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What Utilization Committees Taught Us

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Utilization committees can help doctors to understand how they use hospital beds and also lead to better utilization practices and improved liaison between the medical staff and administrator, Western Pennsylvania hospitals report

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SOMETIMES we speak loosely of hospital bed utilization by the population, giving the impression that patients utilize the beds. Of course, this is not entirely accurate. Physicians utilize the beds; patients lie in them. And a patient cannot have the privilege of lying in a hospital bed unless so ordered by a physician who has the extremely valuable privilege of giving this order.

Patients can, of course, bring pressure on physicians to admit them to hospital beds, but the decision rests with the physician. Similarly with discharge, the physician almost always makes the decision that determines the end of the bed utilization episode.

Most physicians don't yet know very much about their utilization practices. Medical practice has many dimensions, each with a wide range of variation among physicians. Of these, utilization is one of the newest. Today, it is still largely the unknown dimension.

Ask the members of a hospital's medical staff who is the fastest in the operating room. They will know. They will know who are the best diagnosticians. They will know which have the best bedside manner. But ask which ones tend to keep patients in the hospital the longest, and they will either plead ignorance or make uninformed guesses.

Approaches to utilization control must involve direct or indirect efforts to influence the physician's judgment and decision on admission and discharge. The utilization committee concept is based on the assumption that a most important method of influencing the physician's judgment is to help him to understand what factors actually do influence his judgment and that of his colleagues.

Why Physicians Bother

Many observers cannot believe that private practitioners give the necessary time and energy required for utilization committee work. In Western Pennsylvania, they do. Why do they bother?

Medical society leadership here has recognized that many groups in the community besides physicians have a valid interest in ensuring effective utilization of inpatient facilities and services: the patient, labor unions and management sponsoring employe health benefits plans, prepayment agencies such as Blue Cross and Blue Shield, government agencies with regulatory responsibilities such as the Insurance Department, and hospital officials. In Western Pennsylvania, it was clear to physicians that these groups were beginning to act to protect their interests, and that such action was having impact on the daily practice of physicians. Physicians were concerned about the possible effects on the quality of their care as well as on their professional independence and financial position. Extensive discussions convinced them that "the medical profession has a basic role in ensuring proper and effective utilization."

Started in 1959

The initial suggestion that the medical staff of each hospital in Western Pennsylvania establish a utilization committee was made in the fall of 1959.

In response to a request for guidance from hospital administrators and

Who's the "Short-Stay" Surgeon? Me!

In one hospital in Pennsylvania, a detailed analysis was made of all of the cholecystectomy cases for one year. This analysis revealed that four surgeons were responsible for 90 per cent of the cases. After adjustment for ages of patients and for the complicated cases, the data revealed that there was one "short-stay," two "medium-stay," and one "long-stay" cholecystectomy surgeon. This finding was reported to each of them separately and each was asked to guess who was the "short-stay" surgeon. Only one guessed right, because each nominated himself. Each one thought that he was discharging as soon as indicated, and none thought that his colleagues would be rash enough to discharge sooner.

They didn't know about their own utilization practices. They hadn't thought about this dimension of their medical practice. After analyzing the data, the utilization committee knew more about the utilization of these surgeons than the surgeons knew themselves.

There is a sequel to this little story. A year later, when the same data were collected on the next year's cases, the average stay for cholecystectomy cases had dropped. The average stay had dropped for each of the four men, even including the "short-stay" surgeon. The decline occurred in spite of the fact that no one had criticized any of them, including the "long-stay" surgeon. It had been emphasized that the data were collected for study purposes only, and not to judge the men nor to set standards.

This story illustrates the purposes of a medical staff utilization committee: to help to educate physicians with respect to an unknown but important dimension of medical practice, and to help physicians to become more aware of their impact on utilization rates. ■

chiefs of staff, a "Guide to the Establishment and Functioning of a Medical Staff Utilization Committee" was prepared.*

To determine progress, questionnaires were distributed to the hospitals in early 1960, at the end of 1960, and at the end of 1961. Following each survey there was a general meeting of utilization committee chairmen and hospital administrators to discuss problems and progress.

Questionnaires were sent to 38 community general hospitals in the 10th Councilor District of the Pennsylvania Medical Society. The number of hospitals returning usable questionnaires increased from 26 for the first questionnaire to 34 for the second, and 36 for the third. The questionnaires were not identical.

Here are some of the findings:

Size of committees. The number of members on utilization committees ranged up to 21; the average membership was seven.

Number of committee meetings. Twenty-three hospitals reported monthly meetings. Three met every other month; six met quarterly, and four met on no regular basis.

Method of operation. The primary activity of utilization committees was reported to be chart review. Some committees also reviewed admissions daily, or "emergency" admissions, or "long-stay" cases still in the hospital, but all reviewed charts of discharged patients.

Proportion of total cases reviewed. The 36 responding hospitals care for approximately 300,000 inpatients annually. The proportion of these cases reviewed has steadily declined: 18 per cent during the first three months of 1960, 11 per cent for the last nine months of 1960; 6 per cent for 1961.

There was wide variation among hospitals in the proportion of charts reviewed during the earlier periods when a number of hospitals were reviewing half of all the charts or even more, and some others were reviewing fewer than 1 per cent. More recently, there has been less variation among the hospitals. In 1961, a majority of the hospitals reviewed between 2 and 6 per cent of all of the cases. Approximately 50 cases were reviewed at the average committee meeting.

Types of charts that were reviewed. The trend has been toward selection of a specific type of case to be reviewed at a specific meeting of the committee. Most commonly, long-stay cases were given concentrated attention, typically cases staying 30 days or more. Other categories which have received special attention were: "emergency" admissions, short-stay cases (one or two day stays), selected diagnoses, cases in which the discharge diagnosis differed from the admitting diagnosis.

Proportion of cases classified as "questionable." The number of committees that kept data on the number of "questionable" cases has steadily increased from 8 in the first survey to 32 in the third survey.

Among those reporting, the proportion of cases reviewed which were classified as questionable was 10 per cent in the first survey, 5 per cent in the second survey, and 7 per cent in the third survey.

As would be expected, those hospitals limiting their work to Blue Cross referred cases had the highest proportion of "questionable" cases. Those reviewing the largest number of cases, especially those reviewing cases selected at random, had the lowest proportion of "questionable" cases.

Disposition of "questionable" cases. Utilization committees in most hospitals reported that they act to bring "questionable" cases to the attention of the attending physician on an informal, confidential basis, usually with a request for additional information not shown on the chart. A few committees ask the attending physician to add an explanatory note to the chart. A few committees reported that "questionable" cases, unidentified by name of attending physician, have been used as illustrative material in educational programs at medical staff meetings.

Four utilization committees tended to be more officious. In two instances, the "questionable" cases are referred to the executive committee, and, in one instance, to the medical director. One hospital reported that names of attending physicians with unexplained "questionable" cases are posted on the bulletin board in the staff room.

In the questionnaire completed at the end of 1960, committee chairmen were asked to state their opinions as to whether committee activity had resulted in reduction in length of stay, in admissions, or in use of ancillary services. Seventy-five per cent of the chairmen reported in 1960 that they believed that reduction in "excessive stays" had been achieved; 32 per cent cited reduction in "unnecessary admissions"; and 19 per cent cited reduction in use of ancillary services.

The questionnaire completed at the end of 1961 asked only about length of stay. This time, 78 per cent of the chairmen reported that their committee's activity appeared to have resulted in reduction of stays.

In general, committee chairmen believed that, in addition to improvement in utilization practices, the committee had such important side effects as improvements in medical staff-administrative liaison, in charting, and in understanding of utilization and Blue Cross problems. A few chairmen also cited improvement in quality of care, reduction in hospital costs, and elimination of the need for a new wing to the hospital.

A number of chairmen also reported specific changes or improvements in hospital procedures resulting from utilization review activity. Most frequently cited was improvement in hospital charting. Other specific changes reported by committee chairmen included:

- Development of more equitable and efficient admission and discharge procedures.
- Installation of the program of the Professional Activities Study.
- Better liaison between medical staff and the social service department on disposition of long-stay cases.
- Rescheduling of "dental" cases to "dead" time in the operating room.
- Installation of a routine laboratory unit in the admission area.
- Institution of a 24 hour discharge notice procedure, found to be applicable to 80 per cent of the cases studied.
- Advance in the discharge hour.
- Increased emphasis on use of outpatient diagnostic facilities for preoperative work-up.

*This guide was co-sponsored by the Tenth Councilor District of the Pennsylvania Medical Society and the Hospital Council of Western Pennsylvania and published by the local Blue Cross Plan. It is available at 20 cents per copy and sets forth specifics for the organization and operation of these committees.

● Requiring that the final diagnosis be placed on the chart before the patient leaves the floor for discharge.

● Placing a special form on the patient's chart after some specific length of stay (such as 14, 21 or 30 days) on which the attending physician is asked to explain briefly the reasons why the patient must remain in the hospital.

Other comments made by committee chairmen on results of committee activity included:

Increased interest of medical staff members in working with the administration on various problems and improved liaison between medical staff and administration.

Stimulated work on newly discovered problems involving hospital procedures such as week-end laboratory coverage, operating room scheduling, and delays in tissue reports.

Focused the need to avoid delay in completing consultations.

Increased cooperation with respect to discharge hour.

Stimulated discharge or transfer to appropriate facilities for long-stay cases.

Eliminated questionable emergency admissions.

During the spring of 1962, 36 utilization committee chairmen participated in a series of informal dinner meetings, each attended by six to eight chairmen. At these meetings, the following suggestions were made as to how utilization committees might be helped to function most effectively:

The need for top-level support. Utilization committee chairmen were unanimous in the opinion that the committee requires the unqualified support of the medical staff's executive committee and the hospital administrator. All chairmen with well-functioning committees reported that they enjoyed the backing of an enthusiastic executive committee.

Key role of committee chairman. The chairman of the committee should be a physician who enjoys the respect and confidence of the medical practitioners. A number of younger chairmen suggested that those who have been in practice for only a few years have difficulty in obtaining full cooperation of the staff.

There was also general agreement that the committee functions best

WHAT A UTILIZATION COMMITTEE IS NOT

1. Utilization committees are not police bodies with power to ferret out and censure a few "guilty" physicians.

Utilization committees have no disciplinary powers, their records are not incorporated in the patient chart, and their deliberations do not become a matter of official record. Often the data they review are coded, not even identified by name, and in many instances subsequently destroyed. The primary objective of the utilization committee is educational – for each member of the hospital staff. Control of utilization is not considered to be a problem of identifying and dealing with a few bad actors on the staff who indulge in flagrant abuse. Conscientious utilization committees invariably find that almost all physicians are, at some time or another, involved in some aspect of ineffective utilization. A day or even a half day of delay in the discharge of most cases, or even most cases of one category (*e.g.* obstetrical) can have a much greater impact on the utilization rates than can the occasional case of 10 or 20 days of excessive stay.

2. Utilization committees are not scientific research bodies attempting to measure the precise magnitude of overutilization and underutilization.

The primary objective of the utilization committee is to improve – not to measure – utilization practice. Fact-finding and measurement are important aspects of utilization committee work, as they are in any educational or administrative activity. But, precise research standards do not apply to the work of the utilization committee any more than they do to any other active medical staff committee concerned with improving standards of medical practice. Utilization committees can have salutary effects on utilization without being able to define or measure optimum utilization in the same way that tissue, medical records, and other medical staff committees appear to have positive effects on quality, in the absence of precise methodology for measuring or even defining quality of care.

3. Utilization committees are not agencies of Blue Cross.

In Western Pennsylvania, utilization committees function within the framework of the medical staff of the individual hospital, and are concerned with utilization in *all* types of cases. Accordingly, they scrutinize "free," self-pay and commercial insurance cases, as well as those covered by Blue Cross.

As the partner of community hospitals and as their financing mechanism, Blue Cross has a great interest in the over-all problem of utilization control as well as its narrower interest in claims review of Blue Cross cases.

Closely related to the work of the utilization committee within each hospital is that of the Blue Cross Claims Review Committee, which functions on a regional basis. During its auditing process, Blue Cross frequently identifies two classes of cases – those in which hospitalization appears to be unnecessary within the terms of the subscriber contract, and those in which the length of stay appears to be excessive. All of these cases are first referred for review to the utilization committee of the hospital involved, which reports its findings to a meeting of

when the chairman is a clinician. Although several excellent committees are headed by an anesthesiologist, pathologist, or radiologist, they appeared to be unusual cases.

Flexibility of structure. Chairmen of committees felt that stereotyped structure was not desirable because of differences in sizes and types of staff and other factors. Smaller hospitals, for example, reported success in combining several committees (audit, records, utilization). In larger hospitals, it appeared to be desirable to confine utilization review to a special committee appointed for that purpose.

Rotation of committee membership. Some chairmen reported that they have been successful in obtaining cooperation of physicians who were critical by arranging to have them serve on the committee. Because of the work involved, it appears desirable that each member's term on the committee be limited.

Value of a "tight" bed situation. Hospitals with waiting lists appeared to encounter less difficulty in getting the utilization committee functioning effectively than those in which beds were readily available. As one chairman stated, "It's difficult to sell the utilization program to your own staff and administration when there are plenty of empty beds." Action to reduce the number of beds staffed for use appears to be desirable in such situations.

Although most committee chairmen were enthusiastic about utilization review work, some were not so sure, and many cited specific problems.

Most common problem mentioned was the amount of time required by already overburdened physicians serving on utilization committees, especially the time required for essentially routine work.

In addition, a number of chairmen referred to resentment by the medical staff of the committee as a police body. Closely related, a number of chairmen felt that committee members were frequently hampered because of fear of antagonizing chiefs of service and colleagues.

Experience with utilization committees during the past few years in Western Pennsylvania indicates that they have (1) increased the awareness of physicians of their central role in determining utilization rates, (2) resulted in specific administrative changes designed to improve utiliza-

the areawide Blue Cross Claims Review Committee made up of representatives of local hospital medical staffs. Blue Cross has accepted the decisions of this claims review committee without question on payment or withholding of claims.

For some hospital utilization committees, review of cases referred by Blue Cross is the major activity, or even the only activity. Such committees are not functioning effectively and it is not surprising that staff members of these hospitals think of the activity as "Blue Cross work."

Ideally, the work of hospital utilization committees and of Blue Cross claims review complement each other.

4. Hospital utilization committees are definitely not "whitewash" groups.

Some experts concerned with research in hospital use appear to believe that utilization committees are "whitewash" groups. They believe* that utilization committees not only are "ineffective vehicles for measuring" but in addition are "whitewash committees, by their very nature."

This sharp criticism appears to be based on a misunderstanding of the basic function of utilization committees, which is educational. Significantly, these critics also apply the same criticisms to hospital medical staff tissue committees, appearing to assume that the primary task of both committees is disciplinary.

In Western Pennsylvania, these committees do not function to "whitewash" the problem. Like tissue committees, utilization committees don't publish their findings or publicize their activities. They apply neither "whitewash" nor tar and feather. Their very existence presumes that a problem exists which needs correction. These committees require a great deal of work on the part of physicians who would not need to work so hard if the objective were simply to "whitewash." That utilization committees do not yet function in the most effective manner is undeniable. Most are less than three years old, and the whole idea is not much older. Improvement in functioning is clearly indicated. Criticism of their present effectiveness is constructive; to call them a hoax is not.

5. Utilization committees are not the whole answer to the utilization problem.

Utilization committees, by themselves, cannot serve to assure most effective utilization of inpatient facilities. They are but one part of a comprehensive program in Western Pennsylvania. But they are a very – possibly, the most – important part.

No one has yet suggested that medical practice would be improved if the patient's attending physician lost the right – functioning within clearly defined medical staff rules and codes of professional conduct – to make the decisions which determine the inpatient utilization of his patients.

If standards of "proper" utilization are to be developed and applied, aren't they most likely to be practical and acceptable if they have been tested and developed within utilization committees of the medical staff? ■

*Research in Hospital Use — Programs and Problems, Draft of a Conference Report. Pp. 49. U. S. Public Health Service, 1962.

tion practices at a number of hospitals, and (3) improved liaison between medical staffs and hospital administration with respect to medical-administrative problems.

This experience also demonstrates wide variation in practices, procedures and effectiveness among the existing committees. This has led to the creation of a Hospital Utilization Project with a full-time staff which began to function on Jan. 1, 1963. The staff assists individual hospital utilization committees by offering consultive services in defining over-all objectives and methods for conducting analysis of specific problems as well as providing assistance in the use of clerical and mechanical aids and statistical technics. In addition, the staff is attempting to develop reliable utilization measurements, to promote interchange and coordination among existing committees, to develop joint studies related to specific population groups, and to explore possibilities for use of centralized mechanical tabulation technics.

Guiding the project is a steering committee consisting of representatives of the medical societies and the hospital council, representatives of the University of Pittsburgh Medical School and Graduate School of Public Health, the Hospital Planning Association of Allegheny County, the local Blue Cross Plan, and industry.

Medical leaders raised the necessary funds for the project – $250,000 for a three-year period – from industry headquartered in the Pittsburgh area.

The key to the success of the utilization committee effort in Western Pennsylvania has been the leadership provided by dedicated officials of the medical society. ■

More Beds Mean More Utilization: Dr. Roemer

On a nationwide basis in the United States, the striking fact is the degree to which hospital utilization, in terms of days of care in general hospitals per 1000 persons per year, corresponds with the supply of beds.

Hospitals in states with low bed-supplies are not appreciably more crowded than hospitals in states with high bed-supplies, as one would expect if the need for hospitalization were the decisive determinant of bed utilization. On the contrary, the occupancy levels of general hospitals are about the same in states of high bed-supply as in states of low bed-supply.

In one semi-rural county that we studied, almost optimal conditions were presented for an examination of the influence of bed-supply on hospital utilization. After years of "getting along" with a bed-supply of 2.8 general beds per 1000, the supply was suddenly increased to 3.8 per 1000. At the old level, the hospital was not overcrowded, having an occupancy of 78 per cent. With the increase in bed-supply, however, there was an abrupt rise in the admission rate of the study hospital and no compensatory decline in the admissions rates of other nearby hospitals. At the same time, the average length-of-stay for 40 out of 53 diagnoses increased. The utilization rate by Blue Cross members in the study hospital rose by 38 per cent, in response to the 42 per cent rise in the study hospital's bed capacity. – DR. MILTON I. ROEMER, *professor of public health, University of California, Los Angeles*