Revenue Cycle Management: Key Performance Metrics for Access Areas

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Agenda

- Introduction
  - Revenue Cycle Management for Health Systems
- Overview
- Framework
- Pre-Service
  - Strategic
  - Operational and Financial
  - Customer Service

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Introduction

- Increasing importance being placed on Revenue Cycle Management
  - Higher deductibles and co-pays
  - Consumer-driven healthcare
- Antiquated Information Technology (IT) systems
  - The first IT systems installed by health systems
  - Most recent IT focus on clinical systems

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Overview

- Revenue Cycle Task Force identified best practices in IT as last year's project
  - http://www.himss.org/content/files/FinancialSystems/FY08-FS-Revenue_Cycle_Whit_Paper.pdf?src=winews20080827
- Justification – this year's project
  - Performance Metrics
    - Current
    - Best Practice

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Framework

- Followed the same breakdown from the initial white paper
  - Facilitates linking information together for end users
    - Front End – Pre-Services
    - Middle
    - Back End
    - Added Customer Service

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Framework - Definitions

- Performance Metrics over Key Performance Indicators (KPI)
  - Metrics - designed to drive improvement and characterize progress made under each criteria. These are specific quantifiable goals based on individual expected work outputs.
    - SMART
    - Benchmarking
  - KPI - quantifiable measurements, agreed to beforehand, that reflect the *critical success factors* of an organization
    - Strategic

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Performance Metric Framework

- External
  - Customers perspective
- Internal - Day-to-day
  - Operations Management
- Internal – Strategic
  - Dashboard metrics

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Framework

	External - Customers	Internal – Day-to-Day	Internal - Strategic
Front End	Focus of today's webinar	Focus of today's webinar	Focus of today's webinar
Middle – Clinical Care			
Back End			
Customer Service	Touch on some related metrics		

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Strategic Scheduling Metrics

Strategic (Dashboard) metrics:

Operational

- % OP tests entered into scheduling system = 100%
- Number of OP tests scheduled/gross revenue
- Number of calls/test scheduled

Financial

- % denials for no pre-cert/medical necessity
- % OP capacity scheduled

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Strategic Scheduling Metrics

- Customer service
  - % Abandonment rate
  - Average speed of answer

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Scheduling Dashboard

Monthly Call Center Activity Report	PTD		YTD	
Average Speed of Answer	0:00:47		0:00:35	
Abandonment	4.90%		3.40%	
%OP tests scheduled in system	98%		99.20%	
# tests scheduled	135,210		280,250	
Financial Measures	**PTD**	**PTD %GC**	**YTD**	**PTD %GC**
Denied No-Precert	$ (2,559)	0.01%	$(110,995)	0.05%
Denied Not Med Necessary	$ (18,152)	0.09%	$ (46,709)	0.02%

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Scheduling

- Operational Metrics:
  - Associate talk time/call
  - Number of Associate calls/hour
  - Number of outbound calls
  - Number of inbound calls

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Scheduling

	ACD CALLS	SCHEDULED TEST	CALLS/TEST	% ABAN CALLS	STAFF HRS	CALLS/HR
MONDAY	1,791	1,307	1.37	4.8%	157.75	11.4
TUESDAY	1,638	1,009	1.62	4.2%	160.50	10.2
WEDNESDAY	1,487	985	1.51	2.2%	187.75	7.9
THURSDAY	1,415	966	1.46	6.7%	122.75	11.5
FRIDAY	1,440	880	1.64	3.5%	126.00	11.4
SATURDAY	90	41	2.20	8.2%	8.00	11.3
	7,861	5,188	1.52	4.3%	762.75	10.3

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Scheduling

- Operational Metrics:
  - % reschedules, cancellations, and no shows
  - % appointments postponed for lack of pre-cert
  - % tests scheduled with physician order:
    - Faxed
    - Electronic

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Scheduling

- Customer Satisfaction metrics:
  - Next available appointment =≤ 24 hours (best practice) for CT and MRI
  - Average associate call monitoring score
  - % of patients scheduled when requested
    - Evening hours/weekends
    - Mammography

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Scheduling Systems

- Phone accessories to current system:
  - Abandonment rate
  - Reporting/ call tracking
  - Call routing

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Scheduling Systems

- Advanced telephony (ACD):
  - Call monitoring-listening in
  - Call Routing
  - Length of calls
  - Track in-bound and out-bound calls
  - Associate tracking- time off the phone
  - Advanced Reporting

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Scheduling Systems

- Dialer Management:
  - Outbound pre-registration calls
  - Reminder calls
  - Improves employee productivity and number of patient contacts

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Insurance Verification- Definition

- Electronic or telephonic verification of third party coverage directly *from the payer:*
  - For planned date of service
  - For the patient receiving services
  - Includes approved length of stay for inpatients
  - Details coverage terms and patient out of pocket
  - Any limitations- maximum benefits

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What Insurance Verification is Not

- Copying insurance card and filing or scanning
- Confirming third party payer with the patient
- Checking coverage from previous registration
- Reviewing third party payment from prior date of service

All of these tasks can be helpful in identifying source of payment, however they are not insurance verification!

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Insurance Verification Strategic

- Insurance verification rate of pre-registered outpatients (Best practice 98%)
- Insurance verification rate of unscheduled out-patients (>$1000) (Best practice 98%)
- Insurance verification rate of scheduled in-patients (Best practice 100%)
- Insurance verification rate of unscheduled in-patients within 1 day (Best practice 98%)

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Insurance Verification Metrics

- Operational
  - 100% eligibility ***verified*** on line or by telephone with the payer
  - Number of denied days
    - Original authorization for 3 days, patient stays 5
  - Number of appeals- track those overturned and those lost for opportunity to improve pre-service

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Insurance Verification Technology

- Check eligibility technology for ability to provide:
  - Responses for all major commercial payers
  - Medicare and Medicaid HMO's
  - Batch processing
  - Reporting- summary and detail
  - Exception work-listing
  - Dashboard responses that are easy to read

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Insurance Verification Technology

- Batch eligibility- query all self pay
  - Run daily
  - 15-20% of self pay patients have coverage
  - Exception work-listing to add found coverage to patient accounts

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Registration Strategic Metrics

- Operational
  - Registration QA >98% (best practice w/ technology)
  - ABN's collected when required = 100%
- Financial
  - # and $ claims on hold for registration errors
    - ID number
    - Guarantor information

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Registration

- Operational metrics:
  - MPI duplication rate (as % total registrations) = <1.0%
  - Registration interview duration < 10 minutes
  - Number of statements in returned mail (average 2%)

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Registration

- According to Zimmerman Report: Best Practices of Revenue Collection, 2004:
  - If 2% of hospital statements are returned with incorrect address
  - In a facility with10,000 admissions per month:
    - Translates to about $324,000 lost each year
      - $24,000 in staff costs to correct
      - $300,000 in lost and delayed revenue

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Registration

- Customer satisfaction
  - % patients waiting > 10 minutes for registrar
  - Patient satisfaction scores
    - Staff introduction
    - Courtesy
    - Professionalism
    - Wait times

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Registration Survey

	Wait	Courtesy	Competent	Introduce
Responses	125	124	122	101
(1) Not at all Satisfied	0	1	0	0
(2) Not Very Satisfied	0	1	0	0
(3) Somewhat Satisfied	3	4	4	0
(4) Very Satisfied	28	25	20	0
(5) Extremely Satisfied	94	93	98	0
Yes				68
No				33
	4.73	**4.68**	**4.77**	**67.33**

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Registration Systems

- On-line survey tools or inexpensive programs
- Systems to identify duplicate registrations
- Patient tracking mechanism for wait times and durations
- Registration Quality Assurance tools:
  - Conduct 100% audit and correction
  - Positively impact days in accounts receivable
  - Reduce billing re-work
  - Create targeted educational programs
  - Tackle returned mail-Automatically check USPS for valid address

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Financial Counseling

- Operational metrics
  - % of all insured/ uninsured IP discharged with plan for resolution of account = >95%
  - Financial interviews with ED self pay = 100%
  - Screening of all uninsured patients for:
    - Existing third party coverage = 100%
    - Eligibility for Medicaid, other source of payment
    - Eligibility for Charity Care

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Financial Counseling

- Operational metrics:
  - % OP given estimate of out-of-pocket pre-service
  - Balance collected for cosmetic services = 100%
  - % OP with financial plan for account resolution
    - Payment plan
    - Application for Medicaid, charity care

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Financial Counseling Systems

- On line decision trees for self pay- patient interview
- On line financial assistance application tools
- Many states accept electronic Medicaid applications
- Workflow drivers/assigned accounts
- Estimation of patient out -of -pocket

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Summary

- Tough economic times make new information system justifications even harder
  - Low cost solutions are out there
  - Find the right IT tools for your health system
- Performance metric approach facilitates IT system justification
  - Benchmarking against best practices

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Questions for Jill and Shari?

Chapter update:

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