



ZUCKERBERG
SAN FRANCISCO GENERAL
Hospital and Trauma Center

Revenue Cycle Optimization

Eric Wu, Chief Financial Officer

Hemal Kanzaria, Chief of Performance Excellence



San Francisco Department
of Public Health

ZSFG TRUE NORTH



Title: Revewing up Revenue to Improve our Care

Team: Marissa Foster, Reanna Mourgos, Mary Holkway, Thomas Istvan, Amy Ou, Matt Sur, Tanvi Bhakta

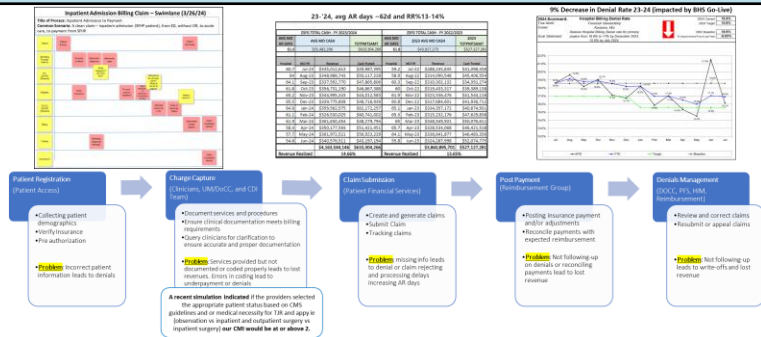
Owner: Eric Wu and Hemal Kanzaria

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I. Background: What problem are you talking about and why focus on it now?

DPH+ SFHN recently shifted to FFS-dominant payment model due to high Out of Network costs, requiring systematic authorization + denials management as inaccuracies can lead to lost revenues. As a result, the strategic focus to date has been on denials. While addressing denials is crucial for recovering lost revenues, it is also important to consider the entire revenue cycle as inefficiencies or errors in any part of this process can cause delays, increased administrative burden, and create compliance issues. Our current challenges include delays in claims processing, high denial rates, and inefficiencies in billing and coding practices, all in the setting of current CCSF forecasted budget shortfall of \$2.96M (FY 24-25), \$7.89M in 2 FYs, \$1.362M by FY 27/28. Optimizing the revenue cycle now is essential to improving financial stability, resource allocation, and enhancing patient care amidst increasing hospital census and financial pressures, while adapting to evolving healthcare regulations and funding constraints.

II. Current Conditions: What is happening today and what is not working? (see next slide)



Problem Statement: What specific, measurable problem will serve as your baseline performance?

Current ZSFG clinical + financial workflows result in ~16% denied claims, lower than expected CMI (1.6), bloated AR days (61d), and a lower than desired medical record completion rate (85%), that collectively result in lost revenues, detract from our True North Financial Stewardship goals, + ultimately limit our ability to be the best hospital for our patients.

III. Targets and Goals: What specific measurable outcomes are desired and by when?

Selected Metrics	Baseline	Metric Type	Target by [When]	Selected Metrics	Baseline	Metric Type	Target by [When]
Days in Accounts Receivable*	61 days	Strategic	Reduce to ≤ 59 days by June 30, 2025	CDI Query Response Rate within 72 hours	75%	Operational	Increase to ≥ 90% by June 30, 2025
Realized Revenue Percent**	14.46%	Strategic	Increase to ≥ 14.5% by June 30, 2025	Medical Record Completion Time	85%	Operational	Increase to ≥ 90% by June 30, 2025
Primary Hospital Billing Denials	16.3%	Strategic	Reduce to ≤ 15.6% by June 30, 2025	Case Mix Index	1.6	Operational	Increase to ≥ 1.8 by June 30, 2025

IV. Analysis: Why does the problem exist, in terms of causes, constraints, barriers?

A. People	B. Method	C. Other	D. Materials/Supplies	E. Equipment	F. Environment	PROBLEM STATEMENT:
1. Incomplete understanding of revenue cycle process 2. Siloed teams (CMI, HIM, PFS, CDI) w/ sub-optimal communication results in claim errors + delays 3. Slow billing and high turnover in positions (rotating Residents, continuity of knowledge/best practices) 4. Lack of accountability + roles not well defined? 5. Unclear instructions/training 6. Lack of metrics to motivate 7. Social and behavioral health complexity of patients + gaps in social safety-net → high LLOC patient volume 8. Remote work impacting client facing positions	1. Inconsistent processes, lack of standardization, variation in knowledge btwn depts a) Scheduling OR time 2. Inefficient processes, policies, procedures slow down revenue cycle 3. Ineffective workflows leads to bottlenecks and delays 4. Improvised science under-leveraged 5. Inconsistent data to access revenue impacts caused by an under-optimized revenue cycle	1. Process changes needed to meet regulatory compliance 2. Payor contracting issues 3. Different requirements for different payors 4. Unexplored opportunity to advance revenue capture 5. Mission-driven culture with limited consideration of financial sustainability.	1. Missing or incorrect documentation on claim 2. Incorrect or inconsistent coding of services 3. Inefficient access to systems or forms necessary for documentation	1. Software/EPIC limitations or under-leveraged 2. Systems are disjointed and not integrated/does not talk to each other	1. Changes in regulatory environment 2. Economic conditions affect reimbursement rates 3. Demand for hospital services exceed supply 4. Over referral to specialty services 5. Civil service rules and union processes reduce ability lead to challenges to adapting to new processes 6. Coordination of care and referral issues between consortium (HIM, LHC, etc)	Current ZSFG clinical + financial workflows result in ~16% denied claims, lower than expected CMI (1.6), bloated AR days (61d), and a lower than desired medical record completion rate (85%), that collectively result in lost revenues, detract from our True North Financial Stewardship goals, + ultimately limit our ability to be the best hospital for our patients.

V. Possible Countermeasures: What countermeasures do you propose and why?

Cause/Barrier Addressed	Countermeasure/Idea	Description and Expected Results ("If-Then")	I	E
Payor contracting issue	Integrate automated authorization process in EPIC	If SFHP had an automated payor authorization processes w/ real time auth, then we would reduce denials and improve efficiencies.	High	High
Missing/incorrect claims documentation; Inconsistent processes, lack of standardization	Draft and implement standard work and checklists to document claims accurately and ensure claim is billable	If we implement standard work and checklists, a single source of truth for data on denials and establish owners, then we would expect a reduction in primary denials rate and reduced AR days.	High	High
Inconsistent processes, lack of standardization, variation in knowledge btwn depts	Implement Monthly Provider Training Sessions and Epic Tools to Demonstrate the Financial Impact of CPT Codes	If we provide monthly training sessions for providers and enhance Epic tools to show the financial impact of each CPT code, then this will improve the accuracy of coding, reduce primary denials, increase the case mix index (CMI), and reduce AR days.	High	High
Siloed teams with sub-optimal communication	Hold Bi-Annual Information Sharing Sessions with Leaders from Key Departments (HIM, PFS, CDI, DOCC)	If we hold bi-annual information sharing sessions with leaders from departments involved in the claims process, then this will foster better understanding and collaboration across teams, ultimately improving the revenue cycle process.	Med	Med
Ineffective workflows leads to bottlenecks and delays	Focus on Reducing Pre-Claim Delays in Patient Access	If we identify recurring trends causing delays in the revenue cycle (e.g. incomplete documentation, slow approvals), then we can collaborate with departments like billing, coding, and clinical teams to implement targeted solutions to streamline workflows and reduce bottlenecks.	High	Med
Current TN goal is not meaningful	Shift the Financial Stewardship goal to a more meaningful metric	If we create a more meaningful True North financial stewardship goal focused on cost and revenue per patient day, then we will have clearer, actionable metrics that directly link financial performance to patient care, improving efficiency, accountability, and alignment across teams.	High	High

VI. Plan: What, where, how will you implement, and by whom and when?

Title of PDSA/Action	What, Where, how?	Who?	When?
Payor contracting issue	1. Share data with payers to highlight workflow challenges and increased denials caused by the lack of an automated payor platform. Present this in a structured format, focusing on inefficiencies. 2. Schedule meetings with key payors to discuss these challenges and advocate for a real-time authorization platform.	Eric Matt	FY25
Missing/incorrect documentation on claims; Inconsistent processes, lack of standardization	1. Identify operational teams involved in claims management (Denials, CDI, Med Rec, CMI) and form a cross-functional team to create the PASTA 2. Analyze metrics to determine root causes of documentation issues, develop countermeasures, and implement A3s to track improvements. 3. Establish regular reporting of key metrics and review progress in Revenue Cycle Strategic Team meetings.	Rev Cycle Mary, Thomas, Tammy, Eric, Aaron, Hemal	FY25
Inconsistent processes, lack of standardization, variation in knowledge between depts	1. Develop a training program for providers on accurate coding and its financial impact, with 8 sessions per year featuring case studies and real-world examples. 2. Integrate real-time feedback tools in Epic or 3M to alert providers about coding implications, ensuring they are accessible and intuitive at the point of care for easy adoption.	Tammy CDI Team Aaron	FY25
Siloed teams with sub-optimal communication	1. Establish regular information-sharing sessions (quarterly or bi-annual) with operational leaders from HIM, PFS, CDI, and DOCC. 2. Set clear agendas to review best practices, standard work updates, and progress on countermeasures, fostering open dialogue to address communication gaps and align on goals and challenges in the claims process.	Tammy H, Thomas I	
Ineffective workflows leads to bottlenecks and delays	1. Assign a dedicated resource to analyze patient access and revenue cycle workflows using data from Epic and other tools. 2. Identify bottlenecks and high-impact areas for improvement, such as incomplete registration and eligibility, and collaborate with billing, coding, and clinical teams to implement targeted process improvements.	Thomas I.	Starting in Dec 2024
Current TN goal is not meaningful	1. Create a True North financial stewardship goal focused on cost and revenue per patient day (CPPD), supported by a cost accounting system.	Eric, Matt Budget Team	April 2025

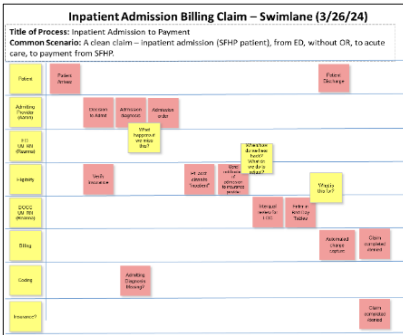
BACKGROUND

- Historic strategic focus on denials management
- In 2024, recognition for need to evolve focus and capture broader scope of revenue cycle
- Current challenges include delays in claims processing, high denials rate, inefficiencies in billing and coding practices, and siloed teams
- CCSF forecasted budget shortfall of \$236M (FY2425) and \$789M within 2 FYs
- Optimizing revenue cycle essential to improve financial stability, resource allocation + patient care

CURRENT CONDITIONS

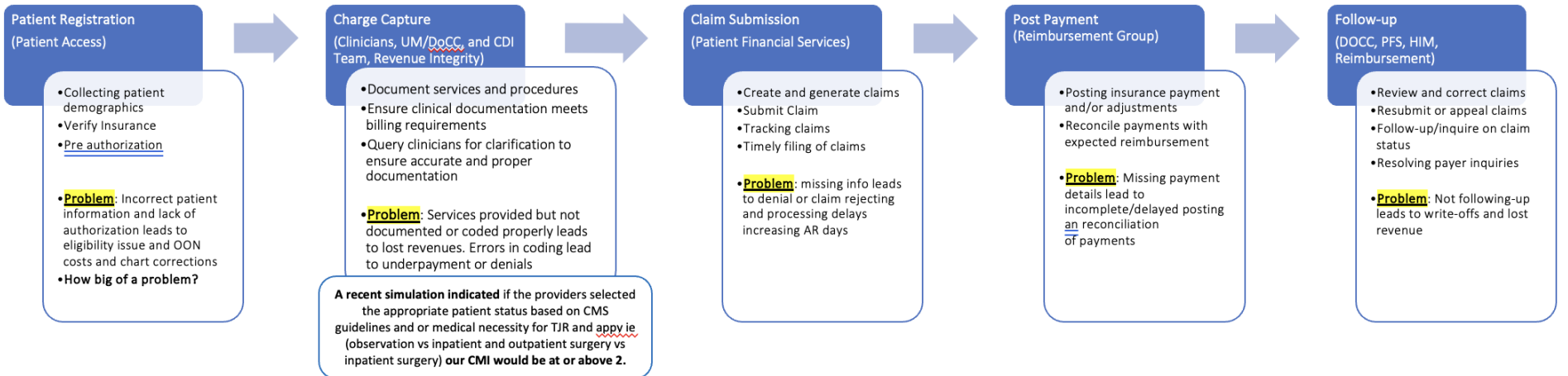
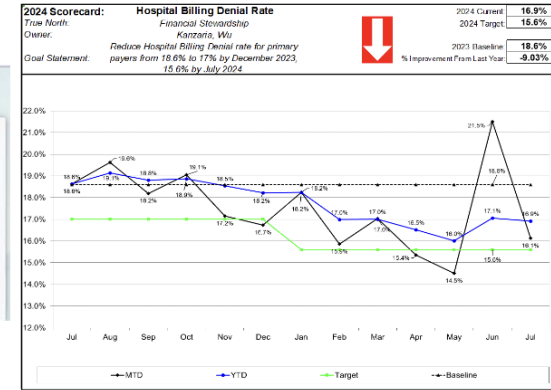
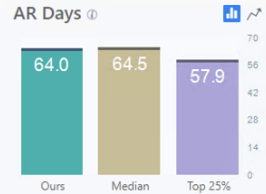
23-'24, avg AR days ~62d and RR%13-14%

9% Decrease in Denial Rate 23-24 (impacted by BHS Go-Live)



ZSFG TOTAL CASH - FY 2023/2024				ZSFG TOTAL CASH - FY 2022/2023			
AVG MO AR DAYS	AVG MO CASH	TOTPMTSAMT	AVG MO AR DAYS	2023 AVG MO CASH	2023 TOTPMTSAMT		
61.6	\$55,482,206	\$610,304,266	61.8	\$43,927,273	\$527,127,281		
Hospital	MO-YR	Revenue	Cash Posted	Hospital	MO-YR	Revenue	Cash Posted
60.7	Jul-23	\$335,012,613	\$49,987,395	59.2	Jul-22	\$288,245,835	\$41,098,458
64	Aug-23	\$348,986,743	\$50,117,228	58.9	Aug-22	\$314,090,548	\$45,406,554
64.1	Sep-23	\$337,592,770	\$47,865,806	60.3	Sep-22	\$310,302,132	\$34,391,274
61.8	Oct-23	\$356,731,190	\$46,867,388	60	Oct-22	\$319,433,317	\$39,389,138
65.2	Nov-23	\$344,995,343	\$44,012,583	61.9	Nov-22	\$323,536,476	\$41,544,116
65.5	Dec-23	\$339,775,808	\$48,718,939	60.8	Dec-22	\$317,684,601	\$41,936,712
64.6	Jan-24	\$359,562,575	\$62,172,257	65.1	Jan-23	\$334,357,172	\$40,674,931
61.1	Feb-24	\$326,530,025	\$60,741,002	65.3	Feb-23	\$315,232,176	\$47,629,838
61.9	Mar-24	\$361,630,454	\$48,279,794	65	Mar-23	\$348,549,501	\$50,076,611
58.4	Apr-24	\$350,177,593	\$51,421,451	65.7	Apr-23	\$328,534,068	\$46,421,518
57.7	May-24	\$361,972,521	\$56,923,229	64.1	May-23	\$336,641,877	\$46,483,356
54.6	Jun-24	\$340,576,511	\$43,197,194	55.8	Jun-23	\$324,287,998	\$52,074,775
		\$4,163,544,146	\$610,304,266			\$3,860,895,701	\$527,127,281
Revenue Realized		14.66%		Revenue Realized		13.65%	

All Epic Comparing to: Safety Net (20 service areas from 20 organizations)



Clinician Role Examples	Auth Requests, CPT Selection	Document clinical care in timely, accurate, and comprehensive fashion; place orders in alignment w CMS requirements; respond to clinical queries	Peer-to-Peer Appeals (Clinician and UM)	Appeals
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PROBLEM STATEMENT



TARGETS & GOALS

Selected Metrics	Baseline	Metric Type	Target by [When]	Selected Metrics	Baseline	Metric Type	Target by [When]
<i>Days in Accounts Receivable*</i>	61 days	Strategic	Reduce to ≤ 59 days by June 30, 2025	<i>CDI Query Response Rate within 72 hours</i>	75%	Operational	Increase to ≥ 90% by June 30, 2025
<i>Realized Revenue Percent**</i>	14.46%	Strategic	Increase to ≥ 14.5% by June 30, 2025	<i>Medical Record Completion Time</i>	85%	Operational	Increase to ≥ 90% by June 30, 2025
<i>Primary Hospital Billing Denials</i>	16.3%	Strategic	Reduce to ≤ 15.6% by June 30, 2025	<i>Case Mix Index</i>	1.6	Operational	Increase to ≥ 1.8 by June 30, 2025

***Days in Accounts Receivable** - Days in AR is a measure of the average number of days it takes to collect payments owed from patients and insurance companies. Days in AR is a comprehensive metric that reflects the efficiency of the entire revenue cycle. Reducing the days in AR is an indicator of improvements in claims processing time, denials management, billing accuracy, and patient collections.

****Realized Revenue Percentage** is a metric used to evaluate the efficiency ZSFG's revenue cycle management. It measures the proportion of billed revenue that is successfully collected and posted as cash, reflecting ZSFG's ability to convert its gross revenue into actual cash received.

ANALYSIS

A. People	B. Method	C. Other:	
<ol style="list-style-type: none"> Incomplete understanding of revenue cycle process Siloed teams (Clinicians, HIM, PFS, CDI) w/ sub-optimal communication results in claim errors + delays Slow HR hiring and high turnover in positions (rotating Residents, continuity of knowledge/best practices) Lack of accountability + roles not well defined? Unclear instructions/training Lack of metrics to motivate Social and behavioral health complexity of patients + gaps in social safety-net --> high LLOC patient volume Remote work impacting client facing positions 	<ol style="list-style-type: none"> Inconsistent processes, lack of standardization, variation in knowledge btwn depts <ol style="list-style-type: none"> Scheduling OR time Inefficient processes, policies, procedures slow down revenue cycle Ineffective workflows leads to bottlenecks and delays Improvement science under-leveraged Insufficient data to assess revenue impacts caused by an under-optimized revenue cycle 	<ol style="list-style-type: none"> Process changes needed to meet regulatory compliance Payor contracting issues Different requirements for different payors Unexplored opportunity to advance revenue capture Mission-driven culture with limited consideration of financial sustainability 	
<ol style="list-style-type: none"> Missing or incorrect documentation on claim Incorrect or inconsistent coding of services Inefficient access to systems or forms necessary for documentation 	<ol style="list-style-type: none"> Software/EPIC limitations or underleveraged Systems are disjointed and not integrated/does not talk to each other 	<ol style="list-style-type: none"> Changes in regulatory environment Economic conditions affect reimbursement rates Demand for hospital services exceed supply Over referral to specialty services Civil service rules and union processes reduce agility lead to challenges to adapting to new processes Coordination of care and referral issues between consortium clinic, LHH, etc 	
D. Materials/Supplies	E. Equipment	F. Environment	

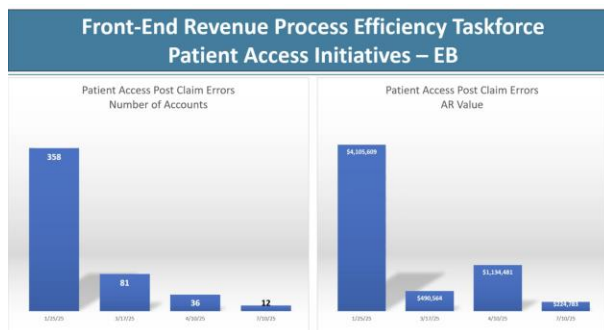
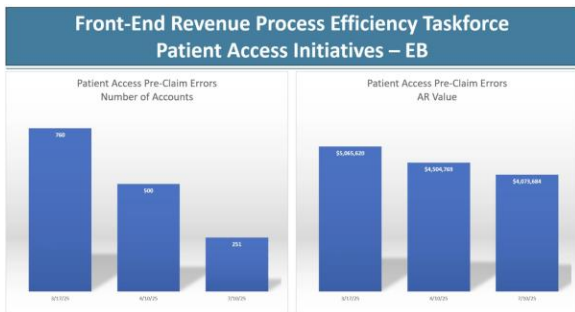
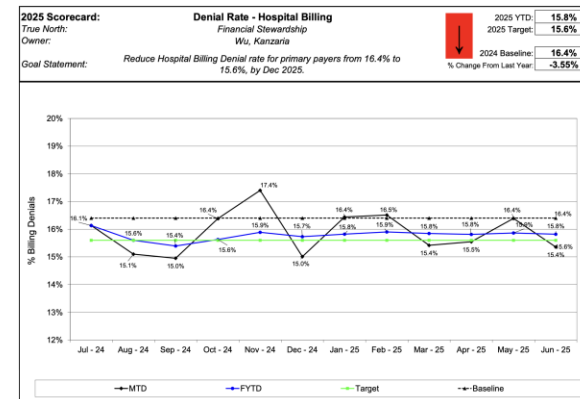
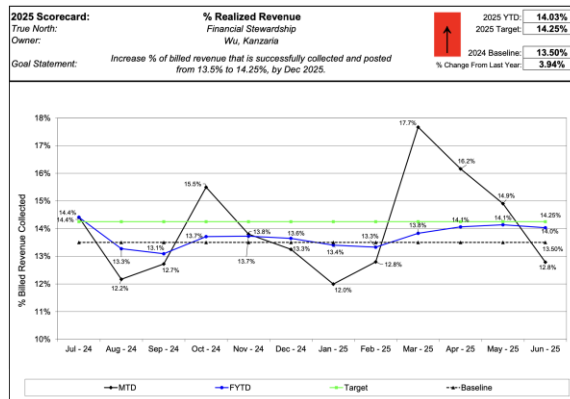
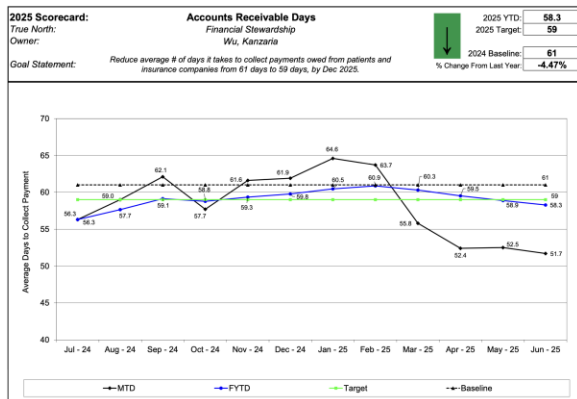
PROBLEM STATEMENT: Current ZSFG clinical and financial workflows result in denied claims and lost revenue which impacts our true north goals of Financial Stewardship and ultimately our ability to be the best hospital for our patients.

COUNTERMEASURES

IV. Countermeasure Implementation: What, where, how did you implement, and by whom and when?			
<i>Barrier/Cause Addressed</i>	<i>Countermeasure</i>	<i>Owner</i>	<i>Status</i>
Missing/ incorrect documentation on claims; Inconsistent processes, lack of standardization	<ol style="list-style-type: none"> 1. Identify operational teams involved in claims management (Denials, CDI, Med Rec, CMI) and form a cross-functional team to create the PASTA 2. Analyze metrics to determine root causes of documentation issues, develop countermeasures, and implement taskforces and A3s to track improvements. 3. Establish regular reporting of key metrics and review progress in Revenue Cycle Strategic Team meetings. 	Eric W, Hemal K with RCO Strategy Team	CY25
Inconsistent processes, lack of standardization, variation in knowledge between depts	<ol style="list-style-type: none"> 1. Develop a training program for providers on accurate coding and its financial impact, with 8 sessions per year featuring case studies and real-world examples. 2. Integrate real-time feedback tools in Epic or 3M to alert providers about coding implications, ensuring they are accessible and intuitive at the point of care for easy adoption. 	HIM/CDI Team Mary H, Tammy H, Aaron H	FY25
Siloed teams with sub-optimal communication	<ol style="list-style-type: none"> 1. Establish regular information-sharing sessions with operational leaders from HIM, PFS, CDI, and DOCC. 2. Set clear agendas to review best practices, standard work updates, and progress on countermeasures, fostering open dialogue to address communication gaps and align on goals and challenges in the claims process. 	Eric W, Hemal K	CY25
Ineffective workflows leads to bottlenecks and delays	<ol style="list-style-type: none"> 1. Assign a dedicated resource to analyze patient access and revenue cycle workflows using data from Epic and other tools. 2. Identify bottlenecks and high-impact areas for improvement, such as incomplete registration and eligibility, and collaborate with billing, coding, and clinical teams to implement targeted process improvements. 	Thomas I.	CY25
Payor contracting issue	<ol style="list-style-type: none"> 1. Share data with payers to highlight workflow challenges and increased denials caused by the lack of an automated payor platform. Present this in a structured format, focusing on inefficiencies. 2. Schedule meetings with key payors to discuss these challenges and advocate for a real-time authorization platform. 	Eric Matt	FY25
Current TN goal is not meaningful	<ol style="list-style-type: none"> 1. Create a True North financial stewardship goal focused on cost and revenue per patient day (CPPD), supported by a cost accounting system. 	Eric, Matt Budget Team	April 2025

IMPACT

Operational Area (Metric)	Baseline 2024	Target by Dec 25	FY TD Actual
Days in Accounts Receivable	61 days	≤ 59 days	58.3 days
Realized Revenue Percent	13.5%	≥ 14.25%	14.03%
Hospital Billing Denial Rate	16.4%	15.6%	15.8%



San Francisco Department of Public Health

HEALTH INFORMATION MANAGEMENT - MID REVENUE CYCLE DASHBOARD
 FY 2024 - 2025

TRUE NORTH LOC	KEY PERFORMANCE INDICATORS	Baseline	FY 2024 - 2025												YTD
			JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	
F.Q	ZSFG Case Mix Index	1.54	1.8	1.56	1.60	1.66	1.66	1.70	1.89	1.88	1.97	1.69	1.63	1.61	1.66
F.Q	ZSFG CDI Query Response within 72 Hrs	70	85	76	70	70	72	73	72	75	72	79	79	73	
F.Q	ZSFG HR Completion Rate	84	90	84	88	83	85	87	87	88	87	95	95	95	
F.Q	All Audit Response	N/A	98	100	100	100	100	100	100	100	100	100	100	100	
F.Q	ZSFG DNFC	30M	<25M	24	24	27	20	67	38	39	35	9	16	24	



Looming financial pressures

- Medicaid Funding Reductions due to HR1
 - ZSFG estimated to lose a significant amount, starting in 2026-2027
- Anticipate Increase in Uncompensated Care
 - Loss of coverage, Resources Strained
- Ongoing CCSF budget shortfall

NEXT STEPS & PLAN

1. Enhance Denials Management & Monitoring

- Leverage denials dashboards to move from high-level denials monitoring to detailed tracking (denial reasons, denials by payer, AR days by payer, dollars denied, recovery rate, etc)
- Target process-driven issues (e.g., coding lag) and differentiate between structural issues (e.g., payer contracting limitations)

2. Education & Culture of Revenue Integrity

- Continue education for operational leaders, clinical teams, and frontline staff on revenue impact of documentation, discharge timeliness, and registration completeness
- Shift from reactive fixes to proactive, standardized workflows with frontline ownership
- Explore ways to leverage AI and digital tools to embed revenue integrity into clinical and operational workflows

3. Metrics & Reporting Improvements

- Slightly refine RR% metric definition to reflect percentage of billed charges collected for patients discharged on a specific date to smooth out reporting variability and seasonality
- Build standard reporting to ensure consistent, reliable visibility across teams

4. Patient Access & Network Initiatives

- Support network-level patient access initiatives (e.g., addressing disenrollments, work requirements, HSF eligibility)

5. Growth & Efficiency Opportunities

- Expand CDI and conduct revenue impact assessments to drive growth, pursue new opportunities, mitigate costs, and improve efficiency

NEXT STEPS & PLAN

<i>VII. Plan: What, where, how will you implement, and by whom and when?</i>			
<i>Barrier/Cause Addressed</i>	<i>Countermeasure</i>	<i>Owner</i>	<i>Date</i>
Lack of standardized processes and cross-department understanding for identifying revenue opportunities and managing cost drivers	<ol style="list-style-type: none"> 1. Environmental scan engaging ZSFG/DPH teams + external stakeholders 2. Develop systematic approach to identify missed opportunities (e.g., understand leakage volume + root cause; market analysis of opportunities; CDI expansion; P4P/QIP; business development) 3. Continued education, embedding revenue integrity into workflows, conduct revenue impact assessments, examine revenue growth and cost-mitigation strategies. 	Eric W, Hemal K	July 25 →
RR% metric variability and seasonality obscure true performance	<ol style="list-style-type: none"> 1. Slightly refine revenue realized % KPI to gross collection ratio percentage of billed charges we end up collecting for patients discharged on a specific date, once their accounts are fully closed 	Eric W, Tim A	Fall 25 →
Limited visibility into denial drivers and performance metrics	<ol style="list-style-type: none"> 1. Develop and utilize denials dashboards to move from high-level denials monitoring to detailed tracking (denial reasons, denials by payer, AR days by payer, dollars denied, recovery rate, etc) to prioritize high-value claims and improve recovery rates. 2. Standardize reporting by creating consistent formats across teams for KPI reporting (denials, AR days, net collection, RR%) 	Angelica A, Jessica T, Denials TF	Oct 25
Suboptimal revenue generation related to documentation	<ol style="list-style-type: none"> 1. Expand CDI and staff education to ensure complete, accurate documentation that maximizes reimbursement. 2. Leverage AI for assisted coding and drafting appeals letters 	Aaron H, Mary H, Tim A	Oct 25
Fragmented access and eligibility impacts due to HR1	<ol style="list-style-type: none"> 1. Partner with SFHN leaders on patient access initiatives to address patient disenrollment, work requirements, and gaps in financial eligibility screening create coverage gaps and uncompensated care. 	Tangerine B, Thomas I, Tim A, Jenine S	Jan 26
Current TN goal is not meaningful	<ol style="list-style-type: none"> 1. Create a True North financial stewardship goal focused on cost and revenue per patient day (CPPD), supported by a cost accounting system. 	Eric W, Matt S, Budget Team	FY25-26

ACHIEVEMENTS & CELEBRATIONS

- Successful launch of foundational elements
 - Strategic Team with Executive and Operational leads
 - Key taskforces - Denials, HIM, and Front-End Revenue Process Efficiency
 - Data dashboards developed to visualize and track progress, and inform improvement efforts
- Improvement on numerous strategic and operational metrics
- Teamwork!



QUESTIONS COMMENTS DISCUSSION

