

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**EDUCATING PHYSICIANS RESPONSIBLE  
FOR POOR MEDICAL CARE: A REVIEW  
OF THE PEER REVIEW ORGANIZATIONS'  
EFFORTS**



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# TABLE OF CONTENTS

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EXECUTIVE SUMMARY .....	i
INTRODUCTION .....	1
FINDINGS .....	3
RECOMMENDATIONS .....	11
COMMENTS ON THE DRAFT REPORT .....	14
APPENDIX A	
Methodological Notes .....	A-1
APPENDIX B	
Sample Overview .....	B-1
APPENDIX C	
Summary of Physician Profile Data .....	C-1
APPENDIX D	
Generic Quality Screens .....	D-1
APPENDIX E	
Summary of Intervention Profile Data .....	E-1
APPENDIX F	
Detailed Comments on the Draft Report and OIG Response to the Comments .....	F-1
APPENDIX G	
Endnotes .....	G-1

# EXECUTIVE SUMMARY

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## PURPOSE

In this study, we assess the educational interventions that the Medicare-funded Peer Review Organizations (PROs) direct to physicians responsible for serious quality-of-care problems.

## BACKGROUND

A major objective of the PROs is to oversee the quality of care rendered to Medicare beneficiaries. In carrying out this objective, they have two major functions: (1) to identify and confirm physicians and/or health care entities responsible for quality-of-care problems, and (2) to direct follow-up actions to the responsible parties.

In this report, we address the latter function. We examine educational interventions because the PROs rely heavily on them as corrective actions, and we focus on the most severe problems (those the PROs assign a Level III) because the PROs determined that those problems involved adverse effects on patients. For a sample of eight PROs, we reviewed all such problems confirmed between January 1 and June 30, 1990. We present our findings around four key questions concerning the 131 physicians identified in our sample.

## FINDINGS

**Who were the physicians identified by the PROs as being responsible for serious quality-of-care problems?**

*Twenty-eight percent of the physicians were in general practice, 60 percent were between 45 and 64 years old, and 98 percent were male. In the 8 States in which these physicians practiced, 17 percent of all physicians were in general practice, 32 percent between 45 and 64, and 83 percent male.*

*At least thirty percent of the 131 physicians had more than one quality-of-care problem identified by the PROs.*

**What kinds of problems were they responsible for?**

*Eighty percent of the physicians were responsible for either (1) care resulting in serious or potentially serious complications, or (2) abnormal diagnostic findings left unaddressed, or (3) both.*

**What kinds of educational interventions did the PROs direct to these physicians?**

*The PROs directed no educational interventions to 14 percent of the physicians.*

***Among the physicians who did receive an educational intervention, the PROs used letters, calls, courses, and meetings most often.***

- . Forty-two percent received a letter.
- . Thirty percent received a telephone call.
- . Twenty-two percent had to attend a continuing medical education course.
- . Eighteen percent had to attend a meeting with PRO physicians.

***Hospitals typically were not involved with or aware of these interventions.***

- . Fifty-one percent of the hospitals were not informed that a quality-of-care problem had occurred there.
- . Eighty-eight percent of the hospitals where the quality-of-care problems occurred had no part in the educational intervention.

**What conclusions can we draw from the PROs' educational interventions?**

***The educational value of the interventions is uncertain.***

- . The letters are typically brief and contain more case summary than educational material.
- . The calls are not documented enough to determine their content.
- . The available courses often do not address the specific quality-of-care problems the PROs have identified.
- . The meetings with the PRO physicians have the most educational value, according to both the PROs and the relevant literature, but were used in only 18 percent of the cases we reviewed.

***The PROs confront three basic constraints in seeking to carry out effective educational interventions.***

- . They have limited information on which to base their educational interventions.
- . They perform oversight roles that inhibit their capacity as educators.
- . They find that remedial medical education programs are seldom available.

## **RECOMMENDATIONS**

The Health Care Financing Administration (HCFA) should ensure that the PROs initiate timely educational interventions in all confirmed Level III cases.

The HCFA should issue a regulation or, if necessary, seek legislation mandating that for all confirmed Level III cases, the PRO share case information with the hospitals at which the problems occurred. That information should include the identity of the physician, the nature of the problem, and the type of educational and other interventions imposed by the PRO.

The HCFA should issue a regulation or, if necessary, seek legislation allowing and encouraging the PROs to involve the hospitals in the planning, conduct, and assessment of educational interventions in all Level III cases.

The HCFA should instruct the PROs to give greater attention to personal meetings as an educational intervention and to explore ways of conducting one-to-one meetings between physicians with confirmed Level III quality-of-care problems and physician consultants.

The HCFA should mandate that before directing an educational intervention to a physician in a level III case, the PROs take into account all prior quality-of-care problems they have identified concerning the physician during the life of the PRO contract.

The HCFA should obtain and disseminate information on the effectiveness of PRO educational interventions.

The HCFA should obtain and distribute to all the PROs the listing of focused/remedial education programs included in the national registry maintained by the American Medical Association.

The Public Health Service, through the Area Health Education Centers Program and/or the Agency for Health Care Policy and Research, should provide demonstration funding for the establishment and refinement of medical education programs that seek to enhance the clinical competence of physicians through individualized assessments and remedial education.

## **COMMENTS**

Within the Department of Health and Human Services, we received comments from HCFA and PHS. The HCFA agreed with the first recommendation, indicated that it would seek legal guidance concerning the second and third, offered to consider the fourth, suggested that the PROs' fourth scope of work addresses the fifth, and commented on more generalized education efforts concerning the sixth.

In response to HCFA's comments, we changed the second and third recommendations so that they call for HCFA to issue a regulation or, if necessary, introduce legislation to further PRO-hospital interaction in Level III cases. We also amended the recommendation urging PROs to take into account all prior quality-of-care problems before making an educational intervention. In that recommendation, we specified that we were referring to Level III cases and to problems identified by the PRO during the life of its contract with HCFA.

The PHS, in relation to the comment we directed to it, suggested that the Area Health Education Centers (AHEC) Program might be a more appropriate vehicle for funding demonstrations than the Agency for Health Care Policy and Research. Accordingly, we added the AHEC program to our recommendation.

Outside the Department, we received comments, generally supportive, from the American Association of Retired Persons (AARP), the American Medical Peer Review Association (AMPRA), and the American Medical Association (AMA). In response, we made some minor clarifying changes in recommendations and added a new recommendation calling for HCFA to keep the PROs informed of focused/remedial education programs included in the national registry of such programs maintained by the AMA.

# INTRODUCTION

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## PURPOSE

The purpose of this study is to assess the educational interventions that the Medicare-funded Peer Review Organizations (PROs) direct to physicians responsible for serious quality-of-care problems. Toward that end, we address four basic questions:

1. Who were the physicians identified by the PROs as being responsible for serious quality-of-care problems?
2. What kinds of problems were they responsible for?
3. What kinds of educational interventions did the PROs direct to these physicians?
4. What conclusions can we draw from the PROs' educational interventions?

## METHODOLOGY

Our methodology is based on a stratified random sample of eight PROs (appendix A), for which we reviewed all confirmed Level III quality-of-care problems involving physicians identified between January 1 and June 30, 1990. The Health Care Financing Administration (HCFA) defines such problems, which involved 131 physicians, as involving "medical mismanagement with significant adverse effects on the patient." We supplemented our review by conducting discussions with administrators and physicians associated with the eight PROs.

## BACKGROUND

When the PROs were established in 1982, their mission was almost completely focused on controlling Medicare costs. Today their mission is much broader and includes major responsibility for overseeing the quality of care rendered to Medicare beneficiaries. The PROs carry out this responsibility by reviewing inpatient medical records against standards of established professional practice. These reviews constitute about 15 percent of all Medicare admissions to hospitals.

When the PROs identify what appears to be a quality-of-care problem, they conduct a second and sometimes third review. If at this point the PRO physician reviewers agree that a likely problem exists, the PROs invite the physicians and/or hospitals involved to provide more information. Upon further review, the PROs either confirm the problem or overturn their previous findings.

As a part of this process, the PROs determine the degree of harm done the patient and, in accord with HCFA instructions, assign a severity level and weight value. Incidents involving no potential for harm are assigned a Severity Level I, with a weight of 1; those with a potential for harm are Level II, with a weight of 5; and those with actual harm are Level III, with a weight of 25. HCFA defines harm, or adverse effects, as prolonged treatment, readmission, impairment, disability, or death. During our sample time frame, the 53 PROs completed 1,055,964 reviews and identified 9,620 confirmed quality-of-care problems: 4,217 Level I, 4,711 Level II, and 692 Level III.

At the end of each quarter, the PROs, in accord with HCFA's profiling requirements, must total the weighted severity score for each physician they have identified as having one or more quality-of-care problems.<sup>1</sup> The interventions the PROs then take are based on this score.<sup>2</sup> For physicians responsible for a Level III problem, HCFA requires that the PROs invoke an educational intervention, conduct an intensified review of subsequent hospital admissions, consider sharing the information with the medical licensure board, and consider recommending a sanction to the Office of Inspector General (OIG).<sup>3</sup> In addition, HCFA requires the PROs to notify the physicians of the confirmed quality-of-care problem in writing and to take an additional intervention, such as requiring pre-discharge or pre-admission approval.

The educational interventions, which are the focus of this report, involve a range of possible actions. For example, they may involve coursework, suggested medical readings, or discussions with PRO physician advisors. These interventions may be taken singly or in any combination. The HCFA allows the PROs to determine the most appropriate type of educational intervention for each physician.

Overall, these educational interventions are a vital component of the PROs' quality assurance efforts. The HCFA mandates them for Level III problems and for Level II problems with a score of 10 or more. And they far outnumber the more punitive interventions involving referrals to the medical licensure boards and the OIG. Yet little is known about the use or effectiveness of the educational interventions the PROs undertake.



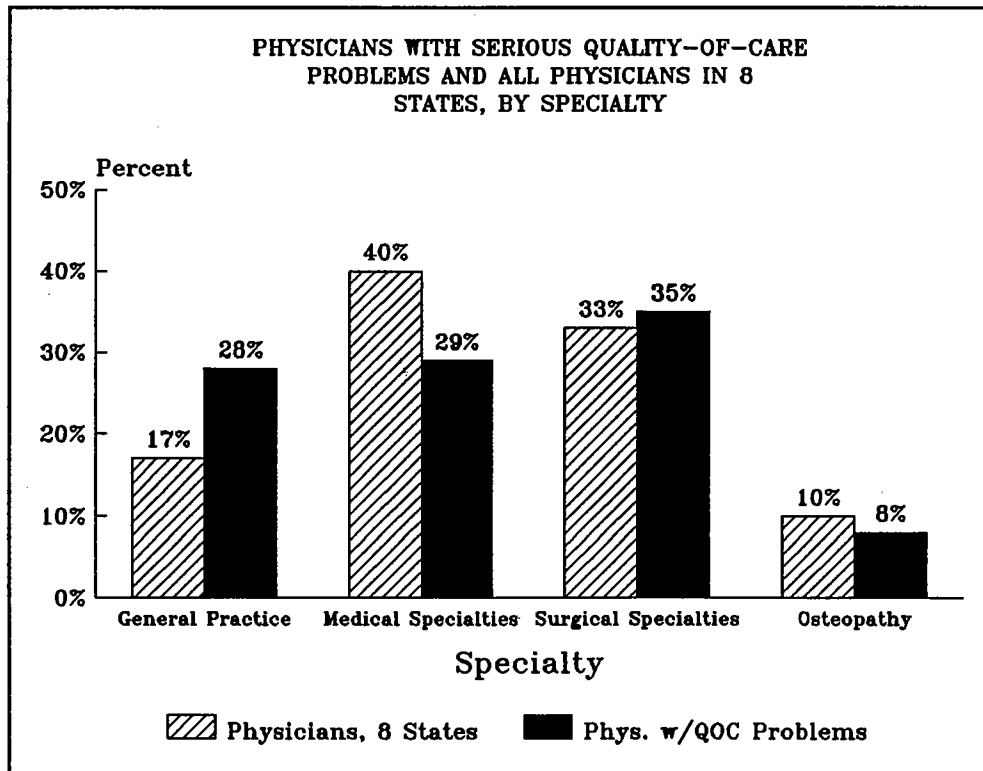
# FINDINGS

Who were the physicians identified by the PROs as being responsible for serious quality-of-care problems?

*Twenty-eight percent of the physicians were in general practice, 60 percent were between 45 and 64 years old, and 98 percent were male. In the 8 States in which these physicians practiced, 17 percent of all physicians were in general practice, 32 percent between 45 and 64, and 83 percent male.*

We identified the specialties<sup>4</sup> for all but one of the 131 physicians in our sample. These 130 physicians represented 22 specialties which we grouped into four types: general practice, medical specialties, surgical specialties, and osteopathy (appendix C). In comparing their distribution among the four types with that of the non-Federal<sup>5</sup> physicians in their States, we found more physicians responsible for serious quality-of-care problems to be in general practice and less to be in medical specialties than would be the case if their distribution mirrored that of the 8 States (figure 1). The difference was statistically significant.<sup>6</sup>

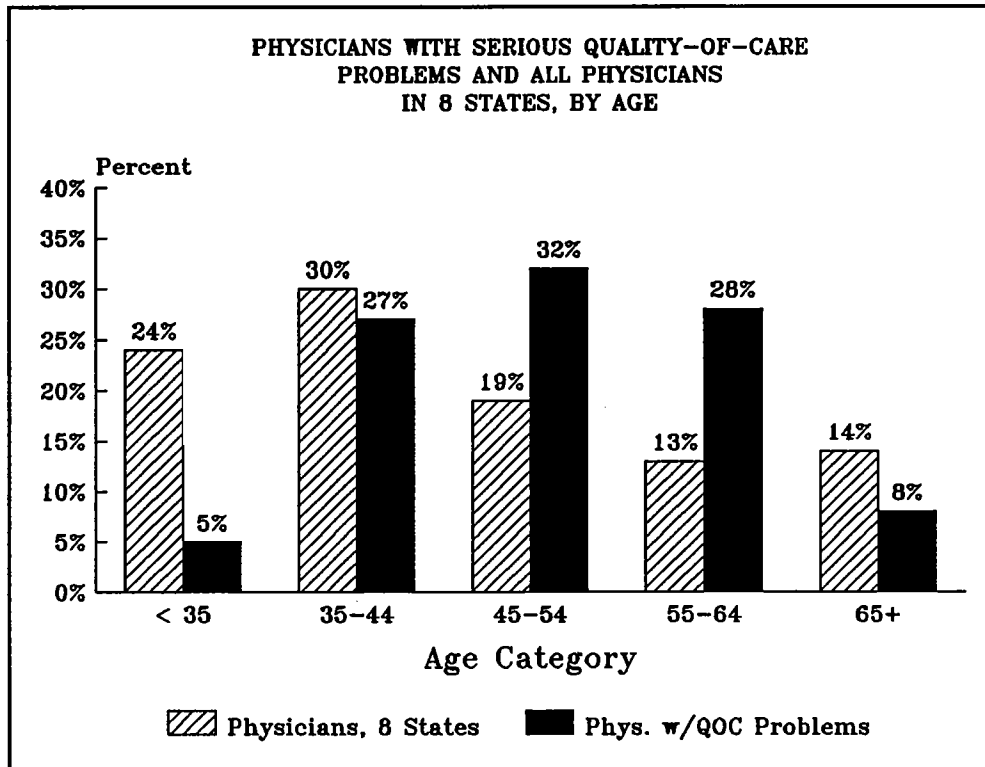
FIGURE 1



NOTE: N=79,581 non-Federal, patient-care physicians in 8 States and N=130 physicians identified by 8 PROs as responsible for a confirmed Level III quality-of-care problem and reported to HCFA for reviews completed 1/1/90-6/30/90.  
SOURCE: OIG/OEI analysis of data from 8 PROs; American Medical Association, Division of Survey and Data Resources, *American Medical Directory: Physicians in the United States*, 32 ed. (1990) and *Physician Characteristics and Distribution* (1990); and American Osteopathic Association, *Yearbook and Directory of Osteopathic Physicians* (1990).

We also compared the gender and age distribution of the physicians responsible for serious quality-of-care problems with the non-Federal physicians in their States. We found a smaller proportion of female physicians than in the 8 States (2 percent compared with 17 percent), and we found fewer physicians either younger than 35 or older than 65 and more between 45 and 64 than in those States (figure 2). These differences in distribution were statistically significant, too.<sup>7</sup>

FIGURE 2



NOTE: N=124,163 non-Federal physicians in 8 States and N=130 physicians identified by 8 PROs as responsible for a confirmed Level III quality-of-care problem and reported to HCFA for reviews completed 1/1/90-6/30/90.

SOURCE: OIG/OEI analysis of data from 8 PROs; American Medical Association, Division of Survey and Data Resources, *American Medical Directory: Physicians in the United States*, 32 ed. (1990) and *Physician Characteristics and Distribution* (1990); Marquis *Who's Who, Directory of Medical Specialists*, 24 ed. (1990); and American Osteopathic Association, *Yearbook and Directory of Osteopathic Physicians* (1990).

Finally, we compared the foreign medical graduate (FMG) distribution among these physicians and the non-Federal physicians in their States.<sup>8</sup> Thirty percent (35) of the physicians responsible for serious quality-of-care problems were FMGs, which reflects the proportion of FMGs in those States.

*At least thirty percent of the 131 physicians had more than one quality-of-care problem identified by the PROs.*

We asked staff at each PRO if they had identified any quality-of-care problems for these physicians prior to our sample time frame. Although the information was not always available, the PROs were able to identify 20 physicians (15 percent) who had confirmed quality-of-care problems prior to our sample time. Those problems

included Levels I, II, and III, and in one case, the PRO was recommending sanction. The PROs identified another 20 physicians (15 percent) who were responsible for additional<sup>9</sup> quality-of-care problems during the sample time or identified in intensified review.

**What kinds of problems were they responsible for?**

*Eighty percent of the physicians were responsible for either (1) care resulting in serious or potentially serious complications, or (2) abnormal diagnostic findings left unaddressed, or (3) both.*

Forty percent (52) of these physicians provided care that resulted in serious or potentially serious complications.<sup>10</sup> For example, one problem involved an attempt to repair a patient's broken femur with a rod implant. The rod implant split the bone, therefore requiring a wire wrap. The wire wrapped the artery and nerve instead of just the bone. Despite the patient's symptoms of vascular impairment, corrective surgery was delayed and the patient died of sepsis.

Twenty-three percent (30) of these physicians provided care that left abnormal diagnostic findings unaddressed. One such problem involved a patient suffering a low-grade fever for three days prior to discharge and whose white blood cell count was high, indicating infection, on the day of discharge. Eight days later the patient was readmitted because of the infection.

Seventeen percent (22) of these physicians provided care that failed both screens. For example, one problem involved a surgeon's premature discharge of a patient after a below-the-knee amputation. The stump was open and draining at the time of discharge and the patient was readmitted with an infected and painful stump. The surgeon performed a debridement and closure, but they were ineffective, and the leg was finally amputated above-the-knee. The PRO noted that the patient's complicated postoperative period was a result of the inappropriate below-the-knee amputation.

The remaining 20 percent of the physicians were responsible for various other problems such as medication errors and nosocomial infections.

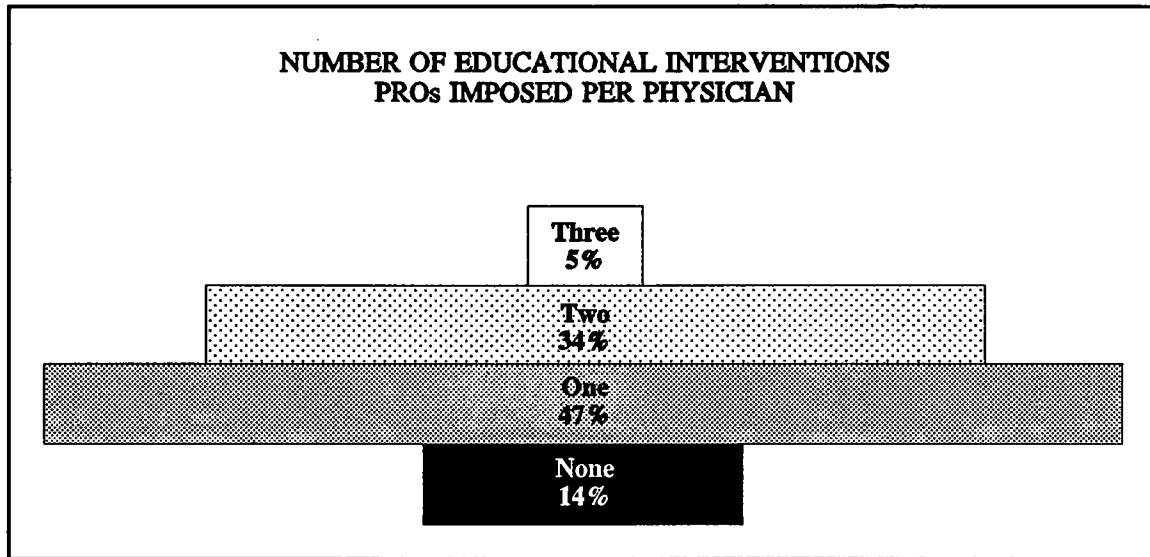
**What kinds of educational interventions did the PROs direct to these physicians?**

*The PROs directed no educational interventions to 14 percent of the physicians.*

The PROs' response to the 131 physicians responsible for serious quality-of-care problems was multi-faceted (appendix E). They sent notifications and conducted intensified reviews on the hospital admissions of all the physicians.<sup>11</sup> They also took various other interventions, ranging from pre-discharge screening to preoperative consultation, against 44 percent of the physicians. And we saw documentation that they considered referring 53 percent of the physicians to the OIG for sanctioning and 39 percent to the State licensure boards. These considerations, however, led to few actual referrals, with only two to the OIG and three to the boards.

For the educational interventions, which provide the focus of this study, it is striking that the PROs directed no such interventions to 14 percent (18) of the 131 physicians found to be responsible for serious quality-of-care problems (figure 3). This omission occurred despite HCFA's requirement that an educational intervention be directed to each such physician. Like the others, these 18 physicians each received the notification of a confirmed quality-of-care problem from the PRO, and each was subject to intensified review (appendix E).

FIGURE 3



NOTE: N=131 physicians identified by 8 PROs as responsible for a confirmed Level III quality-of-care problem and reported to HCFA for reviews completed 1/1/90-6/30/90.  
 SOURCE: OIG/OEI analysis of data from 8 PROs.

These 18 physicians involved 5 of the 8 PROs in our sample. For eight of the physicians, the PROs' records offered no documentation on why the educational interventions were not made. For seven of them, all involving one PRO, the PRO deferred the interventions for many months so that it could undertake retrospective medical reviews to ascertain whether the quality-of-care problems were isolated or part of a pattern.<sup>12</sup> The PROs did not pursue an educational intervention for two physicians because they were recommending sanctions,<sup>13</sup> and for one such an intervention was unnecessary because the physician retired.

*Among the physicians who did receive an educational intervention, the PROs used letters, calls, courses, and meetings most often.*

- . Forty-two percent received a letter.
- . Thirty percent received a telephone call.

- . Twenty-two percent had to attend a continuing medical education course.
- . Eighteen percent had to attend a meeting with PRO physicians.

The PROs used these four educational interventions alone and in combinations. Physicians responsible for serious quality-of-care problems usually received one educational intervention (figure 3), and that intervention most often was a letter. The most common combination was a letter and a phone call, usually from the medical director or, in some cases, a physician adviser or a quality assurance committee member.

The PROs required about one of every five physicians responsible for a serious quality-of-care problem to attend a continuing medical education (CME) course. The CME requirement ranged from as few as 12 hours to as many as 50. In every case the PRO approved the course syllabus and required proof of attendance.

The meetings imposed as an educational intervention usually involved the physician's attending a regularly scheduled meeting of the quality assurance committee at the PRO to discuss the quality-of-care problem. The PRO medical director, peer physicians, and nurse reviewers usually staff these committees.

The PROs' inventory of educational interventions contains more than the four noted above. For example, the PROs occasionally suggested medical readings and, in one case, required the physician to attend a refresher residency.

*Hospitals typically were not involved with or aware of these interventions.*

- . Fifty-one percent of the hospitals were not informed that a quality-of-care problem had occurred there.
- . Eighty-eight percent of the hospitals where the quality-of-care problems occurred had no part in the educational intervention.

According to HCFA policy, the PROs may release physician-specific information about confirmed quality-of-care problems to hospitals where the problem occurred without a request and must release it upon the hospital's request. Three of the eight sample PROs routinely inform hospitals that a physician has been notified of a confirmed problem. The others have informed the hospital in only a few cases, citing both confidentiality concerns and HCFA's policy as reasons.

Usually, the PROs that inform the hospitals do so by sending a copy of the physician's notice to the hospital's quality assurance committee, relevant department chair, and/or designated liaison. The PRO would not necessarily know if the hospital took any action upon receiving the notice, or if the hospital already knew about the problem.

One PRO not only informed hospitals of problems, but also involved them in the educational interventions. In fact, this particular PRO was responsible for 23 of the 25 cases in which the hospital was involved in the educational interventions. The involvement usually included a discussion of the quality problem between a hospital physician (for example, the chair of the quality assurance committee or relevant department) and the physician responsible for the problem. In some cases, they discussed the problem during grand rounds or a morbidity and mortality committee meeting.

For 6 of the 131 quality-of-care problems, the PROs' interventions resulted in changes in hospital policies or protocols that could prevent other quality-of-care problems. For example, one problem involved the delayed treatment of an elderly patient's severe pulmonary edema resulting in the patient's death. The PRO determined that both the attending physician and the surgical resident were responsible for the problem. The PRO notified the hospital of the problem, required both physicians to attend the PRO's quality assurance meeting, and issued a first sanction notice for one physician. In addition, the PRO prompted the hospital's implementation of new policies for geriatric consultations and resident training in geriatric medicine.

**What conclusions can we draw from the PROs' educational interventions?**

*The educational value of the interventions is uncertain.*

- . The letters are typically brief and contain more case summary than educational material.
- . The calls are not documented enough to determine their content.
- . The available courses often do not address the specific quality-of-care problems the PROs have identified.
- . The meetings with the PRO physicians have the most educational value, according to both the PROs and the relevant literature, but were used in only 18 percent of the cases we reviewed.

None of the eight sample PROs had formally assessed the effectiveness of their educational interventions.<sup>14</sup> Some representatives of the PROs, however, indicated that these interventions were important not only for the physicians involved but for other physicians in the State. In this context, they sometimes referred to a sentinel effect, whereby physicians change their practice because of the expectations and oversight activities of the PROs.

In its recent report *Medicare: A Strategy for Quality Assurance*<sup>15</sup> the Institute of Medicine (IOM) reviewed the evolving research on educational interventions involving physicians. On the basis of this research, it suggested five elements that must be

present if educational interventions are to have much effect in changing physician behavior. These elements seldom appear to be associated with PRO interventions.

First, the physician must accept that he or she needs to change. The PROs reported to us that physicians often engage lawyers to respond to a PRO as soon as they receive a notice of a potential quality-of-care problem. In fact, one PRO official said the medical society in its State identified a particular law firm physicians use when contacted by a PRO. In reviewing the case files for this PRO and others, we saw much contentious correspondence between the physicians, their lawyers, and the PROs, and few indications that the physicians accepted the PROs' conclusions.

The second element is that the content of the education must be specific to the area needing change. PRO officials often indicated that they could not find courses that were sufficiently responsive to a physician's particular educational need. This problem is exacerbated in rural areas where access to medical seminars and conferences can be limited.

The remaining three elements focus on a personal meeting with the physician. Physicians, reports the IOM, are likely to respond most positively to an educational intervention when it (1) is offered in a personal meeting, (2) is conducted one-to-one, and (3) is with a trusted and respected colleague.<sup>16</sup> Although most PRO officials reported believing that meetings are effective in changing physician behavior, fewer than one in five of the physicians in our sample had had an intervention that involved such a meeting. Moreover, those who did attend such a meeting often brought their lawyers and almost always found themselves confronting a number of PRO physicians rather than a single, trusted colleague. That is not to suggest that the meetings had no educational value, only that according to the literature the setting did not appear to be conducive to providing the maximum educational benefit.

***The PROs confront three basic constraints in seeking to carry out effective educational interventions.***

They have limited information on which to base their educational interventions.

--The PROs usually base their interventions on one incident of care in one three-month period.

--The PROs' files usually don't identify the physician's specialty, certification status, medical school, or other information about credentials.

--The PROs rarely know about medical board or hospital actions taken against the physician.

--The PROs cannot query the National Practitioner Data Bank about specific physicians.

The PROs typically conduct a thorough inquiry in documenting a serious quality-of-care problem. However, the PROs act in a more restricted manner in determining what kind of educational intervention to take once the problem is documented. This is in large part because the PRO physician advisors who decide on the intervention usually make their decision on the basis of one incident of care in one three month period, in accord with HCFA's quarterly profiling requirement. At some PROs, they do not review their own data for previous quality-of-care problems involving a given physician. They are also unlikely to know if the State medical board, a hospital, or other health care entity has taken or is considering taking action against the physician.<sup>17</sup> And Federal law still does not allow the PROs access to the National Practitioner Data Bank, which would identify any adverse actions taken by medical boards or health care entities such as hospitals and any malpractice payments involving the physician.<sup>18</sup>

**They perform oversight roles that inhibit their capacity as educators.**

In their oversight roles, PROs review the medical practice of physicians, identify those physicians responsible for quality-of-care problems, and then impose certain corrective actions. They must do this in accord with due process safeguards and myriad formal requirements imposed by the Federal government. Understandably, the interactions between the PRO officials and these physicians often become adversarial, as the physicians express concerns about the accuracy of the PROs' judgments and/or the implications for their medical practices.

Amid such interactions, it is difficult for the PRO officials and the physicians with confirmed quality-of-care problems to relate to one another in an essentially educational sense. The PROs impose a certain threat to the physicians, however much they might attempt to deemphasize it. This threat limits, but does not altogether preclude, their opportunity to serve as medical educators.<sup>19</sup>

**They find that remedial medical education programs are seldom available.**

Most PROs are unable to refer a physician with a serious quality-of-care problem to an educational program that offers an intensive and individualized response to the physician's needs. The limited availability of such programs, a number of PRO officials report, significantly restricts what they can accomplish through their educational interventions.



## **RECOMMENDATIONS**

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The physicians we focused on in this report were found responsible for "medical mismanagement with significant adverse effects on the patient." The educational interventions we reviewed were imposed to help these physicians improve their medical management skills and avoid the need for corrective actions of a punitive nature. This educational orientation is central to the purpose of the PRO program.

Yet, as the findings in this report indicate, the educational efforts of the PROs appear to fall well short of their potential. We urge HCFA to give major attention to correcting this deficiency. Toward that end, we offer seven recommendations directed to HCFA. We also present one recommendation to the Public Health Service.

### **THE HEALTH CARE FINANCING ADMINISTRATION**

*The HCFA should ensure that the PROs initiate timely educational interventions in all confirmed Level III cases.*

The PROs should be held accountable for carrying out the educational interventions currently mandated in all Level III cases unless, of course, the physician voluntarily surrenders his/her medical license. In our sample, 14 percent of the cases involved no such intervention at least six months after the PRO had confirmed a Level III quality-of-care problem.

*The HCFA should issue a regulation or, if necessary, seek legislation mandating that for all confirmed Level III cases, the PRO share case information with the hospitals at which the problems occurred. That information should include the identity of the physician, the nature of the problem, and the type of educational and other interventions imposed by the PRO.*

*The HCFA should issue a regulation or, if necessary, seek legislation allowing and encouraging the PROs to involve the hospitals in the planning, conduct, and assessment of educational interventions in all Level III cases.*

Through their own quality assurance efforts, hospitals can and in some cases do play an important role in helping PROs achieve their educational objectives. The PROs, it would appear, could take much greater advantage of this complementary role. Yet, for confidentiality and other reasons, some PROs are reluctant to inform hospitals about quality-of-care problems and any interventions directed to physicians, and even more so to involve them in the conduct of the educational efforts and in the ongoing assessment of these efforts. By carrying out the above recommendations, HCFA could help correct this situation.

***The HCFA should instruct the PROs to give greater attention to personal meetings as an educational intervention and to explore ways of conducting one-to-one meetings between physicians with confirmed Level III quality-of-care problems and physician consultants.***

In our sample, only 18 percent of the educational interventions involved a meeting with PRO physicians. And even when a meeting was held, the educational value was uncertain. A meeting typically involved a number of PRO officials, with an attorney often accompanying the physician, therefore resembling a hearing more than an educational exchange. We urge that HCFA and the PROs examine ways of making more effective use of one-to-one personal meetings as an educational tool and in so doing take account of the research findings concerning how physicians learn.

***The HCFA should mandate that before directing an educational intervention to a physician in a Level III case, the PROs take into account all prior quality-of-care problems they have identified concerning that physician during the life of the PRO contract.***

PRO physician advisors often lack sufficient information about a physician's practice deficiencies to craft a well-suited educational intervention. This can be corrected by obtaining more information from "outside" sources, such as State medical boards, but also from the PRO itself. At a minimum, we believe that the PRO, in developing an educational intervention for a physician, should review any prior quality problems, be they Level I, II, or III, that the PRO itself has identified for that physician over the term of the PRO contract. This would help identify if there is a pattern of medical practice problems that the PRO should address in its educational effort.

***The HCFA should obtain and disseminate information on the effectiveness of PRO educational interventions.***

Do these interventions result in changed physician behavior? What types of interventions are likely to be most effective, under what conditions and in what combinations? Are medical education efforts sometimes relied upon to address problems that in essence are unrelated to medical knowledge or practice skills? To help answer such questions, HCFA should require that PROs prepare a written assessment of the effectiveness of each Level III educational intervention. It should also support research efforts on the relative effectiveness of different educational actions directed to physicians responsible for poor medical care. By doing so, it could help the PROs identify and take advantage of the lessons learned from their considerable experience in undertaking educational interventions.

***The HCFA should obtain and distribute to all the PROs the listing of focused/remedial education programs included in the national registry maintained by the American Medical Association.***

The number of such programs is limited, but those that are available can be an extremely helpful resource for physicians whose medical knowledge or skills are

deficient. The HCFA should assure that the PROs are fully aware of the programs that do exist and consider them when meeting with physicians to discuss appropriate educational activities.

### **THE PUBLIC HEALTH SERVICE**

*The Public Health Service, through the Area Health Education Centers Program and/or the Agency for Health Care Policy and Research, should provide demonstration funding for the establishment and refinement of medical education programs that seek to enhance the clinical competence of physicians through individualized assessments and remedial education.*

Individualized assessment and education programs, such as Ontario's Physician Enhancement Program, can serve as an effective approach for addressing medical practice deficiencies. Yet, with few such programs available in the United States, PROs seldom have the option of referring a physician to one as part of an educational intervention. The American Medical Association has encouraged State and local medical societies to assist in the development of such programs.<sup>20</sup> The Public Health Service, through demonstration funding, can assist by using some of its demonstration funds to help determine the type of physician enhancement programs likely to be most effective.

## COMMENTS ON THE DRAFT REPORT

Within the Department of Health and Human Services, we received comments from the Health Care Financing Administration (HCFA) and the Public Health Service (PHS). In addition, we received comments from a number of private organizations. These included the American Association of Retired Persons (AARP), the American Medical Peer Review Organization (AMPRA), and the American Medical Association (AMA). In appendix F, we present the full comments offered and our response to them.

Our second and third recommendations calling for the PROs to share more information about Level III cases with hospitals and to involve hospitals in the planning and conduct of the educational interventions generated the most attention. The PHS, AARP, and AMPRA expressed support for such action. The HCFA, to which the recommendation was directed, indicated it would seek guidance from its general counsel to determine what if any action could be taken.

In view of the legal uncertainty and the vital importance of these recommendations to the future effectiveness of the PROs' educational efforts in Level III cases, we have changed them so that they call for HCFA to issue regulations or, if necessary, seek legislation to foster closer PRO-hospital interactions in Level III cases.

In our fifth recommendation, calling for PROs to take into account all prior quality-of-care problems before making an educational intervention, we made two changes to clarify that we were referring to Level III cases and to prior problems identified by a PRO during the life of its contract with HCFA. We agree with AMPRA that the PROs should "maintain a capacity to profile quality-of-care problems by individual practitioner(s) over the term of a PRO contract."

In response to the AMA's comments about its national registry on focused/remedial education programs, we added a recommendation urging HCFA to see that all PROs are kept informed about such programs. For some physicians, such programs can serve as a crucial educational resource.

Finally, with respect to our recommendation calling for PHS to provide demonstration funding for such programs, we added the Area Health Education Centers Program as a potential source for such funding. This was in response to comments from PHS addressing the potential relevance of that program.

# APPENDIX A

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## METHODOLOGICAL NOTES

We reviewed all confirmed Level III quality-of-care problems involving physicians identified by eight PROs and reported to HCFA for reviews completed between January 1 and June 30, 1990. We selected the eight PROs by dividing all PROs into three strata, according to their volume of confirmed Level III problems. We then randomly selected 4 PROs from the high (20 or more problems) and 4 from the medium (6-19 problems) volume strata. Those 2 strata represent 30 PROs and 86 percent of all the confirmed Level III quality-of-care problems reported during our time frame. We excluded the PROs with fewer than six confirmed Level III quality problems due to the cost of including them and their lesser experience with interventions.

We made site visits to six of the eight PROs, collecting our information by phone and mail for the others. We reviewed the PROs' records for each of the 131 physicians identified by those 8 PROs (see appendix B for a sample overview). Those 131 physicians account for 22 percent of the confirmed Level III quality-of-care problems identified by the 30 PROs in those 2 strata, and 19 percent of the confirmed Level III problems in all PROs.

During our review we recorded physicians' names, a description of the quality-of-care problem, the name of the hospital, and the interventions taken by the PROs. We also recorded the generic quality screen failures for each case, as a way to group the problems. Using a discussion guide, we went over the intervention process with each PRO's medical director. In some cases, the chief executive officer, physician reviewers, and the quality review director participated.

We collected the physician profile data from the data bases and publications of the American Medical Association and the American Osteopathic Association.

We used Chi-square comparison of proportions tests to compare the distribution of the 131 physicians with non-Federal physicians in the 8 States by specialty, age, gender, and foreign medical graduate status.

## APPENDIX B

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### SAMPLE OVERVIEW

PRO	CONFIRMED LEVEL III QUALITY-OF CARE PROBLEMS REPORTED TO HCFA, 1/1/90- 6/30/90	*TOTAL CASES REVIEWED	**CASES REVIEWED WITHIN SCOPE OF INSPECTION	N USED FOR MOST ANALY- SES
1	7	8	8	6***
2	10	11	11	10****
3	23	19	12	12
4	53	53	48	47****
5	10	8	8	8
6	6	11	11	11
7	32	29	25	25
8	20	19	12	12
TOTAL	<u>161</u>	<u>158</u>	<u>135</u>	<u>131</u>

\* Some of these PROs identified cases not reported to HCFA.

\*\* We omitted cases from our scope for the following reasons: 6 problems occurred in a setting other than inpatient, 4 problems involved the provider rather than the physician as the responsible party, and 13 problems were either overturned or reduced to a lesser severity level.

\*\*\* In this PRO, two physicians were each responsible for two quality-of-care problems, or cases, during the sample time. To avoid double counting the physicians, we omitted one case for each from our analysis.

\*\*\*\* In each of these two PROs, one physician was responsible for two quality problems, or cases, during the sample time. To avoid double counting these physicians, we omitted one case each from our analysis.

# APPENDIX C

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## SUMMARY OF PHYSICIAN PROFILE DATA

Following are summary data of the 131 physicians identified by 8 PROs as being responsible for confirmed Level III quality-of-care problems that were reported to HCFA for reviews completed between January 1 and June 30, 1990. Our sources for this data include:

- . The 8 PROs.
- . American Medical Association, American Medical Directory: Physicians in the United States, 32nd ed., Division of Survey and Data Resources, Department of Physician Data Services, 1990.
- . American Medical Association, Physician Profile Data, Division of Survey and Data Resources, Department of Physician and Data Services, correspondence 2/13/91 and 2/22/91.
- . American Osteopathic Association, Yearbook and Directory of Osteopathic Physicians, 1990 ed.
- . Marquis Who's Who, Directory of Medical Specialists, 24th ed., Wilmette, IL, 1990.

**SUMMARY OF PHYSICIAN PROFILE DATA**

	<b>FREQUENCY</b>	<b>PERCENT</b>
<b>GENDER</b>		
Male	110	98%
Female	<u>2</u>	<u>2</u>
	112	100%
Unknown	19	
<b>AGE (in 1990)</b>		
<35	7	5%
35-44	35	27
45-54	42	32
55-64	36	28
65+	<u>10</u>	<u>8</u>
	130	100%
Unknown	1	
<b>SPECIALTY</b>		
General and Family Practice	36	28%
Medical Specialties	37	29
Surgical Specialties	46	35
Osteopathy	<u>11</u>	<u>8</u>
	130	100%
Unknown	1	
<b>CERTIFICATION STATUS</b>		
Certified	78	65%
Not Certified	<u>42</u>	<u>35</u>
(excludes 11 osteopaths)	120	100%
<b>FOREIGN MEDICAL GRADUATE</b>		
Yes	35	30%
No	<u>82</u>	<u>70</u>
(excludes 11 osteopaths)	117	100%
Unknown	3	



**DETAIL ON SPECIALTY CATEGORIZATION**

<b>SPECIALTY CATEGORIZATION</b>	<b>NUMBER OF PHYSICIANS WITH SERIOUS QUALITY-OF-CARE PROBLEMS</b>	
<b>GENERAL PRACTICE</b>		<b>36</b>
General Practice	21	
Family Practice	<u>15</u>	
	36	
<b>MEDICAL SPECIALTIES</b>		<b>37</b>
Internal Medicine	17	
Cardiovascular Diseases	7	
Medical Oncology	3	
Nephrology	2	
Pulmonary Diseases	2	
Anesthesiology	1	
Geriatrics	1	
Hematology	1	
Neurology	1	
Pathology	1	
Rheumatology	<u>1</u>	
	37	
<b>SURGICAL SPECIALTIES</b>		<b>46</b>
General Surgery	27*	
Orthopedic Surgery	9	
Urology	3	
Neurosurgery	2	
Thoracic Surgery	2	
Obstetrics and Gynecology	1	
Otolaryngology	1	
Vascular Surgery	<u>1</u>	
	46	
<b>OSTEOPATHS</b>	11	<u>11</u>
		130
<b>SPECIALTY UNKNOWN</b>		<u>1</u>
<b>TOTAL</b>		<b>131</b>
*Includes three surgical residents		

# APPENDIX D

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## GENERIC QUALITY SCREENS

Below we provide HCFA's definitions from the third Scope of Work for the inpatient hospital generic quality screens. Following the definitions, we provide a summary of the screens failed by the 131 physicians the 8 PROs identified as responsible for confirmed Level III quality-of-care problems reported to HCFA for reviews completed between January 1 and June 30, 1990.

### DEFINITIONS OF THE INPATIENT HOSPITAL GENERIC QUALITY SCREENS

#### 1. Adequacy of Discharge Planning

No documentation of discharge planning or appropriate follow-up care with consideration of physical, emotional, and mental status needs at time of discharge.

#### 2. Medical Stability of the Patient

- a. Blood pressure within 24 hours of discharge (systolic less than 85 or greater than 180; diastolic less than 50 or greater than 110).
- b. Temperature within 24 hours of discharge greater than 101 degrees Fahrenheit (38.3 Centigrade) oral, greater than 102 degrees Fahrenheit (38.9 Centigrade) rectal.
- c. Pulse less than 50 (or 45 if the patient is on a beta blocker), or greater than 120 within 24 hours of discharge.
- d. Abnormal diagnostic findings which are not addressed and resolved or where the record does not explain why they are not resolved.
- e. Intravenous fluids or drugs after 12 midnight on the day of discharge.
- f. Purulent or bloody drainage of wound or open area within 24 hours prior to discharge.

### 3. Deaths

- a. During or following any surgery performed during the current admission.
- b. Following return to intensive care unit, coronary care or other special care unit within 24 hours of being transferred out.
- c. Other unexpected death.

### 4. Nosocomial Infection

Hospital-acquired infection.

### 5. Unscheduled Return to Surgery

Within the same admission for same condition as previous surgery or to correct operative problem.

### 6. Trauma Suffered in the Hospital

- a. Unplanned surgery which includes, but is not limited to, removal or repair of a normal organ or body part (i.e., surgery not addressed specifically in the operative consent)
- b. Fall
- c. Serious complications of anesthesia
- d. Any transfusion error or serious transfusion reaction
- e. Hospital-acquired decubitus ulcer and/or deterioration of existing decubitus
- f. Medication error or adverse drug reaction (1) with serious potential for harm or (2) resulting in measures to correct
- g. Care or lack of care resulting in serious or potentially serious complications

### 7. Optional Screen

Medication or treatment changes (including discontinuation) within 24 hours of discharge without adequate observation

**SUMMARY OF QUALITY-OF CARE PROBLEM PROFILE DATA:  
NUMBER OF PHYSICIANS FAILING GENERIC QUALITY SCREENS**

	FREQUENCY	PERCENT
<b>DISCHARGE PLANNING SCREEN</b>		
Fail	9	7%
Pass	<u>120</u>	<u>93</u>
	129	100%
Unknown	2	
<b>MEDICAL STABILITY SCREENS</b>		
Fail	56	43%
Pass	<u>73</u>	<u>57</u>
	129	100%
Unknown	2	
<b>DEATH SCREENS</b>		
Fail	20	15%
Pass	<u>109</u>	<u>85</u>
	129	100%
Unknown	2	
<b>NOSOCOMIAL INFECTION SCREEN</b>		
Fail	6	5%
Pass	<u>123</u>	<u>95</u>
	129	100%
Unknown	2	
<b>UNSCHEDULED RETURN TO SURGERY SCREEN</b>		
Fail	8	6%
Pass	<u>121</u>	<u>94</u>
	129	100%
Unknown	2	

	FREQUENCY	PERCENT
<b>TRAUMA SUFFERED IN THE HOSPITAL SCREEN</b>		
Fail	76	59%
Pass	<u>53</u>	<u>41%</u>
	129	100%
Unknown	2	
<b>OPTIONAL OR PROS' OWN SCREENS</b>		
Fail	23	18%
Pass	<u>106</u>	<u>82</u>
	129	100%
Unknown	2	

# APPENDIX E

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## SUMMARY OF INTERVENTION PROFILE DATA

Following are summary data of the interventions the 8 PROs directed to the 131 physicians identified as responsible for confirmed Level III quality-of-care problems that were reported to HCFA for reviews completed between January 1 and June 30, 1990.

**SUMMARY OF QUALITY INTERVENTION PROFILE DATA**

<b>INTERVENTION</b>	<b>FREQUENCY</b>	<b>PERCENT</b>
<b>NOTIFICATION</b>		
Imposed	131	100%
<b>EDUCATIONAL INTERVENTION</b>		
Imposed	113	86%
Not Imposed	<u>18</u>	<u>14%</u>
	131	100%
<b>INTENSIFIED REVIEW</b>		
Imposed	131	100%
<b>OTHER INTERVENTIONS</b>		
Imposed	57	44%
Not Imposed	<u>74</u>	<u>56</u>
	131	100%
<b>SHARING WITH LICENSURE BODIES</b>		
Considered	51	39%
Not Considered	77	59
Shared	<u>3</u>	<u>2</u>
	131	100%
<b>SANCTION</b>		
Considered	69	53%
Not Considered	55	42
1st Notice Issued	5	4
Sanctioned	<u>2</u>	<u>1</u>
	131	100%

**SUMMARY OF EDUCATIONAL INTERVENTION PROFILE DATA**

<b>INTERVENTION</b>	<b>FREQUENCY</b>	<b>PERCENT</b>
<b>LETTER</b>		
Imposed	48	42%
Not Imposed	<u>65</u>	<u>58</u>
	113	100%
<b>PHONE CALL</b>		
Imposed	34	30%
Not Imposed	<u>79</u>	<u>70</u>
	113	100%
<b>COURSEWORK</b>		
Imposed	25	22%
Not Imposed	<u>88</u>	<u>78</u>
	113	100%
<b>MEETING WITH PRO PHYSICIANS</b>		
Imposed	20	18%
Not Imposed	<u>93</u>	<u>82</u>
	113	100%
<b>SUGGESTED READING</b>		
Imposed	3	3%
Not Imposed	<u>110</u>	<u>97</u>
	113	100%
<b>REFRESHER RESIDENCY</b>		
Imposed	1	1%
Not Imposed	<u>112</u>	<u>99</u>
	113	100%
<b>MEETING WITH HOSPITAL PHYSICIANS</b>		
Imposed	25	22%
Not Imposed	<u>88</u>	<u>78</u>
	113	100%



## **APPENDIX F**

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### **DETAILED COMMENTS ON THE DRAFT REPORT AND OIG RESPONSE TO THE COMMENTS**

In this appendix, we present in full the comments on the draft report offered by the Health Care Financing Administration (HCFA), the Public Health Service (PHS), the American Association of Retired Persons (AARP), the American Medical Peer Review Association (AMPRA), and the American Medical Association (AMA). In each case, we also include our response to the comments.



**Memorandum**

Date NOV 18 1991  
From Gail R. Wilensky, Ph.D. *GRW*  
Administrator  
Subject OIG Draft Report - "Educating Physicians Responsible for Poor Medical Care: A Review of the Peer Review Organizations' Efforts," OEI-01-89-00020  
To Inspector General  
Office of the Secretary

We have reviewed the subject draft report which assesses the educational interventions the peer review organizations (PROs) direct to physicians responsible for serious quality-of-care problems. The report found that the educational value of PROs' interventions is uncertain and that the PROs face basic constraints that limit the effectiveness of these interventions.

The report addresses six recommendations to HCFA. Our comments on these recommendations, as well as general comments on the report are attached.

Thank you for the opportunity to review and comment on this report. Please advise us whether you agree with our position on the report's recommendations at your earliest convenience.

Attachment

Comments of the Health Care Financing Administration  
on the OIG Draft Report, "Educating Physicians Responsible  
for Poor Medical Care: A Review of the Peer Review  
Organizations' Efforts," OEI-01-89-00020

Recommendation 1

The HCFA should ensure that the PROs initiate timely educational interventions in all confirmed Level III cases, unless the physician surrenders his/her medical license.

Response

We concur with this recommendation. We require peer review organizations (PROs) to initiate interventions within 30 days after the close of the review quarter, unless the error is so egregious that it warrants immediate intervention. We evaluate the performance of PROs using the Peer Review Organization Monitoring Protocol and Tracking System (PROMPTS). When we perform the PROMPTS evaluations, we review to determine whether educational interventions are implemented as directed. PROs are required to submit corrective action plans which are monitored closely when PROMPTS identifies deficiencies in PRO implementation of educational efforts. In the next PROMPTS review, we will pull a focused sample of Level III cases to ensure that educational interventions were properly initiated.

Recommendation 2

The HCFA should mandate that for all confirmed Level III cases, the PRO share case information with the hospitals at which the problems occurred. That information should include the identity of the physician, the nature of the problem, and the type of educational and other interventions imposed by the PRO.

Response

We will confer with the Office of the General Counsel (OGC) in order to obtain more specific guidance as to what information concerning educational interventions can be shared with hospitals.

Recommendation 3

The HCFA should encourage the PROs to involve the hospitals in the planning and conduct of the educational interventions.

Response

As previously stated, we need to confer with OGC on the issue of sharing information on educational interventions with hospitals in order to determine whether we can implement this recommendation. In addition, we believe that many hospitals (e.g., small hospitals) are not equipped to perform such functions.

Recommendation 4

The HCFA should instruct the PROs to give greater attention to personal meetings as an education intervention and to explore ways of conducting one-to-one meetings between physicians with confirmed Level III quality-of-care problems and physician consultants.

Response

We are currently reviewing options for improving our quality intervention plan and will consider this recommendation in conjunction with other appropriate changes.

Recommendation 5

The HCFA should mandate that before directing an education intervention to a physician, the PROs take into account all prior quality-of-care problems they have identified concerning the physician.

Response

The PROs take prior history into account when deciding what intervention to take. The scope of work for the fourth contracting cycle clarifies that the PRO is to take into account prior history when deciding upon the appropriate intervention.

Recommendation 6

The HCFA should obtain and disseminate information on the effectiveness of PRO education interventions.

Response

HCFA is committed to a strong program of education and information dissemination among the PROs and through the PROs to the community. The specific recommendation to disseminate information on the effectiveness of PRO educational interventions will be realized with the implementation of a program of epidemiologic evaluation and oversight through the PROs. Under the scope of work for the next round of contracts with the PROs, there is significant emphasis on education and feedback to the health care providers and practitioners on patterns of practice and the associated outcomes of care.

General Comments

- o Page i - OIG's background statement implies that the PROs' two major functions are policing activities. We suggest this paragraph be rewritten to emphasize that the primary responsibility of the PROs is to ensure Medicare beneficiaries receive good quality care.
- o Page 10 - OIG indicates that the PROs have limited information and that the PROs rarely know about medical board or hospital actions taken against physicians. We agree that this is true. Although OIG wants the PROs to share information freely with the medical boards and hospitals, there is no companion recommendation that these other entities share information with the PROs. In the future, PRO access to the National Practitioner Data Bank will help in this regard.

## OIG RESPONSE TO HCFA COMMENTS

We respond as follows to HCFA's comments on each of the recommendations:

**Recommendation 1:** We welcome HCFA's follow up to ensure that educational interventions are properly initiated.

**Recommendation 2:** In view of HCFA's reservation about the legal basis of the recommendation as stated in the draft report, we have modified it to call for the necessary regulatory or statutory changes. We urge that HCFA move quickly in carrying out this recommendation because it has a major bearing on the effectiveness of PRO educational interventions in Level III cases.

In this context, we suggest that HCFA take into account that a close working relationship with hospitals (and their own quality assurance committees) supports the continuous quality improvement principles which HCFA is embracing for the PRO program. By involving the hospital in the intervention process and by keeping the hospital regularly informed of educational interventions taken against its physicians, the PRO would be contributing to a more collegial process that involves more effective use of data concerning the quality of care.

We also suggest that HCFA take note of the support for this recommendation expressed by the Public Health Service, the American Association of Retired Persons, and the American Medical Peer Review Association. The American Medical Association did not respond directly to the desirability of the recommendation, but did emphasize that there should be strict limits to any educational activities undertaken directly by the PROs. Our recommendation is made in recognition of such limits and of the major contributions that hospitals can make in assisting physicians found to have serious quality-of-care problems. Indeed, one of the PROs in our sample was working very closely with hospitals, just as we call for in the recommendations.

**Recommendation 3:** Our response concerning HCFA's comments on the above recommendation also apply to this recommendation. Hospitals can and should be major participants in crafting and overseeing educational plans for physicians who have been responsible for serious quality-of-care problems. We urge HCFA and the PROs to move quickly in this direction.

**Recommendation 4:** We regret that HCFA did not offer a more definitive response to this recommendation. One-to-one meetings, as research findings indicate, can lead to more effective educational interventions. We urge HCFA to identify ways to incorporate such meetings into the educational process in Level III cases.

**Recommendation 5:** HCFA indicates that the scope of work for the fourth contract cycle will clarify that the PRO is to take into account prior history when deciding upon an educational intervention. Such language moves in the direction we call for, but is

not sufficiently precise. We urge that HCFA follow the suggestion offered in AMPRA's response to us and require that the PROs "maintain a capacity to profile quality of care problems by individual practitioner(s) over the term of a PRO contract and not just for consecutive quarters which is the mandate at present." Such an approach would help identify any pattern of quality problems and would allow for educational interventions more appropriately tailored to a physician's needs. (Accordingly, we have specified in our recommendation that before fashioning educational interventions in Level III cases, PROs should review all quality-of-care problems they have identified on those physicians during the life of their PRO contracts.)

**Recommendation 6:** In response to this recommendation, HCFA references the epidemiologic evaluation and oversight that will be emphasized in future contracts with PROs (using HCFA's Uniform Clinical Data Set). This future direction cited by HCFA represents an important and potentially constructive redirection in the PRO program. It does not, however, respond to the point of our recommendation.

In our recommendation, as in the report as a whole, we make it clear that we are focusing on physicians responsible for poor medical care--that is, those physicians who have confirmed Level III quality-of-care problems. Our recommendation urges HCFA to determine the effectiveness of the educational interventions undertaken against these physicians. What interventions work best for them? Under what circumstances? Why? These are important questions to answer and should not be confused with other important questions about how practice-related data can best be used to improve the performance of most practicing physicians.



NOV 19 1991

## Memorandum

Date

From Assistant Secretary for Health

Subject Office of Inspector General (OIG) Draft Report "Educating Physicians Responsible for Poor Medical Care: A Review of the Peer Review Organizations' Efforts," OEI-01-89-00020

To

Inspector General, OS

Attached are the Public Health Service comments on the subject draft report. We concur with the intent of the recommendation. However, we recommend that the recommendation be directed toward more appropriate organizations such as the Health Resources and Services Administration (HRSA), with technical assistance from the Agency for Health Care Policy and Research, or perhaps to medical organizations and professional societies themselves. In our comments we discuss some activities undertaken by HRSA in previous years that could be responsive to the issues identified in this report.

  
James O. Mason, M.D., Dr.P.H.

Attachment



PUBLIC HEALTH SERVICE (PHS) COMMENTS ON THE OFFICE OF  
INSPECTOR GENERAL (OIG) DRAFT REPORT "EDUCATING PHYSICIANS  
RESPONSIBLE FOR POOR MEDICAL CARE: A REVIEW OF THE PEER  
REVIEW ORGANIZATIONS' EFFORTS," OEI-01-89-00020

General Comments

The draft report presents findings regarding the lack of consistency and perceived value of Peer Review Organization (PRO) educational interventions, and discusses the significant barriers undermining these efforts. The recommendations are designed, overall, to rationalize this system. We are particularly supportive of efforts to involve hospitals (or other appropriate facilities, such as nursing homes) in the planning of educational efforts.

It is not clear, however, that intensified educational interventions by PROs will overcome the basic problems described in the report. Additional consideration needs to be given to ways to change the adversarial relationship between PROs and individual physicians, and to encourage more active involvement of a range of medical peers and professional organizations in the education and discipline of colleagues.

OIG Recommendation

The Public Health Service, through the Agency for Health Care Policy and Research (AHCPR), should provide demonstration funding for the establishment and refinement of medical education programs that seek to enhance the clinical competence of physicians through individualized assessment and remedial education.

PHS Comment

We agree with the intent of this recommendation, but note that there are several problems with it as currently drafted. AHCPR has the authority to fund demonstrations, but is not currently doing so, nor are specific demonstration funds included in the AHCPR budget. As part of its growing program to address issues related to quality assurance in health care, AHCPR hopes to fund research, including demonstrations, designed to determine the effectiveness of alternative programs for improving physician performance and reducing the incidence of substandard medical care. This is consistent with the agency's statutory authority to focus on research and evaluation questions.

An evaluation of the effects of personalized assessment and remedial education programs on improved physician performance would be eligible for consideration in such an effort. However, the development and establishment of such programs is not within the purview of the AHCPR. The recommendation

should therefore be directed toward more appropriate organizations, such as the Health Services and Resources Administration (HRSA), or perhaps to medical organizations and professional societies themselves. AHCPR could provide technical assistance to HRSA by reviewing methodologies and evaluating proposals for demonstration funding.

HRSA's Area Health Education Centers (AHEC) Program is authorized under section 781 (a)(1) and 781 (a)(2) of the Public Health Service Act. Under section 781 (a)(1), basic support in the form of cooperative agreements is provided to successful applicants (medical schools or their parent organizations) to carry out an AHEC Program in a region of a State or in an entire State, over a 3-6-9 year period. Under section 781 (a)(2), grant support is provided to former recipients of 781 (a)(1) funds to carry out 2-year AHEC Special Initiative projects, including innovative demonstration projects.

Quality assurance has been one of the funding priorities established for the AHEC Program and the AHEC Special Initiatives Program during competitive cycles held in previous years. In Fiscal Year (FY) 1992, quality assurance was not included as a funding priority, since substance abuse was added to the other funding priority areas: geriatrics, HIV-AIDS, and infant mortality prevention. We will reconsider whether quality assurance should be reestablished as one of the funding priorities for the AHEC Program and the AHEC Special Initiatives Program beginning in the FY 1993 competitive grant cycle. This would encourage a range of quality assurance applications that would focus on physician effectiveness educational programs at a State or local level, and would be responsive to the needs and issues cited in the OIG draft report.

The AHEC Program appropriation in FY 1991 was \$19.2 million, with 90 percent of the funds (\$17.3M) awarded to support 15 ongoing AHEC programs and six new AHEC programs. Currently, up to 10 percent of the annual AHEC Program appropriation may be used to support AHEC Special Initiatives projects. In FY 1991, a total of approximately \$1.9M was awarded to support 15 continuation and eight new Special Initiatives projects, some of which address quality assurance issues. The average award was \$75,000.

#### TECHNICAL COMMENT

The name of the Agency for Health Care Policy and Research should be corrected in the recommendation to the Public Health Service on pages iii and 13 of the report.

## **OIG RESPONSE TO PHS COMMENTS**

In response to PHS' comments, we have amended our recommendation to clarify that both the Agency for Health Care Policy and Research and the Area Health Education Centers Program in the Bureau of Health Professions could serve as resources to support and assess demonstration efforts cited. We have also made the technical correction noted.



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September 17, 1991

Richard P. Kusserow  
Inspector General  
Department of Health and Human Services  
330 Independence Ave., S.W.  
Washington, D.C. 20201

Dear Mr. Kusserow:

I am responding to your letter to Horace Deets regarding the draft report entitled "Educating Physicians Responsible for Poor Medical Care: A Review of the Peer Review Organizations' Efforts." The American Association of Retired Persons is very pleased to submit these comments and commends the authors of the report for their contribution to increased understanding of how to improve a program of great importance to Medicare beneficiaries.

The report provides empirical data indicating that the quality intervention plans pursued by the Peer Review Organizations (PROs) are falling far short of their goals. A major conclusion from the report is that, although PROs are effective in identifying Level III problems, they do not have an effective and consistent process for ameliorating deficiencies and certifying the competency of problem physicians. The report is also instructive in not only providing an inventory of the problems that lead to Level III citations, but in recognizing the frequently difficult environment in which remedies for such citations are considered.

AARP continues to believe that a properly functioning peer review system provides vital protection for Medicare beneficiaries. Accordingly, every effort must be made to strengthen existing mechanisms for intervention in cases of poor quality. We have reviewed the draft report and find that, for the most part, we are in agreement with its recommendations and findings. Accordingly, the following comments address those areas where we have additional suggestions.

Background ( pg. 2)

We suggest that you reference the Office of the Inspector General's (OIG) earlier report on PRO sanctions so that readers may be informed about the PROs' experience in exercising their more punitive options for addressing quality of care problems.

American Association of Retired Persons 601 E. Street, N.W., Washington, D.C. 20049 202 464-2277

Robert B. Maxwell *President*

F -12

Horace B. Deets *Executive Director*

Recommendations ( pg 12 - 14)

In its first three recommendations, the OIG calls for:

- o Ensuring timely educational interventions in all confirmed Level III cases;
- o Mandating sharing of case information with the hospitals in which the problems occurred;
- o Encouraging the PROs to involve the hospitals in the planning and conduct of the educational interventions.

We strongly endorse these recommendations. With respect to the second, we note that this sharing, given the PROs existing discretionary authority, would not constitute a significant change in the current confidentiality and disclosure framework established in regulation. With respect to the third, hospital quality assurance committees play a critical role nationally in maintaining quality of care, yet the report indicates 88% had no part in PRO educational interventions. In light of the potential importance of hospitals' involvement, the OIG in its final report also should recommend that:

- o HCFA mandate PRO-hospital interaction with respect to both the planning and evaluation of interventions through changes in PRO regulations and in hospitals' Conditions of Participation. In addition, PROs should be encouraged to reach out and involve medical schools, medical centers, and other appropriate institutions in their areas in the design, implementation, and evaluation of corrective action plans, including innovative remedial education programs. In this connection, we note the report's observation that lack of access to medical seminars and other appropriate remedial courses is particularly acute in many rural areas. Particular attention should be paid to this problem.

In its fourth recommendation, the OIG stresses the value of personal meetings as an educational intervention. It is our understanding that considerable research is underway with respect to strategies for changing physician practice patterns which may be relevant to this issue. We concur that HCFA and the PROs should take into account research findings on how physicians learn in evaluating the efficacy of personal meetings and other interventions.

The fifth recommendation points up a serious deficiency identified in the report, namely the PROs' failure to utilize all available data affecting the judgment about a physician's performance. Accordingly, we strongly concur with the OIG's recommendation and additionally recommend that:

- o Efforts by the PROs and HCFA to achieve PROs' access to

state medical licensure board information pertinent to investigation of Level III cases should be accelerated. This report again documents the reluctance of PROs and state boards to communicate with each other in cases of serious quality problems; the barriers to such information sharing should be evaluated.

- o PROs should be given authority to query the National Practitioner Data Bank about specific physicians.

The OIG's sixth recommendation, that HCFA obtain and disseminate information on the effectiveness of PRO educational interventions, has great merit. In order to implement this recommendation uniformly across PROs, we also recommend that:

- o PROs should be instructed to prepare and document reports on the effectiveness of each Level III intervention. These reports would serve to communicate important information to physicians and their hospitals, as well contribute to the development of a HCFA data base on the impact of PRO interventions.

We appreciate the opportunity to review this important report and to share our comments with you. If you should have any questions, please contact Mary Jo Gibson of the Division of Legislation and Public Policy at (202) 434-3896.

Sincerely,



John Rother  
Director

Division of Legislation and Public Policy

## OIG RESPONSE TO AARP COMMENTS

In response to AARP's comments, we have added a footnote referencing the prior OIG report on PRO sanctions and have modified our third recommendation to call for the PROs and HCFA to work together not only in planning and conducting educational interventions, but also in assessing them.

With respect to AARP's additional recommendations: (1) we do not view it appropriate to recommend that PRO-hospital interactions be included in hospitals' Medicare conditions of participation, given that our focus in this report has been on the PROs rather than hospitals; (2) we have addressed in a prior report the need for closer interactions between PROs and State medical boards (see "State Medical Boards and Medical Discipline," OEI-01-89-00560, August 1990); and (3) we agree that PROs should be able to query the National Practitioner Data Bank and understand that will be the case once Section 5 of the Medicare and Medicaid Protection Act of 1987 is implemented.



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Richard Kusserow  
Inspector General  
Department of Health and Human Services  
HHS Cohen Building  
Room 5250  
330 Independence Avenue, S.W.  
Washington, DC 20201

Dear Mr. Kusserow:

The American Medical Peer Review Association (AMPRA) appreciates the opportunity to respond to the prepublication draft report entitled, "Educating Physicians for Poor Medical Care: A Review of the Peer Review Organizations' Efforts." The draft has not been shared with the AMPRA membership nor discussed by the AMPRA Board of Directors. The following comments, therefore, should be viewed as preliminary and not reflective of AMPRA Board policy at this time.

AMPRA is supportive of the report's recommendations and believe adoption would enhance the PRO's efforts to modify the behavior of individual practitioners. In particular, we support the recommendation requiring PROs to share information with the hospitals about Level III cases attributed to physicians. We would suggest going one step further and mandate that all confirmed quality problems be shared with hospitals. We believe that hospitals are legally responsible for the quality of care delivered in their institutions and, therefore, should be entitled to information relating to confirmed quality problems identified by the PRO.

We are also strongly supportive of the recommendation to encourage PROs to involve hospitals in the planning and conduct of educational interventions. We believe that this would greatly enhance the educational impact by PROs. In the past, HCFA General Counsel has taken the position that to share specifics of PRO intervention with the facility would require a waiver of the confidentiality provisions by the affected physician.

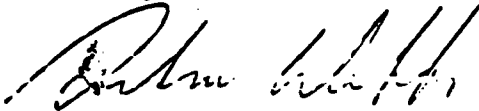
The recommendation that PROs be mandated to take into account all previous quality of care problems when directing an educational intervention for a physician makes good sense. HCFA should consider requiring PROs to maintain a capacity to profile quality of care problems by individual practitioner over the term of a PRO contract and not just for consecutive quarters which is the mandate at present.



Richard Kusserow  
September 30, 1991  
Page two

Once again, thank you for the opportunity to comment on this draft report. AMPRA looks forward to receiving the final report for distribution to the AMPRA membership.

Sincerely,



Andrew Webber  
Executive Vice President

AW/aw

## OIG RESPONSE TO AMPRA COMMENTS

We agree with AMPRA's point that all quality problems be shared with hospitals and suggest that HCFA consider it. However, given our study's focus on Level III cases and educational interventions, we must limit our formal recommendations accordingly.

We also agree with AMPRA's point about HCFA requiring the PROs to maintain a capacity to profile quality-of-care problems by an individual practitioner over the term of a PRO contract. We have reinforced this point in our response to HCFA and have amended the recommendation to clarify that this profiling requirement should apply for the life of a PRO contract.

# American Medical Association

Physicians dedicated to the health of America



James S. Todd, MD  
Executive Vice President

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September 9, 1991

Richard P. Kusserow  
Office of Inspector General  
Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

RE: Draft Report - "Educating Physicians  
Responsible For Poor Medical Care:  
A Review of the Peer Review Organizations'  
Efforts" 01-89-00020

Dear Mr. Kusserow:

The American Medical Association (AMA) welcomes the opportunity to comment on the draft report, "Educating Physicians Responsible For Poor Medical Care: A Review of the Peer Review Organizations' Efforts."

The AMA commends the Office of Inspector General for undertaking the examination of current educational activities of PROs. We support the goal of the peer review organization (PRO) program, to ensure quality medical care for all Medicare beneficiaries, and we believe it can best be achieved by directing current PRO resources toward educational and quality assurance endeavors rather than punitive interventions.

The Omnibus Budget Reconciliation Act of 1990 (OBRA '90) provides that before a PRO submits its report and recommendations to the Secretary of Health and Human Services pursuant to the Quality Intervention Plan of the Health Care Financing Administration (HCFA), the PRO may provide the physician or entity being scrutinized an opportunity to enter into and complete a corrective action plan (CAP). The CAP may include remedial education, if appropriate. In our view, however, PROs should not unilaterally develop or be involved in the actual provision of an educational CAP, nor should they be involved directly in a system for coordinating the educational activity.

PRO entities do not possess the necessary educational resources, faculty or expertise to engage in such an endeavor. Any such actions by the PROs would also constitute a serious conflict of interest, especially if undertaken as a revenue generating activity. We believe, moreover, that PROs must not mandate or require the use of any specific educational program or resource by physicians designated through the problem identification process. Instead, the PRO should recognize the resources already available within the community and rely on those institutions to provide educational programs and remediation.

The following analysis of the recommendations set forth in the draft report will present the AMA's views on appropriate PRO activities to correct deficiencies in technique or practice that affect the quality of medical services rendered.

**Recommendation 1** - The Health Care Financing Administration should ensure that the PROs initiate timely educational interventions in all confirmed Level III cases, unless the physician surrenders his/her medical license.

The AMA believes that the recommendation should be modified by deleting the phrase which states, "unless the physician surrenders his/her medical license." Such a recommendation appears contrary to the intent of the draft report which attempts "to assess the educational interventions that the Medicare-funded Peer Review Organizations (PROs) direct to physicians responsible for serious quality of care problems." The phrase in question, however, implies that PROs may impose a punitive or coercive measure, rather than an educational strategy, to induce a physician to surrender his/her medical license. Deletion of the phrase "unless the physician surrenders his/her medical license" would eliminate the implication that a physician may be encouraged to surrender his or her license, and a PRO would not be required to initiate an educational intervention (based on timeliness) in situations where a license is surrendered.

**Recommendation 2** - The Health Care Financing Administration should mandate that for all confirmed Level III cases, the PRO share case information with the hospitals at which the problems occurred. That information should include the identity of the physician, the nature of the problem, and the type of educational and other interventions imposed by the PRO.

PROs should institute an approach to the notification process in sharing confirmed Level III information with hospitals that will maximize the educational impact of the program. The AMA has urged HCFA to modify current regulations so that: (1) in regard to confirmed quality problems which have been finally adjudicated by the PRO Quality Assurance Committee, the PRO is required to notify both the physician and president of the hospital medical staff in all such cases; and (2) the PRO is required to implement a mechanism to verify receipt of the PRO's notice of both potential and confirmed quality problems by the physician. We have further recommended amendments to the PRO statute: (1) to require that when the PRO review goes beyond the generic screen for intensified review, the physician must be notified within 48 hours of the exact reason for said review; and (2) to repeal the existing prohibition on the release (to a PRO proposed sanctioned physician) of documents or other information produced by a PRO in connection with its deliberations in making quality determinations. The AMA also recommends that HCFA regulations be revised to permit notification to residency training programs of a Quality Intervention Plan letter of inquiry received by a resident during participation in an accredited residency program.

Prior to confirmation of a quality problem by the PRO, notification should occur only at the request of/or with the consent of the affected

physician. The AMA opposes disclosure of unconfirmed PRO quality inquiries as this would unfairly impinge on a physician's right to privacy and confidentiality and also deleteriously affect the physician's professional reputation.

**Recommendation 3** - The Health Care Financing Administration should encourage the PROs to involve the hospitals in the planning and conduct of the educational interventions.

The recommendation to encourage PROs to involve hospitals in the planning and conduct of the educational interventions requires further specification. It is essential that a CAP apply only to the physician identified as the source of the confirmed quality problem. Evidence suggests that, in certain instances, a PRO has required all or a large portion of a facility's active medical or other professional staff to be involved in a focused CAP which should have been more precisely directed to the identified physician. The AMA stands opposed to CAPs of an intrusive and overly expansive nature. Also, in recognizing hospital involvement in the planning and conduct of educational interventions, it should be clarified that such involvement is to include the organized medical staff and not just the hospital administration.

**Recommendation 4** - The Health Care Financing Administration should instruct the PROs to give greater attention to personal meetings as an educational intervention and to explore ways of conducting one-to-one meetings between physicians with confirmed Level III quality-of-care problems and physician consultants.

The AMA supports the concept of increased personal meetings between physicians and physician consultants as a constructive educational tool. Physicians have expressed repeated frustrations at their inability to contact and meet with a physician representative of a PRO. Implementation of Recommendation 4 would be of value in mitigating these concerns.

Consistent with our view that PROs should limit their activities in developing CAPs to the identification of confirmed problems and notification thereof, as well as monitoring compliance with a CAP, we believe that the PRO should not unilaterally be involved in determining an educational CAP, providing such education or requiring the use of a specific educational program. The PRO, therefore, should not participate in any form of instructional arrangement between the cited practitioner and an independent educational program selected to remediate the problem.

**Recommendation 5** - The Health Care Financing Administration should mandate that before directing an educational intervention to a physician, the PROs take into account all prior quality-of-care problems they have identified concerning that physician.

When the PRO considers prior quality of care problems, the AMA believes that it would be useful to evaluate only those cases that relate directly to the confirmed quality problem at hand. An arbitrary review of all

previous unrelated quality questions would not serve to correct technical deficiencies in technique or procedure that have been revealed by the current Level III confirmed quality problem under scrutiny.

**Recommendation 6** - The Health Care Financing Administration should obtain and disseminate information on the effectiveness of PRO educational interventions.

PROs generally lack the expertise, resources and faculty to provide the necessary assessment, education and evaluation of those educational interventions undertaken by physicians identified in the Quality Intervention Plan. It may be appropriate, however, to monitor the referral of physicians to appropriate educational programs or institutions, as well as the evaluation by the relevant educational program of the physician's progress.

In addition, we believe that the PRO program should be redesigned to provide routine feedback to the medical community about its review findings. PROs should be required to distribute aggregate information on a regular basis to state medical societies. Provision of such educational feedback is essential to improving quality of care for the Medicare population and others. Sharing of aggregated information at the state level would enable physician organizations to identify specific areas for which educational materials or programs could be developed or provided.

**Recommendation 7** - The Public Health Service, through the Agency for Health Care Policy and Research, should provide demonstration funding for the establishment and refinement of medical education programs that seek to enhance the clinical competence of physicians through individualized assessments and remedial education.

The AMA supports funding for demonstration grants to implement the intent of Recommendation 7. Such grants should be awarded to educational institutions with the ability to provide individualized physician assessment, necessary education, and evaluation. PROs, however, should not be the recipients of such educational grants.

With respect to the comment in the draft report indicating few available educational programs for addressing medical practice deficiencies, we wish to point out areas where substantial progress has been made in the last two years. The AMA has compiled and maintains a national registry of focused/remedial education programs. A task force comprised of continuing medical education providers, licensing bodies, PRO representatives and others has been assembled to meet on a regular basis to assess progress in this area. To date, the national registry has not been contacted by a PRO or by HCFA regarding information about a specific medical education program.

In conclusion, the AMA applauds your effort to assess educational interventions of PROs as articulated in the draft report. We believe that educational CAPs which minimize undue disruption of the physician's

practice, incorporate principles of fairness and due process, and serve to truly provide an educational approach to quality intervention will best serve the interests of our patients. We would be pleased to work with HCFA and others to formulate principles and guidelines to improve the effectiveness of the PRO program in this area and thereby enhance the quality of medical care provided to Medicare beneficiaries.

Sincerely,

*James S. Todd MD*

James S. Todd, MD

JST:hl

## OIG RESPONSE TO AMA COMMENTS

We agree with the AMA that the PROs' own role in conducting educational activities should be limited. It is for that reason that we recommend that HCFA involve hospitals more in the educational activities and that PHS provide demonstration funding for medical education programs that seek to enhance the clinical competence of physicians through individualized assessments and remedial education.

With respect to the AMA's comments on each of our seven recommendations, we respond as follows:

**Recommendation 1:** In accord with the AMA's suggestion, we omitted the phrase "unless the physician surrenders his/her medical license" from the recommendation. We moved it to a less prominent place in the supporting text, not to imply that the PROs "may impose a punitive or coercive measure," but simply to clarify that an educational intervention is obviously unnecessary in cases where physicians of their own accord have chosen to surrender their license.

**Recommendation 2:** The AMA presents its position on a number of issues concerning the PRO review process, but does not comment directly on our recommendation mandating that information on confirmed Level III cases be shared with the hospitals. It does urge that HCFA take an approach in sharing Level III information with hospitals that "will maximize the educational impact of the program." Our recommendation, if implemented, would facilitate the fulfillment of that objective.

**Recommendation 3:** In accord with the AMA's suggestion, we have amended the recommendation to specify that it applies to Level III cases. As to which parties should be involved in representing the hospital, we would regard a hospital quality assurance committee as being the focal point, but look to HCFA to provide the appropriate specification.

**Recommendation 4:** We share the AMA's concern that the process of developing an educational intervention be a collaborative one. However, given the limited nature of the educational actions that we have found PROs take in Level III cases, we would not lessen the PRO's authority to determine an appropriate educational intervention or to obtain feedback concerning that intervention.

**Recommendation 5:** In calling for the PROs to consider prior quality-of-care problems involving a physician with a confirmed Level III problem, we are not at all calling for "an arbitrary review of all previous unrelated quality questions." To the contrary, we are urging the PROs to have before them relevant information concerning a physician's performance - information that can help them craft an educational intervention suited to a physician's particular needs. Such information could reveal a certain pattern of problems that could be quite helpful to the PROs and eventually to the physician. This approach is in accord with the AMA's desire



that the PROs maximize their educational impact. Accordingly, we urge the AMA to reconsider its position on this recommendation.

**Recommendation 6:** We recognize that the PROs lack resources or expertise to conduct in-depth assessments of their educational interventions in Level III cases. It is for that reason that we urge HCFA to address the issue directly by supporting research efforts and identifying ways of obtaining and disseminating information on this vital matter. This type of information is important in its own right, and should not be confused with information on the effects of more generalized efforts to disseminate practice-related information to the medical community.

**Recommendation 7:** To clarify, we do not urge that the PROs be the recipients of demonstration funding for the establishment and refinement of medical education programs. Rather, our intent here is to increase the availability of significant educational vehicles available both to PROs and physicians. Finally, in accord with the information provided by the AMA, we have added a recommendation calling for HCFA to obtain and distribute to all the PROs information about the focused/remedial education programs included in the AMA's national registry.

# APPENDIX G

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## ENDNOTES

1. The PROs must also total the weighted severity scores for each institutional provider identified as having one or more quality-of-care problems. We have excluded such providers, which, according to HCFA, account for about 20 percent of all confirmed quality-of-care problems, from the scope of this study.
2. The weighted severity score triggers specific interventions which the PRO must impose. At a minimum, HCFA requires the PROs to use the following interventions at the noted weighted triggers:

<u>Intervention</u>	<u>Weighted Trigger</u>
Notification	1
Education	10
Intensified Review	15
Other Interventions	20
Consider Coordinating with Licensing Bodies	25
Consider Recommending Sanction	25

Because the PROs must apply these interventions in a cumulative manner, a physician responsible for a confirmed Level III quality-of-care problem, which has a weight of 25, would be subject to each intervention.

3. In an October 1988 report entitled "The Utilization and Quality Control Peer Review Organization (PRO) Program: Sanction Activities" (OAI-01-88-00571), we focused on the PROs' sanction activities in some detail. One of our findings cited in that report was that conflict between the PROs' concurrent education and sanction roles appeared to undermine the effectiveness of the sanction process.
4. Physician specialty does not indicate board certification in this context. Rather, it is the specialty reported by the physician to the American Medical Association which accounts for the greatest number of professional hours.
5. Non-Federal physicians are those not employed by the Federal Government, i.e., the Army, Navy, Air Force, Department of Veterans' Affairs, the Public Health Service, and other federally funded agencies.

6. Chi-square = 14.5, d.f. = 3, and  $p < .005$ .
7. Chi-square = 55.4, d.f. = 4, and  $p < .005$ .
8. Excluding osteopaths.
9. By additional, we mean other than the confirmed Level III quality-of-care problem reviewed in our sample.
10. To describe the serious quality-of-care problems, we recorded the generic quality screen failures for each. Generic quality screens are criteria applied to the medical records for identifying events that could indicate poor quality of care. We found that the screen failures clustered in 2 of the 20 screens HCFA requires the PROs to apply: (1) care or lack of care resulting in serious or potentially serious complications, and (2) abnormal diagnostic findings which are not addressed and resolved or where the record does not explain why they are not resolved. See appendix D for more information on generic quality screens.
11. The intensified reviews ranged from the next 10 cases with a particular diagnosis or procedure to 100 percent of all cases for a three-month period. In many cases, the PRO kept a physician on intensified review for three months following the completion of the educational intervention.
12. According to this PRO, its practice of retrospective reviews prior to imposing an educational intervention has since changed, and interventions will now be imposed within 30 days following notification.
13. At that time, imposing an educational intervention could undermine the sanction recommendation by indicating the physician was willing and able to change. An amendment in the 1990 Omnibus Budget Reconciliation Act stipulates that a physician's failure to comply with a PRO's educational interventions can be considered evidence of his or her unwillingness and inability to change, thereby not interfering with the sanction recommendation.
14. PRO officials typically consider a quality-of-care problem resolved when the intensified review revealed no further problems in the quarter following the interventions.
15. Institute of Medicine, *Medicare: A Strategy for Quality Assurance*, Vol. 1, (Washington, D.C.: National Academy Press, 1990).
16. All in *Medicare: A Strategy for Quality Assurance*: F. Davidoff, R. Goodspeed, and J. Clive; "Changing Test Ordering Behavior: A Randomized Controlled Trial Comparing Probabilistic Reasoning with Cost-Containment Education," *Medical Care* 27 (1989): 45-58; J.M. Eisenberg, *Doctor's Decision and the Cost of Medical Care* (Ann Arbor, Mich.: Health Administration Press, 1986); K.N.

Lohr, J.D. Winkler, and R.H. Brook, *Peer Review and Technology Assessment in Medicine*, R-2820-OTA (Santa Monica, Calif.: RAND Corporation, 1981); S.A. Schroeder, "Strategies for Reducing Medical Costs by Changing Physicians' Behavior," *International Journal of Technology Assessment in Health Care* 3 (1987): 39-50.16.

17. Office of Inspector General, *Medical Licensure and Discipline: An Overview*, June 1986, and Office of Inspector General, *State Medical Boards and Medical Discipline*, August 1990.
18. The National Practitioner Data Bank operates under Title IV of the Health Care Quality Improvement Act of 1986 (PL 99-660).
19. This conflict has existed from the beginning of the PRO program and its predecessor, the Professional Standards Review Organization program. See *Medicare: A Strategy for Quality Assurance*, pp. 145-147, op. cit.
20. American Medical Association, *Report of the Council on Medical Education: Focused Continuing Medical Education Programs for Enhanced Clinical Competence*, (I-89).