ROUNDTABLE

Engaging Patients as Financial Partners

Efforts to inject consumerism into the delivery of healthcare services such as high-deductible health plans are transforming the role of patients as economic agents. As patients become more involved in their healthcare—and in the financial responsibility for that care—revenue-cycle teams face matching challenges to evolve their operations and patient-engagement strategies. Roundtable panelists examine several related topics, including price transparency; strategies to engage patients as financial partners throughout the care continuum, such as using hospital-employed financial counselors; utilizing data analytics to target patient-outreach efforts; and the evolution of revenue-cycle team staffing needs.

PANELIST PROFILES

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Roundtable Highlights

HEALTHLEADERS: *What are factors for healthcare providers to consider when launching a price transparency initiative?*

AMY FLORIA: It is the value proposition. Why does it cost more? What am I getting? What's included? What do your patients want? What is the price elasticity in your market? How price-sensitive are procedures? What are your competitors providing?

NEVILLE ZAR: It's also about defensibility. There is a lot of regulatory pressure around price transparency, and it is probably every other couple weeks that either a regulator or attorney general or someone calls up and says, "We have a patient complaint," or a patient advocacy group calls up and says, "We have a patient complaint." So we have invested over the last 18 months in the technology, in the processes, to create transparency from a defensibility perspective as well as a market equilibrium perspective.

LYNN GUILLETTE: When patients call our shop for an estimate, what they have heard from their doctor is, "Here is a procedure that we're recommending that you get," and when they call us, they're talking a language that then has to be translated to someone who is looking at particular codes. That's the tough part. And you never know what's going to happen once a patient gets in surgery.

HEALTHLEADERS: *Why do you launch a price transparency initiative in the first place?*

FLORIA: We are looking at it as a couple different strategies. One strategy relates to growing competitors in the retail space and commodity services. We want to make sure we are able to compete. Our patients are also requesting more information on the cost of care.

MELINDA RAMSDELL: What we hear is the ability to be transparent is only as good as the tools utilized to provide price estimates. Many providers that we talk to are investing in upgrades to their estimator tools. There is also a focused effort to simplify patient statements.

HEALTHLEADERS: *How do you address the estimating challenges?*

RAMSDELL: Accuracy is the biggest challenge that we hear about from our clients. Building a historical database is one way to ensure consistency and some level of accuracy.

ZAR: The estimate is only as good as the insurance you have. So before we even provided the estimate, the one thing we started doing is getting what we call the right liable payer—the right insurance plan.

RAMSDELL: Many of our provider clients set up and assume most of the liability for education. How realistic is that long term when all stakeholders—providers, payers, and employers—share in the education responsibility? It is reality that many consumers don't have clarity about their personal insurance plans.

ZAR: We set up a call center in Quincy, Massachusetts, where we've got 50 people on the phone and they're calling patients prior to service and they're trying to educate the patients. They're trying to get the insurance right, they're trying to get the estimate right, and they try to get all the information right before patients come in. ... But I think there is joint responsibility—there's responsibility of the employer as well as of the provider to be more forthright.

FLORIA: Scheduling has changed; preregistration functions have changed and it's no longer simple to register a patient. It's difficult to get colleagues comfortable with having those conversations. We are definitely looking at investing in our colleagues and providing more education in all facets of that previsit workflow as a resource for our patients.

GUILLETTE: The insurance company has an obligation, too. For the HR department at an aerospace company, they're really just trying to make sure that they're providing a benefit to their employees, because that's what the market demands. ... So the insurance companies have an educational role to play.

HEALTHLEADERS: *For decades, there's been an adversarial relationship between payers and providers. How do you enlist payers to help achieve transparency?*

ZAR: We have to try to engage insurance companies, and I would say for our four largest commercial payers, we do have good relationships to engage them. But the challenge is with the small insurance claims. It's those plans that either don't have the resources or the technology to answer your questions.

GUILLETTE: The payers in my market have their own databases that they're making available to the members of

the health plan. Then the members can go on the plan Web portal and check Dartmouth-Hitchcock service costs because the portal has the contractual rate … along with out-of-pocket costs and maybe even an estimation if you've already met your deductible. But the payers don't share that information with the provider systems.

HEALTHLEADERS: *How do you address that quality piece of transparency, and how do you involve clinicians in that process?*

ZAR: We're looking at how you engage the provider so they understand that what they are ordering for the patient has a financial impact on the patient, and the patient could possibly opt out of care.

GUILLETTE: Most providers, when they went to medical school, they didn't go when there was an electronic medical record. If they even had a business course, maybe it was a six-week part of their medical school training. … They

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really want to be able to understand if they're asking their patients to assume a level of financial responsibility that the patients can't meet because it's way out of their financial means. But we have to figure out how we make that happen without just dumping more onto the providers.

FLORIA: We're surveying our larger-volume providers and asking them how they see their role in these financial conversations. Do they want to use an external resource where they can send their patients to get more information, or do they want to play a role? Some of our providers … are very business savvy and want to know the business side of it, but others don't want to know because they don't want the business side to impact decisions on clinical care.

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HEALTHLEADERS: *What are the key elements to engaging patients as financial partners at the various stages of their hospital experience?*

FLORIA: We definitely have to be more collaborative. Today, patients have so many elements of healthcare to manage. We need to work with our patients to help them ease the stress associated with the financial impact of their healthcare.

ZAR: There is a sense of prioritization because consumers prioritize debt. So the mortgage bill, it gets paid straight away. Then the credit card gets paid. Then the question becomes, "Am I going to pay the hospital bill or am I going to pay my cable bill? I'm going to pay my cable bill." So medical debt goes to the bottom of the pile. It's discretionary income being used on nondiscretionary services. We try to approach it that the more patients can do up front, the better.

HEALTHLEADERS: *How do you engage patients financially once they're in your facility?*

ZAR: Scripting is important for the frontline staff. You have a script that's a consistent message to patients.

FLORIA: We have a goal of seeing 90% of our inpatients while they are in the hospital and have a financial clearance conversation with them. It isn't just about seeing those patients who don't have insurance. We confirm coverage with patients who are registered with insurance coverage, confirm eligibility, and discuss other financial resources to help cover possible out-of-pocket cost.

ZAR: Part of the engagement is looking at a single bill. We've got to figure that out. We say to patients, "Send two checks in, one to Steward Medical Group and one to Steward Hospital Group." It just doesn't make sense. … Beyond one bill, the other thing we do is patient scoring. We understand post-service who we can collect from and who is not going to pay.

RAMSDELL: A couple of examples come to mind. One provider has established six key demographic groups, which helps them break down the patient base and understand not only the patient's ability to pay but also how they will pay. It goes back to making it as easy as possible to take in payments. Another interesting point is the correlation between satisfaction and the propensity to pay. One client is doing a satisfaction guarantee, with a refund commitment. That is a way to increase satisfaction and willingness to pay.

HEALTHLEADERS: *How does the issue of patient financial engagement change when you're dealing with the outpatient population?*

GUILLETTE: Being able to accurately provide an estimate of what it is going to cost if you're going in for open-heart surgery versus if you're going in

on an outpatient basis to have your knee scoped, it's entirely two different things.

ZAR: So you may have two touches in an outpatient procedure. For diagnostic imaging, it really should be one call, but most providers will have somebody who will call up and do the preregistration. Somebody else will call and say, "We don't have the referral, so call your doctor's office and get the referral." Someone else may call and say, "You owe a $50 copay." If you can get one call that does it all, we believe you will have better patient satisfaction.

RAMSDELL: We're aware of a situation where a hospital did an intense technology study looking at how long it took a patient to navigate its home page and ultimately get to the payment portal. The study indicated that it took patients much longer to find answers and to make payments on its site versus websites for other types of organizations. Investment in healthcare technology is definitely on the rise—improving navigation is a priority.

HEALTHLEADERS: *How do you help a patient walk through questions that arise when he or she is handed lab orders and there are multiple costly tests?*

FLORIA: It's a delicate balance. As far as prioritizing the clinical care, that's got to be a conversation between the patient and the provider. The provider needs to step up, help patients understand the financial situation, and be able to assist patients to prioritize their healthcare needs or find alternatives.

ZAR: So let's say a patient has a scheduled service and either they don't have coverage or they're underinsured. … We have a process, what we call delay-defer, and we do this 48 hours prior to service. We will delay the service. But at the end of the day, that's the physician's decision. So the reps on the phone aren't making the decision to delay the further service; they're saying, "We have got to take a time-out. We have got to talk to your doctor because if you need that procedure, we're going to do it."

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In any given week, we process thousands of transactions and have 10–15 patients on the delay-defer list, which means we can't verify coverage or they have high out-of-pocket costs that we know they can't meet. We'll delay the further procedure, and we'll create an item list. We'll contact the physician and say, "What do you want to do?" If the doctor says, "Go ahead," then we're going ahead and we know we're going to eat that cost. But if the physician says, "We can delay this for 30 days," then we go back to the patient and say, "We're going to delay this for 30 days until we figure out what your coverage needs are," and with most of those delays, the right outcome happens from just giving you more time to figure it out.

GUILLETTE: We don't currently employ a delay-defer process at Dartmouth-Hitchcock. But in some situations, we don't have a contract with a particular carrier, and we need extra time so that my department can work with a carrier and get a single-case agreement.

FLORIA: We try to shelter our patients from those types of conversations, and by no means do I ever see quickly billing a $250,000 monthly medical oncology bill to a patient because their insurance denied the coverage for investigative purposes. We really try to shelter our patients from those types of things when it becomes an insurance coverage issue. Patients need to focus on getting well. And there's no practical way a patient could ever fathom paying for such a large healthcare bill. We handle these financial conversations with the insurance companies directly and negotiate a payment for the claim.

Melinda Ramsdell
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GUILLETTE: With transplants, it could just be if we can't cut a deal, then the patient may end up having to go someplace else. While our doctors truly don't want our patients to go anyplace else, we also can't absorb $200,000 hits. Sometimes, we take it under compassionate care, but in other instances we let the patient know that their carrier is not going to approve the transplant here and that they may have to go to Boston or Seattle or Sloan Kettering or wherever it is that has been approved as a center of excellence. Those are really difficult conversations because the patient has already chosen where they want to go, whether it's because they live in the area or they have an existing clinical relationship.

FLORIA: If necessary, we have those conversations with the patient to let them know we're investigating coverage with their insurance carrier. It's

important for patients to understand what coverage their health insurance policy provides.

HEALTHLEADERS: *How do you identify what kind of staffing changes you need to make to more actively engage patients as financial partners?*

FLORIA: We collect data and observe our volumes and our patient flow. How long does it take to register patients? How long does it take to register a patient when that patient has been preregistered? How long do our scheduling phone calls last? We've done quite a bit of data-mining to find the variations in the workflow and staff our colleagues according to the data. We hear so much from our colleagues saying that they're busy and generating overtime. We study the data to see what it is telling us. The data clarifies the staffing needs, and we respond accordingly. Staffing changes create another level of complexity. Since we are a smaller organization, when we have colleague turnover, it can be very impactful. If you only have five schedulers and one leaves, that's 20% of your staffing resources. It's a big reduction to absorb. As a solution, we are combining resources from other areas in the facility and cross-training colleagues.

Neville Zar
Senior Vice President of Revenue Operations
Steward Health Care

ZAR: We've engaged with our union, and seven out of our nine hospitals are unionized. We engage with the union as partners to get them on board to upgrade staff. They have a training fund, so having the union pay for the staff training and to upgrade the fund has been important for us. They've started an apprenticeship program where they pay for staff to take them out of production in their current job. The union will put them in an eight-month internship or a training program. We also have a college intern program. They work the entire summer in positions like registering patients or figuring out specific problems. Then at the end of the summer, the best of those interns give a presentation to us, and a handful of them get offered jobs.

GUILLETTE: Even in contracting, we're looking for people who have a different skill set, who may be able to think more creatively and independently, but still collaborate as a team. That's what the rev cycle in general is requiring. You have to be able to be both a team member and function independently throughout the day.

HEALTHLEADERS: *If I was a CFO sitting here in the room, the one thing I would be hearing is we need a higher level of skill set. I would be thinking this is going to cost more money.*

GUILLETTE: With the right training, someone out of high school could be a perfect person for the entry-level positions. They have to be comfortable talking to patients, if that's the position that you're asking them to be in, but they also have to be hungry and want to be proud of the job or the role that they have in the organization.

FLORIA: We have to be more creative and investigate how we can develop current colleagues to fill more complex positions. You look at the talent you have today and ask, "Do we have some up-and-comers? Do we have some superstars that we can develop into these new roles?" It may be more cost-effective to send them to school, or institute a retention program and develop those colleagues professionally. The intangible benefits associated with this type of development program are substantial with the rest of the colleague population.

ZAR: What we've done is we have looked at functions that can be done at home because we want to attract more staff. We have just sent about 60 people to work from home. We purchased the computer equipment for them, so it meets our data security standards. We've provided a secure Internet connection, and we will be able to attract staff that we wouldn't necessarily have been able to attract in the past.

RAMSDELL: Our clients that are the most successful at reengineering their workforce start messaging the change from the top down. There is buy-in at the CEO and CFO levels. Loyal and long-standing employees need to feel valued and appreciated, and they need to be rewarded. Attracting new talent is also critical. The reality is that there is not going to be an unlimited pool of money, so you get innovative. Rewards like flexible work hours or working from home are great examples.

HEALTHLEADERS: *Gauge the financial impact of the HR shift in revenue cycle teams.*

GUILLETTE: Short term, it can be a cost. Over the long term, it can contribute to the overall bottom line of the organization, because you will have the right people in the right jobs doing the right kind of work. But there is an up-front investment that may differ across organizations depending on their existing talent pool and the job market in their region.

FLORIA: I try to be more open to the intangible benefits. It is the long-term view. It is the value of having a more engaged colleague population and decreasing turnover. ... That has a positive impact on patients.

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