Top 5 Takeaways

from HFMA’s 2012 MAP Award Winners
WHAT IS MAP? Created by and for healthcare leaders, HFMA’s MAP initiative is designed to give hospitals and physician practices the tools they need to measure performance, apply evidence-based practices, and perform to the highest standards—and be recognized for this excellence. Components of HFMA’s MAP include:

**mapkeys**
HFMA’s MAP Keys are key performance indicators that set the standards for revenue cycle excellence in the healthcare industry. Using MAP Keys, healthcare finance professionals can improve hospital and physician practice business intelligence, strengthen revenue cycle management, and decide—based on comparisons with peers and the industry as a whole—where to focus for improvement.

**mapawards**
HFMA’s MAP Awards recognize healthcare organizations that achieve excellence and serve as models for the healthcare industry. HFMA’s MAP Award for High Performance in Revenue Cycle recognizes healthcare organizations that demonstrate excellence across all the MAP Key indicators of revenue cycle performance. HFMA’s MAP Award for Performance Improvement in Revenue Cycle recognizes healthcare organizations that demonstrate measurable improvement in a specific MAP Key or set of MAP Keys.

**mapapp**
HFMA’s MAP App is the industry’s premier web-based program to track revenue cycle indicators, compare results with customized peer groups, and learn what it takes to improve performance.

**mapevent**
HFMA’s MAP Event is a place for revenue cycle leaders to learn from industry peers how to build effective teams, extend accountability, and drive high performance.
LEARN FROM THE BEST

Many revenue cycle leaders believe they are doing all they reasonably can to support strong financial performance and maintain patient satisfaction in the face of tightening payment and increasing regulatory and administrative pressures. Yet sometimes it’s not just how hard you’re working, but also where you’re focusing these efforts. So who better to learn from than the best?

Each year, HFMA’s MAP Award for High Performance in Revenue Cycle recognizes healthcare organizations that demonstrate excellence across all MAP Key indicators of revenue cycle performance. Winners show effective revenue cycle practices that deliver sustainable financial performance—and often these practices represent a common approach.

“Year over year, we’re seeing that even though our MAP Award winners are diverse—with differences in market dynamics, payer mix, geographic considerations, and technologies—they share many of the same strategies and priorities in addressing revenue cycle performance challenges,” notes Suzanne Lestina, FHFMA, CPC, HFMA’s director of Revenue Cycle/MAP.

Most notably, HFMA’s review of performance drivers across MAP Award winners shows a consistent commitment to how they address patient experience, cost, at-risk revenue, process improvement needs, and innovation as highlighted in the strategies that follow.

Although each organization approached these strategies in various ways, notes Lestina, the desired outcome was the same: ability to better serve patient needs, cost-effective use of resources, and greater efficiency and integration across the organization through measurable success.

RAISE PATIENT SATISFACTION TO NEW LEVELS

Improving the patient experience is a cornerstone strategy for all high performers. Most MAP Award winners are currently focused on initiatives to advance metrics associated with patient satisfaction, often with revenue cycle-specific strategies directed toward such areas as improving perceptions of quality of communication or responsiveness of staff. Senior leaders—including those representing the revenue cycle—typically hold goals associated with high patient satisfaction scores.

Collaborating around the patient’s experience. Particularly notable this year is that many of the organizations are addressing patient experience through integrated performance improvement initiatives, as exemplified at OhioHealth Riverside Methodist Hospital. Although overall patient satisfaction scores were high, hospital leadership felt that patient satisfaction scores among patients receiving ambulatory surgery services could be improved.

Because every patient interaction and impression involves many departments, Riverside took a true team approach to advancing its performance and service delivery. Leadership assembled a patient satisfaction team that included representatives from patient access services, perioperative services, nursing, physician relations, and support services and charged the team with raising and maintaining Press Ganey percentile ranks in the ambulatory surgery area.

“Bringing this team together enabled us to learn about each other’s areas and how we could better leverage efforts toward attaining our goal of exceptional customer service,” says Pam Carlisle, system director of patient access. “By understanding what role each player contributed to the process, we enhanced our overall commitment to each other and have been able to improve our service delivery.”

Working together, the group created a video for patients to highlight expectations for the ambulatory surgery experience. The team also reviewed and updated all
patient information and presurgery education guides to ensure the information within the materials was accurate, relevant, and clear—and supported a positive patient experience. Several processes have also been revised. For example, parking conditions were improved to support more convenient arrival for patients.

Overall ambulatory surgery percentile ranks have improved 22 points since the beginning of the project, notes Carlisle.

**Prioritizing financial counseling.** Another success at Riverside has been recognition that when it comes to supporting patient satisfaction with revenue cycle functions, patients’ ease in navigating payment and financial assistance information plays a significant role.

At organizations across the country, key challenges such as confusing or lengthy screening programs, lack of coordination among departments or representatives, and missed or inaccurate information on program availability and eligibility criteria often face patients when applying for and completing enrollment in financial assistance programs.

To support a positive patient experience of financial counseling and overcome such hurdles, Riverside has focused extensively on building staff competencies around delivering high-quality financial services. The organization provides annual online courses and a semiannual financial assistance training program for all of the financial assistance application processors, financial counselors, Medicaid eligibility vendors, patient access managers, customer call center representatives, patient accounts managers, and social services representatives.

This training consists of a review of the organization’s charity care programs and policies, best practices in financial assistance applications processing, financial counseling updates and processes, system functionality and upgrades, Medicaid updates, and customer service issues and concerns. A competency level must be met before the associate can continue in the learning process.

“This training ensures that systemwide, everyone is updated and knowledgeable on the most current processes and available programs,” explains Jane Berkebile, system vice president, revenue cycle.

Riverside has also redesigned its financial counseling services over the past year to improve ease of service. Changes included extending department hours, going from a closing time of 4 p.m. to 8 p.m., to better accommodate patients working traditional business hours. Also, the department now runs reports on financial application status twice a day (as opposed to the next day), which allows counselors to have financial discussions with patients in a timely manner. Prior to the changes, financial counselors were seeing approximately five patients per day, with a resolution rate of 80 percent. The new process allows financial counselors to see approximately 14 patients a day, with a resolution rate of 97 percent.

Perhaps most important, notes Berkebile, the organization has focused its efforts on creating a seamless discussion of patient responsibility and sources of financial aid by adopting a “one visit does it all” approach.

“We are now looking at patients from a holistic perspective,” she says. “We are able to encompass all of the patients’ accounts in one financial discussion, as opposed to each individual visit. From this vantage point, we have increased our point-of-service collections.”

Since putting the holistic program in place, the organization has increased point-of-service (POS) collections, on average, by $50,000 per month.

**KNOW HOW TO SAY YOU’RE SORRY** At many high-performing organizations, patient satisfaction efforts include anticipating response when service doesn’t go as planned. At The Valley Hospital, all staff—including those in financial functions—are empowered to perform service recovery when patients have valid concerns or recommendations regarding service. Staff are trained in three steps to turn a negative situation to a positive outcome:

- Acknowledge the situation and apologize
- Correct the situation; make amends
- Take action to enhance the apology (offer token)

Typical tokens include a gift certificate for the hospital’s restaurant/coffee cart, gift cards to local restaurants, or even flowers in some instances. In federal surveys, 82 percent of Valley patients said they would recommend the hospital to friends and family, compared with a national average of 65 percent.
DEVELOPING—AND KEEPING—TOP REVENUE CYCLE TALENT

No matter how spot-on your strategy, it takes the right team to execute. From obtaining accurate patient information to ensuring complete charge capture to effectively communicating with patients about balances past due, revenue cycle policies and practices will only be as strong as those who support them.

Perhaps it’s no surprise then that winners of HFMA’s MAP Award for High Performance in Revenue Cycle prioritize developing and keeping top talent. Consider the following tips from award winners when looking at efforts at your own organization.

Demonstrate that accountability starts at the top. A high-performance revenue cycle begins with recognition of revenue cycle’s role in achieving the organization’s mission. As such, at MAP Award-winning organizations, it’s typical for organizational goals to include aspects of financial stewardship.

Also elevating the importance of revenue cycle, CEOs in addition to finance executives typically hold responsibility for revenue cycle-based strategic and operational goals. A culture that prioritizes the revenue cycle in this way provides a clear vision for achieving high performance and demonstrates to revenue cycle staff at all levels that their individual roles are not only important but valued within the organization.

Just as important, support for the organization’s revenue cycle vision must be seen in the day-to-day actions of senior leadership. Cape Cod Healthcare, Hyannis, Mass., attributes much of its successful financial turnaround to creation of a culture that recognizes importance of revenue cycle initiatives. “I think a lot of staff’s willingness to embrace new practices and efficiency-driving strategies has come from senior leadership showing they really believe in project improvement,” says Michael Connors, CFO, Cape Cod Healthcare. “For about nine months, the CEO, COO, CFO, clinical leadership, and other senior leaders met weekly for at least two hours, sometimes longer, to discuss metric use, processes, and ways to leverage process change for corrective action.” As leadership not only talked the talk but also walked the walk of putting a turnaround in place, he says, others throughout the organization recognized the importance of and placed trust in the change process.

Seek and support high-level competencies. Screening and ongoing education are crucial for ensuring staff have the skills and abilities to effectively manage the demands of their positions. HFMA research has shown that high-performing organizations devote greater time and resources to staff development than others.

In addition to education and training focused on providing employees with skills specific to excelling in revenue cycle functions, MAP Award winners also offer targeted education to address specific organizational goals or better manage response to industry change. As just a few examples, training opportunities at Legacy Good Samaritan Medical Center, Portland, Ore., include instruction in Lean process improvement for all revenue cycle leaders, the organization’s “Patient Experience Bootcamp,” and specific education sequences for various revenue cycle positions around the ICD-10 transition. Such-needed training not only binds revenue cycle staff to organizational strategy but also demonstrates to employees that the organization is committed to helping them address today’s top challenges and those yet unknown. Emphasis on educational opportunity sends a clear message that the organization is invested in its staff.

Reward those who excel. Most high performers link advancement opportunity and financial incentives to achievement of revenue cycle performance goals. As just one example, at Spectrum Health Kelsey Hospital, Lakeview, Mich., employees at all levels are evaluated on job descriptions and on individual performance using SMART (specific, measurable, attainable, relevant, and timely) objectives, which for most revenue cycle employees constitute 20 percent of their annual evaluation that leads to salary increases and advancement. Spectrum Health also offers a compensation program that provides incentive payments to managers, directors, and executives who meet certain KPIs. Leaders within the revenue cycle have annual performance goals tied to specific revenue-cycle metrics under their area of responsibility. The current midlevel management incentive is a 7 percent bonus for meeting metrics, and executive incentives range from 17 to 22 percent.

Promotions and financial rewards, although important, aren’t the only means for demonstrating recognition of a job well done, however. Day-to-day gestures also contribute to staff satisfaction. As a union environment, Cape Cod Healthcare is somewhat limited in its strategies around incentive compensation. In addition to the agreed upon structures, however, the organization finds many creative and low-cost ways throughout the year to reach out to high-performing employees and let them know they are valued. As just a few examples, it’s not unusual for leadership to recognize service delivery resulting in high patient satisfaction with gift cards or offer prized parking spots for an “employee of the month.” The organization also celebrates and communicates individual and project wins frequently with parties and broadcast emails. Regardless of method, recognition of success fosters a sense of enthusiasm and motivation for performance improvement.

“A happy staff member is a productive staff member,” says Janice Ridling, CHFP, vice president, revenue management for Shelby Baptist Medical Center, Birmingham, Ala. “And if you’re happy, you’re also going to extend more patience and graciousness in your interactions. So it’s really critical to ensure employees feel valued, both in terms of setting them up to succeed in reaching their goals and from a customer service perspective.”
**EXAMINE REVENUE CYCLE’S ROLE IN OVERALL COST**

As might be expected, all MAP Award winners were given goals to reduce overall costs while improving financial performance. However, perspectives around cost are changing somewhat. Traditionally, the revenue cycle has largely been a cost silo, focused primarily on reducing billing expense. Yet one notable trend this year across many of the winning organizations was integration of the revenue cycle into the solution of reducing clinical and operational costs across the organization.

At Shelby Baptist Medical Center in Birmingham, Ala., for example, revenue cycle leaders were included in reducing the overall inpatient cost of delivering care by identifying and managing the controllable cost per patient influenced by the revenue cycle process.

Revenue cycle goals to control cost across departments included supporting a corporate 2 percent cost reduction and holding the cost to collect to less than 3 percent of gross revenue. Key efforts that contributed to Shelby’s success in achieving these goals included viewing revenue cycle KPIs within the context of organizational cost management and focusing on optimal staffing.

**Inclusion of revenue cycle KPIs in department performance reporting.** At the system level, organizational goals around KPIs are reviewed annually, compared with meaningful and timely benchmark data, and adjusted as priorities and standards change. Additional KPIs are often added to support corporate initiatives.

Progress relating to revenue cycle KPIs is communicated in two primary ways, notes Janice Ridling, CHFP, vice president, revenue management. Department directors provide variance explanations for revenue cycle KPIs monthly and develop action plans for those that aren’t at goal. The revenue cycle vice president then reviews these variance explanations with the CFO at monthly facility review meetings. Variance reporting follows a SMART format: performance measures are specific, measurable, attainable/realistic, relevant, and time-bound.

In addition, a summary dashboard is produced using the KPIs from each of the revenue cycle departments. This dashboard is presented at facility reviews where facility and corporate executives participate. The dashboard KPIs include patient access quality measurement, POS cash, total patient cash collected, financial counselor productivity, delinquent records, coding accuracy, total discharged not final billed (DNFB), cash percentage of collectible patient net revenue, revenue cycle controllable cost per patient, cost to collect, denial write-offs to gross revenue, credit balances, and net A/R days.

Ridling notes that one particular area where revenue cycle efforts have contributed to controlling cost per patient has been in reducing cost to collect through early discussions of patient financial responsibility. Communication from financial counselors at the time of preregistration with patients unable to pay in full at the time of service has allowed for payment arrangements to be made prior to patients’ date of service. Also, collecting a patient’s financial responsibility at the time of service reduces cost to collect because less time is spent on follow up of those accounts at the back end. As a result, she says, Shelby consistently exceeded its POS collection goal each month (goal for percentage of total patient cash collected at POS [including preregistration payments] was 45.5 percent for the most recent fiscal year; actual was 52.6 percent). Such performance minimized costly follow-up and provided a better service experience to patients.

**Optimal staffing.** Managing staffing has been another source of cost control at Shelby Baptist Medical Center. Patient access managers review the payroll system.
Unfortunately, not all benchmarking efforts are the same. To get the most out of external comparisons, HFMA recommends the following eight strategies:

1. Use industry-standard metrics—or KPIs—that allow for valid comparisons among a broad group of hospitals.
2. Ensure calculations needed to apply the metrics are clearly defined and come from an objective resource.
3. Cover the entire scope of the revenue cycle from registration to collection and include physician practices.
4. Draw on a significant number of hospitals to establish your peer groups and performance targets. Too small a pool will skew the targets you set.
5. Identify valid peer groups using demographic factors that truly differentiate revenue cycle performance. HFMA research shows that although bed size and geographic location are often used to define peer groups for benchmarking, revenue cycle performance is more directly determined by factors including payer mix and net patient revenue.
6. Ensure that all benchmarking data are routinely scrubbed and audited.
7. Use timely comparative performance data. Revenue cycle performance changes constantly. Comparative information needs to be updated frequently to be meaningful.
8. Identify and calculate the ROI on specific improvement opportunities. Identify best practices that drive each metric from a community of high-performing organizations.

**TICK TOCK, DON’T LOSE MONEY TO YOUR CLOCK** At Centra Lynchburg General Hospital, patient access overtime expense was reduced from $31,373 in 2010 to $1,072 in 2011. Total overtime in 2011 among 116 patient access staff covering multiple locations (some around the clock) was approximately 54 hours, which was attributed to “incremental” overtime. What brought about the improvement? The organization began a program of continuously educating employees about proper clock-in and clock-out procedures, and leadership informed staff on a biweekly basis of any discrepancies to policy. Also, the organization tracks overtime and publishes it across departments.

“Many of the full-time staff are appreciative of the additional flexibility that comes with having coverage available,” says Lepp.

The organization also leverages staff availability across the system. Because processes are standardized across Shelby and its three sister organizations (Citizens Baptist Medical Center, Princeton Baptist Medical Center, and Walker Baptist Medical Center), staff can walk into any of the organizations and immediately know how to perform at the same level and ensure the same high-quality service. To take best advantage of this strength, the system is currently working with its human resources leadership to develop a flexible pool for patient access staff.

“So how did such efforts affect the organization’s controllable cost per patient? Baptist’s corporate-level target was $6,739, and it surpassed this target by reducing this figure to $6,668. Of this amount, the revenue cycle target was $190.91, which Shelby surpassed by achieving a cost per patient of $181.13.”

**IDENTIFY AND PROTECT AT-RISK REVENUE** Revenue integrity serves as a unifying force throughout performance initiatives at MAP Award-winning organizations. Advanced systems of accountability are built around practices to support accuracy in collection of patient and eligibility information, documentation, charge capture, and payment.

As an example of ways winners are working proactively to avoid revenue loss, consider a few of the programs associated with clinical documentation and denial management that are taking place at New York Presbyterian Hospital in New York City.
PAIRING UP TO PROTECT PAYMENT Insurance follow-up staff and coding staff meeting proactively? Why that sounds like a match made in denials management heaven—or MultiCare Mary Bridge Children’s Hospital.

Mary Bridge Children’s Hospital offers a job shadowing program across departments to help revenue cycle employees gain greater understanding of different functions affecting payment. Employees choose which area of the revenue cycle they desire greater knowledge about and submit an application to their manager, who in turn schedules the job shadow session with the manager of the chosen area. The sessions last two hours and have been well received as a means to help revenue cycle staff expand knowledge, build relationships, and collaborate on process improvements.

Detailed variance tracking and reporting. New York Presbyterian has created multiple systems to track how well clinical specificity in documentation is supporting the level of care provided. Performance is reported to senior level executives throughout the organization in addition to those in revenue cycle.

Each month, a scorecard on documentation and specialty coding performance is distributed to the administrators and senior leadership of each campus. This scorecard provides a view by campus and clinical service line of such key metrics as monthly revenue generated by the team, severity of illness and risk of mortality, number of cases reviewed, the number of case finds, and the rates of case finds concurrent to the patient stay and post discharge.

“This transparency creates accountability with senior leadership and reinforces the importance of efforts taking place,” says Paul Dunphey, vice president of revenue cycle operations.

In addition, a documentation improvement team comprised of nurses distributes a weekly report to the vice president and director of each clinical service line, providing metrics on targeted monthly changes by service line and by campus. The documentation improvement team acts on metrics that are not consistent with the expected trend by investigating unexplained variations. These variations are then reviewed by documentation improvement nurses, coders, and clinical service line administrators.

William Farrell, CPA, vice president of finance, notes that New York Presbyterian has approximately 25 nurses dedicated to documentation review across the organization’s five main campuses, and each of these nurses is assigned and partnered with a service line to help service line directors better understand their severity data, risk-of-mortality data, and case mix.

“We will work with them to drill down the data across either pairs or triplet DRG categories, and we will compare performance to industry peers,” Dunphey says. “Then there will be an analysis of notable variances and a further drill down. In many instances, the team will conduct chart review of coding accuracy and completeness. And based on these findings, the documentation improvement team will develop a specific program tailored to that service line. Throughout the course of the year, the nurses will report on progress and the impact on severity level during multiple service line meetings.”

Task-based teams. New York Presbyterian also protects revenue by maintaining highly structured systems for managing write-offs and denials. The hospital’s revenue cycle committee, which comprises team members from finance, health information management, patient financial services, IT, managed care, patient access, operations, and others, created a unit dedicated to reducing denial write-offs. Each week, this project team conducts a review of the prior week’s write-offs, searching for write-off root causes, trends, and opportunities for reversals.

Each week, the project team collaborates with representatives from multiple departments, including admitting, patient case management, medical records, and patient financial services, to address root causes and implement process and/or technical changes to prevent specific write-offs.

Tracking documents are reviewed weekly with the interdepartmental team to measure the impact on write-off dollars attributed to the implemented changes. The project team also manages a monthly write-off reporting dashboard that includes monthly write-off dollars by campus, patient type, charge class, and insurance.
Of course, avoidable write-offs are only one aspect of revenue loss. Effectiveness of denials management also affects at-risk revenue. Farrell notes that New York Presbyterian’s success in managing denials also has benefited from task-based teams.

Organizational leadership created a denial management unit and denial root-cause team when implementing a new denial management and workflow tool. The denials management unit meets weekly to review the prior week’s performance, Dunphey says, using status metrics such as denial inflow, volume, aging of denials in review, volume and aging of appeals under review by the payer, and volume of denials not reviewed.

The unit also reviews appeals, follow-up activity, and outcome metrics every week, including denials upheld and overturned, he says. Members of the unit also conduct additional analysis around each of the performance metrics to determine areas of opportunity.

The organization’s root-cause team works in much the same way, notes Dunphey. The team meets monthly to review the prior month’s denials, with the goal of preventing denials by identifying and correcting process deficiencies. The team comprises representatives from admitting, patient case management, care coordination, health information management, and patient financial services. Each area conducts root-cause analysis for its specific denials and reports out findings at the monthly meeting. Specific process breakdowns and areas of opportunity are documented in an ongoing issues log, which is maintained by the denial project team members.

During the meeting and throughout the following month, the denial root-cause team collaborates on process change formulation and training necessary to impact specific types of denials, and once changes are rolled out, success is measured by tracking dollars by denial code and/or payer.

As a result of these denial management and workflow efforts, write-offs have decreased 50 percent over time and now represent less than 1 percent of the hospital’s total revenue.

Farrell credits much of New York Presbyterian’s ongoing revenue cycle success to having leadership willing to invest in improvements and organizational focus on having the right metric tracking systems and teams in place. “It can be easy to hire a consultant and have them come in and tell you what you need to do,” he says. “But if you don’t have the right infrastructure to sustain it, you just put yourself at risk of finding yourself three years later with everything broken again.”

One organization that has proven particularly adept at rapid process change is Cape Cod Healthcare in Hyannis, Mass. The organization went from 75 days cash on hand in 2008 to 140 days in June 2012, and net days-in A/R went from 51 to 31 through a process that involved reviewing department structure, creating consistent policies and procedures, and requiring staff competencies. As this turnaround has taken place, a guiding force has been the organization’s formal PI program.

**High-level, dedicated commitment to PI.** At Cape Cod, individuals at all levels across the organization—including the CEO and senior executive leadership—participate in PI. PI at Cape Cod is based around five pillars: people, service, quality, finance, and growth. All departments choose two to three PI projects each quarter that align with department and strategic goals that support these pillars.

Leadership prioritizes improvement activities according to patient safety and strategic importance, with focus on high-risk, high-volume, or problem-prone areas, says Michael Connors, CPA, senior vice president and CFO. Data analysis is then used to recommend opportunities and changes that will lead to improvement.

All PI projects go through a steering council for approval. The steering council ensures that the projects support the organization’s pillars and have measurable goals, and that measures include appropriate numerator and denominator specifications. All projects are the responsibility of the PI project leader in the department and are placed on a dashboard. PI measures are...
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added and updated on Cape Cod’s organizationwide dashboard quarterly. “Three years ago, the revenue cycle department was tracking approximately 200 key metrics; it has since refined the report to include approximately 80 key metrics,” notes Connors.

Teamwork and transparency to prevent slippage. “Our goal is to ensure that we have good processes and that we know when they’re broken,” says Connors. “We want to find out quickly when performance is off track—not somewhere down the road. The sooner we can identify issues, the easier it is to address root causes and minimizes any impact on patient service or financial performance that could result.”

A recent initiative in the billing department focusing on clean claim submission demonstrates this commitment to PI. There was a competition with the focus on eliminating the need to work denials. The department was divided into teams by payer, and each team elected a champion/adviser from the management team to join their team. “The key role of the champion is to eliminate obstacles that may arise,” says Victor Oliveira, vice president of patient financial services.

Over three months, the teams met weekly and brainstormed ideas on process changes to eliminate denials, improve workflow, and improve patient customer service. A major focus was on work that should be done prior to a claim going out, with a vision of “Bill It Right and Timely the First Time, Every Time.” Teams were recognized in monthly staff meetings for ideas and changes that were implemented. Leadership also created a PI analysis position with the primary responsibility of working with the teams and implementing changes to improve processes.

Revenue cycle leadership incorporated many new work edits as a result. Also, the financial team worked with IT staff to prioritize many efforts and help individuals across the organization recognize the impact their work has on revenue cycle, by helping to track types of denials, denial rate, and volume of claims that would be denied.

Stemming from these efforts, Cape Cod instituted a review of all claims that failed eligibility verification or authorization prior to submission. Case management staff verify whether authorization level matches services approved from insurance for all inpatient and observation cases. A weekly benchmarking report is circulated among the management group of these efforts.

Also, Cape Cod trained ancillary departments on how to work the claims scrubber and allowed them to work claim edits specific to their department, thereby eliminating many hand-offs and delays. Another benefit is that with edits going directly back to the department that provided the service, the departments were given much better insight into how to prevent similar edits in the future.

Olivia Clachar, Cape Cod’s manager of revenue cycle systems/chargemaster, cites the example of commonly missed or inaccurate charges associated with injections. “A lot of specificity is needed to ensure capturing not only the correct injection but also administration,” she says. When claims would be routed back to various clinical areas, it brought a lot of awareness to them of the documentation and charge capture needed.

Cape Cod appreciates PI is continuous. “It’s an ongoing thing,” says Oliveira. “These aren’t one-shot deals we’ve implemented. And I think staff have responded well because they recognize this commitment. They not only are working to understand the business better than in years past, but they also are more enthusiastic in bringing issues forward and trying to get challenges resolved.”

5 TAKE A RISK

Many of the 2012 MAP Award winners explored opportunities to implement creative solutions. Although some projects did not work as intended, organizations stressed that the experience was worth the effort and often opened doors to future conversations and improvement opportunities.

Other efforts brought considerable benefit. As an example, finding a creative solution to improve the patient experience was at the center of an effort by John C. Lincoln Deer Valley Hospital, Phoenix, Ariz., to develop a flat-rate payment option for the hospital and professional services in the emergency department (ED).

In addition to screening for financial assistance and charity care, the organization offers a one-year interest-free, 15-month payment plan for patients. But leadership wanted to go even further with its financial services.

Ingenuity as a response to market change. Like many organizations, John C. Lincoln has witnessed growth in its self-pay mix as the nation’s economy continues to struggle. What’s more, a 2011 Medicaid enrollment freeze for childless adults in Arizona left many individuals without coverage.

To more collaboratively work with the self-pay population seeking care in the ED, the hospital’s revenue cycle team partnered with nursing and physicians to create new processes associated with offering health-care resources and an ED flat-rate payment option that covers both the hospital and physician bill (laboratory and radiology may still bill separately).

“We had a large population of ED patients that suddenly didn’t have coverage, so we wanted to extend an opportunity for them to pay a one-time, flat-rate payment that would not only cover their ED stay, but also take care of the professional bill,”
says Brian Smit, FHFMA, vice president of revenue operations. “We wanted to give them a chance to take care of their bill at the time of service with a discounted rate.”

**Safeguarding new ventures with modeling and ongoing performance monitoring.** Prior to pursuing the innovative approach, the organization thoroughly analyzed its historical data, examining charges available at time of discharge by triage level and ED bill level, and considered operational process flow. This information and input from physicians then shaped the agreement the hospital would use with its contracted ED physicians for the flat-rate approach. “We’ve been successful with collections for the physician group and the hospital. Point-of-service collections for the network have nearly doubled among self-pay patients,” says Smit.

Since the process change, the revenue cycle reports the performance of the operation through a visibility wall located in the ED for all staff to see. Performance metrics include the percentage of self-pay patients that are offered financial counseling at the ED bedside, percentage of patients that participate in a flat-rate payment option, reductions in the number of patients that return for nonemergent care, and total POS collection dollars.

The manager of patient access is responsible for training ED access staff in the program, monitoring their performance, collaborating with nursing and physicians to identify self-pay patients after care has been completed, and improving the overall performance metrics to target.

To date, the program is having both customer service and financial rewards. “Patients have said that they really appreciate the opportunity to pay once and be done, and they appreciate the discount as well, recognizing that the charge could actually be significantly higher” says Fred Pigeon, director of patient financial services. “And the increase in point-of-service collection resulting from the program has had a positive effect on cost to collect, as the organization is able to minimize resources devoted to post-service collection and follow up.”

Pigeon adds that staff are growing a new level of confidence in asking patients for money at time of service through the availability of a flat-rate option as well as extensive POS training and recognition of those meeting individual and daily team goals.

In addition, physician stakeholders have been very receptive to the flat-rate program. “They can empathize with the patient having to receive different bills,” says Smit. “And they recognize that the best time to collect is at the time of service, so as long as the data continue to demonstrate that we’re beating what their historical collection rates would have been through their normal collection process, they are very much on board.”

**Learning from This Year’s Winners.**

It’s easy to see some of the stats from 2012’s MAP App winners and think, “That’s impossible to do here,” or “Surely, they have some sort of advantage we don’t.” After all, 39 net days in A/R or 4.92 days in discharged not final billed can seem unattainable in many settings.

However, winners this year—like many in years past—came from organizations of vastly different size, technology budgets, and payer mix. Whether the organization is a children’s hospital, such as MultiCare Mary Bridge Children’s Hospital, a system with a union environment, such as Cape Cod Healthcare, or a large, teaching hospital, such as New York Presbyterian Hospital, there will always be some sort of obstacle or excuse to keep from reaching higher. Yet these organizations did not let that stop them.

So perhaps the biggest lesson to take away from this year’s winners is that achieving new performance highs truly is possible, says HFMA’s Lestina. “With the right strategy and commitment, supporting the right culture, and being focused on those metrics where greatest opportunities lie, who knows what level of success can be found?” she says. “But one thing is for sure: It all starts with believing in your ability to make a change.”

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**NOW THAT’S AN IDEA!** Are some of your best improvement ideas going unheard? Sometimes employees don’t feel comfortable openly discussing performance improvement opportunities or perhaps they don’t speak up because they suspect their suggestions will never make it to those with authority to drive change.

To overcome these obstacles, Geisinger Health System’s revenue cycle leadership created an email address for employees where they could communicate confidentially and directly with their vice president. Geisinger notes that the communication channel has been well received, with many of the employee suggestions ultimately being implemented.
HFMA’S 2012 MAP WINNERS This year, HFMA recognized 17 hospitals – 11 individual winners and six hospitals from the Baylor Health Care System – with the MAP Award for High Performance in Revenue Cycle. HFMA would like to congratulate the following winners.

- **Shelby Baptist Medical Center**
  Birmingham, Ala.
- **The Valley Hospital**
  Ridgewood, N.J.
- **MultiCare Mary Bridge Children’s Hospital**
  Tacoma, Wash.
- **Cape Cod Healthcare**
  Hyannis, Mass.
- **John C. Lincoln Deer Valley Hospital**
  Phoenix, Ariz.
- **Riverside Methodist Hospital**
  Columbus, Ohio
- **Geisinger Health System**
  Danville, Pa.
- **Centra Lynchburg General Hospital**
  Lynchburg, Va.
- **Legacy Good Samaritan Medical Center**
  Portland, Ore.
- **New York Presbyterian Hospital**
  New York
- **Spectrum Health Kelsey Hospital**
  Lakeview, Mich.
- **Six hospitals from Baylor Health Care System:**
  - **Baylor Medical Center at Irving**
    Irving, Texas
  - **Baylor All Saints Medical Center at Fort Worth**
    Fort Worth, Texas
  - **Baylor Jack & Jane Hamilton Heart & Vascular Hospital**
    Dallas, Texas
  - **Baylor Medical Center at Waxahachie**
    Waxahachie, Texas
  - **Baylor Regional Medical Center at Grapevine**
    Grapevine, Texas
  - **Baylor Regional Medical Center at Plano**
    Plano, Texas

HFMA’S 2012 MAP AWARD WINNERS BY THE NUMBERS Winners of the 2012 MAP Award for High Performance in Revenue Cycle represent organizations of diverse size, payer mix, and market dynamics. Yet they have one thing in common: Measurable revenue cycle excellence. The following top quartile performance was demonstrated among the group.

- **NET DAYS IN A/R**
  33.23

- **CASH COLLECTION**
  100.5 percent

- **POINT-OF-SERVICE CASH COLLECTION**
  22.0 percent

- **AGED A/R 90 DAYS AND GREATER**
  11.3 percent

- **DAYS IN TOTAL DISCHARGED NOT FINAL BILLED (DNFB)**
  4.92

- **FINAL BILLED NOT SUBMITTED TO PAYER (FBNS)**
  0.37

- **DAYS IN TOTAL DISCHARGED NOT SUBMITTED TO PAYER (DNSP)**
  5.50

- **BAD DEBT WRITE-OFF PERCENTAGE**
  1.3 percent