healthleaders CELEBRATES

REVENUE CYCLE TECHNOLOGY WEEK

ADVANCING THE REVENUE CYCLE THROUGH TECHNOLOGY

Sponsored by: agshealth inovalon Omega Healthcare WAYSTAR

TABLE OF CONTENTS

THE EXEC: HOW PMHA'S VP OF FINANCE WILL UTILIZE DATA TO INCREASE REVENUE, REDUCE COSTS

By Amanda Norris

The VP of finance and revenue cycle at PMHA details the health system's quest to secure more revenue, reduce denials, and support better outcomes.

KEY TAKEAWAYS

- When budgets are tight, leaders need to be strategic when investing in technology. Because cost efficiency is so important, healthcare systems and hospitals alike need to get a lot of bang for their buck when considering technology—ROI is always key.
- PMHA is complex with member hospitals with different operating systems and staff. It needed a way to merge and loop the data to provide analysis and identify trends per hospital in order to rectify and create process around each identified item while being cognizant of costs.
- As finance and revenue cycle leaders fight against poor operating margins, reduced reimbursement, and inflated expenses, developing and executing a strategic path to a financially sustainable future is essential.

Nicole Clawson, VP of finance and revenue cycle at Pennsylvania Mountains Healthcare Alliance (PMHA), feels these same pressures at her health system—a collaborative network of independent community hospitals located primarily in Western and Central Pennsylvania.

When budgets are tight, leaders need to be strategic when investing in technology. Because cost efficiency is so important, healthcare systems and hospitals alike need to get a lot of bang for their buck when considering technology—ROI is always key.

Clawson has the same thoughts since the PMHA mission is to enhance the ability of its member hospitals to provide patient-centered community-based care and to maintain their status as independent community hospitals.

To help ensure financial stability, the revenue cycle division at PMHA includes an overall approach to standardization and process efficiencies focusing on people, process, and technology, Clawson explained to HealthLeaders.

“Our core revenue cycle model includes its shared service management division along with the technology in the systems it uses to gain efficiencies, best practices, and create an overall increase in cash collections and a reduction in denials and bad debt,” Clawson said.

PMHA has extension divisions that can be utilized independently of its shared service management, Clawson said. Included in this is its:

- Revenue integrity/charge master division
- Contract management and payer relations division
- Retainer services within its revenue cycle

“The revenue cycle divisions provide overall revenue cycle management using best practice, efficiency, workflow standards, and reporting to enhance the entire revenue cycle process. A key function within hospital operations, our best-in-class experts work to optimize the financial process used to manage administrative and clinical functions associated with capture, management, claims, payment, and collection of patient service revenue,” Clawson said.

When a hospital system has such a multifaceted operation such as this—while also needing to count every penny—streamlining processes while staying cost effective is critical.

Because of this, Clawson says PMHA is in the process of implementing a combination of technology and operational expertise to monitor revenue cycle data flow from beginning to end with four of its member hospitals.

Read on to hear what Clawson had to say about the system's pain points, implementation strategy, and lessons learned so far.

"Healthcare is ever changing, this is known. Our divisions are strong and while we are in a good place within each service line we offer, a strategy to optimize revenue and stay compliant is very important in this environment and looking out 5-10 years and beyond is important."

HealthLeaders: *What sort of pain points were you seeing in your revenue cycle that made you realize you needed to implement a change?*

Nicole Clawson: Healthcare is ever changing, this is known. Our divisions are strong and while we are in a good place within each service line we offer, a strategy to optimize revenue and stay compliant is very important in this environment and looking out 5-10 years and beyond is important.

Our current systems wouldn't allow us to dive deep enough into the issues each of our member hospitals were and are facing. I wanted one database that could give me an 'at a glance' snapshot of each member hospital as well as the alliance as a whole.

We started with an evaluation of our current technology and found it to be inadequate for what our vision and needs were. It was very important for me to find not just a vendor but a partner that understood our model.

We are complex at PMHA, we have member hospitals with different operating systems and staff. While we are the constant in revenue cycle management within the shared service hospitals we needed a way to merge and loop the data to provide analysis and identify trends per hospital and across the membership of hospitals in order to rectify and create process around each identified item.

PMHA spent years developing our current system with best practice rules for eligibility, some general and others very specific for our region (PA/NY) and payers. This was to ensure we were capturing and meeting the needs of our members, putting stops in place to provide clean claims with accuracy in patient demographics, patient insurance information, and all-around front end, point of service, or preservice access points.

PMHA also designed algorithms for back-end billing workflow to optimize biller functions for cash acceleration and appropriate reimbursement.

Dashboards at the combined member level is important as we spend a great deal of time manually compiling reports daily, weekly, and monthly at the facility level and with members in totality. I was looking for automation from a PMHA 'control center' level to be able to drill down to the specific detail where leaders can review by hospital and all intervals through PMHA. This automation is something we didn't have, due to multiple databases.

HealthLeaders: *Since PMHA has such complex databases, would you say that was your main driver for considering new technology?*

Clawson: Yes, we found one vendor that could provide everything we were looking for in the capability for us at PMHA to continue to maintain our custom rules, management of the systems provided with that automation and dashboard functionality that would set our member hospitals apart from others. FinThrive, our vendor for this project, also has an understanding our model at PMHA, one that involves complete oversight of the systems we use.

Aside from the technical 'boxes' the vendor checked off for us, an equally driving force that made it stand out above the rest was the partnership. We felt in the vendor review, they came out as best in class, that partner or ally, with a willingness to give us the ability to continue our expertise that we provide to our members in systems and operations to continue to be the administrators over the technology, filtering any requests through PMHA from our members for approvals and processing.

They provided that level of advanced technology, customer service, and collaboration. We have been a long-standing customer in their claims management and charge master product lines, so expanding into an end-to-end solution was our end goal.

HealthLeaders: *What about an end-to-end solution appealed to you versus taking a more granular approach to streamlining processes?*

Clawson: The integration of data, the ability to loop the front end, data quality, and eligibility to the back end in payments, denials, collections, and everything in between made the difference. Being able to analyze that data and find the root cause for denials or payment issues and correct it going forward to eliminate the issue. I prioritize and focus on prevention.

It doesn't matter if you are a large 'mega' system or an independent rural hospital, the issues are the same, it's the scale that is different. Our community hospitals need every penny that is due to them based on the care provided to the patients in the communities we serve. Accurate reimbursement and timely reimbursement allow us to continue providing that care needed in the communities of Pennsylvania and New York.

Grouping the products we utilize in revenue cycle systems and technology with this end-to-end solution was important for premier pricing. Using the leverage of the membership as a whole when contracting is also important and a standard process in the revenue cycle divisions of PMHA.

"We not only needed what I would call the standard products: data quality, eligibility, denials management, collections, and billing workflow but our other division, contract management and payer relations, was being manually managed and in need of a system."

HealthLeaders: *Why did you choose this particular platform for your organization? What made it such a good fit?*

Clawson: It was chosen due to its ability to provide a true end to end solution. We not only needed what I would call the standard products: data quality, eligibility, denials management, collections, and billing workflow but our other division, contract management and payer relations, was being manually managed and in need of a system.

We were able to get all the products and modules we needed within the platform with all of the functionality and capabilities desired and incorporate it with those products we already had.

HealthLeaders: *What is the process of implementing this new platform like? Who is involved with the decision making and why?*

Clawson: For myself and our organization, it was inclusiveness. What I mean by that is its important to include our members at different levels within our year-long system strategy task force. A committee that included our core PMHA leadership team and various member hospital employees for those within the shared service management division and member hospitals in general.

We had members of managers, directors, and CFOs of our hospitals all involved in the decision making.

We wanted a partner who again understood our model at PMHA, so we did a deep dive into vendor selection that included interviews with over 15 companies, those we considered through research to be the highest ranking in revenue cycle technology. We wanted a company that invested in technology and provided the efficiencies we needed and were looking for.

Overall, it was methodical, we were not going to rush into making a selection. We narrowed it down to three vendors and included all levels of the revenue cycle staff at our shared service hospitals to demo each of the products.■

EXECUTIVE SPONSOR SPOTLIGHT

ags health

What are the top two challenges revenue cycle leaders face when trying to implement new technology and how can they solve them?

Emily Bonham
Senior Vice President of Product Management
AGS Health

Among the challenges we hear from our customers is how they can take advantage of technology to cope with rising labor costs and labor shortages. The options can be overwhelming when determining where to begin when they hear at conferences and from their industry peers that AI is the answer to achieving efficiencies. Getting started with AI in RCM is not as difficult as it may seem, but we recommend that clients take it slow and not try to boil the ocean right away.

We consult with our customers to create a customized roadmap to introduce AI technology within their organization that solves their highest priority challenges first.

The second challenge we hear frequently is that they must pitch technology solutions and the ROI associated with them to their organization's leadership to obtain budget and buy-in. It is no longer acceptable to take risks in technology in the name of "innovation," and RCM leaders now need to prove their investments have real, tangible benefits.

"In spite of the media coverage that AI and automation have received for several years, adoption rates have been relatively low. To date, the implementation of AI and automation has been limited to some of the larger health systems, where monetary and labor resources are more abundant."

To solve this challenge, we help our clients build ROI models based on their data, which illustrate how technology costs are covered and surpassed as time goes on. Specific examples depend on the challenge at hand but typically include both revenue generation and margin improvements.

EXECUTIVE SPONSOR SPOTLIGHT

agshealth

What technology solutions does your company offer to revenue cycle leaders looking to streamline possesses and efficiency?

The team at AGS Health has created a wide variety of technology solutions to enhance the speed, quality, labor efficiency, and revenue outcomes of revenue cycle management operations. These include, but are not limited to, automation for financial clearance and prior authorizations, autonomous coding, computer-assisted coding (facility and professional), clinical documentation improvement, code auditing, clinical NLP APIs, and custom developed robotic process automation. Additionally, many of these technologies are leveraged by our award-winning services to enhance the performance and outcomes of our outsourced revenue cycle management services.

What revenue cycle technology trends do you see emerging over the next few years and why?

In spite of the media coverage that AI and automation have received for several years, adoption rates have been relatively low. To date, the implementation of AI and automation has been limited to some of the larger health systems, where monetary and labor resources are more abundant.

In the coming years, I expect more widespread adoption of these technologies as labor shortages compound and risk perceptions decrease. Large hospitals and health systems will expand their adoption of these technologies as they observe strong ROI and become more comfortable with them. Meanwhile, small to medium-sized firms will begin to emulate some of their larger peers' more successful implementations.

Autonomous coding is an example of this. Finding and hiring skilled medical coders has been a problem for many healthcare organizations. Not to mention the significant increase in wages. In order to avoid this issue, I believe this technology will be rapidly adopted in an attempt to augment human labor.

Coders will then take on a new role in auditing the technology's performance, handling only the most complex cases manually. With AI learning and adapting to this feedback, the need for human intervention will further decrease, which will be particularly beneficial considering changing workforce demographics due to anticipated retirements.■

EXECUTIVE SPONSOR SPOTLIGHT

What are the top two challenges revenue cycle leaders face when trying to implement new technology and how can they solve them?

Allocating resources and managing the technical lift required to get new solutions up and running.

Especially in smaller organizations, the revenue cycle leader must look at all the resources available to them – time, money, and staff time – and make decisions on what to tackle. Is it getting the new technology up and running? Is it managing a backlog of claims or getting new claims out the door? For small teams, not everything can be done.

Revenue cycle leaders can and should prioritize their time investing in integrated platforms. Despite the technical lift this can often require upfront, the sooner they are able to implement the tool and empower their team, they can maximize the value they can get from that software. This allows them to keep providers in their EHR and focused on their patients – not juggling a number of systems or struggling to create one single source of truth.

Travis Fawver
Solution Architect
Inovalon

“Even with the best tools available to them, something is bound to be missed – which is why we have pre-submission auto-scrubbing to help catch and correct claims errors. AI and predictive analytics are allowing us to take this one step further.”

What technology solutions does your company offer to revenue cycle leaders looking to streamline possesses and efficiency?

We deliver front-end and back-end RCM solutions to empower providers to streamline their workflows and improve accuracy. Powered by the Inovalon ONE® Platform, our RCM solutions enhance revenue cycle operations, help ensure accurate and timely payer reimbursements, and boost cash flow. Our data-driven solutions simplify every step of the revenue cycle, from patient access and eligibility verification, to claims submission and tracking, all the way to patient payment – with analytics available to help RCM leaders pinpoint and address weaknesses in their revenue cycle.

EXECUTIVE SPONSOR SPOTLIGHT

Most recently, we introduced a new all-payer eligibility integration to our customers, empowering them to reduce manual work when verifying patient coverage by normalizing the data going into their EHR. This means the patient information lives alongside the transactions for them, now allowing providers to have one single source of truth in one, integrated solution. This reduces friction for their front-end RCM, setting up their claims for success and improving the patient experience as well.

What revenue cycle technology trends do you see emerging over the next few years and why?

I think we'll continue to see a rise in AI and predictive analytics, particularly in helping confirm patient information and streamlining processes. There are many details that fall on RCM staff to get right on every claim, every time.

Even with the best tools available to them, something is bound to be missed – which is why we have pre-submission auto-scrubbing to help catch and correct claims errors. AI and predictive analytics are allowing us to take this one step further. I think in the future, we won't be as focused on flagging a correction needed, but instead, perhaps, identifying the error and making the correction for the user. ■

THE EXEC: A SYSTEMWIDE, 12-MONTH STRATEGY TO COLLECT $12M

By Amanda Norris

With rev cycle tech at the helm, AUMC created a 12-month strategy to increase point-of-service collections.

KEY TAKEAWAYS

- "Patients are providers' second largest payers, so collecting payment prior to or at the time of service is critical to the overall financial health of the organization."
- Annual point-of-service collections should total $12 million, but AUMC was sitting at around $3.6 million annually.
- To change this, AUMC implemented a 12-month strategy featuring revenue cycle tech to increase its bottom line.

As hospitals and health systems battle to increase margins and improve efficiency to remain financially healthy, revenue cycle and finance leaders have been looking to shore up processes in the revenue cycle to increase their bottom lines.

Augusta University Medical Center (AUMC) is no exception. The health system realized it was missing opportunities by not prioritizing pre-service and point-of-service payments and lacked user-friendly automation, which led to a negative patient financial experience, collecting pennies on the dollar, and writing off bad debt.

AUMC includes a 478-bed adult hospital, a 154-bed Children's Hospital of Georgia, the Georgia Cancer Center, and more than 80 outpatient clinics across Georgia and South Carolina, so streamlining these processes was essential to its financial health.

HealthLeaders recently chatted with Sherri Creech, AVP of patient access services at AUMC, on a 12-month strategy she implemented to save big, streamline front-end processes, and help ensure financial stability moving forward.

HealthLeaders: *AUMC runs a huge operation, so what sort of gaps were you seeing that made you realize you needed to implement a change to its revenue cycle processes?*

Sherri Creech: Patients are providers' second largest payers, so collecting payment prior to or at the time of service is critical to the overall financial health of the organization and our ability to serve the community with quality care.

When I joined AUMC in 2021, I could see we were missing opportunities by not prioritizing payment discussions or collecting payment up front. We collected just pennies on the dollar, and sometimes nothing at all. Historical data showed that annual point-of-service collections should total $12 million, and we were sitting at around $3.6 million annually.

There were several factors that contributed to this deficit. The patient access department lacked the automated technology to generate accurate cost estimates for patients, and staff were not trained or held accountable on collecting payment up front. Once we identified the root cause of the issues and set the financial target, we developed a 12-month strategy to get there. It would take system-wide participation to reach our goal and would include a combination of technology, training, and accountability.

In June 2021, we added a price estimation tool from AccuReg to our existing patient access suite. With tools already in place to ensure registration data accuracy and perform real-time eligibility verification on patient benefits, we had the foundation for generating accurate cost estimates and improving the financial patient experience.

With new technology in place, we revamped new-hire trainings and retrained existing staff and supervisors on how to engage patients financially. Attempting to secure payment prior to or at the time of service was no longer just encouraged, it was part of the job and a service we provide to patients.

HealthLeaders: *Budgets are tight, so did you receive support when deciding to implement new tech?*

Creech: Our CFO was supportive of the strategy and understood that meeting our goal would require a combination of technology, people, and processes. Staff needed to be equipped with the tools to confidently engage patients in financial discussions. Our vendor provided training on the software and our internal team conducted trainings on process and procedures around payment collection.

“Staff needed to be equipped with the tools to confidently engage patients in financial discussions. Our vendor provided training on the software and our internal team conducted trainings on process and procedures around payment collection.”

HealthLeaders: *Because of these tight budgets, organizations need to be strategic when investing in technology. Since cost efficiency is so important, how were you able to ensure a positive ROI when investing in this new tool?*

Creech: By and large our process for collecting prior to and at the time of service was manual. In the absence of having a systematized way to go about it, staff relied on various inputs to compensate. As far as cost goes, it was an easy decision because automation has enabled us to do more with less.

HealthLeaders: *Since your previous collection processes were entirely manual, I’m assuming adding in tech was worth it?*

Creech: Yes. One year after launching the price estimation software and establishing new trainings and protocols for payment collection, we reached $9 million in point-of-service collections. While short of our original target of $12 million, that’s a 150% increase from where we started, and that’s a huge achievement. The team couldn’t believe it, how small changes every day, like collecting a copay, can add up over time.

Additionally, by alerting staff to registration errors for real-time resolution, the quality assurance tool saved AUMC $1.4 million in back-end rework.

Staff are much more confident in their roles because they now have the tools to help them succeed. Automating cost estimates saves time and frees staff to provide a more personalized patient experience. Our staff visit with every patient to help them understand their bill and discuss obligations for partial payment or payment in full.

Like any change, it took time. But patients appreciate the cost transparency because it gives them choice and control over their healthcare.

HealthLeaders: *When looking back, what are your thoughts on the overall process?*

Creech: It can be difficult to discuss the financial aspects of healthcare with your patients, but at the end of the day, it is our duty as providers to educate patients on what they owe. We help our staff understand that it's not just about collecting, it's about providing a service for your patients. An informed patient is a happy patient, and that begins with understanding their costs.

Improving the patient access experience was a system-wide goal for us and we were committed to changing how we approached payment. It took all of us, from front-end staff, analysts who created the goals, people working behind the scenes, the staff who invested in training the department, to the leadership who championed the results. ■

EXECUTIVE SPONSOR SPOTLIGHT

What are the top two challenges revenue cycle leaders face when trying to implement new technology and how can they solve them?

One of the biggest challenges RCM leaders face is having sufficient resources available to implement new solutions. This becomes especially difficult when new technologies need to integrate with existing systems, such as EHR, billing, and finance systems. Moreover, ensuring new solutions meet security and compliance requirements is essential. Leaders must stay ahead of evolving policies and regulations in today's environment of cybersecurity threats data privacy.

The second challenge is managing the technology adoption curve. RCM leaders must be able to justify the investment and prioritize their needs against other initiatives within the organization. Administrative staff and clinicians will need to be introduced to new processes that can impact their daily workflows. While operational efficiencies and cost savings typically come with time, RCM teams must be ready to support change management efforts across multiple stakeholders.

Arnab Sen
Chief Strategy Officer
Omega Healthcare

What technology solutions does your company offer to revenue cycle leaders looking to streamline possesses and efficiency?

Omega Healthcare offers end-to-end RCM solutions, enabled by the Omega Digital Platform (ODP), to drive improved outcomes across the Patient Access, Mid-Revenue Cycle, and Business Office functions. The ODP leverages artificial intelligence (AI), machine learning, natural language processing, and robotic process automation, to automate repetitive tasks, reduce turnaround time, and increase accuracy.

"AI and rules-based algorithms are integrated into workflows to identify eligibility and prior authorization issues, prevent denials, enhance coding accuracy, and prioritize high-risk claims."

Given ongoing staff shortages and margin pressures, RCM leaders need solutions that can increase administrative efficiencies to improve revenues and accelerate cashflows, while reducing costs. The ODP uses AI and automation to remove manual tasks, thereby improving productivity and allowing staff and providers to focus on higher value activities and direct patient care.

EXECUTIVE SPONSOR SPOTLIGHT

The ODP also features a predictive engine to help prevent issues across the entire revenue cycle—even before they occur. AI and rules-based algorithms are integrated into workflows to identify eligibility and prior authorization issues, prevent denials, enhance coding accuracy, and prioritize high-risk claims.

Finally, the ODP enables clinical workflows that alleviate administrative burdens. Clinical documentation improvement (CDI) capabilities provide real-time feedback and education opportunities, enabling providers to become more efficient and compliant with their documentation, freeing up their time from administrative tasks.

What revenue cycle technology trends do you see emerging over the next few years and why?

Generative AI is garnering a lot of attention in the industry, and it does hold promise to improve process efficiencies, particularly with manual tasks and clinical documentation.

In addition, solutions are emerging that aim to identify and resolve issues in the front end of the revenue cycle, rather than waiting for a retrospective review during downstream processes.

Finally, the industry will continue pushing for increased integration of clinical and financial data and processes. As value-based care and tighter payer-provider relationships continue to evolve, these integrations will become more essential to enhance outcomes. ■

EXECUTIVE SPONSOR SPOTLIGHT

WAYSTAR

What are the top two challenges revenue cycle leaders face when trying to implement new technology and how can they solve them?

When implementing new technology, there are two common challenges revenue cycle leaders face. First, being strategic and thoughtful when incorporating new technology into the workflow and knowing when modification is needed. Second, being in collaboration with your vendor partner to establish how success will be measured.

What technology solutions does your company offer to revenue cycle leaders looking to streamline possesses and efficiency?

Waystar's purpose is to simplify healthcare payments, so our clients and partners can focus on their goals, patients, and communities. Our comprehensive end-to-end platform of cloud-based revenue cycle management solutions includes Financial Clearance, Patient Financial Care, Revenue Capture, Claim + Denial Management, and Analytics + Reporting solution suites. With a combination of breakthrough technology, innovative software development, and the industry's most advanced transactional network, Waystar's provides actionable insights to optimize the complete revenue cycle while streamlining workflows, increasing operating efficiencies, and driving bottom-line performance.

What revenue cycle technology trends do you see emerging over the next few years and why?

Consumerism in healthcare – Historically, RCM processes have not been structured to account for so much reimbursement coming from individual patients, which has increased the cost to collect and bad debt. Providers are now experiencing competition from consumer-centric companies and patients have become accustomed to frictionless ways to engage with services, including different ways to receive care like telehealth visits. The risk of losing a patient is significant with the average lifetime value of a patient estimated to be $1.4M.[1] With already thin operating margins, that is a significant risk to net patient revenue. If it's too difficult for patients to receive and pay for care, they will go elsewhere.

Leveraging automation and AI – Amidst both material technology advancements and extreme workforce challenges, providers are turning to automation and the hopes for the evolution of AI in the revenue cycle. We understand people do not go into healthcare to spend time on the phone with payers getting the status of an authorization or retrieving missing benefits. They want to work with

patients. According to a poll of healthcare workers, employees that felt they often or always have enough time to do their work were 70% less likely to experience high rates of burnout.[2] Providers are now turning to purpose-built automation, which is used for high-volume, high-value tasks that require more complex business logic, like claim or authorization processing.

Shift care to alternate settings – We see hospital and health system executives expecting significant increases in outpatient volumes in the coming months and years. Since the COVID-19 pandemic, increased attention on helping to prevent the spread of the virus has left patients avoiding emergency departments and postponing or even cancelling elective surgeries. Reimbursement and financial incentives from both commercial and government payers have contracted policies supporting more services being moved to lower-cost care settings. ■

[1] U.S. Census Bureau
[2] Gallup poll

THE EXEC: SHIFTING THE FOCUS BACK TO THE PATIENT AND SAVING BIG IN REV CYCLE

By Amanda Norris

The AVP for corporate case management at Ardent Health Services details how its technology caught $1.76 million in potential missed inpatient revenue.

KEY TAKEAWAYS

- The Hillcrest HealthCare System is large in scale, so in order to advance its care model where patients come first and processes are designed to serve them best, it needed the right technology.
- Hillcrest's inpatient denials were reduced by 102.34% in the first year of its technology implementation.
- In the first two years, Hillcrest's technology caught $1.76 million in potential missed inpatient revenue. Along with a 12% reduction in observation rates, this has resulted in an additional $3.28 million in inpatient revenue.

Automation in the revenue cycle is not an if, but when. As revenue cycle leaders know, automation has the power to transform the business of healthcare by streamlining repetitive tasks to improve efficiency and reduce financial waste while providing administrative support.

One healthcare system has done just that by implementing automation for strategic revenue management. Hillcrest HealthCare System, the Oklahoma market of Ardent Health Services, has created a system in which processes are designed to best serve patients instead of the other way around.

As a result, since technology implementation in 2020, Hillcrest's clinical staff now focuses their effort on patients, not the administrative work, ultimately saving the hospital time and money.

HealthLeaders recently touched based with Rikki Moye, assistant vice president of corporate case management, at Ardent Health Services, about how the system was able to shift its focus back to its patients through technology.

The health system represents eight major hospitals in the area with over 1,200 licensed beds across the system. Moye was brought on as the vice president of case management in 2016 to build a new case management model that prioritizes patients and is supported by processes instead of led by them, she said.

HealthLeaders: *Tell us more about your role at the health system. Was it a challenge creating such a complex case management model?*

Rikki Moye: It was a challenge to be sure, but eventually, I thought, 'Instead of having siloed utilization review, care coordination, and discharge planning functions that sat side-by-side within Hillcrest, what would happen if that model was tipped on its side?' I then realized that utilization review needed to be a top-down view of the patient where nurse resource managers could oversee the efficient use of resources for each patient as they progressed through their stay, and social work and care coordination could work together to manage the patient safely and efficiently with a seamless discharge handoff.

This model we call the 'Right Care Case Management Model,' encompasses five 'rights:' The right patient, care, setting, documentation, and billing/payment. Using this approach, patients are placed at the center of the conversation, with communication and care facilitated by a resource manager following that person throughout their encounter and beyond.

HealthLeaders: *After implementing this new model, why was it important for your organization to throw new technology into the mix?*

Moye: Hillcrest is very large in scale, so in order to set up the Right Care Case Management Model where patients come first and processes are designed to serve them best, we needed the right technology.

Historically, it's been challenging to introduce technology that would enable this process to the level we need. The labor required is too great, the quantity of data needed is too vast, and consistency and leadership at scale are hard to achieve. However, in mid-2020, we implemented XSOLIS' CORTEX® platform to address those challenges and allow clinical staff to refocus their efforts on the patient, not administrative work. With it, the staff has access to a real-time, artificial intelligence-driven view of each patient's medical necessity, prioritizing cases by revenue sensitivity and risk while also using the platform as a channel to communicate with payers.

The traditional Milliman and InterQual care approaches are binary, meaning it's either red or green and then you have to move on. It's also open to nurse interpretation, which means it's at high risk for human error. Our new platform provides an agnostic, analytical assessment of patients, combined with a nurse's clinical care skills, which enhances and encourages clinical expertise rather than defaulting to the binary clinical decision tree where you basically check your critical thinking skills at the door.

"There's always a learning curve when implementing new technology, but the platform is now a vital part of our nurses' jobs. The way the tool is set up, it presents medical records and quantifies data in an extremely intuitive way, telling nurses upfront where their day needs to start so they don't feel like they're constantly trying to figure something out."

HealthLeaders: *Where were you seeing gaps in the revenue cycle that made you realize a change needed to be made?*

Moye: The problems we faced were the same ones that plague care management across the industry: unstructured data that is difficult to harness, gaps in compliance data, lack of consistency with education or supervision, and most impactfully, no way to prioritize the work that has the most significant downstream impact.

HealthLeaders: *Case managers are arguably pretty in the weeds when compared to other leaders in the revenue cycle, so were there any hurdles with administrative or clinical staff buy-in? How did you make your case for adding in a new solution like this?*

Moye: I was originally brought into bridge operations, strategy, and structure, and provide a gap analysis for where Hillcrest could go in the future. At the time, there was not a lot of case management structure at the market or the corporate level, and the organization was looking for a new way of doing things.

There's always a learning curve when implementing new technology, but the platform is now a vital part of our nurses' jobs. The way the tool is set up, it presents medical records and quantifies data in an extremely intuitive way, telling nurses upfront where their day needs to start so they don't feel like they're constantly trying to figure something out. In fact, a company-wide study found our nurses got back roughly two hours in their day once it was implemented.

The tool has also improved job satisfaction among utilization review nurses, as well as the relationship between Hillcrest's hospitals and the payers it interacts with. Hillcrest has a contract with a national payer who also uses the platform, greatly improving our communication and contributing to a better working relationship because everyone sees the same thing. Nurses now know when to push back on decisions, and payers know when to spend time reviewing. Plus, other payers who aren't currently on the platform are learning about the benefits, and the smoke and mirrors around the term 'criteria' are starting to disappear.

HealthLeaders: *What kind of outcomes and improvements have you seen in your revenue cycle since implementing this tool?*

Moye: In the first two years, CORTEX's inpatient-only alerts have caught $1.76 million in potential missed inpatient revenue. Along with a 12% reduction in observation rates, this has resulted in an additional $3.28 million in inpatient revenue.

We were also able to improve observation-to-inpatient conversion rates from 27% to 52% while reducing inpatient-to-observation downgrade rates to about 4%, a 50% sustained reduction. Inpatient denials were reduced by 102.34% in the first year.

HealthLeaders: *What will you be focusing on for the rest of this year and into 2024? What other goals do you have for revenue cycle improvement?*

Moye: Our goals now include moving from a market/regional focus to an enterprise focus across all Ardent Health acute hospitals. Our ability to leverage technology to facilitate throughput and length-of-stay reductions is one of the successes of the Hillcrest team that we are sharing with other hospitals.■