for Disease Control in developing guidelines for influenza immunization. The National High Blood Pressure Education Program has for years been a cooperative effort involving the National Heart, Lung and Blood Institute and a wide variety of health professionals in issuing guidelines for both detection and treatment of hypertension. The Centers for Disease Control periodically publishes guidelines for the treatment of sexually transmitted diseases, and the Food and Drug Administration, again working with the profession, has developed approaches to the use of skull x-rays in cases of trauma to the head. In many, if not most cases, the treatment of many of the cancers follows highly stylized protocols. In the treatment of infectious disease, there is in many cases uniform agreement on the appropriate antibiotic and length of treatment course for specific infections. In each of these cases the College believes that such guidelines, based on the best available hard data and expert opinion, enhance the quality of clinical decision-making rather than inhibiting individual clinical practice.

Professional medical societies have some of the best resources for developing national guidelines of quality. For some time the College has been involved in activities relating to setting national guidelines for the use of medical tests and procedures. The College's Clinical Efficacy Assessment Project (CEAP), an outgrowth of cooperation with the Blue Cross and Blue Shield Associations in the Medical Necessity Project, evaluates and informs the College membership and others about the safety, efficacy, and effectiveness of various diagnostic and therapeutic modalities. Likewise, the American College of Physicians could provide leadership in the development of national standards for other aspects of the practice of internal medicine. Its membership represents over 60,000 doctors of internal medicine and related non-surgical specialties. It is the largest organization of general internists and allied subspecialists in the world. The College's membership expertise and official status lend credibility and influence to this effort. Thus, the College could assess the current state-of-the-art of the practice of internal medicine and make recommendations for national guidelines. Other specialty societies could act similarly for their respective areas of expertise.

National guidelines should also address standards for length of stay (LOS). According to a study released in August 1983 by the Congressional Office of Technology Assessment (OTA), there are wide variations in length of hospitalizations for patients with the same illness across geographic areas in the United States. The study found that variations appeared to be due to physician practice patterns and were not attributable to regional differences in age, sex, race, or severity of illness. Patients hospitalized for longer periods did not appear to have better outcomes than those hospitalized for shorter times. Therefore, this study stands as evidence for the possibility of changing practice patterns to decrease LOS without adversely affecting the quality of care.

During his research pursuits, Dr. John E. Wennberg uncovered systematic and persistent differences in the standardized rates of use for common surgical procedures and other medical services in the U.S. He found that within a region or state, different opinions held by physicians concerning the need for hospitalization -- as measured by per capita admission rates -- are the most important determinant of variations in per capita costs for the treatment of specific diseases. He states that the different opinions of doctors over the need to hospitalize are much more influential in establishing total costs than differences in cost per case or the length of an inpatient stay. Physicians have a professional duty to evaluate the reasons for these practice variations, and to consider seriously the acceptable range of appropriate practice.

#### POSITION

4. Physicians should be encouraged to participate in the conduct of quality assurance and utilization review activities.

## RATIONALE

Physicians are the primary providers of medical care and have the ultimate responsibility for the provision of high quality care. Resource utilization in institutional settings is controlled by physicians from the decision to admit until time of discharge. Physicians have a major responsibility for the system of care delivered to patients, and quality assurance and utilization review activities are integral to that system.

Quality assurance focuses on the primary obligation of the physician to ensure proper performance in the delivery of quality care. Physicians traditionally have recognized a strong professional responsibility for involvement in quality assurance and utilization review activities, and numerous physicians throughout the country have volunteered their time and effort. However, these activities are related to rapidly changing technical fields that often require special expertise and may absorb significant amounts of physician time. Although the College strongly encourages volunteerism in the conduct of these activities, it recognizes that under certain circumstances compensation may be required. The College would distinguish the routine activity undertaken by hospital medical audit committees, for example, which is a professional activity and should be participated in voluntarily, from those activities that may require special knowledge and experience, such as study design and analysis. The College would hold that it is the obligation of the medical professional to sponsor and participate in quality assurance activities, such as the gathering of data, the evaluation of results, and the institution of quality-enhancing changes.

The delivery of high quality care is shared by many health professionals. Quality assurance activities consequently require cooperation between physicians and nonphysician health care practitioners. Nonphysician health care practitioners provide a wide variety of health care services, and review of such services should be performed by their peers. In some instances, nonphysicians might most appropriately perform quality assurance activities. Internists should be actively involved in all worthwhile quality assurance efforts, whether or not they are controlled by physicians.

## POSITION

5. The federal government must continue to support both quality assurance and utilization review programs.

## RATIONALE

The federal government, as a major provider and the largest payer of health care services, has a legitimate role in supporting quality assurance and utilization review programs. The great increase in federal spending for medical care programs over the past decade precipitated Congressional concern about the cost and quality of that care. The establishment of the

PSRO program in 1972 was the federal government's first formal program for reviewing the quality of health care and containing costs. The federal government must continue efforts to ensure that its health care expenditures are spent as efficiently as possible and that an appropriate level of high quality medical care is maintained. The tax-paying public and beneficiaries of publicly sponsored health care programs demand that the quality of publicly financed medical care should meet at least minimal standards. The College maintains that an appropriate governmental role includes adequately funding programs, such as PROs, that assist the profession in ensuring that the proper quality of medical care is provided. Since the prospective payment system provides economic incentives for under-provision of services, the College would argue that the federal government has an obligation, in order to ensure the maintenance of appropriate quality, to fund such programs. Further, government has an appropriate role in supporting the collection and analysis of data that are necessary for effective quality assurance activities.

Research efforts are needed in the continually evolving area of quality assurance. In partnership with the medical profession, the federal government should continue to support research into techniques for improving quality assurance and utilization review mechanisms.

#### POSITION

6. The transition from a retrospective to a prospective payment system for Medicare reinforces the need for effective quality assurance and utilization review mechanisms.

#### RATIONALE

Effective 1 October 1983 a prospective payment system was implemented for inpatient hospital services reimbursable under Medicare. Payments are made on a per discharge basis for a fixed amount, determined in advance, for each case, according to its classification in one of 468 diagnosis related groups (DRGs). This prospective payment is considered payment in full.

The new payment system creates financial incentives for hospitals to be cost conscious. Because the incentives under the prospective payment system are for hospitals to cut costs or increase revenues, quality assurance and utilization review activities are needed to assure that decisions affecting the provision of care are based primarily on the needs of the patient. The economic incentives (some appropriate, some perverse) for hospitals are to (1) provide patient care in all case types as efficiently as possible, (2) increase admissions, (3) classify admissions into the highest paying DRG category, (4) provide more ancillary and nonphysician services on an outpatient basis (unbundling), (5) discharge patients as soon as possible, and (6) treat patients with multiple illnesses through separate hospitalizations for each illness.

The incentive to reduce costs may encourage hospitals to specialize in providing services they do best. Use of cost generating technologies and ancillary services may decline. This specialization in service delivery

may have desirable effects for patient care. However, while specialization could result in benefits, there is an unknown potential that needed services may not be accessible in some areas, especially, for example, if relatively isolated hospitals eliminate necessary patient services or departments (e.g., obstetrics, cardiac care).

As a result of this new payment system, new review approaches need to be instituted, and some existing activities need to be modified and strengthened. The incentives in DRG payment for hospitals to increase admissions or reduce services argue for safeguards in the form of quality and utilization review. Under the statute establishing the new prospective payment system (P.L. 98-21), Peer Review Organizations (PROs) are directed to review: (1) the validity of diagnostic information by hospitals; (2) completeness, adequacy, and quality of care provided; (3) appropriateness of admissions and discharges; and (4) appropriateness of care for which outlier payments are made. The College believes that physician-sponsored PROs are appropriate agencies for performing these functions, and encourages its members to participate and cooperate in such quality assurance activities.

Since under the PRO Scope of Work the first measurable objective of the PROs is to decrease inappropriate hospitalizations for the populations served within the PRO area, it is critical that physicians provide clinical input to the setting of these objectives. For example, it is certain that the health of the population, and not merely financial incentives, is the major determinant of rates of hospitalization. Thus, it would be inappropriate to set similar rates of hospitalization objectives for populations with different prevalence of disease, e.g., Nevada and Utah. Likewise, it is critical that the impact on the health of the population be studied and that the federal government be prepared to fund such evaluation studies. The new prospective payment system will have the following effects on review activities.

#### Quality Assurance Review

The emphasis on review of quality of care mandated by the law requires intensified peer review activities. Peer review needs to focus on making determinations of completeness, adequacy, and quality of care provided. While this new payment system rewards efficiency and discourages the provision of unnecessary services, it also creates financial incentives for hospitals to economize on the quality of care provided and to discharge patients too quickly. Like any reimbursement system, it is also subject to manipulation to maximize provider income. Quality assurance mechanisms must, therefore, be maintained to ensure that Medicare beneficiaries continue to receive complete and adequate hospital care that meets appropriate standards of quality. Adequate resources need to be provided for quality review under prospective payment. Continued physician participation is required for making decisions of quality of care.

#### Utilization Review

Under Peer Review Organizations (PROs), UR will play a critical role in monitoring specific diagnoses, screening admission of inappropriate

and non-emergency cases, and conducting concurrent review of high cost items and outlier cases.

UR by the PROs is particularly important because of the incentives of hospitals to under-produce service. Thus, PRO utilization review, unlike PSRO utilization review, should focus on inappropriate under-utilization rather than (as with PSRO review) inappropriate over-utilization.

A function of the PROs required under the prospective payment system is DRG validation review. Since DRG assignment is based on patient diagnosis, age, treatment procedure, discharge status, and sex, reviews will be conducted to ascertain that the diagnostic and procedural information that led to the DRG assignment is substantiated by the medical record.

Regulations under which the PROs will function suggest that admission reviews must be intensified. Those regulations call for emphasis on determining the necessity and appropriateness of admissions and on monitoring changes in admission patterns. Further, cases in which patients are readmitted within seven days of discharge for the same diagnosis must be reviewed to determine if adequate care has been provided. The regulations note that DRG payments will be denied or approved based on findings of necessity and appropriateness of the admission.

Little note will be made by PROs of hospital length of stay since payment is made on a per-case basis. Concurrent review activities will likely focus on transfer cases to other institutions or to distinct parts within an acute care hospital (e.g., rehabilitation unit, psychiatric unit) that are exempt from the prospective payment system. The potential for abuse through unnecessary admissions and readmissions will likely be a priority concern. One mechanism by which the PROs will probably monitor this abuse is through preadmission review.

Ancillary service review by the PROs should focus on the determination that essential ancillary services and technologies and other nonphysician services are provided to inpatients.

Outliers under the prospective payment system are those cases where the length of stay exceeds the average length of stay in the DRG or where costs are unusually high. All such cases will be subject to medical review to determine justification of the outlier status.

The College endorses efforts to cut inappropriate use and overutilization, but urges caution in implementing the prospective payment system. Physicians must assume responsibility for monitoring its effects on the quality of patient care, and must continue to keep the patient's interests paramount in making medical care decisions.

#### POSITION

7. Research efforts must continue in the continually evolving areas of quality assurance and utilization review.

## RATIONALE

Quality assurance and utilization review activities are changing rapidly, and mechanisms for achieving effective programs are continuing to be refined. Experimentation should be fostered, and research for new knowledge in these continually evolving areas is essential. Investments in research for effective quality assurance and UR programs will undoubtedly yield improvements in patient care and result in substantial future savings in health care costs.

Adequate baseline data are not currently available, and better data need to be developed for establishing valid assessment measures. There are wide variations in physician practice patterns throughout the US, and more research is needed to determine the appropriate normative standards to be used in quality assurance and UR activities. In partnership with the medical profession, the federal government should continue to support research into techniques for improving quality assurance and utilization review mechanisms. Research grants to develop and disseminate new approaches for these activities should be encouraged.

## CONCLUSION

The American College of Physicians encourages efforts to reduce the costs of health care, but insists that the quality of patient care must not be jeopardized. Quality assurance and utilization review programs have the potential for providing important safety mechanisms to guarantee that quality is maintained.

Worthwhile elements of an effective quality assurance program are standards development, reliable and valid data acquisition and analysis, peer review, and means to effectuate behavioral change.

The College favors utilization review as a desirable means of controlling health care costs. Worthwhile elements of that review include standards setting, data collection, prospective and concurrent review activities, and discharge planning.

The College encourages its members to participate in quality assurance and utilization review activities. Further, the College believes that physicians should be involved in these activities whether or not they are physician controlled.

The College favors national guidelines which establish ranges of acceptable care and serve as model guidelines by which care can be measured. Such guidelines could prove effective in ensuring adequate levels of quality and in achieving a more effective allocation of health resources.

The federal government has a legitimate role in supporting quality assurance and utilization review programs. As a major provider and the largest payer of health care services, the federal government must ensure that its health care expenditures are spent efficiently and that an appropriate level of quality care is maintained.

As the Medicare program undertakes to overhaul its hospital reimbursement policies, it is essential that quality assurance and utilization review safeguards be maintained. During the three-year transition period for the new prospective payment system, the need for vigorous quality assurance activities will be most acute. Consequently, adequate funds must be provided to enable PROs to perform effectively their quality assurance functions. Once the prospective payment program is fully implemented the need will continue for conventional quality assurance activities as well as critical reviews to assure that financial considerations do not inappropriately influence patient care.

Research efforts must continue in the continually evolving areas of quality assurance and utilization review. The College supports research into techniques for improving these review mechanisms.