Medical Society-Sponsored Review in Montgomery County, Maryland

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Medicare's Effects on Medical Care

THE Montgomery County (Md.) Medical Society appointed a committee in early 1965 to study the impact of Medicare on the future practice of medicine, especially in the county. In April 1966, the society called a workshop meeting of nursing home directors, hospital administrators, physicians, health department personnel, and other interested people.

The medical society's leadership was eagerly accepted. A wide gap in understanding functions and roles existed between nursing home personnel and physicians, as well as between hospital and nursing home staffs. It was clear that the community physicians would be responsible for closing these gaps, and many physicians began to see Medicare as a challenge and even a new tool for upgrading and maintaining high standards of patient care.

From the workshop evolved the idea of a Medicare coordinating committee within the medical society to insure control by physicians of the flow of patients from hospitals to extended care facilities to home, nursing homes, or chronic disease hospitals. This physician responsibility cannot be delegated.

In December 1966, the Public Health Service awarded a contract to the medical society to establish and begin operating a utilization review plan for extended care facilities in the county.

Organization

The Montgomery County Medical Society has a membership of 650 physicians. The county is a rapidly growing suburb of Washington, D.C., with a population of 465,000. The four hospitals in the county have a total bed capacity of 848, and 10 of its 35 nursing homes, containing 900 beds, have been certified under Medicare as extended care facilities. All 10 extended care facilities participate in the medical society's utilization review program.

A community coordinating committee was organized as part of the Medicare coordinating committee to integrate the extended care facilities into the mainstream of medical care. This committee consists of representatives from nursing homes, hospitals, the medical society, the health department, home health agencies, and others. Meetings are held periodically to exchange information and ideas.

Small subcommittees are appointed to resolve specific problems and develop plans and procedures. For example, if problems with patient

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transfer forms exist, a subcommittee of representatives from hospitals, extended care facilities, and the medical society is appointed. This subcommittee may discuss methods for prompt transmittal of the forms and methods for obtaining adequate information about the status of the patient.

In addition, a three-physician advisory committee was appointed to arbitrate or suggest ways of settling differences of opinion that may arise from reviews or from determining fees.

Physician Review Teams

To fulfill the Medicare requirement that all cases of patients with stays of extended duration be reviewed, the Medicare coordinating committee has established procedures and guidelines for physician participation. The entire medical society membership has an opportunity to serve on the two-physician utilization review teams furnished to the extended care facilities. The composition of the teams and the facilities visited are rotated. We have found it desirable to use physicians in different specialties, as well as those with an interest in geriatrics. Because the county is large, geographic location has been considered in matching physician teams to extended care facilities. Young physicians and those who are new in the community have been frequent review team members. They often are paired with older physicians.

One facility uses its principal physician and part owner as one member of the review team. The county health department and the medical society have tried to discourage this practice with its potential conflict of interest. Obviously, the principal physician is professionally involved with many patients in that facility. Either he has undue influence on the review, or the other reviewing physician is left with the entire responsibility. From the beginning the medical society also has discouraged requests for specific physicians whom administrators may believe to be especially sympathetic toward patients in their facilities.

Ninety physicians have participated in one or more reviews. Serving on a review team once every 3 months seems to be the optimum frequency for most physicians. It is estimated that a roster of at least 100 physicians is needed to schedule reviews on a rotating basis. Continuing to bring new physicians into the program has served to educate physicians and replace physicians whose schedules temporarily preclude participation.

Review Process

The review process has evolved more from a growing background of experience and education than from an imposed structure. The first few reviews were a "feeling of the way" by both physicians and personnel of extended care facilities. As both have become more familiar with utilization review, criteria and guidelines have been established. Present at a typical review are the administrator and the director of nurses of the facility and the two physician members of the committee. Physical therapists, social service staff, and the principal physician occasionally attend meetings.

The medical records of all patients whose cases are to be reviewed are made available by the facilities. Extended care facilities also provide completed utilization review forms which contain information abstracted from the records. These forms, which are used by all the facilities, have space for review committee findings and decisions. A new form, which can be used for the first review and for possible subsequent reviews of the same patient, is being developed. The amount of information on the record varies from one facility to another. The organization of information on the records also varies, and pertinent facts are sometimes hard to find on some records. Likewise, there is a considerable difference between the facilities in the contributions staff members make to the pool of information.

A group of physicians developed the following seven questions as a background for reviews.

1. Why was the patient originally admitted to the extended care facility?
2. To what extent can the patient be rehabilitated as a result of care received in the extended care facility?
3. How much and what kind of nursing care will be needed?
4. Would the patient be able to be cared for in the custodial care nursing home?
5. What was the condition of the patient on admission to the extended care facility?

6. Has the physician seen and recorded the patient's condition, progress, and prognosis in the recent past?

7. Is there evidence of progress in the rehabilitation of the patient?

In the county a stay of extended duration is 30 days, and each facility has regularly scheduled review committee meetings to deal with this. Custodial care is defined as not requiring full-time nursing attention nor frequent medical evaluation, but requiring supervision for everyday living activities—personal hygiene, feeding, dressing, and administration of routine medications such as digitalis.

Types of patient care not considered as custodial care are the care of a patient with severe arteriosclerotic heart disease whose treatment requires trained medical personnel to adjust digitalis dosage and maintain proper fluid balance and who must be constantly watched for signs of decompensation; care of a diabetic amputee whose wound is healed and who needs diabetic regulation, fitting of a prosthesis, and training on how to walk with it and how to care for his remaining foot; or care of a patient with terminal cancer whose life expectancy is not more than a few months, who requires palliative treatment, periodic tapping to relieve fluid accumulation, and careful skin care and hygiene to minimize discomfort.

Using answers to the seven questions as a reference, the reviewing physicians apply their own judgments in making a decision. It is understood that judgments may differ. There have been disagreements between reviewing physicians, although usually the attending physician's opinion has been the deciding factor. Should disagreement remain after consultation with the attending physician, the three-member advisory committee of the medical society is called upon to resolve the difference. This has not been necessary to date.

In cases where further benefits are questioned, a reviewing physician contacts the attending physician. If the attending physician agrees, the final decision is simply noted at the bottom of the review form and signed by the review committee member. If the attending physician disagrees, he is asked to send a letter stating his reasons to the reviewing physician. The reviewing physician may then endorse the reasons and forward the letter to the appropriate facility for its permanent record. The purpose of this procedure is to discourage automatic certification as a path of least resistance.

As required by law, the patient and his family are notified if benefits will cease because of the decision made by a review committee and the attending physician. Administrators of the extended care facilities have informed patients and their families of the utilization review process, but actual membership of the review teams is kept anonymous.

Experience in Reviews

Twenty records is considered the maximum optimum number for review at one meeting. Facilities with a larger number of Medicare patients have two review meetings a month. The average time spent reviewing each record is 6½ minutes. A fee of $25 an hour for physicians on review teams has been recommended by the medical society's advisory committee. Physicians are paid by the facilities, which are reimbursed by the intermediary.

During the first 18 months of the program, 2,431 records of patients with stays of extended duration were reviewed. Some of these were repeat reviews of long stay patients. Continuation of Medicare benefits was questioned for 553, or 23 percent, and attending physicians agreed with the review teams that benefits should cease in 82 percent of these cases.

Reviewing physicians are becoming more exacting in their questions pertaining to the reasons for hospitalization and admission to an extended care facility, kinds of care and treatment required, and future plans for the patient. For example, at the beginning of the program the need for physical therapy seemed to guarantee a patient's receiving continued extended care facility benefits. Review teams are now asking more specific questions about the frequency, purpose, and kind of therapy. Occasionally, physicians have expressed the opinion that actually seeing the patient should be part of the review process.

Both physicians and facility administrators feel that the mere existence of the utilization review process has shortened lengths of stay. In addition to encouraging proper use of extended care facilities, the review process has been of

great value in physician education. It has encouraged attending physicians to visit their patients more frequently and to write more complete progress notes and reasons for recertification.

It is becoming apparent that a single criterion differentiates patients requiring treatment in an extended care facility from those requiring treatment in a nursing home—the change occurring in the patient's status during the course of his illness. This change can vary from the extreme downward trend of terminal cancer to resumption of a normal existence after recovery from a mild myocardial infarction or cardiovascular accident. A short period of observation to determine the future needs of a patient may constitute a reason for certification.

Problems Encountered

A variety of problems have been encountered; some are probably insoluble, some have been resolved, and others have been alleviated. One problem is the diminishing number of vacant beds in extended care facilities. The most recent survey of the 10 facilities indicated that one facility had five vacant beds and the others had only one or two beds or a waiting list. Many patients have remained in the extended care facilities after they no longer require the level of nursing care provided there. These patients do not receive Medicare benefits.

It has become apparent that institutions of different levels of care should be recognized. This would make it possible for patients to be moved to less intensive levels of care which would enable the provision of optimum care at the least possible cost. The flow of patients could perhaps be accomplished by agreements between extended care facilities and long term care or personal care homes in the same manner that hospitals have transfer agreements with extended care facilities.

Two community problems with no immediate solutions have been pointed up at almost all review committee meetings: first, the lack of available beds in chronic disease hospitals; and second, the need for a greatly expanded home health care program.

Transmittal of essential information at the time the patient is admitted to the extended care facility from the hospital has improved. A completed transfer form should always precede or accompany the patient. In addition, the hospital discharge summary, a valuable source of information, should be sent to the facility as soon as possible. Staffs of extended care facilities still have varying degrees of difficulty in acquiring this information, particularly from hospitals outside the county. Fifty-five percent of the Medicare patients in extended care facilities in the county are admitted from hospitals in the District of Columbia, yet few facilities have transfer agreements with these hospitals.

The problem of patient certification by physicians who are not licensed to practice in the State has developed and is expected to increase. A solution may be certification by the principal physician in an extended care facility in cases in which the family or the patient requests that he assume care of the patient. When such a request is not made, the principal physician or administrator could tell the family that under State regulation the attending physician must be licensed to practice in the State. Other referral systems could also be used.

Many physicians do not write adequate reasons for recertifying patients for treatment in extended care facilities, posing difficulties for review teams and administrators. This shortcoming is apparently widespread; the intermediaries have recently published newsletters emphasizing the requirements. Copies of the newsletter have been distributed by the medical society to all physicians in the county who have patients in extended care facilities.

During the summer, when many attending physicians are out of town for extended periods, reviewing physicians are often unable to contact them regarding further Medicare benefits for their patients. Covering physicians are reluctant to make judgments on such patients—a few refuse to work with review committees and others are unhappy about this responsibility. Attempts are being made to resolve this problem.

Although there has been marked improvement in medical records, further improvement is still necessary at some facilities. Both administrators and physicians are responsible for maintaining records which have complete and accurate information about the patient's diagnosis, condition, treatment, and progress.

Plans for an educational program for nursing home personnel of sample utilization reviews were developed by a small group of representatives of the nursing home association and the medical society. A medical standards committee composed of various specialists who will visit facilities periodically to review a sampling of records has been organized. As problems in care patterns are identified, specialists in specific fields will work with the facilities on such matters as procedures and use of equipment. One nursing home administrator remarked, "If this medical standards committee goes well, it will really upgrade nursing homes. We have doctors backing us and it makes a lot of difference."

The contract which the medical society had with the Public Health Service was extended to December 1968. The contract now authorizes developing procedures to insure prompt transfer of medical information on patients and to assist facilities with predischarge procedures such as making plans for home care. It also authorizes exploring possibilities for obtaining data to compare utilization of facilities in Montgomery County with that of areas without a community-based program.

The medical society plans to study the possibility of intermediary financing of the activities of a medical care areawide coordinating committee. This would make possible areawide standardization of procedures and utilization of facilities. It may also include further use of the committee for appeals. It is hoped that such a coordinating program will lead to a better utilization of other less costly services, such as home health care. The medical society could assume responsibility for direction of the program.

Conclusions

Both factual and speculative conclusions can be drawn from the experience of physicians and staff members of extended care facilities, hospitals, and the county health department with this community-based utilization review program.

The educational advantages of involving as many physicians as possible, serving on a rotating basis, has far outweighed possible advantages of a permanent two-physician review committee at each facility. Staffs at extended care facilities have benefited from the knowledge and experience of a variety of physicians, and physicians have become aware of their responsibilities to patients in such facilities and of the purposes of extended care. Physicians also have recognized the availability and limits of all health care agencies and facilities in the community.

The Medicare coordinating committee has helped develop cooperation among all agencies participating in patient care. This cooperation will make possible future efforts to provide an optimum flow of patients through various levels of care and to expand and improve home health care services.

The responsibility of physicians for all levels of patient care and for determining the utilization of various facilities has been recognized. There has been marked improvement in patient care because of the increased interest of physicians in developing and applying standards and policies of patient care on a communitywide basis.

The factor of change—improvement or deterioration—in the patient's condition stands out as the principal criterion in determining the need for continuation of extended care facility care. Under this broad-based and well-understood plan, medical judgments tend to become crystallized and less controversial.

In nursing homes providing all levels of care, an improvement in the quality of patient care and a greater degree of professionalism in standards and in relationships between personnel have been noted by physicians, hospital administrators, and the health department staff, as well as the nursing home administrators themselves. It is recognized that the principal physicians in extended care facilities and others with vested interests should not have a determining voice in utilization reviews.

It is possible that a community-based utilization review program can give rise to a structure within the dynamic processes of patient care so that various community needs, such as home health care, can be determined and met. This could conceivably lead, for example, to the use of community resources such as high schools, junior colleges, and hospitals for the training of paramedical personnel. The mobilization of

personnel and resources in the community could be a significant factor in decreasing the costs of medical care. Not only could patients be treated in less costly facilities, but the cost of care could be reduced by increased use of medical personnel other than physicians and of paramedical personnel.

In addition, a coordinating committee financed through the intermediaries and under the direction of the medical society could encourage more objective utilization review, achieve areawide standardization in utilization review, and keep the control of the flow of patients with physicians.

Federal Publications

Cold Facts About Home Food Protection. *PHS Publication No. 1247; reprinted 1968; 5 cents, $2.50 per 100.* Describes the need for refrigeration of food to arrest bacterial growth, thus lessening the danger of food poisoning through spoilage. Tells why refrigeration is necessary, recommends temperatures at which potentially hazardous foods should be stored, and suggests steps on the proper maintenance and use of refrigerator in food storage.

Health Statistics from the U.S. National Health Survey. National Center for Health Statistics.

THE AGENCY REPORTING SYSTEM FOR MAINTAINING THE NATIONAL INVENTORY OF HOSPITALS AND INSTITUTIONS. *PHS Publication No. 1000, Series 1, No. 6; April 1968; 19 pages; 25 cents.*

THE INFLUENCE OF INTERVIEWER AND RESPONDENT PSYCHOLOGICAL AND BEHAVIORAL VARIABLES ON THE REPORTING IN HOUSEHOLD INTERVIEWS. *PHS Publication No. 1000, Series 2, No. 26; March 1968; 65 pages; 45 cents.*

DEVELOPMENT OF THE BRIEF TEST OF LITERACY. *PHS Publication No. 1000, Series 2, No. 27; March 1968; 29 pages; 30 cents.*

PILOT STUDY ON PATIENT CHARGE STATISTICS. *PHS Publication No. 1000, Series 2, No. 28; May 1968; 59 pages; 45 cents.*

USE OF VITAL AND HEALTH RECORDS IN EPIDEMIOLOGIC RESEARCH. A report of the U.S. National Committee on Vital and Health Statistics. *PHS Publication No. 1000, Series 4, No. 7; March 1968; 13 pages; 20 cents.*

ACUTE CONDITIONS, INCIDENCE AND ASSOCIATED DISABILITY, United States, July 1966–June 1967. *PHS Publication No. 1000, Series 10, No. 44; March 1968; 60 pages; 40 cents.*

LIMITATION OF ACTIVITY AND MOBILITY DUE TO CHRONIC CONDITIONS, United States, July 1965–June 1966. *PHS Publication No. 1000, Series 10, No. 45; May 1968; 66 pages; 45 cents.*

HISTORY AND EXAMINATION FINDINGS RELATED TO VISUAL ACUITY AMONG ADULTS, United States, 1960–1962. *PHS Publication No. 1000, Series 11, No. 28; March 1968; 31 pages; 30 cents.*

OSTEOARTHRITIS AND BODY MEASUREMENTS. *PHS Publication No. 1000, Series 11, No. 29; April 1968; 37 pages; 35 cents.*

MONOCULAR - BINOCULAR VISUAL ACUITY OF ADULTS, United States, 1960–62. *PHS Publication No. 1000, Series 11, No. 30; April 1968; 30 pages; 30 cents.*

HEARING LEVELS OF ADULTS, by Education, Income, and Occupation, United States, 1960–62. *PHS Publication No. 1000, Series 11, No. 31; May 1968; 41 pages; 35 cents.*

TRENDS IN ILLEGITIMACY, United States, 1940–65. *PHS Publication No. 1000, Series 21, No. 15; February 1968; 90 pages; 55 cents.*

How to Import Pets But Not Disease. *PHS Publication No. 1766; 1968; leaflet; 5 cents, $2.50 per 100.* Provides information about Public Health Service regulations relating to importation of pets, particularly dogs, cats, monkeys, and certain birds, by families or individuals.

Legal Aspects of PHS Medical Care. A programmed instruction course. *PHS Publication No. 1468A; 1968; 86 pages; 55 cents.* A companion piece for use with a reference booklet with the same title (*PHS Publication No. 1468; 1968; 90 pages; 50 cents*), this booklet shows legal obligations and barriers that Public Health Service physicians and other health personnel face when treating patients in PHS installations. Combines explanations and test questions for easy learning by busy readers.

This section carries announcements of new publications prepared by the Public Health Service and of selected publications prepared with Federal support.

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