Central Florida Health

Leesburg Regional
Medical Center

The Villages Regional
Hospital

Central Florida Health was founded in 2008, combining the previous entities of Leesburg Regional Medical Center (Leesburg) and The Villages Regional Hospital (Villages).

The hospitals have continued to expand.

Central Florida Health has 626 beds total:

- Leesburg: 329 beds

- Villages: 307 beds (includes 20-bed rehab unit)

Central Florida Health is one of the area's largest employers with 3,154 team members.

Overview

Leesburg Regional Medical Center

ED visits	46,079	Heart catheterizations	6,792
Outpatient visits	30,111	Observation admissions	6,209
Inpatient admissions	14,733	Births	1,308
Surgeries	6,985	Open heart surgeries	740

The Villages Regional Hospital

ED visits	38,485	Heart catheterizations	5,880
Outpatient visits	22,987	Surgeries	5,406
Inpatient admissions	19,188	Observation admissions	6,209

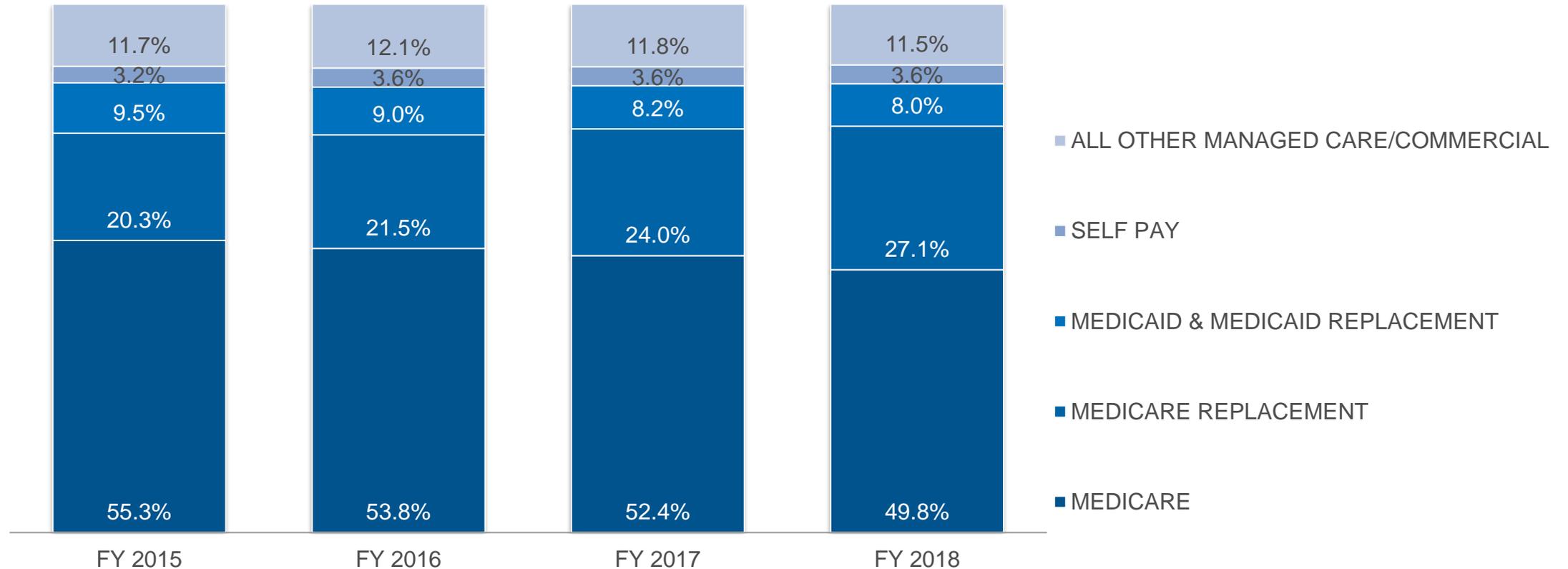# Case management, utilization department
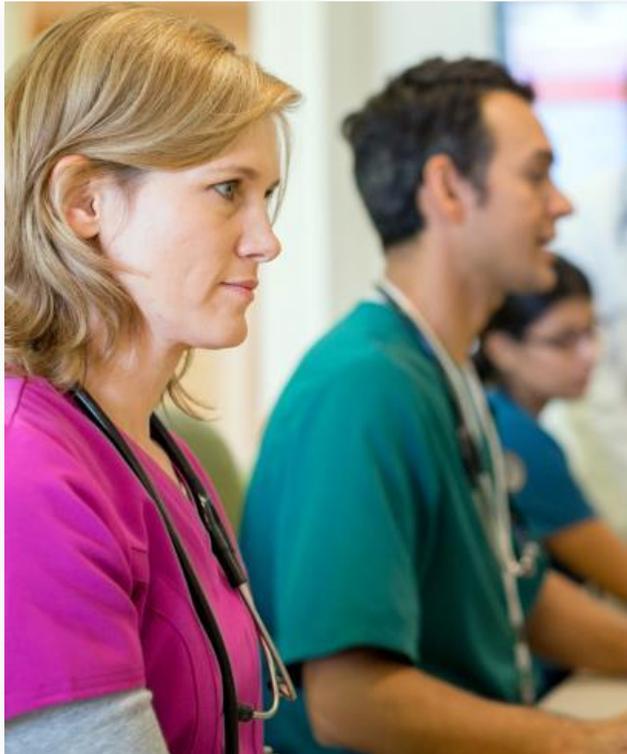
Case management department

- 24/7 coverage

- Utilization review nurse assigned to ED for initial status and reports to finance

- Case management (CM) department handles all other functions including discharge planning and reports to nursing

Central Florida Health payer mix: Acute

CFH payer mix based on acute discharges

	FY 2015	FY 2016	FY 2017	FY 2018
ALL OTHER MANAGED CARE/COMMERCIAL	11.7%	12.1%	11.8%	11.5%
SELF PAY	3.2%	3.6%	3.6%	3.6%
MEDICAID & MEDICAID REPLACEMENT	9.5%	9.0%	8.2%	8.0%
MEDICARE REPLACEMENT	20.3%	21.5%	24.0%	27.1%
MEDICARE	55.3%	53.8%	52.4%	49.8%

Central Florida Health payer mix: Acute

CFH payer mix based on observation discharges

	FY 2015	FY 2016	FY 2017	FY 2018
ALL OTHER MANAGED CARE/COMMERCIAL	18.3%	18.7%	18.5%	16.9%
SELF PAY	5.6%	5.4%	4.7%	5.6%
MEDICAID & MEDICAID REPLACEMENT	11.3%	9.8%	8.9%	9.5%
MEDICARE REPLACEMENT	20.5%	23.1%	25.7%	26.4%
MEDICARE	44.3%	42.9%	42.2%	41.5%
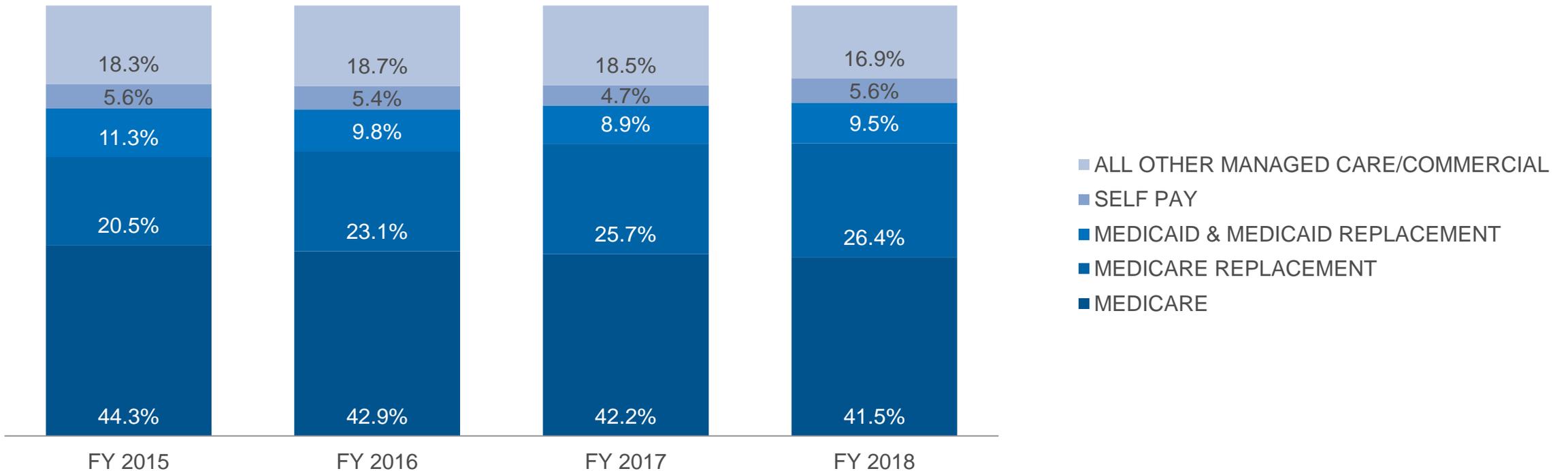
Prior utilization review process

Insourced PAs with EHR backup support

Second-level review

- Contracted with four physician advisors (PAs) from medical staff
- Lack of availability of PAs
- Used EHR physicians as backup
- Lack of on-site expertise
- Barrier interaction with medical staff

Condition Code 44

- Operationally challenging
- EHR PAs not on medical staff; not members of utilization review committee
- Insourced PAs unwilling to question their fellow peers

Peer-to-peer appeals

- Unavailability of PAs from medical staff to review case
- Outcomes unknown and inconsistent
- Area of opportunity to stream-line and improve process

Barriers to success with insourced PAs

Quality issues

- Case load fluctuations and off-hours coverage
- Lack of consistency among multiple PAs across facilities
- Lack of synergy between medical necessity and denial appeals programs

Ongoing PA program support

- Lack of reference material to validate medical necessity decisions and defend appeals
- Unclear financial benefits; lack of accountability

PA recruitment, training and development

- Difficulty finding competent PA candidates (UR/CDI knowledge)
- Constantly changing regulatory issues and medical research
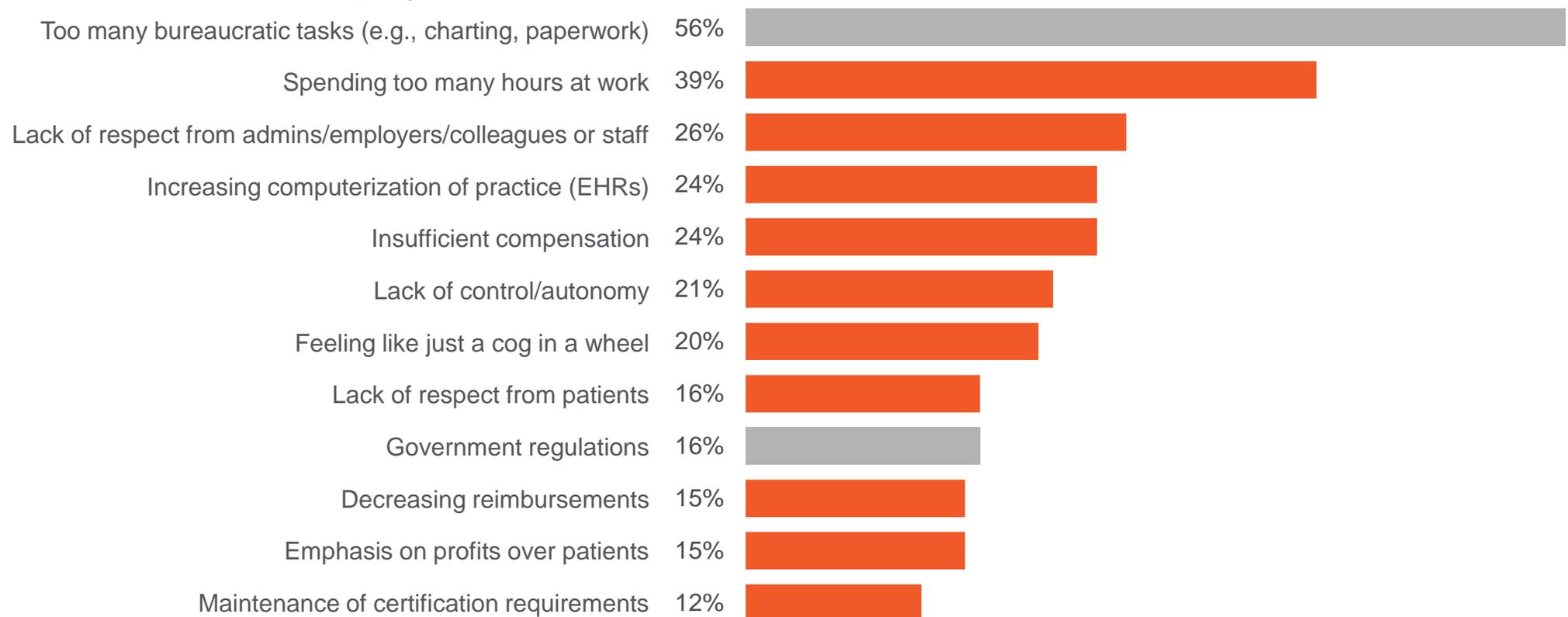
ACDIS PHYSICIAN ADVISOR SURVEY*

60% of PAs deemed ineffective or only moderately effective

Insufficient training cited as key factor

Association of Clinical Documentation Improvement Specialists 2016 Physician Advisor Survey

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The problem of physician burnout

What factors contribute to physician burnout?

Factor	%
Too many bureaucratic tasks (e.g., charting, paperwork)	56%
Spending too many hours at work	39%
Lack of respect from admins/employers/colleagues or staff	26%
Increasing computerization of practice (EHRs)	24%
Insufficient compensation	24%
Lack of control/autonomy	21%
Feeling like just a cog in a wheel	20%
Lack of respect from patients	16%
Government regulations	16%
Decreasing reimbursements	15%
Emphasis on profits over patients	15%
Maintenance of certification requirements	12%

Medscape National Physician Burnout & Depression Report 2018

A BETTER WAY:

A hybrid on-site/ remote physician advisor solution

Hybrid on-site/remote physician advisors

CFH added on-site physician advisors that operated in conjunction with remote physician advisors.

| On-Site PA Responsibilities	Remote PA Responsibilities
• Physician on-site support • Medical and administrative staff education • Patient status recommendations • Utilization review (UR) committee membership • Length-of-stay analysis • UR process improvement • Condition code 44 support • Concurrent denial appeals (summer 2018)	• Concurrent denial appeal support • Retrospective denial appeal support • Off-hours (weekend, holiday, night) patient status recommendations • Overflow support for on-site PA during high volume periods

Value of on-site physician advisors

Enhances greater quality and effectiveness

- Greater process standardization
- Helps build consistency across facilities
- Reduces physician burnout
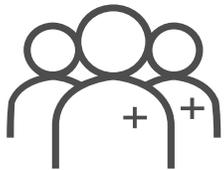
Better, more collaborative processes for utilization review and CDI

- Peer-to-peer physician interaction; team building
- Metric-driven processes yield more accountability and effective issue resolution
- Less bias and hesitation to question peer physicians

More qualified and better trained PAs

- Learned that not any physician can be reassigned to be a physician advisor
- Rigorous PA training (e.g., 120 computer-based training courses)
- Emphasis on keeping up with new payer guidelines and best practices

Post-implementation successes

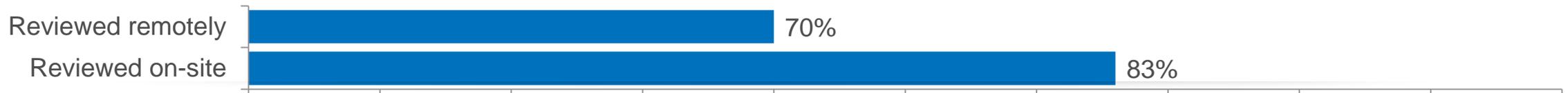| Second-level review	Condition Code 44	Peer-to-peer appeals
• Improved response time with referrals to on-site physician • Full access to hospital EMR • On-site building case with full access to medical record vs. relying on CM to build case (reduced variability) • Enhanced relationship with medical staff • Medical staff seek our on-site PA to discuss borderline cases.	• Operationally flowing better with enhanced and deeper understanding of process by UR staff • On-site PA is member of UR committee • On-site PA developed in collaboration with CM/UR Condition Code 44 algorithm	• Streamlined referral process for peer-to-peer review by remote physician advisors • Future state: incorporate on-site physician advisor in the peer-to-peer review process formally

Hybrid program results

Onsite physician advisor results reflect the power of proximity.

Percentage of cases initially identified as Observation by first-level criteria and identified as Inpatient by PAs:

Medicare

Reviewed remotely	79%
Reviewed on-site	82%

Commercial Payers

Reviewed remotely	70%
Reviewed on-site	83%

Medicare Advantage

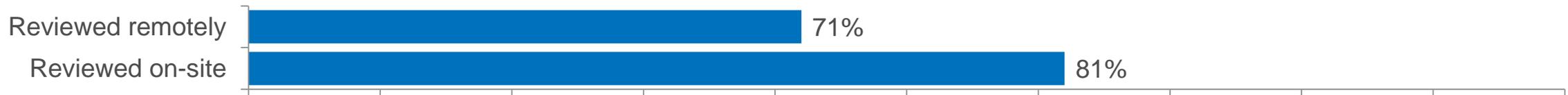|	
Reviewed remotely	78%
Reviewed on-site	84%

Hybrid program results

Onsite physician advisor results reflect the power of proximity.

Percentage of cases initially identified as Inpatient by first-level criteria and validated as Inpatient by PAs:

Medicare

Reviewed remotely	82%
Reviewed on-site	87%

Commercial Payers

Reviewed remotely	71%
Reviewed on-site	81%

Medicare Advantage

Reviewed remotely	81%
Reviewed on-site	80%

Condition Code 44 process

Registered nurse

UR/CM RN to status patient as inpatient (IP) or observation (OBS)

Attending physician

RN speaks to AP about recommendations based on status guidelines

A If **AP agrees to initial status,** no further action is taken.

D If **AP disagrees to initial status** and wishes to put the patient in a different status, a secondary review is performed by a PA.

Physician Advisor

A If **PA agrees with AP,** the patient is placed on agreed upon status.

D If **PA disagrees with AP,** the PA talks with AP to shed more light on situation to determination initial status.

If **AP still disagrees,** another AP who sits on the utilization review committee reviews the case to help decide level of care.

If **order change** from IP to OBS is made and all are in agreement, a Condition Code 44 is initiated, order changed, PA note placed in chart.

Onboarding best practices

Credentialing

- Assist with credentialing packet
- Liaise between medical staff office, central verification office

Onboarding

- On-site physician advisor attends medical staff orientation and EMR class
- Access badge provided
- Determine best place for on-site physician advisor to office

Practice

- Introduction by CM to key medical staff leaders and all attending physicians
- Allow on-site physician advisor room to develop his/her own flow with CM, UR, and medical staff. "Evolution not a revolution!"
- Ongoing monthly meetings with senior leaders

Physician advisor best practices

- All cases that do not meet initial review by the case management or UR departments are reviewed by the on-site PA.

- Any non-Medicare FFS denials require a peer-to-peer discussion with the insurance medical director or the attending physician, with education by the on-site PA, if needed.

- Both PAs are sitting members of the utilization management committee and assist in completing the Condition Code 44 process.

- The PA is in constant communication with the case management and UR departments and is involved in streamlining processes and implementing changes.

Benefits of hybrid on-site/remote program

Timeliness	Decisions based on most up-to-date information from the EMR
Medical staff	Increased physician satisfaction and reduced physician burnout; consistent person to discuss the case
Acceptance by medical staff	Improved understanding of PA role and willingness to collaborate with colleagues
Enhanced referral process	Improved efficiency of case management and UR nurses in referral process
Condition Code 44	Improved Condition Code 44 process and increased understanding by medical staff through education by on-site physician advisor
Flexibility	Ensured coverage on nights, weekends, and holidays and during peaks in case volume

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Next phase of program

- Launch the onsite PA peer-to-peer denials program

- Integrate onsite PA with CDI program and staff

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QUESTIONS?

Thank you

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SVP and COO, Central Florida Health

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