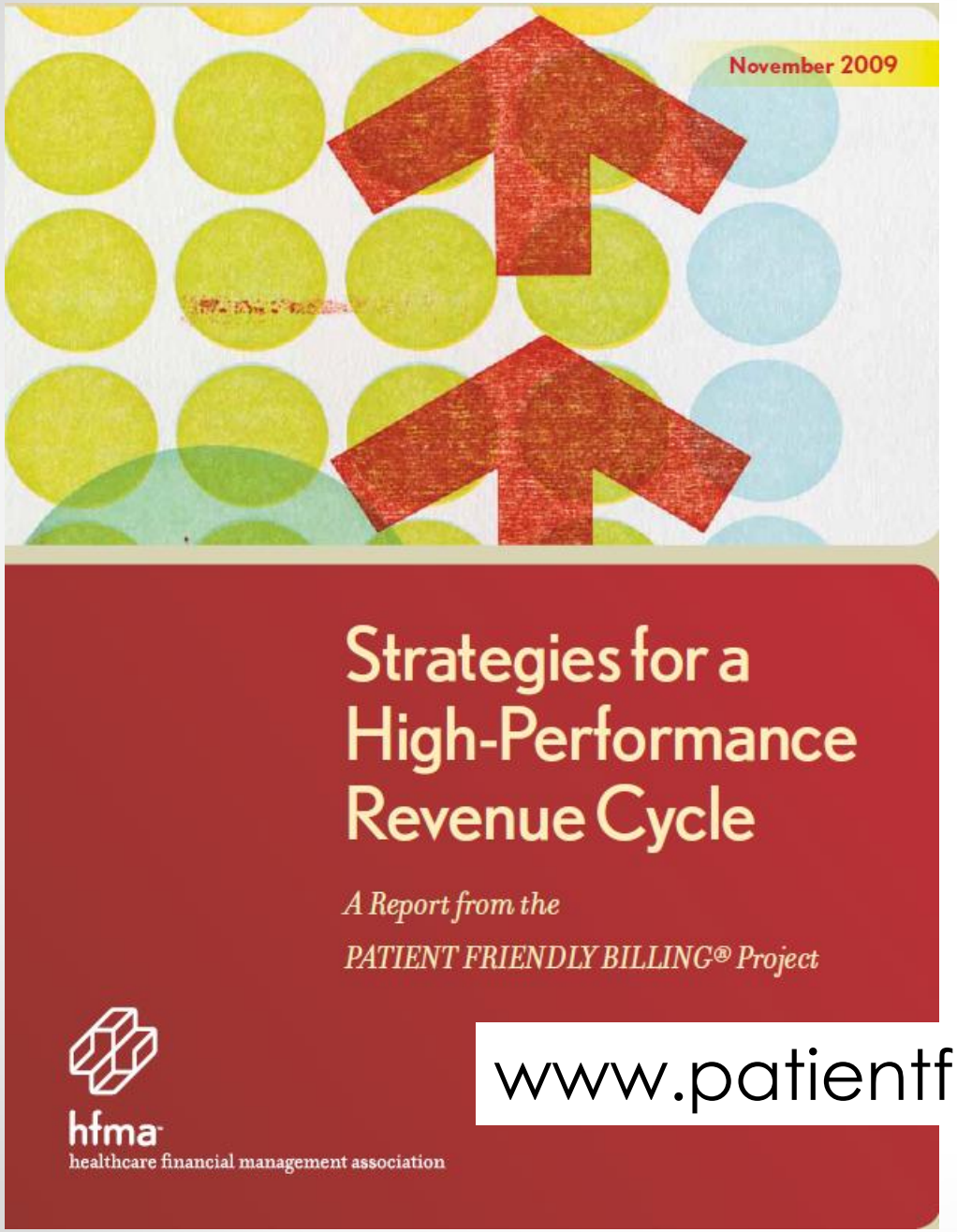
Draffin & Tucker, LLP
CERTIFIED PUBLIC ACCOUNTANTS

PFS Leadership

Achieving revenue cycle excellence



www.patientfriendlybilling.org

The foundation for any successful organization is its people.

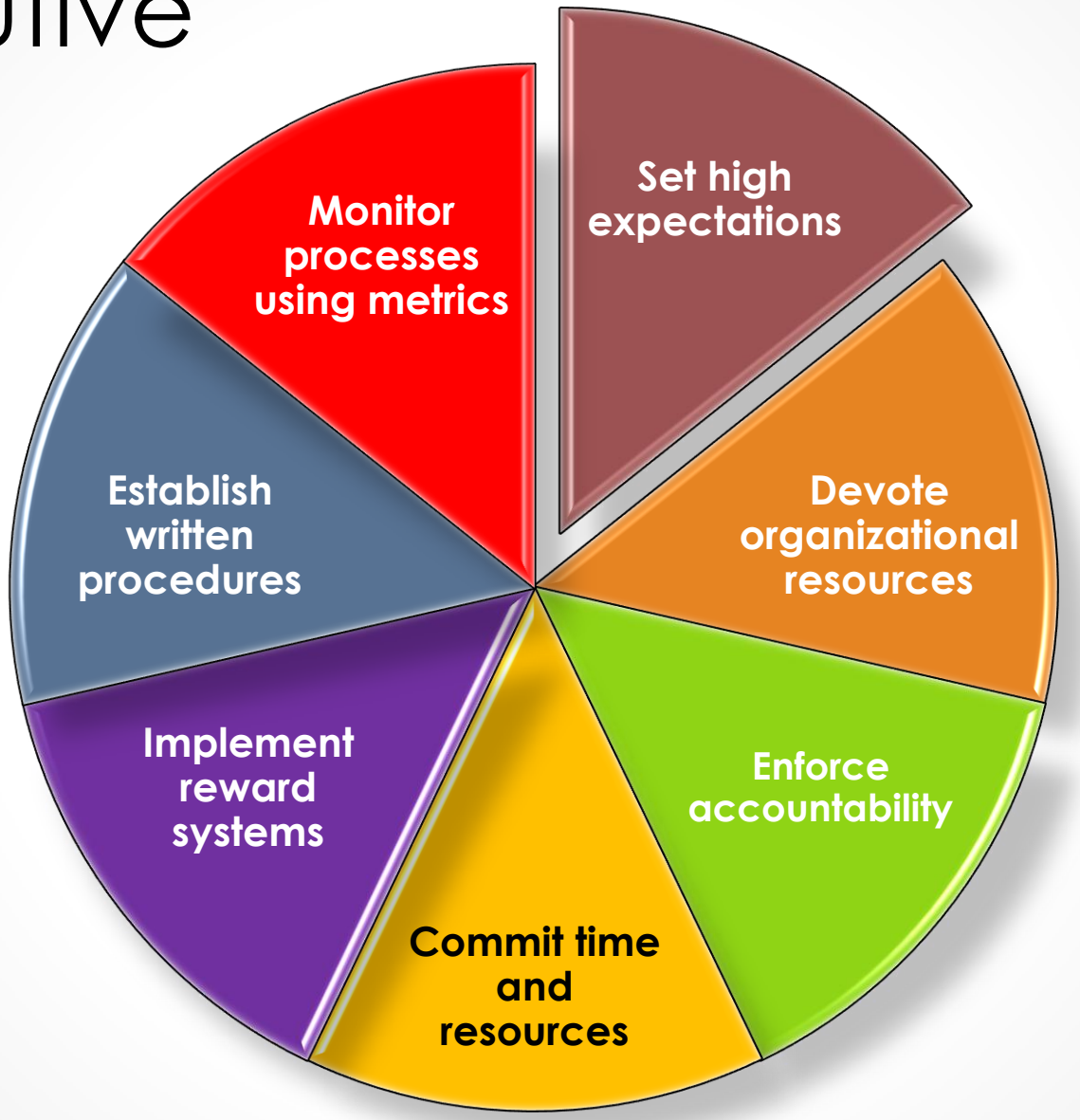
High performance doesn't just happen!

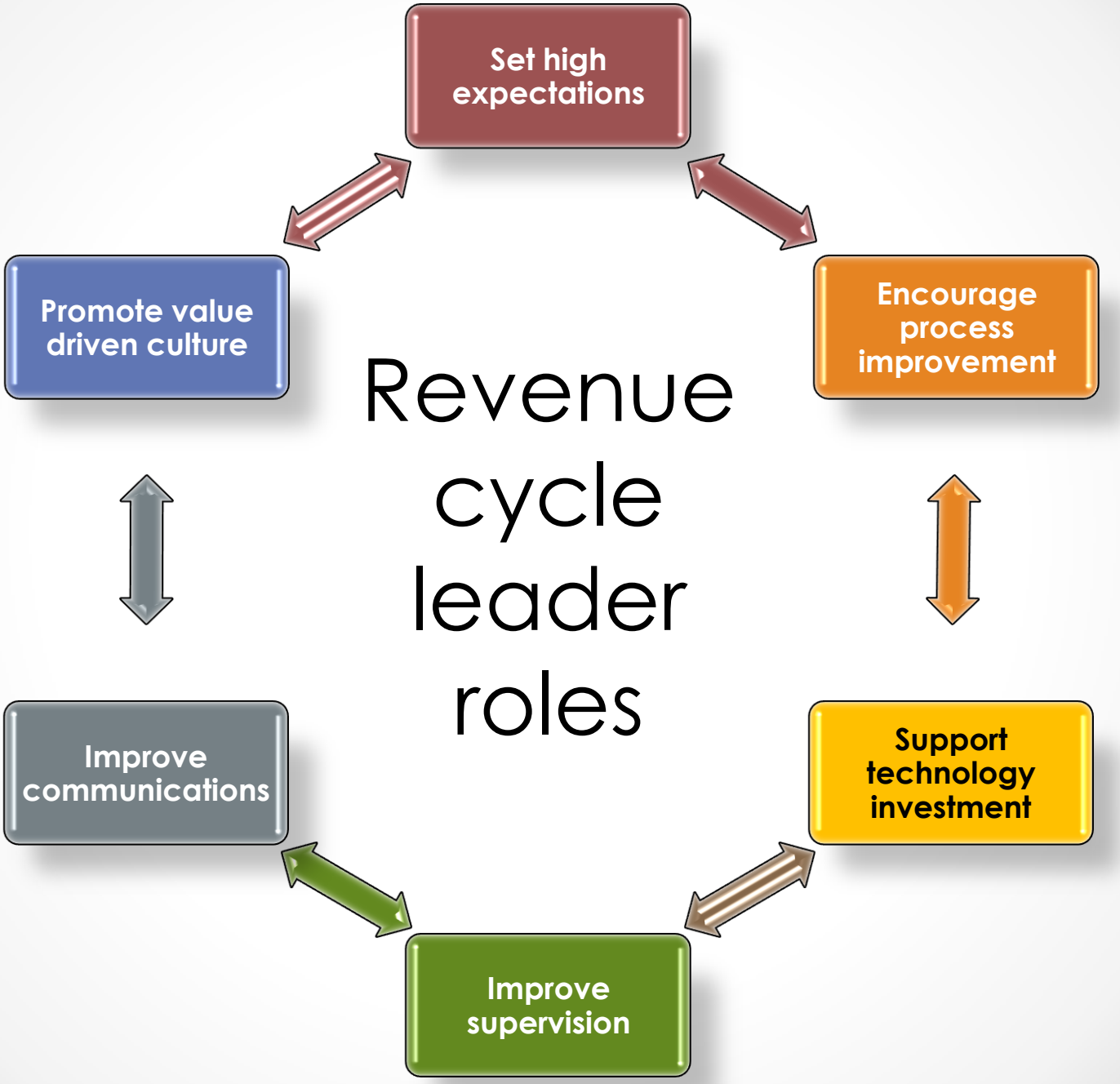
It must be expected, nurtured and promoted as part of the culture.

Those hospitals that have good revenue cycle processes have done so by gaining leader and staff commitment to meeting organizational expectations.

Commitment goes beyond the business office to all sectors of the revenue cycle, as well as, hospital executive leaders.

Executive level roles




Set high expectations
Encourage process improvement
Support technology investment
Improve supervision
Improve communications
Promote value driven culture
Revenue cycle leader roles

Set high expectations

Hire only the most appropriate and qualified staff despite limited pools of qualified applicants and significant turnover

Set high expectations

The right people in the right roles . . .

Minimum education requirements
Minimum experience
Certification levels
Personality attributes

Set high expectations

Significant time in training new and existing staff to handle job demands

New employee training
Lunch and learn
Certification training

Set high expectations

Stepping stone or career?

Limited experience

Interim attitudes

High turnover

Lower morale

Increased training costs

Set high expectations

Create revenue cycle career ladders using . . .

Evidence based promotions

Tenure
Experience
Training
Professional certification
Performance
Exams

Set high expectations

Compensation Arrangements

- Competitive compensation (64%*)
- Accountability with performance incentives (86%*)
- Flexible work arrangements (64%*)

  Work from home office
  Part-time work
  Non-traditional hours

* Percentages of high-performing organizations which use strategy.

Encourage process improvement

Oversight

Project based

Two types of process improvement teams

Oversight

- Meet monthly
- Evaluate key financial and revenue metrics
- Emphasize trending of metrics
- Develop overall strategies for improvement
- Led by CFO or senior revenue cycle leader
- Participation by revenue cycle department leaders

Project-based

- Address specific issues or tasks
- May meet routinely or on temporary basis
- May include participants from
  - Finance
  - IT
  - Clinical areas
  - Compliance

High performing organizations tend to have fewer overall revenue cycle meeting, but more meetings targeted to specific issues.

Support technology investment

Research has shown that high performers do not always have the best technology or work in the most financially viable organizations.

Support technology investment

However high performers are found in organizations that are dedicated to making the changes needed to move toward success.

Support technology investment

Automation alone will not guarantee high performance. Solid processes must be in place prior to seeking fixes through automation.

Improve supervision

Monitoring and reporting must be frequent and actionable.

Improve supervision

Provide feedback as close to the performance occurrence as possible

Improve supervision

Understand and select metrics that will provide insight into revenue cycle performance.

Improve communications

- Streamline interactions required of patients.
- Ensure written communications are clear and understandable.
- Supply scripting to staff so patients receive consistent and appropriate messaging from time of registration until payment.

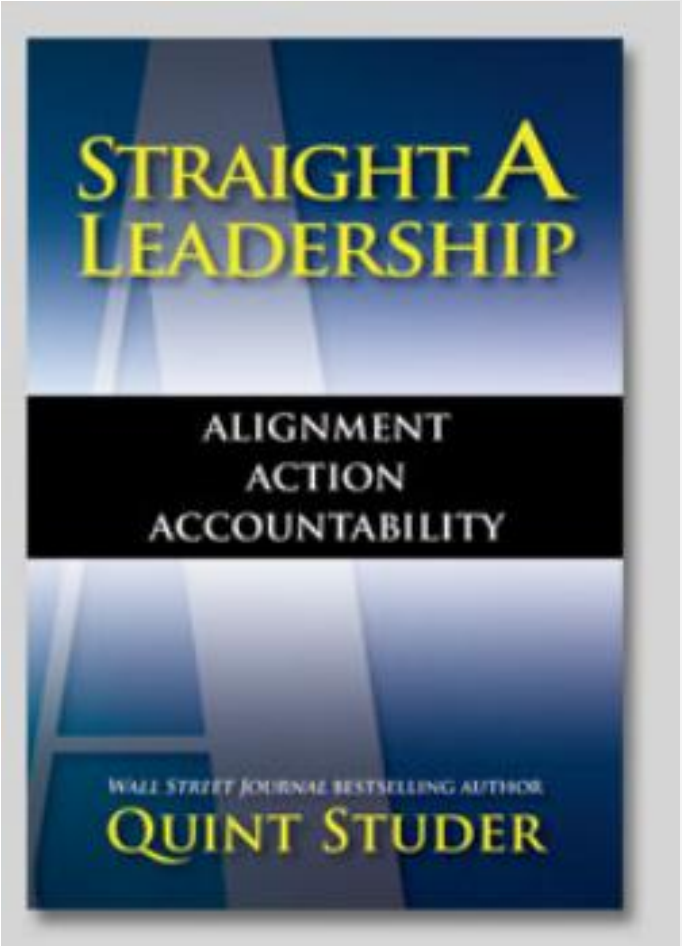
Promote a value-driven culture

Create a shared understanding of importance of revenue cycle.

Promote a value-driven culture

Demand performance excellence and celebrate when high achievers are able to attain it.

How do we achieve performance excellence?



Leaders must be aligned

Get everyone on the same page.

Often, leaders don't tell employees what is going on because they don't want to burden them.
That's my job, they think. But good intentions don't always mean good results.

If everyone in the department (organization) doesn't truly understand the behavior that's needed to be successful, the department (organization) won't achieve its goals.

All department employees, leaders and staff, must offer ideas on what can be done to improve operations during these tough times.

What role does transparency play in alignment?

All leaders are not accountants or financial experts.

All leaders are not clinicians.

We often assume that others know what is going on to affect the decisions we make.

Oftentimes staff may assume the worst, while others think the hospital is "bulletproof".

Leaders need to be transparent in order for their peers and staff to trust in the decisions being made.

How can we expect people to not only accept change, but embrace change, if they don't know **why** we are asking them to change?

We need to explain why we are building a new building or starting a new service at the same time we are cutting staff or freezing expenses.

And those explanations need to be consistent!
From leaders to staff
From leaders to physicians
From leaders to the community

There must be alignment among all leaders in order for the hospital to successfully survive in today's economic environment!

Action

How do we turn alignment into action?

Do leaders always know what is making their internal environment run smoothly?
Or worse yet – not?

Real life example

Small town
Long time loyal employee
Poor departmental performance

How often do "interim" leaders linger long enough to become permanent leaders?

Hire only the most appropriate and qualified staff despite limited pools of qualified applicants and significant turnover

Are your interim leaders empowered to make needed changes?

Is it too late to correct the damage from the "interim" attitude?
Don't be stuck with the consequences of inaction!

So, how do leaders know what is going on in the hospital?

"Rounding and Scouting"

What comes to mind when you hear the term "rounding"?

Why do physicians round on patients?

Why should leaders round on staff?

Rounding lets the staff know you care about them.

Rounding can be used to let the staff know what's going on before they read it in the newspaper.

Rounding provides the opportunity for staff to express concerns or anxieties to leaders.

Here's another true life example from a Mississippi hospital.

The Patient Financial Service staff is overwhelmed. Short on staff. Taking work home at night. Morale is very low.

The radiology staff and lab staff spend much of the day sitting around visiting and snacking in the radiology office with the door open for all to see.

The CEO is unaware of what is going on. He only knows that Days in Accounts Receivable are unacceptable.

How could rounding have helped in this Mississippi hospital?

PFS staff

Clinical staff

When leaders take the time to explain the external pressures and share what they are doing to counteract any problems, it can build trust and confidence in the employees.

Rounding is not only to discuss the negative, but also reinforce positive things going on in the department and by individual staff.

During rounds, ask the employees if their direct supervisors or managers have explained issues to them. Ask if they understand.

And don't forget to recognize staff who are performing well!

Now, how do we know what to talk about with the staff during rounds.

"Scouting"

Think about the use of scouts in military battles. How were they used? Leaders need scouts in hospitals also.

Scouting reports can provide leaders with information about what's going on in a department.

Scouting reports can include staff concerns, accomplishments or questions for leaders.

Scouting reports give the leader the "inside" information and a "heads up" so the leader won't be blindsided.

Leaders should be prepared for tough questions as staff look to leaders for answers.

Leaders should be prepared not only to explain what, but also

THE WHY?

Be factual and transparent.
Staff appreciate honesty.
They can take it.

Leaders need support from staff.
Staff need to trust leaders.
Both need to be Aligned in Action to create solutions.

When there's a problem do we ask the staff, "What do you think we should do?"

What's your suggestion?

If you were in my shoes, what decisions would you make?

Even if you don't know, what would you do if you did know?

Accountability

How well is everyone doing their job?

WHAT WE PERMIT, WE PROMOTE!

High, middle and low performers

Who are they?
How do we handle?

High performers are the "keepers", if we can.

High performers should understand the impact they have on others.

High performers should be asked to mentor other staff or leaders.

High performers have high expectations of not only themselves, but also of the organization.

High performers do better with one-on-one coaching and feedback that is specific to their performance.

High performers may underestimate their significance.

High performers are not motivated by money alone.

Middle performers make up the majority of the workforce.

Middle performers need someone to explain things to them.

Middle performers are not as consistent and high performers.

Middle performers need personal connections with leaders.

Middle performers need to know they are appreciated.

Middle performers need a stable and standardized work environment.

Middle performers have more anxiety.

Middle performers need positive reinforcement to develop their skills.

Low performers make up less than 10% of the workforce.

Low performers take up a significant amount of leaders' time.

Low performers may drag middle performers down to their level.

Low performers may drive high performers out the door.

Low performers are more experienced with "difficult" conversations with leaders.

Low performers have developed “survival” skills.

Blaming others

Blaming supervisors

Blaming personal issues

We want to keep the high performers.

We want to move the middle performers to high.

We must decide what to do with the low performers.

Up or out!

In counseling low performers, describe the poor performance.
Be specific and factual.

Describe to low performers which processes were not followed.

Educate the low performer on what needs to be changed to improve performance.

Clearly explain the consequences of inaction or continued poor performance.

According to Quint Studer (Straight A Leadership), one third of low performers will change, one third will quit, and the other third will simply wait you out.

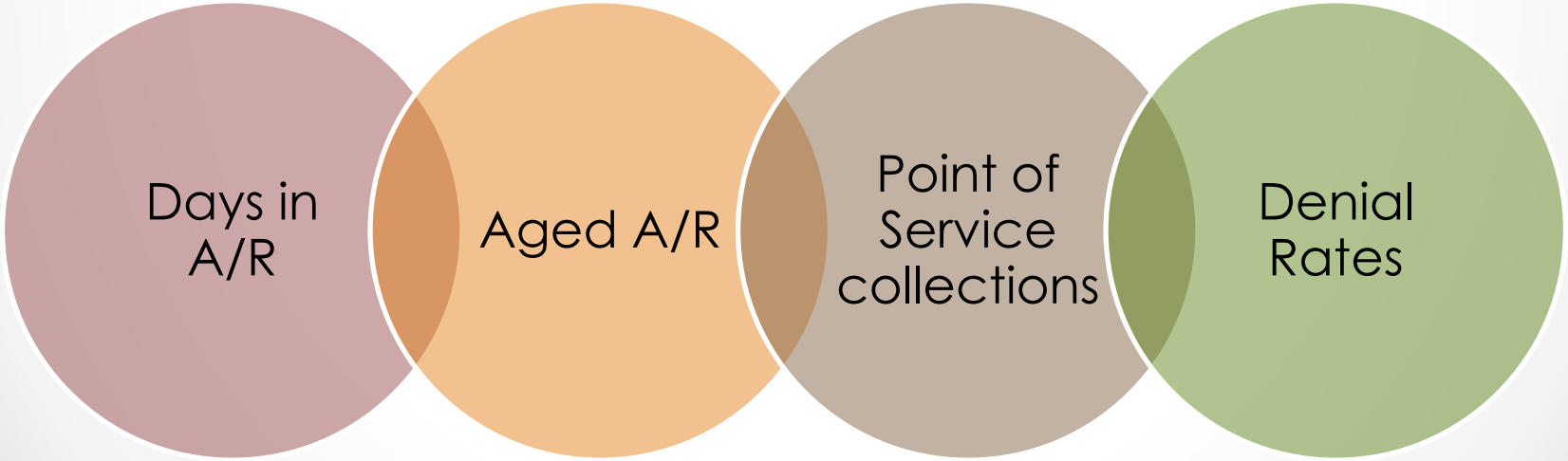
Accountability
Accountability
Accountability

What we permit, we promote!

CFOs deal in precision and performance that can be measured by key performance ratios.

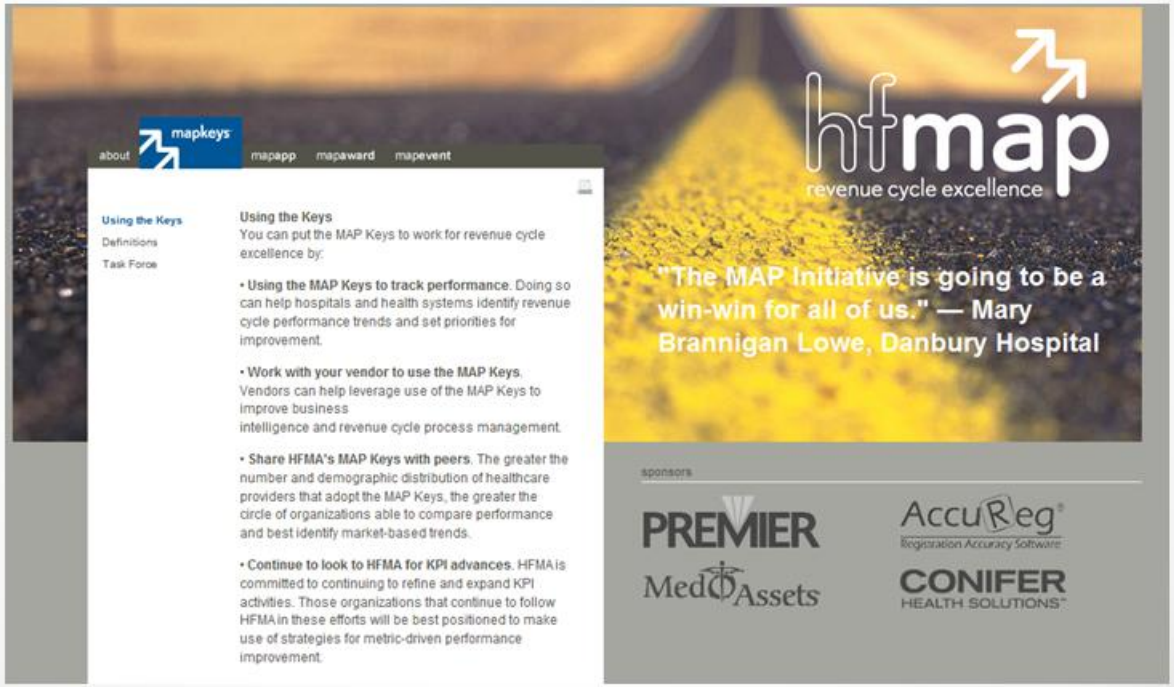
Current ratio
Days cash on hand
Operating margin

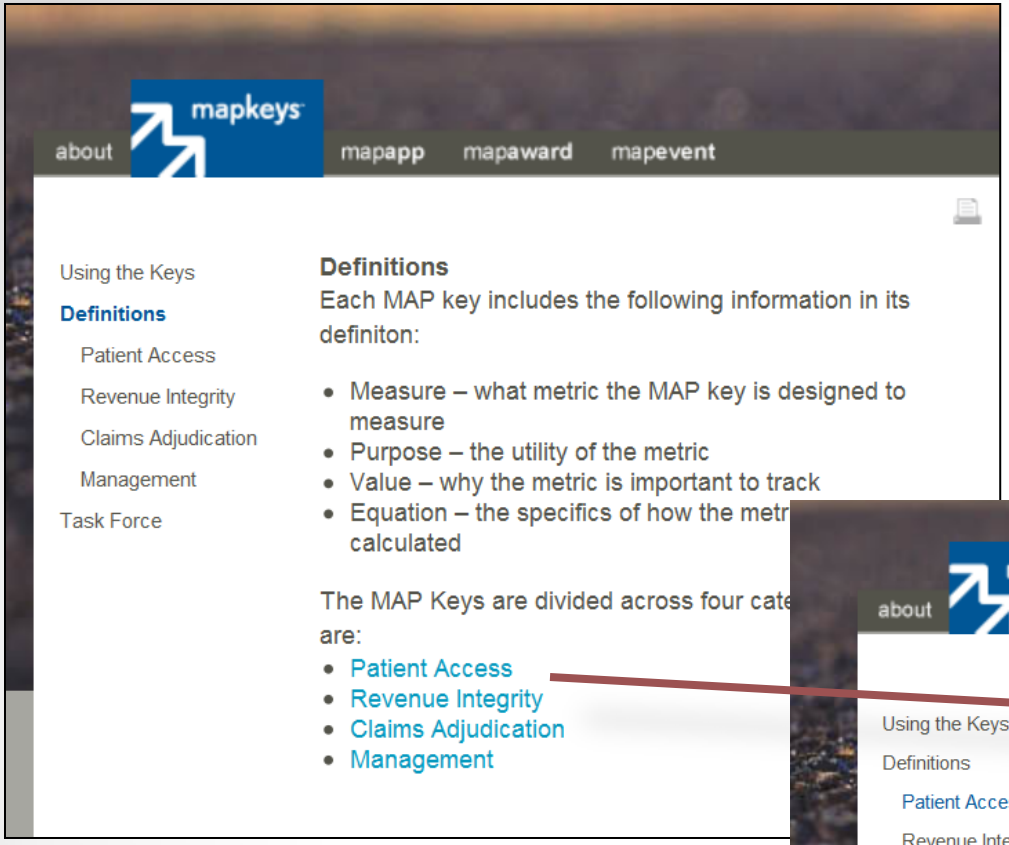
Revenue cycle positions are also measured by using key performance ratios.



Where do we find "best practices" used in Patient Financial Services?

http://www.hfmamap.org/mapkeys





Patient Access
Point-of-Service (POS) Cash Collections

Measure:
Point-of-Service (POS) Cash Collections

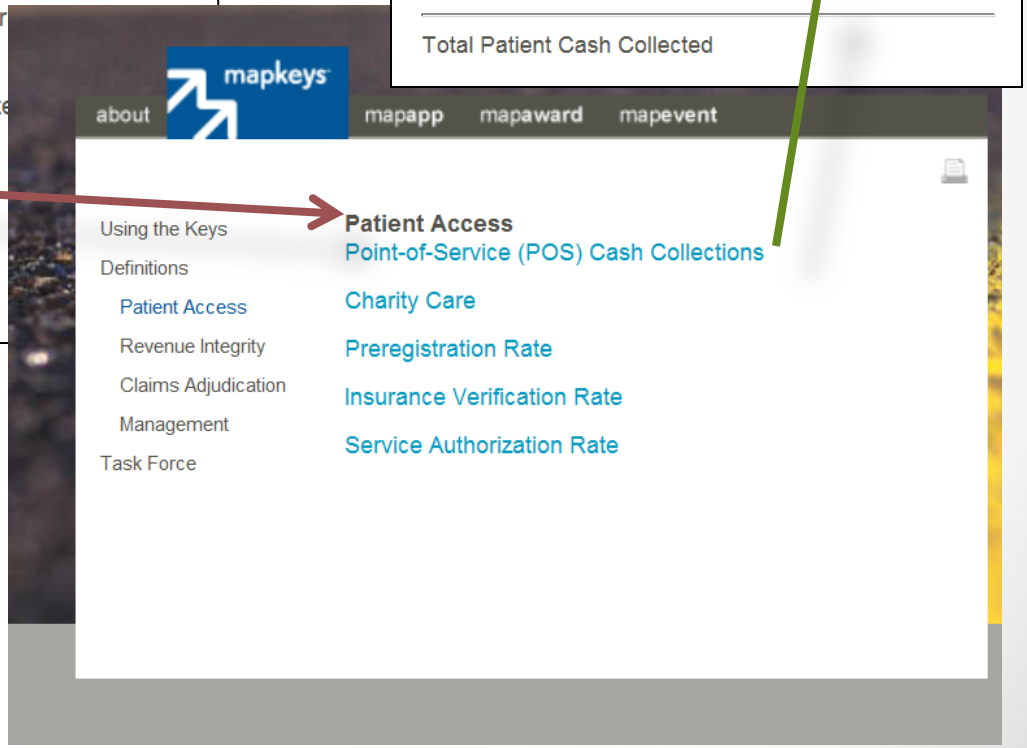
Purpose:
Trending indicator of point-of-service collection efforts

Value:
Indicates potential exposure to bad debt, accelerates cash collections, and can reduce collection costs

Equation:

POS Payments

Total Patient Cash Collected



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Print Clos

The Next Generation of Revenue Cycle Management

David C. Hammer

The revenue cycle universe is changing. Are your revenue cycle operations keeping up?

At a Glance

The revenue cycle management environment is dynamic. Revenue cycle leaders are now responsible for additional functional areas and have to deal with new financing arrangements that expose the organization to greater financial risk. Financial managers can use key performance indicators and the suggested practice processes checklist to determine whether their revenue cycle operations are in good shape or need shaping up.

View all of the Revenue Cycle Key Performance Indicators and Standards

View Exhibit 1

Nine exhibits provided

REVENUE CYCLE KEY PERFORMANCE INDICATORS AND STANDARDS

Scheduling

1. Overall scheduling rate of potentially eligible patients:	100%
> Scheduling rate for elective and urgent inpatients	100%
> Scheduling rate for ambulatory surgery patients	100%
> Scheduling rate for high-$ outpatient diagnostic patients	100%
2. Scheduled patients' preregistration rate	98%

Preregistration/Preauthorization

1. Overall preregistration rate of scheduled patients	≥ 98%
2. Overall insurance verification rate of preregistered patients	≥ 98%
3. Deposit request rate for copayments and deductibles	≥ 98%
4. Deposit request rate for elective admissions/procedures	≥ 100%
5. Deposit request rate for prior unpaid balances	≥ 98%
6. Data quality compared with pre-established department standards	≥ 99%

Insurance Verification

1. Overall insurance verification rate of scheduled patients	≥ 98%
2. Overall insurance verification rate of preregistered patients	≥ 98%
3. Insurance verification rate of unscheduled inpatients within one business day	≥ 98%
4. Insurance verification rate of unscheduled high-$ outpatients within one business day	≥ 98%
5. Data quality compared with pre-established department standards	≥ 99%

Patient Access/Registration

1. Average registration interview duration	≤ 10 minutes
2. Average patient wait time	≤ 10 minutes
3. Average inpatient registrations per registrar per shift	35
4. Average outpatient registrations per registrar per shift	40
5. Average ED registrations per registrar per shift	40
6. Data quality compared with pre-established department standards	≥ 99%
7. ABNs/MSPQs obtained when required	100%
8. MPI duplicates created daily as a % of total registrations	≤ 1

Financial Counseling

1. Collection of elective services deposits prior to service	100%
2. Collection of inpatient patient-pay balances prior to discharge	≥ 65%
3. Collection of outpatient patient-pay balance prior to service	≥ 75%
4. Collection of ED patient-pay balances prior to departure	≥ 50%
5. Screening of uninsured inpatients and high-balance outpatients for financial assistance	≥ 98%
6. Payment arrangements for noncharity eligible inpatients/ high-balance outpatients	≥ 98%
7. Prompt-payment discount %	5-20%

Health Information Management

1. Inpatient charts coded per coder per day	23-26
2. Observation charts coded per coder per day	36-40
3. Ambulatory surgery charts coded per coder per day	36-40
4. Outpatient charges coded per coder per day	150-230
5. ED charts coded per coder per day	150-230
6. Chart delinquency greater than 30 days (Joint Commission definition)	≤ 5%
7. Total chart delinquency	≤ 10%
8. HIM "DRG development" hold greater than late charge hold	≤ 2 A/R days
9. Copies of medical records pursuant to payers' requests	≤ 2 work days
10. Transcription rate per line	$0.08-$0.12
11. Transcription backlog	≤ 1 work day
12. Chart retrieval pursuant to physicians' requests	≤ 90 minutes
13. MPI duplicates as a % of total MPI entries	≤ 0.5%
14. PEPPER potential overcodes beyond 75th percentile	≤ 2%
15. PEPPER potential undercodes below 10th percentile	≤ 2%

Charge Entry/Revenue Protection

1. Late charge hold period	2-4 days
2. Late charges as a % of total charges	≤ 2%
3. Lost charges as a % of total charges	≤ 1%
4. Chargemaster duplicate items	0
5. Chargemaster incorrect/missing HCPCS/CPT-4 codes	0
6. Chargemaster incorrect/ invalid revenue codes	0
7. Chargemaster revenue code lacks necessary HCPCS/CPT-4 code	0
8. Chargemaster item has invalid/ incorrect modifier	0
9. Chargemaster item has missing modifier	0
10. Chargemaster item price less than HOPPS APC rate	0
11. Chargemaster item price is $0	0
12. Chargemaster item description is "miscellaneous"	0
13. Chargemaster item description/ price is editable online	0

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Are leaders and staff held accountable for

Service?

Quality?

Individual behavior?

There are various methods used to modify behavior.

- Values
- Skill
- Recognition
- Consequences
- Money

One method is skill development. If the staff don't have the skills they need, leaders can ensure that they get them.

Another method is recognition. If staff see others being recognized, it might inspire them to improve. This is a form of peer pressure.

Others will not adjust their behavior unless there are consequences to not doing so.

And some people simply respond to money. If there is an incentive plan, the behavior will meet that standard.

But the best behavior modification is from values. Show value driven people a better way and their values will force them to do it.

For instance, if you prove that by acting in a certain way will improve quality, which in turn will reduce deaths, values will make the person act in that way.

Values are ingrained. If you learn someone's values, you can tie expected behavior to that value.

Value driven people especially should understand the “why” of certain behaviors.

Leaders must help staff connect to “why”

If collectors collect money, the hospital has money to cover expenses such as payroll.

If the billers send out a clean bill, the collector can collect more money to cover expenses such as payroll.

If the registrars put in the correct information, the billers can send out a clean bill and the collectors can collect more money. . .

If the ancillary staff puts in the correct charge, the biller can send out a clean bill . . .

If the charge description master is up to date, the ancillary staff can find the right charge, the biller can send out a clean bill . . .

Studer Quote

"I have never met a leader in healthcare – or, for that fact, anyone in healthcare – who said his or her goal was to be average. This goal is not driven by ego but by the knowledge that being the best means people receive the best of care."

From the book "Straight A Leadership"

And finally . . .

"Making sure all people in the organization understand the challenges faced, that they have the skills to be successful in any environment, and that they're held accountable so the patient receives the best of care is values-driven leadership."

From the book "Straight A Leadership"

Questions

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