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.
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

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

<table>
<thead>
<tr>
<th>Phase I</th>
<th>Phase II</th>
<th>Phase III</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Resource Management:</strong> &lt;br&gt;Centralized corporate office conducts utilization review, discharge planning</td>
<td><strong>Care Coordination Dyad:</strong> &lt;br&gt;Model Social worker and care coordinator paired to improve coordination of care; staffing ratios re-evaluated to ensure adequate support</td>
<td><strong>Enhanced Technology:</strong> &lt;br&gt;Case management system evaluation underway</td>
</tr>
<tr>
<td><strong>Medical Necessity Reviews:</strong> &lt;br&gt;VPMA advisors, with support from external agency, reviews cases, interfaces with medical staff</td>
<td><strong>Revitalized Multidisciplinary Rounds:</strong> &lt;br&gt;Representatives across different clinical disciplines collaborate to conduct joint rounds and create a patient-centered care plan(^1)</td>
<td><strong>Post Acute Partnerships:</strong> &lt;br&gt;Case management leaders will collaborate with post-acute care providers to improve transitions, information exchange, unnecessary transfers</td>
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<tr>
<td><strong>Access Coordination:</strong> &lt;br&gt;Case managers embedded at all points of patient access (e.g., ED, OB, etc.) to ensure appropriate level of care provided</td>
<td></td>
<td><strong>Care Coordination Practice Council:</strong> &lt;br&gt;New cross-continuum committee will integrate inpatient, ambulatory-based, and health plan case managers to improve communication and best practice sharing</td>
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</tbody>
</table>

\(^1\) The Text Box States: "Inpatient, ambulatory-based, and health plan case managers to improve communication and best practice sharing"
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

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
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

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
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

Sentara Hospitals Using Centralized Center

- Sentara CarePlex (Hampton) 224 beds
- Sentara Williamsburg Regional Medical Center (Williamsburg) 145 beds
- Sentara Obici (Suffolk) 168 beds
- Sentara Norfolk General (Norfolk) 525 beds
- Sentara Virginia Beach General (Virginia Beach) 276 beds
- Sentara Virginia Beac 160 beds
- Sentara Princess Anne (Virginia Beach) 160 beds
- Sentara Northern Virginia Medical Center (Potomac) 185 beds
- Sentara Williamsburg Regional Medical Center (Williamsburg) 145 beds
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- Sentara Princess Anne (Virginia Beach) 160 beds
- Sentara Northern Virginia Medical Center (Potomac) 185 beds
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

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)
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

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
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

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)
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

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™
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.)

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
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

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
## Reporting - Productivity

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<tr>
<th>Concern Type Description</th>
<th>SCPH</th>
<th>SLH</th>
<th>BNGH</th>
<th>SOH</th>
<th>SPAH</th>
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</tbody>
</table>

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
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 Liable 121 claims
- Process improved with CIU access to MCCM™ utilization documentation
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.

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.
QUESTIONS?