What exactly is the PSRO (Professional Standards Review Organization) network, and what will be its influence on the health care field? This article, prepared by the federal PSRO staff members, should answer these and other questions. The article should also help to emphasize the need for CRNA and other nursing involvement in PSRO's on a state level.

Professional Standards Review Organizations (PSRO's) came into being because of the need for our health care delivery system to provide high-quality care at reasonable cost to our country's citizens. All those involved in the system must bear a part of the responsibility for the failures of that system in the past. And, there is no doubt that while our health care system has had many successes, there also has been failure.

The cost of health care is literally approaching the limit that society can afford, and, indeed, for many has already passed that point.

Access to health services is seriously impaired, not only by its high cost, but by the maldistribution of personnel and facilities.

The quality of care is very uneven and, in too many instances, falls below what the majority of health professionals recognize as appropriate. The difference between what we know should and could be done and what is being done in many areas is wide and growing; and there is increasing evidence that our expensive health resources in manpower and facilities are inefficiently and inappropriately utilized.

PSRO can be a mechanism to help correct many of these failures. It also may be the last opportunity that those in the health professions have to monitor and discipline themselves. If those immediately involved in the system cannot correct many of the problems, then those outside the system will have to step in to protect the public's interest. And, outside interference in the practice of medicine is what health professionals would not like to see happen and what the PSRO law was designed to prevent.

PSRO's purpose

The purpose of PSRO is to provide for the systematic professional review of the necessity and appropriateness of medical care services and to assure the quality of care provided. The program, at present, is focused upon the care provided to approximately 50 million beneficiaries of Medicare, Medicaid, and maternal and child health programs. Among these groups, there are approximately 11 million hospital discharges annually from the nation's 7,000 hospitals.

What most people do not realize is that under the present delivery system, the final judgment as to what is
quality care in this country and what will be paid for is usually not a medical judgment. Those final judgments are often in the hands of intermediaries, carriers, insurance companies, and, in many instances, laymen. PSRO puts the responsibility for assuring the quality and necessity of medical care where it belongs—on the health care professionals and not on the federal government, the insurance companies, or any other outside group.

Health care professionals who will be affected by PSRO include over 300,000 physicians, 825,000 practicing registered nurses, and several thousands of other non-physician health care practitioners. A typical PSRO area, of which there will be 203, will contain 220,000 beneficiaries of the three federally sponsored programs, 1,500 physicians, and 30 hospitals accommodating 50,000 annual patient admissions among the beneficiaries whose care will be subject to review.

The potential impact of the PSRO program on the health care delivery system is great. Through the standard-setting authorities and the decisions on what care public funds should pay for, PSRO could become the long “missing link” between a new finding on what would be a superior type of care and the appropriate, expeditious, and widespread adoption of that better type of care throughout the country. Through the same process, it can rapidly eliminate obsolete or sometimes unnecessarily hazardous procedures from use. Through its standard setting, it could be the first effective tool to use in combat against the massive malpractice and defensive medicine problems.

PSRO will have major educational benefits and can assure the most rational and efficient use of the health care system. And, most importantly, it can improve quality of care.

How it works

Once an organization has received PSRO conditional designation, quality assurance programs will be implemented initially in short-stay general hospitals. Review of care provided in long-term care institutions will be phased in over a period of time. The PSRO may request authority to perform review of non-institutional care provided it is capable of meeting the review responsibilities in short-stay general hospitals.

The PSRO hospital review system is based on three interrelated review mechanisms. These are concurrent review which includes admission certification and continued stay review through discharge, medical care evaluation studies, and analysis of the hospital, practitioner, and patient profiles. This system is designed to assure on-the-spot control of the initiation of the care process, as well as retrospective evaluation studies designed to improve quality.

The concurrent review mechanism is intended to assure that the hospital admission is necessary, that the length of stay is appropriate to the patient’s diagnosis or problem, and that the discharge planning is timely and appropriate to the patient’s needs. In addition, this mechanism is designed to remove the need for retrospective claims review. Although a variety of organizational structures are possible for performing concurrent review within a PSRO or hospital which has been delegated such review, most commonly the two predominant roles are fulfilled by a non-physician review coordinator and a physician advisor working as a team.

Admission certification initially will take place within the first working day following admission for all patients who are beneficiaries of the Medicare, Medicaid, and maternal and child health programs. Continued stay review is performed on or before the last day of the initial length-of-stay assignment. Currently, continued stay review is required for all patients who receive admission certification and remain in the hospital until at least the 50th percentile of length-of-stay for patients with a sim-
Medical care evaluation studies are performed retrospectively and are specifically designed to focus upon particular potential problem areas. Medical care evaluation studies represent in-depth assessments of the quality and/or nature of the utilization of health care services by groups of patients. While in-depth in nature of assessment, they are generally of short duration. The identification of topics for medical care evaluation studies may come from a variety of sources such as the concurrent review process, analysis of profiles, or subjectively perceived instances of substandard quality or administrative inefficiency.

For the most part, medical care evaluation studies do not deal with individual patients or practitioners, but will require information related to the care provided by a number of practitioners to a number of patients. Also, some medical care evaluation studies may embrace the broader interpretation of health care evaluation studies. When these studies include the review of care provided by health care professionals other than that provided by doctors of medicine or osteopathy, the respective disciplines will be expected to participate in all phases of the study that relates to their area of practice.

Medical care evaluation studies are to be organized to ensure that the principles of peer review are upheld and the results are used to effect change in practitioner performance or the care setting that will improve the quality of care. For example, results of medical care evaluation studies may show where knowledge deficiencies exist and, thus, become the basis for developing continuing education programs to be provided in the PSRO area or in the hospital. Other medical care evaluation studies may identify needed changes in the organization and administration of health care delivery. Still others may show where the concurrent review needs to be modified or intensified. All of these possible uses of results of medical care evaluation studies should lead to alteration of patterns and bring the system closer to excellence.

Profile analysis. The third component of the review system, analysis of profiles of hospitals, practitioners and patients, will not be initiated immediately by most PSRO's, as the guidelines for profile generation and analyses are still in the development stage. However, it is believed that analysis of profiles will show patterns of care and over time changes in patterns of care and practice resulting from the other two review processes.

Norms, criteria, and standards are to be used in each type of PSRO review. Although model sets of criteria will be provided to the PSRO's by the U.S. Department of Health, Education, and Welfare, it is the intent of the law that each PSRO will be responsible for the development/adaptation/adoption of norms, criteria and standards to be used in its review system. Each PSRO will be expected to establish a mechanism for the ongoing modification of these parameters as new knowledge is gained and as data becomes available indicating need for change.

The enabling legislation, PL 92-603, specifically states that PSRO's are required to utilize the services and accept the findings of review committees in hospitals which, in the judgment of the PSRO, are capable of performing review effectively. For hospital delegation of all or some review activities, a procedure has been developed to assist the PSRO in determining where and when delegation is appropriate.

In addition, the PSRO is obliged to provide technical assistance to a hospital wishing to develop capability for performing review. After the hospital has received review delegation, the PSRO will periodically reassess its review performance as each PSRO is ultimately responsible for effective review within its area.

494 Journal of the American Association of Nurse Anesthetists
The role of nurses in PSRO's

Although the membership of the PSRO will be comprised only of licensed doctors of medicine and osteopathy performing professional activities within the geographic area of the PSRO, non-physician health care practitioners will have mechanisms for input into the organization. Non-physicians may be included on the governing body of the PSRO, but they will not be eligible to vote on issues relating to the physician practice of medicine and osteopathy.

Advisory groups are to be established to assist each statewide Professional Standards Review Council or PSRO's in states without councils. The advisory groups will be made up of non-physician health care practitioners and representatives of health care facilities within the PSRO area.

As PSRO's gain experience in performing review and as the nursing profession further develops its peer review and quality assurance programs, more extensive involvement of nurses in the overall PSRO review program will probably occur. For example, nurses may become involved in the development of criteria for admission to hospitals or other types of facilities. As methodologies for review in long-term care settings are developed, a major focus may well be the quality of nursing care provided to patients in those settings.

Initially, it appears that two areas in which nurses will participate in the hospital review system are in the discharge planning aspects of concurrent review and in medical care evaluation studies that focus upon problems where the quality of nursing care will make an impact. It is in the area of medical care evaluation studies that nurse anesthetists probably will have their greatest impact upon the peer review process. Through these studies, the quality of health care will be increased if the peer review program works as it has been designed to work.

The concept of quality assurance is really not new in nursing. The nurses' responsibility for the quality of their care dates back to the days of Florence Nightingale. Her guidelines for the practice of nursing might be considered the criteria against which one could measure the quality of nursing care. Most of the major studies on quality of nursing in the United States have been conducted by nurses. And certainly, at the grass roots level, it has been nurses who evaluated the care provided by other nurses—but, traditionally, within a hierarchical structure where the evaluator occupied at least a higher authority position than that of the nurse being evaluated.

It is clear that, while much effort has been expended and considerable progress has been made, nursing is still in the infancy stage in development of nationwide, sophisticated quality assurance programs. There are many forces impelling all health care professionals to establish visible and effective programs that demonstrate accountability for and commitment to quality in the care or services provided within their respective disciplines.

Conclusion

PSRO is an orderly mechanism through which all medical care will be assessed by the medical profession. For the first time, with PSRO, the profession will know what is going on and why it is going on—not only in an individual institution, but in an entire area for which it is responsible—and, in addition, be able to bring about changes where they are appropriate.

Quality assurance is ultimately the best investment this nation can make in health care. Through efforts such as PSRO, the health professionals of this country can provide the best possible medical care in the most efficient and economical setting to all who are in need of it.