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INSIDE

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Patients Want Hassle-Free Financial Experience

Hospitals face all kinds of bad publicity, from accusations of demanding payment the night before surgery to charging thousands of dollars from seemingly minor ED visits to suing patients for unpaid medical bills. Few stories focus on how hospitals help patients financially.

"Revenue cycle leaders can put the good stories out there by communicating how they are advocates for patients," says **Richard L. Gundling**, FHFMA, CMA, vice president of healthcare financial practices at the Healthcare Financial Management Association (HFMA).

The importance of consumer-friendly billing practices is only growing. As of January 2021, hospitals will be required to disclose the cost of all items and services: gross charges, payer-specific negotiated charges, and the amount the hospital is willing to accept in cash.[1] "Price transparency will lead to increased competition among all hospitals and health systems," predicts **David Shelton**, CEO of PatientMatters.

Price-shopping patients want to know the cost in advance. They also want problem-free authorization, accurate price estimates, and no surprise bills. "For hospitals with good financial practices, it's an opportunity to set themselves apart," Gundling offers.

However, the work of patient access is not well-known to the public. "Work with marketing to communicate the consumer-centric work that is being done," Gundling suggests.

Before that can happen, revenue cycle leadership must know how their hospital measures up. "Once there is an assessment of the current state, a revenue cycle leader can develop a consumerism process improvement plan," Gundling says. "Integrate the plan with the organizational budgeting process and marketing."

Revenue cycle departments can ask the hospital's patient and family advisory council for feedback, or put out a survey. "Find out how patients feel about their financial experience," Gundling recommends. If it turns out many dissatisfied people all carry the same health plan, which denied claims unfairly, that is a valuable piece of information. "The hospital can use it as leverage during contractual negotiations to streamline preauthorization and get claims paid faster," Gundling explains.

Good financial experiences start with good front end processes. "Practices such as verifying insurance way ahead of time and telling people costs upfront are ways to avoid bad surprises," Gundling says.

Unexpected bills are huge dissatisfiers, even for those who enjoyed a great clinical

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experience. "Patients don't realize all the complexity that goes into the bill. The patient is stuck in the middle and blames the hospital," Gundling notes.

Patients may not care as much about service level, timely notification, or medical necessity. All they know is the claim was denied. "Let's face it: None of us really fully understands our health benefits until it's time to actually use them," Gundling admits.

Patient access staff can help by simply conveying the message that, "We are committed to helping you thorough this. I'm here for you."

"People need to feel like the revenue cycle is acting as their advocate," Gundling adds.

Before hospitals can market their positive financial experience, leaders need some convincing evidence. Asking patients a simple question (e.g., "How happy were you with the financial communication we provided?") is one way of doing this. "If 95% were very pleased, that's a very marketable metric. It would definitely be a differentiator in positively positioning a healthcare system or hospital," says **Kirk Stahl**, VP of account service for Caldwell VanRiper, an Indianapolis-based marketing agency specializing in the healthcare industry.

Patient access also can broadcast the fact their financial counselors received advanced customer service training. "Hospitals should promote their positive results on all patient-facing tools and materials," Shelton says.

Hospitals conveyed the message it was safe to receive needed care during the pandemic. "People were comforted by very transparent practices," Stahl notes.

Patients saw chairs roped off to offer more space in waiting rooms and saw staff disinfecting rooms. There was no confusion about what was happening to keep everyone safe.

"People want the exact same thing when it comes to their hospital bill," Stahl says.

Clear language in price estimates and bills allows people to compare what they are told to what they owe. "It takes the mystery out of hospital costs vs. going in for surgery and getting a mega bill afterward," Stahl explains.

Patients already know they are going to owe something. Most people understand that it is hard to predict costs of complicated procedures.

"All of us know there is a financial aspect to care," Stahl adds. "If hospitals are open and honest about this up front, it will engender trust." ■

REFERENCE

1. 84 *Fed Reg* 65,524 (2019).

Revamped Price Estimate Processes Demand Accuracy

Price estimates have become a big priority at the University of Texas Southwestern Medical Center in Dallas.

"The landscape is shifting away a bit from point-of-service collections toward financial transparency and patient education," says **Kimberly Huffman**, CHAM, director of patient financial experience and hospital access.

Patients still can pay up front. "But culturally, we do not place a heavy emphasis on payment in advance at our organization," Huffman reports.

At first, the department expected this change would result in less upfront revenue. "Interestingly, it has not resulted in a decrease in point-of-service collections, even though that is not what we start with anymore," Huffman explains.

Previously, staff started conversations by asking for payment. Now, staff

offer some education on the basics of insurance: copays, deductibles, and policy exclusions. Next, they explain what all this means for the patient's out-of-pocket costs. Fifty-four percent of patients receive price estimates currently. "This includes both current patients and 'not yet' patients who obtain self-service estimates via the patient portal," Huffman says.

Many patients choose to pay something up front. "We set minimum standards, depending on the services they're receiving," Huffman says.

For instance, patients might be asked to pay 50% of the quoted estimate before proceeding.

"They're much more likely to pay up front if they trust the numbers," Huffman notes. "The educational conversations are yielding good results."

The following are some changes Huffman's department made to improve price estimates:

• **Estimates are much more accurate.** The department now uses a single estimator tool. When imaging services are ordered, the correct CPT codes are used.

"Automatic — or as I like to say, 'auto magic' — estimates are created once an order is entered. There's nothing more for our folks to do," Huffman says.

Price estimates are immediately visible to patients via the online portal. Staff can engage in financial conversations without worrying about incorrect CPT codes causing problems.

"We are moving toward guaranteeing our estimates for some of our services," Huffman reports. "When we get to that point, it will be something the marketing team can make a big deal about."

• **Estimates are handled the same way at all sites.** Previously, price estimates were handled differently depending on the location. Some sites used a standardized tool; others used a spreadsheet developed internally. Some clinics handed patients a folder with a paper estimate. Others informed patients the estimate was only available through the patient portal.

"It caused a confusing patient experience," Huffman acknowledges.

• **Estimates now include all charges — hospital, providers, anesthesia, drugs, and other ancillary services.** This makes the hospital unique in the region, according to Huffman. Competitors give estimates only for the hospital portion of the bill, so patients end up receiving multiple separate bills.

• **Estimates are much easier to read.** "We have really revamped the physical appearance of our estimates," Huffman says.

The electronic version includes boxes to click that explain all the charges and instructs patients on the next steps to take. Patients can choose to pay when they arrive or contact someone for more information.

The new price estimate processes prevent unpleasant surprises. "Waiting until the day [patients] show up, when they fasted, is not the time to have that conversation," Huffman says.

Some patients end up delaying elective services to save money. Others choose to pay in full or set up payments. "Our whole attitude and approach is that we are here to help you any way we can," Huffman says.

To reflect this mindset, "financial counselors" are called "financial wellness advisors."

"Clinical care is not a one-size-fits-all. We want everybody to get exactly what they need," Huffman says. "The same is true in terms of the financial experience."

Steady progress is happening in the number of patients who receive price estimates at Olmsted Medical Center in Rochester, MN.

"People are picking places to go for healthcare like they do with retail. We need to be more open with them so they understand the cost," says **Robyn Berg**, patient access manager.

Until recently, price quotes were not given at all. "In the old days, we just verified eligibility," Berg reports.

Tools for real-time eligibility response give the amounts of unmet deductibles and coinsurance. Preregistration is occurring, but only for some patients. At most, about 80% of patients are preregistered. The percentage sometimes falls to fewer than half. "Preregistration is still a new concept for my staff, and they struggle to maintain a consistent percentage," Berg says. "We are adjusting our workflows to focus on this important process."

A team of patient service representatives handles scheduling, preregistration calls, and check-in. They now perform those tasks for telehealth services, too. "We need to ensure accurate registrations are completed prior to check-in to reduce rework and lost revenue," Berg says.

Just giving everyone a price estimate is not enough. Staff still need to explain how they came up with the numbers. "It's very scary to talk about money with a patient," Berg admits. "But if you don't, you're setting them up to be worried about the bill."

At Chandler (AZ) Regional Medical Center, all patients receive price estimates before scheduled services. It is usually handled by phone, but if staff cannot reach the patient, it is covered at registration.

"This ensures patients can make an informed decision about their healthcare and financial needs," says **Linda Burke**, patient access director.

Accuracy of the price quotes depends on many factors. Sometimes, a contractual agreement changes. Issues also can arise if new medications or procedures are not loaded in the estimate tool, or because of human error. The important thing is to know what is happening. "Data on identified trends motivates our teams to move to the next level," Burke adds. ■

Health Plans Turn to Third Parties to Handle Claims and Authorizations

Patient access staff make many phone calls trying to find answers on coverage, regardless of whether something needs an authorization, or the status of claims. When they finally reach someone, it is not always a health plan representative.

"Health plans are increasingly working with third-party business partners to manage certain operational activities," reports **Julie Ingraham**, managing director of healthcare practice at Huron Consulting Group. Claims processing, claims adjustments, and authorizations are common examples.

Health plans are looking for ways to lower costs. "The third party may have better technology, a better algorithm, or return on investment to meet the demands of investors and employers," Ingraham says.

For patient access, it could mean more claims denials and authorization hassles. Tying lost revenue to third party involvement can be tricky. "It is important to know specifically what has been outsourced, to whom, and when," Ingraham stresses.

Patient access might be able to pinpoint surging claims denials to the month a third party became involved. Some research might reveal the third party shared incorrect information on authorizations. "Trending reports prove that your challenges are not anecdotal. This can influence future negotiations with the payer," Ingraham explains.

Medicare, one of the largest payers in the world, has been using third parties for decades, notes **Jonathan Wiik**, principal of healthcare strategy at TransUnion Healthcare. Medicare administrative contractors have been setting plan rules for use controls, administering claims, and other functions for Medicare Part A claims.

Now, more commercial insurers are using third parties to manage high-cost claims: imaging, pharmacy, oncology, durable medical equipment, and behavioral health. "These third-party benefit management firms often have restrictive authorization and precertification requirements," Wiik observes.

The rules can constantly change, resulting in claims denials and lost revenue. "Denials have been a pervasive issue, and still represent the largest source of earned revenue loss for most provider organizations," Wiik notes.

Claims are not denied for no reason. "Somewhere along the line, the hospital failed to follow a plan rule. Claim denials are simply a function of not following an agreed-upon process," Wiik says.

To prevent so many denials, identify accounts that do not meet requirements before claims are sent. Also, monitor payer payments with technology and artificial intelligence. Finally, use real-time (or as close to real-time as possible) data that identify the root cause of nonpayment and what exactly should have happened differently. "I have seen so many dashboards and reports with denial management efforts that end up having a fruitless outcome," Wiik laments.

Lack of good, actionable data is the reason. Third-party claim administrators use sophisticated algorithms to manage costs. "Providers must meet them toe to toe with innovative solutions that can protect their earned revenue," Wiik adds. ■

Registrars May Miss Out-of-Network Status if Patient Self-Schedules

For patients, self-scheduling appointments is convenient. For registrars, it complicates matters somewhat.

"We have inserted ourselves, as much as we can, into that self-service process," says **Michael Sciarabba**, CHAM, MPH, director of patient access services at UChicago Medicine.

Hospitals want to fill all available slots and avoid no-shows. Patients want hassle-free appointments. Self-scheduling can help with all that. "The organization's goal around better, quicker access for patients isn't going away," Sciarabba notes.

UChicago was equipped with little patient self-service capability. That changed with the COVID-19 pandemic. Immediate changes were implemented. "If we had more time, we could have automated insurance eligibility coverage screening at self-scheduling," Sciarabba says.

Ideally, the department would have put in a better insurance entry and screening process. Instead, patients enter health plans by selecting from a list of choices. "Basically, it's only as good as what the patient puts in. It's really hard to find a way to have your patient accept the right plan," Sciarabba explains.

To catch incorrect or out-of-network plans, staff verify coverage as soon as something is scheduled. A few out-of-network cases have gotten through because they appeared to be in-network at the time of scheduling. "We are monitoring it closely," Sciarabba reports. It has not been a major problem yet, but

volumes remain relatively low. "It's a dissatisfier for the patient, the doctor, and the organization if we don't follow that up in real time," Sciarabba says.

Ultimately, the solution is to automate eligibility within the self-service scheduling process. For now, self-scheduling is available just for office visits that do not require authorizations. Things will become far more complicated once patients can schedule procedures for radiology and cardiology. "We will definitely need to build stronger insurance scrubbing procedures at the point of self-service," Sciarabba adds.

At Loma Linda (CA) University's Health Access Center, self-scheduling means patients and staff engage in less in-person contact during visits. Most forms already have been signed electronically. The department drew from its existing processes when self-scheduling was implemented on a large scale on short notice.

"Extensive rules and logic were already built into the system. Missing, conflicting, or incorrect registration items fall to a work queue for validation," reports **Ami Shumway**, director of operations.

Some appointments are booked by caretakers or family, who did not always have insurance information at the point of scheduling. Sometimes, insurance was verified, but coverage changed before the appointment took place.

Financial services staff work self-scheduled accounts by appointment date, with enough time to reschedule the appointment if needed. "Patients must make appointments a few days out to allow time for verification," Shumway says.

Staff do their best to identify out-of-network plans. The EMR displays a warning if a plan is not contracted so patients can be notified. Not all out-of-network plans are caught. "We have more than 2,500 plans in our area, and each insurance provider changes their network preferences often," Shumway says.

Patients are warned that it is possible their plan is out of network. Hopefully, this prompts the patient to double-check with the health plan. "It avoids surprises," Shumway adds.

At Rochester (NY) Regional Health, self-scheduled appointments are reviewed three days before the visit. Some patients pick the wrong type of appointment, which would not allow enough time on the provider's schedule. Others pick the wrong type of service.

"Staff reach out to help the patient with proper scheduling," says **Gail Bellanca**, director of revenue integrity.

Preregistration and good insurance verification tools flag out-of-network plans early enough to do something about it. "We have time to follow up with the patient," Bellanca adds. ■

Patient Access Can Assist Those Who Present Without Coverage

Forty-one percent of adults reported job disruption and losing job-based health insurance coverage, according to the results of a recent survey. *(https://bit.ly/3hRjO5z.)*

"In the spring, there was an expectation that with so many people losing their jobs, many would also lose their health insurance," says lead author **Sara R. Collins**, PhD, vice president of healthcare coverage and access at The Commonwealth Fund.

The survey offered some early evidence that this was not happening at the catastrophic levels people had feared. "The recession was different than prior turndowns in that it disproportionately affected sectors of the economy where people are less likely to get health plans through their jobs," Collins says. Jobs in the food and beverage, hotel, and retail industries hit particularly hard. Some key findings:

- Fifty-nine percent of adults who said their partner or spouse lost his or her job or had been furloughed because of the COVID-19 pandemic reported no one received health insurance coverage through that job. Most of this group had been uninsured before the pandemic.
- About one-quarter of respondents reported they received coverage through a job that was not affected by the pandemic, including a partner or spouse's job.
- More than one-third of respondents received coverage through Medicare, Medicaid, or a plan purchased through the individual market.

"Many people who had coverage through their jobs were furloughed and still receiving benefits," Collins notes.

Others received coverage through other employers. Still, one in five adults reported they and/or a spouse or partner were now uninsured. "If the pandemic is not brought under control and the recession continues at its current severity, is it is quite possible that job losses will rise in industries where more people have employer benefits," Collins cautions.

Patient access is in a unique position to help. "Our teams are seeing more and more individuals losing their coverage and not being able to pay their bills," reports **Perla Pace**, manager of patient access services at San Diego-based Sharp HealthCare.

Staff conduct financial screenings at the time of service and assist patients with applying for public assistance programs. "Our teams closely monitored exceptions and special rules instituted by

our state in order to provide up-to-date resources," Pace reports.

For example, in California, the healthcare exchange modified the enrollment period and waiting periods for eligibility.

"Additionally, the DHCS has provided rules to protect Medi-Cal [California's Medicaid program] recipients pending annual or quarterly renewals to be granted extensions," Pace notes.

COBRA insurance coverage is another option for many. "Although the out-of-pocket costs can be high, they are relatively accessible when compared to the uninsured costs for an emergency healthcare service," Pace offers. ■

Financial Counselors Reach Out to Community

At Michigan-based Spectrum Health, many patients are reporting losing health insurance because of job loss.

"Our next question is, 'Are you eligible for COBRA?'" says **Elisa Contreras**, manager of financial counseling. Many patients are, but they cannot afford it. The hospital offers to cover premiums for up to six months.

This is just one way staff can help newly uninsured people.

"We wear many hats in financial counseling. We follow the patient from the front end to the back end," Contreras says.

The registration system includes a financial assistance module that flags all underinsured or self-pay accounts. "We have 44 financial counselors trained to work those cases. We call the patient prior to services," Contreras reports.

Sometimes, it turns out the "uninsured" patient actually has insurance after all. "If we see that the patient did have Medicaid or commercial insurance, we go in, attach the insurance to the account, and send it out," Contreras says.

If the patient truly is uninsured, these steps are taken:

• Staff screen the patient for Medicaid eligibility. About one-third turn out to be eligible. This is ideal, says Contreras, since it means people can receive covered care in the future.

• If the patient does not qualify for Medicaid, staff screen for financial assistance through the hospital. Incomes up to 250% of the Federal Poverty Level qualify for some type of help.

• If the patient really does not qualify for any financial assistance, staff screen some more. This time, they look for possible discounted premiums available through the insurance marketplace.

About 60% of patients qualify for something. "Even if people have good coverage, we ask, 'Is there anything we can do for you?'" Contreras says.

Patients are glad someone asks. Many with high out-of-pocket costs are happy to learn they do qualify for financial assistance. If any assistance or discounts are applied, the account is flagged immediately so there is no confusion about the amount owed going forward.

If all else fails, staff can offer zero-interest payment plans. Some accounts do end up going to collection, which no one wants. However, before reaching that extreme, there is one more possibility.

"We have a self-pay department on the back end who does a second check on the patients," Contreras says. Patients are offered a payment plan again as a way to settle the account and avoid the collection process.

For financial counselors to keep track of all these options, top-notch skills are needed. Their knowledge level of insurance is assessed every 90 days. Ten accounts are audited every month to be sure all the right information was gathered. "Our expectations are high. We want to see that they are really telling the story of the patient's situation," Contreras explains.

Recently, financial counselors expanded their role even more by reaching out to the community. Their goal was to find people who were avoiding seeking needed care because of inability to afford it, undocumented status, or language barriers. Financial counselors took on all three obstacles. They spread word out via radio advertisements and social media.

The main message was, "Don't be afraid to come because you cannot afford care."

"We talked to the community in their native language and encouraged them to call our toll-free financial counseling line," Contreras says.

Four thousand people called. "The phones were off the hook, and that was our intent," Contreras notes.

Almost all the callers were eligible for Medicaid or some type of assistance. "Our No. 1 goal is to help patients with coverage for the long term, not just for the date of service," Contreras says. ■

COMING IN FUTURE MONTHS

- Techniques to financially clear accounts
- Effective training for tough financial conversations
- Departments struggle to automate prior authorizations
- Coverage gaps for patients with chronic health conditions

Productivity Expectations for Remote Registrars Are Clear, Closely Tracked

Patient access staff have worked remotely for months now, and productivity has not slowed.

"We have found that with a remote workforce, our productivity has actually increased," reports **Susan Freiberg**, patient access director at St. Mary Medical Center in Langhorne, PA.

"Non-productive" time (when staff put themselves in a "busy" or "away" state) has decreased from 15% to 20% for every employee. At-home patient access staff handle financial clearance (both preservice and post-service), schedule outpatient diagnostic testing, verify insurance eligibility, obtain authorizations, and check that medical necessity meets criteria. They also collect patients' financial responsibility.

"Our colleagues face fewer distractions working from home than you might find in an office environment," Freiberg reports. The department attributes its success to the following:

• **Leaders set clear expectations from the start.** Remote staff signed an agreement to meet quality and productivity metrics. They also agreed to use a separate workspace with enough privacy to engage in financial conversations. "Our agreement also included the caveat that the colleagues would be able to work any shift assigned, promoting a more flexible workforce," Freiberg says.

• **Supervisors keep close tabs on what staff are doing.** "We have the ability for real-time access to everyone's desktop and phone conversations with patients," Freiberg explains.

Supervisors may spot someone stuck on an unusually long call and remote in to determine what is happening. Using instant messaging, the supervisor advises the employee how to handle the situation.

• **Team members communicate constantly.** Web chats, instant messaging, webinars, and email are used. "We also have real-time workday and work session reports and work queues that promote productivity," Freiberg says.

At Novant Health in Winston-Salem, NC, some new equipment was needed to keep productivity at high levels. "We previously 'hodgepodged' equipment to loan out during severe weather. But it is outdated," says **Kortney Hege**, BS, MHA, MBA, manager of preregistration and insurance verification and preservice collections. The department bought new laptops, webcams, and software-based phones and headsets. "This allows team members to dial out to patients and receive phone calls from patients just as they would in the office," Hege explains.

Productivity was not the top priority when volumes were low and remote work was brand new. Now that volumes are returning to regular levels, expectations also are reverting to normal. "We made it very clear to all team members that productivity was being counted again," Hege says.

Supervisors continuously track the number of accounts completed per hour, the insurance verification rate, and amounts collected upfront. "We have not seen any decline in productivity that can be attributed to the transition to working remotely," Hege reports. ■

Remote Registrars Actually More Engaged

At Tampa (FL) General Hospital, "the move to telework has enhanced employee engagement and satisfaction," says revenue cycle director **Stephanie C. Franz**, MBA, revenue cycle director for patient access. One at-home registrar put it this way in a recent email: "We have the best support system — not only for patients, but for us as employees."

The switch to telework was well underway before the COVID-19 pandemic. Financial clearance and scheduling teams started teleworking in 2018, and the call center teams made the switch in 2019. The remaining teams were deployed in early 2020. Currently, 61 patient access staff telework. "If staff do not meet expectations after support and coaching, they know they will return to the office," Franz says.

Staff agree to respond to all chat inquiries within 60 seconds (except during breaks or lunch), handle an average of 10.5 calls per hour, financially clear an average of six accounts per hour, and collect a certain percentage of dollars preservice. Employees can opt out of telework because of home situations or because they prefer to remain in the office. Only six have chosen to work on site. "Periodically, team members come in for a refresher in the workflow," Franz says.

Refresher examples include when team members struggle with productivity because of a system upgrade, when payer requirements change, or when team members want to connect in person with leadership. Supervisors also look for calls that are taking longer than expected, and step in to help. "The leader messages the team member to determine what assistance is needed," Franz says.

Usually, the supervisor takes over to complete the problematic call.

"Another very effective way to provide immediate support is when leaders and team members share their computer screens to walk through difficulties together," Franz adds.

Many patient financial services and patient access staff at Brewer, ME-based Northern Light Health remain remote workers. The department has kept morale strong in several ways:

• **Colleagues keep in touch on a personal level.** Staff always expected pictures if a co-worker had a new baby or a new pet. Working at home has not changed this. "We do one-on-one rounding with staff," says **Jennifer Cox**, MBA, revenue cycle director.

After managers review work and productivity, they ask, "How are you doing?" This question opens the door for staff to engage in the kind of personal chitchat that used to be common.

• **Managers encourage staff to use mental health resources.** The organization put into place plenty of resources to help staff struggling with anxiety and depression, including counseling, online tools, and educational sessions. "The message is: We are in this together, and we are going to support you," Cox says.

• **Supervisors offer as much flexibility as possible.** Many staff had a fairly idealistic vision of what it would be like to work at home. In reality, there are constant distractions. Staff know they can go on "pause" if they need to attend to something personal during their shift. Staff also can use a weekly leave if it becomes necessary.

"Basically, we are asking leaders to be understanding, and to please be flexible with schedules," Cox says.

Some staff at Texas Health Resources' centralized Patient Access Intake Center (PAIC) always have worked remotely. The at-home staff handled preregistration, estimates, preservice collections, insurance verification, authorization, and admission notification. The comparatively few staff who continued working on site did so out of choice.

"Employees generally had factors in their home lives that made them favor working in the office," explains **Chris Gronek**, senior director of revenue cycle operations.

Some had young children, dependent family members, or lack of workspace. Yet all were sent home when the PAIC closed because of the pandemic.

"They had some pretty significant hurdles to overcome in order to keep up with their work and maintain healthy home lives," Gronek says.

PAIC leaders offered plenty of flexibility. "This was not possible for all roles. But we strived to make accommodations wherever possible," Gronek says.

Staff can work different hours, work a longer day but with longer breaks, or take more frequent short breaks.

"We found this to be particularly appealing to people who did not have regular child care or had a need to be away from their desk throughout the day," Gronek says.

The department initially struggled to connect with remote workers.

"The reality is that even a very well-run video meeting is often a poor analog for face-to-face human interaction," Gronek admits.

Virtual happy hours, lunch meetups, and pet showcases were met with mixed reactions. In the end, the department found successful online socializing included three components: Small groups (fewer than eight), some preprogrammed content (in the form of simple icebreakers), and a set timeframe (30 to 45 minutes).

"Throwing 20 people on a video conference with no structure is much like doing the same in a meeting," Gronek says. "It's not going to be very effective or enjoyable." ■

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