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INSIDE

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Don't Give Patients Reasons to Post Something Negative on Social Media

Patients can vent to a 'huge audience'

Patient complaints about wait times, customer service, and billing could be completely true, entirely false, or somewhere in between. However, once these complaints are posted on social media, lots of people will get an instant negative impression of patient access.

"It's so easy to go on Yelp and vent about patient access. And you have an audience — a huge audience," says **Christine L. Cunningham**, MBA, CPXP, administrative director of the Office of Patient Experience at Lucile Packard Children's Hospital Stanford and Stanford Children's Health in Palo Alto, CA.

Gripes are aired publicly with just a few clicks. "People used to either have to write a letter or make a phone call to complain about patient access. It was harder to do, so most people didn't," Cunningham says.

"SOME TYPE OF RECOGNITION, AND SOME PROACTIVE COMMUNICATION, CAN KEEP A COMPLAINT FROM ENDING UP ON FACEBOOK." — LAUREE MILLER, CONIFER HEALTH SOLUTIONS

Social media complaints can alert patient access to easily fixable glitches.

A recent Facebook post alerted Seattle-based Virginia Mason that its online billing site was malfunctioning. **Mike Sprouse**, associate director of communications, says, "We were not aware of the glitch. We shared the information with patient relations and billing to quickly resolve the issue."

Lauree Miller, senior director of patient access operations and revenue cycle services at Conifer Health Solutions, says, "Social media is a great opportunity to communicate with customers, even if something negative is posted. A complaint is a gift."

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Stop Negative Posts

Patient access can lower the odds of a blistering social media post by improving the patient experience in registration areas. "We are the front door of the organization, so it all starts with us," Miller says.

A terrible registration encounter is very likely to cloud patients' overall satisfaction throughout their hospital stay. "After working in patient access a long time, you sometimes get desensitized to the patient's needs," Miller says. The possibility of negative social media posts motivates departments to reflect on how patients view registration. Miller wants registrars to ask themselves, "What if I was taking care of my family? How would I want them to be treated?"

Miller says two things are needed: excellent customer service training and adequate staffing to reduce wait times. Regardless, things don't always go perfectly. Patients sometimes have to wait for reasons that are completely out of the control of patient access. Smartphone in hand, that patient might be tempted to vent publicly. "That's why you need a good service recovery program," Miller notes. "Some type of recognition and some proactive communication can keep a complaint from ending up on Facebook."

Registrars might tell patients: "We had an emergency today, and I apologize for the wait. Here's a bottle of water while you wait." For minor inconveniences, a voucher for a soda, coffee, or cafeteria meal can be offered. "It doesn't have to take much," Miller explains. However, major inconveniences call for a commensurate response. Miller offers these suggestions for common scenarios:

- If a person travelled from far away only to find their appointment is the following week, registrars might offer a $20 gas card to offset their travel costs while looking into the situation.
- If a patient prepared for a colonoscopy only to find the procedure is scheduled for a different day, and claims he or she was given incorrect information, every effort should be made to squeeze the person into the schedule.
- If things are backed up, a friendly registrar offering free bottled water in a crowded waiting area can go a long way to defuse tension.

Above all, patient access must be proactive instead of waiting for someone to pull out a phone and post publicly. Is someone simmering with frustration because his or her appointment time was more than an hour ago? Miller says, "Tell the patient, 'We are experiencing a delay,

EXECUTIVE SUMMARY

Complaints about patient access posted on social media can lead to negative repercussions throughout the organization. Patient access can help by:

- offering an apology and free bottled water to patients who might be tempted to vent frustration about delays;
- providing necessary information to whoever is contacting the person who posted;
- maintaining good service recovery to prevent people from leaving dissatisfied.

and I really apologize. Here's what the anticipated time is. Do you still have time to stay today?'"

Make Patients Feel Heard

Cunningham's primary goal when responding to social media posts is to make patients feel heard, regardless of whether the complaint is factually accurate. Typical response posts state, "We are really sorry to hear you had a problem with your registration. Please call us so we can learn more about it and make sure it doesn't happen again."

The person who posted doesn't always respond. If he or she does, Cunningham takes the opportunity to learn as much as possible. Often, she learns some useful information that wasn't included in the person's post. "An example is someone who gets a bill and does not know that they have the option of working with a financial counselor who can help them with their finances," Cunningham says.

Terese Vekteris, director of internet marketing at Cooper University Health Care in Camden, NJ, agrees that patients' versions of events should not be refuted publicly: "We acknowledge their disappointment in 'their experience' without confirming or denying that the experience took place."

Recently, a patient tagged the hospital in a series of tweets complaining that she couldn't get in to see her primary care physician for ongoing severe anxiety. The office told her the next available appointment was in 97 days. The hospital's social media manager direct messaged the patient to get contact information, then forwarded the matter to patient relations, who contacted the office's operations manager. "The operations manager then reached out to the physician, who welcomed seeing the patient sooner after reviewing her chart," Vekteris recalls.

Andrew Ray, director of professional revenue cycle at Stanford Children's Health, works closely with the marketing and patient experience teams that monitor social media outlets. "The best thing we have found is being willing to listen and then swiftly responding and taking corrective action, when appropriate, to remedy the issue," Ray says. ■

SOURCES

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Use Social Media Posts to Improve Registration

Social media posts are generating a wealth of constructive feedback about the registration process, something that's not always easy for patient access to come by. "That helps departments to improve," says **Christine L. Cunningham**, MBA, CPXP, administrative director of the Office of Patient Experience at Lucile Packard Children's Hospital Stanford and Stanford Children's Health in Palo Alto, CA. Here are some common reasons for negative social media posts about patient access:

• It took too long to get an appointment.

Cunningham tells the person that strategies are in place to address the issue.

For instance, if the social media post states that it took months to get an appointment at a particular clinic, she can explain that two physicians are on leave, and efforts are underway to recruit an additional physician.

• A caller experienced trouble making an appointment.

"The issue we have is getting a live person on the phone," Cunningham reports.

Lauree Miller, senior director of patient access operations and revenue cycle services at Conifer Health Solutions, offers this suggestion to combat this common complaint: "Have the ability to press zero to speak to a live person so that the situation can be escalated and resolved."

• Patients are unhappy about their bill.

Miller says patient access has a few options to head off such complaints.

"One of the things we're doing to be proactive in that regard is giving patients an estimate before they come in," she says. "Patients need to plan for their financial healthcare in addition to their medical care." Two other recommended approaches:

-Give patients easily understandable materials to reduce confusion over bills;

-Give patients a way to talk to somebody quickly who can answer questions so the patient doesn't have to leave a message.

Although Boston Children's Hospital's patient access team doesn't directly manage social media posts, "they are made aware of major complaints related to access posted on social media," says Senior Social Media Specialist **Lily Vautour**. In some recent posts, patients complained about the difficulty of scheduling appointments, wait times, parking, transportation to the hospital, and communicating with particular departments by phone or email. "In some cases, we flag these kinds of comments to specific departments to help aid in a resolution," Vautour says.

The social media and patient relations teams usually don't defend the hospital's perspective publicly and, instead, try to bring the discussion offline. "But we will step in to clarify certain topics related to access if the information could be useful to others viewing our comment threads," Vautour says. For instance, a patient may complain she missed an appointment because of inadequate transportation to the hospital, without realizing multiple bus routes are available.

Last year, the hospital opened private Facebook messaging to field questions, comments, complaints, and compliments. "Things are always evolving with social media," Vautour says. "I can definitely envision doing more to partner with patient access teams in the future." ■

SOURCE

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Patient Access: Key to Patient Experience

Since patient access is very visible, serves both external and internal customers, and maintains a broad scope of responsibilities, not everybody is going to be happy all the time.

"However, this also opens the door to tremendous opportunity. It's all about the patient experience. Patient access owns a big piece of this," says **Katherine H. Murphy-Padgett**, CHAM, FHAM, former vice president of revenue cycle consulting in the Oakbrook Terrace, IL office of Experian Health, a provider of technology for hospitals and healthcare providers.

Confident, well-trained registrars can diffuse a patient's fear, anxiety, and confusion. "Build trust and loyalty with transparent, timely resolution of complaints," Murphy-Padgett offers. "Commit to change processes or behaviors that may have caused a problem in the first place." Here, she offers six approaches to improve the patient's registration experience:

1. Set clear expectations on out-of-pocket costs.

Someone should tell patients during pre-service phone calls that additional diagnostic testing or procedures might be needed, or surgeries might take longer than expected. Either of these things would make out-of-pocket costs higher.

"An estimate is an estimate, and the patient should be made aware it is not a final bill," Murphy-Padgett says. "This communication is so important."

2. Invite marketing to patient access staff meetings to encourage face-to-face communication.

"Marketing could work to showcase patient access and the many hats they wear," Murphy-Padgett suggests.

3. Include patient access in provider-led focus groups.

"Patient access is the hospitality department, in addition to all of the many financial and clinical things they must understand," Murphy-Padgett emphasizes.

4. Empower employees to "step up" to manage issues before people complain.

"Hire employees with the right skills and emotional intelligence," Murphy-Padgett advises. When patients or families are under stress, registrars must take extra time to communicate, reassure, and show empathy.

"Circle back to them to see if everything has gone well or if they need anything," Murphy-Padgett says. "Show them you care."

5. Record phone calls.

"This really puts service issues to rest without guesswork," Murphy-Padgett notes.

The calls help leaders identify training needs. Leaders might learn that their staff member managed the

situation in a very appropriate manner, or that the complaint was valid but didn't involve registration. "Alert the proper department to service issues," Murphy-Padgett adds.

6. Give patients a brief survey at the time of service.

The survey should contain no more than five or six questions, with the goal of receiving instant feedback before patients leave the facility, Murphy-Padgett explains. Some possible questions: "Was the registrar kind and courteous?" "Was this person knowledgeable about your visit?" "Did you find your waiting time in registration acceptable?" "Did the registrar answer all of your questions or direct to someone who could?" "Was the registration area neat and clean?" "Is there anything else you would like to share about your visit to the hospital?"

"Why wait a month or more to learn how the patient felt about service?" Murphy-Padgett asks. "I think it best to know at the earliest point." ■

SOURCE

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Patients Didn't Know Registration Was Complete

As volumes increased and wait times grew longer in the ED at Winston-Salem, NC-based Novant Health, patient satisfaction scores dipped.

"We tried communication with our patients, but the scores didn't show huge improvement," says **Craig Pergrem**, MBA, senior director of revenue cycle, pre-service, financial counseling, and onsite access.

The department decided to take a new approach by creating Compassion And Respect Everyday (CARE) cards. These cards list the three questions in the organizationwide Press Ganey survey that pertain to the ED visit. *(To see the card, please read the online version of this article at AHCMedia.com.)*

Elkin Pinamonti, MHA, assistant director of onsite access for Novant Health's Greater Winston Salem and Northern Virginia markets, says registrars ask patients if they've met the expectations listed on the front of the card.

Registrars state, "Thank you, your registration is now complete. Do you feel that I was friendly and courteous? Do you feel that I have shown concern for your privacy when discussing your personal and insurance information? Do you feel that I made it easy for you in gathering this information?"

The department tracks the percentage of patients who give a "Top Box" score of 5 for every question. Pergrem reports, "We introduced the cards in our busiest ED and a medium-sized one last June, and saw immediate results." Patient access discovered that patients really needed to know two things:

- That their registration was completed;
- That even if they were admitted to the hospital, all the signatures and paperwork needed for their admission already is in place.

"The comments patients made when we handed them the cards told us they were now understanding some things they hadn't before," Pergrem says. Patients commented, "I never knew my registration was complete." Also, patients didn't understand the difference between registration and the rest of their admissions experience.

Pinamonti says that giving patients the CARE cards "offers a nice segue into the more clinical aspects of the admissions process."

By bringing the CARE card to the patient and saying, "Thank you. Your registration is now complete," registrars bring closure to the process. However, that doesn't mean the lines of communication are closed. Pergrem adds, "We let them know not to hesitate to ask us if they need anything at all prior to their leaving."

Much-needed Morale Boost

Ninety percent of comments about the overall ED visit have been positive. All comments about individual registrars have been compliments. "This has been a great morale boost for the team members. As we all know, the ED is not an easy place to be," Pergrem notes.

Since the CARE cards are returned directly to patient access managers, they can share the praise with team members right away, as opposed to waiting for organizationwide survey results to be shared. "It is often difficult to see the fruits of our labor without our own survey," Pergrem says. "We felt this was a creative way to get around it." Any registrar who has gone "above and beyond" receives a personal note of thanks.

By the end of 2016, the Top Box scores for the largest ED rose 8%, and overall, scores rose to the 88th

percentile. A medium-sized ED saw Top Box scores increase by 5%, and finished with a 92nd percentile in overall scoring.

"The study showed it was worth trying the cards in the rest of the EDs, as well as our other registration areas, to see what kind of feedback we receive," Pergrem says.

The CARE cards are part of an overall focus on the patient experience in the revenue cycle. "We have been able to lower our registration times below the five-minute mark," Pergrem notes. "Our collections rose by over $7 million in 2016 as well, and our patients still like us." ■

SOURCES

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Does Patient Lack ID or Insurance Card?

Prevent misidentification, claims denials

Did your ED patient present without an ID or insurance card? "This can cause a series problems for the front-line registrar," says **Vanessa Gordon-Lewis**, MBA, CHAM, manager of patient registration at Sarasota (FL) Memorial Health Care.

Two of the most dangerous issues: Duplicating medical records or overlaying existing ones. "When duplication or an overlay occurs, it is a major patient safety situation," Gordon-Lewis warns. Either clinicians cannot see the patients' medical history to know their allergies or blood type, or the history they view actually belongs to someone else.

"Not having a photo ID or insurance cards also can lead to identity theft or insurance fraud by someone presenting and providing someone else's name and date of birth," Gordon-Lewis notes.

Patients' Palms Scanned

Photo IDs and insurance cards routinely are scanned into the patient access department's medical records system. "When a patient presents without one, we will look to see if we have it previously scanned and ensure that it matches the patient presenting," Gordon-Lewis says.

The department recently invested in a biometrics identification system that reads the vein patterns in a patient's palm.

"No two individuals feature the same vein pattern, not even twins. This makes this product more secure than other biometric tools on the market, such as fingerprint or iris scanning," Gordon-Lewis says, adding that 222,000 patients have been added since the tool's implementation.

When a staff member scans the patient's palm and positively identifies him or her, the scan launches the patient medical record in the hospital's Admission/Discharge/Transfer (A/D/T) system. This is even true for trauma patients. "Once the patient has been entered into the palm scan system on a previous visit, when they present unconscious or unresponsive, we can select an estimated age range and scan their palm," Gordon-Lewis says. "This can help us identify a John Doe or trauma alias." The number of duplication of medical records and overlays have decreased, she reports.

Recently, a patient who was brought to the ED by ambulance presented with another person's identification. The A/D/T system identified the patient as a current patient who had been in the ED for a long time. "But this was not correct. EMS had just brought the patient in," Gordon-Lewis recalls. "Because it was showing the patient as already being in a room, we were not able to register this patient until we knew his true identity."

Registrars used the palm scanner and determined the patient's true identity. The patient was registered, and medical care was not delayed. "Had we not had this tool, we would have discharged a patient who was currently receiving treatment when that patient should not have been discharged," Gordon-Lewis notes. This was potentially dangerous for the previous patient. "His medical record would have been compromised, because he was actually still here," Gordon-Lewis adds. "It could have become a major patient safety issue."

Another recent technology implementation verifies patients' medical insurance. If a patient presents

without this information, the eligibility system searches for Medicare and Medicaid coverage based on information obtained during the registration process.

"If the patient states they have Aetna but do not have the card, we can go in and enter their demographic information and conduct a search for their eligibility," explains **Tabatha Terhune**, assistant manager of patient registration.

Of course, the tool doesn't guarantee payment of the claim. However, it often finds the patient does have insurance, even though the patient says otherwise.

"Patients present stating that they do not have insurance but they actually do," Terhune says. "We have noticed an increase in this over the last couple of years because there is a great rise in patient deductibles."

Registrars include this information when billing the insurance company, instead of listing the patient as self-pay.

"The patient does not have the burden of trying to clear up the bill after the fact," Terhune says. ■

SOURCES

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'Efficient' Registrars Can Trigger EMTALA Violation

Some violations of the Emergency Medical Treatment and Labor Act (EMTALA) are pretty blatant: A registrar demands payment before the required medical screening examination (MSE), or an uninsured patient is told to go to another ED before receiving an MSE. However, other investigations occur because of a well-meaning registrar.

"The biggest good-faith violation I see cited is what I call the 'efficient employee' violation," says **Stephen A. Frew**, JD, vice president of risk consulting at Johnson Insurance Services and a Rockford, IL-based attorney.

This usually involves a registrar who's simply trying to save the patient some time. The registrar knows the registration process is not supposed to delay the patient from receiving the MSE. "This employee has a patient waiting to see the triage nurse or the physician, and says to themselves, 'This person is just waiting anyway, so I can save time by going out and getting all the information now, and it won't delay anything,'" Frew explains.

The problem is that the Centers for Medicare & Medicaid Services (CMS) has cited hospitals for obtaining financial registration prior to MSE. This is because, in CMS' view, it tends to delay the MSE in general, and tends to cause people to leave over what they perceive as financial pressure.

"This same employee is likely to ask for financial information from the family under similar circumstances," Frew adds. "But CMS views financial questions to the family as financial questions to the patient."

Patient Died En Route

One hospital faced an EMTALA lawsuit because of a conversation between a registrar and a patient about insurance coverage. "The patient experienced chest pain while shopping with his spouse and adult children," reports **Mary C. Malone**, JD, an attorney in the Richmond, VA office of

EXECUTIVE SUMMARY

Some EMTALA investigations are triggered because a registrar, while trying to reduce delays, collects money from a patient who is waiting for an exam, or because patients leave after hearing the hospital doesn't accept their insurance. To avoid problems, registrars can:

- obtain registration information only after the medical screening exam is completed;
- use appropriate scripting to inform patients the law provides for emergency medical care regardless of ability to pay;
- inform patients that payment will be addressed only after the patient has been seen and/or treated.

Hancock, Daniel, Johnson & Nagle. The family persuaded the patient to go to the ED to be examined.

At registration, the patient asked whether the hospital accepted his insurance coverage. The registrar informed the man that, in fact, the hospital did not participate in his plan.

"Despite being dissuaded otherwise, the patient left with his family to go to another hospital a few miles down the road that participated in his insurance plan," Malone says. "The patient arrested en route and died." The family filed a civil EMTALA suit against the hospital.

"During deposition of one of the adult children, that adult child indicated that when his father said he was leaving the hospital to go to another hospital, the registrar said he should not go," Malone recalls. The son also testified that the registrar informed his father that the law provided him access to this emergency treatment without regard to payment. "This statement was used to have the case resolved," Malone notes.

Malone says the case underscores the need to properly educate registrars on EMTALA requirements. "Provide appropriate scripting to address questions about payment that may arise during the registration process, and before screening and treatment," she advises.

Upfront Payment Problematic

Registration staff also can run into trouble by asking patients for copays or deductibles up front. "It's a twofold problem under EMTALA," Malone says. "First, the whole point of EMTALA is to ensure access to emergency services without regard to the ability of the patient to pay for those services."

Requiring upfront payment could be perceived as blocking access based on payment issues. A second problem is that collecting payment up front could create an unnecessary delay in getting evaluation and treatment. This is prohibited by law.

"The same thing goes for waiting for preauthorizations from insurance companies before treating the patient," Malone adds. The bottom line: Registrars must stay away from practices that could cause unnecessary delay in screening or treatment, or that discourage patient access based on payment issues.

Although EMTALA doesn't expressly prohibit collecting payment prior to someone seeing the patient, Malone says, "the far better practice is to advise the patient that payment issues will be addressed once the patient has been seen and/or treated." ■

SOURCES

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Expect Payers to Demand 'Peer-to-Peer' for Many More Claims

There's a recent uptick in requests for "peer-to-peer" from payers, according to some patient access leaders. These require the patient's physician to consult with the payer's physician before a claim is approved.

EXECUTIVE SUMMARY

Some patient access departments see a surge in requests for "peer-to-peer" reviews from payers before authorizations are obtained. Effective strategies to prevent "no auth" denials:

- Anticipate the need for certain pieces of clinical documentation;
- Ask patients to contact payers directly;
- Make it easy for physicians to participate in peer-to-peer requests.

"We have noticed each year more peer reviews are requested," says **Jackie Jordan**, MBA, CHAM, patient access and scheduling manager at Kadlec Regional Medical Center in Richland, WA.

At Health First in Rockledge, FL, Patient Access Service Manager **Shawn Smith** sees peer-to-peer requests crop up in these situations:

• When insufficient clinical information is provided, and payers want more supporting

documentation to prove medical necessity;

• **For claims involving transfers to and from facilities**;

• **When higher acuity level of care is requested**;

• **When the patient is readmitted to the hospital**.

At Kadlec Regional Medical Center, peer-to-peers are requested routinely if there is a lack of clinical information regarding tried and failed conservative treatment, absence of X-rays or ultrasounds, absence of labs, or absence of why a suspected condition was ruled out. "Payers are looking for specific information regarding the length and number of visits of any therapy, treatments, or injections, as well as the results of X-rays, ultrasounds, and lab results," Jordan adds.

At Ochsner Health System in New Orleans, peer-to-peers are requested in these particular cases:

• **When unlisted codes are used**.

Anytime a medication or procedure does not have an official Current Procedural Terminology (CPT) and an unlisted code is used, insurance companies closely scrutinize the supporting clinical documents.

Brandon McCord, director of the pre-service center, says, "If the utilization nurse on the payer side is unfamiliar with the requested service, it will usually go to the medical director." If the payer's medical director is not a specialist in that area, a peer-to-peer is requested.

• **When payment is requested for treatments or services that were recently approved by the FDA**.

Payers will identify the requested service as "experimental." Physician notes citing published statements or guidelines can counter claims denials effectively, as can pharmaceutical companies or vendors. "These groups usually have good resources and reimbursement-related information," McCord notes.

• **When the patient's primary diagnosis conflicts somewhat with the treatment requested**.

"We are seeing this when there is a complex case, or multiple physicians on the same case," McCord observes. A patient might arrive for something oncology-related, but a pulmonary or cardiac diagnosis supports the treatment request. Usually, this triggers a peer-to-peer request.

"This is an opportunity to work with operational leadership in identifying the correct supporting diagnosis," McCord says. ■

SOURCES

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Guide Physicians Through Peer-to-Peer Requests

It's not easy to persuade a busy physician to engage in a time-consuming conversation with an insurance company representative. Sometimes, it's necessary to avoid a denied claim.

"Coordinating with clinical staff is key," says **Brandon McCord**, director of the pre-service center at Ochsner Health System in New Orleans.

Michelle Fox, revenue operations director for patient access at Health First in Rockledge, FL, facilitates peer-to-peers in two ways:

• **She provides education to admitting physicians on payer requirements for medical necessity determination**;

• **She works with case management to coordinate the peer-to-peer request**.

"The easier patient access makes it for the physician to participate, the quicker the claim will be settled," Fox advises.

Patient Applies Pressure

In a decentralized registration setting, patient access probably can alert a physician that a peer-to-peer is needed. "In a larger or centralized setting, the job can be much more difficult," McCord warns. Ochsner's patient access department uses a messaging system to let physicians know a peer-to-peer was requested.

"When this fails, the request is escalated to patient access leadership, who reaches out to counterparts," McCord explains. Patients also are involved early. "Numerous times, we have seen a peer-to-peer be approved without the conversation because the patient is applying pressure," McCord reports.

Richard Garretson, authorization unit representative lead at Kadlec Regional Medical Center in Richland, WA, suggests facilitating peer-to-peers in these ways:

• **Let the provider know exactly what's asked**.

"This helps the provider complete

the peer-to-peer quicker, without having to regurgitate everything that was already sent to the payer in the initial request," Garretson explains.

• **Find out if the payer will allow the peer-to-peer to be scheduled at a certain time**.

"This could help providers be more efficient in completing the reviews," Garretson offers.

Bypass Requests Altogether

Because of the surge in peer-to-peer requests at Ochsner, "measures have been put into place to alleviate the issue," McCord reports.

In many cases, the department has avoided the time-consuming requests successfully. Patient access created a clinical review team specifically for this purpose. The team consists of a group of nurses on the authorization team who handle complex clinical services. "They can help with a nurse-to-nurse conversation when needed," McCord says. "This has proven to be a huge success."

The team handles authorization requests for infusions, medication injections, complex surgeries, and specialty imaging. "If a rep is having an issue with obtaining an authorization or understanding clinical documentation, one of the nurses jumps in to lend expertise," McCord says.

To avoid denied claims, clinical documentation is a must. "But it has to be the correct clinical documents," McCord notes. It's not enough to simply attach the most recent office notes and imaging if these aren't relevant to the issue at hand.

"I don't necessarily mean a full-on chart review by someone who is not clinically trained," McCord continues. "But the rep should at least make sure it is information related to the diagnosis or issue."

It's important not to omit the requesting physician's notes. "A patient could have four additional different visits before the surgery comes around," McCord adds. "The submitted documents need to match up."

Details Matter

Jackie Jordan, MBA, CHAM, patient access/scheduling manager at Kadlec, pays close attention to details when submitting authorization requests.

"If it seems there is information missing in the progress notes, it may help to look at other recent provider visits that are related to the patient's current condition," Jordan suggests.

Reading through the provider's assessment often is eye-opening. "Try and figure out exactly why the provider is ordering a specific imaging study or procedure," she recommends. Payers especially appreciate the most recent specialty visit notes related to the reason for the test.

"If you track via payer the types of peer-to-peer requests, you can create a list of specific information to send upfront," Jordan adds. For instance, visit notes from a pain specialist, imaging results, therapy plan of care, and number of treatments completed has prevented many peer-to-peers for claims involving neck pain, Jordan says. "We have 0.8% denials for our controllable write-offs." ■

SOURCES

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Know Patients' Propensity to Pay

To fine-tune financial counseling processes, some patient access departments are implementing "propensity-to-pay" tools. These determine a patient's likelihood of paying their out-of-pocket expenses, based on their credit history.

"Hospitals typically see a 10-30% lift in their cash flow, if this is fully deployed at the front and back of the revenue cycle," according to **John Yount**, vice president of product for TransUnion Healthcare. This is because of increased point-of-service collections on the front end and decreased bad debt on the back end.

"Innovative, industry-leading hospitals see the importance of engaging their patients up front," Yount notes. "Patient portion amounts in the thousands of dollars are a new paradigm."

Connecting patients with affordable payment options and/or financial assistance in advance of services is essential in today's healthcare environment, according to Yount.

A decade ago, deductibles averaged about $500, and 10% coinsurance was the norm; most patients could afford $30-$50 per month in payments. "Now, they have quadrupled, and are pushing $2,500, making those monthly payments $200, which is similar to a car payment," Yount explains. Additionally, coinsurance is in the 20% range.

"As this trend continues, patients are becoming a payer," Yount says. "Negotiating payment terms in advance is the best way to avoid downstream debt risk."

Providers that engage the patient early to discuss financial implications and collect payment are finding that patient satisfaction is improving while their bad debt is declining, Yount adds. "Using analytics like propensity to pay empower the provider to have the right conversation at the right time with the patient," he advises.

The cutting-edge practice in financial clearance ensures that electively scheduled procedures are "preapproved."

"Patients with funding gaps are now either provided financial assistance or are asked for a down payment or full payment," Yount says.

Forty-four percent of hospitals are using propensity-to-pay tools, and only 45% are using financial assistance presumptive eligibility analytics, according to a 2016 survey conducted by TransUnion. Yount expects this percentage to increase. "As patients shoulder more of the rising healthcare expense, understanding their financial position will become more important."

Pete Kraus, CHAM, CPAR, FHAM, business analyst for revenue cycle operations at Atlanta-based Emory Hospitals, says propensity-to-pay data could streamline registrations for frequent visitors who don't like hearing the same questions during each encounter.

"This is for patients who use the facility regularly or are known to be reliable customers, not first-timers or those who use the facility infrequently," he explains. If a facility offers a payment portal with propensity-to-pay capability and ability to receive scheduling information for enrolled patients, the portal might be able to send emails or texts to patients who pass the screening threshold.

Patient access wouldn't need to call or interview these patients. "Other types of portals or communications systems might be adaptable," Kraus adds. "Maybe there are less high-tech ways to achieve the same result."

Many patients with a high propensity to pay would appreciate not receiving constant calls and emails. "These are the patients who typically complain about being asked the same questions repeatedly at each visit," Kraus says.

This group also would appreciate reviewing their own records for accuracy quickly, then present for service without waiting to be interviewed. "Access staff would have more time to focus on patients with low propensity to pay," Kraus says. ■

EXECUTIVE SUMMARY

Patient access needs new tools to determine a patient's ability to pay, in light of increased out-of-pocket costs. To boost revenue:

- connect patients with affordable payment options;
- inform patients of financial assistance;
- ensure elective procedures are preapproved.

SOURCE

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How to Avoid Financial Disasters

When patients were paying a $20 copay on a $4,000 bill, it wasn't a huge revenue hit to the hospital if the amount went uncollected. Now that patients are responsible for 10% or 20% of their entire bill, "it's crucial to capture as much revenue at or before the point of service," says **Gregory Snow**, vice president of Provider Portfolio Strategy at Availity, a Jacksonville, FL, healthcare technology company.

The right technology can "sidestep avoidable financial disasters," Snow offers.

"A healthy revenue cycle in the age of consumerism begins with patient access management." Here are three things patient access must do well:

• Help patients understand what they owe.

"Industry best practice is to verify 98% of patient eligibility and

benefits prior to every visit," Snow says. Before a clinical encounter, patient access should assess a patient's insurance eligibility and financial responsibility, and determine their ability to pay what they owe.

"Make pre-appointment checks part of your standard workflow, coupled with a liability estimator," Snow advises. "Know how much to collect from the patient."

• **Make it easy to pay**.

"A small technology investment can reduce your reliance on paper statements and bill collectors, and help you get paid faster," Snow says.

Some hospitals offer online payment options, including patient portals that allow automated monthly debits for payment plans.

"These will reduce your reliance on a patient initiating a payment each month," Snow notes.

• **Set patient expectations**.

"Consistent communication is helpful in encouraging patients to keep current with payments," Snow says.

Text messages and emails are available in some financial clearance tools. Still, some of these conversations aren't easy.

"Is the front desk prepared to tell patients they are limited to one yearly procedure, a limit they've already met," Snow asks.

When faced with delivering tough information, offering multiple payment options is critical.

"The reality is that if patient payments are not captured upfront, they probably won't be captured at all," Snow warns. ■

SOURCE

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