Best Practices: Access Case Management

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Objectives

- Identify key components of an effective staffing structure to support case management points of entry
- Describe key points of entry requiring support and how they are best managed
- Explain how an automated system can streamline and improve documentation related to points of entry case management

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Sentara Healthcare

- 125-years, not-for-profit organization
- 11 hospitals; 2,572 beds; 3,825 physicians on staff
- 13 long term care/assisted living centers
- LTACH
- 4 Medical Groups (650+ Providers)
- Optima-453,118 member health plan
- Sentara College of Health Sciences
- $4.9B total operating revenues
- $5.4B total assets
- 25,000+ members of the team

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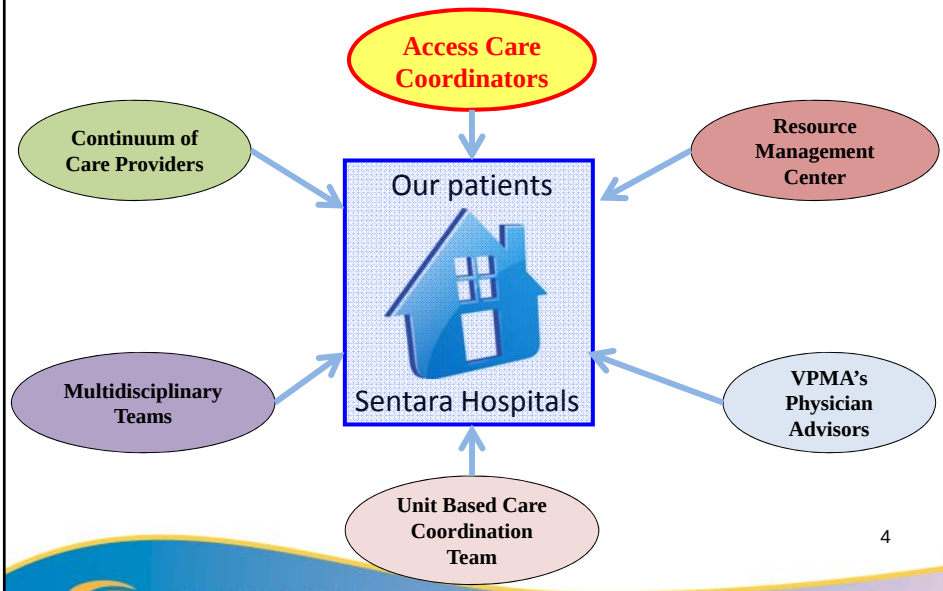
The Sentara Care Coordination Model



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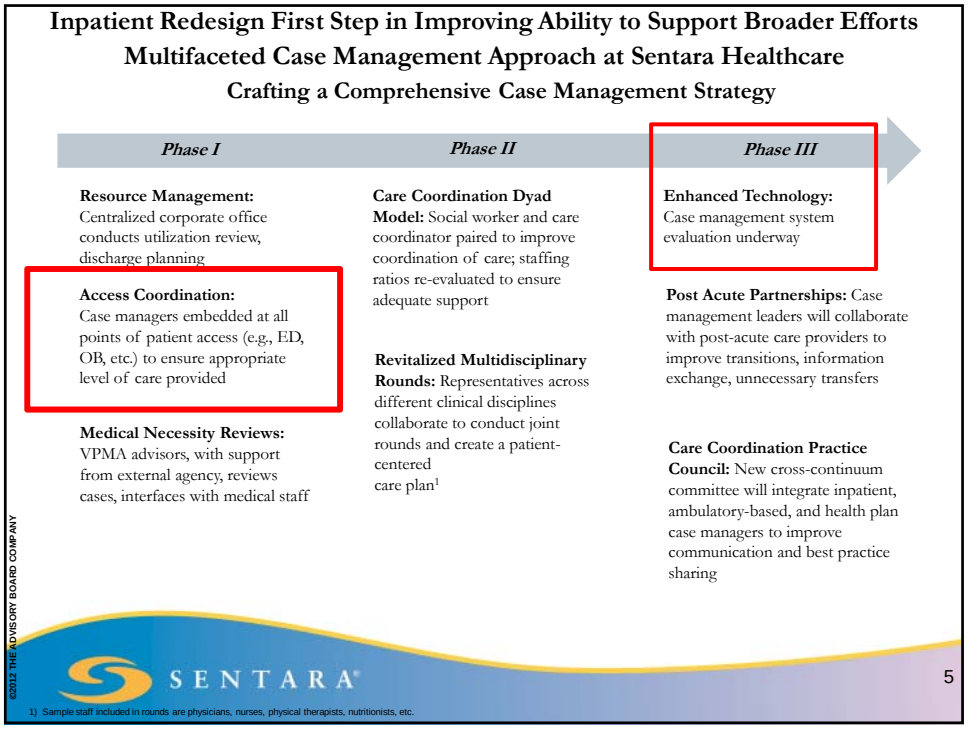

Sentara Guiding Principles for Design

- Ensure operations drives design decisions
- Design with the patient/member in mind
- Understand/adopt best practices as the standard
- Improve clinician care-giving and safety by streamlining processes
- Simplify work and minimize hand-offs
- Work toward a paper-free environment
- Enter information once, share many
- Maintain common look and feel for users of all modules
- Eliminate loop-holes: use system as designed
- Examine "Ripple Effect" of every design decision
- Apply 80/20 rule (Pareto principle)
- Meet or exceed identified benefits

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A world where reporting is a by-product of the required documentation of the work performed to ensure Sentara HealthCare is compliant with the Center for Medicare & Medicaid Services Conditions of Participation and Payer Contracts.

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Implementation Timeline Overview

- Contract finalized October 2012
- Build started in November 2012
- Staff training began January 24, 2013
- Phase 1 **Live** February 13, 2013
  - Focus was utilization management
  - Access role in hospitals
  - Resource Management Center
  - Physician Advisors (VPMAs and E.H.R.)
  - Appeals and Denials

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Implementation Timeline Overview

- Phase 1A **Live** March 18, 2013
  - Readmission Worklist Monitoring
  - Avoidable Delays
- Phase 1B **Live** April 1, 2013
  - Communication with Registration, PFS via MCCM
- Phase 1C **Live** July 15, 2013
  - Detailed readmission assessments
  - Communication between Care Coordinators/Social Workers and Discharge Facilitators

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Implementation Timeline Overview

- Phase 2 **in Design** 4th Quarter 2013/1st Quarter 2014
  - Discharge Planning – Care Coordinators and Social Workers
  - Discharge Planning Extract
  - Uni-directional Interface from Epic flowsheet rows to MCCM ADA's
  - New HL7 Posting Program
  - Single Sign on from Epic
- Phase 3 – Official Dates TBD
  - Bi-directional interface between Epic and MCCM
  - Bi-directional interface between HBOC and MCCM
  - Continuum Modules

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Access Care Coordinators

- At the ***access points of the hospitals***, RNs assess patients to determine medical necessity and provide transition planning
- Guidance provided to physicians ***before*** the order to "admit" is written
- 24/7 coverage as appropriate

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Driving Forces for Change

- Center for Medicare and Medicaid Services (CMS) Conditions of Participation
- Medicare Benefit Policies
- Recovery Audit Contractors (RAC) Program

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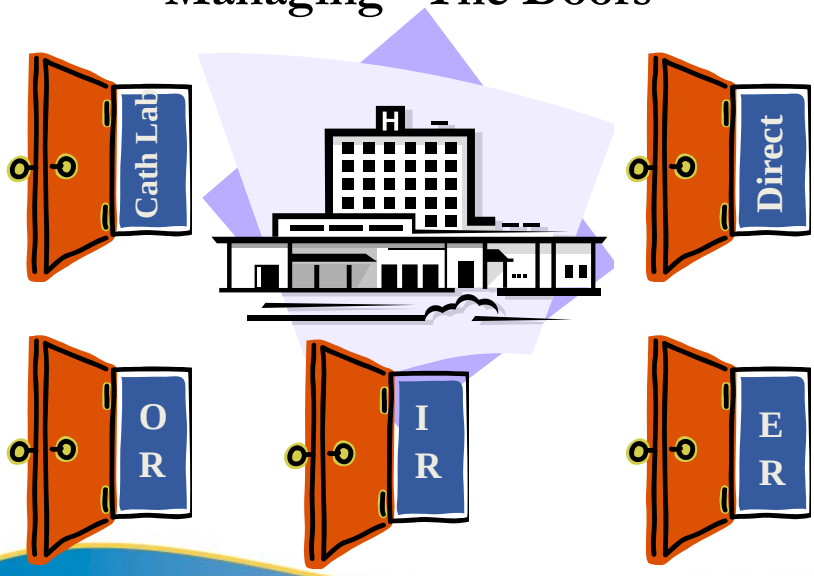
Managing "The Doors"



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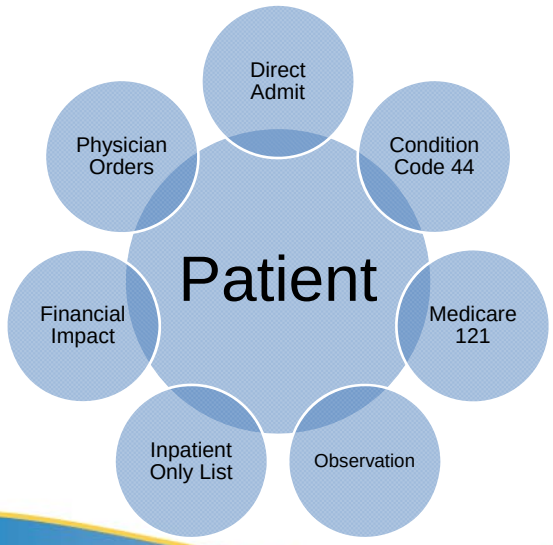
Impact of the Decision to "Admit"



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New Model - New Processes

- Easy identification of potential admissions
- Availability of Care Coordination to review cases before an order is written
- Guidance for Physicians to write the correct order
- Assurance order is written before service is rendered

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Getting it "Right" the First Time

- Initial order in EPIC
  - "Admit to Inpatient"
  - "Place outpatient in observation services"
  - "Bedded outpatient" – new concept
- Changing the order
  - Increases work
  - Changes Medicare billing
  - Can affect revenue negatively

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Challenges

- Electronic Health Record order entry
- Building working relationships with ancillary areas, especially OR and Cath Lab
- Perception of increasing throughput time for admission process
- Identification of patients requiring overnight stays
- Education opposite of old though processes
- Staffing the correct days and hours

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Goals

- Compliance with Conditions of Participation
  - Decrease use of Condition Code 44
  - Decrease use of Provider Liable billing (Medicare 121)
  - Improve accuracy of Observation status to allow for billing and appropriate patient notification
- Decrease write off of Medicare Inpatient only accounts due to missing orders
- Prevent inappropriate admissions

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Partnership for Success

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MCCM
Morrisey Concurrent Care Manager

- Use of Work lists
- Documentation guidance through templates
- Data gathering through Additional Data Answers (ADA's)
- System use by all areas of Care Coordination Model
- Imbedded criteria (InterQual)

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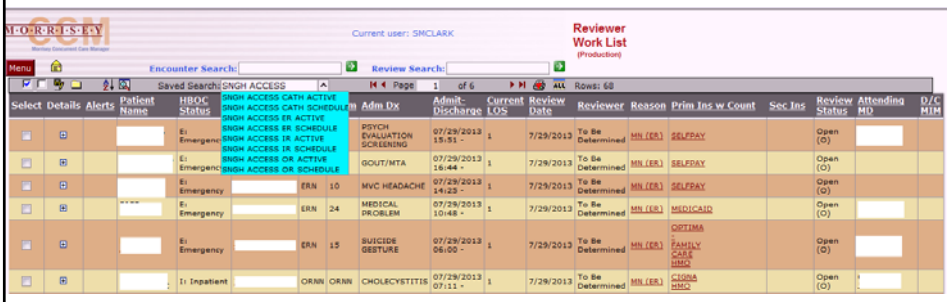
MCCM Worklist



- **Schedule work list** – identified accounts meeting criteria in the rule
- **Active work list** – accounts the access coordinator is actively performing reviews

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Function of Work Lists

- ***Schedule work lists*** are auto-populated based on rules which look at patient types and planned procedure dates
- Cases are moved from Schedule list to the Active list by Access Coordinators
- ***Active work lists*** are used while case is being "worked"

SNGH ACCESS CATH ACTIVE
SNGH ACCESS CATH SCHEDULE
SNGH ACCESS ER ACTIVE
SNGH ACCESS ER SCHEDULE
SNGH ACCESS IR ACTIVE
SNGH ACCESS IR SCHEDULE
SNGH ACCESS OR ACTIVE
SNGH ACCESS OR SCHEDULE

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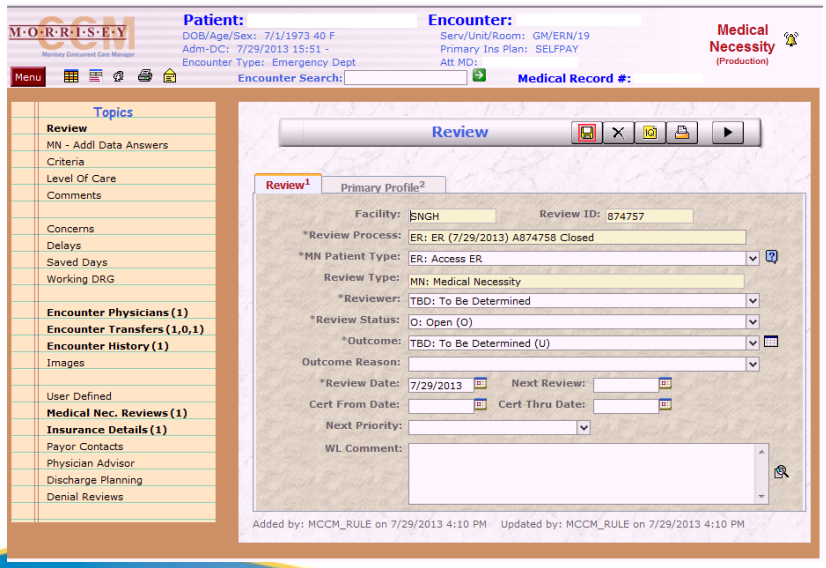
Emergency Room Review



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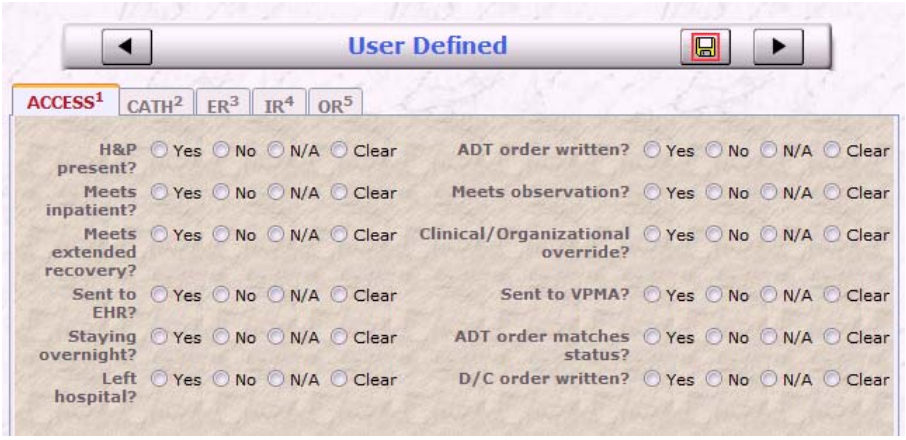
Access User Defined Checklist



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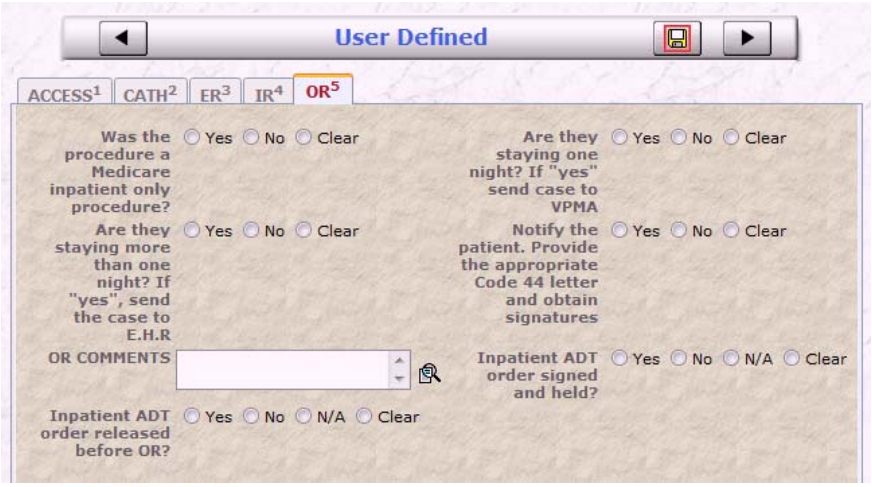
Operating Room User Defined



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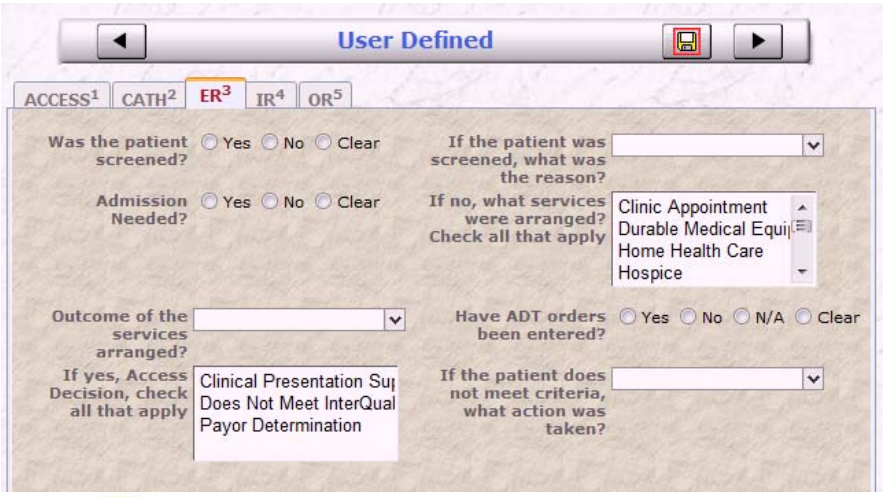
Emergency Room User Defined



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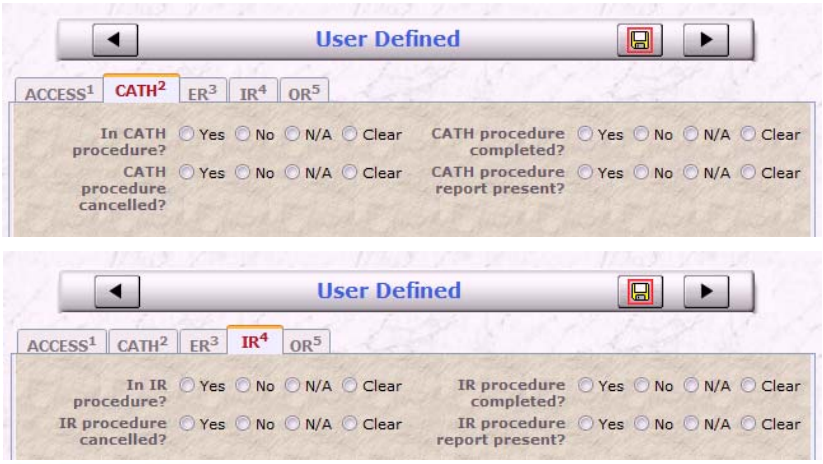
Interventional Area User Defined



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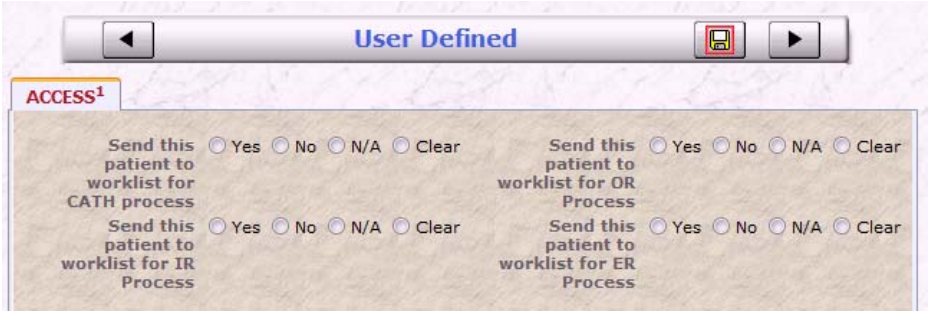
User Defined from Case Summary Activity



- Answering "yes" creates a MN review on a case not automatically identified by the MCCM Rule
- The case is then added to the corresponding "Scheduled" work list.

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Challenges with Automation

- Auto-creation of special Medical Necessity reviews
- Identification of the appropriate cases
- Multiple work lists for Access Coordinator to manage

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Keys to Successful Implementation

- ✓ Staff buy-in and active participation in the design of system
- ✓ Interdepartmental relationships, including physicians
- ✓ Automation of the documentation process – use of MCCM
- ✓ Reporting becomes a by-product of the required documentation

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Keys to Successful Implementation

- ✓ Establish process for reporting issues and requesting modifications
- ✓ Make modifications as issues are identified by end users
- ✓ Constant evaluation of compliance with defined workflow in new model
- ✓ Well defined procedures and job aids for workflow

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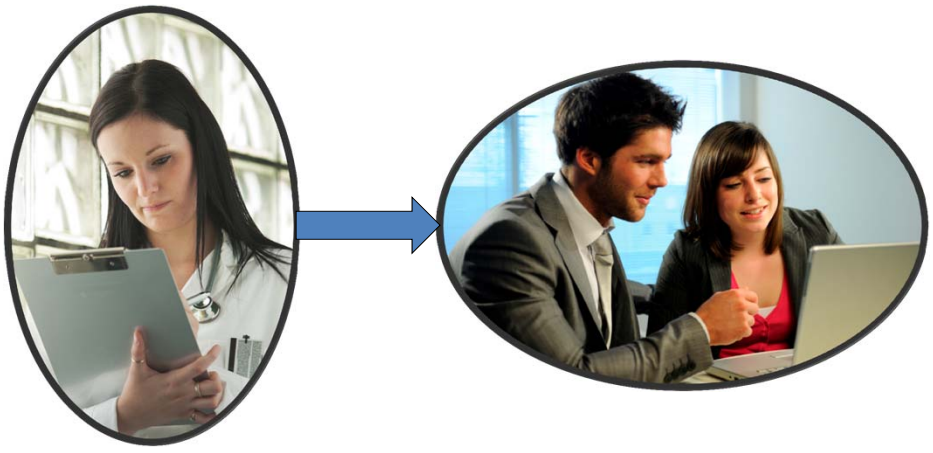
Then Now



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Staff Satisfaction

- "The MCCM software has allowed for better tracking, fewer fallouts and more timely reviews in comparison to our previous technology. This technology has allowed a smoother Access process."

  Tabitha Hapeman, RN, BSN, Team Coordinator

- "Going from a system that required me to create my own case that took 11 steps to the easy access to complete an emergency room MN Review from a work list is a great improvement in our process."

  Lakesha Chapman, RN, BSN, Access Coordinator

- "I don't like computers but receiving my physician advisors review request is very user friendly in MCCM compared to our old system. If I can do it anyone can!"

  Scott Miller, MD, Vice President Medical Affairs

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Summary

- With the help of technology we can continue to improve the access work flow.
- Through the use of reports based on work flow documentation we can provide feedback to the areas of access to the hospital to assure the correct orders are written the first time.
- Through technology we standardize best practices across facilities and eliminate variation.

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QUESTIONS?

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