


**Best Practices:
Achieving Success
with a Centralized
Resource Management Center**

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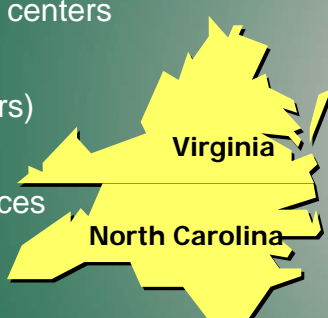
Objectives

- Describe the department structure and how it integrates with the patient care team.
- Outline the key workflows automated by the centralized resource management center.
- List achievements realized from implementing a centralized resource management system.


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Sentara Healthcare

- 126-year not-for-profit mission
- 12 hospitals; 2,727 beds; 3,799 physicians on staff
- 11 long term care/assisted living centers
- Extended stay hospital
- 5 Medical Groups (~900 providers)
- 440,000 - member health plan
- Sentara College of Health Sciences
- \$4.3B total operating revenues
- \$5.9B total assets
- 27,000+ members of the team
- AA/Aa2 bond ratings



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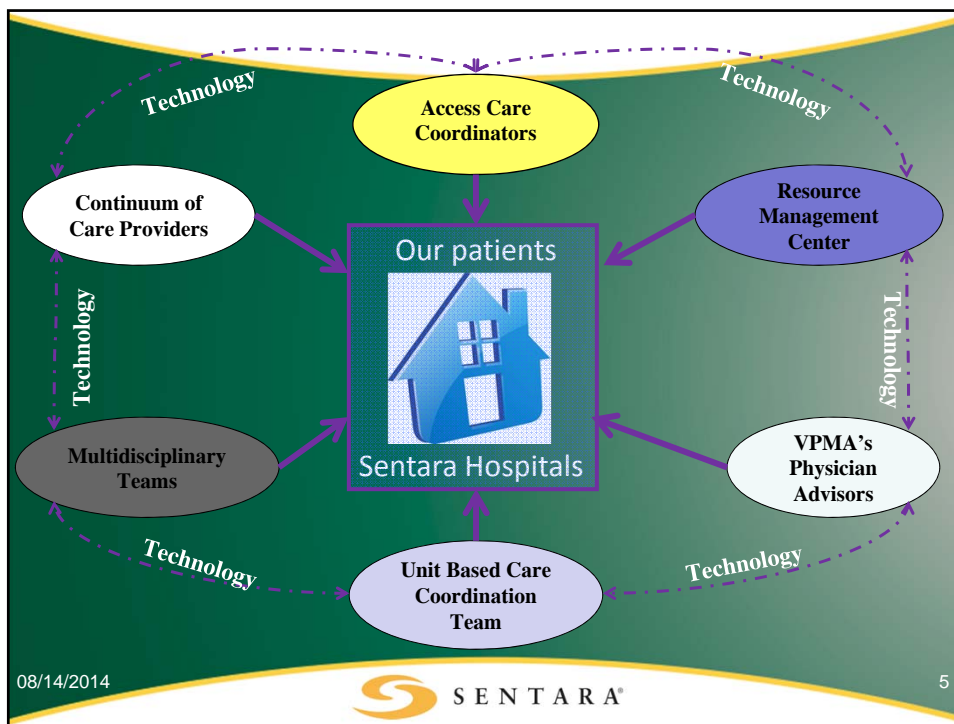


A world where reporting is a by-product of the required documentation of the work performed to ensure Sentara HealthCare is compliant with the Center for Medicare & Medicaid Services Conditions of Participation and Payer Contracts.

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Inpatient Redesign First Step in Improving Ability to Support Broader Efforts Multifaceted Case Management Approach at Sentara Healthcare

<i>Phase I</i>	<i>Phase II</i>	<i>Phase III</i>
<p>Resource Management: Centralized corporate office conducts utilization review, discharge planning</p> <p>Medical Necessity Reviews: VPMA advisors, with support from external agency, reviews cases, interfaces with medical staff</p> <p>Access Coordination: Case managers embedded at all points of patient access (e.g., ED, OB, etc.) to ensure appropriate level of care provided</p>	<p>Care Coordination Dyad Model: Social worker and care coordinator paired to improve coordination of care; staffing ratios re-evaluated to ensure adequate support</p> <p>Revitalized Multidisciplinary Rounds: Representatives across different clinical disciplines collaborate to conduct joint rounds and create a patient-centered care plan¹</p>	<p>Enhanced Technology: Case management system evaluation underway</p> <p>Post Acute Partnerships: Case management leaders will collaborate with post-acute care providers to improve transitions, information exchange, unnecessary transfers</p> <p>Care Coordination Practice Council: New cross-continuum committee will integrate inpatient, ambulatory-based, and health plan case managers to improve communication and best practice sharing</p>

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Driving Forces for Change

- Center for Medicare and Medicaid Services (CMS) Conditions of Participation
 - Patient notifications of Observation status
 - Two Midnight Rule
- Billing Compliance
 - Admit order date and time
 - Medicare Inpatient Only Procedures
- Medicare Benefit Policies
- Recovery Audit Contractors (RAC) Program

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System 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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Department Goals

- Standardization
- Automation
- Improve collaboration with physicians
- Improve collaboration between clinical partners along the revenue cycle
- Improve documentation to support compliant billing of claims

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Implementation Timeline Overview

- Centralized UM function February 2012
- Morrisey 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 Care Coordination 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
 - Avoidable Delays
- Phase 1B **live** April 1, 2013
 - Communication with Registration, PFS, Medicare billing unit
- Resource Management Center Re-location
 - Patient Financial Services
 - Charge Integrity Unit
 - Denials and Appeals
- Phase 1/Phase 2 **live** June 10, 2014
 - SNVMC – Utilization Management to RMC

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Sentara Hospitals Using Centralized Center



Sentara CarePlex (Hampton)
224 beds



Sentara Leigh (Norfolk)
250 beds



Sentara Williamsburg Regional
Medical Center (Williamsburg)
145 beds



Sentara Norfolk General (Norfolk)
525 beds



Sentara Princess Anne
(Virginia Beach)
160 beds



Sentara Obici (Suffolk)
168 beds



Sentara Northern Virginia
Medical Center (Potomac)
185 Beds



Sentara Virginia
Beach General (Virginia Beach)
276 beds

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The Journey

Where We Started - Before 2012


- Care Coordination and Utilization Review performed in each facility
- Staff managed all payer groups
 - 4 sites RN Case Managers managed all payers.
 - 3 sites – RN Case Managers managed Medicare patients and LPN “Certification Specialists” managed Commercial including Medicaid
- Use of criteria screening tool was still new
- No established workflows, No real UM Committee process, No billing for observation care
- Unfamiliar with insurance verification and billing procedures

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The Journey

Change - February 14, 2012


- Utilization Management (UM) functions centralized using “paper” and Cerme®
- Unit Based Clinical Coordinators had to sign in to see what was going on with UM as they worked using paper and Epic®
- Cerme® required manual creation of the reviews needed
- Early development of standardized Utilization Management Committees
- Journey begun for consistent and accurate billing for observation care – (October 2012)

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The Journey

Change - February 13, 2013


- Introduction of Morrisey Concurrent Care Manager (MCCM™)
- Use of automated work list creation through MCCM™
- Assignments based on Units/Hospitals
 - To build relationship between unit based staff and resource management center staff
- Cerme® access from MCCM™, eliminating manual creation of Cerme® review

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The Journey

Change - February 13, 2013 (con't)

- Implementation of Condition Code 44 notification for Compliance
- Implementation of Observation notifications to patients upon admission
- Implementation of Observation Billing supported by Charge Integrity Unit more efficient with access to reviews electronically

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The Journey

Change – September 2013

- Management transferred from Care Coordination to Revenue Management
- Realigned teams by payer groups – redesign of work lists to support payer assignments
- Supported realignment with specialized education
- Centralized office space to support collaboration across the revenue cycle
- Focused on timely, accurate reviews – emphasis on getting it right

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Today's Workflow

- Each payer team has 4-5 clinical staff members and one non-clinical staff member
- Daily assignments automatically created through rules in MCCM™
 - Admission (ADM)
 - Continued Stay (CSR)
 - Insurance (INS)
 - Post Discharge (PDR)


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Today's Workflow

- Clinical members apply screening criteria using either InterQual® or MCG®
- Documentation is done in MCCM™ – including the link to Cerme® - InterQual®
- Clinical data provided to payers via MCCM™ fax transmission
- Very few reviews are done telephonically

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Today's Workflow

- Clinical staff interface with the Hospital Care Coordination team to communicate
 - Status changes (Inpatient ↔ observation)
 - Condition Code 44
 - Medicare 12X bill type
- Letters generated via reports and recorded as coverage notices in MCCM™

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Today's Workflow

- Communication from the Resource Management Center is facilitated via MCCM™
 - Insurance Verification
 - Registration
 - Care Coordination
 - Charge Integrity Unit
 - Physician Advisors
 - Vice President of Medical Affairs (VPMA)
 - Executive Health Resources (E.H.R.)

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Today's Workflow

- Attending Physicians contacted directly by the Resource Management Center
 - Notification of determination after review
 - Obtaining the correct status – including taking telephone orders to support timely changes

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Recent MCCM™ Improvements

- Replaced processes requiring multiple manual steps in HBOC with bi-directional interfaces
 - Authorization information (numbers, days approved and days denied) are directly interfaced from MCCM™ to HBOC (Sentara's billing system) when commercial reviews are completed
 - Comment type of "HBOC" in MCCM™ interfaces the messages needed to the billing system posting it there as a memo

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Recognized Benefits

- Denials immediately escalated to management for appeal consideration – Clinical Appeals manager is just a cubicle away!
- Insurance carrier behavior and practice changes are quickly identified in daily huddles
- Carrier issues escalated to Contracting in aggregate


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Reporting - Productivity

Concern Type Description	SCPH	SLH	SNGH	SOH	SPAH	SVBGH	SWRMC	TOTALS
Authorization Number Obtained	498	1081	1834	667	734	814	407	6035
Insurance Requests Clinical Info	153	220	500	338	159	180	155	1705
Bill account as Condition Code 44	13	9	102	33	14	55	27	253
Occurrence code 72	6	7	5	2			1	21
Set up ACLS Transport	12	0	40	1	0	0	0	53
Set up BLS Transport	416	1	790	0	7	0	0	1214
Send Clinicals to CSB		2	4			8		14
Posting to Home Care Agency	107	507	563	163	241	492	111	2184
Initial Posting to Nursing Home	506	708	925	387	483	1071	329	4409
Set up Special Care Transport	2					2	1	5
OBICI - Post to the SSRC		1		14	1			16
Update Posting to Nursing Home	984	899	1934	536	785	1382	459	6979
Send Clinicals to the VA	11	20	11	2	13	15	1	73
Send Clinicals to Workers Comp Rep		2		2		2		6
Demographic Change	35	94	430	30		194	21	804
FOC Request		5			7	2		14
FYI Only	35	51	177	49	48	78	36	474
Insurance Update	43	151	1046	80	251	288	77	1936
Leadership Review	0	1	1	2	3	0	4	11
Bill account as Incomplete Code 44 or Medicare 121	16	19	42	14	5	31	24	151
PFS to set up Inpatient case	39	49	221	64	55	26	66	520
PFS to set up Observation case	8	27	35	12	17	10	21	130
Retrospective Review	4	9	8	4	2	6	2	35
Status Change Request	346	494	1142	384	365	581	305	3617
Change to IP and REMOVE Code 44	4	6	27	10	16	13	4	80
Uncategorized	31	46	93	16	21	51	42	300

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- ## Observation: Ensuring Compliance and Enhancing Revenue
- Multidisciplinary approach
 - Creation of Charge Integrity Unit
 - Policy updates
 - Deborah Hale education (RN, MD, Billing)
 - Computer software updates
 - Observation billing began in October 2012
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Measuring Outcomes

- Compliance with supporting documentation in medical record
- Increase revenue for new compliant billing for observation services
- Accurate/compliant procedures for Condition Code 44 and Provider Liabile 121 claims
- Process improved with CIU access to MCCM™ utilization documentation

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A group photo of seven people standing together, with a large, multi-faceted award trophy on the right. The trophy is inscribed with the Sentara logo, 'SENTARA CEO Award 2013', and the text 'Observation: Ensuring Compliance and Enhancing Revenue'. Below the trophy, the name 'David L. Bernd, Chief Executive Officer' and 'Sentara Healthcare' are visible.

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The Sentara logo, featuring a stylized 'S' in a circle followed by the word 'SENTARA' in all caps.

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We all must work together to succeed

Where do we go from here?



- Other Sentara hospitals – integration of EPIC record and billing systems with other sites likely will bring opportunities for expanding the Resource Management Center and centralizing utilization review functions for the system
- There are always new chapters to keep the journey interesting... Supporting documentation and regulatory changes will require us to always be focused on documentation improvement that will support payment of claims.

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Summary

- With the help of technology we can continue to improve the resource management center processes
- The use of reports based on work flow documentation can provide feedback to the team and data to leadership
- Technology assisted the standardization of best practices across facilities eliminating variation.

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QUESTIONS?

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