A PEER REVIEW SYSTEM FOR METHODIST HOSPITAL, DALLAS, TEXAS

A Problem Solving Thesis

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CHAPTER I

INTRODUCTION

General Information

Methodist Hospital of Dallas, Texas is a 408-bed acute, general, voluntary hospital situated on a 20-acre tract of suburban business property in the thriving Oak Cliff area. As the only major hospital southwest of the Trinity River basin which divides the major part of Dallas from Oak Cliff, Methodist Hospital in 1970 serviced a population of approximately 350,000 people with primary medical care, double the 1950 requirement. The organizational chart is shown as Figure 1, p. 2.

The Medical Staff of 450 physicians is highly organized, having 160 active and 29 associate staff members who vote, hold office and participate in the functions of 22 committees defined by the by-laws. The Consulting Staff of 20 outstanding physicians represents a close affiliation with the University of Texas Southwestern Medical Branch in Dallas. There is a full-time paid Director of Medical Education and four part-time paid Assistant Directors for major departments. Training programs for interns and residents are in progress for: Internal Medicine, Obstetrics and Gynecology, General Surgery, Pediatrics, Radiology, Pathology and Cardiopulmonary Fellowships. Within the year 1969 a modern, 15-bed Intensive Care Unit and an 8-bed Coronary Care Unit were completed and staffed full time with highly trained specialists at all levels, supplementing the Cardiopulmonary Institute and a highly organized Recovery (Postoperative) Room. A recently added Cardiovascular Surgeon is

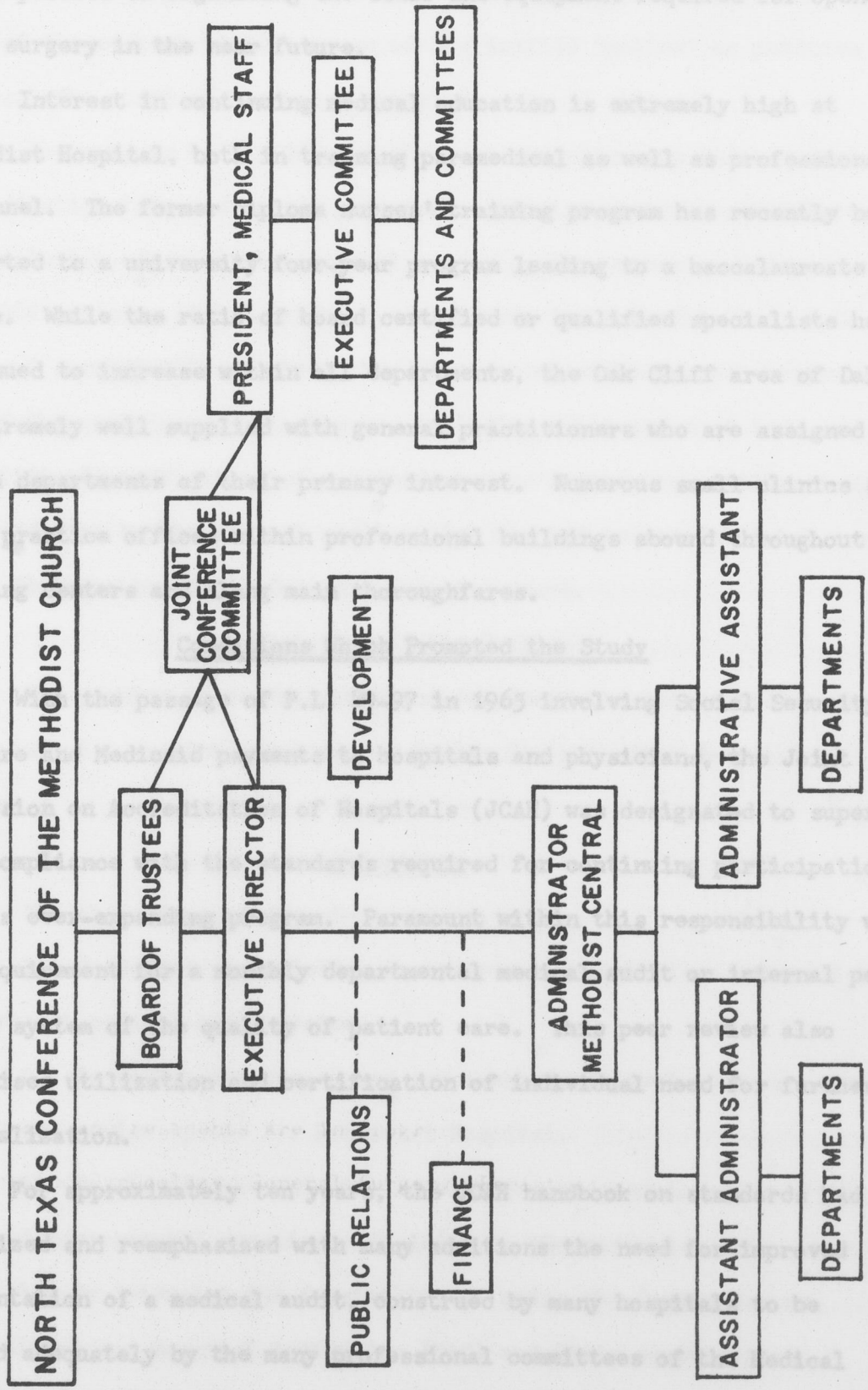


FIG. 1. -- ORGANIZATION CHART - METHODIST HOSPITAL OF DALLAS, SEPTEMBER, 1969

in the process of organizing the staff and equipment required for open-heart surgery in the near future.

Interest in continuing medical education is extremely high at Methodist Hospital, both in training paramedical as well as professional personnel. The former diploma nurses' training program has recently been converted to a university four-year program leading to a baccalaureate degree. While the ratio of board certified or qualified specialists has continued to increase within all departments, the Oak Cliff area of Dallas is extremely well supplied with general practitioners who are assigned within departments of their primary interest. Numerous small clinics and group practice offices within professional buildings abound throughout the shopping centers and along main thoroughfares.

Conditions Which Prompted the Study

With the passage of P.L. 89-97 in 1965 involving Social Security Medicare and Medicaid payments to hospitals and physicians, the Joint Commission on Accreditation of Hospitals (JCAH) was designated to supervise compliance with the standards required for continuing participation in this ever-expanding program. Paramount within this responsibility was the requirement for a monthly departmental medical audit or internal peer review system of the quality of patient care. This peer review also supervises utilization and certification of individual need for further hospitalization.

For approximately ten years, the JCAH handbook on standards had emphasized and reemphasized with many additions the need for improved documentation of a medical audit, construed by many hospitals to be covered adequately by the many professional committees of the Medical Staff. A trial medical audit interdisciplinary group functioning primarily within the Medical Records Committee began to operate at Methodist

Hospital in 1965, but was extremely unpopular with its members and the bulk of the medical staff because of its implied "police" or punitive powers. The audit system was fragmented.

However, in April 1968, at the most recent survey for hospital accreditation, the examiner's principal criticism centered about better documentation of a monthly internal review system within each department. The 1969 revision of the handbook, "Standards for Accreditation of Hospitals," specifically requires the departmental audit or peer review system of the quality of patient care, including utilization of beds and recertification of patients' requirements for further hospitalization. This addition to the medical audit system has had successful trial usage among Michigan hospitals for more than ten years.

Statement of the Problem

The problem is to determine and recommend the procedures required to implement a complete peer review system for Methodist Hospital of Dallas.

Objectives

The objectives of the study are:

1. To define the existing procedures and mechanisms relating to the present medical audit system.

2. To define the procedures and mechanisms involved in a complete peer review system for Methodist Hospital.

3. To clarify the existing regulations and requirements of the JCAH and governmental agencies pertaining to the medical audit.

4. To determine the feasibility of using the Commission on Professional and Hospital Activities (PAS) and their computerized Medical Audit Program (MAP) facilities.

5. To select those methods acceptable to the medical staff that could best improve the present system.

Criteria

Any proposed solution to the problem should:

1. Conform to the existing and implied requirements of the Joint Commission on Accreditation of Hospitals and governmental agencies.

2. Result in improved quality of patient care at Methodist Hospital by providing for the continuing education of professional and paramedical personnel.

3. Provide a comprehensive coordinated monthly review and documentation within each major department of all spheres of interest.

4. Assist in the identification and early correction of deviations from the highest standards of ethical medical practice with appropriate controls set by each department.

5. Conserve valuable professional time by progressive consolidation of multiple committees presently concerned with small facets of the monthly internal medical audit.

Factors Bearing on the Problem

Specific situations and regulations which modify any solution to an ongoing peer review system are:

1. The annual election of Chiefs of Departments (unpaid) from the specialty portion of the Active Medical Staff fosters discontinuity of policy and uncertain delineation of standards of patient care.

2. The Senior Residents of all departments change each year; this requires additional direction in the gathering and presentation of essential data for monthly review.

3. The President of the Medical Staff, elected annually on a nonpaid basis, has neither the time nor inclination to formalize a strict

medical audit by a multidisciplined committee whose very name implies a threat to most of the 450 members of the Active and Courtesy Medical Staff.

4. The Executive Committee of the Medical Staff, on which the Chiefs of Departments serve, is already overburdened with reviewing reports of some 18-21 other committees.

5. The paid full-time Director of Medical Education and the paid part-time Assistant Directors (four) for each major department are not included in the present system of peer review. They are used solely in the training of interns and residents.

Assumptions

Increasing coverage of the entire population with comprehensive medical care will overwhelm present facilities unless proper utilization is carefully supervised and coordinated. It is assumed that:

1. The Joint Commission on Accreditation of Hospitals, governmental agencies and providers of medical care insurance will require full documentation of a comprehensive peer review system for continuing certification and payment of claims.

2. The Executive Director and the Administrator must have consolidated documentation of a monthly medical audit of the quality of patient care at Methodist Hospital of Dallas for examination by authorized representatives of multiple agencies.

3. Special attention to hospital bed utilization and recertification of need for further hospitalization of Medicare patients will be required more frequently as the numbers continue to increase.

Research Methodology

To understand basic problems of the Active Medical Staff and to

identify additional requirements of a complete peer review system, the following studies were undertaken:

1. The present system of fragmentary review by multiple composite committees was studied to identify gaps in the present peer review system.

2. Present by-laws and regulations of the Medical Staff were studied with reference to the standards for hospital accreditation (1969).

3. Personal interviews were held with twenty-seven key members of the Medical Staff and Hospital Administration in all involved departments. Individual problem areas were identified and discussed providing the basis for preparation of comprehensive departmental review agendas.

Literature Review

The latest standards of the Joint Commission on Accreditation of Hospitals published October 1969 state:

> The governing body shall require that the medical staff establish controls that ensure the achievement and maintenance of high standards of professional and ethical practices. . . . There should be regular comprehensive peer analysis of the clinical practice and utilization review activities within the hospital.

Even more specific is the following:

> The medical staff organization shall control the professional performance of its members through the appointment procedure, the delineation of medical staff privileges, and the continual review and evaluation of their clinical activities. . . . Whatever the organizational pattern selected, the medical staff must provide an appropriate peer group method by which the required basic functions of medical, surgical, and obstetrical audit are thoroughly performed at least monthly. Included must be the analysis of necropsy reports and a tissue review (utilization of beds, diagnostic facilities, and consultation services).[1]

Many articles on the purpose and composition of the medical audit have been published, one of the earliest by Vergil N. Slee, M.D., in 1961.[2] His chapter on "The Medical Audit" in The Medical Staff in the Modern Hospital, published in 1967, further defines his ten years

experience as originator and director of the pilot study in fifteen hospitals of the Southwestern-Michigan Hospital Council.[3] As Director of the Commission on Professional and Hospital Activities since its inception in 1957, Dr. Slee has computerized the Professional Activity Study (PAS) and its associated Medical Audit Program (MAP).

Quality control and monthly departmental topic reviews will establish criteria of expected levels of patient care as an educational exercise.[4] The requisites are carefully delineated by information retrieval from medical records. An information system of comparison such as PAS and MAP assist physicians in establishing criteria for each disease classification of the most common types found in their own hospital. Simplification of the basic framework of the Medical Staff organization is possible by consolidation of multiple committees which otherwise consider fragmentary facets of the total medical audit or peer review system. Through consolidation, some hospitals have reduced standing professional committees from as many as twenty-three to as few as seven with full approval of the JCAH.

C. Wesley Eisele, M.D., Associate Dean for Postgraduate Medical Education at the University of Colorado Medical School, has carefully delineated the educational values of the medical audit. He states that the audit:

1. Is universally available.
2. Uses the highly esteemed self-education principle.
3. Involves all members of the staff.
4. Utilizes the physician's own patients and own experience.
5. Engenders motivation for formal as well as informal continuing education.

6. Defines areas of greatest need for educational programs for the staff.

7. Achieves the ultimate goal of improvement in the quality of patient care.[5]

Careful attention is given these values in all professional training centers.

Other community voluntary hospitals, particularly those having intern and residency training programs, have worked out practical applications for the actual organization of a peer review system such as described by Kenneth J. Williams, M.D., Medical Director of the Saint John Hospital in Detroit (500 beds).[6] Essentially, the actual auditing of professional activities on disease, operations, investigation and therapy is carried out by departmental audit subcommittees. These subcommittees, each consisting of two or three members from a particular department and including general practitioners, report to, and are coordinated by, the main Medical Audit Committee. This is known as the "vertical" review system as opposed to the "horizontal" interdisciplinary committee generally felt to be punitive or derogatory in character.

Footnotes

[1]Joint Commission on Accreditation of Hospitals, Standards for Accreditation of Hospitals (Revised; Chicago: Illinois, Joint Commission on Accreditation of Hospitals, October, 1969), p. 19.

[2]Vergil N. Slee, M.D., "The Medical Audit," The Modern Hospital, CI (November, 1961), 49-54.

[3]Ibid.

[4]Vergil N. Slee, M.D., "The Medical Audit," in The Medical Staff in the Modern Hospital, ed. by C. Wesley Eisele, M.D. (New York: McGraw-Hill Book Company, 1967), p. 213.

[5]C. Wesley Eisele, M.D., "The Medical Audit in Postgraduate Education," in The Medical Staff in the Modern Hospital, ed. by C. Wesley Eisele, M.D. (New York: McGraw-Hill Book Company, 1967), p. 395.

[6]Kenneth J. Williams, M.D., "The Mechanics of Medical Audit," in The Medical Staff in the Modern Hospital, ed. by C. Wesley Eisele, M.D. (New York: McGraw-Hill Book Company, 1967), p. 225.

CHAPTER II

DISCUSSION

Present System

The present basic medical audit is carried out monthly by anonymous appointees within each department, reviewing approximately 10 per cent of the previous month's medical records chosen at random. A "Check List for Spot Checkers" (Figure 2, p. 12) is made out for each record, and the tabulation is compiled by the Medical Records Librarian and forwarded to the Medical Records Committee for consideration at each monthly meeting. The other portions of the audit are fragmented among nine interdisciplinary committees such as Tissue, Blood Transfusions, Utilization, Medical Education, Infections, Patient Care and others. The Executive Committee of the Medical Staff reviews and presents significant findings to the monthly Medical Staff Conference. Separate departmental staff meetings follow the joint staff meeting and consist primarily of professional speakers of interest to each department. Weekly teaching conferences for interns and residents are scheduled but usually do not involve members of the Medical Staff other than the paid part-time Assistant Directors of Medical Education and selected speakers.

Four full-time contract pathologists are responsible for material considerations of the Tissue, Blood Transfusions, Infections and Cancer Committees. They also train four residents in pathology. A group of four radiologists, on contract, do all required x-ray diagnosis and

CHECK LIST FOR SPOT CHECKERS - MEDICAL RECORDS COMMITTEE

Answer YES or NO

1. Does the history include

   a) Chief complaint? _____
   b) Present illness? _____
   c) Past history? _____
   d) Family history? _____
   e) Inventory of systems? _____

2. Is the physical examination adequate? _____

3. Is provisional diagnosis included in PE? _____

4. Is consultation necessary? _____

5. Are laboratory examinations and X-rays consistent with the diagnosis? _____

6. Is treatment recorded? _____

7. Are progress notes adequate? _____

8. Is final diagnosis reasonable? _____

9. Does the discharge summary include the following minimum requirements?

   a) Reason for admission? _____
   b) Pertinent findings? _____
   c) Medical/Surgical treatment? _____
   d) Condition on discharge? _____
   e) Continuing care? _____
   f) Final diagnosis? _____

10. Remarks _____

_____

_____

Fig. 2.--Check List for Spot Checkers

radiation therapy; and they perform the radioisotope functions, head the Isotope Committee, and train four radiology residents.

Major Weaknesses

The most urgent deficiency reported by the last survey of the Joint Commission on Accreditation of Hospitals (JCAH) in April, 1968 related to the departmental staff meetings, which were wholly educational in character, leaving all review functions to the multiple committees. There is lack of continuity of departmental policy because of the annual election of each Departmental Chief who assumes office in January of each year. Each new chief then has only five months before summer vacations deplete the attendance at staff meetings and only four months in the fall before the next chief will take over. At present the Assistant Directors of Medical Education, who are paid a part-time salary for the training of interns and residents, play no part in departmental staff meetings except possibly with procurement of professional speakers. Often the minutes of present departmental staff meetings are incomplete, particularly when judged by the monthly comprehensive review required by JCAH standards.[1]

All committee reports are scant in detail regarding the actual considerations of each meeting. Secretarial support has been lacking at the actual meetings; most reports appear to have been dictated later from memory from brief general notes by one of its members. Since each committee has a separate folder, any particular monthly review by an examiner for Hospital Accreditation or by other authorized examiners requires that all folders be pulled for consolidation.

Computerized statistics for each department are prepared monthly and semiannually; an annual consolidated report by department and committee is prepared in rather general terms without analysis or comparison

for review or educational purposes. The full-time paid Director of Medical Education has been away on fellowship in the Middle East almost a year, and this absence has necessarily limited many revisions or additions which the Acting Director might otherwise have made.

Alternate Methods for Improvement

The three principal methods discussed during twenty-seven personal interviews with key professional and administrative staff members are presented in order of complexity. They may be considered as stages, each more sophisticated than the previous, leading up to the so-called "ultimate" peer review system.

Basic peer review system by committees: Method A

A main Peer Review Committee composed of departmental heads will review reports of all departmental staff meetings and professional committees and consolidate them into a single comprehensive monthly report. Secretarial recording of minutes of all committee and departmental staff meetings will be edited by each Chairman and revised as necessary by the main Peer Review Committee. After approval by the Executive Committee of the Medical Staff, the consolidated report will be kept in the safe of the Hospital Administrator for review only by authorized examiners. Committee and departmental meeting file copies will also be maintained separately.

While this method might appear superficially to meet the JCAH requirements and to be the simplest to attain by appointment of another committee delineating additional duties for each chief of department, Method A is not recommended except as a brief phase in the implementation of Method B for the following reasons:

1. Basic criteria for an acceptable long-term solution are not met (page 5). Gaps in multiple committee functions now existing would be difficult to overcome because of uncoordinated information retrieval for

interdisciplinary consideration by too few members of the Active Medical Staff. Since comprehensive monthly departmental reviews must be instituted, duplication of effort with increased loss of valuable professional time would produce resentment without assuring educational benefits or improved quality of patient care. A similar type of audit previously instituted about 1965 proved to be very unpopular with the entire medical staff because of interservice bickering within the committee; its function became punitive rather than educational, thereby losing essential cooperation within the various departments.

2. Many important factors bearing on the problem (page 5) would go unresolved or aggravate this unpopular method. Continuity of an effective ongoing peer review system can be better augmented within departmental subcommittees as a part of the monthly staff review by utilizing the organizational and teaching capabilities of the part-time paid Assistant Directors of Medical Education who are affiliated with the University of Texas Southwestern Medical School in Dallas. These professionals remain for years and can offset the annual changes in the elected Chief of Staff, Departmental Chief and senior residents. Acceptable highest parameters of medical care can be delineated and become a broad-based educational means of improving the quality of patient care by all members of each department. With guided retrieval of data, repeated deviations from the accepted "norm" of prompt diagnosis and effective treatment are easily selected as an anonymous basis for educational programs as well as function essentially as a consultation service to those physicians less well trained. Proper utilization of facilities is also enhanced by these well publicized parameters and emphasis on comprehensive home or outpatient care (Pre-admission Testing, Rehabilitation, Self-care, etc.). These deficiencies of Method A are corrected in the following Method B utilizing a

uniform agenda for all departmental staff meetings.

Departmental peer review system by uniform agenda: Method B

Chiefs of major departments will designate a Peer Review Subcommittee which will include an Assistant Chief of Department and the Assistant Director of Medical Education.[2] The latter will supervise the collection or retrieval of data for consideration by agenda at the monthly departmental staff meetings. Each Subcommittee, subject to approval of the Chief of Department, will select the ten most common diseases or conditions admitted, for discussion during the year. Each month, in turn, all hospital discharge records of each condition selected will be pulled for anonymous general discussion of diagnosis and treatment policies or parameters. This will provide medical education and free consultation which will result in improved patient care. A Radiologist and a Pathologist participate in discussions involving neoplasms, surgical tissue, infections and blood bank, etc. Departmental secretaries (or alternates) will record the minutes by agenda-topics, subject to revision by the Subcommittee. Final typing will include a separate page for each of the ten topics documented by each department when pertinent. When all departmental reports are consolidated by the main Peer Review Committee, as many as eight-to-ten professional committees of the Medical Staff may eventually be abolished. Consolidation of committees has been approved by the JCAH in other hospitals using this system.

Method B is also known as the Vertical Peer Review System (Appendix A, p. 26) with major educational emphasis on each major departmental subcommittee and monthly review meetings involving all members of each staff. This overcomes the objections to Method A, the Horizontal Peer Review System, as an interdisciplinary punitive system. Yet corrective action

can be taken by the Main Peer Review Committee by recommendation to the Executive Committee of the Medical Staff; an uncooperative physician, who knowingly violates the established departmental parameters of good patient care, can be placed on probation or have his hospital privileges suspended until he assures compliance with the by-laws of the Medical Staff. The annual evaluation of physicians for reappointment to the Medical Staff can be useful for removing those who would threaten attainment of accreditation standards or bring discredit upon the hospital.

Method B meets all of the criteria of JCAH and federal standards and has resulted rather consistently in saving of valuable professional time by abolishing or consolidating many committees (Appendix A, p. 26); these functions are better handled by frank discussion within each departmental staff meeting by agenda and secretarial documentation. An Assistant Chief of Department, to become the next Chief, and the Assistant Medical Director add stability and continuity to the subcommittee and utilize recently discharged patient summaries for educational discussion. The basic uniform agenda (Appendix C, p. 31) for all departmental staff meetings has been discussed in detail during interviews with twenty-seven key professional and administrative staff members. Consistent data retrieval on a monthly selective basis for an effective qualitative and educational review of patient care can be achieved with the present computerized statistics and medical records personnel. Secretarial overtime pay for recording adequate minutes of each monthly departmental staff meeting, usually held in the evening, is the only additional cost incurred by Method B.

When the departmental peer review subcommittee approves the final draft of the minutes, three copies are forwarded to the Main Peer Review Committee for analysis of combined departmental subcommittee reports; the

total review comprises a comprehensive report of the quality of patient care and proper utilization of all hospital facilities fulfilling all requirements of JCAH, partially outlined in Appendix B, p. 28, as well as federal requirements for Medicare participation. One complete copy is kept by the Secretary of the Medical Staff after approval by the Executive Committee and the monthly meeting of the entire Medical Staff. The second complete copy is kept under security in the Administrator's office for review by duly authorized representatives of JCAH, federal Medicare representatives and private insurance claim investigators as an additional justification for hospital budget requirements.

The third copy can be divided individually by topic to represent basic committee functions of the whole hospital if documented considerations of each item two through ten of the uniform agenda (Appendix C, p. 31) have adequately covered these topics in each departmental staff meeting. When the Executive Committee finds these reports complete for accreditation standards, then they and the Medical Staff can abolish the interdisciplinary committees such as Medical Education, Infections and Transfusions, Tissue, Therapeutic Agents, Medical Records, Utilization, and others found to be duplicated by departmental consideration. This saving of professional time may stimulate expansion of the proposed uniform agenda to include other functions now carried out by professional committees; broad-based support of the educational aspects of departmental staff meetings must be generated for success of this program.

Departmental peer review utilizing PAS and MAP comparative analysis: Method C

After departmental Peer Review Subcommittees are functioning well and departmental agendas for meetings have been modified appropriately to meet the special requirements (if any) of each, consideration may be

given to contracting for the computerized analytical services of the Professional Activity Study (PAS) and the Medical Audit Program (MAP).[3] This fifteen-year-old Commission on Professional and Hospital Activities is sponsored by the American College of Physicians, American College of Surgeons, American Hospital Association, and Southwestern Michigan Hospital Council.[4] A single check sheet for every patient discharged from the hospital is sent in and monthly summary print-outs are sent to each hospital. Each hospital's results are compared with results from more than 45 million records compiled from over 1,200 hospitals nationwide; trends and areas for educational efforts in departmental staff meetings are thus identified.

The costs of PAS and MAP services would be $0.40 per patient discharged, or approximately $10,000 a year for Methodist Hospital. In addition, if PAS and MAP were to be contracted for, the Medical Records Librarian has stated one additional secretary would be required, plus additional office space currently not available.[5] The Director of Medical Education and this Medical Records Secretary (or Assistant Records Librarian) would require two days special training provided at the home office in Ann Arbor, Michigan; this training would include documentation and retrieval of information from MAP reports for use in the departmental staff meetings (see Appendix D, p. 34).

Method C is considered by its distinguished proponents and the long-term participating hospitals as the "ultimate Peer Review System." In the university teaching hospital and in those which have stabilized, full-time, paid Chiefs of Departments and key staff, the use of PAS and the MAP computerized review system can be readily implemented by including these requirements in job descriptions of those employed. The nonpaid, annually changing professional staff at Methodist Hospital of Dallas

almost universally have voiced opposition to participating in this nationwide statistical competition; as they view it; they cannot give more time from their busy practices which require seventy-ninety hours a week in patient care. They much prefer the comparative statistics of similar voluntary hospitals in the Greater Dallas area which are utilized by the Administrator, Executive Director, and the Governing Body as a means of evaluating the overall performance of Methodist Hospital. The educational benefits from the use of PAS and MAP must be stressed in a continuing development of the departmental staff meeting review; analysis of computerized reports by service and physician on a monthly and semi-annual basis by the paid Director of Medical Education and part-time Assistant Director of Medical Education for each major department could materially assist the Chief and Assistant Chief in developing parameters of patient care as well as indicate a need for specific educational programs.

A $1.00 administrative charge added to each total hospital bill would finance both the PAS-MAP contract and the salary of the additional secretary or Assistant Records Librarian, whose services would become specialized in data retrieval-agenda preparation for all departments or committee meetings. The greatly improved documentation of the quality-control of patient care as an educational program should be ample justification for approval of this minimal charge for payment of bills by private and federal insurance officials.

Summary

The present system of peer review by ten of the twenty-three interdisciplinary committees of the Active Medical Staff has major weaknesses, gaps and deficiencies in adequate documentation of a comprehensive peer review system. This has been hindered by a previous lack of specific delineation of required consideration by each committee and lack of

secretarial support for complete documentation of detailed conclusions/ recommendations. Monthly departmental staff meetings have been purely educational and have not provided an internal review as required by the JCAH. Thus, the Administrator has no comprehensive or composite monthly evaluation/report of the quality of patient care required by JCAH, Medicare and private insurance officials. Budgetary increases are difficult to justify without complete documentation of utilization of present facilities and personnel; cost control measures by utilization review have become an important part of any peer review system.

A discussion of three alternative methods of development of a comprehensive peer review system at Methodist Hospital of Dallas has been presented. Actually these may be considered as a step progression from the simplest to the "ultimate" method.

Method A--An interdisciplinary (horizontal) Peer Review Committee would consolidate committee reports and minutes of the departmental staff meetings, each having secretarial documentation. This method is the most easily obtained but is least effective, is wasteful of professional time, and has little educational value.

Method B--Departmental peer review (vertical) subcommittees with prepared agendas and retrieved data would amplify a comprehensive review by departmental staff meetings documented by secretarial assistance; the main Peer Review Committee of departmental chiefs provide, by topic from all departments, a concise monthly evaluation of total professional activities. Maximum staff participation assists in the formulation of parameters of early diagnosis, effective therapy, and proper utilization. This provides

great educational benefits. Radiologists and Pathologists participate in departmental meetings for consideration of neoplasms, surgical tissue review, infections and blood banking, etc., thus permitting eventual abolition of many present interdisciplinary staff committees. All aspects of this plan are desirable and presently achievable.

Method C--Departmental subcommittees and the main Peer Review Committee would utilize the PAS and MAP computerized analysis systems to evaluate fully the quality of medical care and to delineate more accurately parameters of treatment. Trends and deviations from established "norms" for individual physicians as well as departments are identified on a monthly and semi-annual basis indicating the need for specific educational programs and/or corrective action. While at present this system is not acceptable to the professional members of the key staff, it can be achieved by a gradual evolution from a successful application of Method B which is acceptable to all key personnel interviewed.

Footnotes

[1]Joint Commission on Accreditation of Hospitals, Standards for Accreditation of Hospitals (Revised; Chicago: Illinois, Joint Commission on Accreditation of Hospitals, October, 1969).

[2]Kenneth J. Williams, M.D., "The Mechanics of Medical Audit," in The Medical Staff in the Modern Hospital, ed. by C. Wesley Eisele, M.D. (New York: McGraw-Hill Book Company, 1967), p. 225.

[3]Vergil N. Slee, M.D., "The Medical Audit," in The Medical Staff in the Modern Hospital, ed. by C. Wesley Eisele, M.D. (New York: Mc-Graw-Hill Book Company, 1967), p. 213.

[4]Commission on Professional and Hospital Activities, 1968 Green Road, Ann Arbor, Michigan 48105, Publications and Informational Bulletins, March 17, 1970.

[5]Interview, Mrs. Maifair Offutt, Medical Record Librarian, Methodist Hospital, Dallas, Texas, February 18, 1970.

CHAPTER III

CONCLUSION

Conclusions

The vertical Peer Review System (Appendix A, p. 26) based on departmental subcommittees with uniform agendas (Appendix C, p. 31) for documented monthly departmental meetings will fulfill all of the present standards of the Joint Commission on Accreditation of Hospitals (Appendix B, p. 28) and federal regulations for Medicare.

This Method B was acceptable to all twenty-seven members of the key professional and administrative staff interviewed personally over a three-week period. The composite role of this large group (Bibliography, Interviews, p. 41) will assure a broad base of support.

Method B will be rapidly attainable by utilizing the paid part-time Assistant Directors of Medical Education to coordinate data retrieval for preparation of uniform agendas for comprehensive review at monthly departmental staff meetings.

Method B will be immediately feasible within the present budget by a minimal amount of secretarial overtime to accurately document evening meetings.

Eventual progression to Method C will require a gradual orientation of the professional staff to the educational rather than punitive potentials of using the PAS and MAP computerized analysis of professional performance.

Method C would be financially feasible by adding a $1.00 administrative charge to each patient's total hospital bill to pay for PAS-MAP contract and the salary of the extra Assistant Records Librarian required.

Recommendations

Monthly departmental staff meetings should begin immediately to provide a comprehensive review of all pertinent aspects of total activities such as by a uniform agenda system (Appendix C, p. 31). Secretarial documentation of all departmental staff meetings and professional committee meetings is essential for completeness of any peer review system.

Chiefs of Departments, the Director of Medical Education and the four Assistant Chiefs of Medical Education should promptly determine the format and content of a uniform agenda for all departmental staff meetings. These latter paid staff members can then supervise data retrieval and the preparation of a comprehensive agenda; they can also assure notification of staff members whose case presentations may be indicated for review (deaths, infections, neoplasms, etc.). Each month, in turn, all records of a given illness or condition can be discussed in an anonymous manner to establish parameters of diagnosis, treatment and utilization as an educational feature. A Pathologist and a Radiologist attending each departmental meeting can amplify the discussions greatly for the benefit of all.

Educational brochures on the JCAH requirement for a comprehensive peer review system and on the salient features of the proposed vertical Method B should be prepared by the Executive Committee for circulation to all members of the Medical Staff prior to discussions at two consecutive general staff meetings. Broad-based cooperation must be established and maintained from the Active Medical Staff as well as from the paid full-time and part-time staff. A proposed addition to the updated by-laws

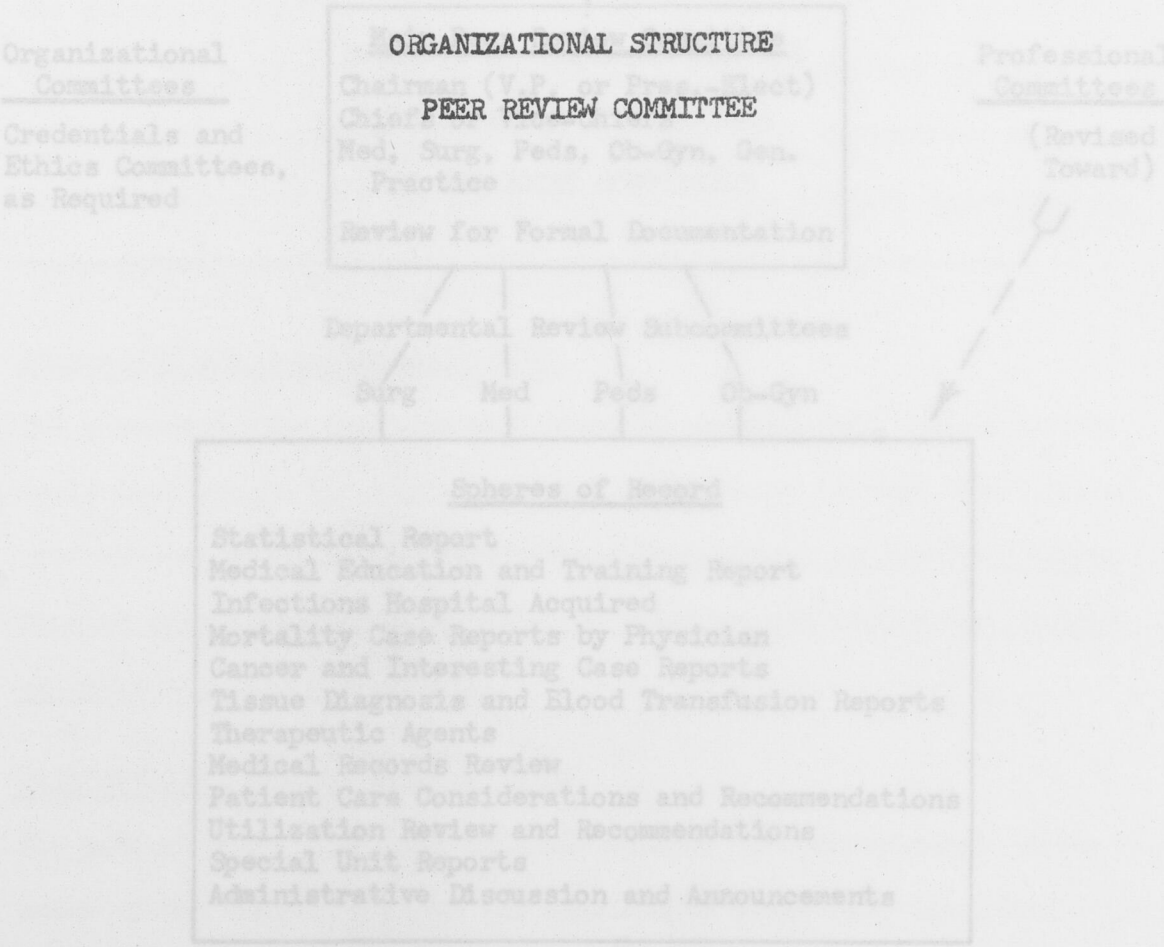
of the Medical Staff (Appendix E, p. 37) should be circulated for approval by the Active Medical Staff. Selection annually of an Assistant Chief of Department who is to become Chief the following year is recommended to help stabilize the peer review system; serving as head of the departmental subcommittee working closely with the Assistant Director of Medical Education in agenda planning and data retrieval, he would be better qualified to become the Chief of Department and to serve on the main Peer Review Committee the second year.

Recommend consideration be given by the Executive Committee and the Active Medical Staff to change the election of officers to the May meeting and the installation of new officers to the September meeting; summer vacations depleting attendance at committee and departmental staff meetings can be manipulated better after nine months of continuity than at the beginning of the year.

APPENDIX A

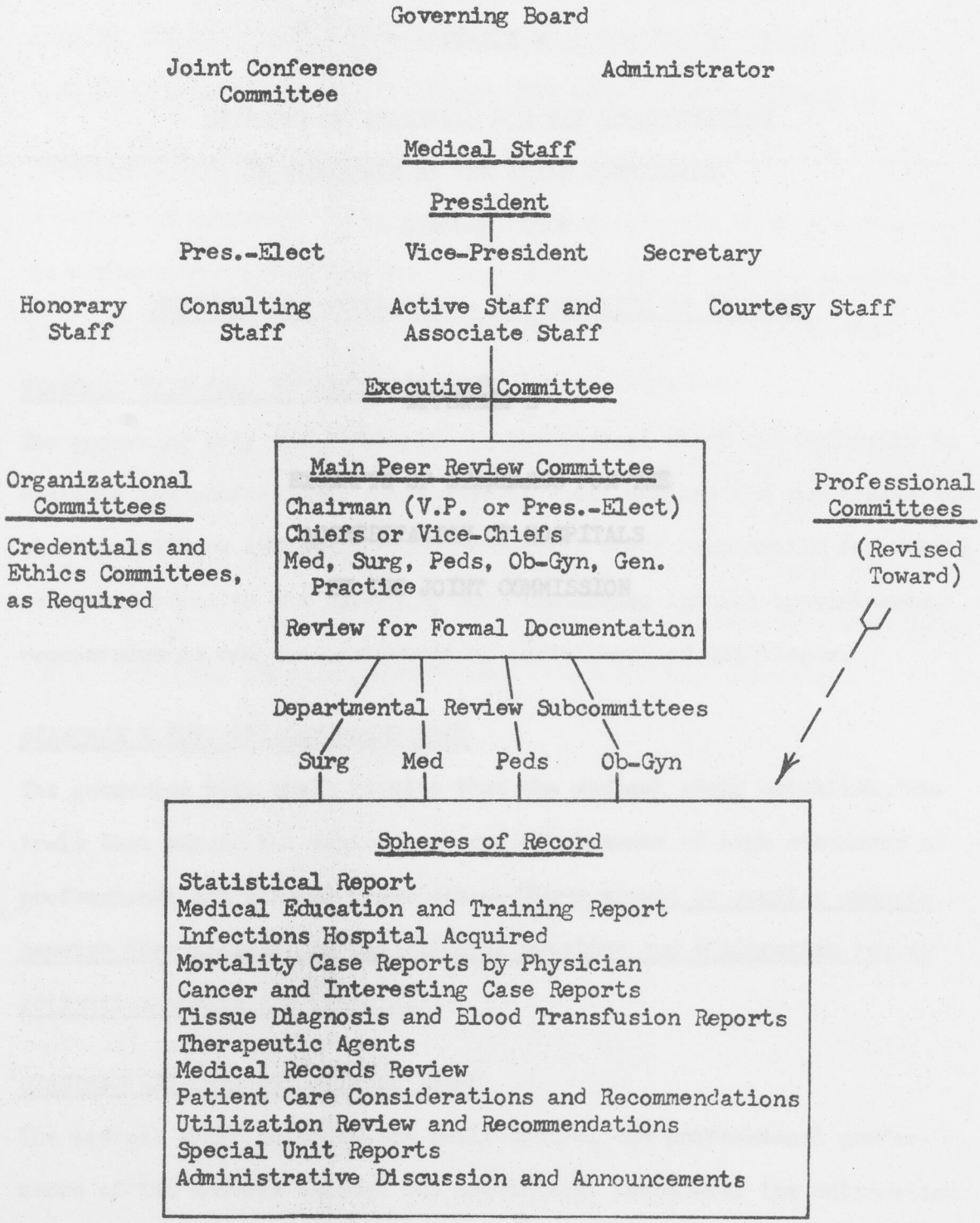
ORGANIZATIONAL STRUCTURE

PEER REVIEW COMMITTEE



APPENDIX A

ORGANIZATIONAL STRUCTURE PEER REVIEW COMMITTEE



APPENDIX B

EXCERPTS OF STANDARDS FOR THE ACCREDITATION OF HOSPITALS BY THE JOINT COMMISSION

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EXCERPTS OF STANDARDS FOR THE ACCREDITATION

OF HOSPITALS BY THE JOINT COMMISSION

October, 1969

MEDICAL CARE EVALUATION - INTRODUCTION OF IV & VII

STANDARD VIII (Pg. 8) GOVERNING BODY

The governing body shall delegate to the medical staff the authority to evaluate the professional competence of staff members and applicants for staff privileges and shall hold the medical staff responsible for making recommendations to the governing body concerning initial appointments, reappointments and the assignment or curtailment of privileges.

STANDARD X (Pg. 10) GOVERNING BODY

The governing body shall require that the medical staff establish controls that ensure the achievement and maintenance of high standards of professional and ethical practices.---There should be regular comprehensive peer analysis of the clinical practice and utilization review activities within the hospital.

STANDARD III (Pg. 19) MEDICAL STAFF

The medical staff organization shall control the professional performance of its members through the appointment procedure, the delineation of medical staff privileges and the continual review and evaluation of their clinical activities.---Whatever the organizational pattern

selected, the medical staff must provide an appropriate peer group method by which the required basic functions of medical, surgical, and obstetrical audit are thoroughly performed at least monthly. Included must be the analysis of necropsy reports and a tissue review (utilization of beds, diagnostic facilities, and consultation services.)

STANDARD V (Pg. 51) EMERGENCY SERVICES

A review of emergency service medical records should be done regularly to evaluate the quality of emergency medical care. Medical records of patients whose death occurred within 24 hours of admission to the emergency service should receive particular attention.

STANDARD VII (Pg. 84-86) PATHOLOGY SERVICES - BLOOD TRANSFUSION SERVICE

-----The medical staff periodically should review the records of all transfusions of blood and blood components in order to assess transfusion reactions, to evaluate blood utilization and to make recommendations regarding specific improvements in transfusion services.

APPENDIX C

RECOMMENDED BASIC AGENDA FOR DEPARTMENTAL REVIEW: SUBCOMMITTEE AND STAFF MEETINGS

APPENDIX C

RECOMMENDED BASIC AGENDA FOR DEPARTMENTAL REVIEW: SUBCOMMITTEE AND STAFF MEETINGS

1. Department of___: Statistics for Month of___, 19__(Graph Updated)

   Admissions___ Avg. Daily Census___ No. Operations__Maj.__Minor__

   Discharges___ Avg. Patient Stay___ No. Special Procedures___

2. Medical Education and Training Report
   - Interns and Residents Progress Report.
   - Paramedical, Technicians--Special Training Groups.
   - Staff Activities, Conferences Attended, Publications.

3. Infections and Complications: Morbidity Detailed
   - Hospital Acquired Infections, Laboratory Investigative Procedures.
   - Unexpected or Serious Complications, Prolonged Hospitalization Requirements.
   - Recommendations.

4. Mortality Case Reports by Physician
   - Selection of Cases for Presentation to Monthly Medical Staff Meeting.
   - Educational Aspects and Recommendations.

5. Cancer and Interesting Case Reports
   - New Diagnoses and Special Case Followup.
   - Therapeutic Review and Trends.

6. Tissue Diagnosis and Blood Transfusion Reports
   - Sterilization Procedures--Indications and Consultations.
   - Blood Bank Problems and Utilization.
   - Special Procedures.

7. Therapeutic Agents
   - Radiation and Isotopes.
   - Chemotherapy, Special Agents.
   - Antibiotic and Drug Controls.

8. Medical Records Review
   - Completeness: JCAH Standards.
   - Anonymous Random Review Report.
   - Appropriate and Timely Diagnostic and Therapeutic Measures.
   - Disposition and Future Care Recommendations.

9. Patient Care Considerations and Recommendations
   - Extended Care and Rehabilitation.
   - Consultations and Special Therapy.

10. Utilization Review and Recommendations
    Departmental Standards and Recertification Procedures.

11. Special Unit Reports
    Emergency Room and Operating Room, ICU, CCU and Respiratory Therapy.
    Problem Area Review and Recommendations.

12. Administrative Discussion and Announcements
    Special Communications and Standard Procedures.
    Federal and Insurance Requirements.

APPENDIX D

THE MEDICAL AUDIT PROGRAM

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THE MEDICAL AUDIT PROGRAM*

The Medical Audit Program (MAP) provides a method of evaluating care in all branches of medicine: internal medicine, obstetrics, pediatrics, and surgery. The Professional Activity Study (PAS) is the foundation of the method and is a prerequisite for the remainder of MAP, which may be elected on entry into PAS or at a later date.

> The PROFESSIONAL ACTIVITY STUDY is a system of access to the information in the hospital's clinical records. By working with abstracts of the individual records, and using electronic computers to handle these abstracts, PAS offers many things:
>
> a professional service accounting system for the individual hospital,
> a source of "yardsticks" for the hospital's own clinical statistics,
> a time-saving approach to the internal medical audit,
> profiles of care for utilization review,
> a research arm for the participating hospital,
> research studies on the clinical data from many hospitals,
> work simplification for the medical record department, and
> a convenient reference on individual patients which often makes chart-pulling unnecessary.

As of today there are 1,314 hospitals participating in PAS. They represent 47 states, District of Columbia, Puerto Rico, Canada, Australia, Saudi Arabia, and Venezuela, and discharge approximately 10,773,800 patients annually. Additional hospitals may join at a fee of 30 cents per patient discharged. Offsetting this fee there is a reduction of work in the medical record department.

PAS operates very simply in the medical record department with no additional work required of the medical staff. The Commission provides training for the hospital's medical record librarian. Thereafter, the librarian submits to PAS the one-page form on every patient discharged. This is the PAS Case Abstract of the clinical record which is the basis of the entire system.

The work-simplifying features of PAS are most easily seen in professional service accounting. From PAS the hospital receives its routine discharge statistics and its disease, operation, and physician indexes, all produced

*Taken en bloc from a letter from the Commission on Professional and Hospital Activities, 1968 Green Road, Ann Arbor, Michigan 48105.

rapidly and accurately by the Commission's computers. Elimination of these laborious hand operations usually results in a net saving to the hospital.

> For the REMAINDER OF MAP, the PAS-MAP reports and the option of participating in the perinatal study, a second contract is executed and an additional fee of 10 cents for every discharge is added: the full MAP totals 40 cents per patient discharged.
>
> MAP greatly increases the efficiency of the internal medical audit since it actually permits ALL of the medical care to be surveyed. Such thorough but rapid review of practice is possible for two reasons. First, PAS and MAP reports, prepared by computer processing of the abstracts, give summaries of essential elements of care. Second, other sections of the reports group similar kinds of patients and give abstracts of every individual case; these usually make reference to the actual clinical records unnecessary.

Should a hospital wish to participate, the Commission will be pleased to send the contracts and the necessary forms to be executed. The exact terms of the contracts are reproduced in the brochure along with the steps to be taken for initiating participation.

APPENDIX E

PROPOSED ADDITIONS TO BY-LAWS OF MEDICAL AND DENTAL STAFF OF THE METHODIST HOSPITAL OF DALLAS, TEXAS

APPENDIX E

PROPOSED ADDITIONS TO BY-LAWS OF MEDICAL AND DENTAL STAFF OF THE METHODIST HOSPITAL OF DALLAS, TEXAS

Composition.* The Peer Review Committee shall consist of the chiefs or vice-chiefs of the departments of surgery, medicine, obstetrics-gynecology, pediatrics, and will include general practice (or their elected representatives) and another member of the staff appointed by the executive committee to serve as chairman. There shall be a sub-committee for each of the departments of surgery, medicine, ob-gyn, and pediatrics.

The duties shall be as follows:

a. To review, analyze, and evaluate the clinical practice of the medical and dental staff in all areas of the hospital.

b. To maintain through its own reviewing procedures a continuing appraisal of medical care as practiced in the hospital.

c. To direct, coordinate, and follow-up the work of the departmental review sub-committees and to receive at monthly intervals reports in writing from the aforementioned sub-committees.

d. To submit to the executive committee each month through its chairman a written report outlining the work done.

e. To review professional activities on disease, operation, investigation, therapy, and individual physician bases.

f. To evaluate medical care on one basis of the medical and dental staff's overall program of continuing education.

g. To make recommendations to the executive committee regarding the establishment, maintenance, and improvement of professional standards within the hospital.

h. To meet at least monthly and keep minutes of all such meetings.

i. It shall have access to all records and abstracts pertaining to any aspect of clinical practice.

*Taken en bloc from By-Laws of Saint John Hospital, Detroit, Michigan as quoted by Kenneth J. Williams, M.D., Medical Director: "The Mechanics of Medical Audit," in The Medical Staff in the Modern Hospital, ed. by C. Wesley Eisele, M.D. (New York: McGraw-Hill Book Company, 1967).

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ABSTRACT

A PEER REVIEW SYSTEM FOR METHODIST HOSPITAL OF DALLAS, TEXAS

A Problem Solving Thesis Submitted to the Faculty of Baylor University in Partial Fulfillment of the Requirements for the Degree of Master of Hospital Administration

by
Colonel Arren C. Buchanan, MC

August 1971 42 Pages

A copy of this document may be obtained from University Microfilms, University of Michigan, Ann Arbor, Michigan 48108.

This paper was the result of a study conducted at Methodist Hospital, Dallas, Texas, to define and implement a comprehensive peer review system.

The study was prompted by the recent revision and amplification of earlier standards of accreditation for hospitals by the Joint Commission on Accreditation of Hospitals (JCAH). Departmental monthly review of many facets of patient care and hospital utilization has become mandatory, materially increasing requirements for documentation and interdepartmental consolidation of reports. Under Social Security Administration Medicare reimbursement provisions, P.L. 89-75, participating hospitals must employ and document a peer review system satisfactory to the JCAH; other third party payors are also requiring this evidence of medical audit to control ever-rising costs of health care and to justify necessary cost increases.

The present system of approximately ten multidisciplinary committees of the Medical Staff constitutes a peer review, but does not include departmental review documentation. It was difficult, under the present system, to present a consolidated comprehensive peer review report to examiners of the JCAH, Blue Cross, other third party payors, or governmental agencies.

A different peer review system, effectively used for over ten years by voluntary hospitals of similar size, has been presented. Departmental monthly meetings document, by agenda and appendixes, the ten or more major areas of interest as subcommittees; when consolidated by the Chiefs of Departments comprising the (Main) Peer Review Committee, a comprehensive monthly report is available for all authorized examiners.

Other hospitals, by carefully documenting departmental activities in this manner, have eventually reduced or consolidated the professional committees of the Medical Staff from twenty-three to seven, retaining full approval of the Joint Commission on Accreditation of Hospitals. Conservation of professional time is also facilitated; improvement of patient care with continuing medical education is stimulated by departmental conferences.