



EDUCATIONAL RESOURCES

# Operational Excellence in Home Health

Hannah Vale, M.Ed.  
CGO; HealthRev Partners



HOME HEALTH



HOSPICE



ACHCU IS A BRAND OF ACCREDITATION COMMISSION *for* HEALTH CARE



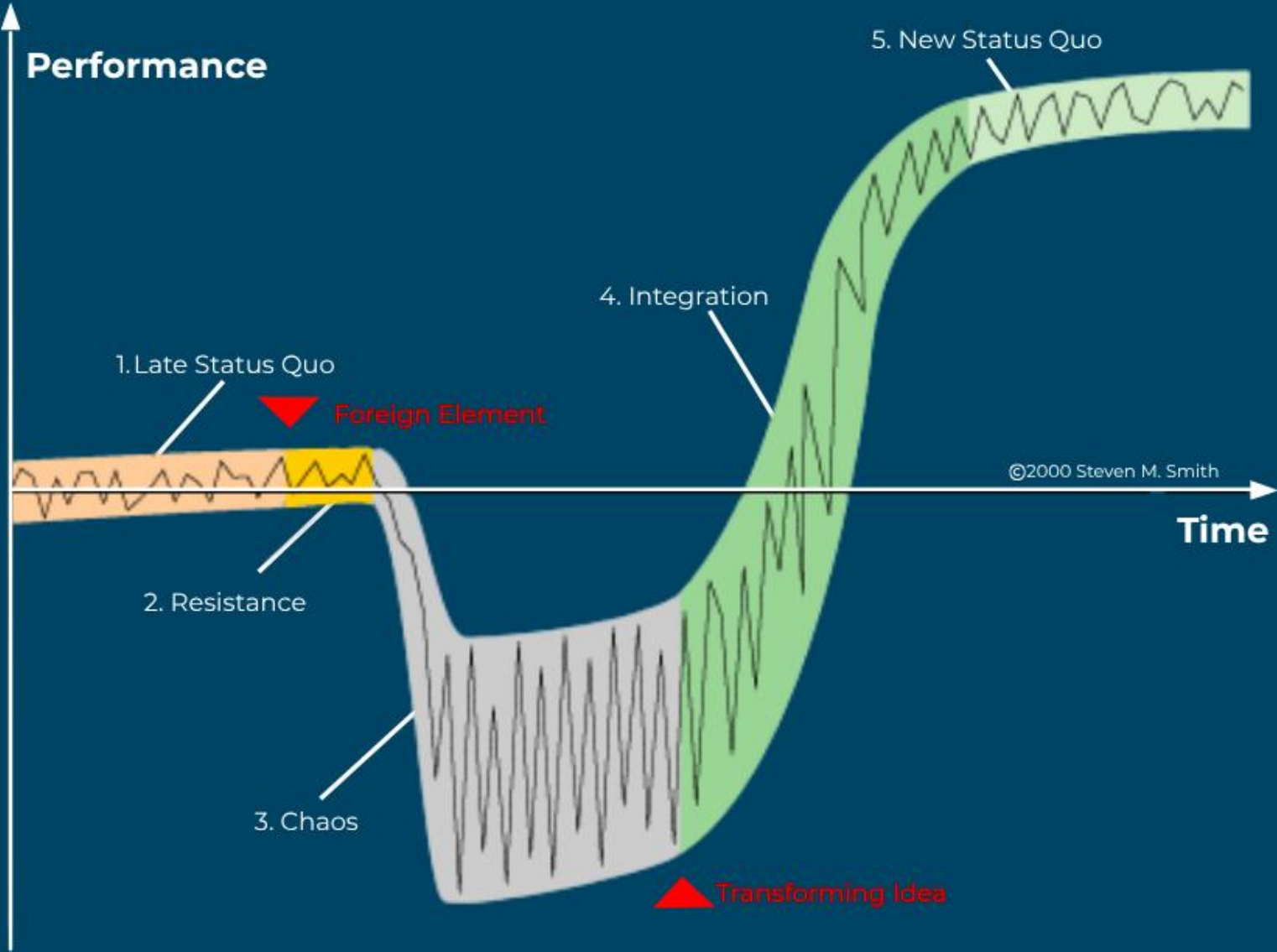
# Objective

- Explore how cutting-edge solutions are revolutionizing the home health industry, driving accuracy, efficiency, and predictable revenue through an operational approach to RCM.

# Key Tech Advancements

- AI-Powered Revenue Cycle Management
- Advanced RCM tools are transforming financial operations:
  - Real-time analytics for multi-site performance tracking
  - AI-assisted coding for improved accuracy and efficiency
  - Automated task prioritization and assignment
- These features help reduce coding errors, improve timely reimbursement, and optimize employee workload.

# Satir Change Model



# An Operational Approach



# 01: Intake Key Performance Indicators

Referral conversion rate

Percent of F2F received at SOC

Eligibility and authorization TAT

Claim denial rate

Patient co-payment collection rate

HHCAPS/CAHPS - communication



# 01: Intake Operational Assessment

- 1. Patient Information Collection & Verification:** How does your intake team collect and verify patient information, and what are the most frequent errors encountered during this process?
- 2. Intake Accuracy & Communication:** How does your team handle incomplete or incorrect patient information, and how is communication structured in the intake department to coordinate smoothly with the E&A team and support revenue cycle management?
- 3. Document Management in EMR:** Are all relevant documents saved in your EMR? How are they organized and indexed for easy retrieval?
- 4. Timeliness of F2F Documentation:** How long does it typically take to obtain F2F documentation? What percentage is obtained before the Start of Care (SOC) versus after?
- 5. Payor Management in EMR:** Are there any known issues with payor setups in your EMR, and who is responsible for managing payor additions and rate updates, especially during annual Home Health and Hospice updates?
- 6. SOC Initiation Process:** What is your process for managing cases where the Start of Care (SOC) is not initiated within 48 hours?
- 7. Contracting & Analytics:** How do you utilize analytics in reviewing payor contracts and ensuring favorable margins?

# 01: Streamlining Intake for a Strong Foundation



## **Best Practices:**

- 1. Automate Data Collection:** Use AI-driven tools to capture patient information accurately during the FIRST point of contact, reducing manual errors.
- 2. Standardize Processes:** Implement a uniform intake checklist to ensure all necessary information (e.g., insurance details) is collected upfront.
- 3. Real-Time Verification:** Integrate real-time insurance verification tools to confirm coverage and avoid delays.

## **Impact on Goals:**

- Reduces downstream errors in coding and billing, supporting the 30% error reduction goal.
- Speeds up the revenue cycle by ensuring clean claims, contributing to the 20% efficiency improvement.

# 02: E&A Key Performance Indicators

Eligibility Verification Rate (95% or > prior to SOC)

Authorization Denial Rate

Eligibility and Authorization TAT

Denials Due to Authorizations

Grok Prompt: “Act as if you are a RCM specialist, struggling with consistent denials due to authorization and eligibility for \_\_\_\_\_payer. Give me the common challenges and a step by step solution for a 100% clean claim rate. Include KPIs for each step of the process”



# 02: E&A Operational Assessment

- 1. Eligibility & Authorization Tracking:** Do you have real-time eligibility verification and authorization tracking integrated within your EMR? If not, what processes or systems—such as spreadsheets—do you use to trigger, track, and manage expirations and reauthorizations?
- 2. E&A Team & Capacity:** Do you have a dedicated team or individual managing Eligibility & Authorization, and how many staff are assigned? Have you assessed capacity to determine if additional E&A staff are needed?
- 3. SOC Completion Without Authorization:** Do you complete a Start of Care (SOC) without obtaining prior authorization?



# 02: Eligibility & Authorization Assessment



## **Best Practices:**

- 1. AI-Powered Eligibility Checks:** Use AI tools to verify patient eligibility and authorization requirements in real-time, minimizing denials.
- 2. Proactive Communication:** Train staff to communicate with payers early to secure authorizations before services are rendered. Immediately upon referral.
- 3. Audit Trails:** Maintain detailed logs of eligibility checks and authorizations to resolve disputes quickly.

## **Impact on Goals:**

- Reduces claim denials, directly supporting the 20% revenue cycle efficiency goal by lowering DSO.
- Decreases administrative overhead, contributing to the 15% operational efficiency target.

# 03: Clinical Performance Key Indicators

Acute Care Hospitalization Rates and  
Emergency Department use without  
Hospitalization.

Timely Initiation of Care

Visit Utilization within State/National Average

Oasis Assessment Accuracy

Clinical Documentation Timeliness



# 03: Clinical Performance Operational Assessment

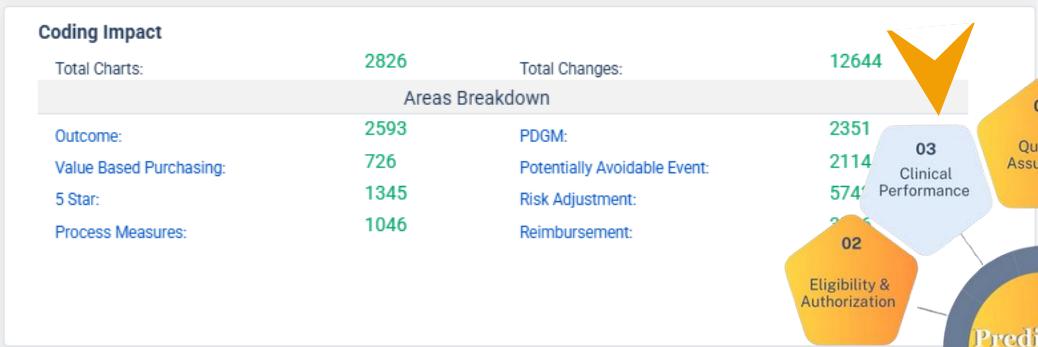
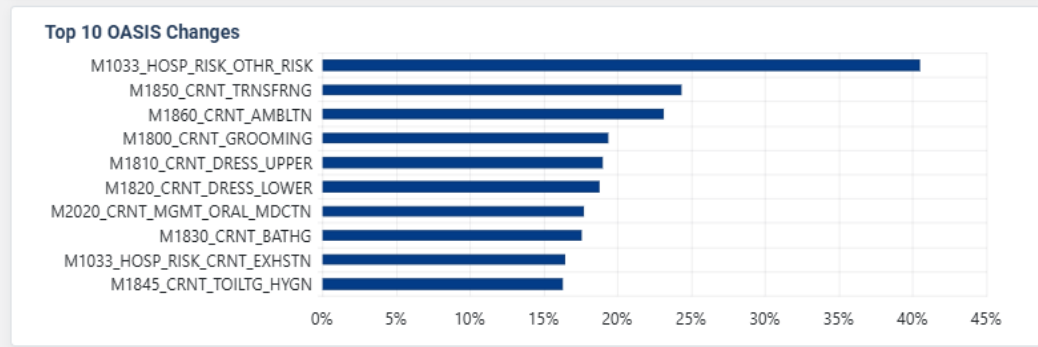
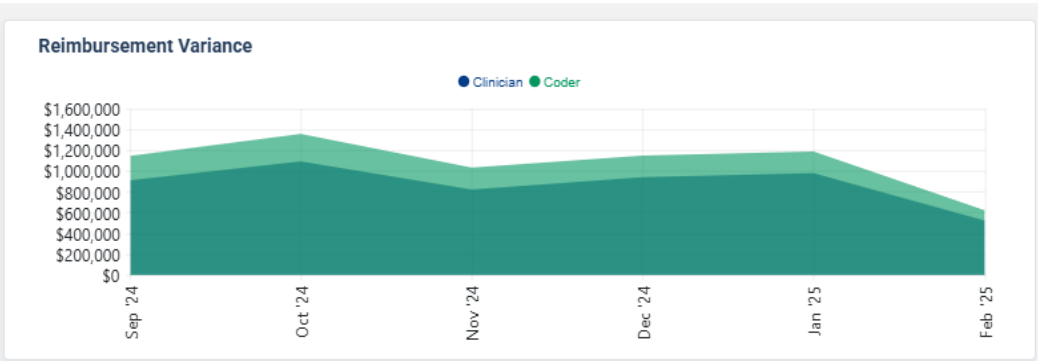
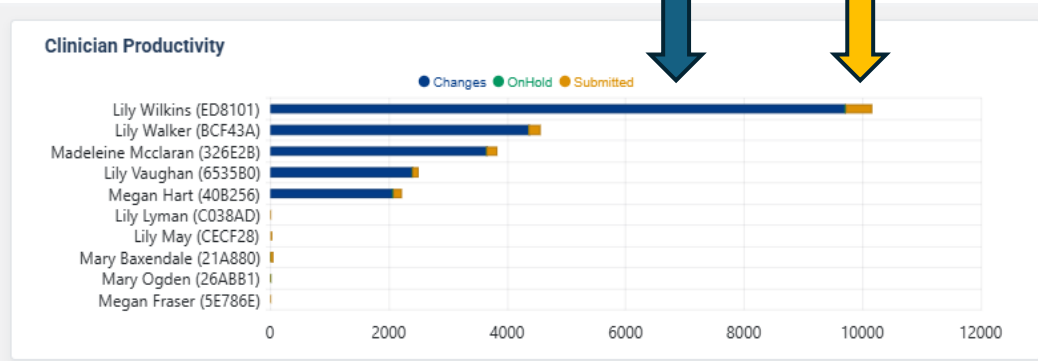
- 1. Documentation Timeliness:** What is the average time it takes for field staff to complete and submit clinical documentation after a patient visit? What is your policy on documentation turnaround time?
- 2. Accuracy Assurance:** How do you ensure that clinical documentation is accurate and consistent?
- 3. OASIS-E Training:** How do you train your staff on OASIS-E during onboarding and on an ongoing basis? Who is responsible for providing this training and support, and how often is it conducted?
- 4. Quality Assurance:** What processes do you have in place to ensure the delivery of quality care, such as joint supervisory visits with all disciplines, QAPI, Performance Improvement Plans (PIPs), multidisciplinary staff meetings, or scheduled Mock Surveys?
- 5. Productivity Management:** How do you monitor and manage staff productivity? What are your expectations regarding staff levels?



# 03: Clinical Performance Feedback



9,710  
427



# 03: Clinical Performance Feedback

**Velocity**



**Coding Impact**

Total Charts:	2826	Total Changes:	12644
Areas Breakdown			
Outcome:	2566	PDGM:	2383
Value Based Purchasing:	722	Potentially Avoidable Event:	2114
5 Star:	1326	Risk Adjustment:	5776
Process Measures:	1046	Reimbursement:	3564



# 03: Clinical Performance Feedback

**Outcome** ✕

Questions Clinicians

Question	Count
M1850	334
M1860	308
M1820	256
M1810	255
M1830	252
M1800	244
M2020	244

1 - 7 of 37 items

Page 1 of 6

Ok

**Outcome** ✕

Questions Clinicians

Clinician	Count
Lily Wilkins (ED8101)	386
Lily Walker (BCF43A)	259
Madeleine Moclaran (326E2B)	242
Lily Vaughan (6535B0)	188
Lily Wilson (813588)	148
Mary Dankert (C2DFC9)	130
Molly Condrey (72FB56)	129

1 - 7 of 46 items

Page 1 of 7

Ok

# 03: Clinical Performance Feedback



## Impact on PDGM and VBP

The dashboard displays three main components: Clinician Productivity, Reimbursement Variance, and a VBP modal window.

**Clinician Productivity:** A horizontal bar chart showing productivity for various clinicians. The x-axis ranges from 0 to 2000. The y-axis lists clinicians including Lily Wilkins (ED8101), Lily Walker (BCF43A), Madeleine Mcclaran (326E2B), Lily Vaughan (6535B0), Megan Hart (40B256), Lily Lyman (C038AD), Lily May (CECF28), Mary Baxendale (21A880), Mary Ogden (26ABB1), and Megan Fraser (5E786E).

**Reimbursement Variance:** A line chart comparing Clinician (blue) and Coder (green) variance from Oct '24 to Feb '25. Below the chart is a table:

2826	Total Changes:	12644
Areas Breakdown		
2566	PDGM:	2383
722	Potentially Avoidable Event:	2114
1326	Risk Adjustment:	5776
1046	Reimbursement:	3564

**VBP Modal Window:** A table showing the number of VBP questions for various clinicians.

Clinician	Count
Lily Wilkins (ED8101)	96
Lily Walker (BCF43A)	95
Madeleine Mcclaran (326E2B)	83
Mary Dankert (C2DFC9)	55
Molly Condrey (72FB56)	39
Lily Wilson (813588)	38
Lily Vaughan (6535B0)	38

Navigation: 1 - 7 of 41 items, Page 1 of 6, Ok button.

# 03: Clinical Performance Feedback



## **Best Practices:**

- 1. AI-Drive Task Prioritization:** Implement AI systems to prioritize clinical tasks based on urgency and revenue impact, ensuring timely care delivery.
- 2. Standardized Documentation:** Use templates and AI-assisted documentation tools to ensure clinicians capture all billable services accurately.
- 3. Training and Feedback:** Provide regular training on documentation best practices and use AI analytics to give clinician feedback on performance.

## **Impact on Goals:**

- Reduces claim denials, directly supporting the 20% revenue cycle efficiency goal by lowering DS.
- Decreases administrative overhead, contributing to the 15% operational efficiency target.

# 04: Quality Assurance Key Performance Indicators

Plan of Care Adherence

Star Rating

QA Review TAT

Oasis Accuracy



# 04: Quality Assurance Operational Assessment

- 1. Quality Review & OASIS Certification:** Do you have an internal quality review team, and if so, how many associates are on it and what are their productivity expectations? Are your quality reviewers OASIS certified?
- 2. Review Turnaround Time:** What is the average turnaround time for the quality review process, and how do you ensure timely completion to avoid delays in coding and claim submission?
- 3. QA Team Knowledge:** Is your QA team educated on case mix analysis, LUPA rates, functional impairment, admission source and timing, and comorbidity adjustments?
- 4. Clinical Bill Holds:** Does your QA team follow up on clinical bill holds?



# 04: Building a Robust Quality Assurance Framework



## **Best Practices:**

- 1. QA Checks:** Flag errors in documentation and coding before claims are submitted.
- 2. Regular Audits:** Conduct on-going audits of clinical and billing processes and identify and address gaps.
- 3. Continuous Improvement:** Use QA data to drive process improvement, ensuring consistent quality across the revenue cycle. Implement FOCUS plans.

## **Impact on Goals:**

- Reduces coding errors by 30% through early error detection.
- Increases clean claims rating, supporting 20% revenue cycle efficiency goal.

# 05: Back Office Key Performance Indicators

MD Order Turnaround Time

Bill Hold Time

Oasis or HOPE Submission Timely



# 05: Back Office Operational Assessment

1. **Order Process & Turnaround:** Can you outline your current order process and tracking system, and what is your average turnaround time for receiving signed orders from physicians?
2. **Document Management:** Are you using any document management software outside of your EMR (e.g., Worldview, Forcura)?
3. **Quality/Review Team:** Do you have a dedicated quality or review team on staff?
4. **RCD Compliance:** In RCD states, who is responsible for your PCR submissions?



# 05: Optimizing Back Office Operations



## **Best Practices:**

- 1. Centralized Workflow Management:** Use a centralized platform to manage back-office tasks like claims processing and follow-ups.
- 2. AI-Driven Denials Management:** Implement AI tools to analyze denial patterns and prioritize resubmissions, reducing DSO.
- 3. Optimize Staff:** Partner with a reputable RCM outsourcing company to improve efficiency and reduce errors while maximizing patient-facing staff.

## **Impact on Goals:**

- Reduces administrative overhead, contributing to the 15% operational efficiency goal.
- Speeds up claims processing, supporting the 20% revenue cycle efficiency target.



# 05: DSO

- **Unbilled Claims Percentage Benchmark** = 10% or less
- **Billing Lag Benchmark** = Less than 2 days
- **Insurance Write-Off Benchmark** = 2% or less
- **AR 90+ Days Benchmark** = 15% or less
- Net Collections Ratio = 98% or greater
- **Definition of Unbilled Claims Percentage:** The percentage of claims that are not billed out to average daily claims volume.
- **Definition of Billing Lag:** The average time from service date to claim billing date.
- **Definition of Insurance Write-Off Percentage:** The dollar value of the claims written off as an uncollectable that should have been collected.
- **Definition for AR 90+ Days:** The percentage of total outstanding AR that is in the 90+ days again bucket.
- **Definition of Net Collections Ratio:** A percentage shows how much you collected versus how much you should have collected.

## Revenue Impact

	Metric
<b>Unbilled Claims Percentage</b>	
Number of Claims Unbilled	35
Avg. daily claims volume	150
Current Percentage	23%
<b>Billing Lag</b>	
Claims billed date	8/1/24
Date of service	7/25/24
Current time (days)	7
<b>Insurance Write-Off Percentage</b>	
Write- Off Amount	\$135,000.00
Collections	\$500,000.00
Percentage of write-off	27%
<b>AR 90+ Days</b>	
Total outstanding AR older than 90 days	\$110,000.00
Total AR Outstanding	\$350,000.00
Percentage of write-off	31%
<b>Net Collections Ratio</b>	
Payments minus Refunds	\$300,000.00
Charges minus Contractual Adjustments	\$315,000.00
Current Percentage	95%



# 06: Coding and Review Key Performance Indicators

Coding Accuracy Rate

Coding TAT

Coder Productivity

Payment Difference



# 06: Coding and Review Operational Assessment

- 1. Coding Process & Consistency:** What is your agency's coding process, and how do you ensure consistency and keep your team up to date through ongoing training and education?
- 2. Coding Review & Clinician Communication:** How is your coding reviewed and audited, and how does your team communicate with clinicians to resolve discrepancies or clarify documentation before claim submission?
- 3. Coding & Impact Reporting:** What types of reports do you receive on coding accuracy, case-mix or payment differences, and clinician performance—and do you also receive reports showing OASIS-E's impact on PDGM and VBP?



# 06: Revolutionizing Coding with AI Assistance



## Best Practices:

1. **AI-Assisted Coding Tools:** Partner *with a tech-driven coding company for optimal accuracy.*
2. **Real-Time Feedback:** Provide coders with real-time feedback on coding accuracy to improve performance.
3. **Ongoing Education:** Offer regular training on coding updates (e.g., ICD-10, CPT changes) to ensure compliance.

## **Impact on Goals:**

- Directly achieves the goal of reducing coding errors by 30%
- Cuts documentation time by 25% through AI automation

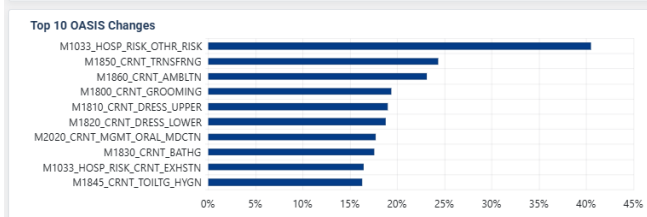
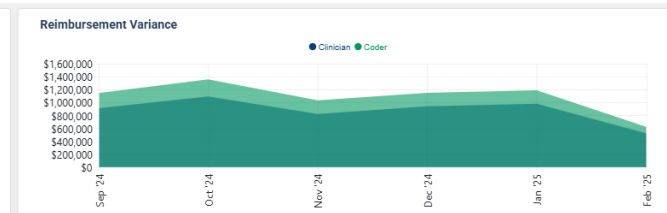
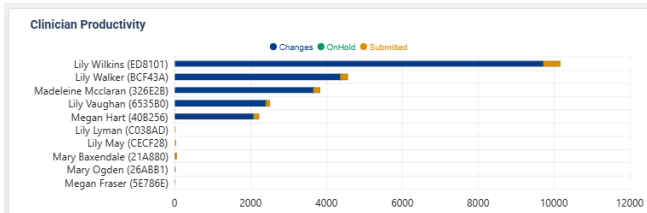
# 06: Coding and Review Performance Improvement

**FREE Training**



**Impact on Reimbursement**

**Key Metrics**



**Coding Impact**

Total Charts:	2826	Total Changes:	12644
Areas Breakdown			
Outcome:	2587	PDGM:	2420
Value Based Purchasing:	746	Potentially Avoidable Event:	2114
5 Star:	1325	Risk Adjustment:	5812
Process Measures:	1067	Reimbursement:	3600



# 07: RCM Operational Assessment

1. **Claims Submission Workflow:** Describe your claim submission workflow, including any manual steps involved. How do you ensure accuracy before submission?
2. **Claim Denial Management:** How does your agency currently manage claim denials, and what processes are in place to analyze and address common denial reasons?
3. **EMR Billing Setup:** Are you currently experiencing any issues with your billing setup in your EMR that are contributing to claim denials?
4. **Aging AR Analysis:** What are the reasons for your current aging AR over 91 days?
5. **Denial Rate Monitoring:** How do you currently monitor your denial rate? Do you track, analyze, and resolve denied claims, resubmit and collect efficiently?
6. **Operational Coordination:** How do you ensure there is operational coordination between front-end and back-end staff to prevent impacts on RCM efficiency and claims submission?
7. **Payor Contracts:** Do you have copies of payor contracts? Do you understand the impact of not reconciling payor setup with payor contracts?



# 07: Optimizing RCM Operations Dashboard Optimization

Clients		Month								
Demo		Dec 2024								
	Total	0 - 30	31 - 60	61 - 90	91 - 180	181 - 210	211 - 240	241+		
# of Claims	2827	40	433	929	727	170	201	927		
Commercial	757	1	88	147	233	38	38	212		
HMO	36	0	3	7	10	0	0	16		
Medicaid	876	5	131	110	239	67	93	231		
Medicare	523	0	136	58	145	33	24	118		
Medicare (MSP)										
Medicare Advantage	634	25	75	6	100	32	46	350		
Other	1	0	0	1	0	0	0	0		
Private Pay										
# of Claims worked	923	8	27	205	301	54	47	281		
Commercial	200	0	2	64	140	22	9	53		
HMO	19	0	0	4	15	0	0	0		
Medicaid	225	0	6	61	83	16	28	31		
Medicare	198	8	19	57	57	16	10	31		
Medicare (MSP)										
Medicare Advantage	191	0	0	19	6	0	0	166		
Other										
Private Pay										

## Elements of an Effective Dashboard

- Visual representation of KPIs
- Real-time or near real-time data
- Drill-down capabilities
- Benchmarking against industry standards
- Trend analysis

## Dashboard Design Best Practice

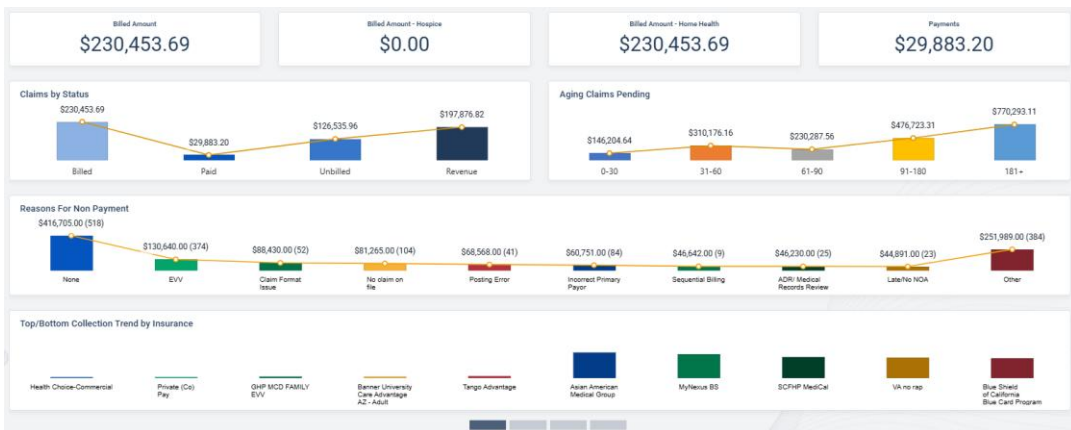
- Keep it simple and focused
- Use appropriate chart types
- Implement consistent color coding
- Include data ranges and data refresh times



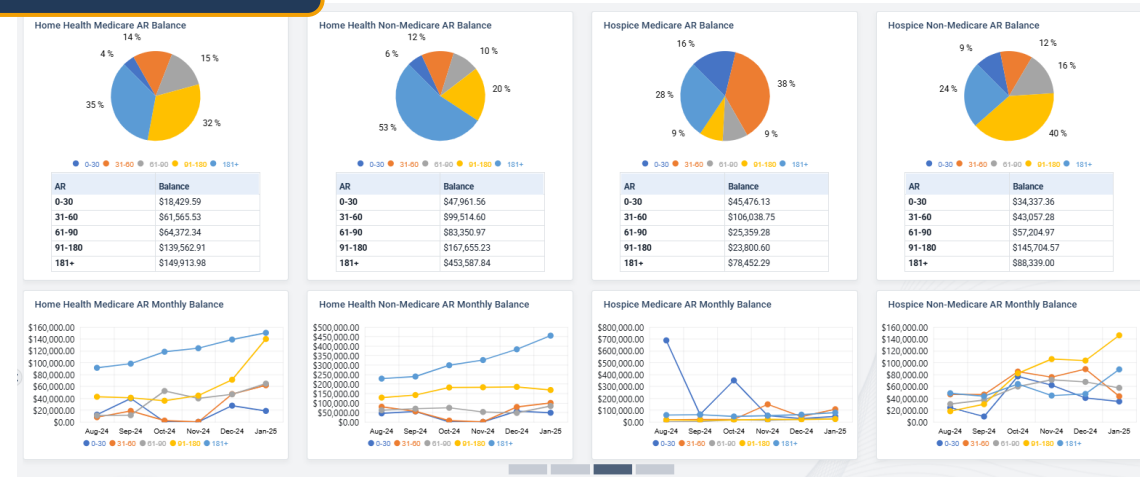
# 07: RCM Performance Metrics



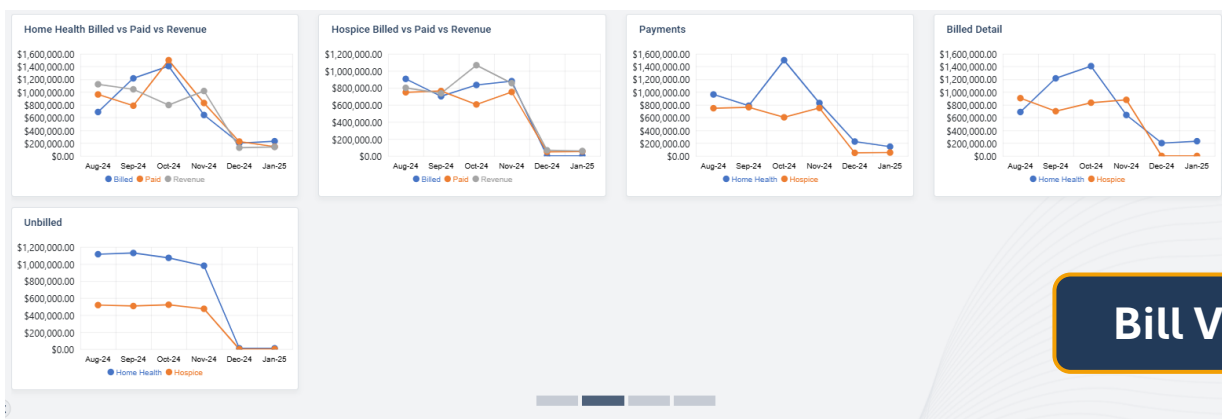
## Claims by Status and Denial Trends



## Predictive Analytics



## Bill Vs. Paid



# 07: Mastering Revenue Cycle Management



## Best Practices:

1. **End-to-End Automation:** Use RCM software to automate the entire cycle, from intake to payment posting.
2. **Predictive Analytics:** Leverage AI to predict payment delays and prioritize high-risk claims for follow-up.
3. **Performance Metrics:** Take key metrics like DSO, clean claim rates, and denial rates to identify areas for Improvement.

## **Impact on Goals:**

- Achieves the 20% revenue cycle efficiency goal by reducing DSO and increasing clean claim rates.
- Supports overall operational efficiency by streamlining processes.

# 07: DSO

- **Unbilled Claims Percentage Benchmark** = 10% or less
- **Billing Lag Benchmark** = Less than 2 days
- **Insurance Write-Off Benchmark** = 2% or less
- **AR 90+ Days Benchmark** = 15% or less
- Net Collections Ratio = 98% or greater
- **Definition of Unbilled Claims Percentage:** The percentage of claims that are not billed out to average daily claims volume.
- **Definition of Billing Lag:** The average time from service date to claim billing date.
- **Definition of Insurance Write-Off Percentage:** The dollar value of the claims written off as an uncollectable that should have been collected.
- **Definition for AR 90+ Days:** The percentage of total outstanding AR that is in the 90+ days again bucket.
- **Definition of Net Collections Ratio:** A percentage shows how much you collected versus how much you should have collected.

**DSO is also listed in 05: Back Office**

## Revenue Impact

### Metric

#### Unbilled Claims Percentage

Number of Claims Unbilled	35
Avg. daily claims volume	150
Current Percentage	23%

#### Billing Lag

Claims billed date	8/1/24
Date of service	7/25/24
Current time (days)	7

#### Insurance Write-Off Percentage

Write- Off Amount	\$135,000.00
Collections	\$500,000.00
Percentage of write-off	27%

#### AR 90+ Days

Total outstanding AR older than 90 days	\$110,000.00
Total AR Outstanding	\$350,000.00
Percentage of write-off	31%

#### Net Collections Ratio

Payments minus Refunds	\$300,000.00
Charges minus Contractual Adjustments	\$315,000.00
Current Percentage	95%

# 07: Revenue Cycle Management- Best Practices

KPI's	Best Practices
Intake, Referrals, Admissions	Conversion Rate = 80%
Days to NOA	2 Days
Days to Final	10-12 Days
AR Over 90 - Medicare	<10%
AR over 90 – Non-Medicare	<20%
Total AR over 90 Days	<15%
DSO - Medicare	25-30 Days
DSO – Non-Medicare	55-60 Days
Total DSO	45-50 Days
Unbilled AR	10% of Monthly Revenue
Bad Debt - Medicare	.5-1%
Bad Debt – Non-Medicare	1-2%
Aged Orders	15 days, no more than 10% passed 20 Days

# Tying it All Together



# Key Strategies for Harnessing Technology for Operational Excellence in Home Health

- 1. Integrated Technology Stack:** Use a unified platform that connects all 7 components, ensuring data flow and reducing silos.
- 2. Data-Driven Insights:** Leverage analytics to identify bottlenecks and improve processes across the revenue cycle and prioritize improvements.
- 3. Staff Empowerment:** Outsource for best practice, efficiency and cost savings. If in-house, invest in training and tools to empower staff, reduce administrative burden and improve productivity.



EDUCATIONAL RESOURCES

# Thank you

**Have Questions? Contact Us:**

Hannah Vale,  
[hvale@healthrevpartners.com](mailto:hvale@healthrevpartners.com)



HOME HEALTH



HOSPICE



ACHCU IS A BRAND OF ACCREDITATION COMMISSION *for* HEALTH CARE

