Automation –
The Key to Hospital Transformation

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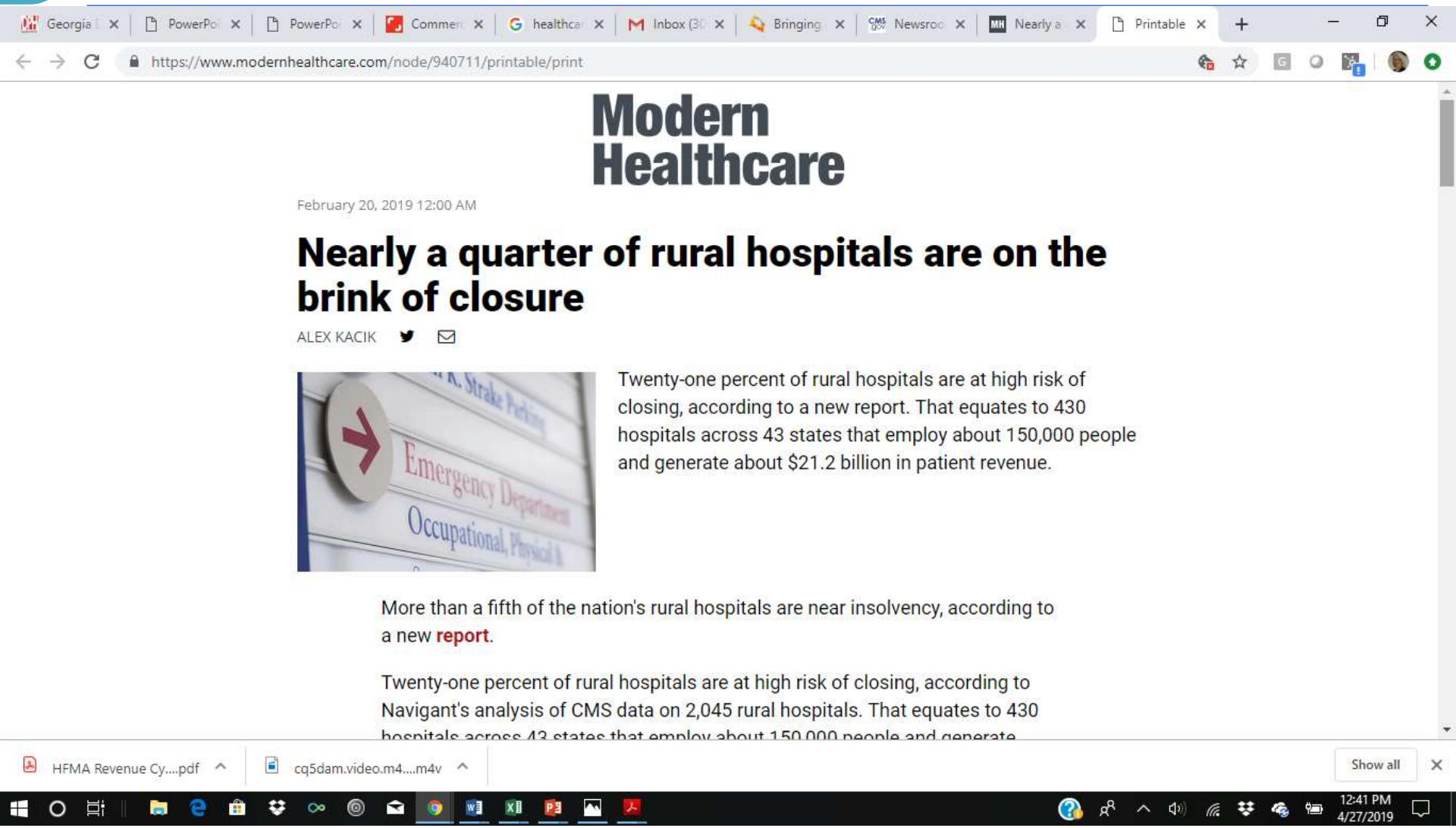
Transforming the Way Health Care is Delivered

2019 MODERN HEALTHCARE HEADLINES

Recent moderation in trend is promising, but not clear yet whether structural



https://www.modernhealthcare.com/article/20190220/NEWS/190229999/nearly-a-quarter-of-rural-hospitals-are-on-the-brink-of-closure

1. It seems like we're constantly seeing headlines about hospitals closing. What do you think is causing this trend and do you think it's going to continue?

1) Brand new set of rules and penalties under the Affordable Care Act of 2010 (ACA) and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

2) Leaders are content with status quo, resistance to change

3) The solution to decreasing revenue is not always cost cutting. Cost cutting means reduces staffing and services. -- Leadership must work with managers to identify the reason and then explore ways to bring the revenue back.

4) No attention to revenue integrity – making sure you are being reimbursed properly and having audit processes in place to identify missed and lost charges.

2. How do hospitals avoid these penalties?

1) Through automation and change

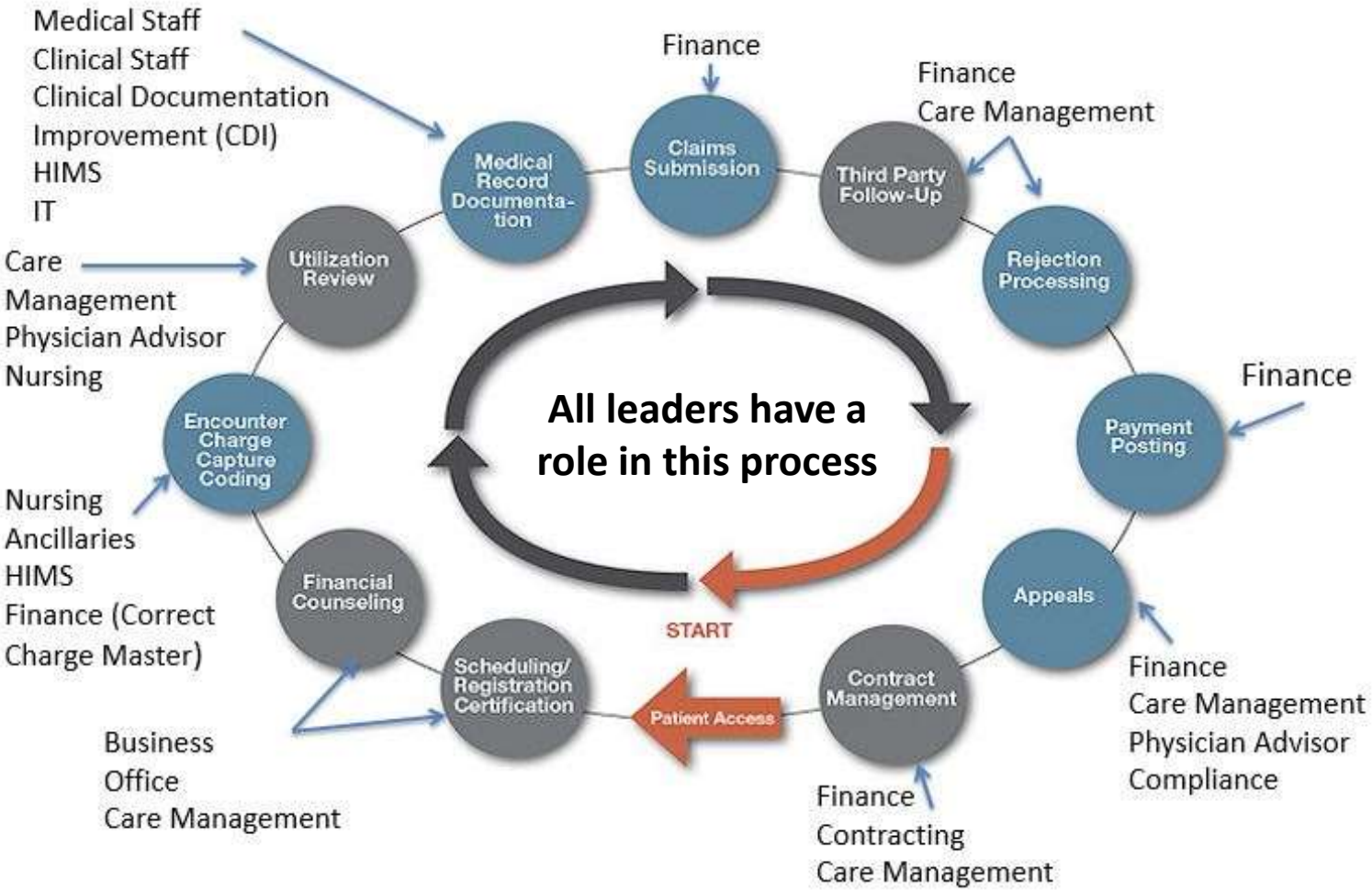
– Larger hospitals ensure that systems are in place to track and trend this data, so it can be acted on immediately when a certain measure starts trending up.

– In many cases, these negative adjustments/penalties average 3 to 5% of total revenue.

2) Through Clinical and Financial integration – or Revenue Integrity

– Thankfully Quadax offers dashboards that the Revenue Integrity team watches to know when denials or negative adjustments and payment penalties are on the rise.

FINANCE, CLINICAL OPERATIONS AND REVENUE CYCLE CAN'T BE SEPARATED - THEY ARE ONE!



3. What are Specific Transformation Initiatives?

HOSPITAL EXAMPLE :

. . . TRANSFORMATION AND CHANGE

1. Complete an assessment and develop a plan to drive change and innovation required to survive value-based payment reform.
2. Apply industry benchmarks to our # 1 and #2 highest cost areas – Salaries, Wages, Benefits and Supply Cost
3. Work with experts to complete a market analysis to learn why patients were leaving our market, and used that data to drive our decision making
4. Create a revenue cycle integrity team and a strategy that focused on integration of clinical and financial departments with workflow and process redesign.
5. Develop your leaders with a one-year leadership training program.
6. And above all, put the patient first with daily rounding and listening to our patients to make their experiences better.

4. How did you get Leadership on board?

1) **Buy-in for Leadership is required for long term success –** This happens by involving all levels of leadership from developing the action plan to celebrating the victories.
2) **Develop or Provide Leadership training** to teach supervisors, managers and executives, basic management skills, process improvement strategies, project management, implementation of best practices and goal setting.

There had been no formal leadership training and the managers and supervisors on the department level, and they had no basic management skills required to hold staff accountable, measure performance, budget revenue and expenses or delegate responsibility to the team.

This step was key to earning the trust and support of the managers and equipping them with basic skill to drive improvement, ***and change management training was the next step– strong change leaders are required for long term transformational change.***

5. How did you fund the turnaround?

Start with the low hanging fruit and holding more complex projects until later:

- A/R reduction of over $10 million of an initial $21 million in gross accounts receivables or approximately $3 million in net revenue annualized. (Days in A/R went from 121 days to 80 days)

6. What did the technology and efficiency audit uncover?

AUDIT FINDINGS -

a. Manual claims processing – less than 15% of processes were automated – when we implemented Quadax claims management the hospital went from processing 2500 claims per month and (being 6-8 months behind) to processing over 5000 claims per month.
b. A coding audit found coders coding at a 70% accuracy rate and outsourcing immediately improved coding to 98% accuracy rate – (this was equivalent to $3000,000 per month)
c. No Denials management or tracking process in place
d. Charge master had not been updated in 10 years.
e. All self-pay accounts were being worked in house with very little return.

7. Other Areas of Revenue Improvement

The areas of revenue improvement areas resulting in the increased revenue:

Patient Access:

- Point of Service Collections increased from $4,000 a month to $40,000 a month or $480,000 annualized.
- Team was trained and certified on HTHU.net, they learned to correct their own errors and clean claims rate improved from 70% to 94%, huge impact on cash!
- Medicaid eligibility service resulted in 100+ Medicaid approvals at approximately $3000 per approval adding another $300,000 to the bottom line.

Areas of Revenue Improvement

The areas of revenue improvement areas resulting in the increased revenue:

Coding, Documentation Improvement, Case Management

- Coding audit resulted in 70% coding accuracy. Outsourced coding to HCCS and improved quality and CPT accuracy from 70% to 94%, which resulted in $200,000 increase monthly or $2.4 million annualized.
- Appropriate documentation to reflect the acuity level of the patient increased the Case Mix Index (CMI) from .95 to 1.5.
- The Case Management team reduced length of stay from 5 days to 3.5. Combined, these two areas of improvement resulted in an additional $1 million net revenue to the bottom line

Areas of Revenue Improvement

The areas of revenue improvement areas resulting in the increased revenue:

Clinical Revenue Integrity - . ***Revenue integrity means that for every clinical action there is an accurate financial outcome.***

- Charge audits in high cost areas like ER and surgery found up to 10% charges missing or not properly documented. Improved Charge capture processes had a positive impact on cash.
- Denials and Appeals Team – Logged and tracked all denials, appealed to the 3rd level of appeal – ALJ and achieved a 50% overturn rate.
- Nurses were educated to ensure that documentation was complete and accurate in order to receive full reimbursement.

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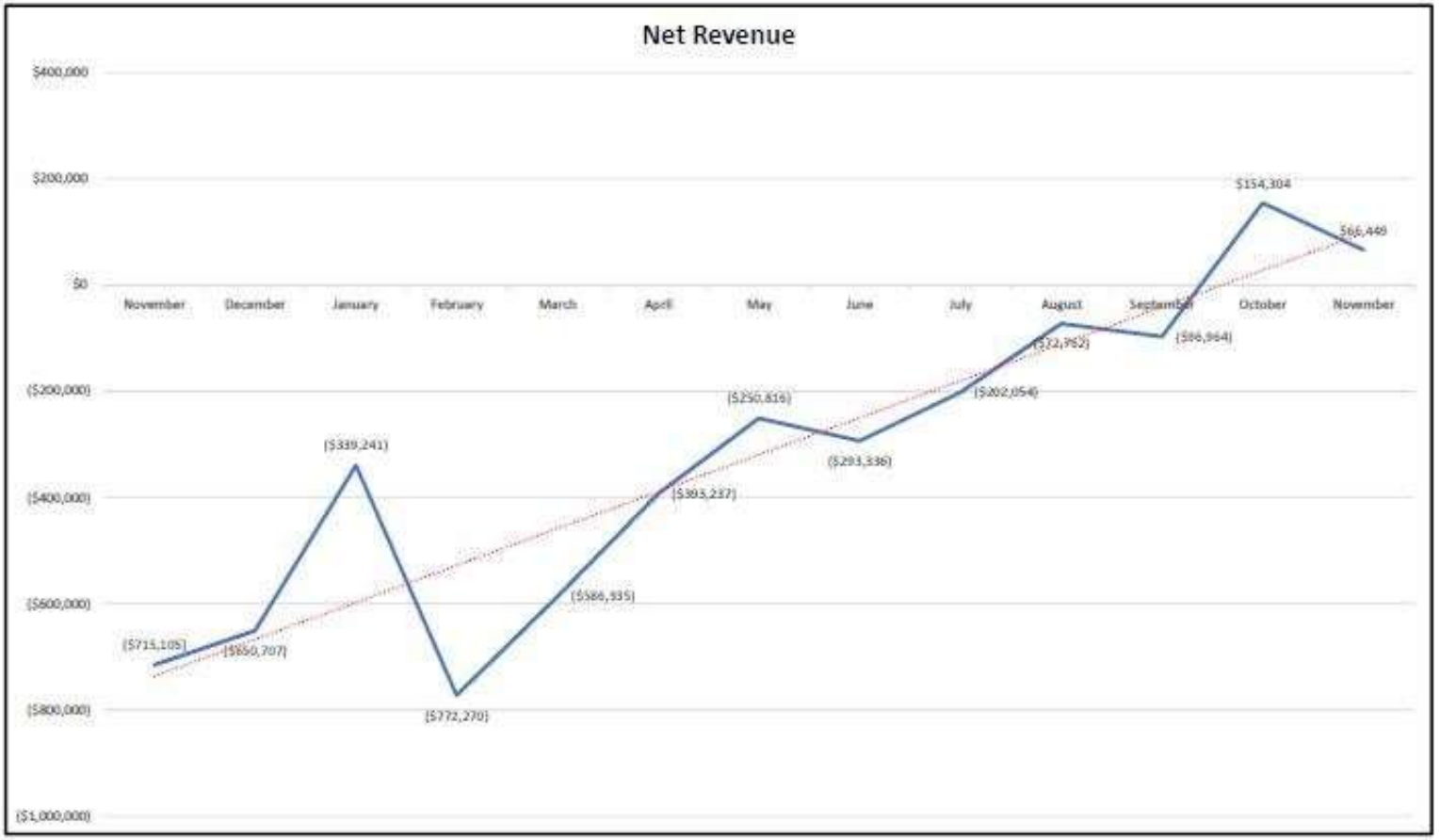
8. WHAT DOES A SUCCESSFUL HOSPITAL TURNAROUND LOOK LIKE?

Net Revenue : FY 2018												
November	December	January	February	March	April	May	June	July	August	September	October	November
($715,105)	($650,707)	($339,241)	($772,270)	($586,335)	($393,237)	($250,816)	($293,336)	($202,054)	($72,762)	($96,964)	$154,304	$66,449



9. What is your advice to hospitals looking to transform?

The top three things a hospital leader needs to do increase revenue and transform the bottom line?

1) **Understand the patient revenue process from the physician order until the account has a zero balance.**
2) **Set up reports to track the dollars to ensure you are receiving full payment – 10% of reimbursement is lost in the process.**
3) **Train and hold managers accountable to industry benchmarks that can be measured daily – weekly – monthly.**

In Summary – Hospital leaders willing to implement change and automation can transform their bottom line

• Point of Service Collections increased from $4,000 a month to $40,000 a month or $480,000 annualized and clean claims rate improved from 70% to 94%	$480,000
• Medicaid eligibility service resulted in 100+ Medicaid approvals at approximately $3000 per approval adding another $300,000 to the bottom line.	$300,000
• A/R reduction of over $10 million of an initial $21 million in gross accounts receivables or approximately $3 million in net revenue annualized.	$3,000,000
• 5% improvement in Medicare reimbursement netting $50,000 per month or $600,000 annualized.	$600,000
• Charge master updates and market corrections realized a net improvement of over $2 million dollars annualized	$2,000,000
• Coding changes improved quality and CPT accuracy from 70% to 94%, which resulted in $200,000 increase monthly or $2.4 million annualized.	$2,400,000
• Appropriate documentation to reflect the acuity level of the patient increased the Case Mix Index (CMI) from .95 to 1.5. The Case Management team reduced length of stay from 5 days to 3.5. Combined, these two areas of improvement resulted in an additional $1 million in revenue.	$1,000,000
• Denials management team achieved an overturn rate of 80% on denied claims which added another $50,000 monthly to the bottom line or $600,000 annually.	$600,000
TOTAL	$10,380,000.

Questions?

Thank you!

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