Transforming an Obsolete Utilization Management Program in a VA Hospital

A Systems Approach to Enhancing Quality and Efficiency

Situation

Hospital Clinical Case Management (CCM) has evolved considerably from the early models deployed in the 1980's when hospital and procedure volume topped the list of priorities for most hospital administrators. Today's priorities are different. Enhancing patient value is the fundamental goal that keeps providers awake at night. In the hospital setting, value is largely determined by how efficiently and effectively the breadth of services, disciplines (including specialists) and hospital operations come together. Hospital care is a complex undertaking; information technology and decision support are important, but they are not sufficient. Hospitals need a better strategy for smoothing care continuity, improving quality, and ensuring efficient coordination at the patient level. One way to achieve this contemporaneously is through a high-performing CCM program. Experienced clinicians with balanced CCM and quality management know-how can help organizations accelerate value.

The VA in this case had not established a CCM program. Innovations in the area of centralized bed control, electronic bed boards, and automated bed cleaning software were implemented to help improve patient flow but medical necessity and utilization decision support was lacking. Care coordination was inconsistent as it was "everyone's" job. In practice, was translated into no one's job. Outpatient observation bed status was never implemented so providers had no choice but to use patient status for management of short-term assessment and care. Utilization review (UR) and risk-adjusted length of stay outcomes revealed major opportunities for improvement.

In May 2010, VHA published a new Utilization Management (UM) directive applicable to all VA facilities with acute care beds. The changes were significant in that UR was expanded from a manual chart review of 20% of all acute inpatient beds to an electronic review of 100% of those beds using a web-based platform called NUMI. The National Utilization Management Integration (NUMI) is a standardized national VA software application that automates documentation of clinical features relevant to each patient's condition and the associated clinical services provided. This data is electronically aligned with evidence-based criteria to ensure acute care services are medically necessary and reasonable, and provided in the most appropriate setting. NUMI effectively automated several components of the UM process including patient reviews, input from physician advisors and UM reporting. In addition to expanded UR and web-based IT enhancements, the philosophy of UM was also changing. VHA was moving to progress UM staff participation in daily patient care management in order to assure "the right care for the right patient at the right time and for the right reason". VHA's overarching goal for UM program transformation was to ensure quality and operational efficiency across the care continuum. A bold but vital move for the agency.

VHA concurrently mandated facility business office reviews of the specific causal factors in cases where VA facilities were unable to bill third party payers for non-service connected conditions. Gaps in medical necessity were thought to be a contributing factor and as such this data was included in the "reasons not billable" analysis mandated by central office. In most VAs, Fee-basis UR nurses are responsible for review and follow-up on inpatients with known third party insurance. These nurses are organized separately from Quality Management UR nurses and report up through a different service organizationally. Collaboration amongst the two groups was lacking in our facility and there seemed to be a prevailing sense that Fee UR and Quality UR were completely unrelated. Fee UR nurses still conduct reviews remotely via the electronic

Key Points

- Midwest VA hospital transforms utilization review (UR) workflow to incorporate a web-based electronic tool, onsite interdisciplinary collaboration and just-in-time reports for patient flow decision support.
- UR clinical transformation opens the door to a value-based Clinical Case Management program – the first in this hospital's history.
- Early outcomes show favorable impact on quality and efficiency.

Impact Summary

If your organization is collecting inpatient utilization data in the absence of onsite integration with the interdisciplinary clinical team, your ability to effect quality and efficiency is likely hampered. Furthermore, if utilization data is not fully employed as a just-in-time tool for managing organizational capacity and patient flow, you may be throwing away precious labor dollars collecting information that fails to deliver real value. Finally, strategic incorporation of select Quality Management activities into CCM workflow can integrate quality system priorities into real-time point of care activities. This broadens both efficiency and effectiveness.

This case study illustrates successful transformation of an ineffective UR program in a large tertiary VA Medical Center. It demonstrates how an outmoded UR program can develop into an interdisciplinary just-in-time clinical tool for patient care. It also suggests ways in which quality improvement can integrate with UR workflow. Early results show promising trends in patient outcomes and readmissions. Full realization of program benefits requires executive leadership support for expanding team-based care in the inpatient setting.

medical record and providers are contacted to clarify clinical data as needed. Utilization of NUMI software is not required and there were no provisions for integrating quality and fee UR programs in the new UM Directive. This separation of staff causes avoidable inefficiencies including duplication of UR work. If hospital CCM was fully developed, onsite Case Managers could aptly incorporate denial management into their workflow. As members of the onsite interdisciplinary team, hospital case managers would seemingly be better apt to oversee and manage accurate and complete clinical information for the purposes of reimbursement. A case management model would also improve the efficiency of physician work flow because Case Managers are available at the point of care during multidisciplinary rounds to provide just-in-time information and to actively participate in the care management process.

From a national perspective The Congressional Budget Office has stated that healthcare reform law will expand coverage to about 32 million people, reducing the number of uninsured Americans to 23 million by 2019. The ability of our national healthcare system to absorb the anticipated increase in demand for care is uncertain. Many thought leaders assert that reform will likely intensify workload on already stretched emergency departments (ED) due to an undersized primary care infrastructure. Given this, VHA will likely have a significant national role to play in supporting healthcare reform. By guaranteeing efficient capacity management and patient flow within VA hospitals and across integrated VHA networks, the agency may curtail veteran patient transfers/referrals to local hospitals and EDs by optimizing capacity to care for VA patients in VA hospitals.

Challenge

In our facility, UR work was traditionally a collateral responsibility for Quality Management Nurses. In addition to UM they were responsible for accreditation and continuous survey readiness, performance measures and improvement, medical record reviews, quality committee facilitation, peer review coordination, etc. As a matter of practicality, utilization review was typically completed in isolation from onsite clinical teams. The relationship between QM UR nurses and inpatient providers was sometimes strained. This was mainly because the UR nurses lacked interdisciplinary relevance when trying to impact medical necessity or delays in care since they were not a part of the healthcare delivery team. In addition, UR work flow was inconsistent amongst the QM staff and most nurses struggled to keep up with their reviews during regulatory surveys and other periods of competing Quality Management priorities. Bed Control business rules had been developed to help facilitate patient flow but UR data was rarely incorporated into the decision-making process. Patient flow was essentially managed by referencing basic admission criteria or physician preferences, and by shifting volume from one patient care area to another when census increased. From time to time, patients scheduled for outpatient procedures were unnecessarily admitted

to the hospital the night before. If scheduled for major surgery, admission could occur several days before the actual procedure. When hospital patient volume exceeded available beds, Bed Control business rules called for patients requiring admission to be sent to a local non-VA hospital until a VA bed became available. The essential contributing factors to this uneven capacity management were 1) lack of integration between UR and patient flow activities, 2) insufficient real-time decision support and 3) weak infrastructure for effective UR workflow. From a Quality leadership perspective, UR activities drained QM staff productivity; data collection was time consuming, UR workflow was constantly interrupted by competing priorities and clinical leadership could rarely use UR information to influence quality or patient flow.

Following release of the UM Directive, the Office of Quality and Performance (OQP) provided regional VA networks with guidance on key components of an effective program but suspended mandates for strict program structure or processes. In essence, this allowed maximum flexibility for networks and local facilities to revamp processes in accordance with their individual quality initiatives and FTE budgets. For our hospital, the stakes were much broader than just expanding the volume of reviews and implementing NUMI – these tasks could have been simple (and painless) to overhaul. The real task was to confront an ineffective UM program and transform it into resourceful strategy for driving quality and value.

Solution

The best path to increasing patient value for our facility was a hospital-based clinical case management program. Value was calculated using the basic formula whereas

PATIENT VALUE = BENEFITS - COSTS

The most substantial costs were associated with human capital. However, since VHA mandated an increase in UR from 20% to 100% , it was understood that there would be some impact on FTEs no matter the future design (e.g. expand UR resources for just UR or implement Clinical Case Management). Given this, the equation shifted weightily towards high benefit. Major risks included slow rate of CCM acceptance by clinical teams, failure to capitalize on CCM resources once hired, and inconsistencies in leadership support for program development.

Using actual facility bed days of care (acute care beds only) and the UM productivity metric of 15 min/patient/day (staffing benchmark provided by OQP) the FTE requirements were calculated and incorporated into the CCM proposal with no additional adjustment except to add a replacement factor. The proposal for CCM was presented in detail to our Medical Center Director. The value of UR transformation was amplified by the prospect of right-sizing UR activities within the context of broader case management work – a positive-sum result.

This meant that incorporation of key functions other than UR such as care coordination and patient flow, on site promotion of quality and patient safety measures, variance tracking, work flow process redesign, readmission rate reduction and direct collaboration with Fee UR nurses to assist with reimbursement and denial management could be realized. The facility already employed discharge planners on most of the acute care wards. Based on the complex discharge needs of the veteran population, the decision was made early on by the Director and Associate Director/Chief Nurse to maintain the distinct role of discharge planning. Collaboration amongst the two groups would be essential and with leadership guidance and clearly defined expectations, this should be achievable.

The Director approved 88% of the total FTE request and provided support for implementation of an inpatient CCM program. Through a series of Director-facilitated meetings with key members of the executive team, the case management proposal was shared broadly to elicit feedback and to garner support. The plan was shared with all key clinical and administrative leaders across the acute care areas. Over the course of the next several months, the implementation plan was continuously adapted and refined based on joint feedback from physicians, nurse leaders and other managers in acute care. For example, initial plans to assign case managers by patient ward were altered to instead align one case manager with each physician -led team. Although this change meant that case managers would be following patients on different wards, it assured care coordination consistency. Additionally, it provided continuity for the medical teams and helped to minimize the disruption of attending and resident turnover that occurred every two weeks.

In July 2010, the newly selected Case Management team was on board with QM. A diverse mix of internal VA candidates with quality expertise and external candidates with Case Management expertise formed a balanced group. Work stations were added in each patient care area and CCM staffs were integrated into the care teams. Their daily workflow included participation in interdisciplinary patient care rounds, which enhanced veteran-centric care coordination and assured communication of concurrent NUMI medical necessity and intensity of services information. The group took on additional quality related initiatives such as inpatient influenza vaccination and readmission rate analysis and reduction. Plans for added quality responsibilities in the areas of reimbursement and continuous survey readiness were planned for the future.

Outcomes

Initial results: 6-9 months following program initiation:

1. The percentage of utilization reviews increased from 20% of inpatient acute care beds to 100% of inpatient acute care beds by the target date of July 2010.
2. Case Managers designed and implemented an electronic work flow that replaced the manual work flow and eliminated all redundancy and rework.
3. Case managers were fully integrated into onsite interdisciplinary care teams. Medical necessity and intensity of services data was provided at the point of care for just-in-time patient flow decision support.
4. NUMI definitions and variance criteria were standardized across the Case Management team to enhance actionable UR variance reports.
5. Acute care risk adjusted length of stay was reduced by well over 50% by the end of the calendar year.
6. Heart failure readmission rates were also reduced by 50%.
7. Both inpatient influenza vaccination rates and patient satisfaction increased.
8. CCM was first to recognize an infection outbreak through a cluster of hospital admissions expanding organizational infection control surveillance capabilities
9. CCM identified opportunities to help non-service connected veterans identify insurance eligibility (e.g. Medicare) - an unforeseen added value for veterans.