The HSA and the PSRO: Toward a Linkage

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OUTLAYS for Federal health programs are estimated to be $28 billion in fiscal year 1976, with the costs for Medicare and Medicaid reaching $22 billion (*1*). Concern over these rising health care costs and uneven quality and access to health care has prompted the passage of new legislation. Two recently passed laws have special significance for the nation's 50 million Americans who are eligible for Medicare, Medicaid, and Maternal and Child Health Care (titles XVIII, XIX, and V) benefits. Those who provide health care and seek reimbursement from these programs are also affected.

Section 249F, Professional Standards Review, of Public Law 92–603 revised title 6 of the Social Security Act. The National Health Planning and Resources Development Act of 1974, Public Law 93–641, created new titles 15 and 16 of the Public Health Act.

Both laws set up mechanisms to help assure that public monies are not used to pay for health care that is unnecessary, of low quality, or inappropriate. Several organizational entities were created to carry out the intent of these laws, but I will focus on the relationship between only two of them—the professional standards review organization (PSRO) and the health systems agency (HSA).

Trying to define the linkage is somewhat like making snowballs out of clouds. Three years have passed since passage of the PSRO legislation and one year since passage of the HSA legislation, yet the structure is just emerging. Areas for both agencies have been designated and, while they are similar in number (each about 200) they are not coterminous. As of July 1, 1975, 105 contracts had been signed between the Department of Health, Education, and Welfare and organizations applying to be PSROs. There are no functioning HSAs.

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Yet the thrust of both agencies, their client groups, and even some of their functions are not completely dissimilar. There is an advantage in laying the groundwork for a relationship now during the current transition period before organizational rigor mortis has set in. Through a better understanding of each other's programs, both agencies could benefit from the encounter; at the least, they could learn when to stay out of the other's way. While the lack of information on operational HSA-PSRO relationships limits the defining of a discrete relationship, there is sufficient evidence to compel further study of how the two agencies can work together.

A Primer in Alphabet Soup

Health planning was not born with the passage of Public Law 93–641. The long history of health planning extends through the health and welfare planning councils and other voluntary planning agencies, hospital and health facility planning agencies and, most recently, the comprehensive health planning agencies, regional medical programs, and the Hill-Burton program.

The unique feature of the HSA is that it is intended to build upon the best features of these and other past planning programs. While the HSA will not be the only planning mechanism, it will be a major vehicle at a community level for bringing together consumers, providers, and government officials to solve health care problems. Unlike its predecessors, the HSA will have an array of implementing tools such as review and approval and development authority. If the appropriations to support them are reasonably adequate, the HSA will become a major actor in the health care community.

The purpose of an HSA is to improve the health of residents in its area by increasing the accessibility, acceptability, continuity, and the quality of health services while at the same time restraining increases in the cost of health care and preventing unnecessary duplication of health resources (*2*).

In carrying out its ambitious mission, the HSA is expected to collect and interpret health data, develop and keep current a health plan that spells out priorities among stated goals and objectives, and implement the plan by reviewing health facility and service proposals against the plan. The HSA is expected to use its limited development resources to stimulate changes that are consistent with its plans.

The basis for an HSA's actions is embodied in its printed planning documents. Annually, the HSA will prepare a statement of its mission and direction, called a health systems plan (HSP). An annual implementation plan (AIP) will be prepared to show how the goals of the HSP will be achieved. Written recommendations will be made at least every 5 years to the State health planning and development agency on the "appropriateness" of all institutional health services offered in its area. And, finally, the local HSA will annually recommend to the State planning agency medical facility changes consistent with its AIP and HSP.

Much more can be said about the HSA—its legal structure, funding, and other issues. For the purposes of this article, it is sufficient to know that the agency's influence rests mainly in its ability to encourage needed development and discourage unnecessary development with a planning document which has been exposed to public scrutiny.

A PSRO is an organization composed of physicians and other health professionals that uses the technique of peer review to help assure that the medical services paid for by Medicare, Medicaid, and Maternal and Child Health Care funds were medically necessary, meet professionally recognized standards, and are provided in the most appropriate setting. Peer review provides for a reexamination of a physician by his equals—equal in the sense they are physicians practicing in the same geographic area and in the same specialty (*3*).

The PSRO system is founded on four basic premises (*4*):

1. Peer review is the most effective means of assuring the public of accountability for the health services provided under third-party financing programs;
2. Effective quality assurance requires the establishment of a full-time system of review encompassing all facets of the health care delivery system;
3. Local community-based organizations are required to operate effective systems of peer review; and
4. Sponsorship of peer review organizations must be external to institutions in order to maintain objectivity.

In carrying out their mission, PSROs develop tools for measuring physician performance, compare actual performance with agreed upon standards and criteria, and stimulate corrective action such as continuing education when problems are encountered.

A Search for Common Ground

A PSRO and an HSA differ in several ways that should be understood by anyone attempting to develop a linkage. While both agencies are community based, they relate primarily to different audiences. PSROs are controlled by physicians. HSAs are controlled by a broad-based community board required by law to have a consumer majority. The PSRO provides a link between the physician and government and is most concerned with the individual patient. The HSA provides a link between health institutions and government and is most concerned with the community.

Both agencies attempt to improve health by controls over care delivery, but their impact under certain conditions could be counterproductive. To researchers of the health policy program in the University of California School of Medicine (San Francisco), conflict appears inevitable between the HSA's drive for efficient utilization

of existing resources and the PSRO initiatives to improve the quality of care. In a preliminary statement of issues for a study of PSRO-HSA relationships that will be completed in January 1977, the study team determined that, except in a few situations such as clearly unnecessary surgery, the objectives of improving quality and controlling costs will come into conflict (*5*). Each agency will be trying to accomplish both objectives and will be evolving its priorities. Both objectives can be satisfied only when overutilization leads to poor quality and also higher costs. Friction may also develop over the point at which cost cutting begins to lower quality.

There is little evidence to support the notion that HSAs and PSROs were developed in tandem as part of an overall strategy; in fact, there is evidence to show just the opposite. Each program came into being for different reasons, and it is only perhaps in retrospect that they are being mentioned together in the same breath as preliminary steps to national health insurance.

In a conversation with me on August 18, 1975, former U.S. Senator Wallace F. Bennett, the "father" of PSROs, clarified the fact that when the PSRO legislation was being drafted, the existing health planning agencies were not considered. "The health planning legislation was in another committee (Kennedy's) and after you've been in Congress as long as I have, you learn to respect the boundaries of different committees."

In the HSA legislation, heavy emphasis is placed on cost containment. Senator Bennett makes it clear that this was not the major intent of the PSRO legislation he sponsored (*6*):

> I challenge anyone to find anything in the legislative history of PSRO in which any intent is indicated, either directly or indirectly, that appropriate care in a proper setting should be bypassed in any way in order to save money . . . if in the final analysis the total end result of PSRO efforts is to save no money or not to moderate costs at all, but to provide professional assurance that patients are getting the right care in the right place at the right time, I think the law will have achieved its true goal.

This background is not intended to discourage formation of a relationship between an HSA and a PSRO, but to provide a basis for setting realistic expectations of what can be gained from a relationship. Because of the limited resources available to both agencies, concrete benefits will need to be identified to justify even a modest investment.

The Case for Linkage

The law mandates a relationship. Public Law 93–641 specifies that each HSA shall coordinate its activities with each PSRO in its area through data sharing, technical assistance, and mutual agreements to assure that actions taken by the PSRO in altering the area's health system are consistent with the plans developed by the HSA (*7*). Public Law 92–603, while not as specific about a bond with the HSAs, encourages a PSRO to cooperate with any public or private agency having review or control functions (*8*).

Proposed regulations for the health systems agencies, published October 17, 1975, specify areas of coordination for the PSROs and HSAs (*9*):

> (10) The agency shall seek to enter into a written agreement with each PSRO whose PSRO area is in whole or in part in the agency's service area, for the purpose of achieving coordination of their respective activities and which shall contain at a minimum, the following:
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> (i) Provision for development of a common data base and exchange of data, subject to the requirements of section 1166 of the Social Security Act;
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> (ii) Provision for review and comment of the PSRO on the HSP and AIP, especially with respect to quality of care, utilization of services and facilities, and need for new resources;
>
> (iii) Provision for technical assistance to be made available by the agency to the PSRO; and
>
> (iv) Provision to assure that actions taken by the PSRO which alter the health system will be taken in a manner which is consistent with the HSP and the AIP in effect for the area. Where an agency has been unable to enter into an agreement with a PSRO within six months from the effective date of the Designation Agreement, it shall submit a statement to the Secretary indicating the efforts that have been made to secure such an agreement and the reasons why such an agreement has not been entered into.

An HSA needs a PSRO more than the reverse due to the types of information currently available. PSROs currently review a skewed sample—only 25 to 30 percent of the population. PSRO data will continue to have major limitations until they cover more of the population and expand to other levels of care.

What may be major differences between a PSRO and an HSA to a person knowledgeable in the health field is lost on the man in the street. For him, the only thing that matters is health care of reasonable quality at a price he can afford. This overriding goal provides an incentive for staff of both agencies to search for linkages, realizing that few may have been preordained.

Exchange of information appears to be the most promising area for constructive interchange. Planners need current utilization data, including data on the Medicaid-Medicare population under observation by the PSRO. Planners need to gauge the impact a PSRO will have on the utilization of health facilities in their area as measured by such indicators as number of admissions, length of stay, and shifts in types and levels of care being utilized. With such information in hand, an HSA would be in a better position to forecast the need for hospital beds and determine the need for program services and their distribution in the community.

The Utah PSRO director, E. David Buchanan, in a conversation with me on September 25, 1975, suggested that PSRO guidelines may be of value to the HSA as it develops its strategy and re-

views proposals. As an example, guidelines for inpatient and outpatient surgery could be used to support judgments about outpatient surgical facilities. The HSA will be looking for input on the clinical state of the art, and the PSRO should provide it.

An HSA could be helpful to a PSRO in developing and maintaining baseline data for their area and in providing technical assistance for projects the PSRO determines would improve quality of care. With its broad base of community involvement and participation, the HSA represents a source of legitimacy and a base of support for unpopular actions by the PSRO.

The HSA's review of institutional health services for "appropriateness" needs to be further clarified in rules and regulations, but such reviews could be an area where the two agencies may work together to help insure that health resources were being used to promote cost containment and quality assurance.

PSROs review four types of activities—concurrent admission certification, continued stay review, medical care evaluation studies, and profile analysis (*4a*). By certifying a patient's admission when it occurs, a PSRO assures that it is medically necessary and consequently can be reimbursed with Federal funds. Two general types of criteria are used for determining the necessity of admission: (*a*) criteria specific to a particular problem, diagnosis, or procedure and (*b*) criteria which specify the types of services which should be provided at a hospital level of care.

Profile analysis is a form of retrospective review in which patient care data are aggregated and analyzed to help the PSRO evaluate its impact. The PSRO legislation requires that the agencies develop and periodically analyze institutional, practitioner, and patient profiles.

Continued stay review occurs during a patient's hospitalization and is used to determine the need for further stay in the hospital and, in some cases, the quality of care being provided.

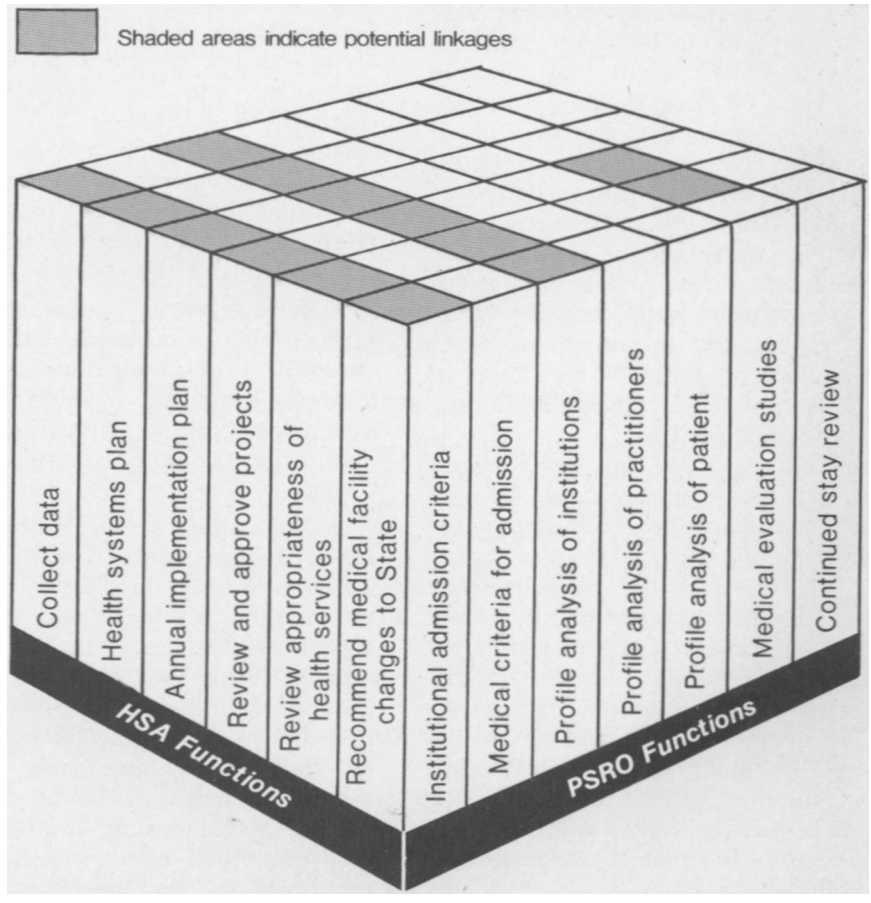
Medical care evaluation studies are a form of review in which an in-depth assessment is made of the quality and administration of health care services. They are designed to assure that (*a*) health care services are appropriate to the patient's needs and are of appropriate quality and (*b*) the organization and administration of health care support the timely provision of quality care. The results of such studies could identify needed changes in the organization and administration of health care delivery that merit consideration by the HSA.

PSROs, in preparing institutional criteria and profiles, could be aided by HSAs, according to J. Louis Schricker, Jr., MD, in a conversation with me on September 29, 1975. Schricker's perspective is unique since he not only was a founding member of the health planning agency for the Salt Lake City area (and its first president), but he also is president of the Utah Professional Review Organization (UPRO). He cited the example of an HSA assisting a PSRO by assembling data on the patterns of utilization and the levels of care within its area. Another example he mentioned was, in determining whether a critically burned patient was in an appropriate institution, the PSRO could rely partly on the HSA's analysis of secondary and tertiary care institutions.

Buchanan agreed in a conversation on October 1, 1975. "If people are in the wrong level of care we both (HSA and PSRO) ought to know about it."

Former U.S. Congressman William Roy, MD, (Kansas) was a

HSA—PSRO interface for exchange of information



principal author of legislation which preceded and formed the basis for Public Law 93-641. In H.R. 14409, Roy urged a stronger relationship between PSROs and health planning agencies than emerged in the final law. Roy's hope, as expressed in a conversation with me on October 1, 1975, was that the PSROs conduct "outcome assessments" and in other ways determine the costs and benefits of the health care being provided in their areas and share this information with the health planning agency. As a hypothetical example, if a PSRO found that hypertension screening was needed to assure a reasonable quality of care, the agency could seek the HSA's support in giving the procedure a high priority in its implementation plan. If the HSA governing board agreed that it deserved a high priority, the board could use its review authority to give preference to this procedure in projects that the board reviewed.

The interface for the exchange of information between an HSA and a PSRO might look like the diagram on page 49. Before one applies the general model to a given locality, considerable caution should be used. Even in the exchange of information with obvious compatibility, care should be taken to not violate the trust put in both agencies by those supplying the data. Data relating to individual practitioners or patients are kept in strict confidence by the PSRO, and these agencies have a general policy that no data can be disclosed except to the extent it may be necessary to carry out PSRO responsibilities (*10*).

PSROs and the agencies that will eventually make up the HSAs are only a few of the factors influencing the utilization of health care. Without a better understanding of how PSROs and HSAs impact on health care, interpretation of another agency's data should be made with a full awareness of the purpose for which it was originally collected.

The exchange of information was emphasized as a beginning point for a mutually beneficial relationship between HSA and PSRO because both agencies are required to collect information; their areas of concern, while not identical and at times conflicting, still overlap; and lastly because the fields of health planning and quality assurance are still emerging and can benefit from careful analysis and analytical tools. Data interchange should not be viewed in isolation, however, or as the sole basis for a relationship. At least the following elements could also be considered:

1. A written memorandum of understanding should be adopted by the respective governing boards. The document should, at minimum, spell out the scope of the relationship, set a fixed term, and provide for evaluation, revision, and renewal.

2. Cross-fertilization should be provided in the agencies' bylaws and administration policies. A representative of the PSRO should be a member of the HSA board and vice versa. Staff should meet regularly to share their current directions and to get to know one another's problems. Both levels—staff and board—need to interrelate since their degrees of contact and roles differ.

3. A few carefully chosen joint projects should be implemented to demonstrate mutually beneficial interaction. Exchange of information, documented as to types, sources, and utility, might be one such project.

A linkage between PSROs and HSAs is inevitable. An attitude of isolation simply does not fit with the reality of increasing public accountability and limited resources. While a formalized relationship founded on realistic expectations of what can be achieved by data interchange and other joint activities may have a good chance of succeeding, in the final analysis it will be up to those at the program level and people in the community to make the linkage viable and truly helpful. Perhaps the sober comment of Anne Somers which ends this paper should really be the watchword for those charged with developing a relationship between an HSA and a PSRO (*11*):

> For those of us who have lived through the ebb and flow of Federal enthusiasm for RMPS, CHPS, OEO Health Centers, HMO, and other acronymic nostrums, the current excitement over PSRO also conjures up a sense of déja vu. Although there is a logical relation between PSROs and health care planning and although some realignment of power within the health care establishment is inherent in the PSRO concept . . ., restructuring the system is not the primary objective. The more grandiose the aims that any specific PSRO sets for itself, the more likely it is to run into serious trouble and the less likely to accomplish the primary objective.

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