Clinical Resource Management: Driven by Data

by R. William Treloar, MBA, RHIA

Not only has my role in HIM changed dramatically in the last several years, my title has too: from director of case mix management to director of clinical resource management. And in my department, our role has moved from educating clinicians and staff about Medicare and DRGs to the facilitation of changes in our clinicians' patient care practices.

Clinical resource management is almost always a team sport: multidisciplinary groups examine the way we conduct the care of discrete patient populations. Populations may be comprised of patients with a common diagnosis or patients who undergo the same procedure. Rarely do we examine the care of individual patients; rather, we look for patterns across large numbers of patients. Increasingly, we integrate efforts aimed at improving multiple patient outcomes—clinical outcomes, patient satisfaction, and the cost of providing care.

When we examine a clinical process, for example, we try to look at it from all perspectives. Typically, we will map out the sequence of events that patients follow and identify delays, unnecessary steps, interventions with marginal benefit, or inconveniences for patients or their families.

The scope of a project often includes outpatient or emergency department (ED) care prior to the admission and extends to post-discharge issues in a variety of settings. A recent project focused on care of patients with chest pain seen in the ED. We created algorithms that direct tests and treatments throughout patients' stay in the ED and, if appropriate, through their critical care unit, cath lab, and floor care as well.

Solid Data, Better Care

In addition to population-based projects, we frequently participate in projects focused on improvements in hospitals systems that affect numerous patient populations. For example, we are currently examining the process by which patients are discharged from the hospital. Given our chronic high census, we are often seeking to accelerate discharges to create capacity for new referrals or ED patients. This project has entailed study of the process by which the decision to discharge a patient is made and communicated by physicians and the process by which this decision is carried out. There are numerous potential barriers to a patient's discharge, including late rounding by doctors, delayed tests, waits for prescriptions, and transportation. We have examined these barriers and implemented system changes to minimize them. We have also instituted measurement systems so that we can track the effect of our interventions.

The process improvement work we do is invariably data driven. Physician participation is key to the success of any effort to modify clinical processes, and because physicians are scientifically trained, they respond to data. In the course of a project, we typically use data from a variety of sources. Whenever possible, we use electronic data that is readily available and easily manipulated.

Our primary source of data is a huge patient database that consolidates data elements from several sources, such as registration, billing, and coding systems. We access this database directly via an intranet-based query tool that allows us to design customized reports. The resulting data can be downloaded into spreadsheet software, which enables further modifications, chart creation, and formatting. We have access to charge data on all inpatients and outpatients, which allows us to drill down to a very detailed level when the subject calls for it. In addition to our internal data, we can also access several external comparative databases. These allow us to identify opportunities for improvements and to build compelling arguments for needed changes.

"The Best Job in the Hospital"

I have said more than once that I have the best job in the hospital. Every project is different, so there is no repetition in my work. Also, these diverse projects allow me to work with a wide range of individuals in various departments and specialties. Our health system includes several hospitals and other facilities, and I get to work in all of them.

I also enjoy access to cutting-edge technology: I'm on the forefront of clinical advances and information technology. The only downside to this job? The resistance I occasionally encounter. I am a change agent, and not everyone shares my enthusiasm for process improvements.

The transition from a medical record focus to an HIM orientation has been a huge step forward for our profession. The healthcare system in this country will only reach its potential when it has learned to collect, store, and process health information electronically and apply evidence-based knowledge in real time. It's appropriate and critical that the HIM profession leads these advances. I have been very fortunate to work in a position that has been part of that movement, and my HIM training and experience positioned me well for this role.

HIM is no longer a behind-the-scenes department. We must be in the front lines, leading multidisciplinary groups in the use of data to improve our processes and our patients' experiences. To do that, we need to become familiar with medical literature because we have to be conversant not only with the care that is provided our patients, but also with best practices as defined in professional journals and other sources. We should feel comfortable with and adept at accessing this information via the Internet and through our medical libraries.

Although my job may not be typical of HIM professionals today, I hope that will change in the future. I urge HIM professionals to put traditional patient data to use in nontraditional, population-based improvement efforts and to become change agents in their institutions.

Collaborating for Better Patient Care: Questions for R. William Treloar

Describe your current duties. What are some of your ongoing projects?

I manage the department of clinical resource management. This group conducts projects designed to increase the efficiency of clinical processes at Shands HealthCare. Much of our work involves the facilitation of multidisciplinary teams and data support to improvement teams. We also lead Shands' teams participating in benchmarking projects with other University HealthSystem Consortium and VHA hospitals. Examples of recent projects include vent weaning in the CICU, bowel surgery, reengineering the discharge process, and blood use.

How did you come to be in your current position?

Like a lot of HIM professionals, I stumbled into this field. Following four years in the US Air Force, I earned an MBA in health administration and took a job as an assistant administrator in a large, inner-city medical center. Not long after, the director of medical records left, and the CEO asked me to manage the department until a replacement could be found. I was ignorant of the workings of a medical record department, and I immediately began working my way up the learning curve.

One of the first things I realized was that the department functioned 24 hours a day, 365 days a year. It didn't take long to appreciate the challenges of managing an operation that never shut down. I also learned the multitude of tasks performed within a "record room" and the extensive knowledge needed to conduct them.

Another lesson was the pivotal role of medical record information in patient care, accreditation surveys, hospital statistics, and hospital finances. I also learned that managing the medical record department was more interesting and satisfying than all the other duties I'd had. So having stumbled into the world of medical record administration, I realized this was what I wanted to do when I grew up, so I needed to get some formal training. I resigned, moved across the country, and completed a program leading to my RHIA.

Armed with my new credentials, I became the director of a large medical record department in an academic medical center. During the next several years, I saw the profession transform itself as HIM and the healthcare industry migrated toward managed care and a competitive model. The defining moment for the latter change came with the arrival of Medicare's prospective payment system. Suddenly, hospitals' financial health depended on the quality and completeness of clinical documentation.

Overnight, a new field appeared—individuals enlisted to lead their institutions and their medical staffs through the minefield of prospective payment. Many of them were given the title of DRG coordinator; at our facility, the position was director of case mix management. I was approached about taking the job and it immediately intrigued me. On one hand, it was a safe bet that the medical record department wasn't going anywhere, while this new position seemed very tenuous. On the other hand, I was ready for a change, and this was truly uncharted territory. So I opted to take a chance and took the position.

Initially, the position was all about education. First of all, I had to educate myself. The concept that Medicare (and later other payers) would pay us a fixed amount of money regardless of what it cost to care for a patient was totally foreign. The fact that our hospital could lose thousands of dollars for failing to code a comorbidity was revolutionary. (From today's perspective, it is amazing we had so much trouble with these concepts.)

I spent hundreds of hours dissecting the decision trees that constituted the DRG grouper and conveying this information to the physicians and coders. I engaged in contract negotiations with a professional standards review organization (now known as quality improvement organizations). I found myself in front of physician groups explaining that "DRG creep" was a term for overly aggressive coding and not an epithet I had acquired. I was a long way from HIM, and yet I wasn't. My HIM training has instilled in me an appreciation for complete, accurate data. My knowledge of medical terminology and science gave me credibility with clinicians. And my communication and management training prepared me for the negotiations and interactions that I encountered every day.

If an HIM professional is interested in working in your setting or in a similar role, what kinds of skills/experience should he/she acquire?

Data, statistics, and technology skills, such as familiarity with spreadsheet, database, and presentation software are important for this position, but strong communication skills are absolutely essential. Almost everything I do involves collaborating and reaching consensus with a highly diverse group of professionals. I need to tailor my approach and vocabulary to the audience at hand. Consecutive tasks may include explaining a complex bubble chart to the chairman of surgery, then addressing a group of unit clerks regarding bed assignments. Not only do I need to communicate appropriately for both audiences, I may also need to facilitate a group that includes both.

What do you find most rewarding in your job?

I find the collaboration with a diverse group of professionals in the improvement of patient care processes the most rewarding aspect of my job.

What has been your biggest challenge in this position? How have you met this challenge?

The biggest challenge has been resistance to change. The principal means of overcoming this resistance are solid data, evidence from the clinical literature, and well-communicated logic.

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