Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA DIRECTIVE 2010-021

May 14, 2010

UTILIZATION MANAGEMENT PROGRAM

1. PURPOSE: This Veterans Health Administration (VHA) Directive establishes policy for VHA's Utilization Management (UM) Program, an integral component of VHA's quality management program that ensures quality and operational efficiency across the care continuum.

2. BACKGROUND: The UM Program, a key component of VHA's Quality Management System, provides vital tools for managing quality and resource utilization. It strives to ensure the right care, for the right patient, at the right time, for the right reason.

a. UM strategies, which provide guidance and do not supersede decisions made by providers, include the forward-looking evaluation of the appropriateness, medical need, and efficiency of health care services according to evidence-based criteria. They are applied to all patients without regard to patient payment source. This proactive approach provides just-in-time information to guide evidence-based decision making and establishes the expectation of ongoing collaboration with other patient management services, such as case and care management, nursing, social work services, mental health, and discharge planning.

b. As a key tool in managing the daily patient flow activities, UM:

(1) Identifies the appropriateness of level of care and services,

(2) Provides information to assist with decision making related to patient care management and discharge coordination processes, and

(3) Identifies delays in services.

c. The substantive data generated through UM reviews are integrated into quality improvement initiatives and support Systems Redesign (SR). The overall result is improved operational efficiencies, such as decreased length-of-stay and enhanced access, while sustaining clinical quality.

d. The UM program addresses admission and continued-stay review of all acute inpatient care, as defined in subparagraph 2e(1), as well as any Veterans Integrated Service Network (VISN) or facility-specific priorities.

e. **Definitions**

(1) **Acute Inpatient Care Review.** Acute inpatient care includes admission and daily continued stay reviews of all patients in the following inpatient treating specialties: medicine,

surgery, mental health, intermediate medicine in acute care (i.e., refers to the few facilities that use intermediate medicine in acute care for post acute patients), intermediate mental health in acute care, and intermediate substance abuse in acute care. ***NOTE:*** *The following treating specialties are not included in the acute inpatient care reviews: Observation, Respite Care, Hospice, Geriatric Evaluation Management (GEM), Rehabilitation Medicine, Blind Rehabilitation, Spinal Cord Injury (SCI), Community Living Center (CLC), and Domiciliary.*

(2) **Admission Review.** The UM admission review is a screening to determine the appropriateness of admission to a specific level of care. This review is typically performed within 24 hours following the admission, or no later than the first business day following the admission. Nationally-approved, standardized, objective, evidence-based criteria must be used to determine the appropriateness of admission to specific levels of care.

(3) **Concurrent Review.** A concurrent review is performed during a patient's hospital stay, or course of treatment, to screen for the appropriateness of the medical services. Concurrent review commences within 24 hours of admission, or no later than the first business day following the admission, and continues daily during normal duty hours. Concurrent review allows the proactive facilitation of quality care and patient flow.

(4) **Continued-stay Review.** The continued-stay review is a screening performed during a patient’s hospitalization to determine the appropriateness of continuation of the patient’s stay at a specified level-of-care. Continued-stay reviews are concurrent reviews performed daily, or no later than the first business day following other than normal duty hours, throughout the patient's hospitalization.

(5) **Inter-rater Reliability.** Inter-rater reliability assessments are conducted in the VHA UM Program to measure consistency in the application and interpretation of standardized criteria among health care professionals.

(6) **Licensed Health Care Professionals.** A licensed health care professional is an individual who:

(a) Has undergone formal training in a health care field, and

(b) Holds a license in a health care field which allows the professional to practice within the scope of the license without the supervision of another licensed professional.

(7) **National Utilization Management Integration (NUMI).** NUMI is a web-based application that:

(a) Automates utilization review assessment and outcomes,

(b) Standardizes UM review methodology and documentation, and

(c) Provides critical functionality to assist UM reviewers to:

1. Organize workload,

2. Document UM review outcomes, and

3. Generate reports to identify opportunities for improving efficiency in relation to system constraints and barriers.

(8) **Physician Utilization Management Advisor (PUMA).** The PUMA is the physician advisor at the facility level designated to provide recommendations for patients not meeting the standardized criteria for a specific level of care. The cases requiring review by the PUMA are referred by the UM reviewers. ***NOTE:*** *It is recommended that the PUMA have expertise in the service being reviewed, such as a psychiatrist designated as the PUMA for inpatient mental health reviews and a surgeon designated as the PUMA for surgical reviews not meeting criteria.* If the PUMA does not have expertise in the service being reviewed, a process must be in place for the PUMA to consult with an expert as needed.

(9) **Prospective Review.** A prospective review is conducted prior to a patient's admission, stay, or other service or course of treatment. A prospective review may be enacted as a preadmission screening, or as a screening prior to a diagnostic study.

(10) **Retrospective Review.** A retrospective review is conducted after services have been provided, or the patient has been discharged, to screen for appropriateness of services rendered.

(11) **Revenue Utilization Review (R-UR).** R-UR, under the auspices of the Chief Business Office (CBO), is the systematic evaluation and analytical review of clinical information in order to maximize reimbursement from third-party payers. In 2003, guidance was established standardizing the clinical review functions with third-party reimbursement responsibilities at Department of Veterans Affairs (VA) health care facilities. R-UR in this context operates to promote improvements in patient care and to maximize the potential for the recovery of funds due VA for the provision of health care services to Veterans, dependents, and others using the VA health care system.

(12) **Systems Redesign (SR).** SR utilizes “science of (quality) improvement” principles from disparate SR methodologies to continuously deliver better health care value across the health care system. An overarching concept within SR is patient flow matching supply and demand. SR uses sets of scientifically-based, patient-centered principles to enable staff to examine health care delivery processes, redesign them to eliminate delay and waste, and provide Veterans with the care that is clinically indicated and delivered in a timely manner. UM data is an integral component in this continuous improvement cycle.

(13) **UM Reviewer**. The UM reviewer is the trained, licensed health care professional who performs UM reviews utilizing the National Utilization Management Advisory Committee (NUMAC)-approved, standardized, evidence-based criteria. The role of the UM reviewer includes:

(a) Performing and documenting utilization reviews consistent with national guidance,

(b) Communicating with the PUMA,

(c) Collaborating across services and departments to impact patient flow, and

(d) Participating in daily rounds, bed huddles, or Interdisciplinary Team (IDT) meetings as appropriate.

3. POLICY: It is VHA policy to establish an integrated UM Program at every VHA facility that supports quality and efficiency in a high performance health care system; by December 31, 2010, those who conduct UM reviews must be licensed health care professionals.

4. ACTION

a. **National Utilization Management Advisory Committee (NUMAC).** NUMAC is responsible for oversight and monitoring of VHA's UM Program. The primary goals are to:

(1) Develop and implement a tactical and strategic plan for the implementation and ongoing refinement of a national UM Program;

(2) Support an organized and standardized approach to UM processes;

(3) Foster communication and coordination of effort among programs with similar goals, such as: SR, Care Coordination, Patient Care Services, and CBO;

(4) Validate and analyze UM data generated through NUMI; and

(5) Foster communication between VHA leadership and the field in sharing priorities and goals to promote effective use of resources while improving quality of care.

b. **Chief Quality and Performance Officer (CQPO).** The CQPO is responsible for:

(1) Providing oversight of resources to operationally implement the UM Program.

(2) Ensuring full implementation of the UM Program; one that yields valid insights leading to actions that improve quality of care and outcomes of importance to VHA stakeholders.

(3) Issuing annual guidance for expanding the program across the continuum of care based on agency priorities.

c. **VISN Director.** The VISN Director is responsible for ensuring that all the following key UM components are implemented in all facilities, to include:

(1) Establishing and meeting the annual VISN UM Program goals.

(2) Communicating UM priorities to the facilities.

(3) Promoting a culture conducive to integrating UM into daily patient care management activities, such as: patient flow, care coordination, and discharge planning processes.

(4) Ensuring UM data is leveraged to drive SR improvement projects.

(5) Ensuring adequate resources for planning and implementing the VISN UM Program.

(6) Ensuring that the written VISN UM Plan includes:

(a) Program structure, scope, goals, and measureable objectives;

(b) Definition of the role of the PUMA and medical leadership in UM program implementation and ongoing UM activities;

(c) Interface between UM, Quality Improvement, CBO, Nursing, Social Work, Care Coordination, and SR programs;

(d) Processes and information sources used to complete UM reviews;

(e) Utilization of NUMI, the automated review and reporting tool approved by NUMAC; and

(f) Goals related to improved efficiency and progress toward goal attainment.

(7) Ensuring a process for communicating UM data analyses to the VISN.

(8) Conducting annual summary reviews of all facilities to validate that the UM Program is fully implemented. This review includes a process for assessing the implementation effectiveness of the UM Program at each facility.

d. **Facility Director.** The Facility Director is responsible for ensuring the following key UM components are implemented, to include:

(1) Meeting the annual VISN UM program goals.

(2) Ensuring that the written Facility UM Plan includes all required components of the VISN UM Plan.

(3) Ensuring adequate resources for planning and implementing the facility UM plan.

(4) Ensuring that NUMAC approved standardized evidence-based UM review criteria are used.

(5) Ensuring review processes are consistent with national guidance. ***NOTE:*** *These processes are available in detail on the Office of Quality and performance (OQP) UM Web site at: http://vaww.oqp.med.va.gov. This is an internal Web site and is not available to the public.*

(6) Ensuring implementation and utilization of NUMI, the automated reporting tool approved by NUMAC.

(7) Ensuring by December 31, 2010, those who conduct UM reviews are licensed health care professionals whose role includes:

(a) Performing and documenting utilization reviews consistent with national guidance;

(b) Referring to the PUMA cases not meeting criteria, or when quality of care or system issues are raised;

(c) Collaborating across services and departments, such as with care coordinators, case managers, discharge planners, nursing staff, patient flow coordinators, social workers, transfer coordinators, and R-UR nurses; and

(d) Participating in daily rounds, bed huddles, or Interdisciplinary Team meetings as appropriate.

(8) Ensuring adequate training of staff responsible for applying and interpreting the NUMAC approved standardized UM criteria.

(9) Ensuring the implementation of an approved process for establishing inter-rater reliability for staff who conducts reviews.

(10) Ensuring acceptable inter-rater reliability based on nationally defined standards relative to the application and interpretation of standardized criteria.

(11) Ensuring designation of one or more providers trained as a PUMA.

(12) Ensuring direction and adequate training of the physicians assigned to carry out the PUMA role.

(13) Ensuring the PUMA collaborates with facility UM and medical staff and provides medical recommendations on cases not meeting criteria referred by those conducting UM reviews. Local policy may specify cases not meeting criteria that do not require referral to the PUMA.

(14) Ensuring ongoing communication of UM review findings to attending physicians and collaboration in resolving level of care discrepancies, quality of care issues or delays in care according to approved local policy.

(15) Ensuring a process for communicating all UM data, including NUMI and any facility generated UM data, within the facility and to the VISN, as a component of the Quality Management System.

(16) Ensuring UM data are used to assist with identifying SR initiatives to improve efficiency.

(17) Ensuring UM data is reviewed on an ongoing basis by an interdisciplinary group, including but not limited to representatives from UM, Medicine, Nursing, Social Work, Case Management, Mental Health, and CBO R-UR.

(18) Ensuring the UM data analyses is reported systematically to identify appropriate benchmarks, trends, actions, outcomes, and opportunities for improving efficiency.

(19) Ensuring the development and completion of relevant SR initiatives is tracked.

5. REFERENCES

a. Office of Inspector General (OIG) Report: Summary Review: Evaluation of Quality Management in VHA Facilities FY 2008.

b. The Joint Commission Hospital Accreditation Standards 2009.

c. Utilization Review Accreditation Commission (URAC), Health Utilization Management Standards, Version 6.0, August 2008.

d. The Utilization Management Guide, Third Edition. URAC. Washington, DC 2005.

e. For detailed information about UM Program procedures, training, and NUMI visit the OQP UM Web site http://vaww.oqp.med.va.gov. *This is an internal Web site and is not available to the public*

f. VHA Handbook 1601C.02, Utilization Review (UR).

g. For more information about CBO programs and Revenue UR, visit the CBO Web site http://vaww1.va.gov/cbo. *This is an internal Web site and is not available to the public*

6. FOLLOW-UP RESPONSIBILITY: The Office of Quality and Performance (10Q) is responsible for the oversight and implementation of this Directive. Questions may be addressed to (202) 266-4533.

7. RECISSIONS: VHA Directive 2005-040 is rescinded. This VHA Directive expires May 31, 2015.

Robert A. Petzel, M.D.
Under Secretary for Health

DISTRIBUTION: E-mailed to the VHA Publications Distribution List 05/18/2009