Utilization Management

The effect of pre-admission and post-discharge planning on health and costs

"Many employers and their health plan members assume that a utilization management program's only goal is to approve or deny medical procedures and save costs for the health plan. In reality, utilization management programs are designed to help members navigate the health care system and achieve optimal medical outcomes in the most timely and cost effective manner possible," says Dr. Jay Moore, senior clinical officer at HealthLink, Inc.

"To achieve this," Moore says, "utilization management teams provide medical necessity recommendations and aid members in making medical treatment decisions, but they also provide important pre-admission and post-discharge outreach that can positively impact a member's health and help contain costs."

How do utilization management programs typically work?

Providers send a notification when they have a patient who is being admitted to the hospital or is being considered for an elective admission in the future. The request for services is compared against evidence-based policies to ensure the care is safe, appropriate and high quality. When this is verified, the service is approved.

If the service is not approved, an explanation is provided to let the patient and doctor know why the decision was made. Specific resources are also provided so that the evidence that underlies the decision is readily available. If the patient or physician disagrees with the decision, simple processes exist to submit more information or appeal the decision. This process usually results in the patient receiving the safest, highest-quality care that is evidence-based and effective.

Why might health plan members mistrust or have wrong assumptions about these programs?

The focus in these reviews is always on medical appropriateness, quality and safety. If a procedure or hospital admission is in the best interest of the patient, it is approved. Members may not always be aware of why a procedure or admission was approved or denied, they only know the end result.

Members who are unsure about these decisions can take a more active role in their health by talking to their doctor or contacting the utilization management team to learn more about the review process and discuss their case.

How should utilization management be employing pre-admission and discharge planning? How will this impact member health and plan costs?

Discharge planning from the hospital should begin as soon as the patient arrives. Utilization management teams should work with hospital staff to address any needs the patient might have before leaving the facility.

With this sort of proactive planning, care gaps may be avoided and members can receive the highest quality medical service.

If this doesn't sound like what happens with a business owner's health plan, what should he or she do?

A utilization management team should be dedicated to providing the highest quality, safest and most effective care to members. This reduces health care waste and allows members to receive high quality care. If this is not happening, the employer should contact their broker or network to discuss medical management options.

Is there anything else you'd like to share?

Medical management programs as a whole can be really effective in helping employers, and their members control their health care spending. They shouldn't assume that their health plan has all the right programs in place.

Employers need to take an active role in the health plan they are offering their members and work with their broker or network to explore their options for medical management programs.