A Partnership Approach to
Getting Your Patient’s Status Right

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Learning Objectives

• Understand the importance of how a consistent, frontline review process upon bed placement will improve patient flow and the communication between providers and payers in a team approach to advocate for the correct patient status.

• Learn about a contemporary model of patient access and status determination using Personal Health Partners and remote Care Management/Utilization Review Nurses.
Learning Objectives

• Review how CMS regulations can significantly affect your Care/Utilization Management structure and processes to ensure that patient rights and financial obligations are addressed and protected.

• Recognize the need for reporting metrics to demonstrate improvements in initial patient status determination and reductions of confusing status changes.
Does patient status matter...
Observation vs Inpatient

*Perception is reality.*
Patient Financial Obligations
IP or Obs - Why does it matter?

Inaccurate use of IP

• Focus of CMS auditors
• Potential False Claims issue if no compliant process is in place
• Eventual loss of revenue on audit and the loss of opportunity for appropriate OBS APC and ancillary charge payment

Inaccurate use of Obs

• Length of stay and mortality data artificially elevated
• Cost of IP care data artificially elevated
• Qualified stay impact on patient’s skilled care benefit
• Unexpected patient financial responsibility (self administered medication charges, inflated co-payments)
What’s the difference?

Inpatient vs Observation  Out of Pocket Expenditures
So what does this have to do with *Case Management*?
Definitions of Case Management

**American Case Management Association**

"Case Management in Hospital/Health Care Systems is a collaborative practice model including patients, nurses, social workers, physicians, other practitioners, caregivers and the community. The Case Management process encompasses communication and facilitates care along a continuum through effective resource coordination. The goals of Case Management include the achievement of optimal health, access to care and appropriate utilization of resources, balanced with the patient's right to self determination."


**Commission for Case Management Certification**

“Case management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's health and human service needs. It is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes.”

The Six Goals of the National Quality Strategy

1. Make care safer by reducing harm caused in the delivery of care
2. Strengthen person and family engagement as partners in their care
3. Promote effective communication and coordination of care
4. Promote effective prevention and treatment of chronic disease
5. Work with communities to promote healthy living
6. Make care affordable

CMS Quality Strategy Aims and Goals

Goal 1: Make care safer by reducing harm caused in the delivery of care.

Goal 2: Strengthen person & family engagement as partners in their care.

Goal 3: Promote effective communication & coordination of care.

Goal 4: Promote effective prevention & treatment of chronic disease.

Goal 5: Work with communities to promote best practices of healthy living.

Goal 6: Make care affordable.

Better Care

Healthier People, Healthier Communities

Smarter Spending

Source:
CMS Quality Strategy Goals and Foundational Principles

1. Make care safer by reducing harm caused in the delivery of care.

2. Strengthen person & family engagement as partners in their care.

3. Promote effective communication & coordination of care.


5. Work with communities to promote best practices of healthy living.


Foundational Principles:

- Eliminate Racial & Ethnic Disparities
- Strengthen Infrastructure & Data Systems
- Enable Local Innovations
- Foster Learning Organizations

MultiCare Health System – Tacoma, WA
MHS Mission, Vision & Values

»Mission: Partnering for healing and a healthy future

»Vision: MHS will be the Pacific Northwest’s highest value system of health:

»Leading as a people-centric community asset
  »Integrating a full continuum of high-performance customer-focused health and health related solutions
  »Delivering world class health outcomes and exceptional experience at a competitive price

»Shared Values:

Respect | Integrity | Stewardship | Excellence | Collaboration | Kindness
MHS Sites of Care

4 Adult Hospitals

2* Future Hospitals
- Covington (58 Beds)
- Psychiatric Joint Venture
* 2 More in 2017

1 Pediatric Hospital
Level II Adult & Pediatric Trauma

2 Multi-Specialty Center
- Gig Harbor
- Covington (Free standing ED)

4 Behavioral Health Network
- Imaging Joint Ventures
  - 6 sites of care

5 Outpatient Surgery Centers
Home Health / Hospice

9 Urgent Care Centers

11 Retail Clinics
Virtual Health Visits (Primary & Specialty)

Inpatient Rehab
Occupational Medicine
Care Statistics

642
Average Daily Census

257,721
ED Visits

1,397
Licensed Beds\(^1\)

5.1
Avg LOS

Payer Mix
MCR 36%
MCD 28%
Self Pay/other 36%

\(^1\)Licensed beds include CON approved beds which may be under construction. Includes 120 beds approved as part of the Behavioral Health joint venture with CHI Franciscan Health anticipated to be operational December 2018.
Our story… *Getting the patient status correct*

**May 2015**

- Utilization Management (UM) and Case Management (CM) under one umbrella but separate departments under Care Coordination
- Both areas evaluated for performance, structure, outcomes and patient value
- CM underwent changes to create a Personal Health Partner Program (PHP). A multidisciplinary team of medical professionals in both the acute and ambulatory setting
- In 2016 UM went under revenue cycle and expanded to include audits (new dept) and payer notification
Our story… Getting patient status correct

? - 2015

- UM was reviewing approx. 40% of admissions at 24-48 hrs post admission.
- Commercial cases were last priority
- Staffing at 9th percentile
- No concurrent appeals process
- Retrospective Denials were taking 8-10 months to appeal with a $25mil backlog
- No emergency room or point of entry (POE) UR
- No data collection or reporting
- UM and CM/PHP staff collaborated only on items for SNF benefits and member appeals
Our story… Getting patient status correct

**Strengths**

- Experienced Nurse Reviewers (RNs and LPNs)
- Software Med Nec review platform
- PA review process
- Supportive leadership that embraced vision and understood the need for change
- Collaborative team spirit that welcomed this model change
Our story… Getting patient status correct

Objectives for 2016

• Increase % of cases reviewed
• Move to POE review to get the patient status correct asap
• Reduce medical necessity denials
• Reduce appeal timeframe to <30 days from denial
• Track and report
• Increase review efficiency
Our story… Getting patient status correct

Changes in 2016 to Meet Our Objectives

• Expanded staffing and added nurses and support staff
• Realigned nurses to payer specialty
• Moved to POE review in collaboration with PHPs (ER and Direct Adm)
• Added evening and weekend shifts (review 6am-11pm)
• Increased appeal nurses and added support
• Re-evaluated our vendor partners
• Created tracking and reports (volume, productivity, denials, appeals)
• Researched industry experts for opportunities
Our story… Getting patient status correct

Impact & Outcomes

• POE review resulted in:
  – Correct status real time which benefits the patient and the hospital
  – Better patient coordination with PHPs and units
  – Enhanced communications with physicians and patients
  – Increase awareness of payer activity and denials
  – Compliances and education with 2MN rule
  – Accurate status impact for MCR beneficiaries (i.e. SNF)

Objective 1. Understand the importance of how a consistent, frontline review process upon bed placement will improve patient flow and the communication between providers and payers in a team approach to advocate for the correct patient status.
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POE Review Model

• Took months to fill vacant spots
• Utilizing remote partner allowed for quick execution of process and meet objectives
• Role model delivery of remote UR assisted with progress of on-premises to off-premises MHS staff
• Collaboration between PHP and UR helps with patient advocacy and satisfaction
• Positive feedback from POE providers as a result of assistance with the interaction with the patient

Objective 2. Learn about a contemporary model of patient access and status determination using Personal Health Partners and remote Care Management/Utilization Review Nurses.
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Patient Impact

- Multiple CMS regulations require hospitals to have a timely and efficient UR process, educated physicians, and internal monitoring.
- UR and partners (vendors and PHP) developed a process to ensure 2MN rule, benefits, status, and other regulations are priority starting at POE, through discharge and after.
- Communication between internal and external partners optimize accurate information flowing to physicians and patients.
- Positive feedback from patients.

Objective 3. Review how CMS regulations can significantly affect your Care/Utilization Management structure and processes to ensure that patient rights and financial obligations are addressed and protected.
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Data Metrics

• We monitor and report
  – Status for trends and fluctuations
  – Real time acuity changes
  – <2MN IP, and > 2MN Obs for exceptions and opportunities
  – Concurrent and retrospective denials by payer and appeal outcomes

Objective 4. Recognize the need for reporting metrics to demonstrate improvements in initial patient status determination and reductions of confusing status changes.
Our story… Getting patient status correct

Our Successes

• 100% internal staff reviews as of 1/1/17
• 89% concurrent review rate
• 92% POE review rate
• Reduction in status conversions including CC44
• Timely Obs notification to MCR beneficiaries and plans to go live with MOON in Jan (2 months before mandatory time of March)
• 75% concurrent appeal rate
• Retrospective appeals are <90 days from denial
• Medical Necessity denials are trending down
Care Management Support Services
Admission and Continued Stay Reviews
Care Management Services

• McBee Associates clinicians will remotely review patient records for:
  – Emergency Department UR/CM Coverage
  – Admission and Continued Stay Reviews
  – Concurrent Commercial Appeals
• Data Analytics and Metric Scorecard
• Care Management Assessments consulting
• Performance/Process Improvements consulting
Soft Benefits

- No staffing concerns
- Value added Data Analytics and Custom Metric Scorecard
- High quality documentation
- 95%> Inter-rater Reliability
- Complete clinical reviews
- Timely submission of reviews
- Care Managers able to focus on Discharge Planning
Questions?

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