Due to increased consumerism in health care, as well as the shift to value-based care, many hospitals and health systems are working to improve the patient experience. Although clinical leaders already have embraced this concept, financial leaders are just beginning to realize the importance of putting patients first to cultivate loyalty, drive market share, and optimize revenue. Forward-thinking organizations are leaving their old ways behind and overhauling financial processes to ensure patients feel more appreciated as customers, rather than as people who owe money.

In this HFMA Executive Roundtable, sponsored by Adreima, several senior healthcare executives discuss how their organizations are revamping the way they interact with patients, making sure that financial operations are patient-focused.

**What is your organization’s current approach to making the financial experience more consumer-friendly? How does this differ from what you’ve done in the past?**

**Gary Breuer:** AMITA Health realized several years ago that we needed to be more retail-oriented and consumer-friendly. Although we made some progress with incremental changes, we recently kicked off a more targeted project that focuses on the experience in patient access. We are looking across all the points where patients initially interact with us, conducting focus groups and capturing patient satisfaction data for the revenue cycle. Our strategy involves laying out a three- to five-year roadmap that identifies the changes that will get us on track and the specific projects that will help us get there. One current target area, for example, involves streamlining wait times across all patient access areas. AMITA Health recently embedded a wait time feature on its website and mobile application that displays the average current length of time from check-in to healthcare evaluation at each of its various locations. We also provide a link for patients to schedule a visit to a primary, urgent, or emergency care site up to 24 hours in advance.

**Patricia Kittell:** For well over three years, Cedars-Sinai has been focusing on the patient experience, including billing. We started by revamping our billing statements to make them easier for patients to understand and added a significant number of staff in the customer service area to quickly and courteously answer the nearly 1,000 calls we get from patients each day.

We also handle patient collections in-house. We ensure our staff understand how to answer patients’ questions completely, accurately, courteously, and in a timely manner by providing a substantial amount of customer service training.

For patients who have major billing issues—whether they have multiple bills from multiple providers, or can’t decipher the explanation of benefits from their insurance company, or are so sick they can’t deal with the bills and let them pile up on the kitchen table—we provide a special patient advocacy service. The advocates manage the billing process until all the statements are resolved or the patients are able to tackle the bills themselves.

**Nap Ramirez:** At Lakeland Health, we are working to elevate the patient experience by communicating information about a person’s financial responsibility and providing any necessary financial counseling at the earliest stage. Our patient financial advocates have conversations with patients immediately after they consult with a specialist. Because they have access to information from our network physician practices, our

**PARTICIPANTS IN THIS HFMA EXECUTIVE ROUNDTABLE**

**Kelley Blair** is executive vice president of Adreima, Chicago.

**Gary Breuer** is vice president for revenue cycle management at AMITA Health, Arlington Heights, Ill.

**Patricia Emmett Kittell** is vice president for patient financial services, Cedars-Sinai Health System, Los Angeles.

**Nap Ramirez** is executive director, revenue cycle, for Lakeland Health, St. Joseph, Mich.
patient financial advocates know the services a specialty doctor is considering and can couple that information with our hospital system’s patient payment history. By the time the advocates speak to the patient, they have already validated his or her coverage for the services the physician plans to order, figured out deductible and copayment amounts, generated an estimate, and calculated the patient’s responsibility. The advocates explain to patients who have insurance that they can take care of the self-pay balance either at the time of care or after insurance has paid. For patients who don’t have insurance, the advocates provide financial screening to determine if patients are eligible for Medicaid, charity care, or an insurance exchange.

**Kelley Blair:** In the past, providers typically wrapped financial services and counseling around a specific care event. They are now expanding services to cover the entire healthcare experience. Regardless of whether a patient is being treated in the hospital or by an affiliated physician network, providers are helping patients understand their insurance benefits, reviewing statements at the time of billing, determining patient responsibility, and providing high-touch services to patients who have ongoing care. Revenue cycle staff are not just collecting money, they are educating and supporting patients so the financial side of health care is less burdensome.

**How do you see your approach changing in the future?**

**Ramirez:** Our patient financial advocacy program was developed for our cancer center services about five years ago. As Lakeland has integrated with other local healthcare entities, we have rolled out the advocacy program in those areas as well. We also are targeting other specialty services and continue to fine-tune our advocacy model as we upgrade technology and consolidate physician practice and hospital operations.

**Blair:** People are looking for healthcare services to be more convenient and responsive to them as individuals. Patients are realizing they are consumers, they have choices, and the complexity of the healthcare world doesn’t have to be their problem anymore. As healthcare organizations grow, they will need to build brand loyalty among patients and recognize how the financial part of health services supports a great consumer experience.

**Breuer:** I agree. To sustain our organization, we need to continue to increase volumes and hold on to market share. Our hope is that if we improve the patient experience, we will perform better than our competitors and draw more outpatient as well as inpatient volume. Although advertising and physician practice acquisition are ways to increase volume, an elevated patient experience will keep patients coming back.

**Kittell:** A specific issue for us, and for other providers in California, is managed care contracting. Ninety percent of our insurance business is managed care, and these contracts are complex and difficult to adjudicate, not only on the payer side but in terms of explaining things to patients, such as case rates, carve outs, and percent of charges on implants. We are in the preliminary stages of exploring whether we can create more streamlined or easier-to-understand managed care contracts.

**How will having a more service-oriented revenue cycle better prepare organizations for value-based care and other emerging payment models?**

**Breuer:** In the near term, as patients’ out-of-pocket expenses increase, we are getting more requests to help them understand their responsibility. Plus, we recognize the need to do more to educate patients so we can better manage self-pay balances and bad debt. As patients make more decisions based on value and quality, the nature of our financial services will become a factor in building loyalty. It’s important for us to do all we can to bring patients to our institutions for health care and keep them satisfied, not only on the clinical side but throughout financial interactions as well.

**Blair:** Providers want to keep patients in network and make sure they feel good about the organization. High-touch, supportive revenue cycle services will be critical in driving that. Patient-focused financial services also will grow in importance because of the complexity of bundled payments and value-based care. Patients will want someone to sort through all the added layers of complexity so they are not left to determine on their own what they do or do not owe.

**Ramirez:** Providing value to our customers is critical regardless of payment model. As models change, customers are shopping more than they were before, so value becomes more critical. Understanding what customers want and consistently exceeding those expectations will be key to survival in a value-based payment environment.

**Do you measure the patient financial experience? What key performance indicators (KPIs) do you monitor? How and with whom do you share the information?**

**Breuer:** We look at a variety of things. For example, we use Press Ganey surveys to measure aspects of service delivery, such as wait times. In addition, we regularly track our ability to collect patient balances and how well our patient access areas function. The CFOs of all our hospitals evaluate revenue cycle operations across the healthcare system on a monthly basis, and the CEO, CFO, and COO of the entire health system review metrics quarterly.
Kittell: On the clinical side, we are very good at measuring performance. However, we are not as strong as we would like to be on the financial side. At the moment, we are tracking and trending issues that precipitate a phone call to our customer service department to identify ways we can improve. For instance, the California Corporate Practice of Medicine Doctrine precludes a hospital from billing for physicians. As a result, a surgical episode of care can generate a bill from the hospital, as well as bills from the surgeon, anesthesiologist, pathologist, radiologist, and any other consultants. When we found that many patients were not able to get information from various physician practices about their bills, we arranged to have patients’ calls transferred directly from us to the physicians’ billing departments, and we waited on the line until someone picked up the call and took care of the issue.

On the whole, however, we are trying to find more specific KPIs for measuring performance. Although we review days in accounts receivable and cash collections, those metrics do not reflect the patient experience.

Blair: Revenue cycle leaders struggle when trying to measure the effectiveness of initiatives related to the patient experience because it is hard to isolate the effect of any one program or change on the ability to collect balances. Patient satisfaction surveys include questions about the billing process, and those answers may be useful as a baseline for measuring progress after creating new patient experience initiatives. Organizations also can consider analyzing patients who have the propensity to pay but are not paying their healthcare bills. By comparing the amounts collected after instituting a high-touch, education-focused patient advocacy service against those that were achieved with the normal collection process, a provider may be able to determine the real impact of new strategies on these kinds of patients. Providers also may benefit by measuring net promoter scores, which highlight whether a patient will recommend a healthcare service and an organization to others. Regardless of the methods chosen, providers should keep in mind that the metrics and the data are not perfect, but that should not impede moving forward with initiatives.

Kittell: I agree that patients want to engage online to find information about pricing, handle scheduling, update demographics, and manage their bills. From that perspective, we are looking at technologies that are used in industries such as retail, banking, and other businesses that interact with customers every day. Our online billing offering is not as robust as we would like. We are working with our electronic medical record (EMR) vendor to get a portal that lets patients take care of their accounts without picking up a phone and waiting for a customer service representative to help.

Blair: We have been looking to the travel industry to find ways of enhancing our patient portal and online support services. When booking hotels, flights, and rental cars, consumers are used to self-service capabilities 24/7 through their smartphones and tablets. We want to make it possible for patients to routinely handle their physician and hospital scheduling and healthcare bills in this way as well. We are making patient statements available electronically and increasing functionality so patients can manage their accounts and payment plans on various devices. Our patient portal allows access to account balances 24/7 and bill payment from any Internet access point. This eliminates paper billing and simplifies payment by providing flexible payment options.

Blair: In addition to oral communications, many providers are concentrating their efforts on written statements. They are moving toward a common patient statement that combines physician and hospital bills, uses layman’s terms, defines jargon, and differentiates what an insurer is paying from what the patient owes.
Breuer: HFMA has done considerable work in this area, including developing a formal adopter program that recognizes organizations that embrace key patient-focused communication strategies, such as patient-friendly billing, providing cost estimates, standardizing communication, and so on. Organizations may want to consider getting involved in this program as a further step in refining the patient experience.

For organizations just starting down this path, what steps would you suggest for retooling the patient financial experience?

Ramirez: It’s important to assess and address your organization’s particular needs. For example, the majority of our patients pay with the first statement; we have less than 2 percent uncollected. The debate for me is whether we should implement point-of-service collection or just let the patient pay through the statement collection process. Our community has come to expect paying for hospital services after insurance. To turn that around and start asking for payment at the time of service may foster a negative reaction. Patients may think, ‘You trusted me in the past. Now you don’t trust me today?’

Once you assess your needs, you should figure out actions you can take right off the bat that will boost the patient experience. For example, our EMR already has a module for estimating patient payments. We can implement that; we don’t have to reinvent the wheel.

No matter what needs you identify, you should obtain endorsement or approval from top leaders and then assemble a group of stakeholder representatives. This step will ensure that your plan or approach incorporates your organization’s culture and allocates enough resources to implement programs correctly.

Kittel: I would recommend identifying and monitoring communication in all patient touch points that are part of the revenue cycle—registration, cashiering, and customer service, for example—and anyone who interacts with a patient directly or online to make sure you are doing the best you can in terms of communicating and resolving problems. Be sure to evaluate technological capabilities as well as staff skill levels. Managing the revenue cycle and the patient experience is about managing people and processes. If your system capabilities are not robust enough to meet patients’ needs, you should think about retooling your computer systems to better reflect what patients are looking for. Finally, I would work on the KPI piece of the puzzle. I know our organization is trying very hard to find and establish key performance metrics that will monitor and measure what and how we’re doing so we can keep on track.

Blair: There is value in segmenting your entire patient population into specific financial pathways, similar to clinical pathways in the care setting. Clearly segmenting patients and driving them through a different revenue cycle process that supports their needs is a way to provide a better patient experience in the revenue cycle.

Breuer: Don’t forget to use information from focus groups with employees as well as patients to pinpoint gaps in your programs and activities. Employees are also consumers and can offer valuable insights.

Overall, organizations must take a comprehensive view of the patient experience, set a long-range strategy, and determine the short-term changes that show progress. Moreover, by getting buy-in and organizational commitment for improvements in infrastructure as well as processes, organizations can ensure that all stakeholders are committed to enhancing and elevating the patient encounter.