Volume 1 Number 1 2016 ISSN 2397-1053

MANAGEMENT IN HEALTHCARE

A PEER-REVIEWED JOURNAL

Henry Stewart Publications
Russell House, 28/30 Little Russell Street,
London, WC1A 2HN, UK
Tel: +44 (0)20 7092 3469; Fax: +44 (0)20 7404 2081
Website: www.henrystewartpublications.com

Henry Stewart Publications
North American Business Office
PO Box 361
Birmingham, AL 35201-0361, USA
Tel: 800 633 4931; Fax: 205 995 1588
e-mail: hsp@subscriptionoffice.com

© Henry Stewart Publications 2016
All Rights Reserved
ISSN 2397-1053

No part of this publication may be reproduced or transmitted in any form or by any means, including photocopy and recording, without the written permission of the publishers. Such written permission must also be obtained before any part of this publication is stored in a retrieval system of any nature.

Printed in Great Britain by Latimer Trend and Company Ltd, Plymouth, UK

Creating a culture of accountability in patient access

Received: 17th December, 2015

Patti Consolver
is a Senior Director of Patient Access Services for Texas Health Resources in Arlington, Texas. She has been with Texas Health Resources for over 23 years and has extensive background knowledge of patient access services and front end revenue services. She has served on the National Association of Hospital Access Managers (NAHAM) Board of Directors in various roles, including President and is currently a Southwest Delegate. She is also an active member of HFMA and AAHAM. Patti has been published in numerous healthcare journals and trade publications in regards to her insight in front end revenue cycle management.

Strategic Revenue Services, Texas Health Resources, USA
E-mail: PatriciaConsolver@texashealth.org

Scott Phillips
is a Senior Director of Patient Access with Texas Health Resources in Arlington, Texas and has been with THR for 15 years. Scott previously served as Director over Patient Access Services at Texas Health Presbyterian Hospital of Dallas, an 866-bed acute care facility. He is also an active member of HFMA, NAHAM, and HPAM, and currently serves on the Board of Directors for North Texas Association of Access Managers (NORTEX).

Strategic Revenue Services, Texas Health Resources, USA
E-mail: scottphillips@texashealth.org

Abstract Texas Health Resources (THR), a 14-hospital system in north central Texas, has taken steps over a number of years to standardize best practices and improve outcomes across its Patient Access organization. To support this effort, revenue cycle leaders implemented a process to capture patient encounters for monitoring against the system's strategic objectives for patient experience, financial performance, quality and compliance. Each encounter is captured and tied to the patient account for a digital audit trail of information exchanged across the continuum. A central point of access facilitates secure sharing of data, reducing rework and back-and-forth between entities in search of patient information. In this article, system directors of Patient Access will share how THR is documenting the revenue cycle experience from the initial scheduling call to the in-person visit at admission. Readers will consider a process to combine voice data with fax and electronic records for a comprehensive view of the patient's path from pre-service to registration and beyond. The article will share strategies for establishing accountability by monitoring and scoring patient encounters against key measures, tracking individual and team performance across the revenue cycle. Readers will take away tools and metrics needed to support the process, as well as evaluate outcomes achieved in patient experience, compliance and financial performance.

KEYWORDS: patient experience, revenue cycle, patient access, scheduling, registration, upfront collections

THE CHANGING LANDSCAPE OF PATIENT ACCESS OPERATIONS

As payment liability in the US shifts more towards self-pay, patients are paying more attention to both the cost and the quality of their care. Now shouldering an increased share of their medical bills, patients often shop around for health services and compare price and quality of experience prior to scheduling services.

Forward-thinking health systems are engaging in this effort as they encourage patients to take greater responsibility for their health and health dollars. By sharing information upfront about the cost of services and the role the patient's insurance will play, health systems serve as advocates to help patients make informed decisions about their care and finances.

Patient Access Operations plays a critical role in this effort. Often referred to as the hospital's 'gatekeepers', Patient Access associates engage with every patient who walks through the hospital doors. They help patients find coverage for care and afford the healthcare services they need; they advise patients about their insurance benefits and manage authorizations for reimbursement of the services provided by clinical associates; and they help ensure the continued financial viability of the organization by collecting patient financial obligations upfront.

Patient Access associates serve not just as data collectors but as educators to help newly insured patients understand how their benefits work, what part of their bill will be covered by insurance and how much they will owe out of pocket afterwards. Staff must explain often complex information — such as co-payments, coinsurance and out-of-pocket expenses — in a manner that is clear, thorough and compassionate.

To guide health systems in building their Patient Access programs, industry organizations have released standards by which to measure revenue cycle performance. In 2013, the Healthcare Financial Management Association (HFMA) released its best practices for patient financial communications, a toolkit to help facilities educate patients about their financial responsibilities. The online training program guides patient access professionals in how to effectively communicate with patients about financial matters, with respect and in ways that enhance patient satisfaction.

The National Association of Healthcare Access Managers (NAHAM) also released a set of Patient Access Keys to help health systems track performance in the following areas: Collections, Conversions, Patient Experience, Process Failures, Productivity and Quality. These keys provide a series of standardized equations hospitals can use to enter their data and compare to other hospitals of a similar size.

Tracking performance across these measures and implementing best practices for patient financial communications have great potential to improve both financial performance and patient experience for health systems. Outcomes can be recognized in higher patient satisfaction scores, increased collections, overturned denials and improved operational efficiency.

A CASE STUDY: IMPROVING THE REVENUE CYCLE EXPERIENCE AT TEXAS HEALTH RESOURCES

Texas Health Resources (THR), a 14-hospital system in North Central Texas, has taken steps over a number of years to standardize best practices and improve outcomes across its Patient Access organization. As a large health system, THR's process is designed to ensure consistency and efficiency throughout the continuum — across all departments and entities.

An important step to set the stage for later improvements was the opening of THR's Patient Access Intake Center (PAIC) in 2007. Through the PAIC, THR merged its scheduling, pre-registration and insurance verification functions into one centralized process. When a patient calls for a service, he

or she is scheduled and transferred directly to the PAIC for pre-registration and insurance verification. By consolidating these activities, THR reduced the number of calls required to pre-register the patient while collecting more of the information needed to complete the registration.

THR continues to work towards centralization, taking its first step towards enterprise scheduling with the centralization of radiology scheduling in early 2015. The system's revenue cycle now consists of 30 enterprise scheduling staff members, 40 pre-registration staff members, 45 insurance verification staff members and more than 570 entity registration staff (Figure 1).

With this number of employees across the revenue cycle, THR has made a priority to set a clear vision and provide tools needed to meet organizational objectives. As a system, THR has set patient experience as a driver of daily business for all hospital functions — both clinical and administrative. For Patient Access, this means caring for the patient in every aspect of the hospital encounter, from the initial scheduling phone call to the point of admission and beyond.

This has required a mental shift for departmental leaders, who have been accustomed to being measured on traditional metrics such as collections, data quality and duplicate medical records. While collecting data elements, processing insurance and collecting co-payments remain key indicators for the entities, they are now just part of the Patient Access job description. The ability to communicate with and care for patients are now primary areas of focus and measures by which all associates are held accountable.

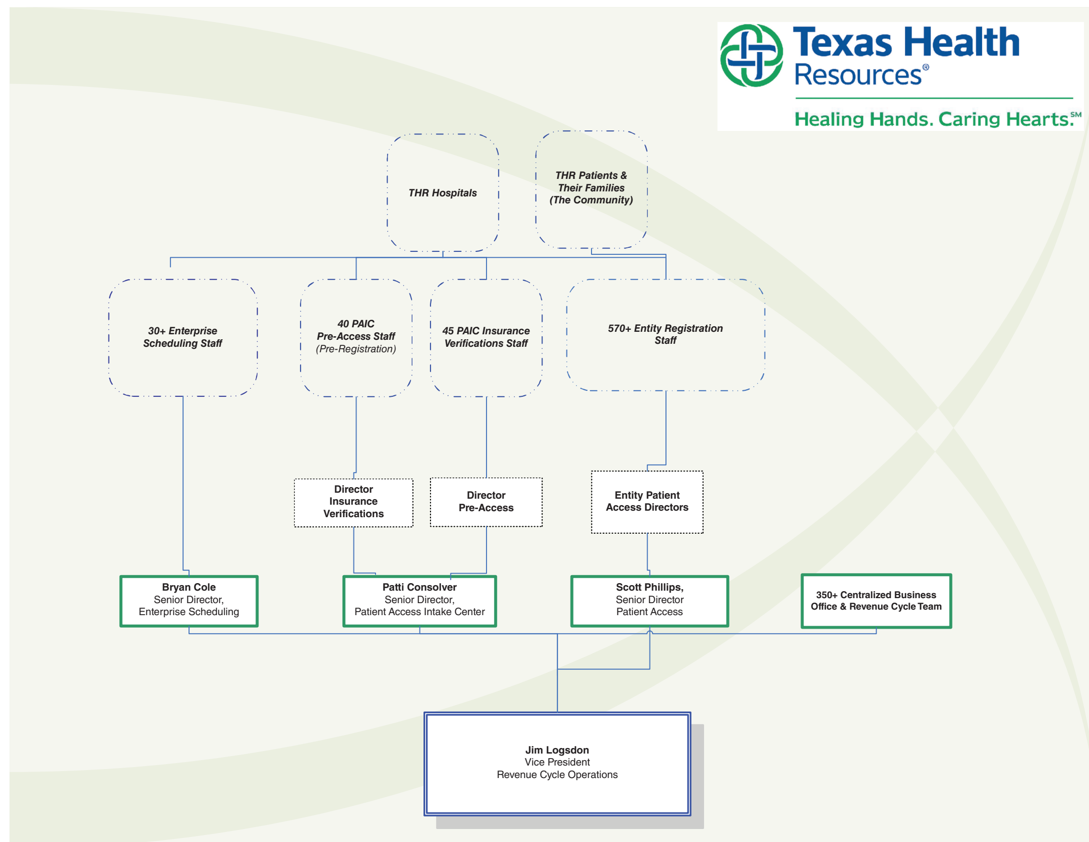

Figure 1: THR's revenue cycle structure

As patient experience is out of the comfort zone for some associates, it has required a shared focus to move the needle on these scores. A process was needed to standardize the system's patient experience strategy across the enterprise, measuring qualitative factors that often impact patient satisfaction. THR's approach was to create a culture of accountability across the revenue cycle and standardize best practices among its teams.

CREATING A CULTURE OF ACCOUNTABILITY IN THE REVENUE CYCLE

As one of the nation's largest faith-based non-profit health systems, THR serves 16 counties in the Dallas-Fort Worth area, home to more than 6.2 million people. The system employs more than 20,500 people in 24 acute care and short-stay facilities. Facilities are scattered across the metro area, with nearly a two-hour drive in between in some cases.

When THR initiated its patient experience focus, leadership instituted three transformational themes to drive the change. They were Centralize, Standardize and Remove Variation. In each step, entities were encouraged to report and communicate metrics. The system tied these metrics to key performance indicators, using leading and lagging outcomes to drive performance.

In the revenue cycle, entities collaborate through regular meetings to review entity outcomes, share operational concerns and foster communication among process owners. Leaders are encouraged to reach out to the team when working through issues or when troubleshooting concerns. By building accountability among revenue cycle leaders, entities can work together towards system goals, committing to and executing action items based on trends and outcomes.

The system's revenue cycle committee is led by the chief financial officer and meets on a quarterly basis, with metrics reported more frequently. The hospital revenue cycle committee is formed with a representative from each hospital and is led by the entity finance officers. This committee meets on a monthly basis to review denial write-off trends, point-of-service collections, quality, case management reviews and performance improvement opportunities.

The goals for these meetings are to achieve standardization, share best practices and implement technology to support system goals. While each hospital has different needs based on geography and patient mix, the system works together to make available solutions fit at each entity and for each process.

During meetings, the objective is to disseminate information that can then be rolled out at each hospital. Entities use data to enforce staff productivity and quality performance standards per the system's guidelines, and dialogue continues in meetings surrounding representative performance. In all initiatives, the objective is to make the role of patient access as transparent to the patient as possible.

In 2013, as part of a revenue cycle Lean initiative, leaders from across THR gathered to discuss strategies to improve the patient experience. Including all entity CFOs, patient access leaders, legal and compliance representatives, the group identified 17 pilot projects that had the potential to significantly improve patient satisfaction from a revenue cycle perspective.

Implemented over the past two years, these projects focused on efforts to improve the registration experience and included initiatives to reduce wait times, provide more written information to patients and more. Coined the 'Patient Delight Projects', THR planned to implement each project at one facility, test and monitor the impact and then roll out successful programs across the organization.

One of these projects involved recording patient encounters across the revenue cycle — from the initial scheduling call to the in-person check-in at registration. The system had existing technology in place to

record insurance verification calls made to payers when securing patient authorization. Recordings were indexed to the patient account and retrievable by any entity for use in overturning denials.

Through the pilot project, revenue cycle leaders recognized the opportunity to leverage the same technology to record interactions with patients, capturing information communicated at each touch point to ensure accuracy and consistency across the spectrum.

RECORDING THE REVENUE CYCLE EXPERIENCE

As a first step, THR began recording phone calls in the PAIC, capturing key elements of the pre-registration interview such as patient demographics, out-of-pocket estimates and directions to the facility. Soon after, THR initiated recording of scheduling calls so leaders could ensure that schedulers were capturing information necessary to generate CPT codes, authorization codes and procedure details. Each recording is indexed to the patient account and centrally stored for access enterprise-wide.

After seeing the benefit of capturing these initial patient encounters, THR began to explore the possibility of extending the recording process to include the in-person interview at the point of registration. Registrars were able to accomplish this by attaching small desktop microphones to their PCs, recording registration encounters and linking them to the patient account. This technology has now been added to mobile work stations in the emergency department for use during bedside registration as well.

By capturing each encounter and tying it to the patient account, THR has established a complete picture of the patient's revenue cycle experience. With this data, leaders can determine what information the patient has received at each touch point and identify any discrepancies or points of confusion. Recordings — along with faxes and electronic documents associated to the patient — combine to form a digital audit trail of the patient's pre-service experience across departments, from the initial encounter to the point of admission. Centralized access permits any authorized employee enterprise-wide to retrieve these records to clarify misunderstandings, provide training for staff or conduct service recovery as needed.

Recording verbal exchanges and integrating them into the patient record has given THR the ability to leverage voice data in a way not possible prior to this project. Voice data is now combined with fax and electronic records for a complete view of patient information exchanged across the continuum. With shared access to these records, THR can now reference recordings to support strategic initiatives including quality assurance, compliance, patient experience and financial performance.

A central point of access to these records has reduced rework and back-and-forth between departments in search of patient information. The process facilitates secure sharing of data, ensuring that PHI is protected in the process. Each record is date-and-time stamped, as well as user-stamped for a digital audit trail of access in compliance with HIPAA and THR security policies. THR also ensures payment card industry (PCI) compliance by preventing the recording of patient credit card information during payment.

REVIEWING PATIENT RECORDINGS: QUALITY ASSURANCE

By documenting each step of the revenue cycle, entity leaders are able to review recordings to ensure compliance with system objectives. While THR has put specific scripting in place, the recordings provide insight into how staff are interpreting the scripting and how it plays out in actual dialogue with payers, patients and physicians (Figure 2).

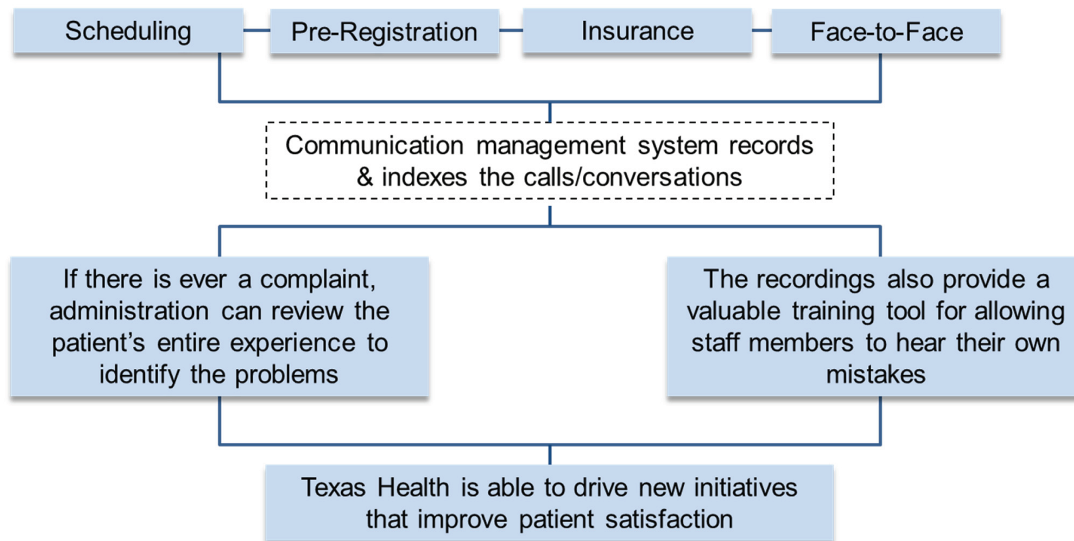

Figure 2: Communication management system – centralization

In scheduling, supervisors check to confirm that the patient's information has been documented correctly and that the scheduled service matches the order received from the physician. Recordings are also referenced to ensure that patients receive complete preparation instructions for their procedures, as well as facility directions and expectations for the day of service. In pre-registration, recordings are referenced to confirm accuracy of patient demographics, benefits and eligibility, as well as communication of self-pay estimates.

Communicating estimates remains a challenge for health systems as final bills sometimes vary from the estimates provided. While patients want to be informed upfront about costs, they may also be dissatisfied when final bills are higher than expected. In one in three cases at THR, doctors perform the same services included in the original order and price estimate. In those cases, estimates are 98 percent accurate. For the remaining two-thirds of patients, however, the final bill varies from the estimate by at least ten percent. For this reason, Patient Access staff are given scripting to emphasize that estimates may vary from the final bill should services change on the day of service.

In insurance verification, supervisors check to be sure staff have authorized the correct procedure, as well as authorized all procedures on the account. They also check to confirm that verifiers have requested appropriate benefits and the correct status for the patient.

In registration, leaders listen to see how staff are interacting with patients in patient financial conversations. How are they asking for payment? Are they getting patients through the process quickly? Leaders also reference conversations recorded during bedside registration in the emergency department, where there is often a different approach to collections than where patients come in for a scheduled case. By evaluating these conversations, leaders can adjust scripting and training to improve outcomes and patient experience.

VOICE OF THE CUSTOMER: INCORPORATING PATIENT PERCEPTION INTO REVENUE CYCLE STRATEGY

Recording revenue cycle encounters has provided great insight into the patient's

perception of the health system. For the first time, leaders are able to hear scripting from the patient's point of view and consider not only what a staff member may have said, but what the patient may have heard. Those are often two different things.

Supervisors conduct proactive monitoring of recordings, retrieving ten recordings per month from each employee and scoring key elements such as the employee's greeting, tone and adherence to scripted elements. Results are used in employee performance evaluations and in staff training sessions. Employees also conduct self-training by routinely listening to their own recordings to troubleshoot issues and determine alternate ways to handle difficult circumstances. By being more cognizant of how they sound when communicating with patients, staff can make adjustments to their scripting to improve patient perception and understanding.

Recordings are also referenced on an as-needed basis to address patient complaints and misunderstandings. If a patient is confused about a co-payment, for example, leaders use the recordings to determine whether the information the employee provided regarding the co-payment was unclear or poorly communicated.

The process of reviewing recordings provides depth for interactive discussions between managers and patient access staff. After listening to a discussion, a supervisor can offer, 'What if you had tried this approach instead?' It also gives high performers the opportunity to request supervisor input proactively by asking them to suggest a better way to handle a difficult circumstance. This is a much richer dialogue than one in which a supervisor reviews a printed report of an employee's numbers for collections, quality and the like.

Over time, staff have come to recognize the recordings as being as much of a back-up for their performance as a measure to improve it. Recordings are often shared in staff meetings as positive reinforcement for a job well done, or referenced to confirm that a staff member accurately communicated information when mistakenly called into question.

This process has also created a better understanding of the role Patient Access plays in the health system. Patient Access employees are able to listen to their own encounters and those from other areas to identify what happens both before and after in the patient's path through the health system. Schedulers can listen to interactions from the PAIC, for example, to understand what happens when they transfer a call to pre-registration. This helps them clarify their job responsibilities and the role they play in the process.

Recordings have also assisted with calibration and continuity of care between departments outside of the revenue cycle. Playing recorded encounters for clinical areas and for the health system's leadership helps clarify the functions of scheduling and pre-registration and what occurs during the registration process. Leaders also have the opportunity to consider what data should and should not be collected at the point of registration. While there are often suggestions for new data elements to be added, recordings reveal how each element impacts the flow of the registration discussion and what additional collection of data can add to the process.

IMPROVING ACCURACY AND REDUCING DUPLICATION IN THE REVENUE CYCLE

THR has used business intelligence gathered from recordings to address common issues and complaints that lead to patient dissatisfaction with the revenue cycle process. For example, one patient complaint was being asked for the same information — address, phone, number and demographics — multiple times during different encounters. Other issues were being told the wrong location for a procedure, given inaccurate preparation instructions for a procedure and

being told a different co-pay during different conversations. THR references recordings to identify these occurrences and take steps necessary to correct them.

An area of focus for THR was removing duplication between revenue cycle processes to reduce the time required to pre-register patients. Patient feedback indicated that long waits, redundant paperwork and delays due to missing information could combine to make registration a frustrating experience.

Reviewing patient recordings confirmed this for revenue cycle leaders. A review of recordings from a mammography registration, for example, revealed that a patient spent 17 minutes on the phone with various hospital departments before ever reaching the facility for service. Although her information was already in the system, the patient was asked for her name, address, social security number and date of birth during each encounter. Listening to the recordings in sequence helped leaders identify duplicative steps that were adding time to the scheduling process and causing frustration for patients.

While THR is working to avoid repeat requests for information already collected, THR does encourage staff to gather as much information as possible during the pre-registration process to facilitate a faster check-in for patients on the day of service. The goal is that hospitals will have all the information they need by the day of service so that the patient can arrive and move straight through registration without any additional paperwork.

To support this effort, THR has implemented a pilot program in which a 'fast pass' enables patients to move to the front of the line when they arrive at the hospital if all of their information has been collected. Through this project, THR seeks to create a better experience for the patient on the day of service, making the day more about care and healing and less about paperwork.

MEASURING PATIENT SATISFACTION IN REGISTRATION

THR uses Press Ganey to administer its patient satisfaction and HCAHPS surveys. The survey includes five questions related to the patient's registration experience and provides scores for the following areas: Outpatient Registration, Inpatient Admission, Emergency Personal/Insurance Info and Ambulatory Surgery Registration. THR is able to view scores in real time and review written comments from patients.

If a hospital receives a survey with a score of 3 or below, supervisors immediately retrieve recordings from that patient's visit and forward them to hospital leaders for evaluation. Hospitals do the same with employee scores, correlating low scoring surveys to individual recordings for root cause analysis.

By connecting its survey scores to patient recordings, THR can listen to exactly what happened during the encounter for greater insight than reading survey comments might provide. Managers also follow up with all patients who provided a '1' or '2' response to attempt service recovery or to better explain a policy or decision. Through this exercise, leaders are able to identify the root of the issue, helping to identify risk and training opportunities with staff.

Recordings provide insight, not just into whether something did or did not happen, but into the patient's perception of the condition. And more importantly, they offer the opportunity to drive change and monitor and measure its impact. If there is a complaint, managers encourage staff to go back and listen to the encounter. While giving staff the benefit of a doubt, they ask staff to identify opportunities to improve.

STANDARDIZING BEST PRACTICES AND DRIVING PERFORMANCE IMPROVEMENT

While incentives in registration have traditionally been tied to quality or productivity

or cash collections, THR is now evaluating a model to tie employee incentives in registration to patient satisfaction through Press Ganey scores. In this model, employees earn incentives on a sliding scale based on performance for the five questions pertaining to the registration process. Without reaching a specific percentile, they do not earn the incentive.

The thought behind this model is that incentives should be tied to patient satisfaction rather than to quality, which is a metric that should now be assumed in registration. Measuring and monitoring these activities will help drive the registration focus on patient experience, improving service levels as the industry becomes increasingly sensitive to the needs of the patient.

To assist in driving performance and increasing transparency, THR has implemented a Patient Access indicator report that creates consistent metrics and goals across the system. The comprehensive front-end revenue cycle performance dashboard includes 74 metrics and incorporates performance keys and best practices from industry organizations such as HFMA and NAHAM.

A quality scoring module helps leaders score patient interactions against these metrics. With this tool, supervisors randomly select recordings from each employee and generate online scorecards that track quality performance over time. The online scorecards help quantify qualitative factors such as tone and empathy, and provide an objective measure to compare and establish a performance trend over time. Supervisors score factors they cannot see in the notes, such as, 'What is our attitude? Are we listening? Are we taking ownership?' If new scripting is needed, leaders initiate the change at one facility, measure its impact and then standardize the change among the remaining facilities.

This initiative helps supervisors quickly identify outliers, mine data and address training needs. Reports track performance by associate, team and department — both at the hospital and system levels. A snapshot of team data is reported back to employees and to leadership on a monthly basis. During the audit process, agents are able to see their individual performance trend and where it stands in comparison to the rest of the team.

ANALYZING RESULTS: PROCESS IMPACT AND RETURN ON INVESTMENT

Documentation of revenue cycle encounters has given THR valuable data to improve both financial performance and patient experience. In 2015 alone, the system has leveraged documentation of insurance authorization to overturn $2.5 million in denials.

Ultimately, the process has allowed THR to maintain its existing goals for data accuracy and collections, while significantly improving patient satisfaction in the process. For Press Ganey's registration section, THR raised scores from the 40th percentile in the first quarter of 2012 to the 86th percentile by the third quarter of 2015. THR accomplished these improvements while increasing point-of-service collections by approximately $7 million over the same time period.

Through this project, THR has achieved a complete view of the patient's revenue cycle experience from pre-service to registration and beyond. Capturing the entire encounter — from the initial scheduling call to the in-person visit at admission — provides valuable business intelligence to track hospital performance against the system's strategic objectives for patient experience, financial performance, quality and compliance. By providing focused, individualized training for staff, the system is able to standardize patient financial communication best practices among revenue cycle teams. As a result, THR has maintained its goals for data accuracy and collections, while significantly improving patient satisfaction in the process.