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Patrick McDermott
Jess Jones
Larry Stuckey

maintaining revenue cycle health during IT change

An electronic health record at one of Presence Health's hospitals was implemented in stages to ensure minimal disruption to the revenue cycle.

An electronic health record (EHR) implementation, particularly one that includes other system components such as patient access and patient revenue, can disrupt many areas of hospital operations. But its impact on the revenue cycle may pose one of the greatest financial risks. During these implementations, organizations often see their days in accounts receivable (A/R) and denials increase while cash flow drops.

At Presence Health, a not-for-profit health system formed by the November 2011 merger of Provena Health in Mokena, Ill., and Resurrection Health Care in Chicago, however, a systemwide conversion to a new EHR was undertaken in a way that not only minimized disruption to the revenue cycle, including integrated patient access and patient revenue systems, but also ensured the continued optimization of revenue cycle performance throughout the project. Continuous improvement became an even more crucial goal because the conversion was happening at the same time as the Presence Health merger. A merger of this magnitude is predicated on achieving cost savings and better net revenue performance. Stabilizing the revenue cycle during a system conversion was paramount to achieving those savings. In addition, Presence leadership had to balance the challenge of leading through the conversion while undergoing major organizational changes as they shifted to a single corporate governance structure.

Presence Health's Approach

Presence Health was able to minimize negative revenue cycle trends and maximize performance at its pilot hospital, 375-bed Saint Francis Hospital in Evanston, Ill. It was also able to move quickly into recovery mode, and apply lessons learned to optimize implementations for the remaining hospitals in its system. Presence Health achieved these results by employing a multistage approach that started 24 months before go-live at the first facility.

Although typical system implementations can cause days in A/R to spike—and for some, that spike can take a year or more to stabilize—Saint Francis Hospital's A/R spike was minimized to five days, and returned to system norms in approximately three months. Here are the key elements of Presence Health's approach.

AT A GLANCE

Key objectives in the EHR implementation process for Presence Health were to:

- Optimize revenue cycle processes
- Optimize the new health information system to support peak revenue cycle performance
- Build a plan for the go-live window
- Optimize and accelerate revenue cycle performance after the EHR became active

Pre-Implementation Phase: Optimize Revenue Cycle Processes

A high-performing revenue cycle is less vulnerable to disruption during a system conversion than a low-performing revenue cycle. Presence took the following steps as it embarked on EHR selection.

Standardize and centralize the revenue cycle. An important first step was to establish consistent, proven revenue cycle standards and to centralize those standards within a common management structure. This step also included an evaluation of all revenue cycle processing vendor relationships to ensure that the level and quality of service would support the new approach. This effort yielded net patient revenue improvement before the EHR implementation.

Analyze the most critical revenue cycle functions to manage and track through system conversion. Presence's next step was to identify the functions that had the highest impact on revenue cycle performance and set performance targets for each. These functions were determined to be insurance verification, financial counseling, discharged-not-final-billed (DNFB) management, claims submission, third-party payer collections, and vendor management.

Install a set of stand-alone, independent, revenue cycle workflow management and reporting tools to create a highly accountable environment. Revenue cycle tools that operated independently of the current or future EHR were installed six months before undertaking system design work. These tools compiled data feeds from both systems, minimizing EHR implementation disruptions to performance by:

> Ensuring revenue cycle staff could work within a workflow tool that was comfortable, familiar, and consistent during the conversion process
> Providing a stable platform for management to access metrics and workflow productivity no matter which system was in use
> Providing new reporting and dashboards that clearly showed key performance indicators (KPIs) and supported Presence's updated, optimized processes and workflow

Design Phase: Optimize the New EHR to Support Peak Revenue Cycle Performance

Although some of the latest generation comprehensive EHR systems have advanced functionality and are highly configurable, the standard "out-of-the-box" revenue cycle functionality may not support every aspect of an organization's optimized processes. These processes must be incorporated into the new system, whether by customizing the system, updating the processes themselves to adapt to the system, or using revenue cycle tools that complement the system. Conversely, without a comprehensive and well-thought-out design process, enhanced functionality now available in the new system application could be misused or underused.

The design phase is the time to determine how all of these factors will come together, and it is essential that revenue cycle leaders advocate for system changes to support optimized processes. Presence took the following steps to accomplish this goal.

Establish collaborative relationships between revenue cycle leaders and department leaders. In focusing on clinicians' needs, system design can miss requirements for revenue cycle functions. It is

About Presence Health

Presence Health was formed by the merger of Provena Health, Mokena, Ill., and Resurrection Health Care, Chicago, in November 2011. The organization is the largest Catholic health system and largest Medicaid provider in Illinois, comprising 12 hospitals, 27 long-term care and senior residential facilities, 50 primary and specialty care clinics, and two outpatient surgery centers. The health system serves 4.5 million individuals at more than 100 sites.

REVENUE CYCLE KPIs BEFORE, DURING, AND AFTER EHR IMPLEMENTATION AT SAINT FRANCIS HOSPITAL

	Monthly Averages						
Metrics	**October**	**November**	**December**	**January**	**February**	**March**	**April**
Insurance Verification Secure at Admit Rate	97%	91%	93%	92%	92%	93%	91%
Preregistration Complete Rate	93%	89%	82%	75%	82%	92%	86%
Charity Care Conversion Screening Rate	81%	76%	69%	75%	82%	77%	71%
Billing Work in Process Days	3	8	13	8	5	4	5
Days in Accounts Receivable	37	43	46	43	42	41	42
Cash Collections (Millions)	$14.947	$14.041	$10.521	$15.454	$14.792	$16.476	$16.285

After Revenue Cycle Improvement/Before Go-Live Go-Live Peak Recovery

important to create clear roles and responsibilities for collaboration between each hospital department and revenue cycle leaders for every phase of a comprehensive EHR implementation.

For example, Presence established a collaborative process among patient financial services, patient access, and its health information management (HIM) team to identify widely accepted practices for scanning documents that needed to go into the EHR. Understanding that a comprehensive set of clinical documentation is important for both care management and revenue cycle purposes, these teams worked together to analyze the appropriate patient access points for scanning, and to identify the necessary document types (e.g., consent for admission, physician orders, and ID cards) so that documents would be placed correctly in the system. The HIM team set up processes to provide a daily audit to patient access during go-live on the accuracy of scanning and indexing documents so that errors could be quickly corrected.

Create forums for collaborative, in-person, visual reviews of EHR modules. Presence revenue cycle leaders found that the most productive conversations happened when revenue cycle and IT leaders met in the same room and looked at a visual of the tools together.

For example, to ensure that all departments were getting what they needed from the system's radiology schedule, the teams sat down together and analyzed each field in the schedule to ensure they were in agreement about how the fields should be filled out and how those data would be used. This interactive, in-person approach ensured the teams were "speaking the same language" during design.

Assign a dedicated liaison between IT and revenue cycle departments. To fill this role, Presence appointed a project manager who had both revenue cycle operational experience and a technical background.

The project manager position proved extremely valuable throughout the process. For example, as Presence assessed its chargemaster needs, the project manager was able to bridge the gaps among the departments entering charges, the revenue integrity unit that reviewed the charges, and the IT group building the new chargemaster to ensure the new system was meeting the needs of each group.

Identify risk mitigation focus activities. Presence focused on a few specific activities to minimize risk leading up to and following go-live, such as:

> Establishing a minimum data set
> Creating a claims testing plan
> Implementing chargemaster review, clean-up, and trigger testing

In establishing a minimum data set, Presence worked with each scheduling department to ensure that it had a complete data set needed for the revenue cycle team to support timely billing and minimize denials.

Presence's claims testing plan involved not only the traditional integrated testing of the new system, but also implementation of a process to complete parallel claims testing. Presence took 40 to 50 claims that reflected disparate populations and ran them end to end through both the new system and the old system to ensure that each system produced the same result. According to Presence's CFO John Orsini, parallel testing was crucial to success. "This approach helped us identify and address micro-issues before go-live so that we could proactively improve our claim submission readiness. This triangulation of testing also reduced the claims build up and limited the number of issues post go-live. It also provided valuable training for our managers," Orsini says.

Rather than build the chargemaster to match what currently existed, Presence's revenue integrity team visited units throughout the pilot hospital and watched staff in each area enter charges to understand the charging practices in each unit. This process enabled Presence to build a new chargemaster that would meet all hospital unit needs, with unnecessary charges removed and with a charge trigger testing plan to ensure accuracy.

Go-Live: Build a Plan for the Go-Live Window

Presence's revenue cycle leadership team took three primary steps to ensure a nimble, proactive approach to go-live challenges to mitigate account "black holes" and identify and correct any ineffective processes.

Establish a revenue cycle "command and control center." The revenue cycle team had its own command and control center, separate from the overall EHR go-live team. It included supervisors and staff from the patient access, patient financial services, chargemaster, and training departments. All scheduled and registered accounts for the first several weeks were audited to ensure that each account was subjected to the necessary verification, authorization, and charge-entry activities. This audit drove two key activities:

- Revenue cycle leaders and the IT team met each morning to review any build or training errors and determine appropriate next steps to correct any issues.
- The training department revised training materials each day based on the previous day's performance. Revenue cycle leaders also discussed the changes with the staff during daily start-of-shift huddles.

Implement daily revenue cycle leadership meetings. Daily meetings led by the CFO of Saint Francis Hospital were conducted with leaders from each affected department (e.g., patient access, patient financial services, HIM, and IT). Each department leader was assigned high-impact revenue cycle KPIs to track and was responsible for reporting the status of those metrics. The resulting information allowed leadership to review high-priority issues and assign each issue to a department head for swift correction. Presence continued to hold the daily meetings until the target KPIs stabilized back to organizational norms, which took about three months.

Temporarily increase staff in high-volume patient access areas. All patient access areas were overstaffed by 25 percent for the first week following go-live so that patient wait times would not increase while staff became accustomed to using the new system. This overstaffing included not only borrowed staff level resources from other system facilities, but also managers and directors from every facility in the system. Employing the system leaders not only ensured that leaders were available to make quick decisions as issues arose, but also provided them with valuable insight as they prepared their own facilities for EHR implementation. Although 25 percent overstaffing is a significant amount, Presence Health leaders felt that the investment of time and resources would pay off during the transition. Adding people to help work through the steep learning curve in the

registration area provided hands-on training to more people simultaneously, and helped reduce the risk of long waiting times for patients. Managers and directors remained on call at their own facilities during the one-week period.

Year 1: Optimize and Accelerate Revenue Cycle Performance After Activation

No matter how successfully an organization can mitigate revenue cycle risk during a system conversion, it should anticipate disruptions in performance for six to 12 months following the implementation. To respond to and minimize those challenges, Presence used the following strategies to maintain and even improve performance in the months after go-live at Saint Francis Hospital.

Leverage reporting tools to highlight risk areas and allow for swift course correction. Presence's external revenue cycle management workflow and reporting tool clearly indicated immediate risk areas. For example, billing work in process (unbilled A/R) at go-live was $0, but 30 days later, it was

Minimizing Revenue Cycle Disruption Through System Conversion

Presence Health used the following timeline for key revenue cycle strategies and tactics.

18 months (or more) before go-live:
- Begin optimizing revenue cycle processes and establishing organization revenue cycle widely accepted practices.
- Review existing vendor tools to determine which ones will be essential for support throughout the conversion process.

12 months before go-live:
- Begin design meetings; establish clear roles between revenue cycle and other departments to ensure the right individuals are included in design meetings.
- Ensure that timetables are established so design meetings can occur in person whenever possible.
- Begin implementation of necessary vendor tools to support revenue cycle widely accepted practices throughout the conversion process.
- Begin to identify areas for temporary increase in revenue cycle staff to ensure a smooth transition to the new system.

Six months before go-live:
- Finish implementation of vendor tools to enable staff to become comfortable working with these tools.
- Begin implementation of staff increases to support A/R conversion and minimize impact of new system training on staff's productivity.
- Based on current design, begin integrated and parallel testing procedures to ensure design will meet revenue cycle needs.
- Begin work with any external vendor tools on necessary data feeds or customizations based on the new health information system.

Three months before go-live:
- Begin to formulate go-live day work plan, including roles and responsibilities for leadership "command center," staffing plans in patient access areas, and a clear process for troubleshooting and resolving new issues that arose.
- Continue integrated and parallel testing process.
- Ensure external vendor tools are included in ongoing testing so that they are available to support conversion go-live.

One month before go-live:
- Finalize staff back-up/increase strategy for patient access areas.
- Finalize leadership "command center," identifying individuals and their roles leading up to and throughout go-live.
- Establish meeting schedule for daily facility CFO and department leadership meetings.
- Establish clear metrics that will be reviewed daily to ensure revenue cycle health is closely monitored.
- Set expectations with staff around daily shift huddles and ad hoc training plans.

Post go-live:
- Leverage existing and new reporting to ensure metrics are consistent between old and new systems so that key performance indicators can be monitored throughout and problems can be dealt with quickly.
- Continue to look for opportunities to implement improvements to the revenue cycle with small, targeted initiatives that can be easily tracked, improve the revenue cycle, and give staff a sense of success and achievement.
- Keep revenue cycle leadership focused on the fundamentals of strong revenue cycle management: high-dollar risk mitigation techniques, consistent feedback to staff on quality, root-cause analysis on denials, and maintaining a culture of accountability. Take lessons learned from each system go-live and apply to each successive facility.

$33 million. Using management tools that were consistent between the periods before and after the conversion, leadership was able to quickly dig into the issues and better understand the key causes, including a backlog in the coding department and a process gap in working the charge router work queues. (See following pages for a revenue cycle work flow and reporting tool.)

Identify targeted improvement opportunities. Leadership understood that it was important not to forgo revenue cycle improvement during the system implementation period. For example, two months following the first facility go-live, leadership implemented a new patient liability collections process, which resulted in a 35 percent increase in collections during a three-month period. This opportunity had a specific focus and provided clear goals that could be easily measured. (See following pages for implementing a patient liability collections process.)

Focus on strong revenue cycle management, not just strong system implementation. It is difficult for leaders to maintain focus on a successful revenue cycle while also managing a comprehensive EHR implementation. At Presence, weekly meetings with revenue cycle leadership created a forum for ensuring that each manager had the tools and the support needed to maintain a strong and value-added revenue cycle for the entire organization during this disruptive period.

Apply lessons learned from the pilot go-live to mitigate risk to the remaining facilities. By carefully tracking challenges faced at each implementation, and developing proactive plans to address those challenges in future implementations, Presence was able to give each hospital the benefit of lessons learned at its sister facilities. The successful application of these lessons paid off during the go-live of Presence's second facility, Saint Joseph's Hospital, where the billing work in process (unbilled A/R) increase was half that experienced by Saint Francis Hospital, and there was no cash flow slowdown.

Maintaining Strong Performance

Using these approaches, Presence Health not only established strong revenue flow for its pilot hospital, but also created the foundation and framework for increasingly strong performance across all of the hospitals in the system before, during, and after system implementation. ●

revenue cycle workflow and reporting tool

A key management strategy for Presence Health during its electronic health record (EHR) conversion was to leverage a stand-alone, independent revenue cycle workflow and reporting tool that not only provided a consistent daily work driver for staff, but also enabled management to quickly recognize and respond to issues.

The tool provided reports that allowed managers to relate business analytics directly to workflow and take proactive steps to minimize risks that could lead to denials. Of those comprehensive dashboards, several of the metrics were especially important for triaging accounts during the conversion to minimize the risk of denials. Those metrics are captured in the tool template.

CORE METRICS TO TRACK DURING EHR CONVERSION

Core Metrics	Week 1	Week 2	Week 3	Week 4
Total number of billing errors				
—Percentage change week to week				
Total dollars of billing errors				
—Percentage change week to week				
Deviation from goal				
—Percentage change week over week				
Percentage of change that's new inflow				
Verification secure at admit rate				
—High-dollar accounts still requiring authorization				
—Notification needs for urgent/elective admits				
Preregistration complete rate				
Charity care conversion screening rate				
Aged A/R as a percentage of outstanding A/R				
Cash collections				

patient liability collections process: 7 steps

Presence Health leadership felt it was important to continue to focus on revenue cycle improvement, not just maintenance, while implementing its electronic health record (EHR). One improvement initiative focused on patient liability collections in the emergency department (ED). To effectively implement the process, Presence Health followed these six steps:

1. Establish a baseline for each of the hospitals. Each hospital's patient access director completed a seven-day study on ED visit volume and determined the percentage of those visits that had an actual copay opportunity.

2. Define collection targets and goals. Presence Health used the baselines from each hospital to set collections targets. Initial improvement goals ranged from 60 to 80 percent, depending on each hospital's baseline.

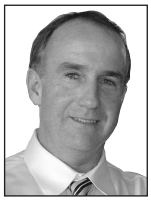
3. Establish and implement copay collections processes and scripts. ED staff began to use standard co-pay collections processes and scripts. They also began to document reasons for noncollection. Based on this documentation, Presence Health developed customized scripts and procedures for each discrete reason patients are unable to pay.

4. Measure and report on metrics to support accountability. All patient access directors implemented a daily point-of-service tracker for their respective ED to document collected and uncollected copays. They also began weekly calls with patient access directors from each hospital reporting their results from the prior week. These calls allowed patient access directors to share best practices and refine and improve processes.

5. Recognize successes. To recognize success, Presence created a trophy that was awarded each month to the hospital that had improved the most from the prior month. For teams that were lagging in their goals, Presence Health worked collaboratively to determine what barriers (from ED layout to staff challenges) could be causing the lags and to address and remove the barriers.

6. Continue to monitor and measure improvement. Presence Health refreshes targets and goals on a bi-annual basis. Today, eight months after this implementation, Presence is continuing to trend above previous year's collections and is preparing to reassess goals given this consistent increase. ●

About the authors



Patrick McDermott
is senior vice president, revenue services, Presence Health, Des Plaines, Ill., and a member of HFMA's First Illinois Chapter (pmcdermott@reshealthcare.org).

Jess Jones
is a senior director, Huron Healthcare, Chicago, and a member of HFMA's First Illinois Chapter (jjjones@huronconsultinggroup.com).

Larry Stuckey
is a managing director, Huron Healthcare, Chicago, and a member of HFMA's First Illinois Chapter (lstuckey@huronconsultinggroup.com).