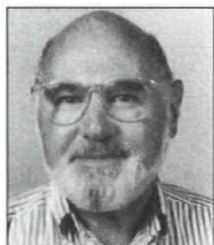
Providers Question PROs' Effectiveness

Critics Contend Peer Review Organizations Are Too Costly and Fail to Improve the Quality of Care

BY RICHARD D. ROTHSCHILD



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Is the cure worse than the disease? The debate is growing between advocates of peer review organizations (PROs) and the rest of the medical profession. PRO supporters claim the program improves the quality of healthcare and reins in costs, whereas physicians and hospital leaders contend the PRO program undermines the quality of healthcare by demoralizing physicians, tying them up in bureaucratic red tape, and impairing the confidential patient-physician relationship.

Is the PRO program a miracle cure for the ills of the U.S. healthcare system—runaway costs and less-than-optimal results? Or does it portend the declining quality of care, resulting from inept oversight and mindless standardization? To decide, we first need to understand what the PRO program is all about.

The Peer Review Program

Congress created PROs in 1982 under the Social Security Act to ensure that services which Medicare recipients received were medically necessary, met professionally recognized quality standards, and were provided in the most suitable setting. The program was initiated in part because of the federal government's perception that county and state medical societies and hospital quality assurance committees were not doing their jobs well enough, particularly in ridding themselves of unqualified and unethical practitioners.

Today, 54 peer review organizations under contract to the Health Care Financing Administration (HCFA) oversee physicians who care for Medicare patients.[1] Most PROs operate statewide. Their contracts, which typically run for two years, require them to review a specified number of Medicare patient hospital discharge records. These PRO contracts are awarded by competitive bidding, but there are few bidders large and experienced enough to qualify.

Nevertheless, PROs are big business. Island Peer Review Organization (IPRO), for example, is working under a $56 million government contract, examining a fourth of New York State's 1 million hospital discharges, according to IPRO's Sheila Burke.

PROs employ physicians and registered nurses

Summary The Health Care Financing Administration (HCFA) established physician review organizations (PROs) to ensure that Medicare recipients receive care that is medically necessary, of high quality, and provided in the appropriate setting. While arguing that oversight is necessary, many healthcare professionals believe PROs do not accomplish what they were set up to do because physicians focus on the possibility of being penalized rather than on improving patient care.

PRO critics claim that the program's peer reviewers are not peers of the physician under review and that, to be effective, they should come from the same local area. They contend the best peer review is conducted within the hospital. They believe intrafacility review can be more effective at bringing about improvement because hospital peer reviewers act as supportive, nonthreatening consultants.

The confidentiality of the physician-patient relationship is another issue PRO critics raise. HCFA staffers say hospitalized Medicare patients are required to sign a waiver allowing inspection of their charts, but critics counter that waivers are only for the release of records for payment claims. Changes encouraging cooperation between PROs and hospitals could improve the PRO program and enhance quality of care.

to perform the reviews. IPRO pays nurse reviewers about $30,000 a year, and it pays physician reviewers $55 per chart review. Currently IPRO has 10,000 physicians on a part-time basis do this work, notes Burke.

The Peer Review Process

The typical PRO process works as follows[2]: Nurse reviewers read patient discharge records to reconstruct patient hospital stays. Applying criteria (screens) the PRO has developed, the nurses examine charts for potential care problems and "flag" those which do not pass through the screen. They then assign severity levels to these cases. Nurse reviewers send level 1 cases, the least serious, to physician reviewers only if the practitioner under review has been identified as having three or more potential problems within three months or five problems within six months. The nurses immediately send level 2 and level 3 cases (those in which medical mismanagement has or may have caused patients significant adverse effects) to physician reviewers for further evaluation.

Physician reviewers then determine whether the care provided was necessary, appropriate, and of acceptable quality. Their decisions are supposed to be based on their own knowledge, experience, and training and on discussions with the attending physicians under review.

If a physician reviewer concludes that the physician under review mismanaged the case, the PRO notifies him or her, allowing an opportunity for a written response. If the reviewer or a PRO committee still concludes there has been medical mismanagement, HCFA requires the PRO to intervene.

The kind and degree of intervention are determined by a point system on the basis of the problem's severity or frequency.[3] For a level 1 problem, the PRO notifies the physician involved, describing the mismanagement and the appropriate action that he or she should have taken. If the problem is a little more serious, the PRO also requires that the offending physician read suggested material or attend discussions, meetings, or continuing medical education or self-education courses.

Level 2 infractions require a complete review of the physician's previous cases.

For a level 3 offense, the PRO can disclose the problems to licensing and accreditation bodies. If the PRO finds the physician has committed a "substantial" or "gross and flagrant" violation of quality-of-care standards, it may apply sanctions such as exclusion from the Medicare program and monetary penalties. In the worst case, the PRO could recommend to the surgeon general that she suspend or revoke the offending physician's license.

SuperPRO

In 1984 HCFA established SuperPRO to ensure that the PROs were doing high-quality work. SysteMetrics/McGraw-Hill in Santa Barbara, CA, had SuperPRO up and running in 1985. In September 1990 HCFA awarded the physician consulting contract to the American Medical Association (AMA) to resolve disagreements between SuperPRO and the PROs.[4] Under the contract, the AMA began using local physicians in active practice to review disputed cases. Although HCFA terminated the contract after a year's operation because of a low volume of work, SuperPRO illustrates how bureaucracies tend to snowball.

Do PROs Promote High Quality?

Most healthcare experts agree that healthcare recipients are entitled to oversight to ensure an acceptable level of care. Physicians and hospital administrators strongly disagree, however, about whether the current PRO oversight program is

encouraging health-care professionals to provide higher-quality care or to focus more on possible penalties, to the detriment of high-quality care.

Pat Booth, director of HCFA's Division of Review Programs, claims PROs have been a resounding success. She cites reports such as the *Results of Peer Review Organization Review for the Third Scope of Work*.[5] From April 1, 1989, to March 31, 1991, PROs completed more than 4 million hospital reviews. They identified quality problems in 64,338 cases, only 1.6 percent of the cases they reviewed. Many of the problems they cited were irrelevant to the outcome of the patients' care. According to the report, only 3,358 confirmed quality problems with significant adverse effects were found. This is approximately 0.5 of 1 percent of the cases reviewed. Each review cost about $1,150, not including HCFA's administrative costs or related costs borne by physicians and hospitals.

> In 1988 PRO review cost more than $9 million for each physician removed.

An earlier report for fiscal year 1988[6] showed that, of $418.1 million in direct costs, HCFA recouped $278 million by denying payments in 1.9 percent of the cases reviewed. HCFA calculated these savings by multiplying the number of cases in which payment was denied by the average amount Medicare reimburses an approved case. I believe it reasonable to surmise that in many of these instances only part of the Medicare reimbursement was denied, reducing HCFA's actual savings to a fraction of the estimated and reported amount. The report shows that of 30,136 denial reconsiderations completed, 13,040 resulted in revisions or modifications.[7]

The cost of PROs is increasing rapidly.[8] From 1988 to 1989 the PRO program funds dedicated to Medicare review grew 56 percent (from $418.1 million to $652.5 million). If HCFA administrative costs and hospital and physician reporting and defense costs had been factored in, the 1989 total would likely have exceeded a billion dollars.

If a major objective of PROs is removal of incompetent and unethical physicians from Medicare, the PRO program seems to be a costly and inefficient way of accomplishing it. In 1988 $164 million was spent on PRO review, and only 18 physicians were excluded from the Medicare program.[9] Viewed from that perspective, it cost more than $9 million for each physician removed.

A Negative Message

New York City internist and hematologist, John Olichney, MD, is convinced the PRO program is lowering the quality of medical care by undermining physicians and suffocating them in red tape. Olichney, who also teaches Columbia Medical School interns at St. Luke's/Roosevelt Hospital in New York City, believes the program erodes the confidential patient-physician relationship and discourages bright, idealistic young people from entering medicine.

On the other side of the fence are people like Sheila Burke, IPRO spokesperson. She believes that PROs *are* effective. "As a result of our educational and focus review efforts, we are now seeing fewer quality problems in certain areas," says Burke. "This program is based on due process and is as objective as it can be," she adds. HCFA's Booth agrees.

Olichney sees PRO review as a modern-day witch-hunt, seeking to punish physicians for minor infractions. He questions, "Can a punitive system ever effectively raise performance levels?"

James Cannon, executive vice president of the Utah Peer Review Organization (UPRO), concurs. "I agree that the PROs have developed a bad reputation, and HCFA is to blame for requiring them to carry out a punitive program," he says. Cannon believes that quality control programs should concentrate on improving the mainstream practice of medicine rather than targeting infrequent deficiencies. In his view, quality control should provide feedback on the basis of data collection and analysis. This would enable physicians to determine what procedures are most effective in specific cases so they could assess and improve their own performance. The argument for this approach is that education works better than the threat of punishment.

Olichney believes that PROs have to justify their existence by finding offenders, even if that leads to concentrating on minutiae inconsequential to the patient's well-being. For example, he tells about a 75-year-old woman who was discharged from the hospital after a mastectomy and readmitted three days later because of phlebitis. To encourage staff to empathize with the

patient's situation, he wrote the following note on her chart: "Patient depressed about being back in the hospital."

The woman made a quick and complete recovery. However, her readmission triggered an IPRO chart review. "I was penalized 5 points for not having called in a psychiatrist because [the patient] had been depressed," Olichney says. "My own peer review committee recently told me that if I had used the words 'appears depressed,' instead of 'depressed,' on the patient's chart, it would not have tripped off the IPRO computer, and I would not have been cited or penalized. What could be more demoralizing?"

Lower board scores and fewer applicants to medical schools are signals that medicine is not attracting as bright and as highly motivated young people as it did only a few years ago.[10] Olichney is convinced this is because prospective medical students believe the frustration of dealing with bureaucracy, as typified by the PRO, will outweigh the good they will be able to do.

Olichney is also concerned that young physicians are getting the wrong message. "I tell them to have patient empathy," he says, "but what interns and residents are becoming most concerned about is protecting themselves against punitive reviews and lawsuits."

Who Is a Peer?

Another potential problem with PROs lies in their interpretation of "peer" review. Olichney believes in peer review, but finds that its effectiveness depends on whether reviewers are true peers of the physicians whose performance they are examining. If reviewers do not practice locally, he argues, they are less effective.

This statement echoes the attitude of a recent study by the Institute of Medicine,[11] which says: "Physicians and hospitals heard from during this study widely contend that PRO reviewers are not peers." Some examples cited are "specialists not reviewed by members of their own specialty, physicians fully in private practice reviewed by physicians partly in private practice, physician reviewers for whom the relatively low PRO review reimbursements are an important part of their income, and physicians in prepaid group practice settings reviewed by those in fee-for-service settings."

Three of the physicians I interviewed said that peer reviewers should come from the same county as the physicians they are evaluating and that the best peer review is conducted within the hospital itself. At St. Luke's/Roosevelt Hospital, for example, the Quality Assurance Committee of the Medical Board focuses on the patient. Marianne Legato, MD, chairs the committee, and staff representatives include physicians, head nurses, and administrators. They continually review medical occurrences in the hospital, bringing inadequacies in patient care to the attention of the appropriate parties. Two other committees concentrate on other aspects of patient care, and the professional practice committee, which monitors physician performance and credentials, also oversees the general conduct of quality assurance.

Most physicians I interviewed believe that hospital quality assurance committees improve patient care more effectively than PROs. They are convinced that those responsible for quality assurance (acting as supportive, nonthreatening consultants) are bringing about desirable change and improvement. The carrot is more powerful than the stick when it comes to long-term performance improvement, they contend.

The approach of government and insurance company reviewers is different from that of hospital quality assurance committees. It is likely to instill defensive thinking in physicians. Legato describes the questions of a physician thinking about admitting to the hospital a 72-year-old patient with severe chest pain:

- If I admit this patient and he must stay more days than the allotted time I write on the chart, who will pay for the additional days? Will the patient?
- Will I spend my time writing letters to justify my decision to admit and keep the patient in the hospital until I decide he is ready to go home?
- Will I spend days in court to argue the decision about whether those days in the hospital will be paid for by the third-party payer or by the patient?
- If I do admit the patient, will I be able to prove I used the time well? Will I be able to explain to a reviewing agency why a day went by when no test was performed?
- Will the tests I order be considered excessive? How few can I get by with?
- Will I be able to construct a chart that convinces the reviewer I am accurate, efficient, and economically practical?

"The relationship between the PROs and the medical community is adversarial right now," says Legato. "With all the time and effort being expended by the PROs and other third-party payers, wouldn't it be useful if we could sit down together and, for once, try to focus on the patient?"

Confidentiality Issues

One of the stickiest issues in the peer review program is the confidentiality of the physician-patient relationship. HCFA's Booth says that hospitalized Medicare patients are required to

sign a waiver allowing inspection of their charts. The hospital Medicare waiver forms I have seen, however, authorize records to be released only for payment claims. Patients are unlikely to be aware their charts are being pulled and examined by outsiders for other purposes.

JUST AROUND THE CORNER

Recognizing the limitations of chart screening by nurse reviewers and the computer's potential for accumulating, storing, and analyzing the vast quantities of data in charts being reviewed, HCFA is looking to computer analysis of the outcomes of care to usher in what some call "a revolution in medicine."

HCFA's Booth explains that the computer will facilitate the collection of a large clinical data base and the use of elaborate algorithms to evaluate and interpret the collected data. PROs will have the tools to analyze patterns of care to identify problems needing attention.

"A PRO could use this information to review an individual case and intervene or it could initiate peer interaction, something we would like to see," says Booth. For example, Booth explains:

> A PRO physician could say to physicians at an institution, "Do you realize that you are having twice as many deaths after open heart surgery as St. Joseph's across the street, and your case mix is about the same? Why is that?" And they might respond, "Holy Cow, we never realized that. We need to look and see how soon those patients died after surgery—was it within a 24-hour period? Were those deaths related to operative technique or to postoperative support?"

UPRO's Cannon is familiar with this approach, having served on the task force for the development of the uniform clinical data set. Computerized algorithms have been developed on the basis of the work of many specialists who focused on the factors that most frequently trigger hospitalization. According to Cannon, this work was done hastily and has not been clinically validated sufficiently to be adopted in a nationwide system. He says that the government's Health Standards and Quality Bureau is totally committed to having all PROs on this system, using it for all their reviews by the end of 1993.

Although initially enthusiastic about the uniform clinical data set, Cannon criticizes the government's failure to build the infrastructure to support it, particularly citing weak training for the nurse reviewers. He also predicts "the notion of a uniform clinical data set will turn out to be impractical because it will not prove to be economically feasible to collect the same data on every kind of patient."

AMA AND THE PROs

The AMA has gone along with the PRO program. As Neil Baker, AMA's senior health analyst, noted in a recent presentation, "While the PRO program has been an issue of intense debate, mostly critical, at every AMA House of Delegates meeting since 1983, and an effort to have the AMA seek repeal of the program in 1987 was barely defeated, current strategy is to work within the program."[12] He added, however, that the AMA will aggressively lobby to modify sanctions and a perceived lack of due process.

Rather than getting embroiled in the PRO controversy, the AMA is concentrating on the development of practice parameters—patient management strategies to help physicians make better clinical decisions.

John T. Kelly, MD, PhD, director of AMA's Office of Quality Assurance, points out that "central to any effort to improve quality of care is the need to define what constitutes appropriate medical care." Practice parameters (more than 1,300 have been developed already) will help define high-quality care in medical procedures and treatments. For example, since the issuance of the American Society of Anesthesiologists' practice parameter on basic intraoperative monitoring, anesthesiologists have been able to reduce hypoxic injury among patients and, in the process, have also reduced their professional liability premiums.[13]

WHERE DO WE GO FROM HERE?

Clearly, the simplest, most promising strategy to improve the quality of healthcare is to attract bright candidates to medicine. To do so, the healthcare system will have to reduce the adversarial, punitive, and bureaucratic components of quality assurance programs like PROs.

The following changes in the PRO program might bring about improvement in the quality of care at lower cost:

- Require PROs to concentrate their reviews on geographic areas and institutions providing substandard care
- Limit case review in other areas to patient discharges where the result of treatment was unsatisfactory
- Eliminate duplicative reviews by establishing a cooperative partnership between PROs, county medical societies, and hospital quality assurance committees
- Pass legislation to enable county medical

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A Warning to Change

Reich places responsibility to address structural problems with both the public and private sectors. He suggested such initiatives as performance standards for schools, consolidation of school districts to achieve parity in quality, and higher teacher pay. Business can form partnerships with schools, providing apprenticeships for particular jobs. In his opinion programs that focus on preschool education and health to develop "the capacity to learn" are especially important.

Healthcare organizations are particularly risk averse and resistant to change. Reich advised healthcare leaders, who are "educators in their institutions and communities," to be agents for change. Leaders can demonstrate with real-life answers and anecdotes the benefits of innovation and encourage their organizations to reward people who experiment, even when they fail, he said.

Another factor inhibiting change is the prospective payment system. The Medicare and Medicaid programs, which often do not pay for valuable services, are based on the high-volume paradigm and offer little incentive for innovation and change. Reich urged leaders to educate policymakers and political leaders about how public policies are harming children and families and the quality of healthcare.

Reich left the audience with a warning in the form of the parable of the frog that is put in boiling water and immediately leaps out. But if it is put in lukewarm water and the heat is gradually turned up, the frog is unable to move by the time the water reaches the boiling point. "My fear is that with regard to long-term structural problems, the heat is being turned up too gradually," he said.

"The riot in Los Angeles has focused public attention for a while on economic problems," he noted, "but we may not be able to take the leap when we have to take the leap. We may not be able to change when we have to change." —*Judy Cassidy*

Removing Life Support

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Origins, January 30, 1992, p. 554.

20. American Academy of Neurology, *Neurology*, January 1989, p. 125; Committee on Ethics, American Nurses Association, *Guidelines on Withholding and Withdrawing Food and Fluid*, Kansas City, MO, 1987; "Position Of American Dietetic Association: Issues in Feeding the Terminally Ill Adult," *Journal of American Dietitica*, 1987; "Current Opinions," Council on Ethical and Judicial Affairs of the AMA, 1989, no. 220.
21. Edmund Pellegrino and David Thomasma, *For the Patient's Good: The Restoration of Beneficence in Health Care*, Oxford University Press, New York City, 1988, pp. 80-83.
22. Leon Kass, "Neither for Love Nor Money: Why Doctors Must Not Kill," *Public Interest*, Winter 1989, p. 25.
23. When referring to the "reliability of prognosis for many such patients" (persons in PVS), the committee's document makes a blatant error. In footnote 39 it quotes an article on a study of patients in vegetative state, as though the statistics concerning recovery of consciousness were valid for patients in *persistent* vegetative state (Harry S. Levin et al., "Vegetative States after Closed-Head Injury: A Traumatic Coma Data Bank Report," *Archives of Neurology*, June 1991, pp. 580-585). Levin confirms that "the statistics quoted in our article do not refer to patients in persistent vegetative state" (phone conversation, April 2, 1992).
24. Schneiderman, p. 952.
25. Richard McCormick, "Moral Considerations Ill Considered," *America*, March 14, 1992, p. 214.
26. *Re Estate of Sidney Greenspan v. Andrew Gelman*, Docket N.67903 (July 19, 1990), pp. 708-711.
27. Peter Steinfels, "Prelate Raises Questions on the Dying," *New York Times*, April 23, 1987.
28. Richard M. Gula, "Euthanasia: A Catholic Perspective," *Health Progress*, December 1987, p. 28ff.
29. "Termination of Life Support Legislation," Society for the Right to Die, New York City, 1991.
30. Jay Copp, "Illinois Bishops Back Life-sustaining Treatment Bills," *New World*, June 21, 1991, p. 1.
31. See footnote 2 above; others taking this position include the bishops in Providence, RI, and in Minneapolis.

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societies to suspend or revoke physician licenses without undue exposure to litigation

Steps like these might put the U.S. healthcare system on the road to higher-quality care at lower cost. □

Notes

1. Utilization and Quality Control Peer Review Organization Program, report to Congress, fiscal year 1988, p. 1 and attachment H, p. 49.
2. *New York PRO Scope of Work*, Island Peer Review Organization, Lake Success, NY, pp. 7-11.
3. *New York PRO Scope of Work*.
4. Department of Health and Human Services, Contract No. 500-90-0026, "Physician Consultant," attachment J-3 Statement of Work, Baltimore, September 1990, p. 2.
5. *Results of Peer Review Organization Review for the Third Scope of Work*, based on reports submitted through April 30, 1991, reflecting reviews completed through March 31, 1991.
6. Utilization and Quality Control Peer Review Organization Program.
7. *Results of Peer Review Organization Review for the Third Scope of Work*.
8. Utilization and Quality Control Peer Review Organization Program.
9. Utilization and Quality Control Peer Review Organization Program.
10. *Barron's Guide to Medical Schools*, Barron's Educational Services, Happauge, NY, 1991, p. 50; Saul Wischnitzer, *Barron's Guide to Medical and Dental Schools*, Barron's Educational Services, Happauge, NY, 1991.
11. Committee to Design a Strategy for Quality Review and Assurance in Medicare, Division of Health Care Services, Institute of Medicine, *Medicare: A Strategy for Quality Assurance*, vol. 1, National Academy Press, Washington, DC, 1990, p. 188.
12. Neil Baker, presentation to the Michigan State Medical Society Liaison Committee with the Michigan PRO, 1991.
13. John T. Kelly and James E. Swartwout, "Practice Parameters: A Foundation for Quality Advancement," *AAPPO Journal*, February-March 1991, pp. 33-38.