Moving the needle

Delivered on July 18, 2019
Revenue Cycle Leaders Have a Story

As an advocate for providers, I’ve spent the past 15 years partnering as a resource sharing best practices and the wealth of data that we’ve amassed. One day when I’m retired, I hope to be able to step back and say “we created a better system; we moved the needle just a bit!”

Each revenue cycle advocate and leader we interact with feels the same, both provider and partner.

I think you do too!
Everyone Needs an Inspiration

As we move through this data, I hope to help you find your inspiration to create something, to push a bit to get a new process or technique working in your facility, to advocate for your patients to have a better financial experience and to give you ideas for measurement of your success.

You need to be here
My Inspiration
What We Will Cover Today

• What patients are telling us they need
  • Harvested information from phone calls - why are they calling
• Who is calling and Who is paying and How are they paying
  • Busting myths (for now)
• Why we need to change it up
• An action plan
• Metrics
The Revenue Cycle is Largely Left Out of the Patient Experience Discussion

- HCAPPS surveys only asks two questions which could loosely refer to the patient’s financial experience: Overall how would you rate this hospital; would you refer others to our hospital.

- HCAPPs only have a 30% completion rate and the variability of delivery between 48 hrs and six weeks means that the patient in all likelihood hasn’t received a bill for their balance due.

- We know that patient satisfaction matters. According to a study by Deloitte Health Solutions, facilities which achieved an excellent rate averaged a 4.7% profit margin compared to those with the lowest scores which had a 1.8% profit margin.
Patient Financial Experience Matters!

We tell everyone who interviews with us for revenue cycle positions that while we are never going to be as cute as the OB Department...

Or as glamorous as the surgical suite...

We are every bit as important to the health care delivery experience!
So...How Does Everyone Think We’re Doing?
Burning Up What You Might Think

We have analyzed over 2 million calls and $1 billion dollars in payments.

I’m going to share with you what we learned, what we confirmed and what shocked us.
Let’s Talk Numbers

• We know that the percentage of revenue collection from patients has jumped from 10% in 2002 to 30% in 2016

• Nearly half of that out of pocket expense goes uncollected

• Medical bills rank 7th after mortgage, car payments, cell phone payments, credit card bills, etc.
Call Behavior

Repeat callers account for roughly 45% of our inbound calls

- 43% of the callers who call us back do so within the hour

- 9% of the messages we leave are returned when using automation and 12% when using PSRs. This is down from 2005 when the numbers were 22% (we didn’t have the automated message drop in 2005)
Call Length

Call length has increased over the past decade. For us, the average call went from 3:00 min to 5:58 min. We have identified several reasons:

- More people using self serve options—as long as their bills are uncomplicated
- Baby Boomers in the Medicare program understand their coverage

However:

- ACA coverage meant that people new to coverage had many questions
- Things are not getting more clear

So the shorter calls that drove down our average are eliminated while more complicated and longer calls are driving up the call length. Self service options are not fully self-serve.
Cost of Calls

• Average employee salary has increased by 15% as unemployment drops and a competitive market has us jockeying for capable staff

• Average call costs have increased over 50% in the past decade. This includes wages, benefits, technology, regulations (thanks FDCPA, NACHA, 501r)

• While self serve options assist, their effectiveness as a substitute for human interaction is limited
### Breakdown of Calls

<table>
<thead>
<tr>
<th>Primary Reason for Call</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay the Bill</td>
<td>25%</td>
</tr>
<tr>
<td>Insurance Questions</td>
<td>23%</td>
</tr>
<tr>
<td>Questions about the Balance</td>
<td>16%</td>
</tr>
<tr>
<td>Wrong Demographics / Guarantor</td>
<td>10%</td>
</tr>
<tr>
<td>Already Paid</td>
<td>5%</td>
</tr>
<tr>
<td>Itemized Statement</td>
<td>4%</td>
</tr>
<tr>
<td>Financial Assistance</td>
<td>3%</td>
</tr>
</tbody>
</table>

Source: Avadyne Health 2018 Inbound Calls
Use of Technology Doesn’t Align with Expectations

Out of $1B in Patient Payments Annually....
Generational Impact

- What do we think about the Millennials, Gen X, Baby Boomers and Traditionalists?
  - Who calls the most?
  - Who uses self-service options?
  - Who has the largest amount of frustration with billing complexity?
What We Know About the Generations and Technology

Data shows that younger generations use technology and social media more than older generations...

This fuels our assumption that younger generations would be more self-service...but older generations are closing the gap

Our data shows this does NOT hold true in healthcare
## Common Generational Themes

<table>
<thead>
<tr>
<th>Millennials &amp; Gen X</th>
<th>Baby Boomers &amp; Traditionalists</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Switches providers often</td>
<td>• Sticks with providers for years</td>
</tr>
<tr>
<td>• Questionable trust of providers</td>
<td>• High trust in providers</td>
</tr>
<tr>
<td>• Complicated Insurance</td>
<td>• Less complex Insurance</td>
</tr>
<tr>
<td>• Minimal experience with insurance</td>
<td>• Lots of experience with insurance</td>
</tr>
<tr>
<td>• Perceived as more tech savvy</td>
<td>• Perceived as non-tech savvy</td>
</tr>
</tbody>
</table>
Guess Who is Calling the Most and Paying the Least?

Patients Who Require Assistance and Pay by Generation

- % Assisted
- % Paid

- Gen Z (1997)
- Gen X (1965-1980)
- Baby Boomers (1946-1964)
- Traditionalists (1900-1945)
What Does This Mean?

Are there differences between self-service usage and payment trends between various generations?

INSIGHT:

• Older generations require less assistance (self-service) AND pay more
• Younger generations pay less and require more assistance
• Per every $ collected, younger generations have a higher cost than older generations for healthcare payments
What Do We Do With This Knowledge?

Patients want self-service...but need assistance, until we simplify the industry and process

1 out of 2 patients want a dedicated concierge (support person) to engage with them throughout their financial experience
Why is Healthcare Different?

Patients want self-service…but need assistance, until we simplify the industry and process

- A price is not a price – hospital charge masters versus actual liabilities - “pricing transparency” is not “cost estimate”
- People don’t understand their insurance and liability
- Three party system (Patient, Provider, Insurance Company)
- Clarity of other industries – Price, Value, What we will receive
The History of Self-Service

What is significant about Piggly Wiggly® and Self Service?

- The concept of the "self-serving store" was patented by Piggly Wiggly founder, Clarence Saunders in 1917
- Piggly Wiggly was the first to:
  - Provide checkout stands
  - Price every item in the store
  - Provide shopping carts for customers in 1937
What do Patients Want?

In a survey conducted by AH in early 2018, the 500 respondents indicated that:

• 84% pay non-medical bills on time with 12% saying they are “sometimes” late
• 29% make a partial payment before treatment or immediately after service
• 13% make multiple payments
• 53% wait until they are fully satisfied that all insurance has been handled
• 5% wait until at least 60 days

501r inserted a delay in the resolution for payment by shielding patients from Extraordinary Collection Actions for up to 240 days.
People Still Want People

In 2014, the “new” initiative was self serve kiosks. How many of you have them in your facilities? What worked well?

Why does it work in many industries?
Interestingly, respondents to the survey said the following have little to no impact:

- Email or automated reminders about open balances (68%)
- Self-service payment portals (64%)

WAIT, WHAT…but portals and emails and technology. You have been telling us that these are needed. Yes, you need them but patients are asking that we also have the ability to “speak” to someone at every billing point: chat, one button calling from phone/mobile device or app. The minute that they can’t figure things out, they want someone to help.
Factors Which Do Not Impact Satisfaction

According to our “Bridging the Gap” survey, patients feel that the following will have a positive impact on their satisfaction:

• Unified bill (56%)
• More engagement before the service (41%)
• Dedicated person to serve as a guide through the financial process
What We Need to be Doing!

Bridging the Gap survey also demonstrated that patients want:

- Payment plans (63%)
  - Only 27% of providers are offering extended payment plans yet a majority of patients indicate a need.
- Pre-service estimates
- Meeting the patient at the place that matters to them
What Helps?

• While patients who receive guidance from a hospital resource show 66% satisfaction rates, nearly a third report less satisfaction.

• Confusing terms: deductible, co-insurance, LCD, ABN, EOB, subrogation, COB

• Concierge must explain what each thing means:
  • “Are you familiar with the annual deductible and how it works in health care? (patient stammers) I am happy to take a moment to explain because you’ll encounter it each year that you have insurance coverage. In the insurance world, they create an annual amount that they want the patient to pay before they will start to pay. It is called a deductible. It might change from year to year or as you change plans but it will refresh again each new year and must be paid before your insurance will make payment for your hospital services.”

• A commitment to advanced training is required. The standard “smile while you speak with people” is simply not sufficient.
What Helps?

Simple, easy to understand billing statements.

- Gen X is the most unhappy (60%),
- Boomers at 50% and
- Millennials at 43%
- A stack of bills from multiple providers leads to distrust and dissatisfaction.

- There are currently several legislative bills in various phases to attack “surprise billing”. While a few have to do with emergency care and out of network claims adjudication, there are some that specifically address ancillary providers (anesthesiologists, radiology, pathology, etc) which frequently bill without meeting the patient and thus are a “surprise” when received. Congress is less than impressed with the finger pointing occurring between both provider and payer.
What Helps?

• Pre-service price estimates are important to 71% of all respondents yet in a survey of 100 health system facilities, only 37% are providing pre-service estimates and 25% of those who do are less than happy with the accuracy of their own estimates.

  • This must include much more than the estimate of out of pocket expenses. Consumers want options for resolution: patient financing, payment plans, discounts

  • They need to fully understand that as medical conditions change and their physician pivots to what is best for them, this number may fluctuate. The use of advanced technology is essential here.

  • Refunds for any overpayments must be made immediately.
What Helps?

• A financial experience consistent with a positive retail purchase experience. Think of your favorite online or bricks & mortar store vs your least favorite retailer. What are the factors?

• Order ahead

• Delivery

• Logical layout/Easy to navigate

• Multiple ways to pay

• Assistance when you need it
Measure your Metrics

- Each hospital IS unique
- In order to prioritize and justify the dollars, you have to quantify and document the drivers that lend to patient satisfaction. In order to determine if a new process is helping or hurting, there must be measurement. If a payer changes procedures and there is no baseline measurement, how can you effect change?
- Surveys are of little value:
  - Completion rates of 6%.
  - Most satisfied or dissatisfied
  - Repeat completers
Metrics

• Much like a patient’s vitals, the change of a satisfaction metric must be analyzed for cause and resolution.

• Each hospital should define the indicators that are:
  • Measurable
  • Correlate to patient satisfaction

• Imagine trying to decide to implement a pre-service estimation and collection program without a baseline of either collections or patient satisfaction. How would you know if it is having a positive impact other than the anecdotal stories that might escalate? How do you influence negative opinions of those who might be opposed?
Action Plan

Action plan in three easy steps:

1) **Map what you think patients care about**
   (I’ve given you a huge step in this direction)

When we did it, we polled our more senior CSRs to ask them the top reasons that they felt patients called us. We then tried to validate that with the reasons for the call and words of satisfaction. There were some surprises in the “common beliefs.” Remember this?

<table>
<thead>
<tr>
<th>Primary Reason for Call</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay the Bill</td>
<td>25%</td>
</tr>
<tr>
<td>Insurance Questions</td>
<td>23%</td>
</tr>
<tr>
<td>Questions about the Balance</td>
<td>16%</td>
</tr>
<tr>
<td>Wrong Demographics / Guarantor</td>
<td>10%</td>
</tr>
<tr>
<td>Already Paid</td>
<td>5%</td>
</tr>
<tr>
<td>Itemized Statement</td>
<td>4%</td>
</tr>
<tr>
<td>Financial Assistance</td>
<td>3%</td>
</tr>
</tbody>
</table>
What We Thought Would Show Up

• Why do I have separate bills from the hospital and physician?
• Do you accept assignment from Medicare
• Why do I have more than one account number?
• What should I do if this was an automobile accident?

Together these questions account for less than 1% of the measured calls.
ePFXscore – How Speech Analytics Work

100% Interactions
with metadata

Transcriptions & acoustic measurements (redacted)

Use case specific automated tagging (language tagging)

Use case specific scoring & tracking

Compliance, behavior & targeted coaching insight

PSR: Thank you for calling ABC Hospital. How can I help you?

Pt: This is my third time calling! You overcharged me on my last bill. I need to speak with a manager.

PSR: May I confirm your name, address and last four digits of your social security number?

Pt: I’ve already entered account information in the phone! You people are useless!

Proper Greeting, Right Party Contact, Chum Language, Payment Language, Dissatisfaction, Empathy, Collector Effectiveness, Politeness, Close Language
Action Plan

2) Measure what is actually happening.

Do people care about timely billing? Balance size? Accuracy of price estimates? Determine what is important to your facility and patients.

This can be accomplished via call mining software or a corporate partner. Surveys are less accurate and will only capture 5-10% of the patients.
Measuring Satisfaction

ABC Health System

ePFXscore

B-

PATIENT PAIN INDEX

Smiley Face

RELATIVE RANKING

DECILE RANKING: BOTTOM 20%

AVERAGE ePFX SCORE: B-

ePFX Report Card

March 2019

Oct
B-  Nov
B-  Dec
B-  Jan
B-  Feb
B-  Mar
B-

Assignment Aging When Placed for Early Out

BAA Accounts with Insurance Adjustments or Payments

Accounts Placing to Bad Debt

Accounts Returned to Hospital

Amount Owed by Patient

B+

A

C+

A-

D-

Timing of First Payment on Accounts

Volume of Inbound Calls

Negative Speech Analytics Triggers

Speech Analytics Will Not Pay

C-

D

B+

B
3) Choose and implement your initiative.

- Pick what is urgent/makes the largest impact.
- Project manage it
- Track it
Measure and Report on Great Achievements

If you implement a pre-service program, ideas could include:

• Collections before, at time of, post-service. Even if the patient didn’t pay prior to or at time of service, they paid more quickly during the self pay billing.

• Reduction of bad debt

• Number of payment plans

• Reduction of notices

• Increase in Financial Assistance

• Improvement in accuracy of insurance information = faster payer payments!
Measure and Report on Great Achievements

If you invest in advanced customer service training, measurements could include:

- One call resolution
- Collections
- Reduced staff turnover
- Fewer escalation calls
Measure and Report on Great Achievements

If you implement a unified statement, you could measure:

- Fewer inbound calls per account
- Reduced notice and cost savings
- Improved satisfaction scores
- Increased collections
- Increased portal traffic
Summary

• We need to champion our own story via data collection and process improvements as the common data analysis largely leaves out the revenue cycle.

• Patients are demanding a more consistent and customized financial experience similar to their retail experience. This includes a variety of communication methods backed by a personal touch when they need it.

• The demographic behaviors frequently attributed to each generation do not currently apply to healthcare.

• Capture, prioritize, measure for results!
Thank You!

Julie VanPelt

jvanpelt@avadynehealth.com

309-292-1700