LBMC

ARH
Appalachian Regional Healthcare

Revenue Cycle, Clinical Documentation Integrity & Care Management Transformation

Client Background

Appalachian Regional Healthcare, Inc. (ARH) is a nonprofit healthcare system whose mission and purpose is to serve the vulnerable communities of Central Appalachia through the operation of 14 acute care hospitals and 111 ambulatory locations throughout eastern Kentucky and southern West Virginia generating approximately $850M in annual revenue.

Client Pain Points

- Declining cash position driven by troubled revenue cycle performance
- Weakening reimbursement due to suboptimal clinical documentation and lower than expected case mix index
- Disruptions in access and capacity attributed to increasing avoidable care days and observation utilization
- Decreasing staffing levels and ability to replenish staff brought about by economic decline in the region's primary industry leading to relocation of skilled professionals from the region

LBMC Solution

Revenue Cycle Management

- Implemented a redesigned revenue cycle structure supporting enhanced ownership of processes at facility and centralized business office locations
- Established an enhanced productivity monitoring system for all revenue cycle staff which included a view into daily accounts receivable (AR) worked versus outstanding AR to facilitate a greater understanding of the impact of each team member's work
- Developed standard work processes, key performance indicators (KPIs) and associated targets in support of transitioning to a high performing revenue cycle program

Clinical Documentation Integrity

- Completed redesign of Clinical Documentation Integrity program staff model and creation of standard review expectations
- Established system wide processes around account escalation
- Designed and implemented a physician champion program for Clinical Documentation Integrity

Care Management

- Drove frontline process improvement and supporting staff education
- Implemented standardized multi-disciplinary rounds across all 14 facilities
- Developed redesigned team including department leadership and staffing structure to enhance efficiency and outcomes
- Performed standardization of system-wide processes and expectations around utilization review, transition planning, denial management and physician advisor utilization
- Established system and facility specific goals and benchmark targets
- Implemented standard system, facility and department dashboards

Results

- Reduced length of stay by over one whole day – surpassing the 75% improvement target set by client leadership
- Improved CDI program performance by 20%, resulting in $3M in improvement
- Improved annualized net collection rate by 8 basis points to 98%
- Reduced claim rejections by 50% or approximately $37M
- Reduced credit balances by 40%