Federal Efforts To Improve Peer Review Organizations
by Thomas G. Morford

The notion that the federal government as payer has an obligation to assure high-quality health care is the driving force behind federal regulations and review processes. Rightly or wrongly, the federal government has in effect become accountable for the quality of the care it pays for. This set of legal and public expectations poses a formidable task. Given the number and diversity of services, how can we reasonably assure quality of care with the finite skills and limited resources of government and without so overburdening health care providers that their skills and resources are wasted in complying with the processes of federal oversight?

The Peer Review Process

We have spent considerable human and fiscal resources over the past several years assuring that the peer review organizations (PROS) were able to operate effectively. To move forward, the fundamentals of staffing, organization, administrative process, and medical review needed to be stabilized. With a few minor exceptions, this has now occurred. PROS have sound management and organizational structures, stable budgets, and operate fundamentally sound review processes incorporating the judgments of physicians in active practice.

Yet the entire process of peer review is still labor-intensive, most notably in: (1) the cumbersome physical review of voluminous medical records; (2) the photocopying of these records to allow review; and (3) the time involved in having skilled health care professionals (such as nurses) screen the entire record to determine if the case merits physician peer review.

In addition, this review process limits our capability to conduct in-depth analyses over time. After review, the medical records are returned to the record center and the details “lost,” unless the particular record is retained because of a potential problem. No further data are recorded.

The major problem in this review process, however, is the lack of measurable, positive results. The review is devoted to finding specific problems with individual cases. Any patterns developed are focused on individual physicians or hospitals. This approach is necessary to protect Medicare patients from the poorly performing physician and/or hospital and to monitor those whose performance is marginal. However, it focuses on problem discovery and, other than allowing remedial education to improve problematic practice, is ineffective for improving general medical practice.

Our major goal is to streamline and improve the peer review process, retaining its ability to protect (to deny unnecessary care, to remove the few egregiously substandard physicians from Medicare) while providing the means to improve the general practice of medicine. To accomplish this, the Health Care Financing Administration (HCFA) Standards and Quality Bureau has instituted the following initiatives.

Actions Under Way

Pilot projects. One of the most critical ini-
tiatives in the PRO program has been the process for assuring orderly change. Heretofore, PROS endured major changes with a new set of contract requirements every two years. All too often these requirements implemented political decisions, representing the opinions of a few as to the tasks PROS should perform with neither the data necessary to make these decisions nor the reasoned critique of outside experts.

Now all PROS are on the same third set of contract requirements, or scope of work, which will not change radically in two or three years to a fourth scope. Instead, pilot projects will be conducted to test new ideas and alternative methodologies. At the conclusion of these pilots, data will be analyzed and decisions made to change requirements for all PROS at the same time.

We now are beginning or have under way pilot projects in: (1) physician office review; (2) alternative review methodologies for home health agencies and skilled nursing facilities; (3) alternative review for “good” hospitals (those hospitals with good quality records); (4) alternative health maintenance organization (HMO) review; and (5) special review methodology for group practices.

Remedial medical education. We are working with the American Medical Association (AMA), the PROS, and state medical societies to link specifically the results of PRO review and remedial medical education. Very few physicians’ performance is so poor that no remedial education will help. These physicians must be excluded from Medicare and perhaps from medical practice. For most physicians with poor performance, change is gradual and can be remedied if quick, direct action is taken by the individual and his or her peers.

We are directing the PROS to work with state medical societies and hospitals to take such quick remedial action. This is one benefit of the current peer review process. While these efforts are conceptually simple, their success depends on the strong support of the physician community to take action.

Small area analysis. We have a contract in place to use the technique of small area analysis developed by John Wennberg of Dartmouth Medical School. Every state will be divided into small areas by zip code, and the use of certain medical practices will be analyzed for these areas. The analysis will be provided to PROS as computer software, so they can show the medical community the variations in procedure rates within a state. This will stimulate further analysis to discover the reasons for these differences.

A major part of this effort is to develop model educational programs between the PROS and state medical societies and other physician and hospital groups. There is no attempt to remove diversity or to take punitive action. Rather, the emphasis is on improving medical practice by enabling physicians to study their own use patterns and, where appropriate, change these practices.

**Actions Planned**

**Uniform Clinical Data Set (UCDS).** In 1987, we established a UCDS Task Force composed of academicians, researchers, representatives of the AMA and the American Hospital Association, and members of the HCFA staff. The purpose of the task force was to explore the feasibility, utility, and practicality of incorporating a uniform clinical data set and electronic screening methodology into the PRO review process.

The work of this task force, supplemented by other outside experts and HCFA staff, has led us to conclude that we can and should complete the development and implementation of the UCDS. Key elements from each case PROS review will be abstracted and computerized into the UCDS.

The UCDS will serve two purposes. The first is to provide a more efficient and effective means for PROS to identify cases that require further review by physicians. Currently, a typical PRO has a high rate of false positives; that is, cases that fail nurse reviewer screens, are referred to physician advisers for review, but eventually pass physician scrutiny and are approved (no actual problems identified). The UCDS data acquisition and case-finding system will reduce false positive referrals to physicians and will thus increase the efficiency of PRO review. This increased efficiency should
more than offset the additional time the UCDS record abstraction process requires compared to current PRO manual review.

False positive referrals should decrease because electronic screening algorithms (used in the UCDS) can be far more complex and comprehensive than the written criteria now used by the PROS. At the time, this type of system would allow more reliable comparison of review results and statistics among PROS. Of course, the UCDS will not replace physicians’ judgment in determining the necessity, appropriateness, and quality of care. It is simply a tool to facilitate physician review.

The second major purpose of the UCDS is to provide an epidemiologic database. It will allow tracking of medical practice over time and facilitate the review of patient outcomes. This huge database consisting of millions of patient records (every case PROS review) will provide a wealth of information to researchers and the medical community on the effectiveness of various treatment modalities and surgical procedures.

Pilot testing of the UCDS is nearing completion, and field testing will begin shortly. We expect the UCDS to be implemented in late 1989.

**Long-Range Initiatives**

**Inpatient review.** We have learned through hard experience that clinical data provide the key to efficient review and longer-range analysis. Inpatient hospital data are the easiest to deal with, since the medical records are in one place. Successful, efficient inpatient review is heavily predicated on automation—in terms of both information from the medical record and automated screening. Software to automate much of the preliminary PRO screening and decision-making process has been developed. We are addressing the absence of sources for automated clinical information as we proceed toward implementing a new PRO review system based on the UCDS.

Optimally, computerized hospital records would further streamline PRO review and would enhance the potential for large-scale databases on patient outcomes. The expenses hospitals would incur in doing so, however, make it inappropriate to mandate this step. Instead, under our scenario, PROS will use UCDS definitions and requirements to computerize the records they select for review. We have no long-range plans for the inpatient setting beyond the UCDS and the products derived from it.

**Ambulatory review.** Data problems reach astronomical proportions in the ambulatory setting. Medical records are diverse, ranging from surgery to the most perfunctory checkup. Record keeping is a science in hospitals; it is a hodgepodge in the ambulatory setting. Volume in the ambulatory setting reaches into the hundreds of millions of encounters; thus, it is a complex task at best to conduct reviews of samples of cases—either random or focused.

These problems have occurred in reviews of HMO care, in which required data and record keeping are poor to nonexistent in all but a few highly centralized plans. These tasks grow more problematic in independent practice association (IPA)-model HMOs and individual physicians' offices. We now must decide how much we can and should burden physicians for data collection to allow thorough and uniform review.

The notion of filling out a form is anathema to most physicians. While many provide sufficient information to satisfy third-party payers, a significant number will not accept assignment; that is, they do not agree to be bound by the payment and information requirements of a payer such as Medicare and Blue Shield. Consequently, the patients of these physicians must submit their own claims. Since the third parties are in business to insure patients, they have little control over whether or not physicians participate in their programs. HMOs have more control because they can mandate information from physicians as a part of employment or contractual obligations.

The development of an ambulatory data set should take two tracks—one for HMOs and the other for physicians in independent practice. The nature of HMOs, particularly in relation to the federal government as well as other payers, makes the need for data
more acute. Since payers contract with HMOs to provide high-quality managed care to their beneficiaries on a capitated basis at a reasonable price, one would assume that HMOs need data on patient encounters. Such data could also be provided in proof that the HMO’s care and services are of high quality.

This type of information could reduce drastically the need for extensive external review. The major criticism of PRO review of HMOs is that it is costly and burdensome because it focuses on the medical record. The fact remains, however, that the medical record is the only source of diagnostic and outcome information. Alternatives to check HMOs’ internal quality assurance systems have been unacceptable because these systems contain only procedural measures and no patient diagnostic data. If these systems did include the appropriate data, external records review could be drastically reduced to an audit of the internal system through a random check of a few records.

There are two possible solutions to this problem: (1) development of a data set by and for the HMO industry, and (2) provision of additional funds to HMOs in their contracts from payers to facilitate external review. This second option would need to be weighed in terms of cost-effectiveness: at what point would these additional funds make HMO contracts too expensive? In addition, simply paying more money for medical records would not contribute to internal quality assurance. Plans lacking the capability to analyze practice patterns and outcomes would not be helped.

Review in physicians’ offices is more problematic. Given the numbers of encounters and the total number of patients, a random review of medical records is a waste of effort. Instead, the following two approaches seem more appropriate.

First, pilot tests should be conducted on reviews emanating from specific areas on the Medicare physician bills. This process should improve, since the Medicare Catastrophic Coverage Act of 1988 requires diagnostic information on these bills beginning April 1, 1989. We are working to add a scale that will indicate functional status in the near future. Small-scale tests using various indicators from the bills may well yield fruitful areas for review. Pilot studies also should be conducted using a set of hospital conditions that likely are caused by inappropriate ambulatory care. The thirteen conditions selected by a group of HMO physicians for reviewing ambulatory care in HMOs would be a useful and appropriate place to start.

Under the second approach, physicians would determine the elements necessary for a uniform ambulatory encounter record. If the HMO industry is able to develop an appropriate instrument, it would greatly facilitate this broader effort. Implementation would be more problematic. Clearly, the fewer data elements the better. Ideally, these could be added to the billing form.

The underlying weakness in the whole approach to a uniform data set is the number of physicians who do not accept Medicare assignment. In these cases, beneficiaries will still fill out claims forms and attach itemized bills, making the database less accurate than desired. Nevertheless, it would be a major step forward to develop a consensus-based set of data elements.

There are two key points to keep in mind. First, the potential impact of review is far greater for inpatient services regarding productivity (potential problems found per number of reviews) and the severity of problems found. Second, ambulatory review is a vast, largely uncharted area. Review methods need to be developed and implemented for two reasons. First, without such methods there can be no systematic check on care provided. Second, such methods will provide the information necessary to improve patient care by allowing an analysis of utilization patterns, outcomes, and general practice patterns. However, only a careful approach based on experimentation is appropriate. The hurried approach to begin large-scale, unfocused review will frustrate both the consumer and medical communities and lead to misuse of resources, because in all probability the review will be largely unproductive.