



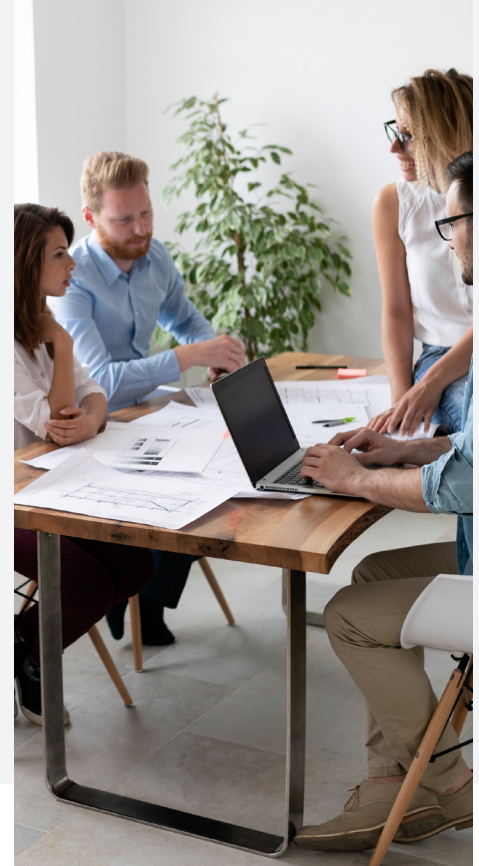
Getting the most out of your people.

Claims Backlog Improved With Training, Tools, and Quality Audits

Amidst the need to alleviate claims backlog, a trend is surfacing in payer organizations highlighting the significance of optimizing the operational efficiencies of both their people and processes. However, a recent survey by HealthEdge reveals that 41% of health plan leaders still consider driving operational efficiencies among their top challenges. This persisting issue stems from a lack of available knowledge, skills, resources, adaptability, and collaboration. To combat this, 44% of respondents in the 2022 HealthEdge study believe that increasing interoperability and workforce interactions would be the most effective way to reduce costs while increasing claims accuracy¹.

Based on our experience all these challenges stem from a foundational shortcoming which is the lost art of the human touch.

Over the years, various strategies have been employed by payer organizations to solve inefficiencies and reduce claims backlog. Some organizations have opted to increase hiring and mandate overtime. Others have worked to manage fluctuating demands by using partnerships with ineffective third-party vendors. But, these solutions have lost connection with empowering people through training, technology and quality audits.



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1. Managing costs, operational efficiencies top challenges for payers. (2022, August 17). Healthcare Finance News. <https://www.healthcarefinancenews.com/>

From Clarity to Claims

Throughout this whitepaper, we'll explore 3 approaches that go beyond the traditional response to overcoming backlogged claims and excess inventory through improved, human-focused operational efficiencies. This includes the expert-driven recommendations of training, automation and auditing.

- Transformational Training
- Automation for the People
- Culture Empowerment

Transforming Talent with Prioritized Training

The key to workforce success lies within the ability to transform talent using strategic, prioritized training. In the past, training has been used as a one-size-fits-all approach. Now, organizations need to go from impersonal to personalized training to transform their claims workforce. Trainers must leverage a prioritized curriculum that is carefully constructed to help reduce overload and confusion within an interactive, fast-paced learning environment. Most importantly, this training should be applied at the right time such as early in the year or when an influx of claims is expected.

Prioritized training is the key. Not only must the trainer understand the intricacies of claims, they must also be an excellent leader who builds and manages achievable expectations. They must develop an empowered team with the right training, tools, and support needed to succeed.

- Prioritized training is personal and customizable.
- Prioritized training is also hands-on and engaging.
- Prioritized training is finally scalable for both existing and new workforce members.

The effectiveness of prioritized training is underscored by a recent HFMA study, revealing that 41.2% respondents identified a lack of adequate staff as a primary source of inefficiency, while 33% pointed to it being due to inadequate training or knowledge². It's clear that payer organizations are continuing

People are the heart of healthcare. Even as technology automations continue to expand, the human touch still plays a vital role in the claims management process.

to struggle with their operational efficiencies due to a lack of prioritized training. Yet, with most training only requiring a few weeks to a few months' worth of dedication, a quick turnaround time to enhancing staff capabilities and optimizing claims processing efficiency is more obtainable than ever.

Technology Automation Starts and Ends with People

Just as people remain essential to the claims process, so does the use of technology and automations. When successful it gives time back to people. Leading payer organizations must continuously modernize their infrastructure and systems with core capabilities that position them for success in the market.

Before an investment is made the research to choose the right tool has to start with the proprietary documentation of goals and objectives. If documentation isn't done correctly prior to choosing a technology tool, your team is at the whim of the technology limitations and there is no benefit. If done correctly, this documentation serves as a roadmap, guiding organizations to identify innovative automation solutions needed for a customized and efficient claims management process. Only then can an informed decision be made whether to make an investment on developing tools in-house or to search for an outside solution.

Engaging people from the very beginning is paramount. Even with the right technology tools and automations in place, payers must also understand how to empower people to adopt new processes efficiently. According to a recent study conducted by PwC, 60% of healthcare workers say they can thrive in the future world of work and are willing to adapt to new technologies³. This desire to adapt is stimulated by an organization's ability to set expectations and offer sufficient resources through executive/champion support.

Leveraging technology and automation has to involve the whole organization and must be optimized at the human level.

Catalyzing Culture with Internal Auditing

With training and automation in place, it's integral for payers to use a robust internal auditing process to support a culture of continuous improvement. According to Gartner, Inc., "observability and auditing enables organizations to reduce the time it takes to identify the root cause of performance-impacting problems and make timely, cost-effective business decisions using reliable and accurate data"⁴. But, in order to be as effective as possible, a new way of auditing must be implemented that takes a multifaceted approach across the organization.

Auditing must first take place at the team level to evaluate the accuracy and speed of individuals. These examiner audits collect quality scores based on performance to identify areas where training improvements are needed. Then, a systematic evaluation of processes can be deployed to discover better opportunities for automation and streamlining processes. Once these observations are made, organizations can take proactive steps towards implementing change throughout their workforce and organization. With change comes the power to cultivate a culture of continuous improvement and trend adaptability, positioning payers to thrive in dynamic environments.

Auditing Tip: As noted in Financial Management, "variables that should be tracked throughout the auditing process include claims payment accuracy and timeliness, number and type of denials, resolution of appeals and other problems, and contract negotiations"⁵. By examining each of these factors, a holistic evaluation of performance is provided and informed decisions can be made to further empower the culture of change.

4. Gartner Identifies the Top 10 Data and Analytics Trends for 2023. (2023, May 9). Gartner. <https://www.gartner.com>

5. New year's resolution: Optimizing audits of your medical practice's payer contracted rates. (2023, October 18). MGMA. <https://www.mgma.com>

Tailor Your Backlog Solutions

Getting started on the path to improvement starts by aligning your organizational goals with the unique needs and challenges of your organization. Once identified, you can prioritize the implementation of training models tailored to address these challenges systematically. Simultaneously, you'll also want to start strategically investing in automation tools that will set your people and processes up for success.

Ensuring the effectiveness of these initiatives requires vigilant internal auditing for tracking progress and identifying areas of improvement. Be sure to regularly review the outcomes of both training programs and automation integrations to assess their alignment with organizational objectives. To ensure even further success, you can seek innovative external expert support. This valuable guidance can be applied during pivotal timeframes such as during a system conversion or workforce restructuring. It can also ensure a swift and informed response to specific challenges at hand, overcoming struggles such as being understaffed or requiring mandatory overtime to get the job done. Their expertise leverages professional insights to fine-tune strategies and maximize the efficacy of your efforts. By adopting this comprehensive approach to initiation and validation, your payer organization can navigate the path to continuous improvement with confidence and precision when going beyond the backlog.

Conclusion

The persistent challenge of reducing backlogged claims while enhancing operational efficiency continues to impact healthcare payers across the nation. Yet, when trying to overcome these challenges, too often payer organizations lose sight of the single most important aspect of their claims process - the human touch. By implementing prioritized training, automation investments and internal auditing, payers can equip their workforce with expert-recommended tools that make everyone's job easier and more effective.



Clarity Performance Solutions is a business processing partnership that moves beyond traditional outsourcing with our flexible services backed by analytics and automation.

With over 10 years of experience delivering successful results, we alleviate operational challenges faced by healthcare payers and TPAs through our beginning-to-end claims, contact center, and cross-functional services.

If you need help reducing your claims backlog, contact us at **1-855-275-4747** and **info@clarityperformance.solutions**.