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Strategies for a High-Performance Revenue Cycle

*A Report from the
PATIENT FRIENDLY BILLING® Project*



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Introduction

About Patient Friendly Billing

The **PATIENT FRIENDLY BILLING®** project began as a collaborative endeavor spearheaded by HFMA to promote clear, concise, and correct patient-friendly financial communications. For nearly a decade now, the project has provided the nation's hospitals and health systems with information, educational programming, and practical tools to aid efforts in streamlining financial communications and optimizing billing and payment functions.

Notable Patient Friendly Billing reports over the past several years have included *Reconstructing Hospital Pricing Systems* (Summer 2007), *Consumerism in Health Care—Achieve a Consumer-Oriented Revenue Cycle* (Summer 2006), and *Hospitals Share Insights to Improve Financial Policies for Uninsured and Underinsured Patients* (February 2005).

Most recently, the Patient Friendly Billing project has begun to explore optimal practices for the revenue cycle. Results of these efforts and related research discussed in this latest report, *Strategies for a High-Performance Revenue Cycle*, are put forward to help the industry identify common revenue cycle characteristics and processes with the most impact on value to consumers and hospitals.

To access more information about high-performance revenue cycles and stay abreast of current project activities, see the Patient Friendly Billing web site at www.patientfriendlybilling.org.

About This Report

A high-performance revenue cycle is vital in today's environment. Providers of care are being buffeted by significant economic and financial challenges. And pressures continue to mount to fundamentally change patient care delivery and payment systems. For today's hospital and health system leaders, ensuring payment of every dollar that is appropriately due to their organizations has become critical to continue missions of care.

Recognizing the industry's urgent need for revenue cycle guidance, the Patient Friendly Billing project recently set out to identify what makes some healthcare organizations do a better job than others when it comes to achieving high patient satisfaction and financial performance. This undertaking was comprehensive, fed by primary research that included visits to high-performing sites across the nation and interviews with numerous executives and revenue cycle staff.

The culmination of these efforts is this report. Within the following pages, revenue cycle leaders will discover ready-to-use ideas as well as numerous key strategic practices to share with their CEOs and other executive leaders as a means to better fortify their organizations into the future. More than ever, revenue cycle performance needs to be a top organizational priority, not only for the health of providers' bottom lines—but the patients and communities they serve.

Strategies for a High-Performance Revenue Cycle

Hospital executives typically share some sense of what the revenue cycle experience should look like. Whether they are striving to estimate out-of-pocket costs prior to service or develop capabilities for on-line billing, payment, and financial communications, most hospitals and health systems are working toward making billing and payment processes at their organizations more efficient and consumer-friendly.

But what does it truly take to achieve revenue cycle effectiveness?

It is one thing to recognize what high revenue cycle performance should be. But all too often it's quite another to have the necessary strategies in place to achieve it. Given such pressures as increasingly complex payer rules, rising bad debt, and a rapidly changing regulatory environment, today's hospital executives face tremendous challenges as they strive to determine revenue cycle practices that will deliver the most value to their organizations, patients, and communities.

Satisfying consumer needs, protecting margin, and maintaining operations that will be nimble enough to respond to these challenging times requires constant prioritization and a clear understanding of actions likely to yield greatest success: Which revenue cycle competencies are most important? What is the best way to distribute limited technology and training resources? Where are process changes most likely to improve payment speed and accuracy?

It's these types of practical concerns that shaped the latest efforts of the Patient Friendly Billing project. Over the years, the Patient Friendly Billing project has developed numerous reports, resources, and tools to aid hospitals in streamlining their billing and collection functions. Most recently, the project began devoting its energies to studying optimal revenue cycle practices.

In the spring of 2009, the Patient Friendly Billing project, with assistance from Noblis, a Virginia-based not-for-profit strategic advisory firm, used these insights as a foundation for researching common characteristics and strategies employed by those hospitals with high-performance revenue cycles.

Researchers analyzed data from more than 5,000 nongovernment, short-term acute hospitals, and rated these organizations' financial and patient satisfaction performance using criteria such as days in accounts receivable, patient willingness to recommend the organization, return on assets, and operating margin. Researchers then conducted site visits with 14 of the high-performing hospitals, with consideration given to diversity in geography, size, ownership status, and other factors. Finally, researchers surveyed hospitals across the industry to identify commonalities and contrasts with practices in place at high performers. (For more information about the survey and selection process, see page 34.)

Interestingly, researchers found that strategies to support revenue cycle high performance vary greatly by organization. Some high performers believe strongly in centralized registration while others do not. Some place great priority on address verification and Medicaid eligibility while others focus elsewhere. Differences can even be seen among the metrics that organizations use to track performance and identify opportunities for improvement.

Still, researchers did note several commonalities:

- High performers have an organizational culture that elevates the importance of the revenue cycle.
- High performers master areas important to their particular circumstances. They don't necessarily focus on the same revenue cycle areas as others for improvement, but they target those elements most crucial to their success. Simply put: They are good at what they need to be good at.
- High performers accelerate improvements. High performers aren't just good at setting goals; they are good at how they take action and execute strategies to achieve these goals.

Perhaps most significant, researchers discovered that it's possible to achieve high performance regardless of particular financial means or patient mix. Although

high performance was seen slightly more often at system-based hospitals, numerous standalone facilities were high performers as well. Excellence was seen in settings urban and rural, large and small.

Given such widespread relevance, the Patient Friendly Billing project encourages revenue cycle leaders to use results of its research on high performance as a means for engaging the entire C-suite around their organization's particular revenue cycle needs. Such engagement is necessary to ensure that revenue cycle leadership and staff have the right infrastructure,

skills, and tools to support patient-centric and value-driving processes. Whether the objective is to focus priorities, set appropriate hiring criteria, or shape procedural direction, the role of buy-in at the executive level cannot be overlooked. Organizational alignment is critical for ensuring that a high-performance revenue cycle is not only a top priority but also ingrained in daily practice. The reward of these efforts is increased resources available to support and strengthen all areas within the organization.

At a Glance: Roles in a High-Performance Revenue Cycle

	People	Processes	Technology	Metrics	Communication	Culture
C-Suite	<ul style="list-style-type: none"> Set high expectations for revenue cycle positions Devote organizational resources to improved training and compensation 	<ul style="list-style-type: none"> Develop and participate in intraorganizational teams around revenue cycle Use patient experience as the cornerstone for setting revenue cycle strategy 	<ul style="list-style-type: none"> Appreciate community dynamics and those with the greatest impact to the organization when prioritizing technology needs 	<ul style="list-style-type: none"> Encourage improved monitoring of revenue cycle processes through use of traditional and nontraditional metrics Develop and enforce systems of accountability around monitoring and reporting practices 	<ul style="list-style-type: none"> Support organizational alignment around clear, correct, and patient-friendly messaging Set clear and transparent financial assistance policies and procedures 	<ul style="list-style-type: none"> Demonstrate value for the revenue cycle through significant commitment of time and resources Establish systems to reward high revenue cycle performance
Revenue Cycle Leadership	<ul style="list-style-type: none"> Apply high standards to hiring Emphasize education Take a career approach to revenue cycle positions Leverage compensation and work arrangements for employee satisfaction 	<ul style="list-style-type: none"> Use formal structures to obtain stakeholder input Target revenue cycle improvements around the consumer's experience Adopt established improvement methodologies including those not traditionally used in health care 	<ul style="list-style-type: none"> Selectively use technology for interactions with customers Manage for investment value Dedicate IT staff to the revenue cycle 	<ul style="list-style-type: none"> Measure and report frequently Look beyond traditional metrics for success Seek the consumer's perspective 	<ul style="list-style-type: none"> Drive a positive scheduling/registration experience Provide estimates of financial obligations Promote financial assistance Support clear and simple billing and collections materials Recognize the importance of external communications 	<ul style="list-style-type: none"> Support revenue cycle at the highest level Garner appreciation for the revenue cycle from nonfinance staff Find purpose through the patient Demand high performance Celebrate success Make innovation a priority

Research Findings

So what exactly does high performance at the practical level look like? To best understand how high-performing organizations differ from others in executing core revenue cycle strategies, researchers examined their competencies in six key areas:

- People
- Processes
- Technology
- Metrics
- Communication
- Culture

What follows is a discussion of how these high performers compared with other hospitals and health systems in relation to these areas. Readers are encouraged to keep their own organization's practices in mind as they view these findings.

People

The cornerstone of any successful healthcare organization is its people. Revenue cycle functions, in particular, are heavily influenced by the quality of a hospital's talent largely because of the numerous, complex, and sometimes sensitive communications that must take place for appropriate financial services to be delivered and payment to occur.

A common theme among all the high-performing revenue cycle organizations was a concerted focus on their people. This focus took many different forms, including hiring the right people, focusing on education, taking a career approach to revenue cycle positions, and leveraging fair compensation and flexible scheduling arrangements to promote satisfaction with the work environment.

Establishing high standards for hires. The high-performing revenue cycle hospitals that were visited were very selective in their hiring decisions. Hiring managers stressed the importance of getting "the right people in the right roles." There were different approaches, however, in the best way to achieve this fit.

Some organizations emphasized recruiting those with a minimum level of education or experience, while others underscored the importance of personality attributes such as a customer-focused demeanor.

As with most hospitals, each of the organizations visited had detailed job descriptions outlining the qualifications and skill requirements needed for various revenue cycle positions. What may have differentiated these organizations from their peers, however, was their steadfast conviction to hire only the most appropriate and qualified staff despite potentially limited pools of qualified candidates.

To take it one step further, these organizations were willing and, in fact, often had incurred significant staff turnover as they began to implement various revenue cycle process improvements. Yet they did not waiver in their conviction to hire only the most appropriate staff. As just one example of such selectiveness, consider high-performing Henry County Health Center, a 25-bed critical access hospital in Mount Pleasant, Iowa, that requires individuals to already have or immediately obtain selected certification as a condition of hire for many of its revenue cycle positions. Leadership believes that attainment of certification can be a key factor in getting the right people in the door. Such a stance may not sound that significant at first glance, but it becomes so when one considers the limited labor pool available in the organization's chiefly rural setting.

Devoting significant resources to education. Also common to organizations with high-performing revenue cycles is that they spend significant time training and educating new and existing employees. Leadership believes that sizeable resources must be devoted to ensuring that staff have the necessary training and education to effectively handle the demands of their positions.

For the high performers, this training took many and varied forms. Most of the organizations devoted at least 10 days to training and educating new employees, with some offering significantly more. In addition,

How many days of initial revenue cycle training are required for the following positions?

High Performers					
	1 day or less	2-3 days	3-5 days	5-10 days	>10 days
Registrars	0%	14%	14%	14%	57%
Billers	0%	14%	14%	14%	57%
Collectors	0%	7%	21%	21%	50%
Financial Counselors	0%	7%	14%	14%	64%
All Others					
	1 day or less	2-3 days	3-5 days	5-10 days	>10 days
Registrars	7%	11%	15%	25%	42%
Billers	4%	10%	7%	25%	54%
Collectors	5%	9%	10%	30%	47%
Financial Counselors	5%	7%	11%	26%	52%

these hospitals frequently offered both formal and informal continuing education, such as “lunch and learns” to their staff.

Some organizations also rely on external education resources. Like Henry County Health Center, hospitals may require attainment of particular certifications or completion of particular training programs as a condition of hire or within a certain period after hire for specific positions.

Regardless of the particular training origin or approach, an emphasis on educational opportunity appears to be a top priority to high performers and is seen as useful for ensuring revenue cycle staff have the body of knowledge and proficiency necessary to meet day-to-day revenue cycle demands.^a

Taking a career approach to revenue cycle positions. Traditionally, one does not think of a front-line revenue cycle position as a career. Rather, employees frequently view these positions as stepping stones to other, higher-paid opportunities. As a result, such positions often are filled by staff with limited experience and can be particularly prone to high levels of turnover. Unless addressed, this high turnover can result in reduced departmental efficiency and effectiveness, avoidable recruiting and training costs, lower employee morale among staff that remain, and potential patient dissatisfaction.

Some hospitals address this challenge by creating career paths or ladders for revenue cycle personnel. At these organizations, positions are designed in such

a way that staff can eventually be promoted to other positions with increased compensation and responsibility based on meeting requirements such as tenure, experience, expanded training/attainment of professional certification, performance, or successful completion of an exam.

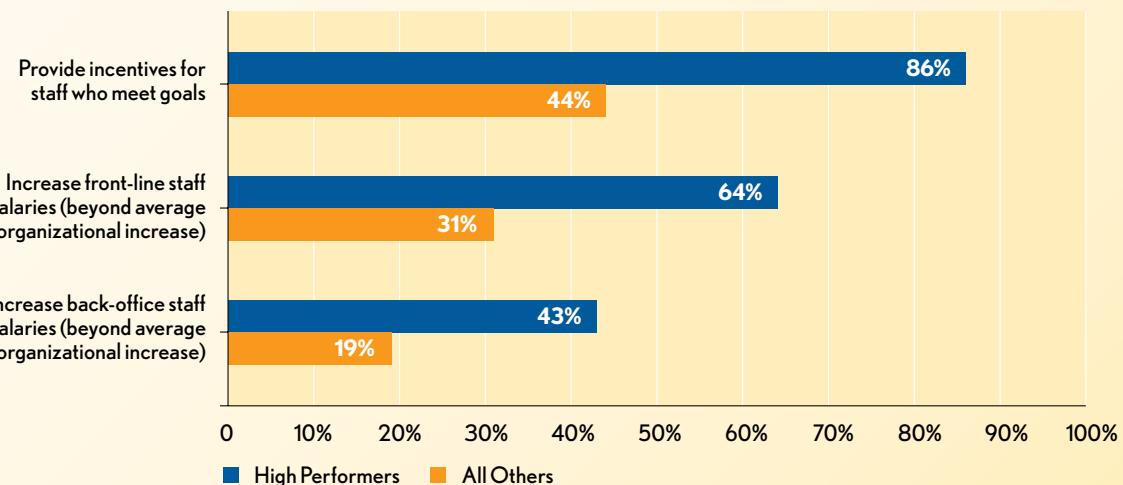
As an example, at high-performing Carolinas Medical Center, an 874-bed hospital in Charlotte, N.C., a career ladder was started in 2002. For front-end staff, it includes three position levels for registrars. To move from one level to the next, a registrar must be in good standing (i.e., no disciplinary action) with successful evaluation ratings, take additional educational classes, pursue cross training in at least two areas, and successfully pass an exam. The organization also offers a leadership, education, and development (LEAD) program in patient access. Every six months, two individuals are nominated, interviewed, and selected. The staff selected spend six weeks shadowing and working on projects at several facilities, and two of the six graduates have moved into management roles.

Leveraging compensation and work arrangements for employee satisfaction. Key to combating turnover is providing competitive compensation, either directly through pay levels or through performance incentives. High performers were more likely than other organizations to use compensation increases as a means for elevating staff competencies or recruiting/retaining staff.

Of course, financial rewards aren't the only way to support employee satisfaction. A number of

Strategies to Recruit/Retain High-Performing Staff

Which of the following strategies have you employed to elevate staff competencies or to recruit and/or retain high performers?



Career Tracks at Baylor All Saints Medical Center at Fort Worth

High-performing Baylor All Saints Medical Center, one of 14 hospitals in the Texas-based Baylor Health Care System, supports a career approach for revenue cycle positions. As Hollan L. Fenner, executive director of centralized business services at Baylor, explains, “To support employee longevity, we must provide the ability for staff to move up.”

Staff progress from entry level positions to higher levels with enhanced responsibility and compensation as they prove themselves. The diagram below demonstrates a typical career track progression.

Rarely does the organization need to recruit for positions other than entry level. Retention also is aided as staff have incentives to learn more about other areas in central billing and improve themselves professionally. Employee satisfaction scores are very high. Staff also report being pleased to see themselves and others promoted.

“Over half of my staff has been in central billing services for more than five years, and over one third has been here more than 10 years,” Fenner says. “My directors, including myself, have 165 years of combined hospital business office experience.”

Staff work in support services, pulling data for management and other staff.



Staff progress into billing, credit balance adjudication, or payment and adjustment posting.



Staff progress into collections.



Staff progress into contract compliance, transplant claims adjudication, and customer service.



Staff progress into management positions, which include coordinators, managers, directors, and one executive director. Each manager has one or two coordinators who are being groomed for a manager position. Each director has four managers who are being groomed for a director position. Four directors are being groomed for the executive director position.

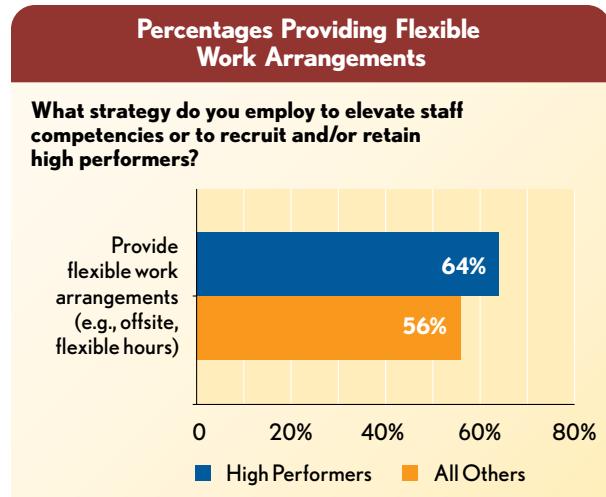
high-performing organizations offer flexible work arrangements, including options for staff to work from home offices, select part-time work to reduce hours, or work nontraditional hours (for example, beginning early, starting late, or putting in time over the weekend). Such perks typically have little or no cost impact to the department and, in some cases, may actually provide savings. Further, some of the high-performing organizations have been able to attract and retain the best employees in the market through such innovative arrangements.

Although the percentage of high performers that offer flexible work arrangements is not significantly different from that of other hospitals that do so, it is still interesting to note the high percentage of organizations that are employing this strategy.

Processes

With seemingly constant changes in the areas of technology, regulations, and reimbursement—to name only a few—providers are constantly required to modify processes to ensure both efficiency and effectiveness. Amidst this turmoil, high-performing revenue cycle hospitals attempt to go the extra mile by creating patient-friendly processes aimed at improving the overall patient experience.

Enhancing the patient experience requires that hospital revenue cycle leadership and staff be simultaneously inquisitive, responsive, innovative, and flexible. High-performing revenue cycle hospitals have and continue to make tangible improvements to their



revenue cycle processes. Although there is no set formula for making improvements, many hospitals are refining processes in similar ways.

High performers generally use formalized structures to obtain stakeholder input, target improvement efforts around those areas of the revenue cycle with greatest effect on the consumer's experience, and rely on widely recognized improvement methodologies as a means to examine and redesign processes.

Using formal structures to obtain stakeholder input.

Most executives with high-performing revenue cycles have very specific ways they leverage relationships, focusing at the organization, consumer, physician, and payer levels around process improvement needs.

Organization. Typically, hospitals and health systems with high-performing revenue cycles rely on two types of teams to address process improvements. The first type is a team that performs oversight functions. Members monitor and evaluate key financial and revenue cycle metrics, with an emphasis on identifying trends and developing overall strategies for improvement. Typically this team is led by the CFO or a senior revenue cycle executive and includes directors or managers from the key revenue cycle departments, such as scheduling, registration, financial counseling, billing, and customer service. The team typically meets at least once per month.

The second type of team is project based. These teams focus on a specific area of the revenue cycle or are specially created to address a particular issue or task, such as managing response to a new software implementation. Regardless of whether the project-based team meets routinely or on a temporary basis, it generally includes participants from financial service areas as well as IT, physician relations, regulatory compliance, and/or clinical departments. Most high performers also have periodic mechanisms in place for soliciting employee input or feedback into processes.

Research shows high performers tend to have fewer overall revenue cycle meetings, but more meetings targeted on specific issues than other organizations.

Consumer. It may not come as much of a surprise that high performers rely on formal processes for soliciting consumer feedback around process improvements. After all, hospitals frequently use focus groups to assist

Revenue Cycle Leadership Structure at Spectrum Health Grand Rapids

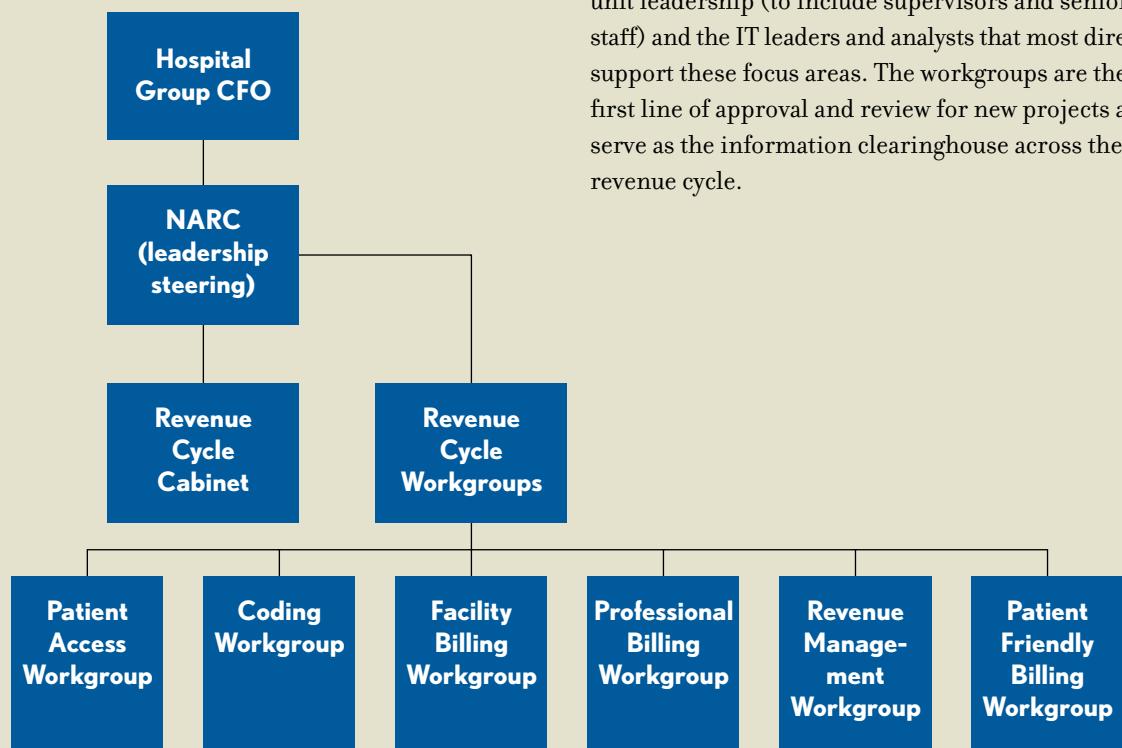
High-performing Spectrum Health Grand Rapids, located in western Michigan, participates in a three-tiered leadership structure to manage its revenue cycle operations.

The *NARC*, or new age revenue cycle team, is headed by the hospital group CFO and comprises senior Spectrum Health leadership, including hospital CFOs; several vice presidents and controllers; the directors of finance, revenue cycle, patient financial services, coding, registration, revenue integrity, revenue management, organizational integrity, patient placement, and IT; and clinical

and nursing representatives. The NARC provides strategic leadership to the entire system's revenue cycle and resolves resource and prioritization issues arising in workgroups or in the revenue cycle cabinet.

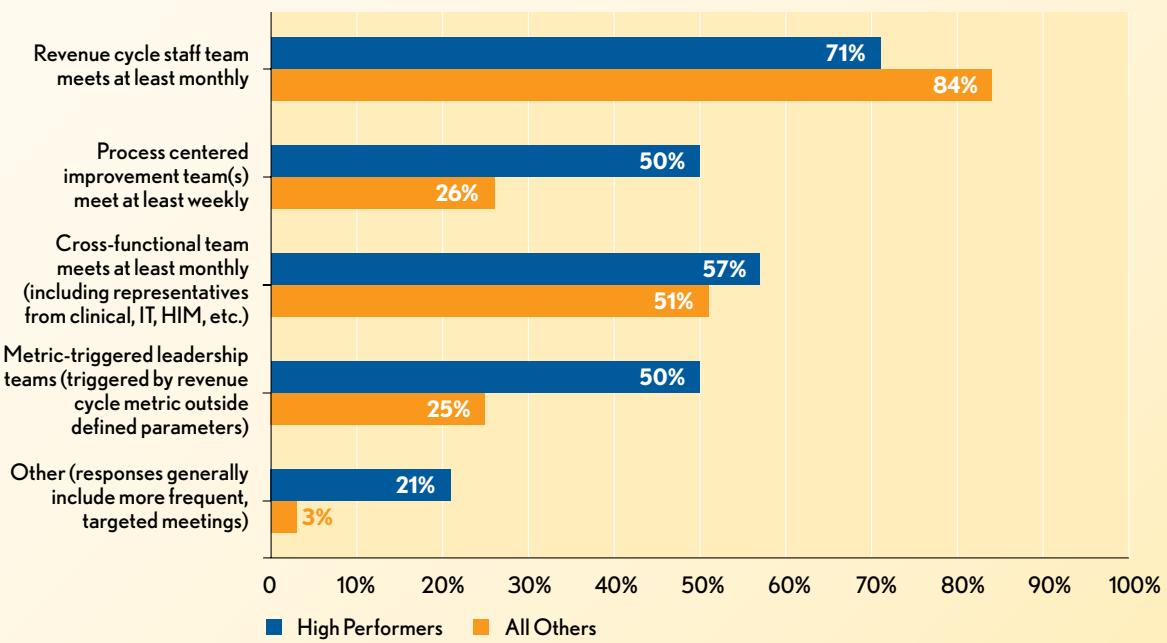
The *revenue cycle cabinet* includes the directors of revenue cycle, as well as many managers, supervisors, and analysts who are accountable for day-to-day revenue cycle performance. Although this group coordinates workgroup activities, it is mainly focused on business operations and information sharing.

The *workgroups* are teams focused around specific areas of the revenue cycle. They include the business-unit leadership (to include supervisors and senior staff) and the IT leaders and analysts that most directly support these focus areas. The workgroups are the first line of approval and review for new projects and serve as the information clearinghouse across the revenue cycle.



Revenue Cycle Teams: Design and Meeting Frequency

Please tell us about your revenue cycle teams.



in setting strategic direction, enhancing services, and gauging community perceptions of the organization and its programs.

What is notable is the frequency and depth to which individual organizations involve patients in their revenue cycle activities. High performers often use focus groups when attempting to create more consumer-friendly bills. Typically, patient focus groups will be convened to provide input at the time that the initial bill redesign begins as well as throughout various stages of the improvement process. Ultimately, “approval” of focus groups is often sought regarding final design edits.

Although many focus groups, such as those involved in bill redesign, tend to be temporary and project-specific, some high-performing revenue cycle hospitals have established patient advisory groups on an ongoing basis to assist in a variety of areas, including revenue cycle.

Physician. To make the most of revenue cycle relationships with physicians, high performers make communication a high priority. They typically collaborate on the content of patient scheduling forms and surrounding processes to support consistent expectations around the gathering of patient insurance and clinical

Patient Advisory Councils at Spectrum Health Grand Rapids

Spectrum Health Grand Rapids has formed eight permanent patient and family advisory councils that meet regularly to provide guidance in seven key business/clinical areas for its hospitals. Each of the councils has up to 20 members.

Those seeking positions on the councils are interviewed by Spectrum Health management. Interestingly, Spectrum Health management often gives greatest preference to individuals who have had an unfavorable experience with the organization. The hope is that Spectrum Health detractors can be turned into promoters, and that these individuals will offer valuable perspective on issues, challenge the current thinking and processes, and lend practical advice for improvements.

The councils have been integral in a number of revenue-cycle-related process improvements, including those related to patient access, bill redesign, and web site enhancements.

Physician Dynamics Supporting a Seamless Patient Experience at Geisinger Health System

When looking to the future, many revenue cycle leaders envision a day where there will be a seamless clinical and business experience for patients across the entire care continuum. One approach for achieving this vision already is taking place at Geisinger Health System, an integrated healthcare delivery system based in Danville, Pa., that comprises two medical centers, outpatient surgery centers, a children's hospital, and other services built around a 740-member employed physician group and an insurance company that covers one third of its business.

Geisinger is jointly led by physicians and healthcare administrators at all levels, a structure that provides significant opportunities for financial incentive alignment and unifying patient perceptions of clinical and revenue cycle operations.

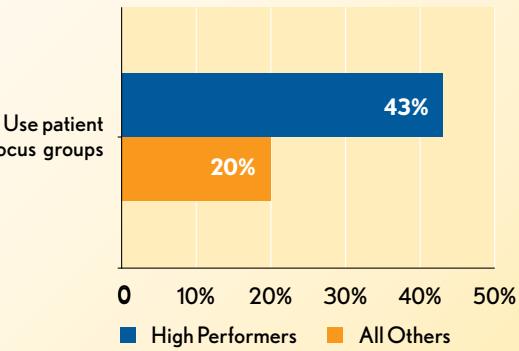
Here are two of Geisinger's innovative approaches:

- A medical-home model that coordinates disparate elements of patient care by providing round-the-clock access to primary and specialty care. Focus is on proactive care and chronic disease management centered on evidence-based practices. The chronic care program offers financial incentives of as much as 20 percent of a physician's total compensation for meeting quality, value, and patient satisfaction objectives.
- Acute episode care, or Geisinger ProvenCare, reengineers the management of acute episodes by identifying and implementing best practices across the entire episode of care, instituting risk-based pricing, and engaging patients in their care. Under ProvenCare, an overall price covers preoperative evaluations, hospital and professional fees, routine discharge care, and complications within 90 days of discharge.

Patients also reap the benefits of such unification. A billing system that combines both hospital and professional fees means less confusion on origination of bills and an integrated experience—from start to finish.

Use of Patient Focus Groups

What strategy have you used in the past three years to improve revenue cycle processes?



information. They also routinely solicit feedback from physicians and their office staff to ensure that their needs are being met.

As one example, when high-performing Iowa-based Henry County Health Center redesigned its business processes, it worked closely with its community physicians. The organization sought input from physicians regarding changes to the hospital admitting and registration processes, and it worked with them to develop similar policies around discounting services and charity care. Most important, Henry County Health Center kept physicians informed of how process changes would affect their patients. This collaboration has been integral to the revenue cycle enhancements.

Some organizations view revenue cycle and physician relations as so important to success that they have even developed systems to support integration within their organizational structure. At HCA's Redmond Regional Medical Center, a high-performing 230-bed acute care facility located in Rome, Ga., relations are supported through employment of a physician development representative. As a liaison between the hospital and its physicians, the physician development representative carries responsibility for routinely visiting physicians and their staffs to assist with any revenue-cycle-related problems that may be occurring. Issues may include difficulties associated with scheduling patient appointments or the timeliness or accuracy of either party when sharing patient financial or clinical information.

At least quarterly, the physician development representative, accompanied by representatives from

Redmond Regional Medical Center's scheduling/registration department and HCA's regional customer service center, holds physician luncheons. At these get-togethers, physician office staff and hospital personnel discuss issues and concerns and brainstorm potential solutions. If not solved immediately, problems identified are addressed on an ongoing basis.

Payer. High performers are more likely to routinely communicate with payers about payment issues or technology processes than others. During site visits, all of the high performers told interviewers that they routinely engage in scheduled and impromptu communications with their largest payers, whether by phone or in person. The focus of these conversations typically is on ways to reduce the number and causes of payment denials. Frequently these exchanges are either led by or include the executive in charge of managed care contracting, and are supported by revenue cycle personnel who can provide the necessary data and, in some cases, clinical staff.

Some of the high-performing hospitals also work collaboratively with insurers to electronically exchange data, thereby enhancing both the timeliness and quality of shared information and reducing impediments for

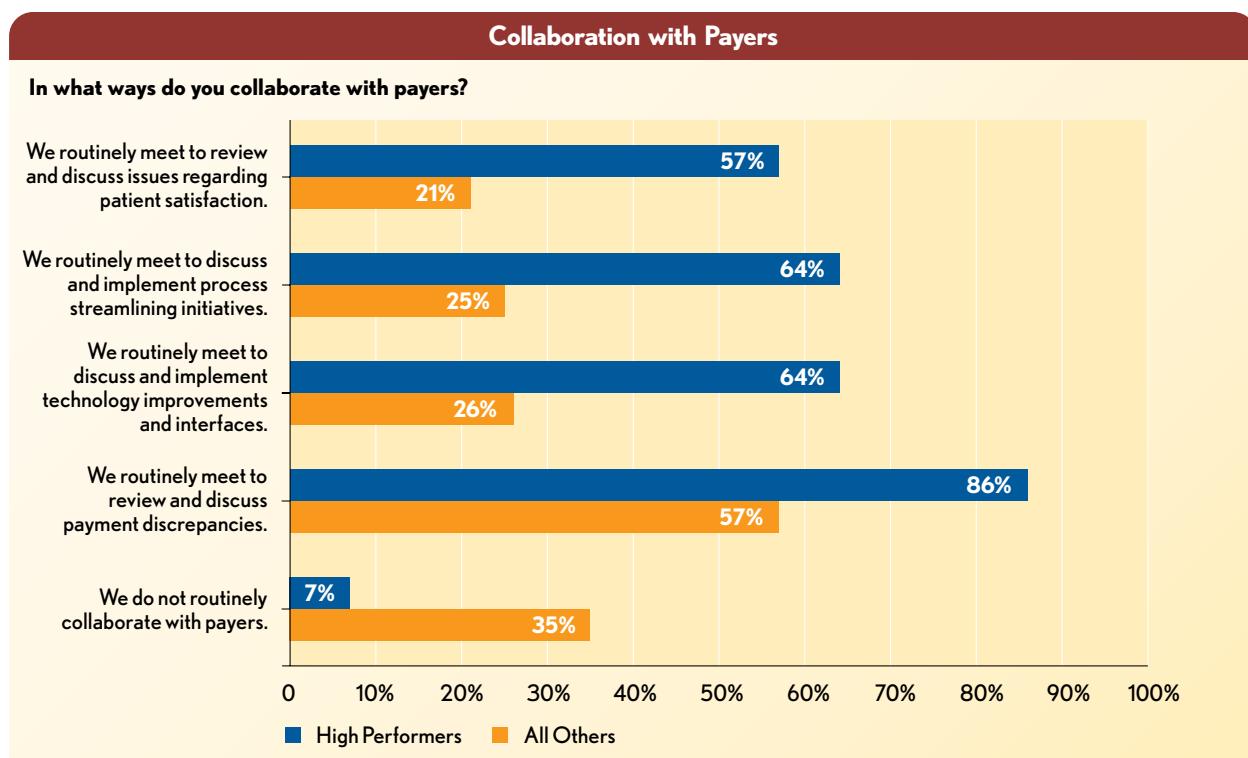
payment. Clearly, much is being done to improve interfaces between hospitals and insurers.

That said, many of those interviewed at the high-performing revenue cycle hospitals indicated that insurers generally are more interested in transaction flow issues than consumer-focused practices. Several high performers reported success in getting payer attention to these areas only after locating the right party willing to engage in these discussions.

Regardless of the type of issue being discussed, high performers generally attributed their successful relationships with payers to such factors as frequent communication, a collegial mind-set, and staff willingness to view issues from the insurer's perspective.

Targeting improvements around those revenue cycle areas most affecting the consumer's experience. High performers generally have focused their improvement efforts on such areas as front-end processes, point-of-service collections, and charity care.

Front-end processes. First impressions matter. As such, many providers, including the high-performing revenue cycle hospitals, are recognizing that patient satisfaction and understanding of payment obligations



Redmond Collaborates with Insurers

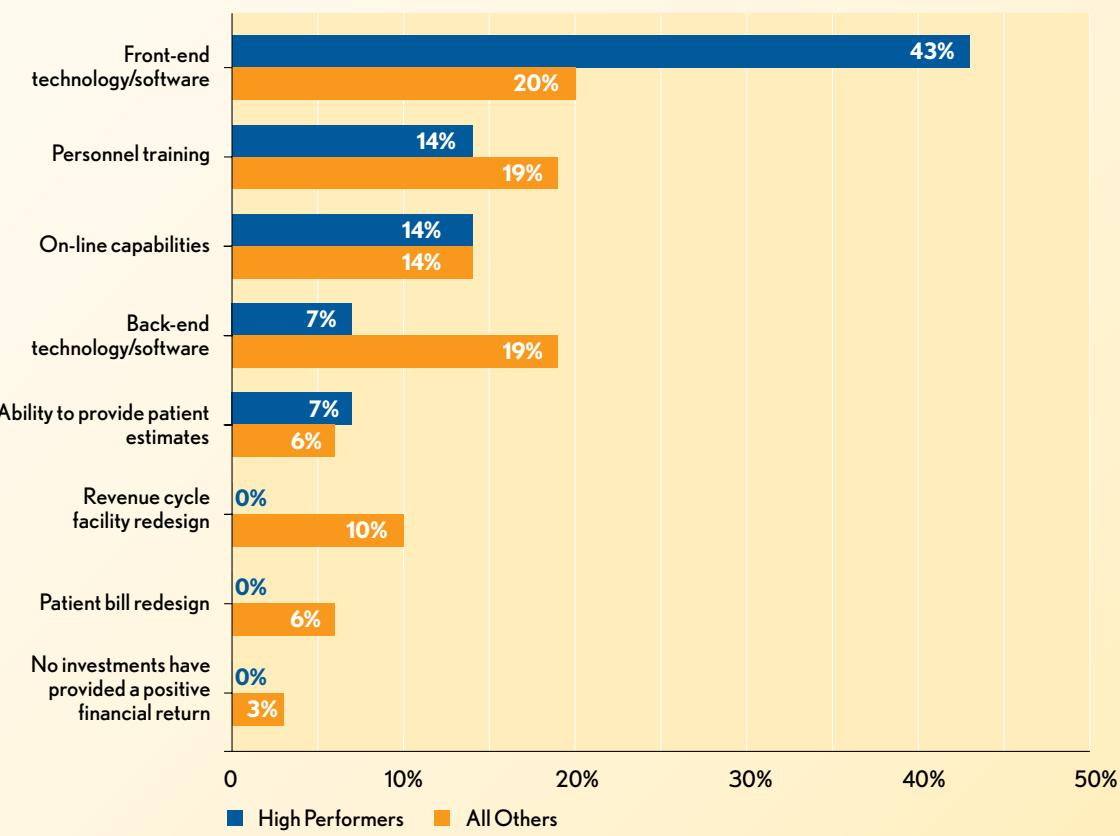
HCA, the parent company of Redmond Regional Medical Center in Rome, Ga., has made a concerted effort to enhance its collaboration and communications with insurers. In addition to verifying eligibility and benefits with payers on the front end, the system's regional shared services site in Atlanta recently completed a pilot with one of its largest payers to electronically exchange data. The process involves using a shared, web-based relational database to provide claims information and status. Once the payer indicates that additional or missing information is needed, the shared services center uses a secured site to automatically provide electronic copies of uniform bills, medical records, itemized bills, and implant invoices. The site also provides electronic copies of daily census information to the payer so it can

confirm service authorization. This pilot project was completed in February 2009. Given the project's success, HCA would like to expand the program. At present, eight facilities are served for one major payer at the Atlanta site; HCA has plans to add another nine facilities. In addition, the organization would like to work with other major payers to develop similar capabilities.

In Redmond Regional Medical Center's experience, the key to improving connectivity is to ensure that both providers and payers have dedicated IT resources available to work through these types of initiatives. The successful implementation of the pilot project required staff with an in-depth knowledge of security standards, firewall connectivity, and file transfer protocols.

Relative Performance of Investments in Terms of Financial Return

In your opinion, which investments have provided the greatest financial return?



is enhanced when increased emphasis is placed on improving front-end processes. This front-end focus includes:

- Emphasizing scripting for patient interactions to support clarity, consistency, and completeness of communication
- Increasing training and continuing education of front-end staff
- Upgrading front-end personnel requirements
- Enhancing pay scales and/or implementing incentive programs for schedulers, registrars, and financial counselors
- Developing integrated revenue cycle processes and teams that include both front-end and back-end personnel to enhance communication and continuity
- Streamlining scheduling processes to reduce the number of persons with whom a patient, patient's family, or physician office staff must communicate
- Introducing or upgrading technology to better serve front-end processes, including software related to address and/or insurance verification

Research shows high performers are much more likely than other hospitals to have made

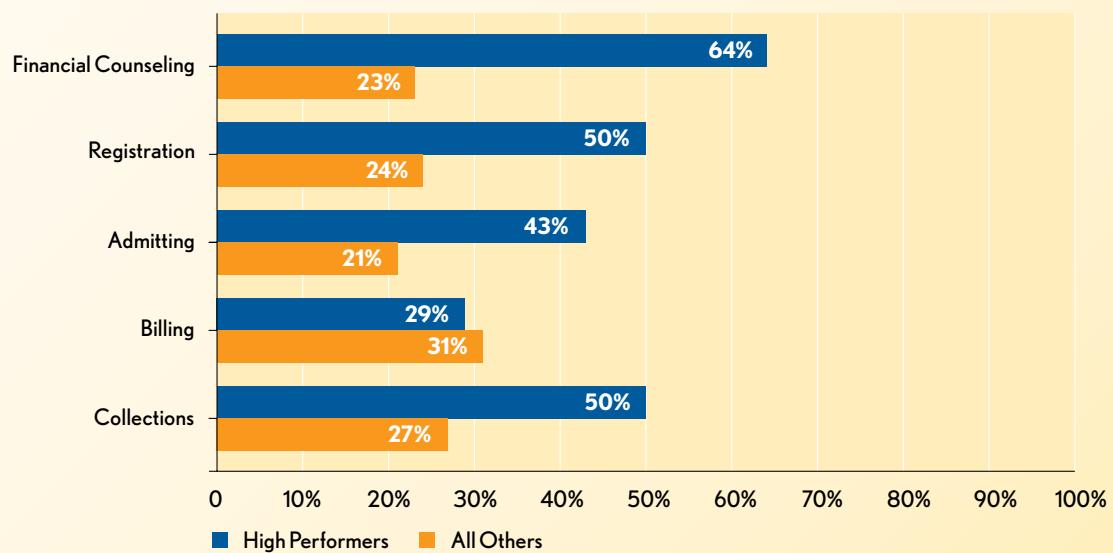
significant changes in registration, admitting, and financial counseling. It's also interesting to note that a high percentage believes investments in front-end technology and software have provided greatest financial return.

Point-of-service communications and collections. Along with this front-end focus, most high performers are educating their patients about what their insurance covers as well as the meaning and amount of copayments, deductibles, and coinsurance. High performers accomplish this by conducting insurance verification on most procedures prior to services being rendered. Such efforts aid collection at the point of service. Focus is on providing patients with cost estimates at the time of scheduling or preregistration and improving clarity of communications regarding payment expectations and processes. In addition, front-end personnel are being provided with significant training and scripting to alleviate any potential discomfort associated with seeking payments from patients.

Although most hospitals seek to collect patient copayments (and, in a few cases, deductibles) up front, the rigor associated with these efforts does vary by organization. Some hospitals will seek to postpone

Comparative Level of Improvement Efforts

Have you made any significant changes to the following areas of the revenue cycle process within the past three years?
1 = No Improvements to 7 = Complete Overhaul. (Percentage indicating 6 or 7)



Improving Patient Payment at Oaklawn Hospital

Oaklawn Hospital, Marshall, Mich., started a point-of-service copayment collection initiative in its emergency department in June 2008. By October, it expanded the program to scheduled areas with high charges, such as outpatient surgery and select radiology and endoscopic services.

Patients are provided with a written estimate of their anticipated copayment amount and deductible by letter when they preregister seven days in advance of service. Staff then collect copayments at time of service.

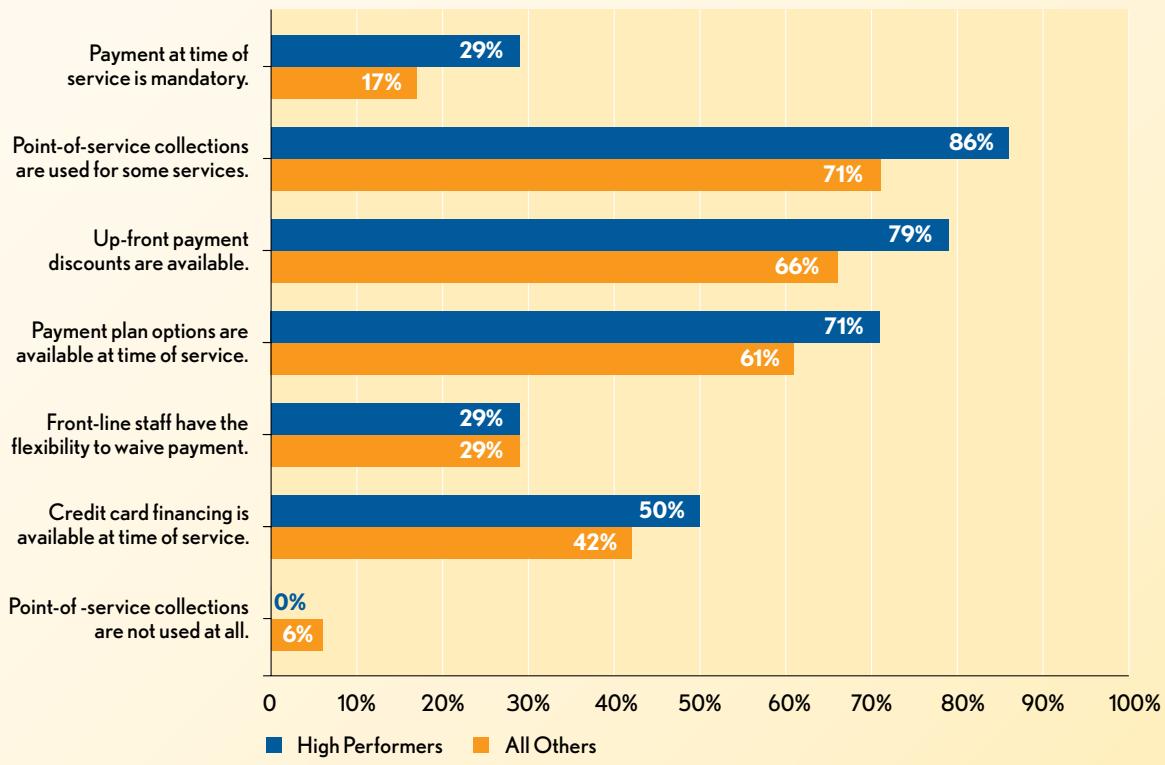
As part of the program, the organization provides formal training where staff involved in registration

learn consistent practices for completing registration and requesting payment. To help ensure buy-in to these practices, participants receive scripting and conduct role-playing exercises. Everyone involved in registration—a decentralized process at Oaklawn—goes through this training, from the phlebotomists to the radiology managers.

From June of 2008 through April of 2009, Oaklawn collected \$297,000 through its point-of-service processes—all without additional staff! The program has been so successful that Oaklawn Hospital plans to expand it to obstetrics and chemotherapy services in the future.

Relative Use of Point-of-Service Collections

Please tell us about point-of-service collections at your organization.



elective procedures in instances where patients do not provide payment, but most remain relatively flexible. Regardless of methodology or process, almost all of the high-performing hospitals have indicated that they have experienced improved point-of-service collections and that, in almost all cases, patients are surprisingly amiable to such efforts.

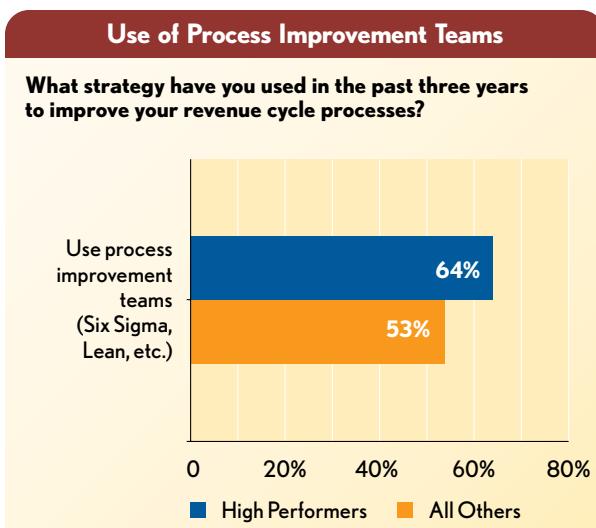
Charity care and financial counseling. Another key focus for many high performers has been updating charity care practices. Over the past few years, virtually all of the organizations visited have modified their charity care policies and financial counseling processes.

Most high performers are attempting to more openly communicate the availability of charity care through actions such as providing brochures at registration, posting policies on their web sites, and including language referencing availability of charity care on patient bills. Also, some organizations are empowering patient access staff to identify potential recipients and administer the charity care policies.

In addition, high-performing revenue cycle hospitals generally have sought to enhance financial counseling capabilities within their organizations. Many hospitals are improving the pay, training, and scripting that they provide to financial counselors. Further, many organizations with high levels of self-pay activity or a high Medicaid population are supporting onsite availability of state and/or other third-party personnel to assist patients with applying for Medicaid, payment arrangements, or other types of funding.^b

Adopting formal process improvement methodologies. Regardless of the particular process areas they select for improvement, high performers generally rely on proven redesign methodologies to support these efforts. Typically, these methodologies consist of bringing together temporary, high-performing teams to examine, measure, and improve on current processes. Team composition may include revenue cycle staff, non-revenue cycle business staff, clinicians, and process engineers. Some of the common methodologies used by high performers are Lean, Six Sigma, and Kaizen.

No common methodology is used among all high performers. In fact, in several instances, high performers even looked toward improvement approaches common to other industries but not traditionally employed in health care. Perhaps, as one revenue cycle leader



noted, "The simple fact of creating a framework and a high level of rigor around process measurement and redesign is what is important."

Technology

Technology often supports improved communication, provides decision support, and creates efficiencies throughout the revenue cycle. Yet ability to realize these benefits requires more than simple investment.

Ways organizations leverage technology use to support revenue cycle high performance include being selective in application, managing the technology to ensure its potential is realized, and ensuring adequate IT support for their investments.

Selectively using technology for interactions with customers. Many of the high performers talk about walking a line between automating processes and providing human interactions. Most of these organizations view high-volume, transactional processes as being the most appropriate for automation. By contrast, those functions that require customized or customer-specific information generally are viewed as requiring a human touch.

High-performing revenue cycle organizations tend to have employees respond to most patients' inquiries, as opposed to using voice-activated systems. With the exception of some basic functions (such as balance inquiry response or generation of appointment reminders), these organizations rarely use automation for customer service issues.

A Fresh Perspective on Performance Improvement at CHRISTUS St. John Hospital

Ten years ago, CHRISTUS St. John Hospital would never have been considered a revenue cycle high performer. At the time, the 150-bed hospital in Nassau Bay, Texas, was hemorrhaging millions of dollars due to denials, timely filing issues, and other revenue cycle problems. Other hospitals across CHRISTUS Health weren't realizing their potential as well.

CHRISTUS Health decided rather than tweak inefficiencies hospital by hospital, it would completely overhaul its entire revenue cycle processes. Rather than applying traditional improvements seen in health care, however, leadership chose to borrow best practices from somewhere unexpected: the manufacturing industry. Specifically, the organization began implementing the philosophies, methods, and (ultimately) the culture of the Toyota Production System into its healthcare revenue cycle. Just a few of the many practices taken from a manufacturing setting:

- **Gaining insight through significant observation of "as is" processes.** At the project's outset, a group of revenue cycle leaders and associates from a hospital in the system's Gulf Coast region, many of whom were trained in the Toyota approach, conducted a baseline of the entire revenue cycle process. This process involved analyzing all encounter records for an 18-month period to understand where the biggest impacts could be made. This intense understanding of functions in place set the foundation for a detailed plan to implement organizational change, a performance management system, and standardized processes.
- **Greater focus on "visual workspace."** (All elements associated with improved operational efficiency and quality are arranged carefully to optimize

productivity, including arrangement of equipment, tools, and information.) Physical layout changes were made in some instances to improve information and claims flow. Most notably, organizational structure changed so that aggregated associates from preadmitting, HIM, and patient financial services were moved into a single, cohesive structure with centralized regional ownership.

- **Enhanced focus on "system status."** (Information on how the process is performing should be visible at all times using simple visual queues.) A balance scorecard was created with new metrics to include cash realization, collections quality, billing quality, and transaction cost per encounter alongside more traditional metrics. Tracking is automated and users can drill down for root cause. In addition, team-level metrics were deployed that are discussed daily during shift briefings. Revenue cycle leaders also make use of a tracking board that includes the metrics as well as issues, problems, and opportunities.

CHRISTUS Health views this "fresh perspective" as a success and continues to seek opportunities for improvement. At CHRISTUS St. John Hospital, in particular, performance on financial measures has improved significantly: Bill hold has dropped by more than 70 percent, denials have decreased significantly to 0.51 percent of net patient revenue, days in accounts receivable are the lowest they have ever been, and net to cash 120 days is hitting 93 percent. Patients have also benefited, especially from efforts to streamline registration and billing and improve customer service. Press Ganey patient satisfaction scores for admissions continually rank in the high 90th percentile.

Managing for investment value. High performers do not differ from other organizations so much in the types of technologies that they employ as they do in the level at which they manage these investments. Simply put: They're good at realizing the potential and obtaining the greatest value from their investments.

As one interviewee noted: "The specific piece of technology you choose to buy is far less important than if you know how to use it well. The usefulness of the technology comes into play when you can leverage its capabilities. Far too many people have the most expensive pieces of technology, but they don't really know how to use them." High performers generally believe that it is better to adopt a modest solution very well than to adopt a superior (i.e., think all the bells and whistles) solution only moderately well.

Organizations typically make the most of their revenue cycle technology investments by focusing on improving processes prior to applying automation and prioritizing their purchases by their particular market needs.

Process before purchase. At high-performing revenue cycle hospitals, investments generally are seen as a means to address a problem, but not a quick fix. Those interviewed say too many organizations implement technology as a bandage to an underlying broken process, rather than simply trying to fix the process. High performers, prior to technology adoption, typically examine the revenue cycle processes that the technology will complement to ensure they aren't simply taking a short-term approach to a larger issue.

Market-based priority. Technology is a great asset, but it is also an expensive asset. What's more, capital expenditures for the revenue cycle are competing for the same dollars as revenue-generating clinical technologies, such as operating room equipment or a new MRI machine. As such, high performers focus on making the most of limited funds by investing in technologies that will have greatest effect on their business. For example, organizations with high levels of indigent and Medicaid patients might use address and insurance verification tools.

Dedicating IT staff to the revenue cycle. High performers have revenue cycles that are well supported by IT staff. However, the structures for integrating revenue cycle

Address Verification and Medicaid Eligibility at Touchette Regional Hospital

High-performing Touchette Regional Hospital in East St. Louis, Ill., serves a high self-pay and Medicaid population. Touchette realized that many patients were arriving at the hospital for care who were eligible for Medicaid, but not enrolled. Further, Touchette recognized that some self-pay patients were providing incorrect home addresses, leading to potentially impaired collections.

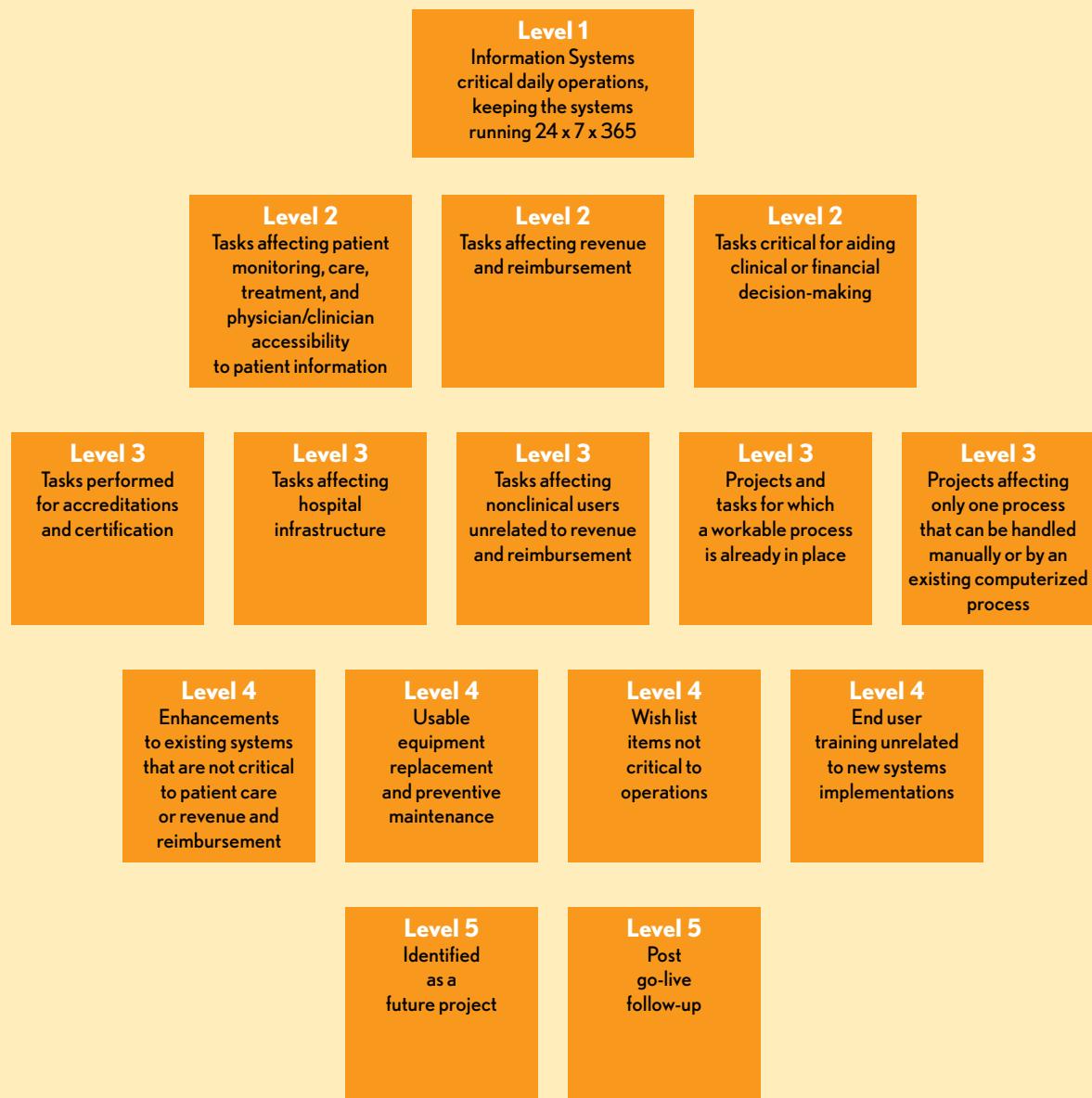
Recognizing that these issues were causing undue financial hardships to the organization and, in some cases, its patients, leadership elected to invest scarce capital resources on state-of-the-art address verification and Medicaid eligibility software. The investments have greatly enhanced the accuracy of patient data, which ultimately are supporting collection, minimizing delay or return of medical insurance billing documents, and improving accuracy of bad debt and charity care reporting.

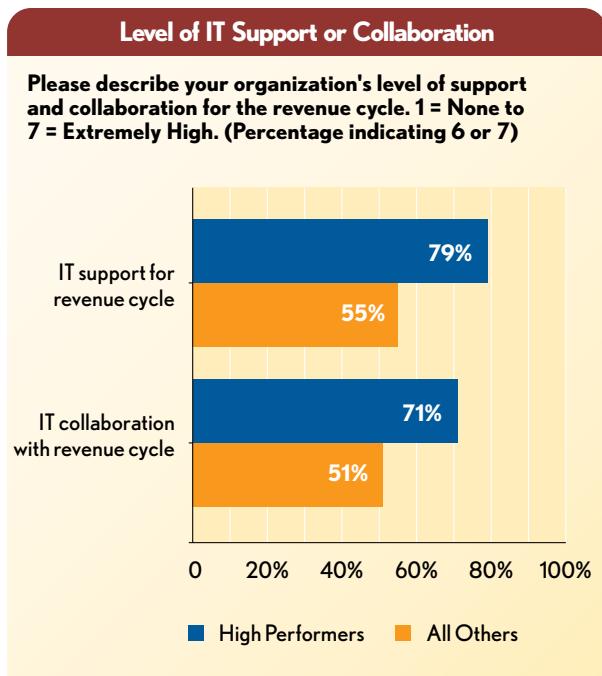
To recoup its monthly eligibility system fees, Touchette only needs to obtain coverage fewer than three times per month. Since implementing the new eligibility system, the organization has found that almost daily, a patient presents without insurance information and the system determines that, at the time of registration, the patient in fact does have valid coverage. In addition, Touchette's system often finds that patients who have presented with insurance cards have either transitioned into or out of a Medicaid HMO product. Although this finding does not add to reimbursement, it does help reduce the revenue cycle time by enabling Touchette to bill the appropriate payer the first time. With these achievements, Touchette's Medicaid payer mix has increased by approximately 3 percent—a result that can be attributed to the eligibility system—while its self-pay volume has held steady at a time when other facilities have seen increases.

Revenue Cycle within the IT Hierarchy at Oaklawn Hospital

At Oaklawn Hospital, a 94-bed, not-for-profit organization in Marshall, Mich., the IT needs of the revenue cycle are viewed as a true organizational priority. Oaklawn has created a diagram depicting the hierarchy for provision of IT support that its staff members follow. At the top of the list are the clinical information needs that directly influence patient care—and equal to clinical information needs—are the IT systems of the revenue cycle. Oaklawn realizes that a “hiccup” in revenue cycle information systems can significantly impact the organization’s bottom line and patient satisfaction.

Information Systems Support and Implementation Levels





and IT vary. Many of the organizations have IT professionals that are either embedded in the revenue cycle departments and budgets or are specifically assigned to revenue cycle activities (though remaining in IT departments). At high-performing organizations where IT support isn't formally structured for the revenue cycle, IT professionals tend to proactively visit revenue cycle departments periodically to determine whether needs are being met. In addition, the high-performing hospitals actively collaborate with IT staff to obtain frequent, actionable, and on-demand reports to improve revenue cycle processes based on staff needs.

Regardless of the organization's structure, having IT professionals dedicated to the revenue cycle allows issues to be handled in a timely manner by those staff most familiar with the specific processes and technologies used by the revenue cycle departments.

Metrics

Despite how complex and far-reaching revenue functions are, it's interesting to note that improvement can be dramatic in a relatively short time. Leaders at some of the high-performing hospitals stated that they felt they had poorly performing revenue cycles just a few years ago.

Leaders at these organizations report that a fundamental contributor to such dramatic turnaround has been their improved monitoring of revenue cycle metrics. Organizational commitment to measuring and monitoring performance is key for setting appropriate goals and making process adjustments necessary for achieving these goals. Some high performers noted that meaningful progress reports help staff best identify those actions that are most likely to improve performance. Also, frequent measurement allows organizations to identify concerns before they become significant problems.

Even though high performers generally agree on the importance of metric use, they vary considerably in both the number and types of metrics they use. Even some traditional revenue cycle measures, such as days in accounts receivable and discharged but not final billed, are not calculated or measured consistently among organizations; ranges for acceptable performance around these traditional measures also are diverse. (Note: Researchers suspect these findings simply reflect an industry need for generally accepted key performance indicators that can be used for benchmarking.)

Although high performers' approaches differ more with use of metrics than they do with other strategic areas of the revenue cycle, organizations do share some commonalities. Notably, high performers tend to examine performance frequently, possess a willingness to look beyond traditional metrics as needed, and place great importance on the consumer's perspective.

Monitoring and reporting frequently. A compulsion for measuring and monitoring performance is universal among high-performing revenue cycle organizations. High performers frequently review their chosen metrics, at least monthly and sometimes even weekly or daily. Although the particular metrics selected may be inconsistent among high performers, these organizations are able to measure their own performance and improvements (or declines) over time.

At many of these organizations, focus is on closing the loop between monitoring and reporting performance to users. Real-time is more frequently finding its way into strategies, whether it be error tracking systems for registrars or call length and abandonment reporting for appointment schedulers.

Looking beyond traditional metrics for success.

A number of the high performers look at not only traditional revenue cycle metrics (such as net days in accounts receivable, discharge not final billed, or aging accounts receivable categories), but also nontraditional revenue cycle metrics (such as net-to-cash percentage after 120 days and actual collection at point of service by amount owed). Many high performers said such nontraditional measures are useful to better understand the origin of larger trends and identify opportunities for improvement specific to their organization.

Also, many high performers expressed willingness to go beyond traditional measures of return as a means for measuring effectiveness of large-scale revenue cycle initiatives. Rather than making solely a financial case for change, many organizations examine such factors as patient satisfaction or reduced turnover when making their business case. In many instances, those interviewed expressed achievement in these areas as being even more significant to their strategy than results of financial analysis.

Seeking the consumer's perspective. Most high-performing organizations are measuring some form of patient satisfaction—for example, relying on Press Ganey scores or feedback from patient focus groups or patient councils. However, many of these organizations are working to improve the specific satisfaction measures they are using and timing of these efforts. Traditionally, patient satisfaction feedback has been collected prior to the patient's receipt of the bill. High performers, therefore, are looking into ways to assess satisfaction later in the process, so they receive enhanced perspective on billing and collections performance.

Also, although most hospitals' efforts at measuring patient satisfaction are designed around the clinical care experience, organizations are beginning to recognize the importance of better understanding revenue cycle impressions. High performers appreciate that issues such as ease of completing paperwork and understanding billing processes, quality of interactions with admitting and registration staff, and expectations and sensitivities regarding collections can be significant for patients.

Real-Time Metric Use at Baptist Hospital of Miami

Baptist Health South Florida operates a centralized call center, which services not only Baptist Hospital of Miami but also other outpatient diagnostic departments spread throughout the Southeast Florida area. The center schedules approximately 40,000 to 42,000 patients per month and provides diagnostic test results to physician offices.

Despite such volume, the center strives to answer 80 percent of all calls within 20 seconds, with a call abandonment rate of less than 5 percent. Large, highly visible monitors are located throughout the center that continuously track call activity, wait times, and other metrics so that agents and their managers can continuously observe their own, as well as the overall group's performance.

Such real-time feedback helps managers quickly attend to performance aberrations and provide additional support as needed. Transparency of tracking also serves as incentive for agents to reach the same performance levels as high achievers.

In addition, all calls are recorded, with 10 randomly selected calls per agent per month reviewed jointly by a quality analyst and the scheduler for both content

and tone. As an incentive for meeting desired measures, agents earn performance points that can be used to "buy" various rewards.

To encourage employee buy-in to its aggressive use of metrics and metric-based goals, Baptist ensures agents have the support they need to succeed. Training processes are designed to provide the necessary foundation of skills and knowledge, which includes exposure to not only information on the scheduling system, scripting, quality standards, and the like, but also courses on medical terminology and human anatomy. New hires shadow "good" employees—first observing, but eventually transitioning to actually taking calls and scheduling appointments. Notably, new employees also are taken on a site visit to all of the locations for which they are scheduling so they can be familiar with locations, directions, and even equipment at the facilities when speaking with patients.

Use of metric-based goals and processes in a setting seen as rigorous but fair provides a solid base for performance excellence.

Nontraditional Revenue Cycle Metrics at CHRISTUS St. John Hospital

As part of its performance monitoring, CHRISTUS St. John Hospital relies on nontraditional revenue cycle measures. These measures were developed with the help of an outside consulting firm that facilitated the redesign of its revenue cycle process. The following are just a few of these nontraditional measures.

120 net-to-cash percentage without self pay. At month end, staff look back to accounts discharged four months previously and determine whether they were paid. In June 2008, for example, staff measured inpatients and outpatients discharged in February 2008 and found that 91 percent of the accounts were closed.

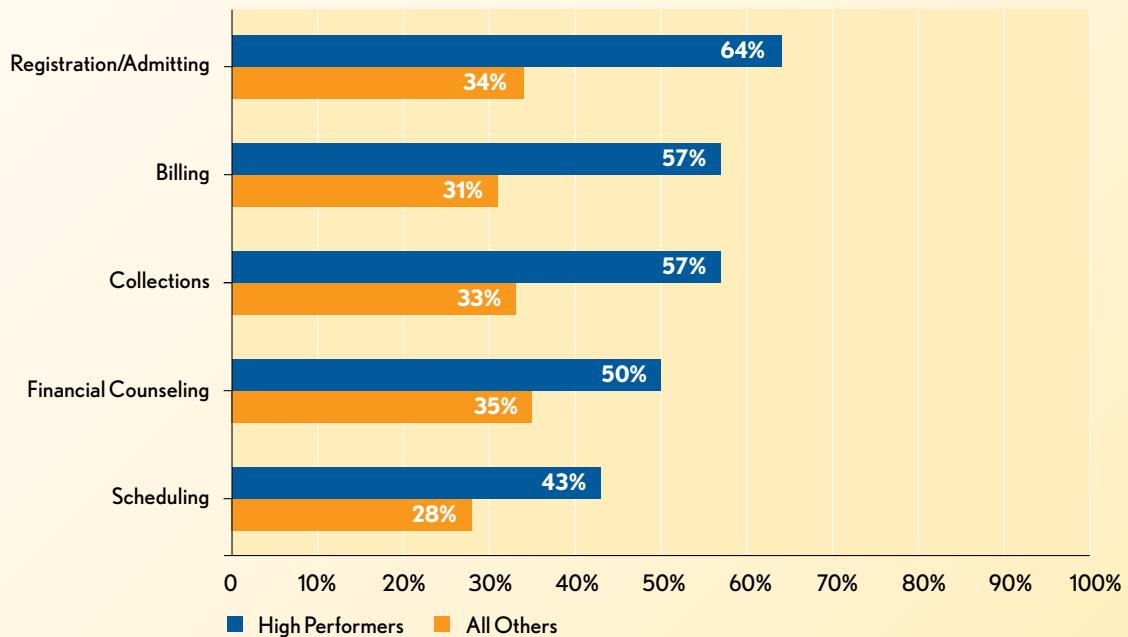
120 net-to-cash percentage with self pay. This metric is the same as the previous one, but includes self pay and, thus, it always has a lower percentage.

Quality/length of time to liquidate (without self pay). This metric looks at efficiency in receiving payment. For example, of the 91 percent collected in the aforementioned metric, it considers the percentage collected during the first 30 days, 31 to 60 days, 61 to 90 days, and 91 to 120 days. Staff bonus plans are built around this metric.

Time of service collection potential. This one measures the actual collection at point of service and compares it with the amount owed, 30 days out, after payment from insurance. CHRISTUS St. John had been collecting 45 percent in May 2008, but was collecting 52 percent as of July 2009.

Degree to Which Revenue Cycle Is Patient Friendly

**In your opinion, how patient friendly is your organization's revenue cycle?
1 = Not at All to 7 = Completely Patient Friendly. (Percentage indicating 6 or 7)**



Communication

Communication between hospitals and their patients is extraordinarily complex. The healthcare landscape is littered with medical and business terminology and acronyms that are unfamiliar and may even be daunting to the vast majority of the population. These barriers, coupled with complex regulatory and payer requirements that often focus on how and when information is conveyed, often create significant communication challenges.

As such, high-performing revenue cycle hospitals place great emphasis on the effectiveness with which they communicate with patients and their families. Actions typically focus on supporting a positive scheduling/registration experience, providing estimates of financial obligation, publicizing financial assistance, developing clear and simple formats for billing materials, and establishing consistent external communications.

Supporting a positive scheduling/registration experience.

One of the best ways to support successful communications with patients is to minimize redundant interactions. Many of the high-performing hospitals have streamlined processes by converting to centralized scheduling and/or registration for hospital departments where doing so offers efficiencies or potential for service improvement. Even in instances where scheduling and/or registration remain decentralized, effort is expended to ensure that patient information is shared by departments.

Also key is ensuring consistent messaging during these interactions. High performers frequently provide staff with scripting and monitor their conversations with patients for accuracy, friendliness, and overall appropriateness. Making scheduling and registration resources available in multiple languages also helps support standard communications.

Providing estimates of financial obligations. Efforts to enhance communications and service to consumers often focus on providing patients with estimates of their anticipated out-of-pocket expense prior to delivery of services. Although high-performing revenue cycle hospitals generally aspire to make this information available to patients through patient portals on their

web sites, currently they provide these estimates to patients through a variety of communication mechanisms, including phone or mail.

Although hospitals and health systems increasingly are using average cost information for procedures or services to develop preservice estimates for those without insurance, most organizations still struggle with out-of-pocket cost estimation for the insured. Technology is aiding these efforts considerably, with some hospitals now able to apply (to a limited extent) a payer's negotiated contract rate, deductible, copayment, and co-insurance percentage through automated means.

Publicizing financial assistance. Also an important communications priority for high performers is educating patients and their families about charity care, early pay discounts, and other potential financial arrangements or resources prior to or at the time of service delivery. Ways some high performers publicize their charity care policies include posting charity care information on their web site, inside billing communications, and in brochures at registration desks. Further, a number of individuals throughout the organization have the ability to grant charity care to patients meeting predetermined criteria.

It should be noted that while all of the high-performing hospitals offer charity care, there is variation in how charity care policies are made available to potential recipients.

Supporting clear and simple billing and collections materials. High performers place great attention on messaging and communication practices around billing and collections. Such communications can significantly affect a patient's impression of the organization and overall service experience, and the patient's willingness to promptly pay.

To improve consumer understanding of billing communications, high performers simplify their bills by removing acronyms, low-cost items, and nonessential details. Included with bills are letters of explanation that, among other things, discuss what the patient can expect during the billing process.

Staff use carefully crafted scripts and make resources available in the most prevalent languages to support consistency of interactions. Many high performers will also provide patient advocates, when necessary, to work

with or on behalf of patients regarding payer issues. The objective is to resolve denials or other payment barriers that may affect patient financial obligations.

Recognizing the importance of external communications.

Messaging that occurs on-line and in print is particularly important to high performers. These messages often shape the community's first impressions of the organization. Also, educational materials supporting business processes will stay with patients long after they visit.

At high-performing organizations, marketing and revenue cycle staff often collaborate to ensure brochures, billing communications, and on-line content are consistent in messaging and are appropriate and easy for readers to comprehend.

Web site content tends to be comprehensive. High performers often include charge and/or cost information for selected procedures (sometimes by payer), bill status, on-line bill pay options, and, in a limited number of cases, patient test results.

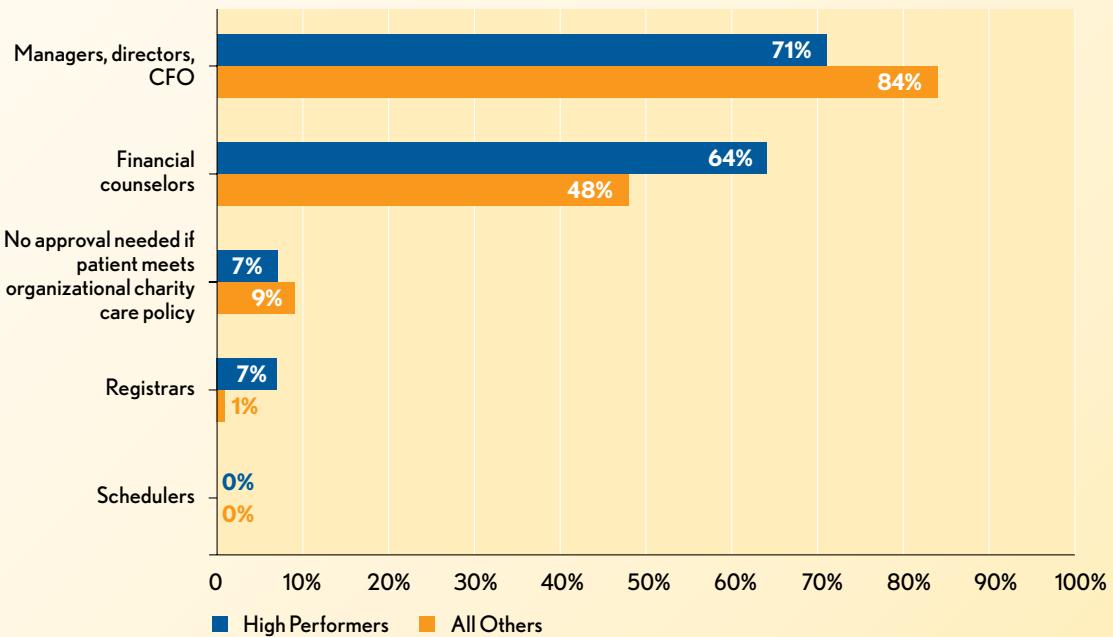
Effectively Communicating the Organization's Financial Services and Charity Care

A key element to clear revenue cycle communications is helping patients and families understand their financial responsibilities for care, and what services or programs are available to help them if needed.

Although community benefit commitments, including the charity care policy, should match what hospitals can afford to deliver given their financial capacity, providers' focus within that capacity should be on helping patients and their families access and pay for needed medical services—and that includes ensuring those who need financial assistance receive it according to a well-published and supported charity care policy, as HFMA president and CEO Richard L. Clarke, DHA, FHFMA, notes in "Revenue Cycle: What's It All About?" (*hfm*, September 2009).

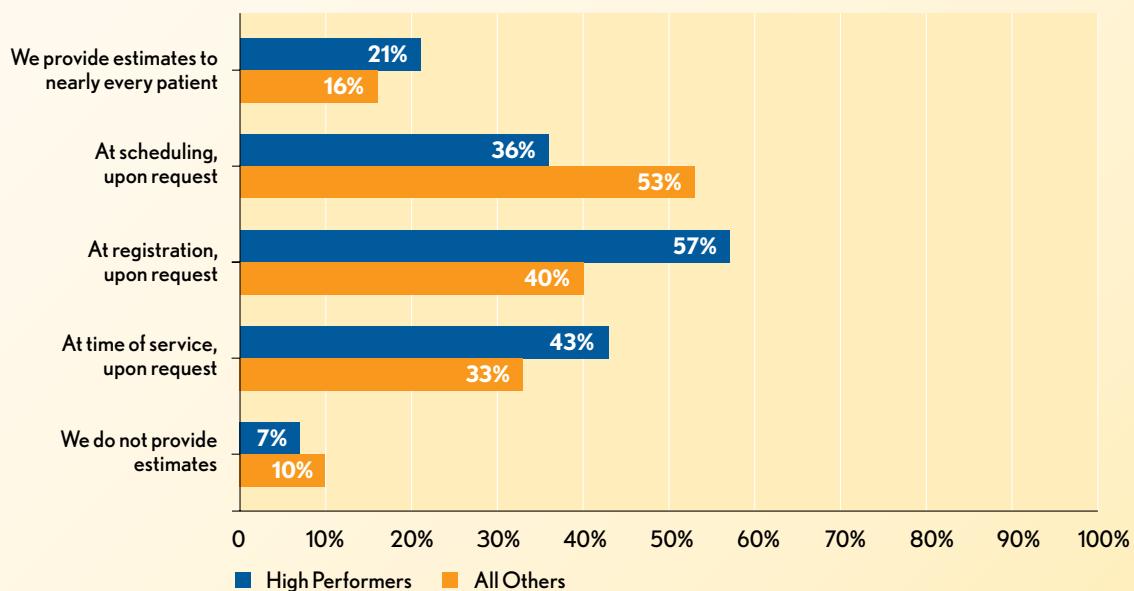
Authority to Approve Charity Care

Who in your organization has the ability to approve the provision of charity care?



Availability of Estimates for Patient Liability

How readily available are estimates for patient out-of-pocket liability?



"My Cost" at Bergan Mercy Medical Center

Bergan Mercy Medical Center, a high-performing 400-bed facility in Omaha, Neb., is moving toward a more meaningful and transparent system for reporting both cost and quality. Leadership hopes that by linking quality scores with personally relevant, meaningful, and actionable cost data, patients will have the information they need to understand the value of their health care and to make more informed choices that can lead to better health outcomes.

With its customized, on-line tool, referred to as "My Cost," the center provides cost estimates based on an individual's health plan coverage for a specific medical test or procedure, along with a patient's out-of-pocket responsibility.

Cost estimates are available for the most frequently utilized hospital inpatient and outpatient procedures, hospital diagnostics (i.e., CT, Lab, MRI, mammography, radiology, X-ray), therapy services, select physician clinic procedures, pharmacy, cosmetic procedures, and Quick Care clinic services. The cost estimates include facility fees, as well as professional fees for any radiology service (e.g., MRI, CT, diagnostic, X-ray, and mammography).

Through "My Cost," consumers can obtain out-of-pocket cost information that is customized to their insurance plan design. Currently, 75 percent of insured consumers, as well as those who are self pay, are able to access cost information through the program. For the 25 percent of insured patients for which data are not available through the tool, estimated costs can be obtained either through e-mail or by phone.

Although the primary driver for the technology is the ability to give real-time, relevant cost information to consumers, the program has had some secondary benefits for consumers and the organization as well, according to CFO Tim Meier. To the surprise of leadership, statistics show more than 80 percent of people using the tool are not those with consumer-driven health plans as was expected, but rather patients without insurance. So "My Cost" has proved valuable for opening communications with self-pay patients about cheaper care alternatives and financial assistance, thereby helping to ease some of the organization's bad debt burden.

Considering Patient Perspective in Communications at Sharp HealthCare

Sharp HealthCare, a not-for-profit integrated regional health care delivery system based in San Diego, uses color as a key element to keep its bills patient-focused. When patients first view a bill, an area blocked in blue immediately draws attention to those elements that may require them to take action, such as a need to verify the accuracy of insurance information, the opportunity to seek charity care, and the amount due from the patient from the total charges. When a patient does not respond after two bills, a third bill is sent that is differentiated with a pink blocked area, versus the blue.

Customer service center staff contributed to the format. "In 2009, we revamped the patient's bill and asked staff to edit the draft based on the comments they often receive from patients during calls," explains Gerilynn Sevenikar, vice president, patient financial services, Sharp HealthCare. "Patients wanted greater clarity around what was really getting billed, according to staff, so we modified the billing format accordingly using color."

Creating a Patient-Friendly Web Site at Henry County Health Center

As a rural, 25-bed critical access hospital, Henry County Health Center in Mount Pleasant, Iowa, has the challenge of using its limited financial resources to effectively communicate with patients over a wide geographic area. To help meet this challenge, HCHC has focused on creating a robust patient portal that enables the hospital to support two-way secured communication between the hospital and patients. Along with functionalities such as a web nursery view and on-line job posting and application processes, HCHC has devoted much attention to the revenue cycle.

Capabilities of the site include:

- Preregistration
- Bill payment
- Patient insurance updates
- Pricing estimates
- Patient satisfaction tools

- A personal health management tool that tracks medical expenses, keeps family health history, stores medication history, logs immunizations, lists patient allergies, and sets diet and fitness goals

As a result of these and numerous other enhancements over the years, in 2007, 2008, and again in 2009, HCHC was recognized as one of healthcare's most wired organizations. More important, the web site is increasingly being used by patients. For the five-month period between August 2008 through January 2009, HCHC's web site had 38,321 site visits and 73,057 page views from 2,199 different cities (in all of 2007, there were 6,970 visits resulting in 12,884 page views).

Clearly, HCHC's web site has proven to be a great communication vehicle for its patients and the vast community it serves. And all this from a 25-bed, critical access hospital!

Culture

An organization's culture is made up of the shared attitudes, values, and goals that it puts into practice. It can be tempting sometimes to dismiss these intangible aspects. Yet how well an organization develops a sense of mission and vision surrounding the revenue cycle can dramatically affect performance. Without the right culture in place, the organization's efforts around people, processes, technology, metrics, and communication will be less than effective. As one executive noted, "When you don't have the right culture, you can only tinker around the edges."

In many ways, addressing issues relating to culture presents the greatest challenge for healthcare executives. It isn't just about creating and sharing a sense of values; it also requires obtaining buy-in toward applying these values to improve the current state.

Organizations with high-performance revenue cycles generally employ several strategies as part of their efforts to address culture. Actions include recognizing importance of the revenue cycle at the executive level, garnering appreciation from nonfinance staff, using patient service as a means for connecting employees with a sense of purpose, setting high expectations, celebrating successes, and encouraging innovation.

Supporting revenue cycle at the highest level.

Among high performers, support for the revenue cycle comes from the top of the organization—not just the top of the finance department. Organizations

with high-performing revenue cycles typically possess leadership that understands and appreciates the critical role that financial performance plays in supporting care delivery. Value of the revenue cycle is elevated through executives' willingness to devote time and resources to issues that affect financial services. Revenue cycle strategy is a key organizational priority.

Garnering appreciation from nonfinance staff.

Several high performers have encouraged a culture of organizational support for the revenue cycle by providing specific and high-level revenue cycle training to nonrevenue cycle departments. Whether providing education to nonfinance and clinical professionals through classes, training manuals, or rotations within the revenue cycle, these organizations seek to foster better understanding of revenue cycle workings and help participants understand how they can positively impact the revenue cycle through actions within their own departments. Such efforts also help to cement revenue cycle contacts and networks throughout the organization and garner a culture of deeper appreciation for revenue cycle functions.

Finding purpose through the patient. High performers recognize that successful financial services are a key contributor to patient satisfaction. Consumer-focused processes and communications are just a start. At these organizations, employees understand how their interactions with patients directly contribute to the quality of the patient's care.

Finance 101 at Touchette Regional Hospital

At Touchette Regional Hospital, a 105-bed facility in East St. Louis, Ill., leadership has sought to make revenue cycle an organizational priority. This emphasis includes expanding revenue cycle discussions beyond the business office.

John Majchrzak, Touchette's vice president of finance, created and conducts a "Finance 101" curriculum for all managers throughout the organization, including those from departments as diverse as radiology and housekeeping. The goal of these sessions is to create a common understanding of the hospital's finances and supporting revenue cycle

processes. Management education of the revenue cycle recently included a second course focused on health reform on a broad basis and the expected impact to the hospital as well as to individuals. By offering such education to those outside of finance, leadership believes that employees will gain a more complete understanding of not only the financial opportunities and obstacles that the hospital faces, but their role in addressing these challenges and providing a consistent high-quality experience for those patients visiting Touchette.

Recognizing Revenue Cycle Staff at Valley Health System

For the past decade, Valley Health System, a Ridgewood, N.J.-based system comprising The Valley Hospital, Valley Home Care, and Valley Health Medical Group, has had a finance morale committee that holds an event for employees almost every month. The finance morale committee celebrates promotions, holds lunch celebrations where performance-based cash incentives are awarded, and fosters a sense of unity with staff through social activities, such as

holiday-themed parties. Members of management participate and attend these meetings on a rotating basis. Josette A. Melillo, Valley Health's patient accounts director, financial administration, notes that Valley's CEO was in attendance at a recent event and made a point to say thank you to staff and recognize the positive effect that high-quality financial service has on customers. "You need support from the top, and we definitely have it," Melillo said.

At Spectrum Health in Grand Rapids, Mich., the pride of all the hospitals in the system was evidenced when leadership chose a very visual way to demonstrate this relationship. At an employee meeting, a recent patient was asked to the stage. One-by-one, the many employees who played a role in that patient's hospital stay were then asked to join him. In addition to the expected group of clinicians, these individuals included the revenue cycle staff who helped to schedule care, coordinate with the insurance carrier to ensure appropriate communication and certification of care, maintain the medical record, create an accurate patient bill, and address any other financial issues. By the time the roll call ended, more than 100 employees were on the

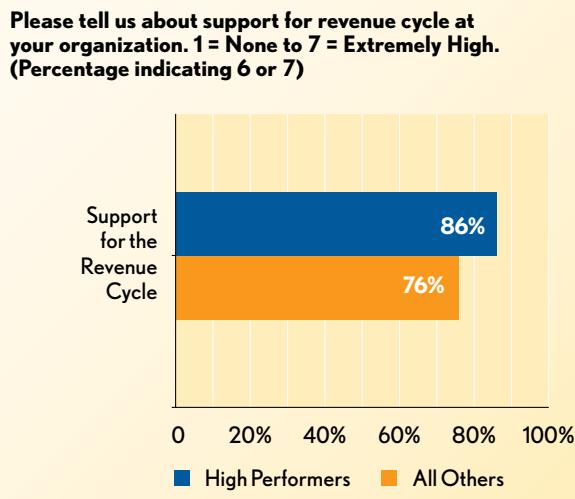
stage celebrating the patient's favorable clinical outcome and experience—a true connection to purpose.

Demanding high performance. High performers are rarely satisfied. Leadership demonstrates a passion to do better and drives excitement around improvement initiatives.

Interestingly, not one of the managers, directors, or executives interviewed thought their organization had approached the pinnacle of patient-friendly revenue cycle performance despite ranking among the best in the nation. What's more, despite their many accomplishments, virtually all of those visited identified a number of areas in which they are enthusiastically pursuing further enhancements to revenue cycle processes or technology.

Celebrating success. Although high performers understand that there is always room for improvement, they also are not hesitant to celebrate their victories through employee recognition and incentives. Whether through letters of recognition, monetary incentives tied to performance, or simple verbal acknowledgement of jobs well done, leadership focuses on identifying and celebrating excellence. As just one example of integration of this approach with culture, consider the experience of high-performing Sharp Grossmont Hospital. Part of its five "must have" practices to support behavior standards include one that notes: "Foster an attitude of gratitude. Send thank-you notes to deserving employees."

Level of Support for the Revenue Cycle



Making innovation a priority. High performers generally possess a willingness to be innovators or early adopters of new processes or technologies. If following tradition is not working for them, they are quick to search out new ways that would be better suited. Being an innovator means they occasionally risk results that may not deliver as planned. That said, they often reap benefits associated with being quick adapters to change.

As an example of innovation in action, Carolinas Healthcare System—which owns, leases, and manages 25 hospitals, including high-performing Carolinas Medical Center—was the first healthcare provider in the country to integrate palm scanning technology into

its revenue cycle processes. The technology supports patient identification through recognition of the distinct pattern of veins in a person's hand (said to be even more singular than a fingerprint). Each patient's palm is scanned, recorded in a registry, and assigned a number that can be instantly matched with the patient's medical record. Although such a significant investment presents multiple risks, the organizational culture is one that is willing to tread in new territory if it means minimizing patient need to supply identification and medical history information multiple times. The results to date? Carolinas has provided a more satisfying and safer customer experience by minimizing the potential for patient misidentification, data theft, and data entry errors.

An Innovator's Twist on PACS Monitors at CHRISTUS St. John Hospital

CHRISTUS St. John Hospital is leveraging nontraditional technology in new ways. During a departmental redesign and improvement study, it was identified that billers were spending significant time scrolling and switching between screens. Although this seems like a minor inconvenience, the collective time wasted throughout the day and throughout the department was substantial. CHRISTUS St. John Hospital implemented a side-by-side monitoring system,

commonly used in IT departments, to reduce the screen flipping. In addition, PACS radiology monitors (i.e., extra long monitors that can be flipped on their end) were installed for billers accessing the UB-04 form, whose length requires one to scroll up and down the screen as data are input. The extra-long monitors, flipped on end, now allow the billers to input the data without any scrolling—a creative fix saving time and satisfying users.

Delivering High Performance

Although organizations pursue a variety of strategies to attain revenue cycle excellence, results of the research are clear: High performance doesn't just happen. Those hospitals and health systems that are making good on efforts to realize patient-focused and value-driving revenue cycle processes have done so by instilling organizational commitment to their goals.

Efforts must reach beyond the business office. Revenue cycle performance is affected by those across the organization, with success dependent on support from health information management, physicians, nurses, and IT, to name only a few. As such, key actions will be needed from both the C-suite and revenue cycle leadership to attain the widespread support vital for achieving high performance.

Roles in Driving Value

C-suite executives as well as revenue cycle leadership will need to take active roles in ensuring organizational dedication to improvement in the revenue cycle. The significance of revenue cycle to achieving the organization's mission needs to be communicated throughout the organization.

Executives. At the organization's executive level, it is important that leaders focus on instilling an elevation of the revenue cycle at both strategic and operational levels:

- Set high expectations for revenue cycle positions.
- Devote organizational resources to improved training and compensation.
- Develop and participate in intraorganizational teams around revenue cycle.
- Use patient experience as the cornerstone for setting revenue cycle strategy.
- Appreciate community dynamics when prioritizing technology spending.

- Encourage improved monitoring of revenue cycle processes through use of nontraditional metrics.
- Develop and enforce systems of accountability around monitoring and reporting practices.
- Support organizational alignment around clear, correct, and patient-friendly messaging.
- Establish clear and transparent financial assistance policies and procedures.
- Demonstrate value for the revenue cycle through significant commitment of time and resources.
- Establish systems to reward high revenue cycle performance.

The importance of executive buy-in to revenue cycle improvement can't be emphasized enough. The role senior leadership plays in pursuing the above actions is fundamental for organizations to truly be effective in executing any operational change.

Revenue cycle leadership. At the revenue cycle leadership level, focus should be on ways to extend these concepts into everyday practice. As such, revenue cycle leaders will play key roles in not only developing and implementing tactics to support high performance but energizing the organization around these tactics as well.

To set high expectations for revenue cycle positions:

- Hire only the most appropriate staff
- Create detailed job descriptions that outline optimal staff qualifications and skill requirements for revenue cycle positions, and work with executive leadership and human resources so these descriptions align for a natural career path progression from one position to the next
- Develop and provide formal and informal continuing education, with ongoing training targeted for revenue cycle problem areas
- Seek improved compensation structures as well as other efforts that drive employee satisfaction, such as bonuses for achieving performance goals or work arrangement flexibility

To encourage patient-focused revenue cycle process improvement throughout the organization:

- Apply teams of both revenue cycle staff and nonrevenue cycle staff around key process challenges
- Support inclusion of patient focus groups or advisory councils, ongoing and at the outset of any significant revenue cycle improvement initiative
- Prioritize process improvements based on what will have greatest impact on patients (Chances are, your top to-do list will include education surrounding out-of-pocket financial obligation and access to financial assistance.)
- Consider use of established improvement methodologies to assist in defining and streamlining processes

To support value-driving technology investment:

- Ensure solid processes are in place prior to seeking fixes through automation
- In addition to financial factors, weigh impact on patient base when making a business case for technology investments

To encourage improved supervision of revenue cycle processes:

- Strive for performance monitoring and reporting that is frequent and actionable
- Seek opportunities to provide feedback as close to performance occurrence as possible
- Explore metrics that others are using and how they are using them to discover new ways to learn more about your organization's revenue cycle performance

To establish communications that are clear, correct, concise, and patient friendly:

- Streamline the number and repetitive nature of interactions required of patients
- Ensure written billing statements, applications for financial assistance/charity care, and other financial communications explain what the patient can expect and where to obtain additional help (Use easily understood language, make it available in multiple formats, and provide the communication in other languages if needed.)

- Supply scripting to staff and similar language on web sites and printed materials so patients receive consistent, appropriate messaging from the time of appointment scheduling through payment processes

To instill a culture of value for the revenue cycle:

- Create a shared understanding of the importance of the revenue cycle by finding opportunities to demonstrate the impact of revenue cycle functions on patient satisfaction (Educate staff about the many ways their actions can influence the patient's experience.)
- Demand revenue cycle performance excellence and celebrate when high achievers are able to obtain it (Whether expressed through formal incentive programs or simple notes of gratitude, recognition of success fosters a sense of enthusiasm and motivation for performance improvement.)

Positioning for the Future

Despite how daunting these actions may seem at first glance, particularly given the current environment, it's important to know that challenge alone should not become an excuse for lack of action. As the research has shown, high performers don't always have the latest technology in place or belong to organizations with the most financially desirable characteristics.

What these organizations do possess, however, is a spirit of perseverance. Regardless of the particular revenue cycle strategy pursued, an organization's dedication to successful execution makes the difference.

High performers aren't just good at setting goals. Organizations able to realize their goals possess both the competencies to recognize opportunities and enthusiasm to put these goals into action. Simply put: Attitude makes the difference. Those organizations that stay the course on performing well in those areas that are most important for delivering value to their organizations and the patients and communities that they serve will be best positioned for future success.

Epilogue: Putting the Patient Friendly Billing Vision into Practice

The Patient Friendly Billing project's 2006 report, *Consumerism in Health Care—Achieve a Consumer-Oriented Revenue Cycle*, exposed radical changes for the experience of the patient in 2011.

How close is anyone today to achieving this vision? In many ways, Geisinger Health System, an integrated healthcare delivery system with headquarters in Danville, Pa., has stepped up to the challenge. Practices listed below, observed in 2009, show great strides toward realizing this "future" patient experience.

"Jack" visits his internal medicine physician to follow up on a sinus infection.

Patient Friendly Billing Vision	Geisinger Practice
M ORNING	
Jack makes this appointment using his physician's secure web site.	Geisinger offers on-line appointment scheduling capability, patients can request and/or make their appointment online via MyGeisinger.org.
Jack updates his medical file with a description of the symptoms from his persistent sinus problems.	Patients can view their medical history on-line, and submit concerns to their physicians online. Symptoms cannot be added at this time.
Jack also updates his insurance and address information on file.	Patients can update demographic information (address, phone, e-mail) and submit insurance updates via e-mail. Patient self-service to update insurance coverage is not yet available.
When scheduling the appointment, Jack receives an electronic message that he will be responsible for a \$40 copay for the visit.	MyGeisinger.org does not provide the patient with a display of copay due when scheduling the appointment via MyGeisinger.org. Patients are presented with estimated copayment amounts when they view their upcoming appointments. Patients are able to price their services on-line using Geisinger's "Cost Care Estimator."
After Jack's exam, his physician determines that he does have a sinus infection and needs an antibiotic. She checks Jack's medication history through the electronic health record (EHR).	Geisinger's integrated EHR is available throughout the health system and allows all providers involved in Jack's care to see his medical history.
The EHR alerts the physician to a potential adverse medication interaction.	EHR has alerts built into the system for adverse medication interactions.
The EHR recommends generic alternatives.	EHR has formularies built into the system that alert the physician to generic alternatives.
The EHR details pharmacy costs for the drug.	Pharmacy costs are not available in the EHR.
The physician sends an e-prescription to the pharmacy.	All prescriptions are sent via e-prescription to the patient's pharmacy of choice.
The physician documents Jack's medical exam in the EHR, and orders a sinus CT scan and a follow-up visit. Before leaving the physician's office, Jack uses a kiosk to schedule the sinus CT scan that evening at the hospital.	Patient self-scheduling is not available on kiosks at the present time. However, staff can schedule follow-up, ancillary, and specialty appointments on-line at any time.
When scheduling the appointment, Jack receives driving and parking instructions.	Patients receive a summary of future services and locations. Patients also receive reminders of future appointments with driving and parking instructions (reminders are available electronically to the patient's e-mail address if this is a preferred method of communication); if the patient views the appointment in MyGeisinger.org, there are driving and parking directions provided to the respective service area.
Jack also receives information about what to expect during the CT scan during scheduling.	When an appointment is scheduled (at point of check out or otherwise), the patient is provided with instructions and information on what to expect. This is also followed up with patient instructions that accompany the appointment reminder notice sent to the patient's home (or electronically if that is the communication method of choice).
Jack also receives an estimate of the amount he is expected to pay at the time of the CT scan during scheduling.	Estimates are provided to patients via the pre-financial clearance process in advance of the appointment date.

Patient Friendly Billing Vision	Geisinger Practice
A F T E R N O O N	
When Jack arrives that evening at the hospital to register, the receptionist greets him by name. She recognizes him from her screen, which shows photographs of all patients registered for procedures.	Geisinger has the technology infrastructure to do this and is evaluating deploying this functionality in light of the Red Flag rules.
The hospital's information system automatically re-verifies his eligibility, benefits for the procedure ordered, deductible status, and copay.	This is currently in place via Geisinger's EHR, which is integrated with the electronic insurance eligibility application. All scheduled events are checked in advance of visit—all others are verified same day.
After Jack's CT scan, the radiologist checks his notes, which were entered via automated speech recognition software from his dictation as he reviewed Jack's scan.	Not available at this time.
He steps into Jack's room to give him the preliminary results of the scan.	This is currently available with EHR.
He electronically sends a follow-up note to Jack's physician.	This is currently available with EHR.
He electronically signs the health record.	This is currently available with EHR.
The actions automatically post to the physician and hospital billing systems.	This is currently available with ancillary information systems.
The insurance claims are sent in real time to Jack's health plan.	Electronic insurance claims generate two days post patient visit.
Diagnosis and procedure coding is validated consistent with EHR documentation.	Diagnosis and procedure codes are validated consistent with EHR documentation.
The insurer adjudicates the claims, and within seconds the physician and hospital receive electronic payments.	Real-time adjudication is not currently available.
Jack pays his personal liability with a debit card from his HSA.	Point-of-service collection is available—a patient's FlexCard is treated as a debit card to process payment. The patient's payment posts the same day.

With this vision, physicians are able to focus on providing exceptional patient care, the insurer has everything necessary to electronically process the claim on the first try, the hospital has zero days in accounts receivable, and, most important, the patient has a seamless clinical and financial experience—a true win for all.

About the Survey and Selection Process

The selection process included three screening processes and culminated in site visits with 14 high-performing revenue cycle hospitals, followed by a survey to compare and contrast findings with common industry practices.

First Screen

Relying on 2006-07 data from the American Hospital Directory (www.ahd.com), researchers used measures of the revenue cycle, financial performance, and patient satisfaction to identify a group of potentially high-performing hospitals from a national pool of more than 5,000 nongovernment, short-term acute hospitals. Hospitals were first screened by days in accounts receivable. Those scoring in the 90th percentile or better were then segmented for further consideration. These hospitals were then measured on three additional metrics: patient willingness to recommend the organization, return on assets, and operating margin. Those making it into the next round of screening needed to score above median in all three of these metrics.

Second Screen

The hospitals then received a score based on their percentile ranking within each metric. Each hospital's total points were then summed and the 150 hospitals with the highest total scores were identified as potentially high-performing hospitals. Analysis was completed to ensure that the hospitals identified as "high performing" included a reasonable cross-section of hospitals in terms of bed-size, geography, tax status, system-affiliation versus independence, and teaching status.

Third Screen

With the objective of identifying highest revenue cycle performers within this pool, researchers sent an electronic survey seeking data on performance level to

approximately 150 hospitals. Beyond basic elements such as the hospital's payer mix and revenue cycle information systems used, the survey requested calculations specific to the following revenue cycle metrics:

- **Discharged Not Final Billed (DNFB)** defined as $(\text{Gross Patient Revenue})/(\text{Total Gross Patient Revenue}/365 \text{ Days})$
- **Net Days in Accounts Receivable** defined as $(\text{Total Net Accounts Receivable[A/R]})/(\text{Total Net Patient Revenue}/365 \text{ Days})$
- **Accounts Receivable over 1 Year as a Percentage of Billed Accounts Receivable** defined as $(\text{Total Net Accounts Receivable} > 365 \text{ Days})/\text{Total Net A/R}$
- **Bad Debt Expense as a Percentage of Net Patient Service Revenue** defined as $(\text{Total Bad Debt Expense})/\text{Net Patient Service Revenue}$
- **Cash Collection as a Percentage of Net Revenue** defined as $(\text{Total Cash Collected})/\text{Net Patient Revenue}$

The hospitals then received a score based on their percentile ranking within each metric. Adjustments were made to the scores for net days in accounts receivable and bad debt expense as a percentage of net patient service revenue, correlated with Medicare and self-pay volumes, so hospitals were not rewarded or penalized for payer mix. Each hospital's total points were then summed. The 14 hospitals that researchers visited were selected based on their ability to represent a cross-section of the nation's hospitals in terms of bed size, geography, system, or independent status, and teaching affiliation.

Onsite visits included interviews with leadership and staff in relation to such practical concerns as process flow, revenue cycle organizational structure, communication practices, and technology deployment. The results of these interviews not only are being featured in this report, but also will be included in future resources being made available at www.patientfriendlybilling.org.

High-Performing Contributors

Patient Friendly Billing project leaders express their deepest appreciation to the following high-performing hospitals for their willingness to share their expertise through onsite visits and extensive interviews:

- Baptist Hospital of Miami
- Baylor All Saints Medical Center at Fort Worth
- Bergen Mercy Medical Center
- Carolinas Medical Center
- CHRISTUS St. John Hospital
- Geisinger Medical Center
- Henry County Health Center
- Legacy Meridian Park Hospital
- Oaklawn Hospital
- Redmond Regional Medical Center
- Sharp Grossmont Hospital
- Spectrum Health Grand Rapids
- Touchette Regional Hospital
- The Valley Hospital

HFMA Revenue Cycle Resources

A variety of resources are available through HFMA for meeting today's revenue cycle challenges. Those of particular interest include the following.

Video-Based Training Modules

www.hfma.org/store/TrainingSeries

HFMA's Revenue Cycle offers two video-based training modules: Module 1: Excellence in Customer Service, and Module 2: Mastering the Revenue Cycle from Key Concepts to Clean Claims to Denials Management.

On-line Training

www.hfma.org/events/e-learning/

HFMA also offers on-line training at the individual and organization level.

Individual/organizational instruction. HFMA offers two revenue cycle e-learning courses. The first, "Mastering Patient Access," is geared to patient access staff. The

course provides about 25 hours of training. The second course is "Mastering Medicare Billing." The course provides nearly 48 hours of training.

Organizational instruction. At the organization level, HFMA offers a credentialed revenue cycle representative (CRCR) program. The program consists of an on-line self-study course and an on-line proctored exam to obtain the CRCR credential. Participation is geared toward revenue cycle professionals in such areas as patient access, finance, patient accounts, managed care, health information management, and compliance. The CRCR program provides 12 to 15 hours of training for CRCR certification.

HFMA Revenue Cycle Forum

www.hfma.org/forums

HFMA's Revenue Cycle Forum provides job-specific content to assist with job function, continuing education, and networking.

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