

A quarterly publication providing topics of interest to the healthcare industry

MiraMed has recently merged with Coronis Health, creating a leading platform that provides end-to-end technology-enabled solutions to healthcare companies across the US. We are excited to start this next chapter and continue bringing the best thought leadership to our esteemed colleagues in healthcare.

**FALL  
2023**



# Signs of Stress:

# Hospitals Faced with Increasing

# Nursing Woes

**BY JUSTIN VAUGHN, MDIV**

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Incoming! The exclamation is not foreign to the ears of those in the military. Those who've been under the incessant bombardment of the enemy are well aware that this word of warning means that another munitions round is on its way. From the trenches of WWI to the killing fields of Ukraine, men under arms have had to face the stress of that familiar whizzing sound, signaling the hurtling of yet one more shell toward their position.

This is the essence of real stress—not just the single advent of bad news but the continual barrage of bad news. It seems that this is what hospitals in the U.S. have been experiencing for some time now, and the bad news keeps coming.

Even before the pandemic, there were the incipient stages of the doctor shortage crisis, as well a general increase in financial pressures. And we don't need to recount the panoply of predicaments endured by the nation's frontline medical

facilities during the darkest days of the public health emergency (PHE). It bears repeating, however, that the COVID crisis continues to have ramifications on the healthcare system long after the peak of the pandemic. Now that the PHE is winding down, hospital board members have been looking forward to a break in the bad mojo and getting back to business as usual. Unfortunately, there is one issue that continues to act as a major stressor for many an American hospital: the nursing crisis.

## GAUGING THE SITUATION

According to *Forbes Magazine*, the U.S. Bureau of Labor Statistics recently reported that more than 275,000 additional nurses will be needed from 2020 to 2030. Employment opportunities for nurses are projected to grow at a faster rate (nine percent) than all other occupations from 2016 through 2026.

**Continued on page 3**

## INSIDE THIS ISSUE:

Signs of Stress: Hospitals Faced with Increasing Nursing Woes .....	1
A Change in the Air .....	2
The Pros and Cons of Hiring Outside Consultants .....	5
Four Ways to Stop Working Against Physicians: So They Can Start Working for Your Patients.....	8
Collaboration is Key to the Financial Health of Healthcare: Is your "Bottom Line"	
Like a Hot Air Balloon—Lost in Space? .....	12
How to Get Claim Denials Under Five Percent .....	15
Converting Data into Cash .....	18
Professional Events .....	20

# A Change in the Air

**BY TONY MIRA**

**Interim CEO**

For those of you who have baked for the last three months under an unrelenting summer sun, you can take a deep breath and relax, because fall is about to arrive. No more 105-degree temperatures and no more August drought. We can look forward to colorful leaves and an invigorating nip in the air. Seasonal change is a reminder that change, in general, is intrinsic in nearly all things. Over the next year or so, there will surely be changes in our personal lives and in our nation's life. The eddies of time bring us to new and unexpected places.

Fall is a time that will bring changes to the nation's healthcare industry. Each November, the government, via the Centers for Medicare and Medicaid Services (CMS), publishes its Medicare Physician Fee Schedule (PFS) final rule for the following year. The PFS establishes a vast number of new rules by which medical providers must abide, as well as setting the payment levels for medical services provided to Medicare patients. Based on the PFS proposed rule published earlier this year, anesthesia providers may be facing a more difficult 2024 from a reimbursement perspective. But, as with nearly everything else, this, too, is subject to change.

There is always a possibility that a bill that is currently making its way through Congress will provide a permanent fix to the seemingly yearly reductions in the



PFS and anesthesia conversion factors (CFs); or Congress could step in at the last minute with yet another band-aid bill that will mitigate the CF reduction for at least one year. Regardless of what the future holds, let us remain hopeful but also vigilant as we await the next changes soon to unfold. We will remain by your side, ready to provide expertise and solutions, come what may.

In the meantime, we have another slate of excellent articles to submit for your edification. Healthcare researcher Justin Vaughn brings a tale of woe concerning the current nursing shortage crisis being faced by many hospitals in the U.S. Is there a ray of hope? Read the article to find out! Consultant Mitch Mitchell really delivers with an article on the pros and cons of hiring outside consultants. Sounds like consultant Mitchell knows what he's talking about! CEO Louis Carter dazzles us with a discussion on the hospital-physician dynamic and what hospitals should do to enhance that relationship. Company president Lyman Sornberger addresses

the importance of collaboration as a key to financial health within the healthcare space. We then have health executive Jim Yarsinsky bringing us a helpful article that lays out the strategies for getting claims denials under the five percent mark. Finally, lab and path expert Michael Ferrie tells us the secrets of converting data into cash. Sounds like a 21st century alchemy lesson—but one that works!

We're thrilled to have such eminent professionals contributing to this edition of Focus. We hope you enjoy their offerings and consider well their facts and recommendations. With change happening all around us, it is incumbent upon all of us to undertake a few changes, as well. Take care!



# Signs of Stress

## Continued from page 1

So, the need for nurses has been solidly established, but will this need be met? All indications are that, unless conditions change, we may be looking at a long-term problem.

The American Nurses Foundation (ANF) and Joslin Insight conducted a survey of nurses across the U.S. this past November. Over 12,000 individuals participated, and all 50 states were represented. According to the ANF, the survey has a 1.15 percent margin of error.

The nurses completing the survey work in a wide spectrum of settings, including 53 percent employed in acute care hospitals of all sizes. Seventy-two percent of respondents provide direct care to patients, with 78 percent being employed full-time. Four percent of respondents identified as a travel nurse. Importantly, 41 percent of respondents indicated being 55 or older.

## FEELINGS OF FATIGUE

The survey revealed several significant findings that will have widespread implications for hospitals' ability to provide patient care over the long term. Sixty-four percent of nurses reported feeling stressed, with 57 percent identifying with the term "exhausted." Surprisingly, it is those younger and more

inexperienced nurses who "are struggling more with emotional health than their more experienced colleagues." Nearly one-third of nurses with less than 10 years of experience indicated being "not emotionally healthy." This is compared to just eight percent of nurses with 41-50 years' experience.

Ominously, 33 percent of nurses under 35 years of age indicated feeling depressed in the past 14 days, compared to 18 percent of nurses 55 or older. This is a trend that has been identified and monitored since 2021, according to the ANF report.

## ROOTS OF THE PROBLEM

We're all well aware that burnout has been, and continues to be, a significant problem among hospital nursing and other clinical staff. When asked what the prime contributors were to their feelings of fatigue, burnout and low morale, the leading responses from the nurse survey were as follows:

- »» Not enough staff to adequately do their job (38 percent)
- »» Lack of respect from employer (14 percent)
- »» Too many administrative tasks (10 percent)
- »» Insufficient compensation (nine percent)

I was talking with a trauma nurse at a major medical center just recently. She told me that the administration had recently increased the patient-to-nurse ratio, due to an insufficient number

of nurses at the facility. That is, there would now be less registered nurses (RNs) for each patient than what prior protocol had allowed. This, of course, only makes it more difficult for her to sufficiently do her job, and patient care is thereby compromised. The role of licensed practical nurses (LPNs) had also been expanded at the facility to fill in the care gap, which may further compromise patient safety.

The scenario described above is no doubt being seen in multiple hospitals in multiple states. To address the problem, some are looking to their legislatures. It is being reported that organizations



representing the nursing profession in the states of Washington and Oregon have been instrumental in getting bills introduced that will mandate patient-to-nurse ratios that are in keeping with established standards that stress patient safety. If passed, such bills would mandate either the hiring of sufficient numbers of nurses or the reducing of a facility's patient volume.

Let's look again at the bulleted survey data above, as it may prove helpful to hospital decisionmakers to see this quantification of the reasons behind

Continued on page 4

### Continued from page 3

the growing dissatisfaction among nurses. For example, from the above numbers, one may derive that it may not be as important to raise the wages of current workers as it is to hire additional nurses and to foster a better working environment. The bottom line to this section is the following message: retaining and recruiting a sufficient number of nurses will be a vital mission for many U.S. hospitals over the foreseeable future.



## THE PROBLEM MAY GET WORSE

The bad news is that there is more bad news—at least potentially. According to the survey we've been discussing, some 22 percent of nurses said they have changed positions in the past six months. As an indication of what hospitals may expect in the future, 19 percent said they intend to leave their position in the next six months, and 27 percent said they are considering leaving. While this is a modest improvement compared to survey results from one year ago, it is still cause for concern.

Of those who intend on, or are considering, leaving their position, 13 percent said they plan to leave nursing altogether. From an anecdotal

perspective, one nurse stated, "I have seen many caring people step aside from nursing because they have found it is no longer worth it." Another nurse echoed this sentiment, stating:

*The staffing shortage has gotten even worse and most of the medical staff currently working are burned out and ready to leave. It's hard to stay positive in this type of environment. I'm at the point where I want to leave nursing, but I am unable to because I'm supporting my family.*

The report concludes this section by stating, "The effects of burnout are far-reaching, and employers need to

heed the warning." So, unless hospitals intervene, the nursing shortage may continue to intensify. It is, therefore, incumbent on hospital administrators to recognize the severity of the crisis, admit its potential for worsening, and take steps to reverse it. This may include an array of options based on the particular circumstances of each facility. What hospital executives cannot do is sit back and hope for the best.



### JUSTIN VAUGHN, MDIV

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# The Pros and Cons of Hiring Outside Consultants

**BY MITCH MITCHELL**

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To some, having an independent consultant write an article with the above title can look somewhat promotional or self-serving. Luckily, I've been on both sides of the equation, which means I have served as both an internal staffer and an outside expert. As a result, I can discuss openly and honestly the pros and cons of retaining the services of a consultant; at least I hope this article comes across that way.

## A PERCEIVED NEED

Healthcare is one of the strangest businesses in the country. Whereas in every other industry there are people in positions of authority who know the inner workings of an organization, and there are multiple opportunities for these workers to move up the corporate ladder, that is not always the case in healthcare—especially as it pertains to most hospitals and almost all physician groups.

Most departments have one director and possibly some supervisors, who many times don't know everything about their department because certain information has not been readily shared. The same goes for C-suite leaders, where in most facilities there is only one vice president responsible for a number of departments—in some cases,

departments they might not know much about. That's not blaming anyone; it's telling the truth, as most of you already know.

In many cases, something comes up that is going to require the services of someone outside of the organization. I know that to be the case because, at two facilities I was employed at, neither had anyone on hand who knew anything about the charge master until I got there. At two of the facilities for which I provided consulting services, one hadn't had anyone looking at the charge master for over three years; the other had given the duties to an accountant without any training and who was unable to do the job properly. The overall problem at both facilities was that there wasn't anyone in the C-suite who knew how important a charge master was to their revenue and overall profitability; and, with the utmost humility, I was able to have a positive impact on them both.



## WHO YOU GONNA CALL?

So, while bringing in the right consultant can be a real boon to a healthcare facility, there is also the downside of hiring the wrong consultant. Not only will such an individual fail to bring about the necessary improvements, he or she may actually leave the organization in worse shape than they found it. Often, these consultants will give advice based on analytics alone, rather than—I'm sorry to say—a bit of common sense.

## CASES IN POINT

Many years ago, a major consulting firm that no longer exists went into a major hospital in California, charged a lot of money over the course of three years, and only fixed one of the problems that had been identified as needing correcting. Closer to home, I consulted in a different capacity at a hospital in Pennsylvania that had a previous consulting company use their analytics to decide that the billing department was overstaffed. This determination was made without taking into consideration that the facility had just installed a new computer system without sufficient IT staff, and the only person they had with a working knowledge of the new system had left two months after it was installed.

Continued on page 6

# The Pros and Cons

Continued from page 5

That same consulting company was later sued by the hospital for failing to adequately address a single problem the hospital had been having over an extended period while charging a pretty penny for their so-called services.

I was also at two hospitals where the powers that be decided to have an independent consultant come in to evaluate my billing employees to see how proficient they were. At one of these facilities, the consultant found there to be 63 errors that needed to be addressed. When asked about it later by the chief financial officer (CFO), I pointed out how I'd requested more staff to address 62 of these issues; but, of course, that never happened. The second time the consultant found 21 problems, and the CFO talked to me about it, saying he knew about all 21 issues because I'd already told him about them, and he thought they were minimal. Both times, the only recommendation from the outside consultants was to involve more staff; that's not helpful if that's the only recommendation.



There are two major problems concerning all of the above stories. First, none of the hospitals had anyone on staff who knew anything about what needed to be corrected, as well as not having anyone who knew how to initiate those same corrections. Second, which is probably the biggest problem, hospital administrators are very private when it comes to needing some outside help, which means they rarely discuss these types of issues with other facilities within the area.

## THE DECIDING FACTORS

I've highlighted some of the problems. Now it's time to present some ideas that should help facilities in deciding whether they need consultants or not, or at least some idea in how to evaluate them.

First, if you can afford it, hire a revenue cycle manager or vice president. Make sure this person understands billing, registration, charge master, the concept of diagnosis coding (this person doesn't have to be certified as a coder, just knowledgeable about how the process works so as to be able to discuss issues with the HIM department) and the concept of corporate compliance. This person should also know how to help determine whether the processes are working well, be able to make suggestions as to improvements or otherwise help to

determine that outside help might be needed. Someone with these skills would have the ability to figure out whether an independent consultant or a consulting company knows what they're talking about and what they can offer to address issues that might be beyond the skills or time of the position.

Second, drop your pride and ask someone at your level at other facilities if they've ever worked with a consultant or consultant company, and see if they have any feedback about them, good or bad. Many different levels at healthcare facilities have employees who belong to organizations that have either quarterly or monthly meetings. You don't have to tell anyone why you're asking if you're uncomfortable about that part, but it never hurts to ask the question in general terms.

Third, interview at least three consultants or companies before making a decision. Have a set of specific questions that center on the types of consulting you need (if you know what you need) and, if possible, the specific circumstances related to your issues, how they addressed them in previous jobs and what the outcomes were. Don't forget to ask them if you can contact any of those other facilities to verify those accomplishments, whether you do it or not.

Fourth, hire someone based on the scope of your needs. If you have multiple needs, it makes sense hiring a larger firm rather than an independent consultant. (A larger firm might hire a team of independent

consultants who'll actually do the requisite work, but they'll have already handled the vetting process for you.) If you only require one item to be addressed—like a charge master review—you only need one person to handle it. Going this route might cost less than having a large corporation handling the single issue. In today's environment, many of these tasks can be performed remotely, which cuts down on costs drastically. (However, if the task also involves someone needing to see how the charge capture works in different departments, the consultant might need to make an in-person trip for at least a few days for a deeper evaluation.)



Fifth and last, don't always hire the consultant or company that costs the least amount of money. If you perform your due diligence and you discover that the choice you've made ends up costing a bit more, go for it. Hospitals generate significant revenue; if someone's going to help you add to that profitability over the long haul, don't let the upfront cost keep you from hiring the best choice for your facility.

At the end of the day, hospitals will have to determine whether they have sufficient

resources in house to address their biggest needs and most pressing challenges or should instead look to an outside consultant or consulting firm for solutions. While costs are a consideration, the ultimate goal is to ensure the long-term success of the hospital; and, sometimes, that means making the occasional investment in outside expertise.



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# Four Ways to Stop Working Against Physicians: So They Can Start Working for Your Patients

**BY LOUIS CARTER**

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Give physicians the right tools, technology and supportive environment required to thrive daily, and they will be much more willing to put up with the pressure, on-call shifts and time away from their families. Health system leaders often need to catch up on this extremely important point. The healthcare industry has almost entirely corporatized. However, it is also true that most physicians continue to adhere to the moral standards that initially drew them to the profession; and that is what compels many physicians to work in hospitals. Corporate medicine has extracted nearly all of the system's "efficiency." The productivity figures can stretch only so far with restructuring and mergers. However, the professional integrity of medical staff members is one resource that looks endless.



The enterprise as a whole is held together by this ethic. Patients would suffer terribly if doctors and nurses left their workplaces after their paid shifts were over. Nurses and doctors don't do it because they know the repercussions. Over the past few decades, the pressure put on medical personnel has increased steadily without a corresponding increase in time or resources. Patients will only get the care they need if doctors and hospitals work closely together. In light of these conditions, hospitals must plan improvements to attract and keep the best doctors, ultimately benefiting patients. Here are four ways hospitals can stop working against physicians so patients can get the care they need and deserve.

## TRANSFER NON-PHYSICIAN DUTIES TO OTHER HOSPITAL STAFF

According to an article on [AMA Wire](#), MultiCare Health System (MHS), located in Tacoma, Washington, developed the Provider Wellness Program to identify and solve the main reasons behind its doctors' and advanced practice

providers' workplace inconveniences. The health system discovered that, at too many organizations, doctors perform many duties that other non-medical staff can quickly complete. For example, a staff member can schedule endoscopies and screenings for patients, but often physicians have to do it.

Hospitals can reduce physician burnout by letting team members manage work that accumulates in the in-basket of the online medical records systems, such as lab results, patient messages and queries, as well as requests from care homes or referring providers.

## ENSURE BETTER WORK/LIFE BALANCE FOR PHYSICIANS

Providing a better work/life balance is becoming more critical for hospitals, as [92 percent of young doctors](#) say it is a top priority. Doctors are driven away by burnout and discontent; those who remain are less likely to offer patients high-quality care. Most doctors and nurses find it impossible to leave their work unfinished because doing so could





endanger their patients. I will abstain from charging the system with creating a deliberate business plan to exploit medical professionals for free labor. Instead, administrative creep is to blame.

The medical staff members, especially physicians, are burdened with one additional assignment after another because they can't and won't refuse them. People continue receiving prescription drugs, having surgeries and visiting doctors' offices. From an administrative standpoint, everything is running smoothly.

All is not fine, though. Doctors are experiencing unprecedented levels of burnout, which is much worse than the general population and is steadily rising. The World Health Organization (WHO) has acknowledged the detrimental effects of burnout from prolonged professional stress. More medical professionals are committing suicide each year than nearly any other occupation group. Nurse burnout is also rising and is highest among those who provide direct patient care. Increased burnout is also linked to increased instances of medical error and decreased patient safety. This situation cannot continue, neither for medical personnel nor the patients that depend on them. The people in charge must consider the effect of their decisions. It's

more than just a lousy tactic to rely on nurses and doctors to put up with it because you know they won't abandon their patients. It's medical malpractice. Doctors need support to continue providing the care patients need and deserve.

One of the top priorities for doctors is scheduling flexibility, allowing doctors to share their workload or work part-time. Consider rotating on-call duties to give doctors more time to enjoy their free time without any disturbance. It can be an excellent way to lower the burden on physicians to help them avoid burnout and achieve work/life balance.

## STRIVE FOR ALIGNMENT BETWEEN PHYSICIANS AND HEALTH SYSTEMS

According to research published by the Harvard Business Review, one of the core problems plaguing U.S. healthcare is the need for more alignment between doctors and health systems. The conflict between enhancing clinical quality and reducing costs, including coordinating physician compensation with value-based payment systems, is one of the major causes of misalignment. The burden of logistical and documentation work, such as maintaining electronic health records, on doctors who would instead devote that time to patients is another problem causing misalignment. These problems will impede efforts to provide high-quality, reasonably priced healthcare.

Hospital management must take action, because the quality of care is at risk. Disgruntled patients, poorly coordinated care, unequal access to care and rising expenses are issues that have troubled the healthcare system but have worsened during the Covid-19 pandemic. Health systems faced their distinct epidemic as the country battled the crisis, which saw a steep rise in physician discontent and burnout. Health systems' effectiveness and resilience depend on having coordinated, cooperative partnerships with physicians. These relationships require time to develop with honesty, transparency and trust.

New care delivery models appear. Improvements are made in production, quality and efficiency, all of which improve the financial performance of the hospital/healthcare facility. Alignment, however, is relatively easy to achieve. It is because alignment happens at physicians' discretion, and the onus is on hospitals/healthcare organizations to convince them to make that choice. Getting physicians on board involves a person-to-person strategy that begins with establishing shared organizational values and a purpose for the health system, with physician input. To achieve alignment, leaders must consistently remove friction points along the path. It requires will, commitment, grit, tactics, supporting resources and iteration.



# Working for Your Patients

Continued from page 9

## DEFINE THE ALIGNMENT'S CONDITIONS

As a result of the fragmentation of American healthcare, patients typically receive poorly coordinated and uncentered care. Physicians are crucial in determining the costs and outcomes of the healthcare system because they are the ones who write prescriptions for treatments.



Physicians would have to take the lead in implementing these changes and ensure they were founded on shared organizational values if hospitals were to improve healthcare's efficacy, safety and cost.

By identifying and systematically implementing "guiding principles of professionalism," doctors, CEOs and board members can lay the groundwork for this. The values embodied by these pillars—which include practicing medicine responsibly and with compassion, embracing evidence and

educating oneself and others in the interest of patients—represent the qualities of physicians and, most importantly, principles.

## CHOOSE EXEMPLARY MEDICAL PROFESSIONALS TO DRIVE THE CULTURAL CHANGE

Organizations should encourage clinicians to identify colleagues who have embodied the abovementioned pillars through their leadership and practice. These physicians should subsequently be honored at a formal event. The approach grounds the principles in real people rather than just words. It serves to demonstrate the organization's overall dedication to the pillars. In addition, the pillars must be in physician work contracts, and performance reviews of physicians ought to focus on execution. Healthcare organizations must intentionally take measures to develop the best physician team players having these qualities with each recruitment and performance evaluation. Many health systems significantly undervalue the importance of these processes, and they have had to pay the price.

## CONNECT WITH PHYSICIANS AS UNIQUE PEOPLE WITH UNIQUE NEEDS

Health systems must acknowledge physicians as unique people with their



perspectives and motivations before alignment can begin. Doctors can interact with health systems in groups and teams, but they should be able to do it individually if they decide to align. Holding staff meetings to convey changes and new guidelines is one of the traditional methods for achieving alignment. Still, most doctors don't just line up to follow orders and read memos, because they are accustomed to exercising autonomy and making decisions for others in the field.

This means that organizations must put forth the effort to learn what is essential to and motivates individual physicians, bringing their perspectives into the discussion. Also, health system leaders must work with physicians to find solutions rather than go it alone. Physicians must be involved in all clinical, administrative or strategic decisions. Proper alignment entails doctors being free to reject decisions not in their patient's best interests.

While all of this is evident to doctors, for many health systems, it is a revelation. Physicians' abilities and inventiveness

happen when the environment strengthens rather than diminishes what they do. What little free time doctors have remaining in their schedules is wholly consumed by imposed productivity demands and electronic health record documentation requirements. However, engaging physicians' enthusiasm by allowing them to investigate, discover and take action on their priorities is crucial for their well-being and a strategy to avoid burnout. According to experts, maintaining energetic alignment requires just 10 to 15 percent of a physician's time to be set aside for activities like research or learning new skills.

## LET THE PHYSICIANS TAKE CHARGE

Leaders of health systems usually are unaware that physicians practice medicine not only to improve patients' lives directly but also to have a more significant impact by influencing the course of the healthcare organization where they work.

One study focused on three critical medical specialties—cancer, digestive diseases and cardiovascular care—examining the CEOs of the top hundred hospitals in the USNWR. The research focused on whether hospitals perform better when run by qualified medical doctors or non-medical professional managers. According to the report, physician-controlled hospitals have quality ratings around 25 percent higher than those run by managers. This is despite the fact that most doctors have received little to no training in program



deployment, finance, operations and executing ideas at scale. So, it may prove beneficial for those in charge of the healthcare system to invest some time in training doctors in the mechanics of implementing change and assisting them while they do so.

## FINAL WORD

Physicians must understand how their actions directly advance the larger objectives of the healthcare system. Doctors need to be aware of what to expect from colleagues, organizational leadership and patients, and what they must do to live up to the expectations of these people. The ultimate result will be a healthcare system that assists doctors in providing better patient care.



**LOUIS CARTER**

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results. His newest book is *In Great Company: How to Spark Peak Performance by Creating an Emotionally Connected Workplace* (McGraw Hill). He is a partner with *Newsweek* on the Top 100 Most Loved Workplaces and runs a separate BPI branded entity to provide benchmarking and data insights to Most Loved Workplace companies. His work on leadership philosophies and styles has been used by over 42,000 leaders worldwide. He can be reached at [lou@bestpracticeinstitute.org](mailto:lou@bestpracticeinstitute.org).

# Collaboration is Key to the Financial Health of Healthcare: Is your “Bottom Line” Like a Hot Air Balloon—Lost in Space?

BY LYMAN G. SORNBERGER

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The number one concern these days in healthcare is inflation, and over 70 percent of healthcare leaders say that their “financial health” is at risk. Hospitals and providers of all sizes have been on a mission now that prioritizes, among other goals, higher-quality care at a lower cost. Forward-thinking revenue cycle management (RCM) and other financial leaders are making moves *now* to prepare for the continual economic uncertainty.

The financial instability brought on by COVID-19 is beginning to ease for most organizations; and, over the next three to five years, healthcare transformational strategies will focus on creative cost-saving options with improved patient care.

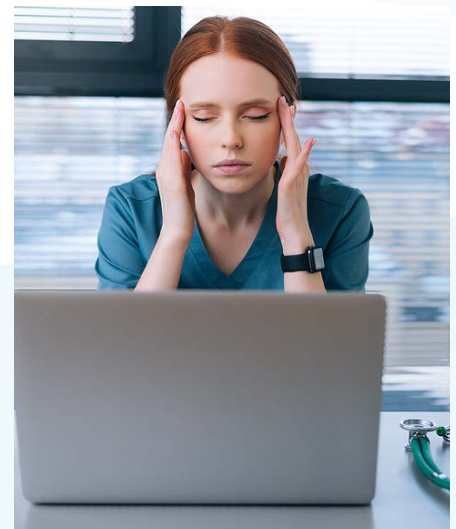
## THE PRIORITY OF COLLABORATION

In order to try to dig themselves out of their financial strife, healthcare providers and organizations are ready for new partnerships that will align talent and expertise from inside and outside their “four walls.” Their ultimate objective is to accelerate their financial results while

supporting a broader transformation through managed services and expanded collaboration with their colleagues. Siloed organizations can no longer fiscally survive the increased burdens of diminishing reimbursement, increased cost and patient dissatisfaction.

Those healthcare organizations that create successful collaboration strategies will not only optimize their current systems through “lessons learned” and technology that aligns with their mission and goals, but they will promote their industry brand.

Seasoned healthcare leaders are now being cornered into looking at what they can realistically achieve *alone* versus looking to *outside networking and business relationships*. Nowadays, it’s career suicide to maintain the mantra of “go for the status quo; we always did it that way; and/or we are the industry’s best.”



Continued education will always be key to personal and professional growth, but reaching across the aisle will now revolutionize the healthcare RCM world. For years, outsourcing managed services models or aligning with the “competition” has been at arm’s length. For various reasons, leaders have been hesitant to think too far outside the box and only give lip service to the term collaborate. What they may not realize is that the future and financial health of their organizations will be at risk unless everyone is cognizant of the need to find strategic partners.



## WHAT COLLABORATION LOOKS LIKE

Without question, those committed to collaboration will be required to be humbler and less threatened in their relationship vision. That does not mean that they relinquish control or become subservient, but rather that they realize that an amazing brain trust exists, and we just need to tap into it more aggressively. Healthcare organizations are becoming more complex while seeking to operate more seamlessly across the continuum of care inside and outside of their hospitals and provider offices.

New, more collaborative and holistic models are emerging that promote financial stability and performance improvement without sacrificing the healthcare organization's mission, goals and culture. The traditional transactional or siloed outsourcing may work for a few areas, but a more realistic hybrid collaborative model will be the most effective way to accelerate the crucial revenue cycle business functions while also supporting the organization's broader transformational strategies.

Without question, the approach will require RCM leaders to combine the demands of a high-performing committed revenue cycle team with a shared vision around patient loyalty, engaged employees and fiscal obligations. The heart of any healthcare's plan is to rein in cost, accelerate and increase revenue and maintain the financial health and industry brand of its RCM.

Among the biggest trends affecting how work gets done with RCM are staff shortages, diminished talent pool,



automation and collaboration through education and networking.

Revenue cycle management is the ideal springboard for new ways of operation that brings together the expertise and talent from not only inside but outside of healthcare organizations. How much would we all learn if we could just listen to "what NOT to do?"

Healthcare financial leaders need and want more from their personnel, talent pool, technology and systems but lack the resources, internal expertise, education and time to optimize every part of their business. Case in point: before the coronavirus pandemic, most organizations did not have the structure to fully support remote workforces. Now, leaders face the challenges of improving performance, sustaining culture and reducing cost in a virtual environment. Seeking collaborations to carry some or part of the operational load will be critical to maintaining the momentum behind this major cost-saving trend.

## THE FOCUS OF COLLABORATION

Technology strategy, now more than ever, should be a major consideration for any new collaboration, whether fully outsourcing the revenue cycle organization or selecting vendors for a

portion of its functions. In the last decade, healthcare organizations made huge investments in their current systems, especially electronic health record (EHR) platforms, yet technology-related inefficiencies continue to frustrate the industry. Additionally, clunky, inefficient software has been a pitfall of past outsourcing relationships, particularly in revenue cycle optimization.

Organizations can't afford to waste time and resources on new technology simply because it's the next new thing. Their ability to realize quick returns on vendor or outsourcing investments depends on how well their partners understand and can leverage their technology stack. In the future of healthcare, collaborations should be designed to optimize current systems and address the interoperability of EHR platforms. This enables smarter business decisions about when to layer in technology that truly aligns to the organization's goals.

Whether fully or partially outsourced or insourced, the success of the revenue cycle hinges on talent and a pool of some of the same resources in the industry. Yet, for many health systems, years of status quo operating has stagnated its workforces' skill sets. Revenue cycle employees, or more importantly leaders, are struggling to support trends like shifts to value-based care, integration

# Collaboration is Key

Continued from page 13

and consumerism in spite of enterprise technology. Universally, organizations are experiencing a shortage of talent while also understanding they can't hire for the same skills that they did five years ago.

The revenue cycle employee of the future is a data-driven problem solver who understands the patient consumerism and the financial experience of healthcare. But what now has changed? With the talent pool diluted from COVID burnout, retirements and experts seeking new careers, management education, communication and collaboration are more important than ever. Budgets are lean, but it's not the time to cut your lifeline to enhancing reimbursement and decreasing cost through limiting education and collaboration opportunities. The cost to replace a seasoned RCM leader has been



underestimated and the cost-benefit is well worth its investment. Rethinking how to upskill and retrain revenue cycle teams is needed, and organizations will have to evaluate if their internal capabilities will be sufficient.

Exploring collaborations that prioritize professional development, training and change management provides a foundation to make change stick and helps organizations build the culture to

support their continual improvement. Clearly, the investment in business relations with other healthcare systems and third-party vendors are key for the "new world" transformation of the financial health of revenue cycle management. In summary, all parties—internal and external—will be required to plan and act differently and harness the momentum of major cost containment trends. This is the new definition of collaboration.



**LYMAN G.  
SORNBERGER**

Lyman G. Sornberger is President and CEO for Lyman Healthcare Solutions Inc. Prior to his roles at Lyman Healthcare Solutions, AHIMA Board of Directors, Knowtion Health Advisory Board, Hilton Law Firm and Source1 Healthcare Inc, Sornberger was the Chief Strategy Officer of Capio Partners, Executive Director of Revenue Cycle Management for Cleveland Clinic Health Systems (CCHS) from 2006 – 2012. This role comprised the revenue cycle management for all 11 Cleveland Clinic Health Systems Ohio and Florida hospitals and 1,800 foundation

physicians. His responsibilities included all CCHS patient access services, health information management and billing. Prior to his affiliation with CCHS Mr. Sornberger was with the University of Pittsburgh Medical Center for 22 years as a leader in revenue cycle management. Sornberger is a graduate from the University of Pittsburgh with a BS and a Masters Degree in Business. He can be reached at 216.337.4472 or [lymansornberger@lymanhcsolutions.com](mailto:lymansornberger@lymanhcsolutions.com).

# How to Get Claim Denials Under Five Percent

BY JIM YARSINSKY, CRCE-1

President, Zinserv Healthcare, Marlton, NJ

The most important action a revenue cycle department can make is to implement a well-thought-out process for managing claim denials. Of course, the best way to manage denials is to avoid them in the first place, and this should be a top priority.

## CLAIM DENIALS CAN DRAIN YOUR REVENUE

Denials are climbing at an alarming rate for many hospitals. The average claim denial rate across the healthcare industry is five to 10 percent. These claim denials cost each healthcare provider an average of **\$5 million** every year. One problem is that only 35 percent of denied claims get followed up on by hospitals by appealing them or by submitting a corrected claim.

Claim denials represent one of the biggest causes of lost revenue for medical facilities and adopting a set of best practices surrounding claims can help keep denial rates low and make appeals successful more of the time.



## DENIALS ARE EITHER PREVENTABLE OR UNPREVENTABLE

According to [“The Change Healthcare 2022 Revenue Cycle Denials Index”](#) on Health Leaders Media, registration and eligibility remain the top preventable denials in medical coding. This is mostly due to coordination of benefits, missing or invalid claims data or lack of medical documentation requested. A denial may be triggered if just one field is left blank, including social security number, plan codes, modifiers or address.

There are additional reasons that preventable denials occur:

- »» Medical documentation requests
- »» Medical necessity
- »» Medical coding
- »» Avoidable care
- »» Missing or invalid claim data
- »» Untimely filing

Do you have a general idea of how much you lost to denied claims last quarter? What about which direction that number is trending? Here are some helpful tips to get you on the right track:

### 1. Know the Main Reasons for Your Claim Denials

A proactive approach is essential to identifying root causes as the basis for denial management and prevention. Getting to the root cause of preventable denials can help a provider improve their revenue cycle and prevent these denials.

### 2. Addressing Claim Denials

Getting claim denials under control means determining the root causes of your denials. To do this, you must first examine what happens before a claim is created and submitted. This can be hard work, but it can make a positive difference in your revenues if you do. You

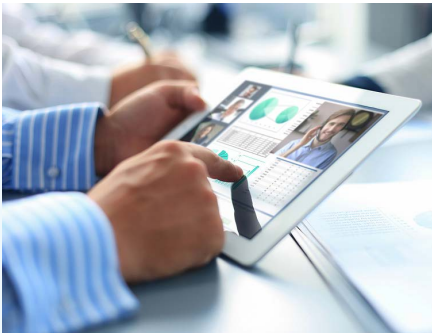


Continued on page 16

# Claim Denials Under Five Percent

Continued from page 15

may notice trends, like claims being filed late or repeated issues with pre-authorization. If you identify a trend in claim denials, you can address the cause by reviewing the entire claims submission process end to end. Ensure your scheduling and intake personnel understand how to conduct pre-authorizations and when they are necessary; and, if claims are repeatedly submitted late, examine the workflow process to see where it could be accelerated or automated.



Almost 90 percent of denials are avoidable. The key to avoiding denials is to train your staff to avoid mistakes before they are made.

At least 24 hours before a patient's scheduled service, the patient's demographic data should be verified, as well as their insurance coverage and benefits. It is important that you follow up quickly. On a regular basis, distribute denied claims to the billing staff for proper handling. This should happen every day.

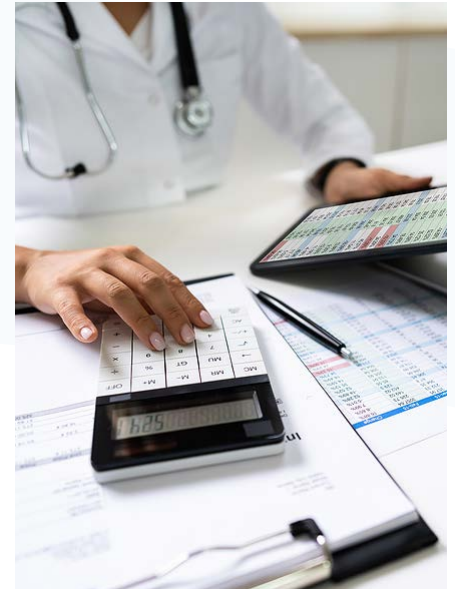
All correspondence should be read daily for changes in billing or reimbursement

policy from providers. This gives providers the opportunity to amend their policies and procedures to avoid denials. Use denial codes to educate medical billing staff when there is a denial due to incorrect medical coding.

Some denial management processes report and prioritize denials based on claim charges or balances. This may lead to suboptimal prioritization because some payers and some contracts have a lower payment-to-charge ratio than others. A better measure of value for prioritizing denials is the expected reimbursement on the claim. The expected reimbursement is based on the provider's contract with the payer and is a measure of the true revenue-at-risk.

Segmenting and prioritizing the **non-preventable denials** based on their expected value, level of effort involved to overturn, and the probability of overturning, can help the organization make the denial management process more efficient, as well as increase and accelerate the cash flows. Identifying the preventable denials can help you improve the revenue cycle.

Denied claims are also either soft or hard denials. A *soft* denial has a temporary effect on cash and has the potential to be paid in full. The facility will need to follow



up, but an appeal is not required. A *soft* denial can be overturned by submitting a corrected claim or by submitting additional information. A *hard* denial represents a loss of revenue that must be written off, and therefore, an appeal is required.

### 3. Making All of This Part of an Overarching Strategy

A *clean claims strategy* should be a *strong priority*. Simply putting out metaphorical fires when dealing with claim denials is not a good strategy for achieving and maintaining high clean claims rates. Ultimately, your overarching strategy for keeping denied claims to a minimum should include counting denied claims, identifying why they were denied and tracking claims to measure clean claims performance over time. Doing this effectively requires full understanding of your billing management workflows and medical billing software. Problems



leading to denied claims may be found at just about any point in the patient cycle, from when they first schedule an appointment until the insurer pays (or doesn't pay) the claims.

#### 4. Have a Denial Appeal Process

Naturally, you would like to never have to appeal a denied claim, but that is not realistic for most providers. Develop a process for dealing with denied claims, and make sure your billing staff understands what to do and what documentation is required. It is also important to know how different insurers deal with appeals. For some, a phone call



may suffice. For others, you may have to submit more forms or documentation to get them to even consider your appeal. Having a streamlined claims process helps because it can eliminate the problem of claims being denied due to late filing.

#### 5. Set Goals and Monitor Progress Toward Them

As with any type of business improvement measure, setting goals and then tracking your progress toward them

is essential to minimizing claims denials. Goals should be shared with all affected staff members, as should the mechanisms for how progress will be tracked. Every quarter, you should find out what the numbers tell you compared to the previous quarter.

When you reach your goals for minimizing claims denials, let your team know. Achieving goals can be terrific for morale, and it is okay to celebrate the big successes.



**JIM YARSINSKY, CRCE-1**

Jim Yarsinsky, CRCE-1, is president of Zinserv Healthcare. Zinserv employs over 100 elite professional medical billing experts and revenue cycle consultants. The company's services range from interim revenue cycle staffing, A/R legacy cleanup and extended business office to coding and consulting engagements. Mr. Yarsinsky is a specialist at creating process efficiency and partnering

with our customers to provide industry-leading revenue cycle solutions. He earned the designation of Certified Revenue Cycle Executive (CRCE-1) in 1995 from the American Association of Healthcare Administrative Management. Yarsinsky also earned his BA in Business Administration from Rutgers University. He can be reached at 877.266.6691 or at [jyarsinsky@zinserv.com](mailto:jyarsinsky@zinserv.com).

# Converting Data into Cash

BY MICHAEL J. FERRIE, MBA

President, Laboratory & Pathology, Cononis Health, Fenton, MO

Any discussion of converting data into cash begins and ends with understanding what constitutes *usable information*. For the world of laboratory & pathology, usable information comes out of data elements spit out by generally horrible information systems. CPT codes? Diagnosis codes? Payers? Rejections by ANSI codes? What does it all mean?

Short answer: NOTHING. Data without analytical frameworks is like looking through a microscope without focusing the microscope or producing an automated clinical test result without a critical value. What does it even mean? Data begins to mean something when it is analyzed and structured in digestible segments, wherein conclusions can be deduced or inferred from which actionable information is borne.

## IT'S ABOUT THE INFO

Information's value expands quickly with awareness of surroundings or how outside considerations impact the meaning and applicability. Consider the idea of "backing up into a laboratory or practice." All of a sudden, when we consider reportable revenue cycle management (RCM) information in the context of laboratory processes, we can marry tests to revenue and expense, creating understanding about profitability. Or, often overlooked, rejection reasons point back into

upstream processes in labs or practices, or even hospitals or surgery centers where process issues confound the ability to bill a clean claim. Information emanating from the RCM process can profoundly impact operations and profitability if developed properly and used with open minds.

Poignantly part of this discussion is how to find sources of good information that can provide the framework for actionable steps. Traditional "billing reports" are simply awful, especially those still on green-bar paper (truly paper or in electronic reproduction). These reports of all kinds regurgitate continuously useless bits and bytes that are connected to no foundation are unhelpful because they draw no conclusions other than, "Yep, we billed \$10,000,000 in charges and collected \$4.3 million in cash." Do we really care about the obvious?



Unfortunately, RCM reports do not often exist in volume or quality but are relegated to the like of billers' reports. You've seen them. Lots of undigestible data elements unless you want indigestion. The data elements often result in observations and perhaps conclusions, but they are linear at best with little depth.

Therein lies the ultimate answer: depth and breadth of perspectives, conclusions, action items, answers to age-old issues and problems.

Where does that level of understanding originate? How do you get your hands on sophisticated information versus outdated data? You can call it many things; but, most frequently, it's artificial intelligence (AI) or machine learning or a few other terms. Therein lies the greatest potential strength of understanding and action.

First up: what is it? Where does it come from? What does it mean? How's it used?

## TOOLS OF THE TRADE

However, before we embark on the aspects of this technology, it is actually

used by very few in ways that make a discernible difference. It's talked about a lot, even hypothesized as if it is real. One needs to be very careful when navigating the avenues of empty promises. How does it work? Where are the results? What are they? We'll get back to that.

The nexus for success is tying the AI technology to sound A/R process with layers of fundamental follow-up leading to full adjudication of claims. The key focus is probability of payment, as instructed by the AI software. The best possible results come from looking past the traditional average trial balance (ATB) to view A/R issues or opportunities in broad scope, viewing hundreds—even thousands—of claims with the same denials or problems within or across multiple payers. It's a view into A/R that cannot be accomplished via any other mechanism—certainly not within traditional tools.

That said, losing sight of traditional tools is unwise. Using an AI tool should always be augmented by targeted tools like the ATB or A/R aging, combined with advanced appeals tracking software, to make sure that every account at every level can be identified for action and resolved.

## ALL ABOUT THE RESULTS

Results. What are they? The Coronis Ai4AR service line has created a new sense of focus in performing A/R tasks, ultimately generating more cash for clients. Best described by experience, the results of Ai4AR for Coronis Laboratory & Pathology clients are:

- »» More cash, more quickly
- »» Increased efficiency
- »» Less cost in performing A/R tasks
- »» Increased success rates = increased satisfaction for staff and clients

- »» Better process management upstream

Better process management upstream is something to consider.

- »» Clients educated on data and process elements negating success in billing
- »» Internal edits reduced substantially for quicker claim resolution
- »» Clearinghouse and payer edits greatly reduced
- »» Denial down materially
- »» ROIs improved with increased cash

At the end of the day, it's not about software, which is often touted as solving for "X." The key to applying AI is to integrate software with good old-fashioned processes and sage expertise to drive better cash realization.



### MICHAEL J. FERRIE, MBA

Michael J. Ferrie, MBA serves as the president of Laboratory & Pathology division for Coronis Health. Mr. Ferrie has over 25 years of diverse experience in healthcare, including, starting and

operating a physician billing company, directing a practice management firm, owning/operating a compliance management company, directly managing physician practices, building and managing independent physician associations (IPAs), consulting in health care marketing/sales, acquiring and selling health care organizations, and physician recruitment. Mr. Ferrie's experiences stretch across very large multi-specialty groups, focused single-specialty groups in several medical fields, independent specialty laboratories, and reference clinical laboratories. Mr. Ferrie molded the

Coronis Health's Laboratory & Pathology division to focus on what he refers to as "the practice management approach". In billing, this approach serves the needs of pathologists as if Coronis was the pathology practice. With this frame of mind, concentration of activities allows stronger results to come forth. Mr. Ferrie holds a Bachelor of Science in Business Administration degree from Georgetown University and a Masters of Management degree from the J. L. Kellogg Graduate School of Management at Northwestern University. He can be reached at [mcferrrie@coronishealth.com](mailto:mcferrrie@coronishealth.com) or 314-503-8775.



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# Professional Events

DATE	EVENT	LOCATION	CONTACT INFO
September 27 – 29, 2023	New Jersey & Metro Philadelphia HFMA 47th Anniversary Annual Institute	Borgata Hotel Casino & Spa Atlantic City, NJ	<a href="https://web.cvent.com/event/317d8ff7-28f0-4dc6-82be-9e28ce54cd46/summary">https://web.cvent.com/event/317d8ff7-28f0-4dc6-82be-9e28ce54cd46/summary</a>
October 8 – 10, 2023	American Health Information Management Association 2023 Global Conference	Baltimore Convention Center Baltimore, MD	<a href="https://ahima23.eventsscribe.net/">https://ahima23.eventsscribe.net/</a>
October 26 – 28, 2023	Becker's Healthcare The Business and Operation of ASCs	Swissotel Chicago Chicago, IL	<a href="https://conferences.beckershospitalreview.com/beckers-october-asc-annual-conference-2023">https://conferences.beckershospitalreview.com/beckers-october-asc-annual-conference-2023</a>
October 29 – 31, 2023	Healthcare Financial Management Association Region 9 Annual Conference	Sheraton New Orleans New Orleans, LA	<a href="http://www.hfmaregion9.org/">http://www.hfmaregion9.org/</a>
November 27 – 29, 2023	Treatment Center Investment & Valuation Retreat West	Fairmont Scottsdale Princess Scottsdale, AZ	<a href="https://www.hmpglobevents.com/tciv">https://www.hmpglobevents.com/tciv</a>

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