How to Marry Clinical, Revenue Cycle, and Analytics to drive improved Inpatient financial performance

January 21, 2025

About Us

Andrew Jacobsen
Principal
Pinnacle Healthcare Advisors, Inc.
ajacobsen@pinnaclehca.com

Regina Berman
Value Based Care Executive
Adventist Health
BermanRS@ah.org

Key Topics

1. Introductions
2. Session Objective(s)
3. Adventist Health Background / Overview
   a) Setting the Stage
   b) Problem Statement(s)
4. Detailed Inpatient Functional Flow
5. Key Initiatives
   a) Core Foundational Items
6. Area Spotlights
7. The Journey Continues

Sponsored By **The Queiro Group**

Mentimeter Sponsored By The Queiro Group

Sponsored By **The Queiro Group**

Session Objective(s)

Overall Objective: Improving reimbursement performance within the inpatient service line

- Review critical functions within the inpatient flow broken out by owner
- Review foundational items that should be investigated as part of assessing current state performance
- Highlight critical infrastructure, workflow, tool, and role changes made within the Utilization / Case Management / Clinical space to support the overall objective
- Spotlight critical functions within the Utilization / Case Management / Clinical space and the analytics / metrics implemented to create visibility and monitor performance
- Review forums established to improve cross functional collaboration and governance

Faith-based, nonprofit, integrated health system

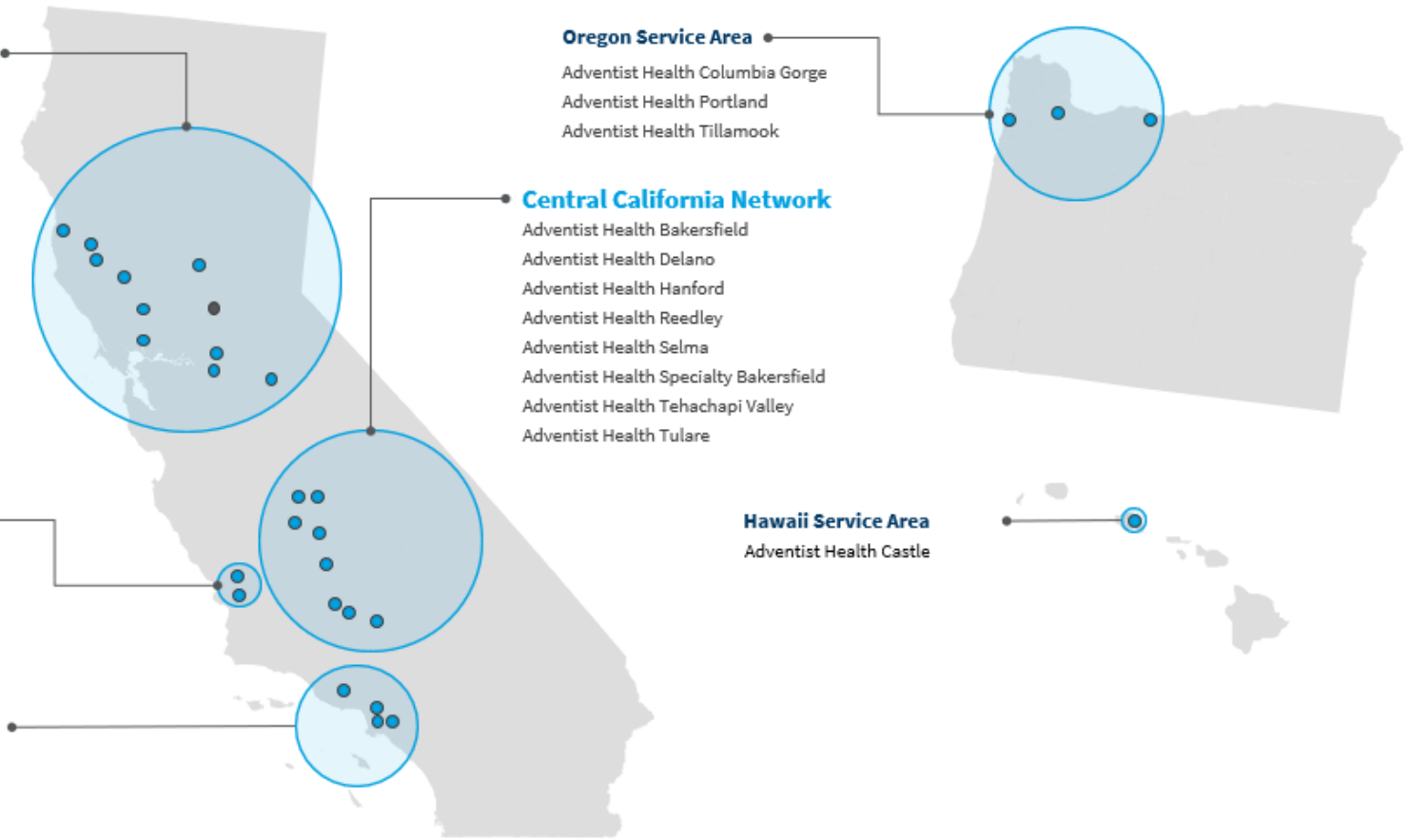
Together, we are transforming the healthcare experience with an innovative and whole-person focus on physical, mental, spiritual, and social health to support community well-being.

- Serving more than 100 communities on the West Coast and Hawaii
- 27 hospitals, more than 430 clinics (hospital-based, rural health, and physician clinics)
- Blue Zones
- Home care, SNF and hospice services

Our Mission

Living God's love by inspiring health, wholeness and hope

Adventist Health Networks



Northern California Network

Adventist Health Lodi Memorial
Adventist Health and Rideout
Adventist Health Sonora
Adventist Health St. Helena
Adventist Health Vallejo
Dameron Hospital*

North Coast Service Area

Adventist Health Clear Lake
Adventist Health Howard Memorial
Adventist Health Mendocino Coast
Adventist Health Ukiah Valley

Oregon Service Area

Adventist Health Columbia Gorge
Adventist Health Portland
Adventist Health Tillamook

Central California Network

Adventist Health Bakersfield
Adventist Health Delano
Adventist Health Hanford
Adventist Health Reedley
Adventist Health Selma
Adventist Health Specialty Bakersfield
Adventist Health Tehachapi Valley
Adventist Health Tulare

Central Coast Service Area

Adventist Health Sierra Vista
Adventist Health Twin Cities

Hawaii Service Area

Adventist Health Castle

Southern California Network

Adventist Health Glendale
Adventist Health Simi Valley
Adventist Health White Memorial
Adventist Health White Memorial Montebello

*Managed facility

Vision vs. Reality

Vision:

- Centralized model
- Technology to drive efficiency, correct status orders, and LOS
- Standard workflows across all hospitals
- Consistent cross team / department collaboration
- Healthy financials

Reality:

- Siloed UM and care coordination
- Disconnect between clinical workflow and technology
- Silos between clinical and revenue cycle teams
- Inefficient, inconsistent processes
- Unhealthy financials

The Perfect Storm

Don’t Let a Good Crisis Go to Waste!

1. Ongoing COVID-19 pandemic
   - Shift to remote working
   - Staffing challenges
   - Low morale and burnout
2. Growing financial pressure
   - Reintroduction of elective procedures didn’t solve the problem
3. Change in leadership

Problem Statement(s)

- Avoidable Adjustments / Write-offs in the inpatient segment far exceeding industry benchmarks
- Silos between Clinical and Revenue Cycle Teams
- Lack of visibility / metrics for ALL critical functions within the inpatient flow
- Lack of consensus on the true root cause(s) driving loss
- Lack of clear tools / workflows within the centralized Utilization Management Department and hand-offs / communication with site Case Management and Revenue Cycle Teams
- Lack of business operations / analyst focused roles within Case Management

Key Initiatives by Year

2022

- Initial Cross Department Assessment (14 quick wins!)
- Business Operations and Analyst Roles added to CM
- Workflow Redesign (FC, UM, PFS)
- Integrated CM Triad Model
- Initiated Peer to Peer Tracking
- Initiated Escalation Tracking
- InterQual Tool Training and Optimization, IRR, productivity
- Initiated first UM Focused Payer Meetings
- CM reports to Medical Officers
- PA Program Redesigned
- Physician Education Admission DX

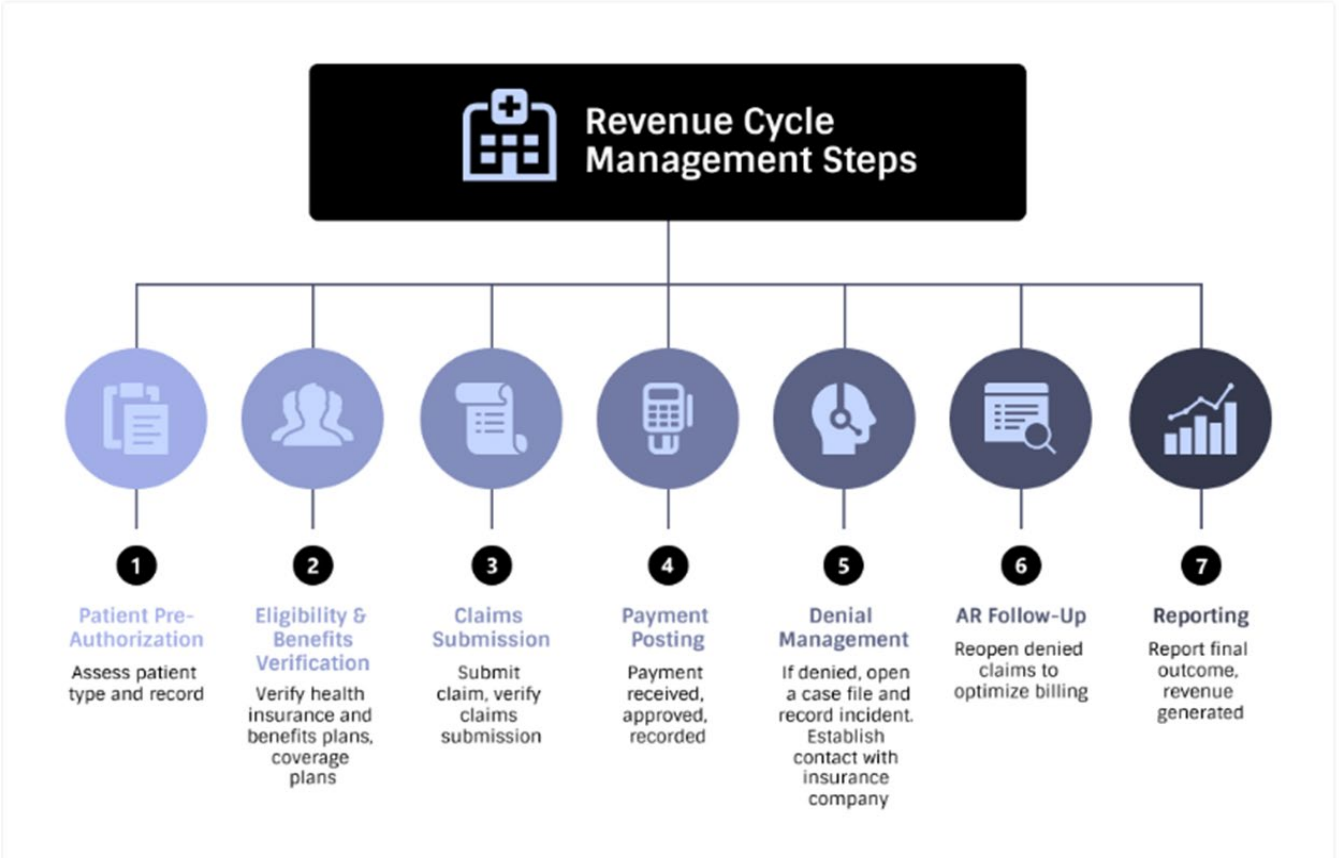
2023

- Care Expedition Rounds
- Accommodation Code Project
- Avoidable Day reporting
- EHR CM module optimization
- Dedicated Clinical Appeal team and Tool Implementation
- Expansion of Medi-Cal TAR Free Program to all CA sites
- Escalation Workflow Optimization
- Peer to Peer Workflow Optimization
- Revised Revenue Cycle Council Governance Meeting (to include Clinical
- Stabilize Hospitalist teams
- More Physician Education CDI & UM

2024

- Order Set Optimization
- Accommodation Code Set Optimization
- Market Based Clinical Appeal Workgroups initiated
- Midnight Census Process Roll-out and Accuracy Tracking
- Automation of dashboards (kick-off)
- Status Order writing MD
- Perioperative Care redesign
- And more Physician Education

Standard Revenue Cycle Flow



Critical Inpatient Functions by Owner

IP Flow Checkpoints (ER Admit)			
#	Step / Function	Owner (Revenue Cycle / Clinical)	Owner (Department)
1	*Accurate IP Order*	Clinical	Physician
2	*Insurance Capture*	Revenue Cycle	Registration
3	*Insurance Verification*	Revenue Cycle	Financial Clearance
4	*Payer / Plan Selection*	Revenue Cycle	Financial Clearance
5	*Notification of Admission*	Revenue Cycle	Financial Clearance
6	*Clinical Documentation*	Clinical	Physician
7	*Initial Review (InterQual) 10-12 hours from admit*	Clinical	CMRC
8	*Clinical Review Submission to Payers*	Clinical	CMRC
9	*Accommodation Code / Charge Code Accuracy*	Clinical	Nurse Unit Secretary
10	*Escalation Workflow*	Clinical	CMRC / Site CM
11	*Peer to Peer Workflow*	Clinical	CMRC / Site CM
12	*Administrative Wait Day Capture*	Clinical	Site CM
13	*IP Authorization Follow-up*	Clinical	CMRC
14	*IP Authorization Validation to order*	Clinical	CMRC
15	*2ndary Review Process*	Clinical	CMRC / PA
16	*Charge Corrections*	Revenue Cycle	Revenue Integrity
17	*Billing*	Revenue Cycle	Patient Financial Services
18	*Follow-up / Denials*	Revenue Cycle	Patient Financial Services
19	*Appeals - Technical*	Revenue Cycle	Patient Financial Services
20	*Appeals - Clinical*	Clinical	CMRC

Foundational Items

- Clinical / CM
  - Order Set Configuration
  - Accommodation Code Set Configuration
  - Bed Licensure / Usage Mapping (post-Covid Waiver reset)
  - Tool Usage / Optimization (e.g., InterQual) initiate Auto-review and review-on-demand
  - Medi-Cal TAR Free Program (CA)
  - Separate clinical appeals team
- Revenue Cycle
  - Payer / Plan Dictionary Optimization
  - DOFR Tool Build / Maintenance (CA)
  - Avoidable Adjustment Code Definitions and Usage
  - Accommodation Code to Charge Code Mapping
  - Policies to align clinical, coding & billing
    - LLOC, IPO procedures, Secondary reviews

The Introduction of UM Transformation

Distributed Onsite UM (Dyad Model)

May 2020

Introduction of Medical Review Automation

Centralized Onsite UM (Triad Model)

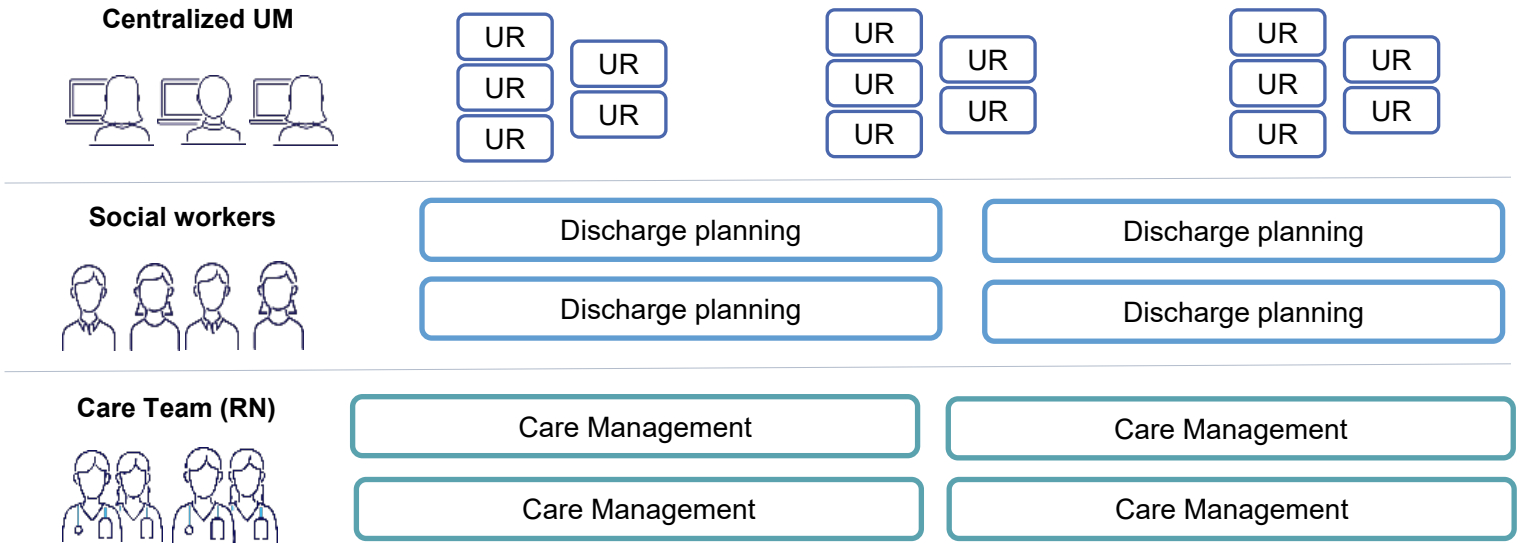
2019

Integrated Triad Model

October 2021/2

Triad Model - Centralized (but Siloed) UM

Running in parallel tracks. Lack of synchronization.



Multidisciplinary Rounds (MDR)

A patient-centered model of care, emphasizing safety and efficiency

- Enables **all** members of the care team to offer individual expertise and contribute to patient care in a concerted fashion
- Disciplines come together to coordinate patient care, determine care priorities, establish daily goals, and plan for potential transfer or discharge

From the Institute for Healthcare Improvement 2005

Adaptations of MDR process can be used to solve specific problems

- Focus on outcome of concern (e.g., length of stay, staffing shortages)
- Participants may be a subset of full care team
- Gather full group in one location to identify system issues

TRADITIONAL: UNIT BASED MDR

Focus: individual, patient-centered care

Clinical care team (all disciplines)

On units, at bedside with patient & family

Coordinate care plan

- Set daily goals and plan to achieve
- Update and progress discharge plan

Learning: local based on patient-focus on units with local care team

ADAPTATION: CARE EXPEDITION ROUNDS

Focus: Ensure appropriate LOS & adopt a Care pathway to address the “reason for admission”.

CM driven with physicians, CDI

Group setting: conference room

Identify discharge goals & criteria

- Raise barriers & determine actions
- Note delays impacting discharge

Learning: system issues identified by discussing patients across hospital

Tool and Process Optimization

MDR tool adopted and deployed.

- No cost, available in PowerChart
- Includes Working DRG and LOS calculations
- Pre-populates content from the medical record to reduce data collection by various teams
- Action items can be exported or referenced to support follow-up
- CIS supported

Companion Q2 hour discharge report is built and distributed to all Nurse Managers to identify patients with an active DC order yet remains occupying a bed. DC lounge opportunity

Accommodation Code Accuracy

- **What is it?:** The accommodation code selection drives the room and bed charge on the claim.
- **The Problem:** Inconsistent midnight census process with limited validation of accommodation codes leading to significant volume of needed charge corrections / denials.
- **The Fix:**
  - Reconfigured order and accommodation code sets to align
  - Implemented Midnight Census process
  - Implemented daily accommodation code accuracy reporting
- **What are we tracking:**
  - Order to Accommodation Code Accuracy % by day by market
  - Order to Accommodation Code Accuracy split between Initial Admission Status and Change Level of Care
  - Breakouts for high cost service lines (e.g., NICU, ICU)

Accommodation Code Accuracy Reporting

Facility	Baseline (3/28/24-3/31/24)			Prior Month (DECEMBER)			Prior Day (1/12)			TARGET	VARIANCE	JANUARY MTD			TARGET	VARIANCE	MTD VARIANCE to Baseline	% Opportunity (System)
	YES	NO	%	YES	NO	%	YES	NO	%	%	%	YES	NO	%	%	%	%	%
Adventist Health Mendocino Coast	40	15	72.7%	364	10	97.3%	11	0	100.0%	99.0%	1.0%	139	0	100.0%	99.0%	1.0%	27.3%	0.0%
Adventist Health Simi Valley	347	45	88.5%	3365	62	98.2%	115	3	97.5%	99.0%	-1.5%	1243	20	98.4%	99.0%	-0.6%	9.9%	0.1%
Adventist Health St Helena	153	33	82.3%	1159	30	97.5%	38	1	97.4%	99.0%	-1.6%	579	10	98.3%	99.0%	-0.7%	16.0%	0.0%
Adventist Health Howard Memorial	52	28	65.0%	609	15	97.6%	18	0	100.0%	99.0%	1.0%	198	4	98.0%	99.0%	-1.0%	33.0%	0.0%
Adventist Health Delano	226	34	86.9%	1988	34	98.3%	55	1	98.2%	99.0%	-0.8%	721	19	97.4%	99.0%	-1.6%	10.5%	0.1%
Adventist Health Bakersfield	690	173	80.0%	6864	155	97.8%	235	9	96.3%	99.0%	-2.7%	2838	75	97.4%	99.0%	-1.6%	17.5%	0.3%
Adventist Health and Rideout	422	274	60.6%	5461	360	93.8%	187	8	95.9%	99.0%	-3.1%	2302	65	97.3%	99.0%	-1.7%	36.6%	0.3%
Adventist Health Castle	249	42	85.6%	2069	36	98.3%	63	3	95.5%	99.0%	-3.5%	733	21	97.2%	99.0%	-1.8%	11.6%	0.1%
Adventist Health White Memorial	923	167	84.7%	6312	181	97.2%	244	3	98.8%	99.0%	-0.2%	2755	86	97.0%	99.0%	-2.0%	12.3%	0.4%
Adventist Health Tillamook	51	8	86.4%	382	27	93.4%	13	1	92.9%	99.0%	-6.1%	155	5	96.9%	99.0%	-2.1%	10.4%	0.0%
Adventist Health Glendale	913	325	73.7%	9451	303	96.9%	303	6	98.1%	99.0%	-0.9%	3593	119	96.8%	99.0%	-2.2%	23.0%	0.5%
Adventist Health White Memorial Montebello	0	0	0.0%	1714	53	97.0%	55	2	96.5%	99.0%	-2.5%	672	35	95.0%	99.0%	-4.0%	95.0%	0.2%
Adventist Health Tulare	107	6	94.7%	849	46	94.9%	36	4	90.0%	99.0%	-9.0%	415	22	95.0%	99.0%	-4.0%	0.3%	0.1%
Adventist Health Hanford	366	87	80.8%	3548	183	95.1%	140	8	94.6%	99.0%	-4.4%	1517	81	94.9%	99.0%	-4.1%	14.1%	0.4%
Adventist Health Lodi Memorial	431	92	82.4%	3696	257	93.5%	110	4	96.5%	99.0%	-2.5%	1373	77	94.7%	99.0%	-4.3%	12.3%	0.3%
Adventist Health Reedley	73	7	91.3%	608	29	95.4%	19	1	95.0%	99.0%	-4.0%	268	17	94.0%	99.0%	-5.0%	2.8%	0.1%
Adventist Health Selma	57	5	91.9%	524	22	96.0%	26	2	92.9%	99.0%	-6.1%	237	17	93.3%	99.0%	-5.7%	1.4%	0.1%
Adventist Health Clear Lake	60	19	75.9%	642	22	96.7%	18	1	94.7%	99.0%	-4.3%	232	17	93.2%	99.0%	-5.8%	17.2%	0.1%
Adventist Health Ukiah Valley	125	54	69.8%	1198	35	97.2%	36	1	97.3%	99.0%	-1.7%	451	35	92.8%	99.0%	-6.2%	23.0%	0.2%
Adventist Health Sonora	172	44	79.6%	1430	99	93.5%	43	15	74.1%	99.0%	-24.9%	564	53	91.4%	99.0%	-7.6%	11.8%	0.2%
Adventist Health Specialty Bakersfie	102	33	75.6%	807	52	93.9%	28	3	90.3%	99.0%	-8.7%	329	32	91.1%	99.0%	-7.9%	15.6%	0.1%
Adventist Health Tehachapi Valley	35	17	67.3%	536	15	97.3%	18	0	100.0%	99.0%	1.0%	214	21	91.1%	99.0%	-7.9%	23.8%	0.1%
Grand Total	**5594**	**1508**	**78.8%**	**53576**	**2026**	**96.4%**	**1811**	**76**	**96.0%**	**99.0%**	**-3.0%**	**21528**	**831**	**96.3%**	**99.0%**	**-2.7%**	**17.5%**	**3.7%**

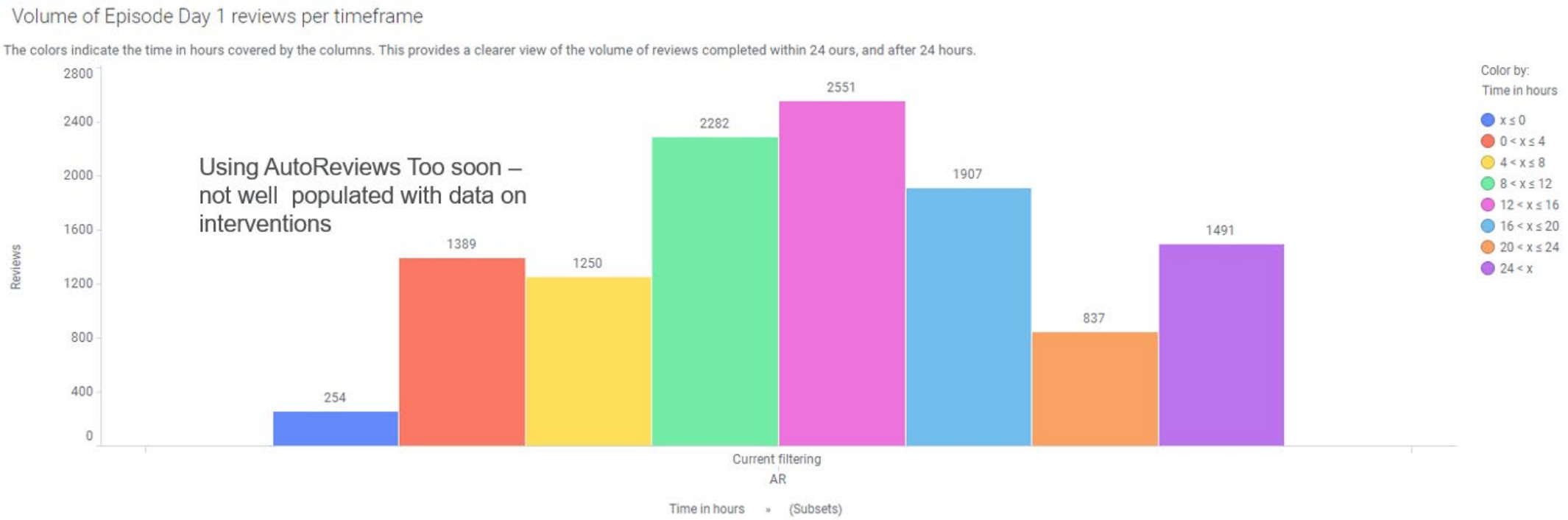
- Additional views target high-cost service lines (NICU, ICU etc.)
- View distributed daily for day prior and MTD performance by market

InterQual (Medical Necessity Checker)

- **What is it?:** Screening tool to assist in determining if the proposed services are clinically indicated and provided in the appropriate level or whether further evaluation is required.
- **The Problem:** Inconsistent usage with limited quality monitoring resulting inaccurate reviews.
- **The Fix:**
  - Yearly training and testing around updates
  - Ongoing quality monitoring program
- **What are we tracking:**
  - Review Quality
  - Time to first review
  - Productivity
  - Top failed criteria sets to drive physician / clinical education

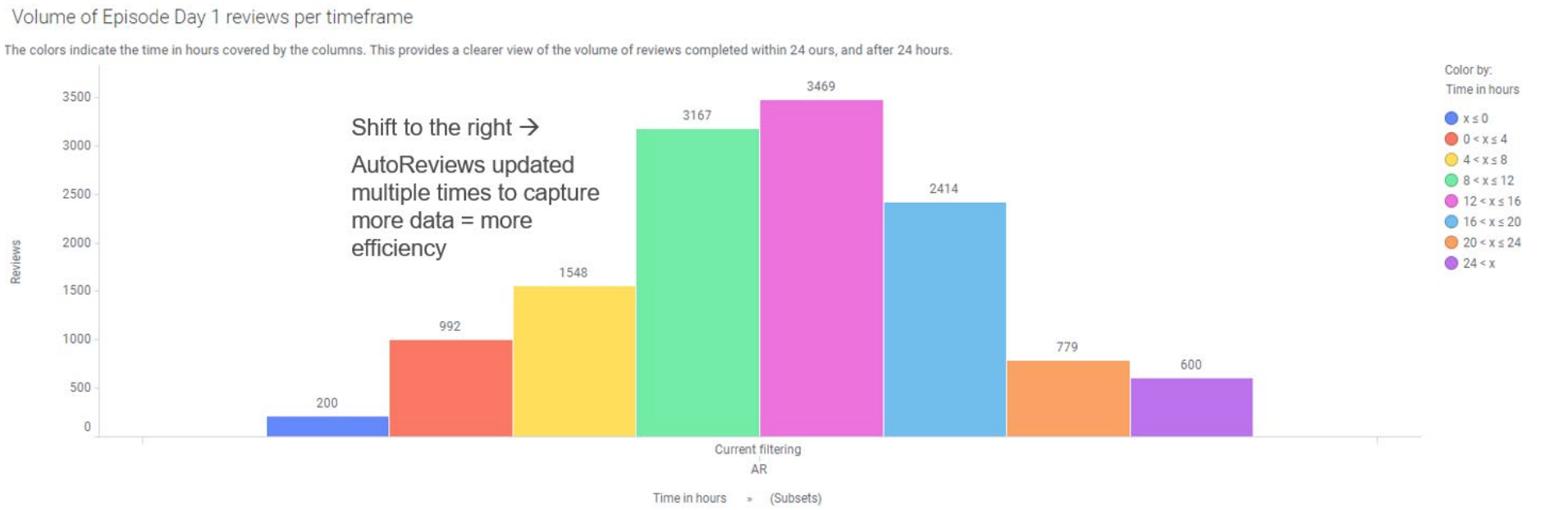
InterQual: Time to first Review

Time to First Review October 2022 → December 2022

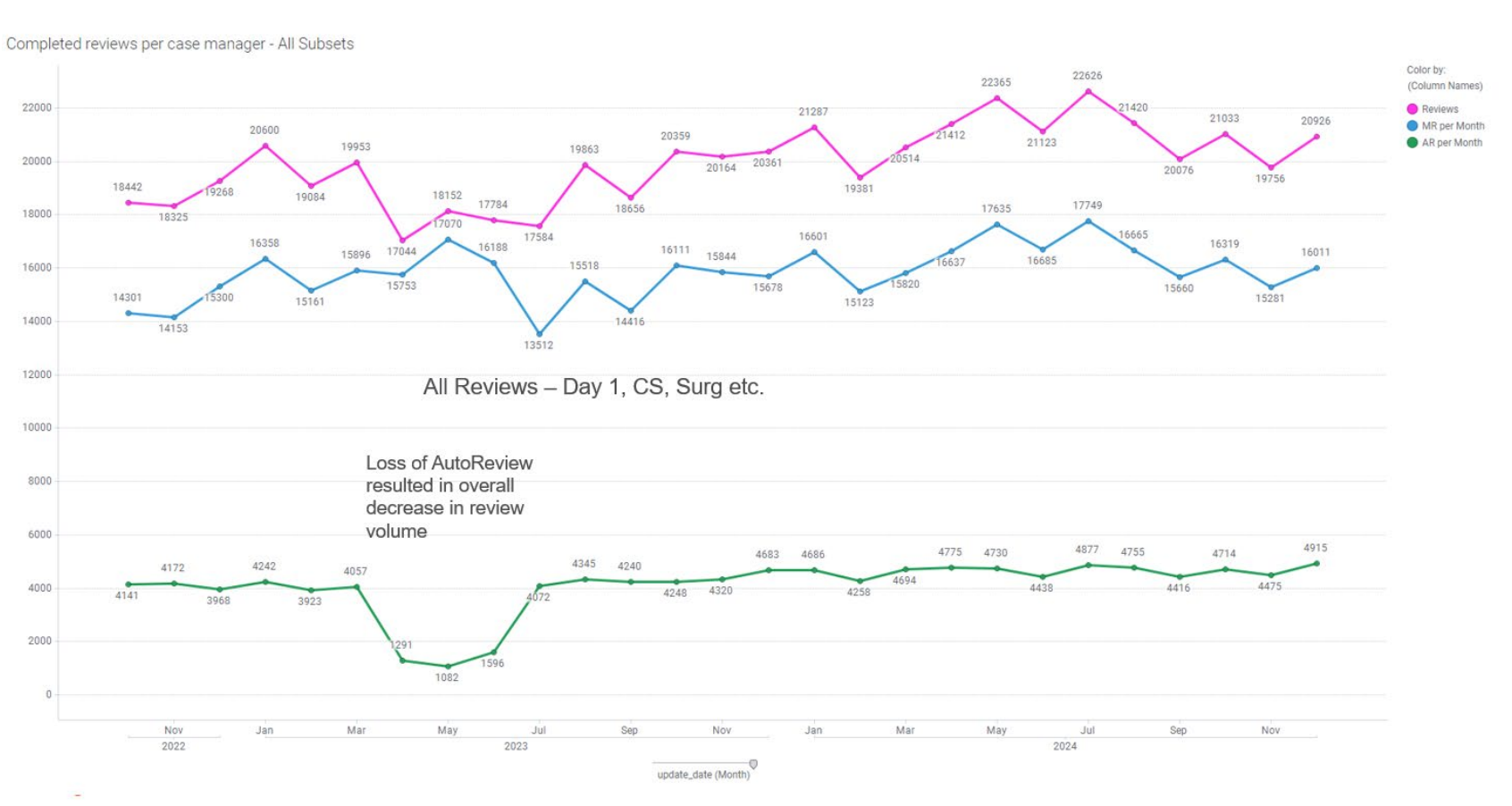


InterQual: Time to first Review

Time to First Review October 2023 → December 2023



InterQual: Productivity



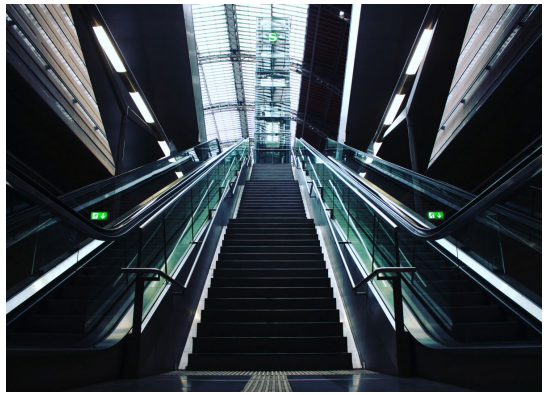
Escalation Workflow

- **What is it?:** In a centralized Utilization Management model, clinical reviews are completed centrally using standard tools (e.g., InterQual) with any issues identified requiring escalation to the site Case Management team to address with the attending physician

- **The Problem:** Lack of clear expectations, training on tools / process, or monitoring of escalation metrics / trends resulting in little to no action taken on critical escalations

- **The Fix:**
  - Established clear expectations for all teams and associated job aides
  - Provided necessary training on all escalation types and interventions
  - Created visibility on escalation themes and performance through reporting
  - Automated daily escalations log (3pm view of all escalations for the prior 24 hours)

- **What are we Tracking?**
  - Escalation Rates by Market / Provider
  - Escalation Trending by type (e.g., Does not meet IP criteria)
  - Escalation Conversion Rate (meets IP escalation for observation encounters)
  - Breakouts by internal providers vs hospitalist groups



Escalate. Don’t Pass the Problem Forward

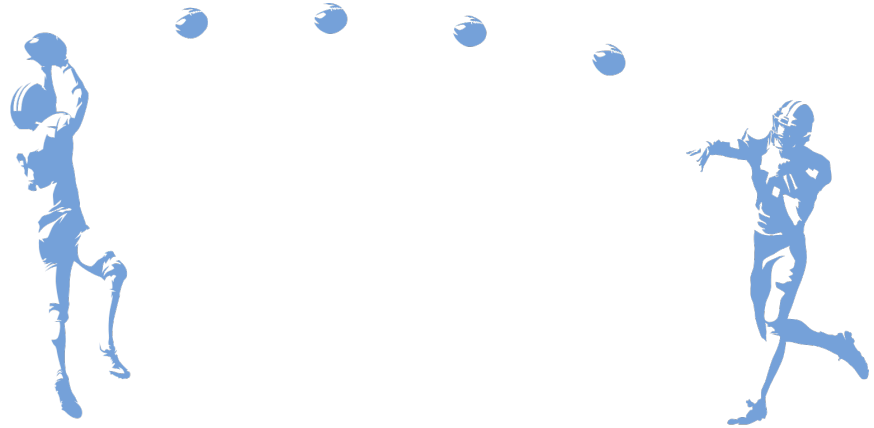
Decreased avoidable medical necessity write-offs are highly driven by the ability to:

1. Accurately place patients in the right level of care from the start
2. Communicate escalations from central UM team to onsite care teams with timely and appropriate response

Onsite CM

Escalation Response:

- Improved documentation
- Move to appropriate level of care

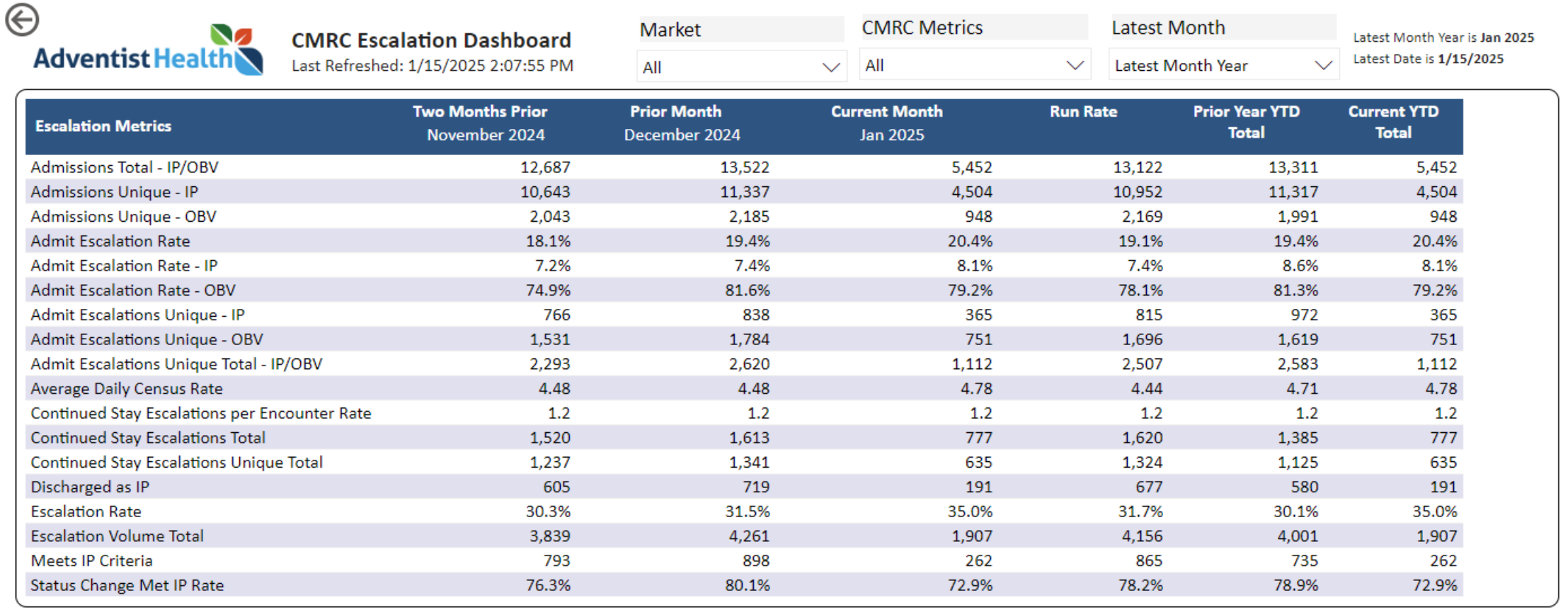


Central UM

Escalation Types:

- IP not meeting criteria
- OBS meeting IP
- OBS not meeting criteria
- OBS approach 2nd MN

Escalation Workflow Reporting



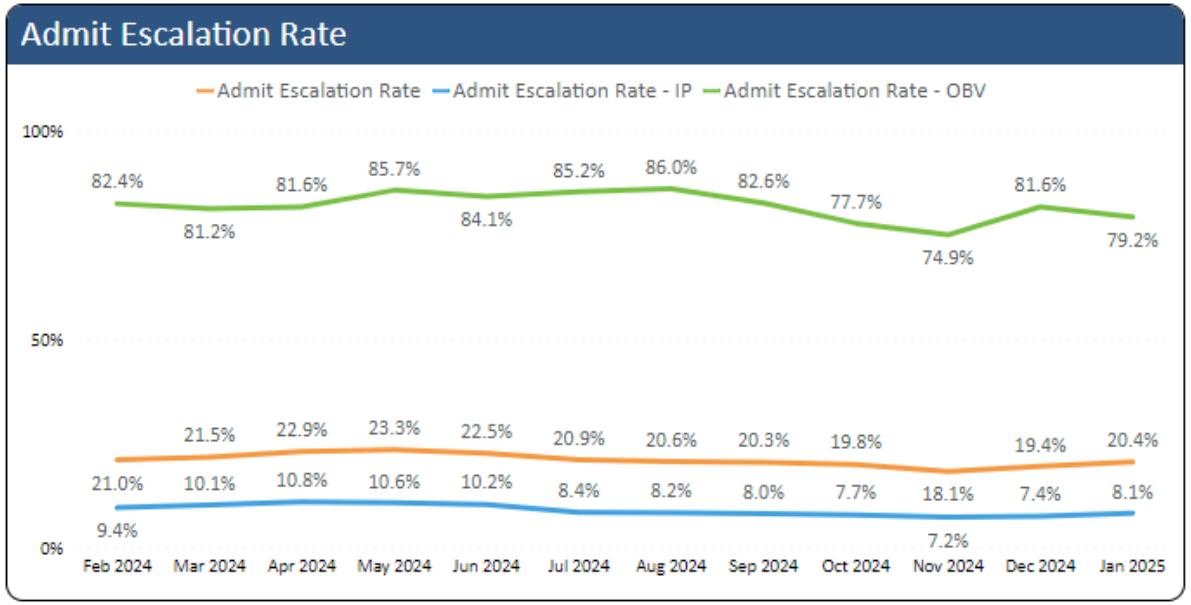
CMRC Escalation Dashboard
Last Refreshed: 1/15/2025 2:07:55 PM

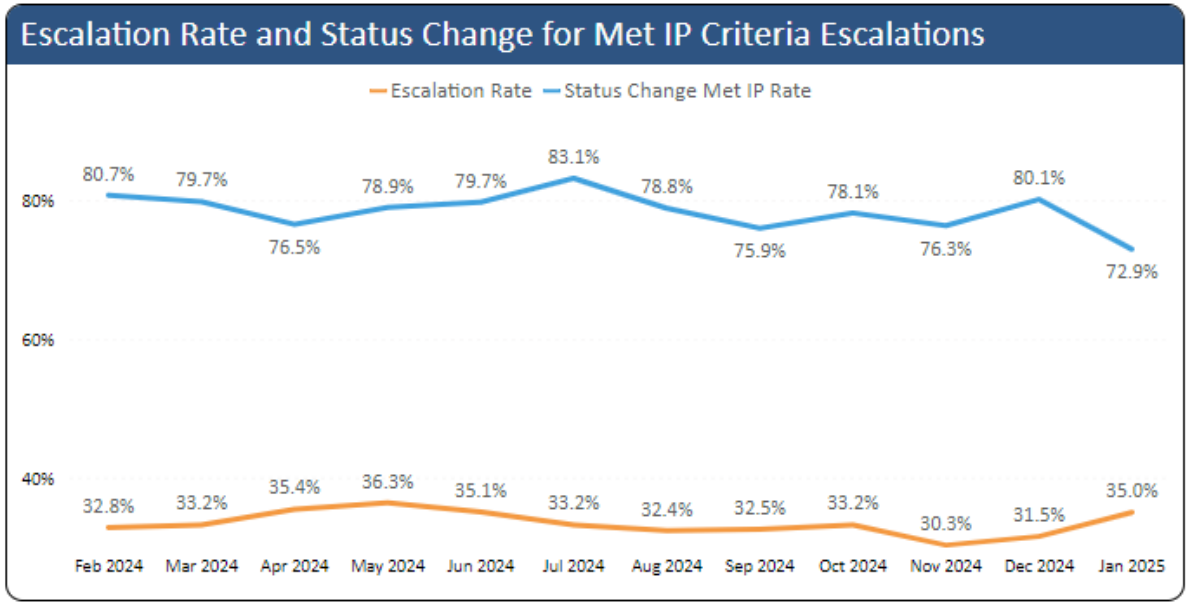
Market: All
CMRC Metrics: All
Latest Month: Latest Month Year

Latest Month Year is **Jan 2025**
Latest Date is **1/15/2025**

Escalation Metrics	Two Months Prior November 2024	Prior Month December 2024	Current Month Jan 2025	Run Rate	Prior Year YTD Total	Current YTD Total
Admissions Total - IP/OBV	12,687	13,522	5,452	13,122	13,311	5,452
Admissions Unique - IP	10,643	11,337	4,504	10,952	11,317	4,504
Admissions Unique - OBV	2,043	2,185	948	2,169	1,991	948
Admit Escalation Rate	18.1%	19.4%	20.4%	19.1%	19.4%	20.4%
Admit Escalation Rate - IP	7.2%	7.4%	8.1%	7.4%	8.6%	8.1%
Admit Escalation Rate - OBV	74.9%	81.6%	79.2%	78.1%	81.3%	79.2%
Admit Escalations Unique - IP	766	838	365	815	972	365
Admit Escalations Unique - OBV	1,531	1,784	751	1,696	1,619	751
Admit Escalations Unique Total - IP/OBV	2,293	2,620	1,112	2,507	2,583	1,112
Average Daily Census Rate	4.48	4.48	4.78	4.44	4.71	4.78
Continued Stay Escalations per Encounter Rate	1.2	1.2	1.2	1.2	1.2	1.2
Continued Stay Escalations Total	1,520	1,613	777	1,620	1,385	777
Continued Stay Escalations Unique Total	1,237	1,341	635	1,324	1,125	635
Discharged as IP	605	719	191	677	580	191
Escalation Rate	30.3%	31.5%	35.0%	31.7%	30.1%	35.0%
Escalation Volume Total	3,839	4,261	1,907	4,156	4,001	1,907
Meets IP Criteria	793	898	262	865	735	262
Status Change Met IP Rate	76.3%	80.1%	72.9%	78.2%	78.9%	72.9%

Escalation Workflow Reporting





Escalation Workflow Reporting

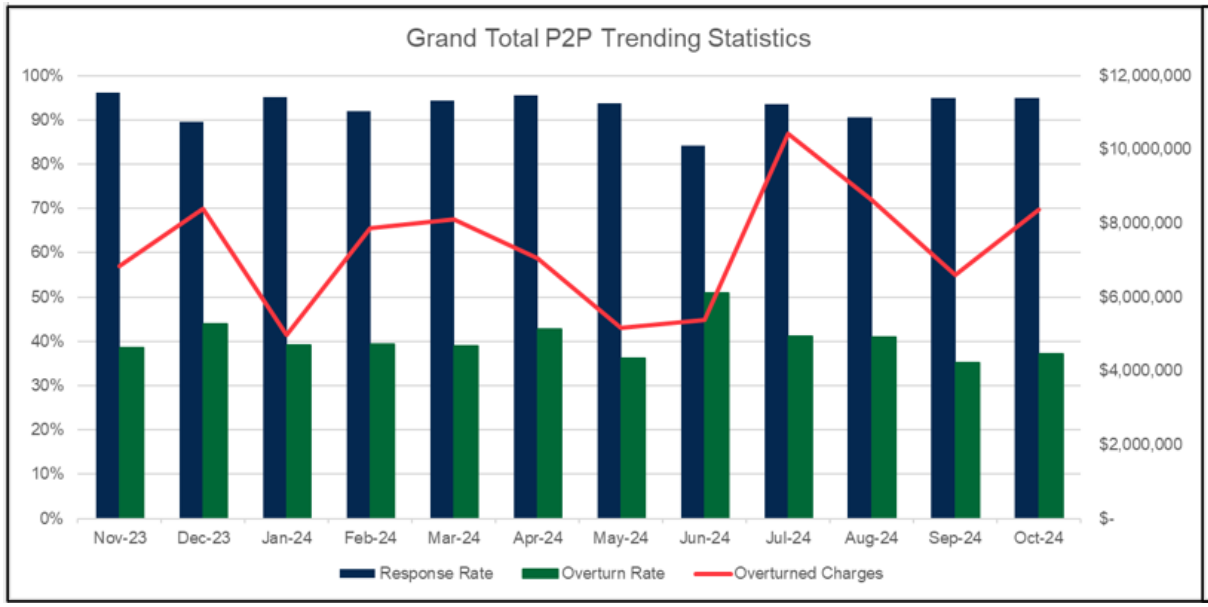
"Meets Inpatient" Escalation Conversion to IP

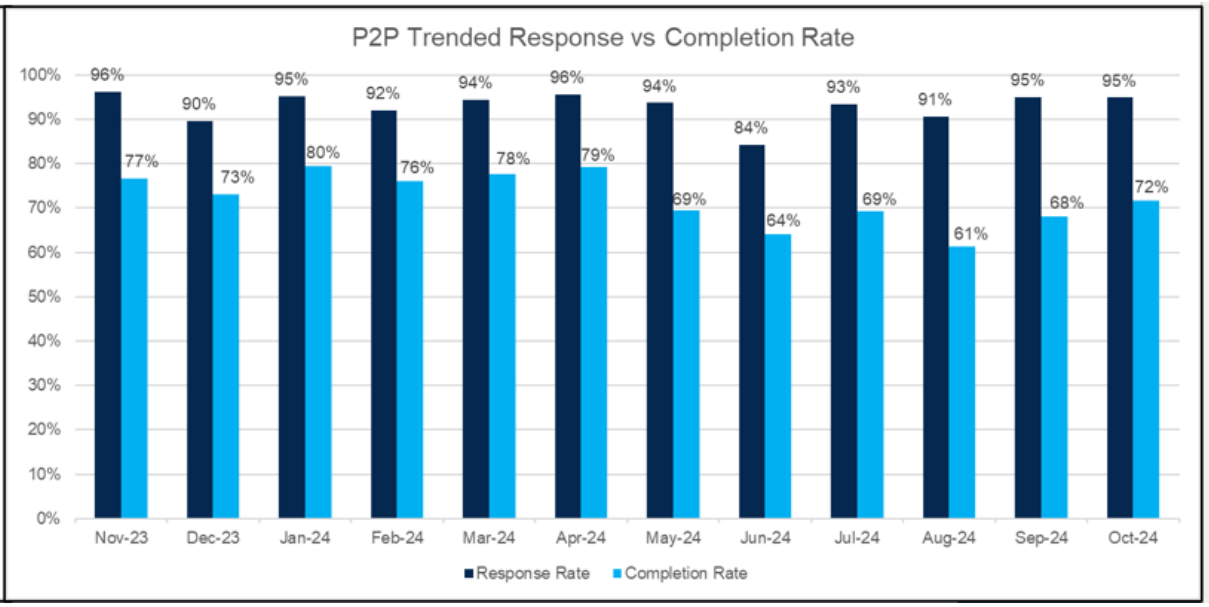
Facility	2022 Average	2023 Average	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	2024 Esc	2023 Esc
Bakersfield	62%	69%	79%	71%	77%	76%	69%	76%	83%	72%	67%	64%	70%	78%	1476	1892
Castle	51%	59%	78%	48%	65%	68%	73%	58%	57%	72%	57%	57%	65%	53%	299	351
Clear Lake	63%	67%	83%	83%	100%	100%	63%	33%	25%	33%	0%	100%	100%	83%	44	73
Delano	N/A	63%	69%	100%	N/A	100%	100%	78%	80%	50%	86%	60%	86%	33%	70	26
Frank R Howard	66%	68%	76%	92%	100%	85%	91%	80%	100%	100%	100%	67%	82%	100%	121	180
Glendale	66%	68%	61%	86%	66%	66%	77%	75%	79%	77%	71%	71%	64%	65%	1031	1208
Hanford	83%	89%	88%	83%	92%	93%	86%	95%	93%	86%	92%	95%	95%	94%	776	1158
Lodi	73%	81%	80%	89%	88%	85%	88%	87%	87%	89%	87%	80%	79%	94%	731	634
Mendocino	83%	74%	0%	71%	67%	67%	88%	100%	83%	N/A	0%	100%	20%	50%	36	48
Montebello	N/A	N/A	N/A	N/A	N/A	86%	65%	68%	76%	66%	71%	73%	100%	N/A	258	0
RideOut	76%	79%	81%	83%	83%	76%	68%	78%	82%	79%	76%	74%	72%	75%	990	1422
Selma / Reedley	74%	86%	71%	91%	87%	79%	100%	90%	90%	100%	89%	100%	83%	100%	164	192
Simi Valley	78%	82%	81%	80%	74%	71%	83%	78%	88%	86%	78%	90%	76%	73%	776	949
Sonora	50%	62%	81%	64%	52%	74%	83%	75%	78%	64%	67%	64%	83%	47%	364	306
Specialty Bakersfield	N/A	40%	N/A	N/A	N/A	100%	N/A	N/A	100%	N/A	100%	100%	N/A	100%	2	10
St. Helena	67%	77%	75%	33%	67%	83%	100%	80%	88%	73%	83%	86%	88%	86%	87	120
Tehachapi	49%	60%	40%	25%	63%	63%	N/A	71%	43%	71%	71%	73%	73%	92%	99	74
Tillamook	48%	67%	60%	73%	56%	33%	33%	100%	67%	86%	67%	88%	40%	60%	75	79
Tulare	N/A	89%	100%	88%	100%	67%	100%	100%	100%	100%	78%	100%	N/A	N/A	84	81
Ukiah	42%	62%	85%	86%	75%	57%	82%	85%	79%	63%	70%	63%	75%	75%	280	219
White	69%	77%	79%	82%	79%	78%	89%	86%	91%	86%	78%	90%	89%	85%	1019	948
Grand Total - Met IP	**68%**	**75%**	**78%**	**78%**	**77%**	**76%**	**79%**	**80%**	**83%**	**79%**	**76%**	**77%**	**76%**	**77%**	**8809**	**9970**

Physician to Physician (P2P) Workflow

- **What is it?:** In the event of a concurrent inpatient medical necessity denial, many payers have an option for a physician-to-physician conversation. Rules vary by payer.
- **The Problem:** Lack of clear process and expectations for all teams involved (centralize UM team and site CM team), training / prep for physicians, and visibility into performance / outcomes
- **The Fix:**
  - Established clear expectations for all teams
  - Provided necessary training and physician prep support
  - Created visibility on performance through metrics / reporting
- **What are we Tracking?:**
  - Peer to Peer Response / Completion Rates
  - Peer to Peer Overturn Rates by market / payer
  - Peer to Peer Overturned Charges ($)

Physician to Physician (P2P) Reporting





- Metrics can be run by site or by payer to better understand market and/or payer trends

Medicare 2ndary Review Process

- **What is it?:** CMS requires all inpatient encounters less than 2 midnights to be reviewed for a 2-midnight rule exception. If the encounter does not meet one of the exceptions, a self-denial and zero reimbursement is the result.
- **The Problem:** Lack of clear process and expectations for all teams involved (centralize UM team and site CM team), training for UM Team and Physician Advisors completing the review, training for physicians on documenting exceptions, and visibility into performance / outcomes
- **The Fix:**
  - Established clear expectations for all teams
  - Provided necessary physician training on documenting 2 midnight rule exceptions
  - Created visibility on performance through metrics / reporting
- **What are we Tracking?:**
  - 2ndary review process volume by market
  - 2ndary review process self denial rate

Medicare 2ndary Review Process Reporting

Facility	Review Month														2024 Running Average	2024 Total MCR Reviews
	2022 Average	2023 Average	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24		
White Memorial	32%	35%	38%	36%	50%	60%	75%	50%	43%	25%	100%	N/A	33%	50%	48%	65
Montebello	N/A	N/A	N/A	N/A	N/A	N/A	25%	0%	100%	75%	N/A	N/A	50%	50%	47%	15
Glendale	54%	69%	85%	76%	73%	74%	86%	80%	77%	95%	87%	87%	87%	74%	81%	445
St Helena	0%	47%	50%	89%	50%	75%	100%	83%	83%	71%	88%	73%	100%	100%	82%	88
Rideout	44%	48%	52%	36%	64%	56%	60%	70%	62%	100%	80%	57%	50%	67%	58%	137
Lodi	30%	46%	30%	46%	64%	75%	57%	80%	78%	100%	86%	71%	100%	80%	64%	105
Castle	N/A	76%	87%	84%	50%	100%	71%	83%	58%	75%	86%	100%	86%	83%	79%	114
Hanford	N/A	75%	60%	80%	57%	67%	100%	60%	88%	60%	70%	58%	50%	50%	68%	81
Selma	N/A	N/A	100%	80%	100%	100%	50%	100%	100%	100%	N/A	67%	100%	67%	85%	27
Tulare	N/A	50%	100%	92%	100%	100%	100%	100%	100%	100%	33%	50%	100%	57%	80%	41
Reedley	N/A	N/A	N/A	N/A	N/A	100%	100%	100%	N/A	N/A	N/A	N/A	0%	N/A	80%	5
Simi Valley	63%	51%	92%	86%	100%	100%	76%	83%	85%	69%	67%	92%	100%	88%	85%	150
Sonora	N/A	86%	64%	86%	82%	79%	87%	100%	86%	91%	90%	91%	86%	75%	84%	159
Tillamook	100%	26%	100%	50%	N/A	100%	67%	75%	N/A	100%	N/A	100%	100%	N/A	76%	25
Mendocino	N/A	N/A	N/A	N/A	N/A	N/A	75%	0%	0%	14%	13%	55%	67%	N/A	33%	45
Ukiah Valley	N/A	50%	63%	68%	63%	100%	53%	100%	100%	57%	100%	63%	91%	91%	75%	135
Howard	N/A	29%	71%	50%	100%	75%	100%	50%	100%	100%	N/A	71%	0%	80%	73%	40
Delano	N/A	50%	100%	67%	0%	75%	100%	100%	67%	100%	50%	100%	67%	100%	76%	33
Bakersfield	63%	61%	83%	75%	85%	71%	85%	92%	80%	85%	79%	89%	63%	91%	81%	170
Tehachapi	67%	57%	75%	67%	75%	100%	80%	50%	63%	100%	100%	N/A	60%	80%	75%	61
Specialty Bakersfield	N/A	N/A	N/A	50%	0%	50%	50%	100%	100%	78%	100%	83%	67%	100%	63%	79
Clear Lake	100%	43%	67%	83%	75%	N/A	67%	100%	33%	67%	33%	0%	100%	50%	64%	39
Grand Total	**52%**	**56%**	**71%**	**68%**	**69%**	**79%**	**75%**	**79%**	**73%**	**80%**	**78%**	**74%**	**77%**	**78%**	**74%**	**2059**

- Represents % of Medicare 2ndary Review encounters that meet a 2-midnight rule exception and can be billed
- Additional layer down can be utilized to investigate outlier markets to better understand root cause

Clinical Appeal Workflow

- **What is it?:** Post claim appeal process
- **The Problem:** Lack of tools, tracking, and visibility on the clinical appeal workflow and performance metrics / outcomes. Lack of clear workflows between central UM team and Revenue Cycle teams.
- **The Fix:**
  - Established clear workflows and expectations for all teams
  - Implemented tool to track all clinical appeals and outcomes
  - Created visibility on performance through metrics / reporting
- **What are we tracking?:**
  - Overturn Rates (overall and by payer group)
  - Appeal Status by Stage
  - Root Cause Issue Tracking

UM Focused Payer Meetings

- Established monthly UM focused payer meetings with top denial payers beginning in 2022 with continued implementation into 2023 /2024

- Forum has been effectively utilized to establish optimized workflows, establish escalation contacts, share / resolve challenges, and escalate high value problem encounters

Standard Agenda Topics

1. Concurrent Auth Process Walkthrough (both sides share)
   a) Standard expectations on timeline
   b) Peer to Peer Process
   c) Any special requirements (e.g., discharge notification)
   d) Outlet for correcting "late notification"
   e) Auth communication process (portal vs. fax)

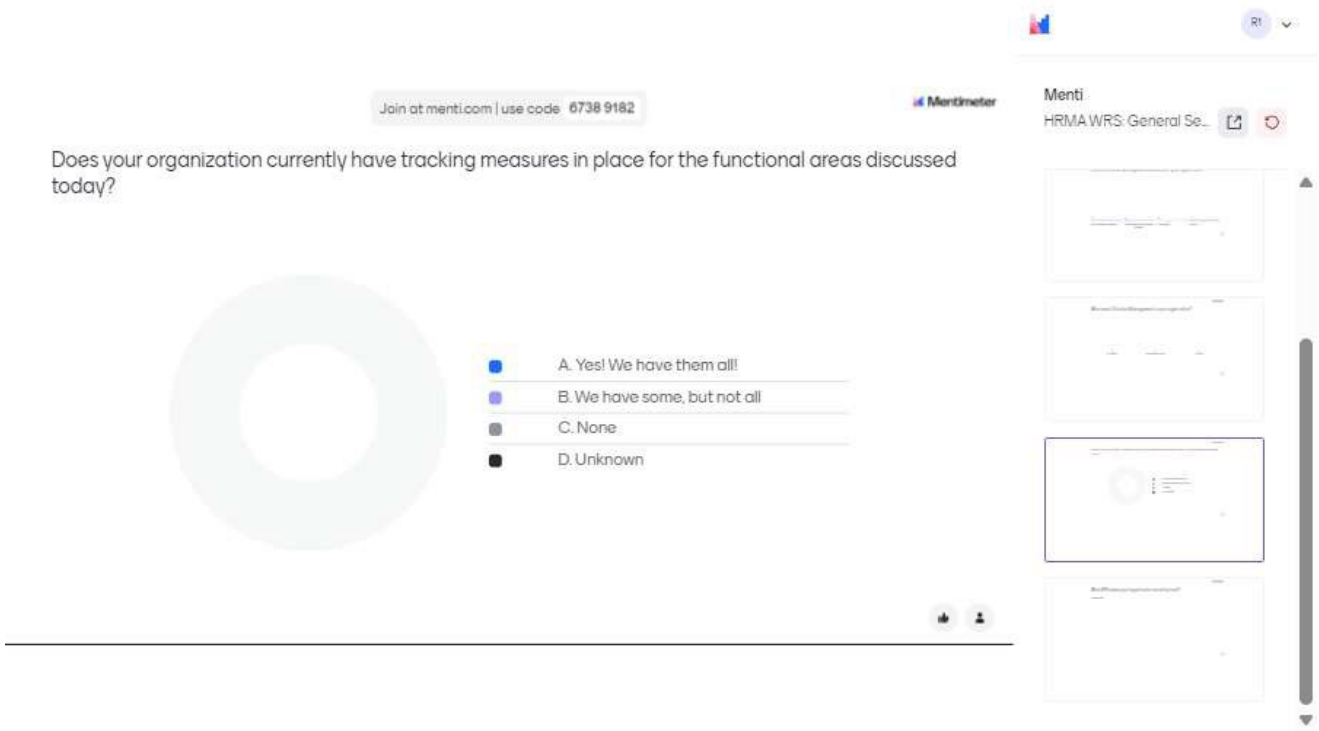
2. Confirm fax numbers are accurate
   a) Where are we sending clinicals
   b) Where are approvals / denials being faxed back

3. Establish escalation contacts for delayed authorizations

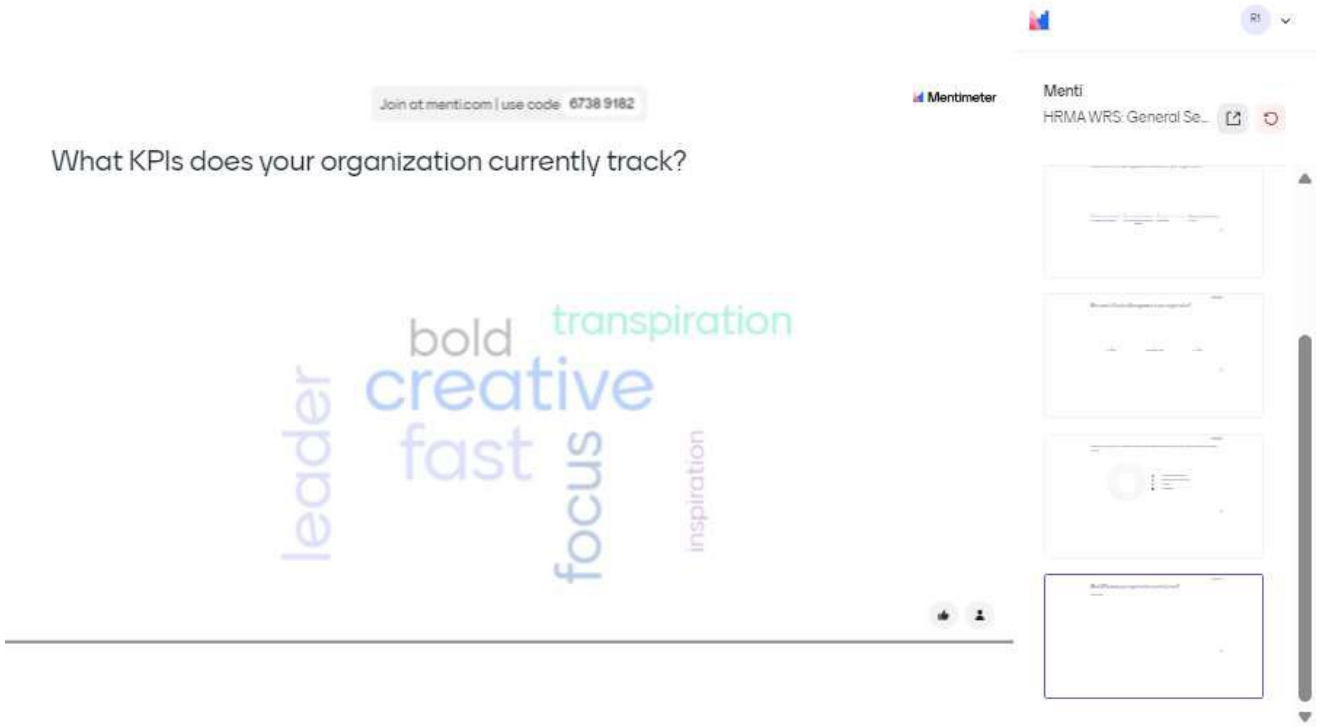
4. Discuss known challenges (examples included below)
   a) Peer to Peer (e.g., restricted peer to peer window)
   b) Delayed authorization determinations
   c) Stating missing clinicals when they have been faxed

Forums for Collaboration

- Revenue Cycle Operations Council
- Market Based Clinical Denial Workgroups
- Market Based Revenue Cycle Monthly Deep Dive Meetings
- Market Utilization Management Committees
- UM Focused Payer Meetings



Sponsored By **The Queiro Group**



Sponsored By **The Queiro Group**

Results Highlights

- 25% reduction in overall IP avoidable write-off rate from 2022 to current
- 10% reduction in critical escalation types (e.g., does not meet IP criteria) 2022 to 2024
- 50% increase in overturned charges through the peer-to-peer process from 2022 to 2024 (42.1M in 2022; 82.2M in 2024)
- 16.1% improvement in converting "meets IP criteria" observation patients to inpatient level care from 2022 to 2024
- 45% reduction in self-denial rate for our Medicare short stay population (2ndary review process) from 2022 to 2024
- 12.3% increase in post claim clinical appeal overturn rate (2023 to 2024)

Questions

About Us

Andrew Jacobsen
Principal
Pinnacle Healthcare Advisors, Inc.
ajacobsen@pinnaclehca.com

Regina Berman
Value Based Care Executive
Adventist Health
BermanRS@ah.org