King Saud University
College of Business Administration
Department of Health Administration - Masters` Program

HHA 510 – Health Resources Utilization Management & Review

Second Semester 1441/ 1442

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Introduction to utilization management

Learning objectives

- **Describe the purpose of utilization management**
- **Discuss utilization management measurement, assessment, and improvement activities;**
- **Recognize the role of physicians and nonphysicians in managing the use of healthcare resources;**
- **Describe how clinical practice guidelines are used for utilization management purposes;**
- **Identify sources of comparative healthcare utilization data.**

Introduction to utilization management

- **Quality management is a broad term that encompasses many healthcare performance measurement, assessment, and improvement activities.**
- **Patient safety, is one component of quality management, another component is utilization management.**
- **The activities involved in utilization management are somewhat different from those involved in patient safety and other performance improvement initiatives.**

Introduction to utilization management

Utilization Management

- **In the early 1980s, the American Hospital Association defined utilization management (UM) as planning, organizing, directing, and controlling healthcare products in a cost-effective manner while maintaining quality of patient care and contributing to the organization's goals. In other words, providers and payers use UM to eliminate underuse and overuse of medically necessary healthcare services.**

Introduction to utilization management

Utilization Management

- **The Institute of Medicine defines utilization management** as "a set of techniques used by or on behalf of purchasers of health care benefits to manage health care costs by influencing patient care decision-making through case-by-case assessments of the appropriateness of care prior to its provision."
- **Standard utilization management services** include **prospective review**, **concurrent review**, **retrospective review**, **pre-certification of hospital stays**, and **discharge planning**

Introduction to utilization management

Utilization Management

- **Utilization management** is the evaluation of the appropriateness, medical need and efficiency of health care services procedures and facilities according to established criteria or guidelines and under the provisions of an applicable health benefits plan.
- **Typically**, it includes new activities or decisions based upon the analysis of a case.

Introduction to utilization management

Utilization Management

- **The principal objective of utilization management is the reduction of practice variations by establishing parameters for cost-effective use of health care resources.**
- **There are four main techniques or tools used in utilization management: demand management, utilization review, case management, and disease management. Utilization management helps HCOs control costs and improve quality.**

Introduction to utilization management

Utilization Management

- **Fundamentally, the purpose of UM is to ensure that patients receive necessary medical services at the least cost.**
- **In any business transaction, buyers do not want to pay for something they do not need, and they do not want to pay for top-shelf products when a less expensive product will work just as well.**

Introduction to utilization management

Utilization Management

- **For instance, when your car needs an oil change, you don't want to buy extra parts or high-performance oil blends you do not need. You pay the entire bill in this transaction, so you decide what is necessary.**
- **You may consider the mechanic's recommendations, but you also know that the mechanic's desire for profit could motivate him to suggest unnecessary products or services.**

Introduction to utilization management

Utilization Management

- In healthcare, the buyer–seller relationship is different.
- First, an insurance company often pays the majority of the bill, whereas the patient pays nothing or only a small portion of expenses.
- Health insurers are the primary buyers of healthcare services, and like all buyers, insurers do not want to pay for unnecessary care.
- Healthcare customers—patients—rely almost solely on physicians and other providers to decide which services are necessary.

Introduction to utilization management

Utilization Management

- **Profit considerations could influence healthcare recommendations, as in other industries; however, the average patient cannot distinguish between necessary and unnecessary services, putting her at a disadvantage.**
- **Likewise, the average patient cannot recognize underuse of services—situations in which beneficial services are not provided.**
- **Fortunately, those in the best position to judge medical necessity—practitioners and healthcare organizations—actively evaluate services to prevent overuse and underuse.**

Introduction to utilization management

Utilization Management

- **Medically necessary** **Appropriate and consistent with diagnosis and, according to accepted standards of practice in the medical community, imperative to treatment to prevent the patient's condition or the quality of the patient's care from being adversely affected.**
- **Underuse, Failure to provide appropriate or necessary services, or provision of an inadequate quantity or lower level of service than that required.**

Introduction to utilization management

Utilization Management

- **Utilization**, Use of medical services and supplies, commonly examined in terms of patterns or rates of use of a single service or type of service, such as hospital care, physician visits, and prescription drugs.
- **Overuse**, Provision of healthcare services that do not benefit the patient and are not clearly indicated or are provided in excessive amounts or in an unnecessary setting.

Introduction to utilization management

Defining Appropriate Services

- **Many healthcare decisions are easily made. For instance, a patient with a broken arm needs bone realignment and a cast. Some medical decisions are not so obvious, however.**
- **To practice UM, purchasers and providers must have a way to judge the appropriateness of services.**
- **Until relatively recently, only physicians decided whether services would benefit their patients.**

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Defining Appropriate Services

- **In the early 1970s, researchers who studied physicians' care for patients with the same medical condition found a pattern.**
- **One of these researchers, John Wennberg, MD, a Dartmouth Medical School expert in geographic variation in healthcare delivery, uncovered substantial evidence of overuse—unneeded healthcare.**

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Defining Appropriate Services

- **In one analysis, for example, despite a lack of discernible improvements in health in the higher-spending locations, he found that 70 percent of children who grew up in Stowe, Vermont (higher spending community), had tonsillectomies by age 15, compared with 10 percent of children from the neighboring town of Waterbury (lower spending community)**

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Defining Appropriate Services

- **Similarly, approximately 50 percent of men in Portland, Maine, had prostate surgery by age 85, compared with about 10 percent of men in Bangor.**
- **These studies tended not to label utilization as appropriate or inappropriate, but the variability of the results suggested that many services were unnecessary. These findings caused purchasers to strengthen UM efforts.**

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Defining Appropriate Services

- **Researchers found that in areas of treatment that enjoy strong professional consensus on the appropriate use of particular services (e.g., surgery for cancer of the bowel, hospitalization for hip fracture), utilization varies relatively little, whereas in areas that enjoy low consensus (e.g., the need for hysterectomy and prostatectomy), utilization varies more.**
- **Health insurers encouraged the development of clinical practice guidelines and standardization of care for UM purposes, specifically to reduce the provision of unnecessary services.**

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Defining Appropriate Services

- **Although hundreds of clinical practice guidelines are in place, for many conditions evidence is insufficient to use as a basis for judging treatment appropriateness. In these situations, physicians have considerable latitude in making treatment decisions.**
- **For this reason, variation in the services provided to patients with similar conditions is still evident.**

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The Role of Health Insurance in UM

- **There are many who believe that unrestrained fee-for-services medicine has led to inappropriately high utilization an is therefore the root cause of the health care cost crisis.**
- **While there is merit in the argument, it is simplistic.**
- **Health care costs are escalating at an alarming rate for many reasons, not just fee-for-service medicine. UR has emerged as a key feature of cost management.**

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The Role of Health Insurance in UM

- **Historically, providers and healthcare organizations have been compensated for care provided based on fee-for-service reimbursement models.**
- **When a provider is reimbursed based on a fee-for-service model, they are compensated for each procedure, test, treatment, etc. they perform, regardless of whether that procedure, test or treatment results in a better outcome for the patient.**

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The Role of Health Insurance in UM

- **Essentially, with the fee-for-service model, providers are financially rewarded for quantity over quality.**
- **With this payment model, it's easy to see how patients can sometimes undergo unnecessary tests or treatments when perhaps less invasive, lower cost, and just-as-effective options are available.**

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The Role of Health Insurance in UM

- **Volume has become an important indicator of healthcare quality. The basic premise, which on the surface may seem intuitive, is that the higher the volume, the better the quality.**
- **However, this simplistic view may significantly underestimate the complexity of the issues.**
- **Historically, payers have concentrated their cost-containment energies on the unit price of medical services and have directed less attention to the volume of those services provided by institutions and practitioners.**

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The Role of Health Insurance in UM

- **Although some hospitals used committees to monitor utilization in an effort to cope with the short supply of hospital beds during World War II, the first explicit use of retrospective utilization review to control fee-for-service payments for unnecessary and inappropriate hospital services seems to have begun in the 1950s.**
- **These tools may have had some impact, but they often were neither rigorously applied nor rigorously evaluated.**

Introduction to utilization management

Health Insurance

- **While market competition has been exported to European nations and many developing countries as the solution that will slow down or lower health care costs, many countries have concluded that competitive schemes in health insurance are likely to produce higher costs and inequities.**
- **The inherent causes of market failure concerns two weaknesses in the health insurance market, namely adverse selection and moral hazard.**

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Health Insurance

- In health insurance, adverse selection refers to the scenario in which higher-risk or sick individuals, who have greater coverage needs, purchase health insurance, while healthy people delay or decide to abstain.
- Adverse selection refers to the difficulties associated with providing health insurance to individuals who know more about their true medical condition than the insurer does. (organizations have difficulties distinguishing high risk from low risk consumers)

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Health Insurance

- **Moral hazard arises when the insured that pays only part of or none of the marginal cost of covered services overutilize these services and knowingly engage in behaviors that allow controllable aspects of their health to deteriorate.**
- **Moral hazard became an important question in the modelling and build-up of the German health insurance system created in the 19th century. The main point of moral hazard in health insurance could be described as follows: when people are insured, they use more medical care services than if they didn't have health insurance.**

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Health Insurance

Paying for medical care

- **Consumers pay for most medical care indirectly, through taxes and insurance premium. Healthcare managers must understand the structure of private and social insurance programs because much of their organizations' revenues be shaped by these programs.**
- **Exhibit 3.1 depicts a healthcare market in general terms. The direct payment paid by consumers are often called out-of-pocket payments.**

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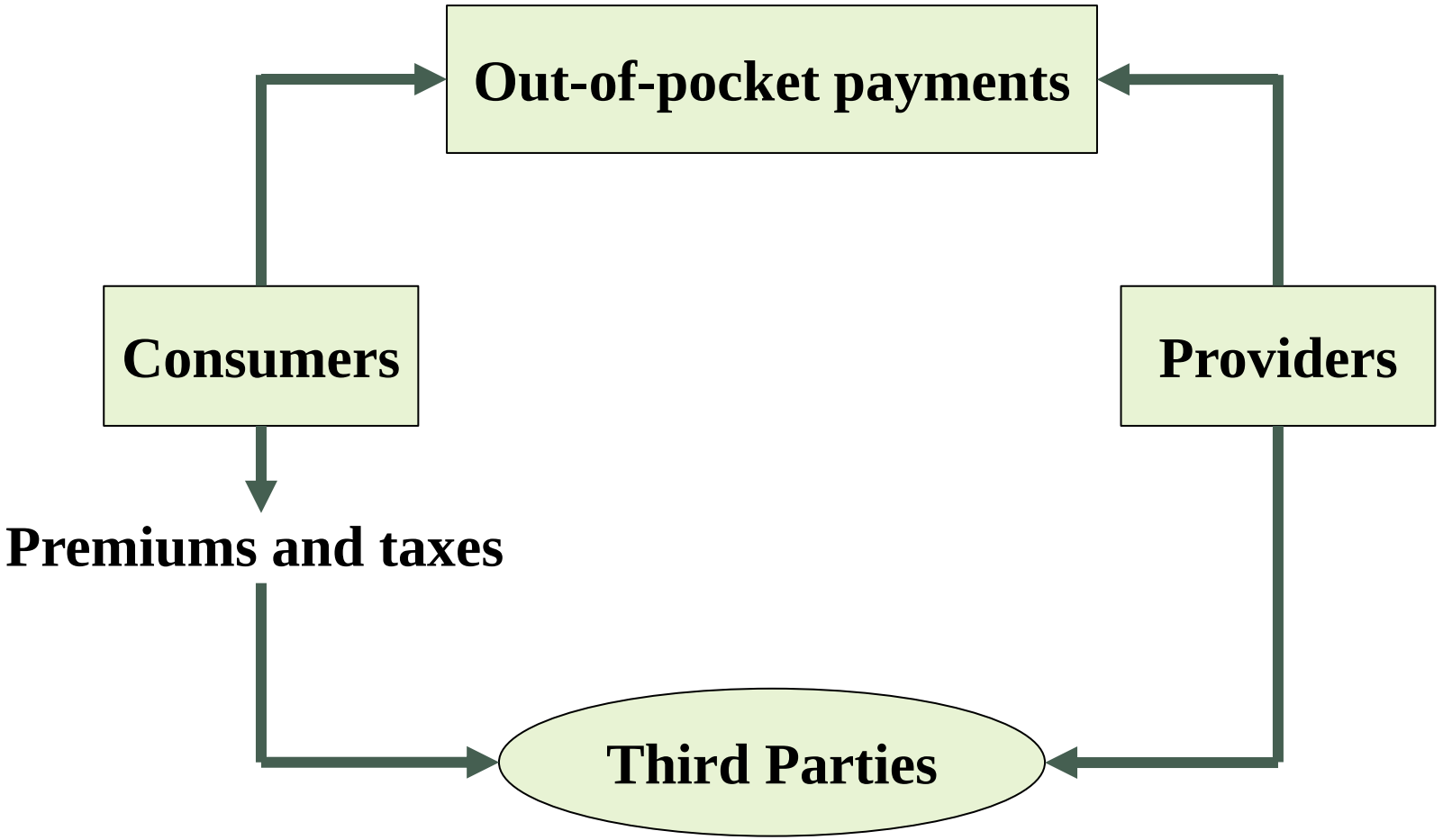

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Health Insurance

- **The difficulty in controlling costs in health insurance arises because sickness is not always a well-defined condition and many of the costs of treatment are within the control of the insured.**
- **The costs are partly within the control of the physician and hospital, which may profit from additional services and raise prices as the patient's ability to pay increases.**
- **So particularly in a society where the government does not directly finance and operate the hospitals, health insurance involves a severs problem of moral hazard.**

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The Role of Health Insurance in UM

- **For staff members in case management, the business office, or the medical records department, the mention of the words utilization review (UR) draws a collective groan.**
- **For physicians, it's a reminder of their distrust of the insurance companies who are just trying to stick it to them, or of the avoidance tactics that kick in automatically when they see the "UR police" approaching them in the hospital hallway.**

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The Role of Health Insurance in UM

- **In 1954, Fred Carter, a physician, wrote in *The Modem Hospital*, "Why not appoint a standing hospital staff committee designated as the 'hospital utilization committee' to do in the field of hospital and medical economics what the tissue committee does . . . in the field of surgery. Abuses in the use of hospital services and facilities coming to the attention of this hospital utilization committee could be disciplined to the point of near deletion".**
- **Apparently, high optimism about the impact of utilization review was born with the idea itself.**

Introduction to utilization management

The Role of Health Insurance in UM

- **Tissue committee A group that evaluates all surgery performed in a hospital or other health care facility. The evaluation is usually made on the basis of the extent of agreement of the preoperative, postoperative, and pathologic diagnoses and on the relevance and acceptability of the diagnostic procedures.**
- **This is the first step toward the critical evaluation of the quality of surgical care given hospital patients and is now required by: the joint commission on Accreditation of hospitals. However few hospitals have tissue committee that are providing an effective evaluation of surgery at the present time**

Introduction to utilization management

The Role of Health Insurance in UM

- **The 1950s also appear to have seen the first attempt to establish provisions in health benefit plans to encourage or require second surgical opinions.**
- **The San Joaquin County Foundation for Medical Care (FMC), founded in 1954, not only served as a model for many IPAs (Independent Practice Association) but also helped inspire several medical societies to organize peer review of health care utilization and quality.**
- **FMCs pioneered many utilization reviews tools, including model treatment profiles to assess physician performance, protocols for reviewing ambulatory care, and computerized screening of claims.**

Introduction to utilization management

The Role of Health Insurance in UM

- **Utilization review also spread in other settings. In the early 1960s, more than 60 Blue Cross plans reported programs to review hospital claims for the appropriateness of admissions, and more than 50 looked at the length of stay.**
- **Some required physicians to certify at admission that hospital care was necessary for cases such as diagnostic and dental admissions, and more than two dozen required physicians to certify the need for continued hospital care after a specified length of stay.**

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The Role of Health Insurance in UM

- **Odin Anderson noted in 1968 that as payers showed increasing interest in medical practice patterns, "the central concern of the medical profession today and in the years ahead might well be "bureaucracy"**
- **Many argue that the UR process can be tedious and intimidating and that working with the insurance companies on behalf of the patient, the physician, and the hospital is a frustrating exercise pitting the providers against the payers.**
- **The medical staff are frustrated by the payer reviewers and don't understand why their judgment is being called to task, when all they want is to ensure the patient's well-being.**

Introduction to utilization management

The Role of Health Insurance in UM

- **Physicians grumble about the intrusions and challenges they constantly encounter by the hospital's UR specialists, clinical documentation improvement specialists, case management medical directors or physician advisors, the government, and the insurance companies.**
- **They don't believe that good documentation is a cornerstone of good care. They are privately—and sometimes publicly—annoyed when they perceive that someone else is questioning their professional judgment.**

Introduction to utilization management

The Role of Health Insurance in UM

- **Prior review of proposed medical care is not entirely new in the 1980s.**
- **Review organizations for Medicare were performing some preadmission review in the 1970s, and some private payers made limited use of the technique even earlier.**
- **However, widespread application of this approach to managing health care utilization is a phenomenon of the 1980s.**

Introduction to utilization management

The Role of Health Insurance in UM

- **What accounts for this rapid spread of utilization management through external assessments of the need for proposed medical services?**
- **The most obvious factor is rapidly rising health care costs.**
- **Purchasers' search for effective ways to limit their financial liability for health benefits stems directly from their belief that costs are out of control.**

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The Role of Health Insurance in UM

- **To the dismay over rising health care costs has been added a growing perception that much medical care is unnecessary and sometimes harmful.**
- **The studies that have contributed to this perception have also produced some optimism that external review of physician practice decisions could detect unnecessary care, influence physician behavior, and reduce costs without jeopardizing access to needed services.**

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The Role of Health Insurance in UM

- **The continuing evolution of utilization management is most evident in its scope and its operational efficiency. The reasons for these developments are several.**
- **First, the initial savings from shifting the site and timing of care have largely been realized, and the survival of review organizations may depend on their continuing ability to affect benefit costs.**

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The Role of Health Insurance in UM

- **Second, review organizations are being influenced by researchers' beliefs that much care is still inappropriate and unnecessary.**
- **Third, the administrative and other costs of review programs, including physician dissatisfaction and employee confusion, make simplification and efficiency important objectives.**

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The Role of Health Insurance in UM

- **To summarize, as third-party payment for medical care services expanded from the 1930s into the 1960s, payers—primarily insurers and health maintenance organizations (HMOs)—tried various tools to control these costs.**
- **These tools may have had some impact, but they often were neither rigorously applied nor rigorously evaluated.**
- **In general, concerns about controlling costs were still overshadowed by society's desire to expand access and improve health outcomes through the development and implementation of advances in medical care.**

Introduction to utilization management

The Role of Health Insurance in UM

- **Utilization management (UM) (from the health insurance organizations perspective) refers to any clinical restriction on utilization designed to approve or disapprove care based on clinical necessity.**
- **UM techniques do not preclude patients from obtaining the service; they simply say that the insurer is not liable for the cost of the service if UM procedures are not followed. .**

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The Role of Health Insurance in UM

- **Several types of UM techniques have been used over the years, including:**
- ***Preadmission certification*. The insurer requires that nonemergency hospital admissions be approved by the insurer before the patient is admitted to the hospital.**
- ***Concurrent review*. This is typically used in conjunction with preadmission certification. It specifies the number of hospital days a patient is authorized to stay. If a physician wants a patient to stay longer, additional days have to be requested.**

Introduction to utilization management

The Role of Health Insurance in UM

- **Several types of UM techniques**
- ***Retrospective review*. This inpatient review is undertaken after the patient has been discharged. If the insurer determines that the patient should not have been admitted or should not have stayed so long, it will advise the provider to follow the insurer's admission protocols.**
- ***Denial of payment*. This inpatient review is used in conjunction with retrospective review. If the patient should not have been admitted or stays too long, the insurer will not pay for the inappropriate admission or days.**

Introduction to utilization management

The Role of Health Insurance in UM

- **Several types of UM techniques**
- ***Mandatory second surgical opinion*. This protocol requires the patient to obtain a second opinion before a nonemergency surgical procedure is undertaken. If the second opinion does not confirm the initial recommendation, it is typically left to the patient to decide whether the procedure should be done.**
- ***Case management*. This program identifies high-cost cases. A case coordinator has authority to approve the substitution of some otherwise uncovered services as lower-cost or more-appropriate alternatives to covered services. Home healthcare as a substitute for additional hospital days is an example.**

Introduction to utilization management

The Role of Health Insurance in UM

- **Several types of UM techniques**
- ***Discharge planning*. This program requires the provider to have a plan in place at the time of admission for the patient's care on discharge from the hospital.**
- ***Gatekeeper*. This program assigns a primary care physician to each subscriber. Gatekeeper describes the person in charge of a patient's treatment. A gatekeeper's duty primarily is to manage a patient's treatment. This means the gatekeeper is in charge of authorizing the patient's referrals, hospitalizations and lab studies, or the insurer is not obligated to pay for the services.**

Introduction to utilization management

The Role of Health Insurance in UM

- **Several types of UM techniques**
- ***Disease management*. This program provides coordination of care across multiple providers for patients with chronic diseases for which there are well-defined practice guidelines.**
- ***Intensive case management*. This is an individualized program that targets patients with high-cost and multiple or complex medical conditions.**

Introduction to utilization management

The Role of Health Insurance in UM

- **In the 1980s, health care payers in the public and private sectors have relied increasingly on utilization management to help control health care costs.**
- **As a result, the autonomy of health care providers—hospitals and professionals—has been curtailed as payers have applied predetermined criteria to judge the appropriateness of care.**
- **The medical community, in turn, has expressed concerns about the design of the clinical standards or algorithms governing utilization review decisions by health insurers.**

Introduction to utilization management

Peer Review Organizations (PRO)

- **Peer review organizations were established by Congress in 1984 to add accountability to Medicare and Medicaid programs.**
- **PROs are contracted by the Center for Medicare & Medicaid Services (CMS) to review medical services provided by hospitals and individual practitioners, including issues of reimbursement and quality.**
- **Each year the CMS contract defines specific areas of focus that are consistent across the country, but the review work is contracted to individual PROs in each geographic area.**

Introduction to utilization management

Peer Review Organizations (PRO)

- **PROs have the power to request patient records and conduct on-site record reviews. When lapses are detected, PROs also have the power to invoke sanctions and require corrective action plans.**
- **The utilization management procedures used by federal utilization and quality control peer review organizations (PROs) have been shaped by the financial incentives created by the Medicare prospective payment system.**

Introduction to utilization management

Cost Quality Connection

- **Cost and quality affect the customer experience in all industries. But in healthcare, these factors are harder for the average consumer to evaluate than in other types of business.**
- **Tainted restaurant food is easier to recognize than an unskilled surgeon is.**
- **As for cost, everyone agrees that healthcare is expensive, yet, if someone else is paying for it—an insurance company, the government, or a relative—the cost factor becomes less important to the consumer. If your surgery does not go well, however, you'll be an unhappy customer regardless of what it cost.**

Introduction to utilization management

Consumer–Supplier Relationship

- **The consumer–supplier relationship in healthcare is influenced by different dynamics.**
- **For example, consumers may complain about rising healthcare costs, but most are not in a position to delay healthcare services until the price comes down.**
- **If you break your arm, you immediately go to a doctor or an emergency department to be treated. You are not likely to shop around for the best price or postpone treatment if you are in severe pain.**

Introduction to utilization management

Consumer–Supplier Relationship

- **In most healthcare encounters, the insurance companies or government-sponsored payment systems are the consumer's agent.**
- **When health- care costs are too high, they drive the resistance against rising rates. These groups act on behalf of consumers in an attempt to keep healthcare costs down. They exert their buying power by negotiating with healthcare providers for lower rates.**
- **In addition, they monitor billing claims for overuse of services and will not pay the providers—the suppliers—for services considered medically unnecessary.**

Introduction to utilization management

What is Healthcare Quality?

- **What is healthcare quality? Each group most affected by this question—consumers, purchasers, and providers—may answer it differently.**
- **Patients want to receive the right treatments and experience good outcomes; everyone wants to have satisfactory interactions with caregivers; and consumers want the physical facilities where care is provided to be clean and pleasant, and they want their doctors to use the best technology available.**

Introduction to utilization management

What is Healthcare Quality?

- **Consumer expectations are only part of the definition, however. Purchasers and providers may view quality in terms of other attributes.**
- **Purchasers are individuals and organizations that pay for healthcare services either directly or indirectly. If you pay out of pocket for healthcare services, you are both a consumer and a purchaser.**
- **Purchasers view quality in terms of cost-effectiveness, meaning they want value in return for their healthcare expenditures**

Introduction to utilization management

What is Healthcare Quality?

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Introduction to utilization management

What is Healthcare Quality?

- **Providers are individuals and organizations that offer healthcare services.**
- **Provider individuals include doctors, nurses, technicians, and clinical support and clerical staff.**
- **Provider organizations include hospitals, skilled nursing and rehabilitation facilities, outpatient clinics, home health agencies, and all other institutions that provide care**

Introduction to utilization management

What is Healthcare Quality?

- **In addition to the attributes important to consumers and purchasers, providers are concerned about legal liability—the risk that unsatisfied consumers will bring suit against the organization or individual.**
- **This concern can influence how providers define quality.**

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What is Healthcare Quality?

- **Suppose you have a migraine headache, and your doctor orders a CT (computed tomography) scan of your head to be 100 percent certain there are no physical abnormalities. Your physician may have no medical reason to order the test, but he is taking every possible measure to avert the possibility that you will sue him for malpractice. In this scenario, your doctor is practicing defensive medicine ordering or performing diagnostic or therapeutic interventions primarily to safeguard the provider against malpractice liability. (over utilization of services)**

Introduction to utilization management

What is Healthcare Quality?

- **Cost-effectiveness is the minimal expenditure of dollars, time, and other elements necessary to achieve a desired healthcare result.**
- **Defensive medicine, diagnostic or therapeutic interventions conducted primarily to safeguard the provider against malpractice liability.**

Introduction to utilization management

What is Healthcare Quality?

- **Historically, quality has been defined as the degree of adherence to standards or criteria**
- **Peer review was one of the earliest methodologies used to measure quality of physician care**
- **Process of peer review was also called medical audit**

Introduction to utilization management

Defining Healthcare Quality

- **In the early 1970s, The Joint Commission required quality assessment activities, a variation on medical audit.**
- **By 1980, the concept of quality assurance (QA) had become a Joint Commission standard.**
- **Quality Assurance is an evaluation activities aimed at ensuring compliance with minimum quality standards.**

Introduction to utilization management

Defining Healthcare Quality

- **The Institute of Medicine (IOM), a non- profit organization that provides science-based advice on matters of medicine and health, brought the stakeholder groups together to create a workable definition of healthcare quality.**
- **In 1990, the IOM committee charged with designing a strategy for healthcare quality assurance published this definition:**

Introduction to utilization management

Defining Healthcare Quality

IOM's Six Healthcare Quality Dimensions

- **Safety**
- **Effectiveness**
- **Patient-centeredness**
- **Timeliness**
- **Efficiency**
- **Equity**

Introduction to utilization management

Defining Healthcare Quality

IOM's Six Healthcare Quality Dimensions

- **Safety**
  - **Safe, delivering health care which minimizes risks and harm to service users**
  - **Example: Computerized physician order entry system to prevent medication errors**
  - **Example: Surgeons "sign your site" of the body part that will be operated upon**

Introduction to utilization management

Defining Healthcare Quality

IOM's Six Healthcare Quality Dimensions

- **Effectiveness**
  - **Effective, delivering health care that is adherent to an evidence base and results in improved health outcomes for individuals and communities, based on need**
  - **Avoid overuse and underuse of services**

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Defining Healthcare Quality

IOM's Six Healthcare Quality Dimensions

- **Effectiveness**
  - **Example: Redesign processes based on best practices such as ensuring that patients at risk for heart disease take appropriate medications**
  - **Example: Implement utilization management to reduce inappropriate hospital use**

Introduction to utilization management

Defining Healthcare Quality

IOM's Six Healthcare Quality Dimensions

- **Patient-centeredness**
  - **Acceptable/patient - centered, delivering health care which takes into account the preferences and aspirations of individual service users and the cultures of their communities**
  - **Respect patient needs, preferences, and culture**

Introduction to utilization management

Defining Healthcare Quality

IOM's Six Healthcare Quality Dimensions

- **Timeliness**
  - **Accessible, delivering health care that is timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to medical need**
  - **Reduce waits for those who receive and who give care**

Introduction to utilization management

Defining Healthcare Quality

IOM's Six Healthcare Quality Dimensions

- **Efficiency**
  - **Efficient, delivering health care in a manner which maximizes resource use and avoids waste**
  - **Reduce waste of facilities, equipment, supplies, and people**

Introduction to utilization management

Defining Healthcare Quality

IOM's Six Healthcare Quality Dimensions

- **Efficiency**
  - **Example: implement inventory management systems to reduce amount of drugs and other supplies on hand**
  - **Example: Use flexible staffing systems based on patient numbers and needs to adjust number of nurses per patient care unit**

Introduction to utilization management

Defining Healthcare Quality

IOM's Six Healthcare Quality Dimensions

Inefficiency = Waste

- **Waits and Delays**
- **Operating Room Throughput**
- **Emergency Department Diversions**
- **Medical Records Availability**
- **Mismatch Between Capacity and Demand**

Introduction to utilization management

Defining Healthcare Quality

IOM's Six Healthcare Quality Dimensions

- **Equity**
  - **Equitable, delivering health care which does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status**
  - **Reduce racial, ethnic, geographic and socio-economic differences**

Introduction to utilization management

Defining Healthcare Quality

IOM's Six Healthcare Quality Dimensions

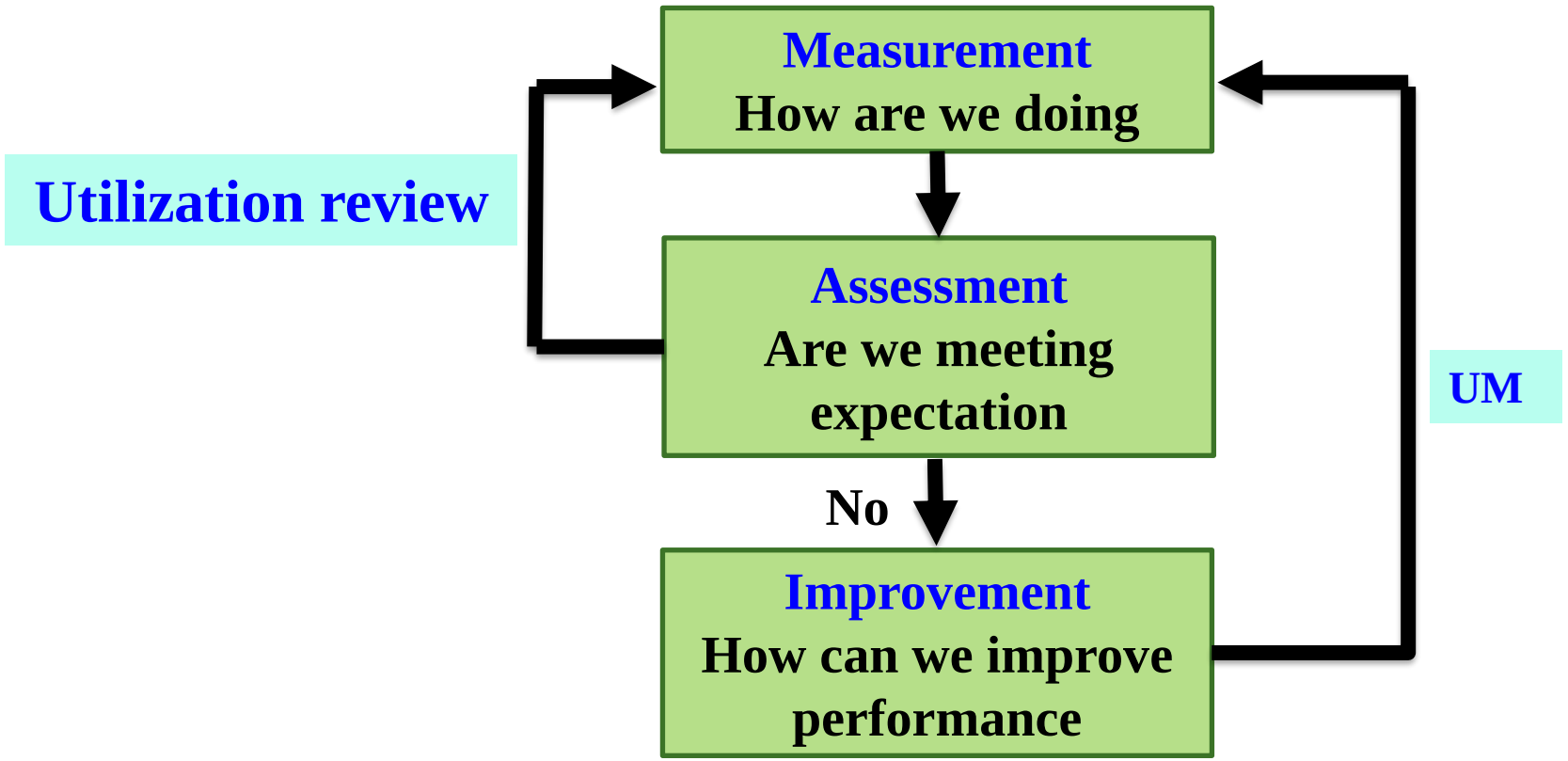
- **Equity**
  - **Example: Provide healthcare services in every region of the country**
  - **Example: Train more physicians from minority racial and ethnic groups**
  - **Example: Establish universal health insurance coverage**

Introduction to utilization management

Utilization Management Functions

- **UM involves the three basic quality management activities: measurement, assessment, and improvement. Exhibit 1.2 The quality management cycle**
- **Utilization review is the term typically used to describe the measurement and assessment tasks, whereas UM is a broad term that encompasses all three activities.**
- **All healthcare organizations are engaged in or affected by one or more of these UM activities.**

Exhibit 1.2 The quality management cycle



Introduction to utilization management

Quality Management Activities

Quality management involves measurement, assessment, and improvement of activities people perform almost every day.

- **Measurement is a collection of information for the purpose of understanding current performance and seeing how performance changes or improves over time.**
- **Assessment is the use of performance information to determine whether an acceptable level of quality has been achieved.**
- **Improvement is planning and making changes to current practices to achieve better performance.**

Introduction to utilization management

Quality Management Activities

Measure, Assess, and Improve

- **Healthcare organizations track performance through various measurement activities to gather information about the quality of patient care and support functions.**
- **Results are evaluated in the assessment step by comparing measurement data with performance expectations.**

Introduction to utilization management

Quality Management Activities

- **Measurement is a tool usually in the form of a number or statistic used to monitor the quality of some aspect of healthcare services.**
- **Performance measures are quantitative tools used to evaluate an element of patient care.**
- **Quality indicators are measures used to determine the organization's performance over time; also called Performance measures.**

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Evidence-Based Clinical Measures

- **Many performance measures that healthcare organizations use for quality management purposes are similar to those found in other service industries.**
- **One aspect of healthcare not found in most service industries is the clinical decision-making process, which must be evaluated with performance measures derived from clinical practice guidelines developed by medical professional groups. These measures are referred to as evidence-based measures.**

Introduction to utilization management

Measures of Clinical Decision Making

- **Healthcare organizations measure both the service aspects of performance and the quality of clinical decision making.**
- **The same principles of measurement applicable to the service aspects of healthcare also apply to clinical decision making.**
- **Process measures are used to determine whether clinicians are making the right patient management choices.**
- **Outcome measures are used to evaluate the results of those choices.**

THANK YOU