1974-04

P/S/R/O update: April 1974 no. 2

Number 2
April/1974

P/S/R/O Update

From Boston University Medical Center

Questions and Answers About PSROs and Foundations

Q: Does the PSRO law mandate that physicians join a PSRO?

A: Public Law 92-603 states that PSROs must be non-profit corporations, with membership open to any physician or osteopath in the geographically designated area. There are no associated dues or fees. To be designated as a "planning" PSRO, an organization must show evidence of the potential to represent at least 25 per cent of the physicians and osteopaths in the area. For designation as a "conditional" PSRO, an organization must actually represent at least 25 per cent of the physicians and osteopaths in its area.

The law also makes clear that, whether or not a physician or osteopath is a "member" of a PSRO, the PSRO will nevertheless monitor his care of Medicare, Medicaid and Maternal and Child Health patients.

Q: What advantages are there to joining a PSRO voluntarily?

A: Although no physician or osteopath must join a PSRO, it would be to his advantage to do so. The advantages include (1) involvement in committees that will establish standards of practice, criteria and retrospective audit; (2) involvement in appeals and policy decisions; and (3) involvement in contractural arrangements with the Department of Health, Education, and Welfare and other state and federal agencies.

Q: In Massachusetts, it appears that Foundations for Medical Care are actively engaged in forming the state's five PSROs. Must physicians join a foundation ? If membership is voluntary, what advantages exist?

A: No physician must join a foundation, although, again, membership is clearly to his advantage, especially if the foundation in his area enters into contractural arrangements to monitor medical care with, in addition to the federal government, other third-party payers, such as Blue Shield/Blue Cross. (It should be noted that PSROs may also enter into such arrangements.) In addition, foundations may initiate HMOs and other group-practice approaches.

Q: Assuming that a physician's office and hospital practices overlap designated PSRO areas, to which PSRO(s) does the physician relate?

A: At the time of writing, no clear answer is available. Federal regulation eventually will provide the answer.

PSRO Contracts: Timetable

Announcement of the final PSRO area designations March 14 was the last step prior to acceptance of contract bids by the Office of Professional Standards Review (OPSR). Three types of contracts are to be awarded:

- Planning contracts of about six-months' duration to groups requiring assistance in developing a formal plan to qualify as a conditional PSRO.
- Conditional-designation contracts of up to 24-months' duration to organizations that already have formal plans and could qualify as conditional PSROs.
- Statewide PSRO Support Center contracts to organizations that can demonstrate expertise in providing professional, administrative and technical support for standards-setting and peer-review activities by local PSROs. Support Centers will be primarily responsible for getting the PSRO program underway in each state, including educating and assisting physicians on the operation of PSROs.

The timetable for these contract applications indicates that requests for proposals (RFPs), which should have already been requested by each foundation office, must be received by the OPSR by April 30.

It is expected that the review period will extend until about May 20, with the review process being carried out both by the OPSR and the PSRO "focal-point" individuals in HEW Regional Offices. William Beck, Ph.D., serves as focal point in the Region I office. His address: John F. Kennedy Federal Building, Room 1400, Government Center, Boston, MA 02203. Telephone (617) 223-6863.

Confidentiality and PSRO/pg. 3

Local Information

Health Care Foundation of Western Massachusetts, Inc.
1414 State Street
Springfield, MA 01109 Tel. (413) 736-7148
Robert LaMarche, M.D., president
Vivian Purdy, executive director

Central Massachusetts Health Care Foundation, Inc.
390 Main Street
Worcester, MA 01608 Tel. (617) 753-1579
James Cosgrove, M.D., president
Joyce S. Forbes, executive director

Charles River Health Care Foundation, Inc.
2000 Washington Street
Newton, MA 02162 Tel. (617) 527-4120
Richard C. Kerr, M.D., president
Lewis S. Pilcher, M.D., executive director

Bay State Foundation for Medical Care, Inc.
100 Charles River Plaza
Boston, MA 02114 Tel. (617) 723-9443
Robert J. Brennan, M.D., president
Richard Kahan, executive director

Pilgrim Foundation for Medical Care, Inc.
Route 28 Office Building, P.O. Box 676
Middleboro, MA 02346 Tel. (617) 947-4358
Samuel Stewart, M.D., president
Paul Egan, executive director

PSRO Contracts: Requirements

Planning contracts will require a group to design a formal plan for assuming the duties and functions of a PSRO in a designated area. The plan will have to include a formal review system, including peer review, to assess medical care, and organizational structure and membership requirements to carry out the plan in conformance with federal guidelines. To be eligible for a planning contract, a group must meet these requirements:

1. Be a professional physician association whose membership is open to all M.D.s and doctors of osteopathy licensed to practice in the PSRO area.

2. Be legally incorporated as a nonprofit organization by the time the contracts are scheduled to be awarded.

3. Have a membership representative of the physicians in the area.

4. Have a membership comprised of at least 25 per cent of the physicians in the area or be able to demonstrate the potential to obtain this membership level before conditional designation as a PSRO.

Although more than one organization in a PSRO area may apply for a planning contract, only one organization will utimately be designated as the conditional PSRO for that area.

Conditional contracts will require an organization to implement a system for reviewing the quality, necessity and appropriateness of medical care provided Medicare, Medicaid and Maternal and Child Health program beneficiaries. To be eligible for a conditional-designation contract, an organization must meet the first three requirements above, plus these:

4. Have a membership comprised of at least 25 per cent of the physicians in the area.

5. Have developed an acceptable formal plan for the gradual assumption of review operations, including:

a. Development and initiation of review in short-stay hospitals.

b. Timetable for phasing in review of long-term-care institutions.

c. Performance by the organization or by the hospitals given review authority of retrospective medical-care evaluation studies.

d. Development of a mechanism by which review findings can be integrated into exisiting programs of continuing medical education.

e. Plan for evaluation of the in-house review capability of all hospitals performing review in the PSRO area.

f. Plan for the involvement of nonphysician health-care practitioners in the PSRO's review system.

PSRO Center at BUMC

Boston University Medical Center (BUMC) has been working actively with a number of Foundations for Medical Care in Massachusetts to help implement applications for planning of conditional PSRO contracts. This role was defined in a grant from the Tri-State Regional Medical Program for technical assistance and continuing education in the planning and development of PSROs in the Tri-State region (see ***PSRO Update No. 1*** for further details).

All of the Massachusetts FMC offices have been made aware of BUMC's capability for technical assistance in the writing of contract applications. The PSRO Manual has just been released by the Federal Office of Professional Standards Review; BUMC's PSRO Center intends to make ample supplies available to interested parties.

For further information about BUMC's role in PSRO assistance, please contact Daniel S. Bernstein, M.D., Boston University Medical Center, 720 Harrison Avenue, Suite 203, Boston, MA 02118. Telephone (617) 247-1973.

Focus: PSRO Data, Confidentiality and the Law

by Jean Rabinow, J.D.

(The author is a research associate in health-services research, Boston University Medical Center, and a member of the technical-assistance component of BUMC's PSRO Center. The following is offered as an introduction to some of the issues involved in implementation of the PSRO law and does not constitute legal advice. — Editor)

To most people, "confidentiality" connotes secrets kept — information given and received on the understanding that the recipient will not impart it further.

This is not its definition either in a court of law or in an administrative agency. To an administrative agency, "confidential" means "not routinely open to public review;" to the courts, "confidential" means "not automatically admissable into evidence during a trial."

Reconciling these definitions with the popular understanding will be one of the major tasks facing most PSROs.

Despite the popular belief and the physician's promise in the Hippocratic oath, it is simply not true that anything a patient says to his doctor is protected from legal scrutiny. **The law protects patients' confidences only from invasion by private parties who have no legally-sanctioned right to know what was said or done.** Anyone who has a legal claim to learn the truth may compel its disclosure. Who has such rights?

- First and foremost, the patient himself. Confidentiality (as it is understood in law) is a privilege that belongs to the patient and the patient alone. If he wants to find out what information is contained in his medical record, he may (usually, by bringing a motion at a trial) compel the doctor or hospital to disclose it to him. No patient can compel disclosure of another patient's record without express permission from that patient, even if the doctor were willing to discuss the case, for the same reason: The privilege of confidentiality is personal to each patient.

- Second, the state, acting pursuant to a constitutional statute. "The state" includes state and federal governments and, of course, acts through its administrative agencies. Some of the disclosures demanded by the Commonwealth of Massachusetts include reports of gunshot and certain kinds of stab wounds, venereal and other contagious diseases, and drug addiction. The federal government collects certain medical data in accordance with the Social Security law. And the police, which is, after all, a state agency, can collect information on any subject it wants, if it can get a warrant by satisfying a judge that such information exists and would be useful in uncovering a crime or leading to an arrest. When the state is the party exercising its legal rights, the patient's desire for confidentiality may be as unavailing as the doctor's.

- Third, the patient's agents. Anyone who is acting on the patient's behalf and on his authority may force disclosure of his medical record. Such agents may include lawyers, insurance carriers (third-party payers), and other physicians or hospitals to which the patient has gone for treatment. Usually such agents will have secured a signed release from the patient before they ask for the information, but, if they have actual authority, a signature is not absolutely necessary.

The PSRO law. It is against this background that one must judge the PSRO law's sections on record-keeping and confidentiality. The following discussion will consider what the law says, what it means in action, and how it may affect the practices and review activities of the physicians involved.

Section 1166 of section 249F of Public Law 92-603 basically empowers the Secretary of HEW to set the rules on when and under what circumstances a patient's records and PSRO profiles may be divulged. In those cases for which no rule is promulgated, the records "shall be held in confidence," which means only that, unlike most records collected at government expense, PSRO records shall not routinely be made available for public inspection.

Because the regulations necessary under section 1166 have not yet been promulgated, it is impossible to determine to what extent PSRO data will be considered confidential. The law itself sets few limitations on the agency's discretion.

Certain facts are clear, however. The presumption that gathered information shall be confidential does not apply in two situations: first, where PSROs or the federal PSRO administration need the information to carry out the work of review; and, second, where the Secretary of HEW permits the data to be released to other organizations (inside or outside HEW) or used within the PSRO system for purposes other than PSRO review.

To what information does this law apply?

Simply: hospital charts and whatever records the PSRO itself generates. While the PSRO law permits the reviewing group to look at as many records of as many types as it desires, the only records it must screen are the inpatient charts of patients whose hospitalizations are being paid for by the Medicare, Medicaid or Maternal and Child Health programs.

This means that individual physicians' office records, hospital charts for privately insured and uninsured patients, and, at least initially, hospital outpatient charts are not going to be regularly reviewed.

"Profiles." PSROs are required to keep a summary sheet on every hospital, patient and doctor involved in the program. In this way, reviewers can spot check to see that each doctor's hospital practice at least approaches the area norms, that each patient is not abusing the system (for instance, by hopping from hospital to hospital and doctor to doctor), and that each hospital provides reasonable service within a reasonable length of time. These summaries are called "profiles."

The initial profiles will probably be short and incomplete, but as the PSROs' computers become more sophisticated the data will become more reliable. The dangers of harm to the

patient or physician are just as great, if not greater, in the early stages, however, because wrongful disclosure of incomplete information may do as much or more harm as wrongful disclosure of the truth.

A PSRO patient's chart will probably be seen by the physician, those people in the hospital who would normally see the chart, and the PSRO initial screener (either a trained paramedical person or a nurse). Normally, the screener would fill out an abstract suitable for rapid review, either by computer or by humans, and return the chart into its normal hospital path. If, however, a question arises about the suitability or medical necessity of treatment, both the record and the abstract might additionally be seen by the hospital's review board, if any, the PSRO's review-and-appeals board, and even a state or federal reviewer.

While this seems initially to be a large number of individuals, it is worth remembering that whenever a physician treats a patient in the hospital, the chart is likely to be seen by at least the following people: the nurses, other physicians (consultants, house staff), students who are following the case in the course of their medical training, and, if the hospital has a utilization-review committee, the UR initial screener and possibly the committee itself.

The only thing that PSRO will add is a slightly increased number of subsequent reviewers. As a result, the risk of information about patients being leaked is only slightly increased. This will remain true even if the Joint Commission on Accreditation of Hospitals decides to demand that hospitals institute medical audits to maintain their accreditation, or if Blue Cross/Blue Shield determines that medical audit will be a requirement in future contracts negotiated with member hospitals, and, as a result, larger numbers of charts are screened.

Single reviews? Of course, if these other organizations demand record review, they may or may not depend on PSROs to be the reviewing organizations. The PSRO law permits the PSROs to contract to do such work, and from a practical point of view it makes sense for hospitals and medical practitioners to have all their auditing done by a single organization. It is therefore likely that, within a very short time, PSROs may be doing more record review than the law requires as a minimum.

If the PSRO does more than the minimum the law requires, neither it nor its reviewing physicians should get into trouble. Almost anything that the PSRO does during its record review is protected, whether or not that work exceeds the required minimum.

The law's protection does not extend to willful misuse of the data, however. If a record reviewer reveals data to any person to whom the data should not be revealed, that reviewer can be fined up to $1,000 or jailed for six months, or both. This means, clearly, that record reviewers will have to know exactly which people and organizations are entitled to get what information. The penalties also mean that there will be less temptation to make unauthorized breaches of confidentiality than there might otherwise be.

The protections and penalties which the law supplies apply to unauthorized disclosure of PSRO-generated records as well as to patients' records to which the PSROs have access. There will be two primary classes of PSRO-generated records: hospital profiles and physician profiles. Neither type has ever existed before, outside of some limited academic and research efforts, and it is, consequently, somewhat difficult to foresee how they will be used or misused once they come into being.

Nevertheless, because the PSRO law says that all records shall be confidential unless otherwise provided for, the chances are good that HEW will limit access to hospital and physician profiles, even though a person looking at such records will not be able to identify specific patients on the basis of what the profiles contain, and despite the fact that the common law has traditionally ***not*** protected the doctor's interest in keeping his "success rate" unpublished.

Override improbable. Furthermore, it is unlikely that a court would override HEW's decision to restrict access, even if a litigant appeared who could actually make use of the material in the profile.

Such litigants might include, for example, a patient who was suing for malpractice. The question in such a case would become: What PSRO data could be used in court as evidence?

At this point, of course, it is impossible to speak definitively. It is possible that overall profiles of area practice might be introduced to show the jury what the area standard of practice is, but it is extremely unlikely that an individual physician's profile would be allowed in as evidence. The reason for excluding the individual profile is that evidence of past acts is not proof that the act that is the subject of the suit took place in the same way. This rule cuts both ways: if the patient cannot use the profile to prove past negligence, the physician cannot use his profile to demonstrate his previous high standards.

The same arguments that would keep physician profiles out of evidence (i.e., that the PSRO law raises a presumption of confidentiality and that they are not probative of the facts at issue) will probably keep hospital profiles out of court as well, in those cases where the hospital gets sued. But, it must be repeated, it is impossible to make any definitive statements until the regulations are announced and the first cases are litigated.

Threat? Does PSRO review present a real threat to confidentiality?

Considering how little protection pre-PSRO law actually has given to patients and doctors, probably not.

Remember that all third-party payers, private as well as governmental, have the right to inspect patients' records. Under the normal rules of the common law, Medicare, Medicaid and Blue Cross/Blue Shield are the patient's agents and have the same right to see his record as he does, assuming he gives them the authority to do so. In the case of Blue Cross or any other private insurer, the authority is written and specific: The patient's contract with the insurer contains a blanket release permitting the insurer to look at whatever part

of the patient's medical record it wants to, for any purpose reasonably relevant to the general agreement to provide coverage. In the case of PSROs, which will review charts for Medicare and Medicaid, the source of authority to review records is not merely the common-law agency doctrine, but rather the congressional mandate of section 249F. Assuming, as I believe we can, that Congress has passed a constitutionally valid law, no further justification is needed.

Similarly, nothing in the pre-PSRO common law would have prevented third-party payers from compiling profiles of participating physicians out of the data to which they have access, should they have so desired.

Therefore, to the question, "Will the PSRO law's provisions on confidentiality result in increased liability to physicians?" the answer may well be "No."

As regulations are issued and positions clarified, we will continue to keep you posted.

Nixon's CHIP Enters the Lists

President Nixon's Comprehensive Health Insurance Plan (CHIP), currently before Congress, is composed of two major sections: The Employee Health Insurance Plan (EHIP) would require all employers to offer coverage to all employees under the age of 65, through a third-party carrier; the Assisted Health Insurance Plan (AHIP) would replace nearly all of Medicaid.

Under EHIP, the employer contribution would be 65 per cent of premium expenses for the first three years of the plan, and 75 per cent thereafter. (However, if an employer's payroll rises by more than three per cent as a result of the required EHIP contributions, the federal government would subsidize these excess costs, beginning with 75 per cent of the excess during the first year and decreasing by 15 percentage points each following year.) The plan would also be available to self-employed and nonworking families, individuals and nonemployer groups (e.g., unions or professional associations), through private carriers.

Under AHIP, states would contract with intermediaries to offer the basic plan to all residents of the state, except those with family incomes in excess of $7,500 or more who are offered the EHIP. Persons who would, in fact, enroll in AHIP include: families below $5,000 income and individuals below $3,500 income, regardless of work status; nonworking families between $5,000 and $7,500 income and nonworking individuals between $3,500 and $5,250 income; very high-risk working families and individuals in the same income categories as the immediately preceding group; nonworking families with unusually high medical risks, regardless of income; and unusually high-risk employer groups.

The CHIP benefit package is a wide-ranging one, including hospital and physician services, out-of-hospital drugs, mental-health services, special and preventive services for children, prenatal, maternity and family-planning services, home-health services, post-hospital extended care, blood and blood products, and certain other services, as in Medicare — prosthetic devices, dialysis equipment and supplies, x-rays, laboratory services, ambulance, etc. Medicare would be retained, but in a broadened sense.

There would be deductibles and coinsurance, with a maximum liability per family of $1,500. All participants would be issued a Healthcard as evidence of financial protection for all covered services.

Whose Responsibility?

At press time agreement was imminent within HEW concerning delegation of PSRO program responsibilities to various agencies. Overall direction of the program will reside with the Office of Professional Standards Review, a part of Assistant Secretary for Health Charles Edwards' operation. The Social Security Administration will control primarily fiscal matters. The Medical Services Administration (Medicaid) and the Bureau of Quality Assurance, part of the Health Services Administration, will also share in the operational tasks. This arrangement was said to have been brought about through the efforts of the two senior members of the Senate Finance Committee, Russell Long (Dem.-La.) and Wallace F. Bennett (Rep.-Utah), the author of the PSRO law itself.

Repeal and Nonparticipation

A number of actions around the nation recently have given the movement to repeal the PSRO law some momentum.

In Illinois, the State Medical Society's House of Delegates voted in February for the society "to work effectively and vigorously towards the repeal of the PSRO provision of Public Law 92-603."

On March 6, the California Medical Association House of Delegates called for an outright repeal of PSROs, but did not take an official position of nonparticipation.

The New York State Medical Society's House of Delegates in early March passed a moderate resolution that calls for amendment of some allegedly objectionable features of the law.

Statewide groups in Texas are attempting to block the inclusion of the Texas Institute for Medical Assessment in PSRO activity.

Interview: OPSR Chief Henry E. Simmons, M.D.

The nations's PSRO program has a potential for good that is "unparalleled," according to Henry E. Simmons, M.D., director of the federal Office of Professional Standards Review. Simmons was in Boston recently for an HEW Communications Seminar and was interviewed exclusively for ***PSRO Update.***

Simmons reported that the program is now moving into an operational phase. It provides, he said, "a real opportunity for the profession to maintain the control of medical practice in the hands of the professionals and to do the job that the public expects us to do in their behalf."

The OPSR director, an internist who did his postgraduate training in Boston and practiced for several years in Lexington and Boston, stated that he "absolutely" believes in the PSRO program.

"I honestly believe that the potential it has for good is unparalleled," he said. It can "help resolve some of the problems that exist in the system: not just in utilization of our resources — that's just part of our responsibility. The program has at least as great a potential in education, in examining why we do what we do in medicine, in doing studies that develop better ways to do it, and in disseminating useful, appropriate innovation much more rapidly into the medical-care system than we do now. It can cut down defensive medicine, it can be an effective tool against the malpractice problem, and it has a variety of possibilities much greater than just utilization-review activity."

A wiser course. In prepared remarks delivered to media representatives after the interview, Simmons said that, in his view, "It would have been wiser if the Congress had legislated a demonstration-type PSRO program so that we could all gain some experience and iron out some obvious problems" before undertaking a nationwide program. But he indicated his enthusiasm for directing the full-blown program immediately.

Simmons indicated in the interview that PSRO is the "bedrock" upon which President Nixon intends to build his Comprehensive Health Insurance system, recently submitted to Congress.

"Whatever care is paid for and delivered under Comprehensive Health Insurance will be part of the responsibilitiies of PSRO," Simmons noted. Such care would have to meet the three tests of the PSRO approach: that the care was necessary, given in the appropriate setting and met appropriate standards. "If that does not occur, then corrective action will be taken with the profession, by professionals, to see that the deficiencies are corrected and to understand why the care differed from standards."

Continuing medical education would also be improved as a result of the PSRO program, according to Simmons.

"PSRO identifies real-life problems," he said, "and that's what education is all about: dealing with real-life problems, with decent data, with outcomes that you can measure, and with bringing about change. PSRO may finally be the effective way to make continuing education work."

Simmons left a message for Massachusetts physicians:

"Simply stated, the PSRO program is a reasonable program, one that will be reasonably administered, and it has the potential for having a greater favorable impact on medical care in this country than anything that has preceded it."

Simmons, in addition to his responsibilities as OPSR director, also serves as deputy assistant secretary for health of the Department of HEW.

Preadmission Certification Reborn?

When the PSRO Manual is published, the Preadmission Certification section may cause a controversy similar in intensity to that brought about by the proposed Utilization Review regulation which became such a cause celebre in February. In that instance, Assistant HEW Secretary for Health Charles Edwards, with President Nixon's intervention, teamed up with the AMA to defeat Secretary Caspar Weinberger's proposal that hospital admissions of Medicaid, Medicare and Maternal and Child Health patients be certified in advance.

Nevertheless, the guideline in the forthcoming manual will say, "When concurrent certification of elective admissions fails to prevent medically unnecessary admissions, admissions would be certified prior to the admission. In addition, in most instances, the patient should be seen by a physician other than the attending physician to obtain an independent assessment of the patient's need for admission."

The PSRO National Advisory Council has termed the requirement for a second opinion "onerous and impractical" and asks that it be deleted. However, OSPR Chief Henry E. Simmons has indicated that it will remain in the guidelines.

Five PSRO Areas Designated

According to the March 18 ***Federal Register***, five PSRO areas have been designated for Massachusetts, comprised of the following cities and towns:

AREA I

Chester
Huntington
Westhampton
Northampton
Hadley
Amherst
West Stockbridge
Stockbridge
Lee
Becket
Alford
Great Barrington
Tryingham
Monterey
Otis
Blandford
Russell
Montgomery
Westfield
Southampton
Easthampton
Holyoke
South Hadley
Granby
Chicopee
Ludlow
Belchertown
Ware
Palmer
Warren
Egremont
Mount Washington
Sheffield
New Marlborough
Sandisfield

Tolland
Granville
Southwick
West Springfield
Agawam
Springfield
Longmeadow
East Longmeadow
Wilbraham
Hampden
Monson
Brimfield
Wales
Holland
Royalston
Athol
Phillipston
Petersham

Williamstown
Clarksburg
North Adams
Adams
Monroe
Florida
Rowe
Heath
Colrain
Leyden
Bernardston
Northfield
Warwick
Orange
Savoy
Charlemont
Hawley

Buckland
Shelburne
Greenfield
Gill
Erving
Hancock
New Ashford
Cheshire
Windsor
Plainfield
Ashfield
Conway
Deerfield
Montague
Wendell
New Salem
Lanesborough
Dalton
Hinsdale
Peru
Worthington
Cummington
Goshen
Chesterfield
Williamsburg
Whately
Hatfield
Sunderland
Pelham
Pittsfield
Richmond
Leverett
Shutesburg
Lenox
Washington
Middlefield

AREA II

Winchendon
Ashburnham
Ashby
Townsend
Lunenburg
Hubbardston
Princeton
Leominster
Lancaster
Shirley
Harvard
Ayer
Barre
Rutland
Holden
Sterling
West Boylston
Clinton
Bolton
Berlin
Northborough

Hardwick
New Braintree
Oakham
Paxton
Worcester
Shrewsbury
Westborough
West Brookfield
North Brookfield
Brookfield
East Brookfield
Templeton
Gardner
Westminster
Fitchburg
Spencer
Leicester
Auburn
Millbury
Grafton
Upton

Sturbridge
Southbridge
Charlton
Oxford
Dudley
Webster
Douglas
Sutton
Northbridge
Uxbridge
Mendon
Millville
Blackstone
Boylston
Dunstable
Pepperell
Groton
Westford
Littleton
Medway
Bellingham
Franklin

AREA III

Hudson
Sudbury
Wayland
Weston
Waltham
Newton

Needham
Wellesley
Natick
Sherborn
Marlborough
Southborough

Framingham
Ashland
Hopkinton
Holliston
Milford
Hopedale

AREA IV

Amesbury
Salisbury
Merrimac
Haverhill
West Newbury
Newburyport
Newbury
Groveland
Georgetown
Methuen
Rowley
Dracut
Tyngsborough
Chelmsford
Lowell
Tewksbury
Andover
North Andover
Lawrence
Boxford
Ipswich
Middleton
Topsfield
Hamilton
Essex
Gloucester
Rockport
Wenham
Beverly
Manchester
Danvers
Peabody
Salem
Marblehead

Swampscott
Lynn
Nahant
Saugus
Lynnfield
North Reading
Reading
Wilmington
Billerica
Carlisle
Bedford
Burlington
Lexington
Woburn
Stoneham
Winchester
Wakefield
Melrose
Malden
Medford
Everett
Chelsea
Revere
Winthrop
Somerville
Cambridge
Arlington
Belmont
Watertown
Brookline
Lincoln
Concord
Acton
Boxborough

Stow
Maynard
Boston
Dedham
Milton
Quincy
Randolph
Braintree
Holbrook
Weymouth
Hingham
Cohasset
Hull
Westwood
Dover
Medfield
Millis
Wrentham
Norfolk
Foxborough
Plainville
North Attleborough
Norton
Taunton
Raynham
Mansfield
Attleboro
Berkley
Dighton
Rehoboth
Seekonk
Freetown
Norwell
Scituate

AREA V

Norwood
Walpole
Canton
Sharon
Stoughton
Avon
Easton
Brockton
Abington
Rockland
Hanover
Whitman
Hanson
Pembroke
Marshfield
Duxbury
Kingston
Halifax
East Bridgewater
West Bridgewater

Bridgewater
Middleborough
Lakeville
Plympton
Carver
Wareham
Rochester
Marion
Plymouth
Bourne
Sandwich

Falmouth
Mashpee
Barnstable
Yarmouth
Dennis
Harwich
Brewster
Chatham
Orleans

Wellfleet
Truro
Provincetown
Gosnold
Gay Head
Chilmark
West Tisbury
Edgartown
Oak Bluffs
Tisbury
Mattapoisett
Acushnet
Fairhaven
New Bedford
Dartmouth
Westport
Fall River
Somerset
Swansea
Eastham
Nantucket

$58 Million More Requested for PSROs

Congressional committees are currently weighing the appropriation of some $58 million for PSRO development in fiscal 1975. The proposed funding, part of President Nixon's federal budget package, would be added to the $34 million appropriated in 1974 for the establishment of 120 provisional PSROs by June, 1975.

The projected PSRO outlays are contained in the funding proposal of Dr. Charles Edwards, HEW assistant secretary for health. Of the $58 million, some $27 million would be transferred from Social Security trust funds. The proposed amounts averages out to about $750,000 for each of the 120 conditional PSROs. It is planned, however, to fund about 20 PSROs that are close to operation with a majority of the allotment; the remaining organizations would receive lesser amounts for development. Roy Ash, director of the Office of Management and Budget, had originally estimated a figure of $300,000 per PSRO.

HEW's Office of Professional Standards Review (OPSR) has 186 projected postions, while 130 more are envisioned for HEW's regional offices.

Upcoming Meetings

The regional conference of the American Association of Foundations for Medical Care (AAFMC) will take place May 3-5 at the Marriott Motor Hotel, Newton. The fee is $75 for members of an FMC and $100 for non-FMC members. Registration should be mailed to AAFMC, P.O. Box 230, Stockton, CA 95201.

HMOs will be the subject of a special conference sponsored by the Medical Administrative Technology Service of the AAFMC May 6-7 at the Statler Hilton in Washington, D.C. Topics will include an overview of the HMO law and a specific crtique of the HMO regulations. For further information please contact the AAFMC at the above address.

Boston University Medical Center presents a symposium on the **Federal Role in Health Care.** Panel members are expected to include representatives of the Senate Finance Committee and the Senate Committee on Labor and Public Welfare, and Dr. Patrick O'Donaghue of the Policy Center, Inc. of Denver. Saturday, May 11 from 9:30 to 11:30 a.m. in the Chester Scott Keefer Auditorium, University Hospital, 75 East Newton Street, Boston. For further information please contact Daniel S. Bernstein, M.D., at (617) 247-1973.

Selected Problems in Trauma is the subject of a two-day postgraduate course at Boston University Medical Center Monday and Tuesday, June 3 and 4. A fee of $60 covers the course and two luncheons. For further information please contact Dr. Bernstein at the above number.

P/S/R/O Update

From Boston University Medical Center

Published by Boston University Medical Center to update Massachusetts physicians on the development of Professional Standards Review Organizations (PSROs) and related trends in the practice of modern medicine. Publication is supported by a grant from Tri-State Regional Medical Program.

Communications officer
Lawrence M. Strum

Senior editors
Donald R. Giller, Owen J. McNamara

For additional copies contact:
Office of Communications
Boston University Medical Center
720 Harrison Avenue/Suite 203
Boston, MA 02118
Telephone: (617) 267-3611

Nonprofit Organization
U.S. POSTAGE
PAID
Boston, Mass.
PERMIT NO. 56031