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# Charting a Revenue Cycle Roadmap

## About HFMA Roundtables

“Charting a Revenue Cycle Roadmap” is the latest in a series of “virtual” roundtable discussions convened by HFMA to consider financial issues of pressing practical concern to healthcare leaders. In this roundtable, prominent industry professionals candidly share their personal views, experiences, and advice about how to enhance the financial health of organizations, in this case by establishing a structure and process to improve revenue cycle management. This HFMA Roundtable is made possible through the support of 3M Health Information Systems.

Nearly every hospital and health system is interested in improving its revenue cycle. But where is the best place to start?

Who should do what? How should priorities be established?

The challenge is intensified by the broad range of departments

that are directly or indirectly involved in the revenue cycle—

scheduling, registration, admissions, patient financial services,

medical records coding, quality assurance, and clinical

operations—making teamwork essential but, historically

at least, not always natural.

*What follows is a discussion of these key issues based on excerpts from the comments of four senior healthcare financial executives from provider organizations and a revenue cycle marketing manager from a technology vendor.*

ROUNDTABLE PARTICIPANTS



**Mary Kay Boudewyns, FHFMA**, is vice president, revenue management, Dartmouth-Hitchcock Medical Center, Lebanon, N.H. This academic medical center includes the 400-bed Mary Hitchcock Memorial Hospital and the Dartmouth-Hitchcock Clinic, a 600-physician multi-specialty group practice.



**Cynthia DeBoer** is associate administrator, patient finance, Memorial Hospital, Colorado Springs, Colo. This city-owned Level II trauma center, which is building a new 90-bed facility to add to its 467 current beds, includes Colorado Springs Children's Hospital.



**Jan Ohlsson** is revenue cycle marketing manager, 3M, Murray, Utah. This global technology company is a major presence in multiple healthcare market segments, including medical and surgical products, pharmaceuticals, and health information systems.



**Wayne Smith** is director of finance services, Singing River Hospital System, which includes Ocean Springs Hospital in Ocean Springs, Miss., and Singing River Hospital in Pascagoula, Miss. The system also owns The Regional Cancer Center at Singing River Hospital System, a 680-bed facility.



**Shoshana Williams** is director, patient financial services, Stanford Hospital & Clinics, Stanford, Calif. The 611-bed Stanford Hospital & Clinics sees 500,000 clinic visits in more than 100 specialty areas annually and includes Stanford School of Medicine and Lucille Packard Children's Hospital.

ROUNDTABLE DISCUSSION

► **How do you begin the process of building a revenue cycle task force?**

► **Smith:** The first thing you have to do is identify the key players: admissions, the business office (or financial services), medical records, and quality assurance. You set up a core revenue cycle team that has someone with the authority to make decisions for each of those areas, plus the CEO and the CFO. We also incorporated administrators from each of our hospitals, including the administrators for nursing—because you need their buy-in, especially if you're posting real-time charges.

► **DeBoer:** The first thing we had to do was to become a real team. It's a lot harder to get mad at somebody once you know the person and have an appreciation for his or her job. So we spent the first couple of meetings getting to know each other, playing some team-building games. We did a Walk-in-My-Shoes program, where the managers from one department spent time in another department to find out what staff did during a typical day. It helped open people's eyes.

► **Ohlsson:** Some facilities have created their revenue cycle task force from their ambulatory payment classifications task force. They use the same personnel, because there are a lot of commonalities. If your APC

task force is no longer in commission, start by identifying the key steps in the revenue cycle that you want to manage—this is a little different for each hospital—and the key people involved in each step. This group’s first job is to define the complete process of getting a claim out the door and pinpoint where there are problems in that process. Each is key: patient access, ancillary, chargemaster, health information management, and patient financial services departments must be represented and have support from the C-suite. I also strongly recommend including a physician liaison member on this task force as well.

► **Williams:** The first thing is to make sure that you have accurate, timely, and credible data, and to benchmark key performance indicators and goals. Doing so is necessary to be able to engage people and provide a roadmap of where you are and where you need to be. The second thing is to get buy-in and sponsorship from the CEO, CFO, and CMO. You need to create an infrastructure of accountability that will lead to a culture of change not only from the top down but also from the inside out. The third thing is to invite the key stakeholders to the table—senior management and department directors—and make them accountable for what happens in the revenue cycle.

► **How do you measure or quantify the problems you plan to address? Are these measurements automated?**

► **DeBoer:** The use of key performance indicators is helpful in measuring the success of improvement efforts in the revenue cycle. Some measurements are automated, such as denial rates, recovery on denials, and reimbursement rates. Other indicators may have to be gathered manually, such as days to assemble or code a chart in medical records. With manually gathered key performance indicators, it’s important to keep them simple and ensure they are not too time intensive for the information you get out of them. Often, after a process has been improved and the improvement measured for an appropriate follow-up period, you can ease off frequently collecting information—particularly if it is manually gathered—and transition to a periodic check of the data.

► **Williams:** You measure your success, in terms of both performance and progress, by your key performance indicators and your established goals. These are measured weekly and the measurement is automated. In order to be credible, the data have to come directly from your accounts receivable system. We have a weekly report that goes to the CEO, CFO, and department director stakeholders. We live and breathe those statistics.

► **Boudewyns:** We have key metrics we use for monitoring our revenue cycle and then specific metrics that we use for measuring individual projects. For example, we launched an initiative to better educate our physicians on the proper documentation and coding for the services they provide. We established their baseline coding levels compared with industry benchmarks and then tracked the changes in their coding levels as a result of the education. Another way of measuring progress is in terms of dollars: If we identify a \$4 million opportunity, for example, we develop a timeline for achieving the \$4 million goal. If we lag behind in achieving the goal, then we step back and ask some questions: Are there barriers we need to eliminate? Were our assumptions wrong? Was our timeline unrealistic?

► **How do you prioritize the projects or initiatives the revenue cycle team will tackle?**

► **Boudewyns:** We look at several things. In addition to the overall revenue opportunity and the ROI, we look at the engagement of the department involved, because it doesn’t do you a lot of good to go after an opportunity if you can’t get the department’s cooperation and support. I have a real bias for those areas that come and knock on our door and say, ‘Will you help us?’ Compliance risk is certainly evaluated in the mix as well.

► **Ohlsson:** From the CFO point of view, the main initiative is to deliver more cash to the bottom line. It’s ensuring full reimbursement, reducing write-offs, and optimizing cash flow. The whole impetus of the revenue cycle is to get the clean claim out the door—the sooner this happens, the sooner the facility

gets paid. So the first step might be a review of denials: What is going wrong in the process? Looking at remittance advices can tell you a lot about the problems that might be related to denial and payment adjustments. From there, one needs to define and prioritize how to get the largest return in the shortest amount of time. We help our customers work through an *is* and *should* map to identify what processes need to change and where technology can provide a key part of the solution.

► **Smith:** When the task force meets, we have a roundtable discussion to identify what issues we're having in each area, such as bills not dropping, a delay in billing, the charges coming in late, or key information missing, and what's causing the problem. We go down the list of issues—we had about 50 at first—and rank them. If you have a coding problem that's costing you \$1 million a month and a late charge posting problem that's costing you \$30,000, it's not too hard to pick a priority. But each department or area has its own sublist of problems to work on. Say financial services has had returned mail and when those patients come back in, they're admitted without anyone updating the address. This is not the business office's fault but it is their problem.

Money isn't the only factor in ranking. Patient satisfaction also is a huge part of it. Generally if you have a revenue cycle problem, you have a patient satisfaction problem.

► **DeBoer:** Initially, the group prioritized according to what was creating frustration and additional workload. After several years of working together, we've graduated to using key performance indicators in all of our top areas. I monitor those, and that gives us a good idea of what processes need to be improved.

► **Williams:** We prioritize our projects and initiatives by looking at the cash flow opportunity. What is the biggest bang for the buck? We prioritize the review of our accounts by descending dollar and focus on those payers that are delinquent in timely claims payment. Of course, quick fixes are identified and executed.

## ► How does the task force set about its work and maintain its focus?

► **Williams:** By persistent review of our key performance indicators and associated drill-down reports, we not only have been able to hold the gains but to incrementally improve our revenue cycle performance over the past six years. This has been the key to maintaining focus.

► **Smith:** The first thing we did was whatever was necessary to correct a problem immediately. Because if you don't do a quick fix, you might spend up to a month working on getting to the root of the issue, and all that time you've got patients going through a process you know is broken. So the first question is, 'How can we make this not happen anymore?' The quick fix often involves doing something manually that may end up as an automated process.

Then you do a root cause analysis to find out what's really happening. You want to be able to identify everything that could possibly happen in this process, and there's no one person who can do that. So that's when you develop subcommittees. The subcommittee does the analysis and brings its conclusions and recommendations back to the full task force. Let's say the problem we have is missing social security numbers or not verifying Medicare status on admission. The subcommittee will bring together people from financial services and admissions so they can figure out where things break down between them. Maybe when they examine steps leading to the problem, they realize that quality assurance staff should have been involved—there may be one little section of the flow chart that spills over to quality assurance if one particular thing happens—so they bring them in.

► **DeBoer:** I think rounding is a very good idea. I will often stop and work at the front desk of our registration areas, just to keep in touch with the front-line staff—they'll tell you what's not working right. And the more you come by, the more they come to know and trust you and the more open they are with relating their perceptions and ideas. It's especially important to get frontline staff involved in the work of subgroups, not just because it creates ownership but also because the best ideas usually come from them.

Creating flowcharts of processes also is very important. In addition to helping you understand how actions in one department affect the workload of another, it helps you spot redundancies, rework, and bottlenecks. Again, having front-line staff assist in this effort is vital. Managers and supervisors can create flow charts of what should be happening, but front line staff are in the best position to add what truly is happening.

► **Ohlsson:** When one looks at patient data workflow there are many departments that provide input to the process. Keeping the task force at a workable size can be an issue. Some of our customers have said that their revenue cycle task force got too large, hampering its effectiveness. You need the right departments represented, but there also will need to be subgroups in each functional area to work on fixing the problems in their departments. The key here is to make sure that the communication flows both ways, so that everyone is working on common goals related to the desired outcome.

► **What steps do you take to bring the physician's office into the revenue cycle improvement process?**

► **Smith:** You have to build a relationship with staff in the physician's office, get them involved, and keep them informed. This doesn't mean just the physician. If you can't get the office managers, insurance clerks, or the lab technicians on board, you're fighting a losing battle. We hold seminars for the office staff in which we have lunch or dinner with them and talk about what's going on with the hospital, what's changed with Medicare. That way, when they're not doing something we need them to do, we can feel comfortable picking up the phone and discussing it with them. We have a couple of large physician clinics, and we will bring their staffs in to the hospital to talk about key issues such as precertification or patient identification problems.

► **DeBoer:** We've just recently started involving physicians' offices. We ran a report identifying who our big referrers are, and we're going out to them in conjunction with our business development department—myself, the director of scheduling, and the business development people. We take their office

## An Improved Revenue Cycle

### What should you keep in mind when navigating revenue cycle workflow?

- Revenue cycle management must take an integrated approach. Task forces often work in conjunction with departmental subgroups more familiar with the problems in their areas. Solutions need to encompass the key elements that impact data accuracy: people, processes, and systems or technology.
- Creating flow charts of the patient data workflow through each functional area provides a reality check for how and where patient data are created and used, and what happens as these data move through the revenue cycle.
- After tackling the more obvious problems, you need to conduct an in-depth analysis of your key performance indicators to help chart a course for additional improvements in each functional area.
- External consultants can be key to analyzing process problems and data issues, outlining corrective actions, and providing education and training to help implement change. Consultants can also be useful for conducting periodic audits to make sure things are on track.
- Process control comes from initiating timely, system-generated reports for key points in the revenue cycle. These reports can help you spot problems and trend and monitor improvements over time.

*Source: Jan Ohlsson, revenue cycle marketing manager, 3M, Murray, Utah.*

staff to lunch and sit and talk with them while they're eating: 'How's it going, what frustrates you, what can we do to make things better? Is there any particular interaction that you have with Memorial Hospital that takes too much time or doesn't make sense to you?' And then we take this feedback and use it to work on those issues.

► **Boudewyns:** As an integrated organization, with hospital and physicians operating under one management structure, we're always looking at both sides of the issue, professional and technical. I've learned the importance of having a physician champion involved to establish credibility with other physicians. We have physician representation on our revenue cycle steering committee. We also have a Clinical Practice and Revenue Steering Committee comprised of the clinical chairs for each of the major departments. That group formed in response to the physicians wanting to make certain we're getting every dollar for the services that they're already providing, as they are being asked to see more patients and generate more revenue.

► **When do you need to bring in a consultant?**

► **Ohlsson:** Our customers tell us, 'Sometimes we're too close to our processes to see them clearly.' I think a consultant can help with that process review, and in facilitating a direct exchange of information between departments. If you do everything you can and still can't reach the goals you've set for key indicators, if you can't perform the way you think you should, or if hospital politics get in the way, it's time to think about hiring a consultant. Chargemaster-related reviews are a good example, either because a hospital doesn't have the expertise or can't quite define what the problem is.

► **Boudewyns:** In 2001, our CFO engaged outside consultants to help us identify the areas of greatest opportunity in the interest of jumpstarting the revenue-improvement process. You may have an awareness of the opportunities already, but when you pay consultants for this information, there can be much more of an onus on the organization to actually act on that information.

We also use consultants in two other types of situations. The first is when we need a specialized skill set or expertise. For example, we needed to augment our internal expertise to assess whether we were capturing all of our radiation therapy charges appropriately or leaving revenue on the table. The other is when we have the expertise but don't have the time.

► **Williams:** We had consultants come in when we started our revenue cycle improvement initiative in 1999. They were objective, they gave us a road map, and they left us with the tools we needed to sustain and continue to improve our revenue cycle performance—tools like productivity, billing, and follow-up tracking software, which gives us weekly reports that allow us to pinpoint bottlenecks, backlogs, and any issues that require immediate action. Another example is our trend tracking report. It shows accounts that are over \$50,000 and 91 days from discharge. If we see the number of accounts increasing, then we will do a sampling and look for trends that haven't come out in our biweekly meetings. We'll drill down to see what's driving that number up. I believe our investment for the consultant engagement has paid off many times over.



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