1.2.15 Utilization Management Program

(a) Policy

(1) The California Correctional Health Care Services' (CCHCS) Utilization Management (UM) Program shall ensure the appropriate use of limited health care resources including, but not limited to, medical procedures, consultations with specialists, diagnostic studies, inpatient beds, and outpatient beds allocated for health programs to promote the best possible patient outcomes, eliminate unnecessary cost, and maintain consistency in the delivery of health care services. The UM Program shall:

(A) Implement evidence-based medical necessity criteria statewide.

(B) Manage requests for specialty services to reduce backlogs, wait times, custody and transport demands, and to improve timely access to care.

(C) Manage care transitions for patients in community hospitals and specialized health care housing beds (e.g., Outpatient Housing Unit, Correctional Treatment Center, Skilled Nursing Facility) through care coordination and complex case management to optimize patient health outcomes and the use of resources.

(D) Provide a centralized process for reviewing and analyzing clinical, financial, and operational data to identify trends and patterns in the use of contract medical services and health care beds within California Department of Corrections and Rehabilitation (CDCR).

(E) Develop the statewide UM Improvement Work Plan at least biennially to include improvement priorities, performance objectives, and associated strategies and activities.

(F) Maintain a committee structure at headquarters and in the field to provide oversight of the UM work plans and UM Program requirements.

(b) Purpose

(1) The purpose of the UM Program is to optimize the value of contract medical services and the use of specialized health care housing by ensuring appropriate, timely, safe, and cost-effective care for patients who require specialty, hospital, emergency, skilled nursing, and diagnostic services and who are admitted to specialized health care housing within CDCR.

(c) Responsibility

(1) Statewide

(A) The Deputy Director, Medical Services, and Deputy Medical Executive, UM, are jointly responsible for the planning, implementation, evaluation, and monitoring of the UM Program at the statewide level.

(B) CDCR and CCHCS departmental leadership at all levels of the organization, within the scope of their authority, shall ensure administrative, custodial, and clinical systems are in place and appropriate tools, training, technical assistance, and levels of resources are available to ensure appropriate, timely, safe, and cost-effective care for patients.

(C) The Headquarters UM Committee (HUMC) is a subcommittee of the statewide Quality Management Committee (QMC) and is responsible for providing oversight of the UM Program at the statewide level, identifying and communicating program goals, developing program-specific improvement plans, and overseeing and supporting implementation of improvement initiatives.

(2) Regional

(A) Regional Health Care Executives are responsible for adherence to the UM Program policy and procedure at a subset of institutions within an assigned region.

(B) The UM Nurse Consultant Program Reviewers are responsible for:

1. Regular monitoring of dashboards and patient registries to identify and address potential issues in accessing contract medical services.
2. Ensuring UM Registered Nurses are adequately trained on their role and responsibilities including the use of dashboards, patient registries, and other clinical decision support tools to support timely, safe, efficient, and cost-effective use of contract medical services and specialized health care housing beds at a subset of institutions within an assigned region.

(3) Institutional

(A) The Chief Executive Officer (CEO), Chief Support Executive (CSE), Chief Medical Executive (CME), and Chief Nurse Executive (CNE) are responsible for the planning, implementation, evaluation, and monitoring of the UM Program and ensuring adherence to the UM Program policy and procedure at the institutional level.

(B) The CSE has overall responsibility for the administrative and support functions of the health care system ensuring local policies and procedures align with and support the goals and objectives of the UM Program.

(C) The CEO has overall responsibility for implementation and ongoing oversight of the health care system at the institution. The CEO may delegate decision-making authority to the CME and CNE for daily operations including, but not limited to, the following:

1. Ensuring that resources are effectively deployed to support timely, safe, efficient, and cost-effective use of contract medical services and specialized health care housing beds.
2. Providing access to equipment, supplies, health information systems, patient registries, patient summaries, and evidence-based guidelines.
3. Reviewing and comparing institution Care Team performance including:
   a. The overall quality of services.
   b. Health outcome data.
   c. Assignment of consistent and adequate resources.
   d. Utilization of dashboards, patient registries, patient summaries, and decision support tools.
   e. Addressing issues as necessary.
4. Updating procedures, roles and responsibilities, and training as new tools and technology become available.

(D) The CME is responsible for the overall medical management of patients and ensures resources are available to meet the needs of the population.

(E) The CNE is responsible for managing and overseeing the daily operations of the scheduling system and coordinating the delivery of health care services by monitoring, identifying, and addressing barriers in accessing contract medical services.

(F) All members of the institution leadership team are responsible for establishing an organizational culture that promotes interdisciplinary teamwork and continuous process improvement.

(G) The Institution UM Committee (IUMC) is a subcommittee of the institution QMC and is responsible for oversight of the UM Program at the local level, developing program-specific improvement plans, and managing implementation of improvement initiatives.

(H) The institution QMC reports to the statewide QMC and is responsible for coordinating institution-wide performance evaluation and improvement activities and communicating UM Program performance improvement activities to the statewide QMC.

(d) Procedure Overview

(1) This procedure outlines major structures, processes, resources, and requirements of the UM Program.

(e) Procedure

(1) Utilization Management Case Review Process

(A) The UM Program shall require review of select patient cases that are high cost, high risk, exceptional, or complex. This process includes up to three levels of review and shall cover prospective, concurrent, and retrospective reviews. The UM case review process shall follow the procedure outlined in the Health Care Department Operations Manual (HCDOM), Section 3.1.11, Outpatient Specialty Services.

(2) Utilization Management Program Committees and Plans

(A) Headquarters and institution committee structures shall be maintained to provide oversight of the UM Program. At least biennially, the statewide UM Program shall prepare an improvement plan that describes statewide priorities and performance objectives for the UM Program. The institution shall establish and maintain a UM Subcommittee Improvement Priorities List and Project Pipeline that tracks underperforming areas per the UM Measurement Plan, identifies other quality or patient safety issues related to UM processes, and assesses each issue to determine a risk score for prioritization and initiation of improvement activities.

(3) Institutional Utilization Management Committee

(A) Responsibilities

1. The IUMC duties shall include, but are not limited to, the following:
   a. Ensure compliance with the HCDOM for the Complete Care Model policies and procedures including systems and processes that support timely access, population health management, care coordination, and complex care management.
   b. Ensure compliance with the UM Program policy and procedure and other related policies and procedures.

c. At least quarterly, review and analyze data including, but not limited to, dashboards, Health Care Incident and Potential Quality Issue reports, and UM operational reports to ensure timely, safe, efficient, and cost-effective access to specialized health care housing beds and to specialty, hospital, emergency, diagnostic, and other contract medical services.
d. Develop and monitor UM work plans that improve timely, safe, efficient, and cost-effective access to and utilization of specialty, hospital, emergency department, and other contract medical services.
e. Establish interdisciplinary workgroups to conduct Root Cause Analyses, and to assess and improve timely access to health care services including, but not limited to, specialty services, care coordination, and care management to ensure that these systems and processes are highly reliable over time.
f. Ensure that institutions' health care staff receive training on the UM Program policy and procedure and that providers receive feedback regarding adherence to the policy and procedure.
g. Identify gaps in specialty provider network resources and provide this information to the HUMC through the institution QMC.

(B) Membership

1. The IUMC shall consist of, but not be limited to, the following members:
   a. CME (Chairperson)
   b. CEO (health care)
   c. CNE and/or Supervising Registered Nurse (SRN) III
   d. CSE
   e. Supervising Dentist
   f. Chief Deputy Warden and/or Associate Warden for Health Care
   g. Chief, Mental Health Services
   h. Chief Psychiatrist
   i. Chief Physician and Surgeon
   j. SRN II staff involved with UM, Triage and Treatment Area, specialty services, and hospital services

(C) Reporting Structure

1. The IUMC reports to the institution QMC. The IUMC shall submit timely and accurate reports at least quarterly to the institution QMC that include its major activities, accomplishments, requests for assistance and training, and recommendations that may include changes to contracts, policy, clinical criteria, or decision support.

(D) Meetings

1. The IUMC shall meet as often as necessary to carry out its responsibilities, but not less frequently than monthly.
2. Meetings shall be conducted informally using a consensus approach. If a consensus cannot be reached on an agenda item, the Chairperson may call for a vote.
3. A quorum of members must be present at all meetings to ensure diversity of view point and well-rounded discussion. A quorum is met when a minimum of five members are in attendance, either in person or telephonically.
4. Records of committee proceedings shall be kept at a secure, accessible medical program site for a period of three years. At a minimum, the record shall describe all committee actions and recommendations.
5. The proceedings and records of the IUMC shall be confidential and protected from discovery to the extent permitted by law.

(4) Headquarters Utilization Management Committee

(A) Responsibilities

1. The HUMC's duties shall include, but are not limited to, the following:
   a. Develop and ensure adherence to the UM Program policy and procedure and clinical criteria that define medical necessity.
   b. Implement and oversee the Statewide UM Program Improvement Plan.
   c. Develop and report UM Program performance indicators based on the Statewide UM Program Improvement Plan.
   d. Analyze and report trends and patterns related to utilization and cost associated with contract medical services.

e. Establish interdisciplinary workgroups to assess and improve timely access to health care services including, but not limited to, specialty services, care coordination, and care management to ensure that these systems and processes are highly reliable over time.
f. Assess and recommend interventions to improve timeliness, safety, efficiency, and cost effectiveness of contract medical services and specialized health care housing.
g. Provide direction for specialty care referrals and bed usage through defining medical necessity, selecting appropriate referral, admission and discharge criteria, and setting statewide standards for UM.
h. Recommend strategies to modify provider network capacity and medical contracts.
i. Refer institution-specific concerns to the respective regional leadership and IUMC for appropriate action.
j. Refer to other headquarters committees for action as appropriate.

(B) Membership

1. The HUMC shall consist of the following voting members:
   a. Deputy Medical Executive, UM Program (Chairperson)
   b. Deputy Director, Business Services
   c. Deputy Director, Corrections Services
   d. Deputy Director, Dental
   e. Deputy Director, Fiscal Services
   f. Deputy Director, Mental Health Program
   g. Deputy Director, Medical Services
   h. Deputy Director, Nursing Services
   i. Deputy Director, Quality Management
   j. Regional Health Care Executives, Region I, II, III and IV
2. Members may designate another manager from their program area, and the Chairperson may add additional members and invite other stakeholders as necessary.

(C) Reporting Structure

1. The HUMC reports to the statewide QMC.

(D) Meetings

1. The HUMC shall meet as often as necessary to carry out its responsibilities but not less frequently than bimonthly.
2. Meetings shall be conducted informally using a consensus approach. If a consensus cannot be reached on an agenda item, the Chairperson may call for a vote.
3. A quorum of members must be present at all meetings to ensure diversity of view point and well-rounded discussion. A quorum is met when a minimum of 50 percent of the members are in attendance, either in person or telephonically.
4. Records of committee proceedings shall be kept at a secure, accessible medical program site for a period of three years. At a minimum, the record shall describe all committee actions and recommendations.
5. The proceedings and records of the HUMC shall be confidential and protected from discovery to the extent permitted by law.

References

- California Civil Code, Division 1, Part 2.6, Section 56 *et seq*.
- California Evidence Code, Division 9, Chapter 3, Section 1157
- California Code of Regulations, Title 15, Division 3, Chapter 2, Article 1, Section 3999.98
- California Code of Regulations, Title 15, Division 3, Chapter 2, Subchapter 2, Article 1, Section 3999.200
- Health Care Department Operations Manual, Chapter 1, Article 2, Sections 1.2.2 through 1.2.9
- Health Care Department Operations Manual, Chapter 3, Article 1, Section 3.1.11, Outpatient Specialty Services

Revision History

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