The Power of Metrics
Part Two

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Altarum Institute: Revenue Cycle Management Practice

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“Remember, you don’t know how to get there unless you know where you are going? This was the closing sentence to my Part One article on “The Power of Metrics” and it certainly is the message that I would like to share with you in Part Two. If you read my first article on this subject, you will remember that I used some basic areas of our life where we are familiar with metrics – sports and life. Sports has so many metrics that books are published on the subject. Wins, losses, championships, stolen bases, etc. are just the few that many of us are familiar with. In life, “keeping up with the Joneses” is the umbrella statement for metrics. I mentioned these particular examples to begin to build a “mind-set” for the reader as we moved into the overall discussion of metrics in the Revenue Cycle.

Since the last article, I have become more keenly aware of the daily measurements that we almost take for granted. In fact, we have become dependent on some measurements without fully realizing it. Do you have a GPS? If you use the GPS, you have basically removed yourself from decision making in going from one place to another. Sure, in the beginning, the GPS may give you “choices”, such as do you want major highways or avoid major highways, but once you make the choice…it tells you where to go! How about cooking? How about choosing a restaurant? How about buying a car? Each of these normal events clearly involve the statement “you don’t know how to get there unless you know where you are going?” Think about it.

Revenue cycle metrics:
The description of the revenue cycle (indicated above) is typically described as three distinct areas:

- Access Management (Scheduling, Pre-registration, Registration, Contract Management and Insurance Verification)
- Medical Management (Clinical Quality Management, Charge Capture and CDM, Medical Records Documentation, Inpatient and Outpatient Coding)
- Patient Financial Services (Claim Generation, Third Party Follow-up, Payment Posting, Denial Management, Appeals, and Final Resolution)

Each of these individual functions can have one or more measurements that establish a baseline and a goal for improvement. The driving force is to “never be satisfied where you are”. So many
times I hear from PFS managers or CFOs or HIM Directors…”we are maintaining (or slightly above) our established goal and senior management is satisfied”. For me that means – relax, keep doing what you are doing at the same pace and every one stays happy. If that is where you are…you have reached your destination and do not have to go anywhere else.

Some possible measurements to consider:

**Access Management:**
- Percent of error in data collection
- Upfront collections
- Percent of scheduled patients
- Percent of pre-registered patients
- Percent of insurance verified
- Percent of pre-certifications and/or pre-authorizations
- Admits through the Emergency Room
- Percent of ABNs and MSPs completed (and appropriate)
- Percent of self pay referred to financial counseling
- Percent of self pay eligible for assistance (Medicaid, charity care, etc.)

**Medical Management:**
- Backlog of unfiled paper
- Discharged-not-final-billed statistics
- Incomplete discharge summaries
- Concurrent review process
- Incomplete outpatient charts
- Inpatient charts per coder
- Outpatient charts per coder
- Transcription timing turnaround

**Patient Financial Services:**
- Accounts Receivable (days and numbers)
  - Total aged
  - By third party payor
  - Greater than 90 days
  - Greater than 180 days
  - By self pay
- Discharged-not-final-billed
- Bad debt write-off
- Charity write-off
- Cost-to-collect
- Collection goals
- Upfront collections
- Self pay collections
- Credit balance report
- Denials
Now that we have listed some of the metrics that can be utilized within the Revenue Cycle, let’s talk about some actual experiences.

Scheduling and Registration is the FIRST opportunity to appropriately collect information about a patient. This information should not only be appropriate but also correct and complete. There has always been some question regarding the “ability” of this staff to do this job fully since there has been a historical attitude that they are either too busy or too “part time” or not really smart enough to do it. And with this prevalent attitude, the areas behind scheduling and registration have created “work arounds” to make up for this “inadequacy” in scheduling and registration.

The above chart shows the percent of errors per 100 claims that occurred during one year from each of the identified departments. These errors were directly related to the main function within each area and therefore we can say that in the scheduling and registration function, for the third quarter there was an average of 20% (1 in 5) that had a direct error due to incorrect or incomplete information. Based on this history, many facilities want to improve their customer service but wonder what amount of effort is needed to “make it worthwhile”. The return on investment (ROI) is something that may be hard to measure if you do have not kept any history of ‘error rate’. As a simple start, one could do a high level analysis of third party denials based on scheduling and registration errors and continue with that measurement throughout the training and for six months following. This article highlights the ROI in a graphic manner and we were able to “translate” education and training into dollar return. For instance, the error chart above was further broken down into more specific data. Each area had monthly specific goals to reduce the error percentage. Each month they were informed of progress and the types of errors (by shift) that were occurring. Each quarter, we adjusted their goals (since they were improving) and challenged them to keep improving.
The chart below shows percentage information based on registration error (demographics), procedure error (wrong scheduled information), insurance information incomplete, and medically necessary diagnosis information is in error.

![Chart showing percentage information](chart.png)

NOW, senior management adopted policies and procedures implemented in both the scheduling and registration areas to help reach their goals. The approval for specific education and training sessions available to all staff (24/7) was given and for the period of two to three months emphasis was placed on staff education, as well as education for affiliated physicians and their office staff. Monitoring techniques were designed and implemented and scheduling and registration were “highlighted” as high performers and “quality-driven” people. Staff was provided “tools” to access information as well as a resource for questions. The pride in their work grew so that in just the one area of medically necessary diagnosis, the number of monthly errors dropped significantly, as indicated below.

![Chart showing outpatient and inpatient cash](chart2.png)

CASH is now the last question and here is the answer: For the six months following the education and training period, the collection period for claim resolution dropped by 43 days and this translated into almost $2 million dollars. The chart below indicates outpatient cash in Blue and inpatient cash in Red. Since there was a measurement for the number of “clean claims” that went through the system without “re-work”, we believe that these numbers reflect a good realization of the ROI for education and training.
In a similar environment, the education and training outcome was to reduce the number of third party audits occurring in the facility. This was a specialized facility and the number of outside audits was causing a lot of internal distraction. A team of nurses was set up and specifically trained in pre-authorizations and pre-certifications as well as case management discussion. We set up initial goals for these nurses to increase the numbers of pre-auths and pre-certs as well as working the case management nurses to assure accurate information. With the education and training processes and the monthly meetings to fully discuss this program, I am proud to say that, after one year, the number of third party audits dropped to a “scheduled” ONE every six months with the ONE major payor in town. All other third party payors recognized the intensity of the work performed by this group and stated that they did not see any need for an audit unless there was a real “outlier” case.

Successes like these can be reached with the right internal environment and senior management support.

In some of the other areas of the Revenue Cycle, we have also seen the Power of Metrics change behavior and bring enthusiasm back to staff and department. AHIMA publishes some data on the number of charts a coder should accomplish in a day. Since this is input from all across the country, it is only a good start to discuss its application to a specific HIM department. Two quick examples:
Centralized charts:
Chart location and delivery to clinics was a particular problem for one HIM department. The records were all centralized but the clinics were all over the campus. Each clinic did their own scheduling and requesting for charts. Each night, the next day clinic schedules were sent to HIM for preparation and delivery by 7 am the next day. Problems occurred with duplicate time scheduling, not recording the patient’s visit time in the system, charts moving from clinic to clinic, etc. This facility did not have full electronic medical record. Measurements were taken and even a small patient survey was performed. Results were tabulated and metrics were established for both the clinics and the HIM department. One added feature, we established a central scheduling area for both inpatient and outpatient. The outpatient scheduling system also had some logistics built in so that the patient was scheduled and visited multiple clinics in a logical manner. Metrics started at 65% of patients were scheduled in the system and ended up with 95% after a period of 9 months. Physicians loved it since not only was there patient satisfaction and comments about the new system but also the charts were there, delivered by assigned runners (or volunteers whenever possible). Not only did the scheduling improve for the preparation and delivery of medical records but also over two dozen letters went to the CEO reflecting patient satisfaction.

Patient Financial Services:
Typically, there are many different metrics imposed on the PFS department. Let me just reiterate one. Prior to establishing and implementing a central business office, this network of five (5) hospitals had decided to establish metrics for the CBO to accomplish one of the outcomes presented in the initial proposal. Five hospitals basically dealing with the same sets of third party payors BUT whose business office staff never really communicated with each other. In pursuing the desired outcome of CBO process, we made the decision to create third party teams in each of the five hospitals as if they were all located in one place. We ran a series of reports from the various systems to assure we had “apples to apples” and established team leaders at each hospital to meet on a monthly basis but also to have a conference call every other day to talk about the specific payors. Individual metrics for billing and collections were established for each team and adjusted quarterly. So many advantages came from this program that it is hard to document them all. Third party “game playing” was identified; specific diagnostic information was shared to obtain payment quicker; documentation requirements were standardized; certain patients flagged when coverage ran out, etc. The bottom line is that when we started this project, in conjunction with establishing the CBO, the network’s days in accounts receivable was 118. After 18 months and moving into the CBO, the days in accounts receivable was 62. Each day reduction represents about one million dollars in cash.

Well, it is clear that the Metrics have Power if you know what to measure, how to measure and update, and reward success each time you beat your metric. Numbers are just numbers, it is YOUR people who have the Power to meet and beat the number. This builds pride in the individual, pride in the department and pride in the facility…and even pride in the community.

Don’t abuse the power…use it wisely.