

Optimizing the Revenue Cycle IT Investment

Healthcare providers are increasingly turning to technology to improve revenue cycle efficiency—leveraging integrated electronic health record (EHR) solutions to streamline workflow, accelerate cash flow, optimize revenue integrity, and lower the cost to collect. Unfortunately, many providers still struggle to fully realize the benefits of this technology. In this roundtable, sponsored by Navigant, several healthcare leaders discuss how they are working to get the most from their automated solutions, particularly with regard to revenue integrity and preparing for value-based payment models.

When describing your organization’s EHR platform conversion, what was the driving market catalyst?

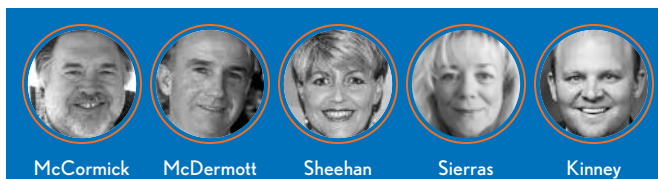
Jennifer Sierras: Sutter Health was committed to moving from a “best of breed” philosophy to an integrated EHR that combines the clinical system with revenue cycle and administrative components. We believed this would better support care across the continuum and improve efficiency. Instead of building care episodes in different systems separately, we could use our integrated solution to create one holistic, longitudinal record that everyone could access. In addition, with the same system for financial and clinical operations, we could reduce the need for interfaces and eliminate delays in real-time information exchange. When considering which vendor to use, we chose one that was already fully implemented in our ambulatory setting. Because we had software in place on a small scale, we saw its advantages and how those could translate to the larger organization.

Rosemary Sheehan: Partners was looking to more effectively manage patient care across the continuum, and we thought we could provide more unified care if we all shared one clinical record. That includes our community-based physicians, community hospitals, academic medical centers and the physicians within them, and then our post-acute hospitals, specialty psychiatric hospitals, and our home health service.

Thomas McCormick: There was more than one catalyst that drove the decision for Penn Medicine’s EHR conversion; however, a significant

impetus was to capture meaningful use dollars. We also wanted to become more efficient and felt that a proven, integrated system would allow us to better share information and eliminate redundancy. Finally, we were interested in lessening the complexity of our “best of breed” environment, which had multiple interfaces to monitor and manage, so we decided to move toward a single-vendor scenario.

Tim Kinney: Among our clients, I would say the main market catalysts are the shift to value and the desire to connect the clinical and financial sides of the house in a way that they never have before. Providers are



HFMA Roundtable Participants

- Thomas McCormick is vice president of patient accounting for Penn Medicine in Philadelphia.
- Patrick McDermott is vice president of revenue cycle for Sutter Shared Services in Sacramento, Calif.
- Rosemary Sheehan is vice president, revenue cycle operations for Partners Healthcare in Boston.
- Jennifer Sierras is CIO for Sutter Health in Sacramento, Calif.
- Timothy Kinney is managing director for Navigant in Chicago.

looking for greater transparency between the two areas in terms of clinical documentation, coding, and billing to ensure the correct financial reimbursement.

If you peel the onion a little more, another driver that emerges is the need to consistently foster best practice performance, which can enable comprehensive revenue capture while reducing expenses. There is also a desire for greater efficiency. Historically, the revenue cycle has involved multiple handoffs and rework. With denials, for example, there are many manual tasks when following up on rejections, underpayments, and so on. With technology, providers can embrace a more proactive approach that reduces back-end work.

What steps did your organization take to achieve a positive ROI through the process, and what are some examples of the successes you achieved?

Sheehan: A defined ROI is difficult to generate when it comes to an EHR implementation because it's so expensive to onboard these solutions. Plus, Partners took a slightly unusual path to implementation. We had a project team that was introducing a different system on the revenue cycle side. When the clinical part of the organization made the decision to install a new EHR, the revenue cycle team began to rethink its decision. Did we want to create integration points between the two systems, or was it better to consider using the vendor the clinical side chose so we would have one, unified program? We opted for the latter. Because we already laid the groundwork for the other revenue cycle system, we implemented the revenue cycle components of the new program in two hospitals before the clinical elements, and that allowed us to get familiar with the vendor and solution. There were positive lessons learned from this experience. We minimized some of the stress involved with the change and were better able to understand our revenue cycle tool. By the time we brought the clinical functions online in three hospitals and across 1,000 physicians, we had been live on our revenue cycle system for 18 months with the two hospitals—one of which was our largest hospital, Massachusetts General. That staggered approach was beneficial in keeping things on track.

The implementation team was also disciplined around our design and execution to minimize any disruptions in cash flow. We were prescriptive about how we onboarded the revenue cycle side and established a solid governing structure to make the appropriate design and build decisions. One important lesson we learned during testing and training was that we focused a lot on standard workflows where things proceed perfectly—we trained to a positive experience where everyone along the continuum handles their parts of the workflow well. Unfortunately, once you go live, you realize that there are processes that aren't necessarily followed across the board. Then, you find yourself in

a challenging situation because someone upstream didn't follow the specific protocol. We quickly learned that we needed standard operating procedures for those more difficult cases. Once those were in place, then we figured out how to work the system more effectively. Our accounts receivable dropped dramatically at that point. Now, in almost every setting, our A/R days are lower than they were in our legacy system.

We're beginning to see some real opportunities emerge from our integrated solution, but taking advantage of those opportunities involves time and workflow changes. Although we've started to see some improvements, it's going to be several years before we can truly say that we have seen a positive ROI.

Kinney: If you look thematically at the differences between a strong go-live and one that has faltered, there are a couple of things that emerge. The first is engagement. Overall, an implementation must be operationally driven. Those organizations that have the best outcomes are the ones where the operations team leads design and workflow decisions, and IT comes to the table to support them in the decision-making process. There is also a need for regular clinical involvement with physicians and other providers weighing in on what works and what doesn't. This strategy is something that should be established from the beginning. If your revenue cycle and clinical leaders work together with your CIO, you will set yourself up for success.

Providers also should focus on some leading indicators like charge capture, revenue, and whether bills are going out timely and clean. Both revenue cycle and clinical staff need to know and appreciate their roles in ensuring these metrics improve with the implementation of a next-generation EHR. Our experience is that organizations that focus on those larger, leading indicators are able to minimize revenue misses and cash disruptions, as well as ensure they enhance revenue integrity. There is a change-management component to this work, and the more upfront rigor you can put around it, the better off you are going to be.

Sierras: Sutter's EHR implementation journey began in 2007 for our acute sites, although we did pause and restart it. What we developed during this project was not only an implementation plan but also a benefits realization framework. This examines key financial and clinical performance indicators and outlines the benefits an entity could achieve. We didn't go live in one big bang; we onboarded our system regionally, and each hospital/region started at a different place of automation. As such, each organization was able to take the framework and customize it to how they would benchmark and validate their progress.

Patrick McDermott: During the second half of the initiative, Sutter decided to form a shared services center. A hospital would turn on the EHR, and then the shared services team would map all the people, processes, and technologies into the shared services center. Since 2014, we have used this approach for the revenue cycle, and we essentially manage the accounts receivable for 27 hospitals.

How has this conversion positively affected relationships within your internal teams, including clinical departments or relationships with IT?

McCormick: Penn Medicine has seen a dramatic change in the relationships between clinical and non-clinical departments. Workflows and accountabilities are better defined and accepted, which results in more collaboration and less finger pointing. Our organization also saw a significant improvement in the efficiency of getting a clean claim out the door—improving over baseline. We have also seen an uptick in physician engagement, which has resulted in less resolution work on the back end—speeding cash flow and preventing rework.

Sierras: When we established our system implementation team, we crafted a complete governance structure to understand the relationship between clinical and financial tasks. We wanted to be sure that when we made changes, we fully understood all the ramifications. It required the two teams to come together to review proposed changes and processes and then determine what the impacts would be. We've continued this collaboration to this day, looking at both perspectives when pursuing improvement opportunities.

Sheehan: This initiative has certainly forced a dialogue between revenue cycle and clinical operations that didn't exist before—although it's not always an easy dialogue. The revenue cycle environment—due to our payers—has become more focused on clinical documentation and clinical workflows, and we are asking more from physicians. Much of the work that is now required—like proving medical necessity—may appear to a physician to be administratively burdensome. That said, the implementation of the new system has opened dialogue, and the clinical side is beginning to appreciate their role because they have a better view of the big picture.

What is your structure for implementing long-term EHR optimizations and keeping up with the latest functionality and code set for your platform?

Kinney: The guiding principle that we see as we look across the industry is to revert to the implementation mindset. Every year that an upgrade becomes available, providers should gather their operational, clinical, and IT teams and determine what system functionalities will deliver value to the organization. Hospitals and health systems also should consider upgrades that will foster a more patient-friendly experience—things like generating a single patient bill, enabling smoother registration and easier scheduling, and leveraging mobile solutions. Keep in mind that it all comes back to having your operational leadership in the driver's seat.

McCormick: Penn Medicine has a governance structure, led by our top executive group, which oversees three subcommittees—revenue cycle, clinical, and patient access. These committees meet monthly to review key performance indicators, the status of open projects, and any new projects—discussing their priority levels. The new priorities generally involve upgrades and optimizations.

McDermott: Once Sutter implemented the IT system in our 27 hospitals, we intentionally declared that we were in an optimization phase. The revenue cycle team informally joined with our IT team to create a virtual group that works on all upgrades and enhancements. This group put in place a disciplined change control process so that testing, user acceptance, and monitoring are robust and defined.

Sierras: Our revenue cycle and IT departments have also sought commonalities in their leadership objectives. Although oftentimes IT and revenue cycle have separate and distinct goals, Sutter has found it beneficial to assign common objectives to both departments so they share the same system goals and work toward a mutually beneficial result.

McDermott: Sutter is also closely reviewing all the functionalities our integrated system offers and trying to reduce—and ultimately eliminate—the need for bolt-on solutions and outsourcing. The whole purpose of an integrated system is to simplify our technical architecture. So, as the integrated system brings on new functions, we make sure that they meet our standards, and if they do, then we begin to migrate away from the bolt-on solutions to avoid redundancies, non-value-added work, and duplication. We still have a way to go before we fully optimize our system, and we are working every day toward that.

When we identify waste and duplication and there is not a way to address it in our integrated system or through a bolt-on solution, we are starting to get creative, trying robotics technology, for example. Sutter has several pilots underway where we're programming robots to perform the repetitive and simple tasks that our revenue cycle staff engage in every day, finishing these jobs at night so our people can work to the level of their licenses and talent and not be sidetracked by mundane tasks. All of these efforts help create more efficiencies, which translates into great benefits to our teams and the patients we serve.

How has or will the EHR platform support your organization's migration to a fully formed revenue integrity department?

Sheehan: Partners has had a revenue integrity team as part of revenue cycle operations for years; however, our integrated system has allowed us to refocus the team's efforts to be more efficient and effective. Before we went live, our revenue integrity teams were structured by hospital, and a team would cover the gamut of specialties at each location—with every hospital having its own charge master. Now that we are all on the same system, we have one charge master and a generally consistent

charging methodology. As a result, we've created revenue integrity teams by specialty that cut across all hospitals. So, team members become experts in the workflows for their specific specialties, allowing them to apply lessons learned and best practices to the entire organization. The teams can identify revenue-enhancement opportunities or technology build issues more easily because they're solely focused on one space. Since making the transition, revenue integrity has become a high-performing management team that ensures we're capturing all our revenue, holding departments accountable, and appropriately charging for the work.

Kinney: The revenue integrity function is the forward-thinking part of the revenue cycle, and a system implementation can sometimes be a catalyst for creating this department, if an organization doesn't already have one. Not only could this group guide IT optimization efforts, but it can also handle new projects, leading the charge for innovation and pushing the envelope.

What role does clinical integrity and use of advanced IT play as it relates to shifts in reimbursement models, and what should providers do today from a revenue cycle management standpoint to prepare for these shifts?

McCormick: Clinical integrity is an important part of being able to work with changing reimbursement models. The accuracy and adequacy of documentation will determine how well an organization reports its quality and what level of payment it receives. As such, utilizing advanced technology to facilitate clinical documentation improvement will be important as organizations participate in these

programs. Providers need to invest time to develop the functionality in the EHR to assist physicians with efficient, complete, and accurate service and outcome documentation.

Sheehan: Like all organizations, we're straddling the fee-for-service and value-based care worlds. I would say our population health management team is taking the lead on experimenting with new payment methodologies. As they begin to form these experiments, our EHR implementation team is typically brought in to design the system workflow. This is where having one system helps because we can more effectively address how we would function in an outcomes-based model because we have a cohesive approach to our practices. We have a single team that can brainstorm and decide how to handle any changes within the IT solution. In the past, we would have to think about changing several different billing systems, and swiftly executing change was challenging—if not impossible. Someone might make a change in the Mass General solution, for example, but he or she would forget to make the change in the Brigham software, and so on. Now, we're able to make consistent enterprise changes that will further our evolution toward value-based care.

Kinney: Although the revenue integrity team should comprise the people who understand system build, charge capture, revenue flow, and back-end processes, there should also be a clinical component. Nurses and other clinicians in these departments should look at payer management, reimbursement, and the ability to appeal and overturn denials. This is only going to become more important in the future as reimbursement models shift their focus. Providers must have the right documentation, coding, and clinical information to ensure correct payment. Innovative, top-percentile performers will have to establish—and fully leverage—a comprehensive revenue integrity function that involves both financial and clinical perspectives if they want to successfully navigate the future. ■

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