



**ACHIEVING A NEW STANDARD IN PRIMARY CARE FOR
LOW-INCOME POPULATIONS: CASE STUDIES OF REDESIGN
AND CHANGE THROUGH A LEARNING COLLABORATIVE**

**CASE STUDY 3: REVENUE MAXIMIZATION PROGRAM AT THE
BROWNSVILLE MULTI-SERVICE FAMILY HEALTH CENTER**

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CENTER PROFILE

The Brownsville Multi-Service Family Health Center (BMS) is located in the Brownsville section of Brooklyn across the street from the largest concentration of public housing in New York City, including apartment buildings dating back to the late 1940s. A single-site facility that recently celebrated its twentieth anniversary, BMS has been an integral part of the Brownsville community throughout the center's existence, providing much needed health care to a patient population with complex needs.

Most of the center's 12,500 to 13,000 clients are low-income residents of public housing. They visit the busy center for an average of 45,000 visits annually, often presenting a complex range of health issues. BMS President and CEO Maurice Reid attributes these complex needs to the high-stress lives patients lead. BMS clients "do not routinely go for health care. They are so involved in life issues, trying to survive, that when they finally show up they need multiple types of attention," he says. A typical patient may come to BMS to be treated for a cold. Providers often then identify and address other pressing medical and behavioral issues.

True to its mission as a multi-service facility, BMS offers a myriad of services. The two-floor, 27,000-square-foot building houses administrative offices, waiting and examination areas, and a WIC (Women, Infants, and Children) program. Patients receive primary adult and pediatric care and specialty services such as dentistry, optometry, podiatry, dermatology and acupuncture. Approximately 80 percent of the patients at BMS are African-American, Caribbean, and African; about 15 percent are Latino, mostly of

Puerto Rican descent; the remaining are white. About 80 percent of patients are on Medicaid, 7 percent to 8 percent are on Medicare, and the rest are a mix of self-paying clients and the uninsured.

BMS has remained vital throughout its two decades in Brownsville because management and staff understand what life is like in the neighborhood and are receptive to patient needs. Patients wanted an on-site drugstore, for example, and in response the center recently leased open space in its large entry area to a pharmacy. Opening the pharmacy provided clients with a service they requested, used existing space more productively, and served the center's mission of providing multiple services in one location.

CENTER CONDITIONS PRIOR TO REDESIGN

The Need for Productivity Versus Quality Care

Management at BMS was keenly aware that the center was collecting revenue inefficiently. Examples of inefficiency occurred during all phases of the collection process: self-pay patients at the front desk, encounter forms that never reached the billing office, and inaccurate claim forms that were denied payment. Management had tried to overhaul the collection systems for years, to no avail. "We knew we were looking at fairly extensive receivables with Medicare, things that were over 120 days old," says Reid. But staff members never were able to catch up with work so they could focus on these invoices. Even when BMS "revised our self-pay procedures...everyone was excited about this but it was not making a difference" in bringing in money, he says.

The need for revenue was pressing, and the problem was too complicated to resolve by simply imposing new procedures on staff. As Reid puts it, providers and staff were "caught in the vise of needing productivity and needing to service the patient. Although they were somewhat concerned about using time efficiently they didn't see their jobs in terms of money. As long as they got the patients in and gave them good care, that's what counted."

Quality of care was not an issue. But at the same time, employees felt discouraged that their efforts did not generate the revenue necessary to keep BMS in financial health. "Patients would talk highly of the center," says Dr. Camille Taylor-Mullen, head physician in the BMS adult medicine unit. "Providers and staff were clearly working hard. Yet at staff meetings productivity being reported was not what you would expect. It was disheartening that we were doing a lot of work but were not able to generate revenue."

Management turned to PCDC for help. The group has assisted many types of community-based health centers with facility building and program operations for years. Many of these community-based centers operate on slim financial margins, and their ability to support operating costs is severely hampered if they fail to collect all revenue. PCDC understands the challenges centers face in collecting revenue and addresses these issues in the Revenue Maximization Collaborative, which BMS participated in from February to June, 2002.

THE REVENUE MAXIMIZATION LEARNING COLLABORATIVE

Tracking, Communication, Teamwork

Revenue Maximization (RevMax) gives health facilities strategies and tools for streamlining financial processes. The goal of the program is to transform revenue collection systems so that facilities efficiently collect all money to which they are entitled. The transformation of financial systems takes place over the course of an intensive five-to-eight month RevMax Learning Collaborative that is led by national experts. During this time, teams of participants from different health facilities learn to:

- Track the path of revenue collection in their facilities
- Identify breakdowns and loopholes in the collection process
- Design new procedures to make revenue collection more efficient

RevMax's Collateral Benefits: Seamless Work Processes, Improved Morale

RevMax helps participants design solutions for managing and expediting self-pay collections, lag times between dates of service and billing, and claims rejections.

The program also stresses the importance of communication and teamwork. Enhanced communication and strong teamwork help seamlessly integrate the work of the front desk with clinical and back-office operations. This seamless process helps RevMax participants generate and collect more money. Moreover, it results in a better working atmosphere, improved staff morale, and efficient work processes that improve the quality of patient care. These are welcome collateral benefits of the RevMax program that were particularly important for employees at BMS, who placed a high value on their relationships with patients and wanted to increase revenue without sacrificing those relationships.

“The focus of the program was to improve revenue,” says Mohammed Sadique, BMS’s comptroller and deputy financial officer. “In order to improve revenue, we had to

examine our whole collection process. As a result, we identified shortcomings in our systems. Once we brought these to the attention of management and they were addressed, we were able to improve efficiency and productivity. And that impacted revenue.”

A Learning Collaborative Model

Like all of PCDC’s operations programs, RevMax is structured as a learning collaborative, which takes place over several months. Financial experts lead the collaborative and serve as guides as the facility’s staff embarks on a journey of discovery about health center operations. There are two critical elements of the learning collaborative: *collaborative principles* and the stages of the collaborative process.

Collaborative Principles: Identifying Roadblocks on the Path to Change

The learning collaborative features five strategic collaborative principles:

1. Build a high-functioning team.

BMS’s team was drawn from many departments. Members included the deputy financial officer (Sadique, who was also the team leader), the billing manager, a patient care associate, a clerk, and a physician (Taylor-Mullen). The mix was “excellent,” says Reid. “They worked together extremely well, individually and collectively. They were well-respected by the rest of the staff and taken seriously.” The patient care associate played a particularly significant role on the team. Since she had worked both at the front desk and in the clinic during her years at the center, she was an invaluable liaison between the two areas throughout the collaborative, helping to solidify a connection that lasted long after the program ended.

2. Cultivate leadership support and involvement.

BMS’s management had tried fruitlessly to transform revenue collection over the years. They started with the RevMax Collaborative feeling that success would come only if staff members drove the changes themselves. As Reid describes it, management realized that the employees “were in the trenches. We said, ‘Look guys, what we tried to do over the years hasn’t worked. Whatever resources you need we will give you.’” Reid adds that the team “made some pretty tough demands,” but as promised, management met the demands. “We could sense the excitement [from team members]. They brought enthusiasm to the center and that was worth it.”

3. Track data and map the process from the patient’s perspective

The first job of the new team was to begin capturing data. Team members tracked patients from the moment they “walked through the door to the end point of their visit when

their encounter form was billed,” says Taylor-Mullen. By doing this, the team was able to pinpoint baseline numbers:

- Average weekly cash receipts (\$66,434)
- Average reimbursement per patient visit (\$78)
- Total amount of outstanding denied claims (\$368,000)

Tracking also enabled the team to identify the roadblocks that impeded revenue generation and collection:

- Complete patient information was not being collected on encounter forms during registration, which led to a high percentage of denials once the visit was billed
- Providers were not adequately credentialed to see all patients, which led insurance companies to deny submitted invoices
- The billing department and the patient account department were inadequately staffed
- No single person on staff had a direct, ongoing relationship with the managed care companies that insured patients

With its greater awareness of center procedures, the team was able to design practical changes that it hoped would increase efficiency. Increased efficiency would ideally increase revenue. The team set a goal of a 20 percent increase in revenue over the course of the collaborative.

4. Open lines of communication.

The BMS team let everyone at the center know about the exciting gains in revenue. “This helped morale,” says Taylor-Mullen. “Staff could see that things were improving as money was coming in, and that this was because staff was holding each other accountable.”

5. Utilize the expertise of PCDC coaches and program leaders.

RevMax Collaborative director Cheryl Modica and collaborative financial consultant Ken P. O’Neil visit each facility twice during the collaborative, once during the early stages of the process and again later on. During the visits, Modica works closely with team members and other staff on team building and goal setting. She sets up systems during the first visit and follows the team’s progress during the second visit, at which time she helps

adjust strategies if the team has gotten off track. Modica also is a liaison between staff and leadership and communicates with participants between site visits by phone and e-mail.

“Sometimes we came across barriers that we weren’t sure how to handle, or staff who were resistant and who we didn’t know how to approach,” says Taylor-Mullen, describing the team’s attempt to relay RevMax concepts to the health center’s staff. “Cheryl was in touch with us weekly and very supportive. She gave us ideas about how to break through to staff so that they bought into the program. She also helped us see the big picture when we were getting into too much detail. She kept us focused, on track, on our toes. If we were going off on a tangent she brought us back to reaching our goals.”

Modica works on team building through weekly coaching contact. O’Neil, meanwhile, spends his time during each site visit educating the center about its financial infrastructure, raising awareness about business practices, asking bottom-line questions about the quickest ways to generate cash, and teaching staff how to analyze and use data.

He often helps a center see the bigger financial picture. Before RevMax, for example, BMS tried to generate self-pay income. O’Neil acknowledged that this effort was necessary but pointed out that only 3 percent of the center’s income would come from that source. Instead, O’Neil went directly to the billing department and said, “Let’s look at where most of the outstanding money is coming from. You have an extended amount of money expected to come in that is not here yet. Go after the money that is outstanding.”

With O’Neil’s help, the BMS team and the billing department identified \$368,000 in denied claims that would have been lost revenue if the health center took no action. The team focused its energy on reprocessing these claims. Almost immediately, they brought the claim balance down to \$177,000, generating \$191,000 in revenue. This short-term solution was exciting, but would not prevent rejected claims in the future. To avoid future denials, the team instituted ongoing training of all staff in how to verify and capture accurate demographic and insurance data on the encounter forms. This effort would mean that the claims submitted were complete, which decreased the percentage of denials.

REVENUE MAXIMIZATION PRINCIPLES: TAILORING REVMAX TO CENTER NEEDS

Each PCDC operations program has its own distinct set of organizing principles that assist teams in making operational changes. The financial experts who designed and lead the

RevMax program know that all health facilities are not alike. The RevMax principles succeed because they can be shaped to the needs of an individual facility.

Applying Principles Creatively: Generating Change Principles

Principle: Do it right the first time.

Before:

The front desk had a high staff turnover rate and new employees were not trained to correctly gather registration information. Mistakes made by inadequately trained staff during the registration process contributed to a high denial rate.

After:

The BMS registration supervisor and the MIS associate established short-term and long-term training sessions for employees:

- Short-term training consisted of two sessions, lasting two hours, for all clerical staff, nursing supervisors, lead physicians, and administrators. They all learned proper methods for complete registration.
- A more detailed and ongoing system of training was instituted for clerks, taking them through each step of the registration process, including using the insurance verification machine. After the training, employees must pass a series of checkpoints in order to be qualified to use the computer for registration purposes. A refresher training course is administered once a year. All new employees must participate in one- to two-week training sessions and pass a test before they begin their jobs.

In addition, the team produced an invaluable tool. They created a manual that outlines everything about the registration process, and put a copy of the manual at each service area so that staff could easily refer to it.

Before:

Front desk staff spent much time on the telephone with managed care companies regarding individual patients and their status with that HMO.

After:

- A staff person was assigned to be a direct liaison between BMS and the managed care companies. This person was responsible for creating a roster of BMS patients and their insurance coverage available for the front desk staff to consult. This roster was updated monthly.

- The new registration manual includes codes for HMOs and is easily referred to by staff.

Before:

- Certain codes on the encounter forms could only be completed by providers, but not all providers knew these codes, nor did they routinely fill out the codes correctly after examining patients.
- Encounter forms that had improper coding either resulted in denied claims or generated less revenue than if the encounter form was coded correctly for a higher-fee service.

After:

- Training was held to educate all providers about the encounter form coding process. Emphasis was placed on the importance of entering all the required coding information as soon as they finished the patient's exam.
- Complete coding information is posted in a computer file so that providers can easily access correct information from anywhere in the clinic.

Principle: Collect money due at the point of service.

Before:

BMS had revised its self-pay procedures prior to RevMax, but tracking revealed that front desk staff was not implementing the new policies.

After:

- The training sessions emphasize how important it is to collect money when the patient is in the office.
- The training sessions make front desk employees appreciate their direct role in buoying the financial health of the center by collecting self-pay revenue.
- Computer screen flags pop up when a patient's file is accessed and show exactly how much a patient owes so that staff can communicate this directly to the patient.

Principle: Eliminate lag times between service and billing.

Before:

Because the billing department was understaffed, lengthy periods of time elapsed between the date of a patient's appointment and the posting of that patient's bill to the financial system.

After:

The team recommended the hiring of an additional employee in the billing department, which management approved.

Before:

There was no system for keeping track of encounter forms. The total number of patients seen each day was not reconciled with the number of forms at the end of the day. The billing department spent time hunting down missing forms from the front desk, providers, or patient charts; often the forms were lost. Late and missing forms translate into lost income.

After:

A new encounter reconciliation procedure was created to hold staff members accountable for passing the encounter form to the next person in the patient visit chain. At the end of the day, the nurse supervisor makes sure that the number of forms matches the number of patient visits, and the forms are delivered to the billing department.

Principle: Manage claim rejections.

Before:

Submitted claims were routinely rejected because information was incorrect or incomplete, or because the BMS providers were not credentialed for the services being billed.

After:

During the collaborative:

- With the assistance of O'Neil, the consultant, the BMS team reprocessed claims that had been denied, generating \$191,000 in revenue.

Post-collaborative:

- Through ongoing training, employees learn to gather complete and accurate patient information at the time of registration. This procedure eliminates denials because of incomplete or inaccurate information.
- The managed care liaison and a credentialing committee meet every two months. They work with providers on applying for certification with managed care companies so that fewer claims will be rejected because of inadequate credentialing.

Principle: Redesign bad processes.

Before:

Tracking revealed that processes and procedures were inefficient or ineffectively completed.

After:

Processes were streamlined. Training sessions were held. Assistance was provided in the form of additional staff, printed manuals, and flagging critical information on the computer.

Principle: Encourage teamwork.

Before:

The highly dedicated staff and providers were extremely committed to providing quality care, but they often were overwhelmed by patient volume and the complexity of patients' needs. They worked together without an awareness of how they interacted with each other or how they influenced the success of the health center.

After:

Weekly RevMax team meetings strengthened the bonds among team members. The team brought its sense of spirit and enthusiasm to the entire center through frequent meetings, presentations, training, and the sharing of data that documented financial success.

Principle: Leverage technology.

Before:

One full-time employee spent almost an entire week each month manually posting Medicaid and Medicare payments to the computer system.

After:

The team suggested using a software package that would automatically download Medicaid and Medicare payment information directly into patient accounts. Once installed, the package saved 35 hours a week of work and freed the billing employee to focus on areas that were previously neglected, such as following up on aging claim rejections and deciphering causes for denials.

Principle: Share the data.

Before:

Everyone worked hard and provided quality care, and employees and providers felt discouraged when they learned about inadequate revenue collection.

After:

The team set up a series of ongoing meetings and presentations throughout the collaborative. Here, they shared collaborative concepts, discussed problems identified through tracking, and proposed strategies for addressing these problems. They suggested how the entire center could work together as a team and documented how much revenue was being generated and how much time was saved through newly efficient processes.

Principle: Establish good internal control systems.

Before:

There were no systems in place to monitor such critical activities as gathering correct registration information, reconciling patient visits with encounter forms, or researching why claims were denied.

After:

- Consistent registration training was established
- Computer screens include flags that indicate payment is due on patient accounts
- Encounter reconciliation procedures are in place
- Computer screens include flags that indicate payment due on invoices
- Billing department generates reports on aging bills to keep track of payments not received on time
- Managed care liaison and credentialing committee consistently follows up with HMOs and providers throughout the credentialing process

- A recommendation is under consideration for installing computer software that tracks denials

Principle: Maintain appropriate staffing.

Before:

Tracking revealed that the billing and patient accounts departments were understaffed and that the center needed a staff person with expertise in managed care.

After:

After considering the team's recommendations, management hired one additional person for the billing department and another to work in patient accounts. A new employee served as liaison between BMS and managed care companies. This job entailed overseeing the accuracy of insurance information for each patient as well as the process for credentialing providers.

Utilizing Principles Strategically: Overcoming Obstacles to Change

Efficient processes based upon collaborative and program principles lead to streamlined revenue generation. These same principles help centers negotiate all obstacles that arise during the health center's reorganization.

The major obstacle that arose at BMS in response to the RevMax program was resistance from line staff who "felt like the team was looking over their shoulders," says Taylor-Mullen. Transformation is impossible without the support of the line staff. The team brought the line staff into the redesigned processes as full participants, reinforcing job skills through training and education. Sharing positive outcomes made employees view themselves as partners in the new processes. The team succeeded in winning over line staff through a combination of collaborative and program principles. These strategies included:

- Leadership support and involvement
- Open lines of communication
- Utilizing the expertise of program coaches
- Encouraging teamwork
- Sharing data

THE DATA: DRAMATIC QUANTITATIVE RESULTS

The health center's financial condition greatly improved because of streamlined processes and greater efficiencies. As a result of the process improvements made, the members of the BMS team exceeded their goal, a 20 percent increase in revenue.

Before RevMax	After RevMax
Weekly cash receipts: \$66,434	Weekly cash receipts: \$97,174 ↑ 46%
Reimbursement per visit: \$78	Reimbursement per visit: \$121 ↑ 55%
	Total revenue increase: \$345,000 ↑ 51%

BEYOND THE DATA: BEDROCK OF A HIGH-PERFORMANCE ORGANIZATION

BMS was highly successful in reaching its RevMax goals. The collaborative more than paid for itself through recovered revenue and long-term potential for realizing income. The collaborative also produced a permanent shift in the organization's culture. The health center was able to begin operating as a high performance organization in a way that was impossible before the program. This section describes several fundamental organizational transformations that took place at BMS.

Making a Connection: Efficiency, Productivity, and Quality of Patient Care

- Before RevMax, center personnel did not fully appreciate that more efficient work processes could generate higher revenue *and* improve the quality of patient care. They thought the quality of care would suffer if they focused on collecting money from patients or seemingly hurried patients through the examination process at times. But the staff and providers then experienced the benefits of implementing RevMax principles such as do it right the first time, redesign bad processes, and encourage teamwork. They now see it is possible to generate money for the center and improve the quality of care at the same time.

Heightened Morale

- Provider morale is enhanced because of improved productivity and efficiency and a sense of work done well.
- The morale of clerical employees is enhanced because they see a connection between their work and the center's success at achieving goals for patient care and revenue.

The Power of Teamwork

- Staff works together as a team to achieve shared goals and team members are accountable for upholding the center's vision.

Committing to Communication

- Staff members are routinely informed of the center's progress and provide input on procedures through daily and weekly meetings.

An Enhanced Relationship Among Leadership, Staff, and Providers

- Leadership is sensitive to the needs of staff and providers, and conversely, staff and providers are sensitive to the constraints guiding leadership.

An Enhanced Relationship Between Staff and Providers

- The team spirit created by the collaborative process led to a collegial work environment, with individuals recognizing and valuing the contributions of coworkers.

SUSTAINING THE OUTCOMES: CONTINUING ON A STRATEGIC JOURNEY

BMS is pleased with the transformations engendered by RevMax and determined to sustain this new approach to efficiency and quality care. Leadership and staff are aware that maintaining their hard-won gains requires ongoing, vigilant effort. They are confident that they will succeed because the RevMax journey taught them to appreciate the results that such efforts produce.

Key changes made in center procedures as a result of the RevMax program:

- Front desk staff, providers, and administrators receive ongoing training on how to gather complete patient information during registration
- Creation of a registration manual
- Computer screen flagging of patient accounts to indicate payment owed, which helps staff collect self-pay fees
- Additional staff hired in the billing and patient accounts departments
- Computer screen flagging of invoices to indicate payments overdue
- Regular generation of aging reports by billing department to track payment due

- Creation of a new staff position: liaison between BMS and managed care companies
- Creation of a roster matching patients with insurance carriers that is updated monthly
- Ongoing monitoring of the provider credentialing process
- Continued meetings of the RevMax team
- Implementation of software that downloads Medicaid and Medicare payment information into patient accounts
- Providers assume responsibility for entering encounter codes on forms
- New encounter form reconciliation procedure ensure that all encounter forms reach the billing office at the end of each day

Plans to ensure continued success:

- Continued weekly meetings with team members who participated in the program and remain passionate and committed to RevMax principles
- Continued involvement by senior managers who embrace RevMax principles, provide ongoing support, and are willing to allocate financial resources to new staff and necessary equipment
- Ongoing tracking of revenue generation and collection processes to highlight areas experiencing breakdowns in communication, paperwork, or procedural flow

BMS leadership entered the RevMax program with hopes of improving the bottom line. It ended the program with transformed operations. The center not only has enhanced revenue, but also streamlined work processes, informed and skilled staff, and the capacity and knowledge to continuing improving operations.