United Health Services Case Study

HOW A FOCUS ON UTILIZATION MANAGEMENT SPURRED A HOSPITAL-WIDE PERFORMANCE IMPROVEMENT PROJECT & REALIZED $7.3M IN REVENUE ENHANCEMENT

About UHS

United Health Services, Inc. (UHS) is a not-for-profit, community health system located in New York State. UHS consists of Wilson Medical Center, Binghamton General Hospital, Chenango Memorial Hospital, Delaware Valley Hospital, Senior Living at Ideal and UHS Home Care. UHS is a progressive integrated delivery system, committed to providing the best care for its communities through continuous performance improvement.

Challenges Faced

PATIENT CARE AND FINANCIAL GOALS

In mid-2017, the leaders at UHS noticed that both their Observation (OBS) Length of Stay (LOS) and OBS rate were rapidly escalating. The OBS LOS was > 31 hours compared to national benchmarks between 18-24 hours and the OBS rate was 36%. Cause for alarm was warranted since correct status determination (OBS versus Inpatient) at a hospital's points of entry is crucial to patient satisfaction, patient outcomes, and safeguarding regulatory compliance, which help to achieve a hospital's financial goals. During this time, a second issue became evident. UHS was tracking a high increase in insurance denials related to patients being placed in the inappropriate status. In order to receive appropriate reimbursement hospitals must obtain proper documentation to support their clinical decision making. Proper administrative support is needed to resolve denied claims successfully. Without it, the hospital will face higher costs and loss of revenue.

"I have seen firsthand and heard secondhand the value of CI's approach. Open, candid, fair, and action oriented. I like how your team sought to understand and then attacked the issues with balance, but with an eye always on our objectives."

Dave MacDougall
Senior Vice President,
System Chief Financial Officer UHS

Issues Discovered

LACK OF UNDERSTANDING OF STATUS DETERMINATION, INEFFECTIVE COMMUNICATION, LOW CONFIDENCE

After identifying these issues, UHS leaders quickly organized internal meetings, which revealed they did not have clear insight on root causes. UHS enlisted the help of Clinical Intelligence (CI), a consulting firm specializing in defining and activating impactful solutions in advanced care management and cost of care reduction.

As UHS leaders and CI consultants began to investigate the source of challenges, they realized:

- **There was a lack of understanding regarding status determination:** Some physicians were simply defaulting to OBS status since they had not been educated on the meaning of various patient statuses and level of care determination processes. Although there had been previous attempts by the Care Management (CM) department to educate physicians, they had not been successful. There was also much confusion around the two-midnight rule for Medicare patients.

This all resulted in:

- Costly avoidable days
- Uncompensated care provided
- Higher out-of-pocket expense for the patient
- Lack of post-acute benefit coverage (SNF) for traditional Medicare patients
- Negative impact on patient satisfaction just because they were place in an incorrect status

- **There was a lack of communication between departments:** UHS had inconsistent communication between CM / Revenue Cycle Management / Finance / Coding, which created a hospital of "siloed" departments. Additionally, UHS lacked a dictionary of consistent, patient status definitions, which created confusion between clinical and financial departments.

- **There was a lack of denial prevention and appeal management:** UHS was not confident in its ability to challenge insurance denials and did not have a team in place to pursue opportunities in recouping denied or reduced payments.

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Clinical Intelligence
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Taking Action and Making Changes

In March 2018, UHS teamed with CI to host a three-day, Rapid Performance Improvement workshop for key stakeholders from multiple departments.

The result was a 114-item action plan in the following six categories:

1. Care Management Structure
2. Utilization Management Committee and Dedicated Physician Advisory
3. Bed Access Management
4. Short-stay Observation Management
5. Care Coordination
6. Denials and Appeals

Within each of the six categories, a litany of action items was developed and owners and timelines were established for all items. However, possibly more valuable than a list of action items, were three overarching principles that came out of the workshop.

UHS committed to:

- Placing an emphasis on educating and empowering physicians.
- Focusing on correct patient status determination in the Emergency Department (ED)
- Creating a change in the hospital's culture as it relates to appropriate patient status

With three guiding principles outlined, the UHS team began its 16-week improvement project. The first step was to rally the departments followed by the decision to imbed a CI consultant for the duration.

Improvements Realized

Many hours of hard work and dedication resulted in improvements for UHS. Highlights include:

Education and Empowerment

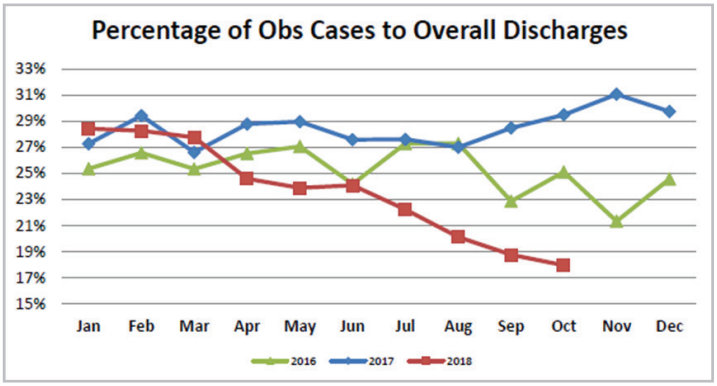
- A Physician Advisor was appointed to work directly with the CM department who made recommendations about LOS and OBS during regular morning meetings
- Meetings were held with each department and individual service lines about appropriate patient status
- An escalation process was developed to standardize the process for when CM was to seek a secondary level review for status determination
- A commitment was made to complete daily and monthly scorecards to demonstrate the impact of Physician Advisor interventions
- CI assisted UHS in the development of a standard dictionary, which included consistent patient status definitions to ensure that everyone was on the same page throughout the organization
- An emphasis was placed on encouraging physicians to use their complex medical judgement in making decisions regarding patient status and to seek the guidance of the ED case manager as needed
- A denials dashboard was created within CI's analytics platform, ClinView®, which was used by Denial Prevention Specialists to drill down to the root causes of insurance denials and pursue appeals backed with data
- A new status of "Outpatient in a Bed" (OPIB) was created to address surgical patients that were outpatient, not OBS or Inpatient, which avoided the OBS default

ED Focus

- CM deployed a staff member to the ED to serve as a "gatekeeper". This resource reviewed documentation as patients presented and made status recommendations to the ED physician and admitting physician based on medical necessity. In addition they assisted with discharge planning for patients where documentation did not support the patient being placed in the hospital

Change in Culture

- There was a revitalization of the Utilization Management (UM) Committee with medical staff leaders
- A shift was made to focus on the improvement of patients' rights and to preserve their insurance benefits
- There was an emphasis on the coordination of interdisciplinary teaming, which broke down the department siloes and led to developing better relationships and comradery



Results

- UHS realized $7.3 million in revenue enhancement
- Volume of Observation has dropped from 6,700 (2017) to 5,255 (2018)
- Percentage of Observation has gone from 36% (Mar. 2018) to 18% (Nov. 2018)
- Inpatient volume has gone from 11,852 (2017) to 12,954 (2018)