CommerceHealthcare Health Leaders Webinar

Alexandra Pecci

Good morning and welcome to the Health Leaders Revenue Cycle Now online summit. My name is Alex Pecci and I'm the revenue cycle editor for Health Leaders. Over the next several hours, we'll be bringing you thoughtful, insightful and engaging content that will explore key areas that will be critical for the current and future success of your organization. Before we get into our opening keynote session, I want to give a special thanks to our platinum sponsor, CommerceHealthcare and our gold sponsor Acuity for making this event possible. Finally, a thank you to all of our Health Leaders community for registering and participating.

Alexandra Pecci

Kicking off our event this morning is our opening panel session sponsored by our platinum sponsor CommerceHealthcare, titled "Breaking Down Barriers: Payment Strategies to Enhance Overall Patient Experience." Before we get started, I have a few housekeeping details. Our program this morning will be 60 minutes in length. Note that an on-demand version of this program will be available approximately one day after the completion of the event and can be accessed using the same login link that you used for the live program. To ensure that you can see all the content for the event, please maximize your event window and be sure to adjust your computer volume settings and or PC speakers for optimal sound quality. Next, you'll find a resources list for today's webinar in the upper right of your screen.

Alexandra Pecci

Here we have listed resources for you to interact with. At the bottom of your console are multiple widgets you can use. To submit a question, click on the Q&A widget. It may be open already and appear on the left side of your screen. You may submit questions at any time during the presentation. However, please note that it's likely your question won't be answered until the Q&A portion of the program. Finally, should you have any technical difficulties during today's program and need assistance, please click on the Help widget, which has a question mark icon and covers common technical issues. This time, it's my pleasure to introduce our panelists, we have Mary Wickersham, vice president of patient financial services at Avera Health. Sarah Hartwig, patient access officer at Avera Health. Lisa Schillaci, vice president of revenue cycle operations for Houston Methodist and Ward Svavari, MBA, vice president, national health care executive for CommerceHealthcare. Thank you all for joining this morning.

Alexandra Pecci

And with that, let's get into our discussion. So first question, how has the patient financial experience at your health system changed over the past five years? And Lisa, why don't we start with you?

Lisa Schillaci

Sure. Good morning. Hi everyone, I'm Lisa Schillaci. I work at Houston Methodist and just a little bit about Houston Methodist is we're a eight hospital system where we're strategically located in Houston and our, just our surrounding counties. And just for scope and size, our net patient collections on an annual basis this year are going to be about $4.3 billion. Just to give you guys some scope and size at Houston Methodist. But how is our patient financial experience changed in the past five years? We want to ensure that patients have access to health care and let finance not be a barrier. Let access not be a barrier. So what we've done in the last five years is we've invested in technology. We went live on a new EHR in 2016. We have a culture of innovation where we're constantly looking for the better and the best technology to help, to help ease the friction for patients to access care.

Lisa Schillaci

And we've created a culture of innovation. We're not afraid to fail. We fail. We want to fail fast. It's really all about the patient journey. We've created a culture of everything is really centered around the patient. So I know those are a lot of words, and we'll probably talk in a little bit about what we're encountering are some barriers to what we really want to have happen. So I would say over the last five years, it's been investment in technology, investment in innovation and really creating a culture where the, where the patient is the center.

Alexandra Pecci

Thank you, Mary, would you like to weigh in?

Mary Wickersham

Good morning, I'm Mary Wickersham. I'm from Avera Health along with Sarah Hartwig and just a little bit about Avera. We are a hospital health system that also has clinics, long term care, Avera Home, which is our home care hospice service lines. We are, our footprint is in South Dakota, Iowa, Nebraska and Minnesota. And so we have anywhere from a large flagship hospital, 545 beds down to our smaller 25 bed or less critical access hospital. So a really good variety here to there, which makes it kind of unique and challenging to make sure that in large communities as well as small communities, you have a good PFX, patient financial experience. From a PFX perspective., we've started our huge project to really revamp the patient experience online, as well as the use of a single statement. And so patients want Amazon, right? They want ease of ability to pay. And so we're in the process of completely revamping our online presence, as well as the look and the feel of our statements so patients can easily pay online, easily apply for charity care, sign up for payment plans, get e-statements, really have a better digital doorstep for our patients. Over the last five years, we've continued to look at options for patients and how they can pay us. You know, requiring a patient to pay a $5,000 bill down in six months just isn't feasible, right? So we've adjusted to using bank loan programs, different discount programs just to be able to make the patient have an easier way to pay us.

Alexandra Pecci
Thank you, and Sarah, I want to talk about this question from patient access point of view.

Sarah Hartwig
Sure, I think just to add to that, what we've seen for changes is really more often patients have a higher out of pocket, right? So with benefits changing for patient access, it really is bridging that knowledge and understanding for patients. So trying to address patient education and that financial acumen, but also bridging that with our care teams, we really see access as an extension of the care team. So making sure that those conversations are very much in line with what's happening behind the door with providers and trying to keep that consistent for that patient experience. And that really means financial wellness as a part of the conversation up front. So really trying to get those conversations much more up front in those pre-services, pre-arrival arrangements and trying to normalize that concept. It's a lot of translation of ever changing benefits. So that's where much of the change for us in patient access is taking place, along with those changes Mary outlined.

Alexandra Pecci
And Ward, do you want to kind of weigh in on what you're seeing from a bigger, broader perspective?

Ward Svavari
Sure. Thanks, Alex, and thank you, everyone for taking the time to join the panel today. So briefly, I'm Ward Svavari, national health care executive with CommerceHealthcare. CommerceHealthcare's a specialty division part of Commerce Bank that's focused primarily on health care around the payments and really focusing on bringing health care expertize both in finance revenue cycle supply chain to help with the disbursements and the receivables, or anywhere where there's a financial transaction that happens. We really strive to be kind of that preeminent premiere payments bank within health care. But from my standpoint, I've spent a number of years in the consulting area in revenue cycle, and I'd say over the last five years very much what Lisa, Mary and Sarah already hit on. I think there's a number of things. One of the things that the health care industry has been focused on was, you know, access to care, so that actual physical access with a lot of the facilities and moving out of the spoken hub.

Ward Svavari
But along with that and the rising costs with the advent and the adoption of high deductible health plans, it's really that financial access to care, right? And so that's where we've been able to help a lot of provider organizations provide other, more financial sustainable means to take care. Right? So not only do you need to get the care, but how can you better afford the care that's needed? Because we all know there's been lots of studies that show that people are putting off care just due to the costs, and that's not good for the patients or the provider because we're now seeing sicker patients and then the costs are higher not only for the patients, but for the health systems as well. So as much as providers, payers

and other vendors that serve the health care industry can find more efficient, more economical ways for the patients to afford the care that they need will be better for everyone within the ecosystem.

Alexandra Pecci

So now let's dig in a little bit deeper and talk about some of the elements of the patient financial experience that you're really proud of, that you've put into place. Mary, would you like to start?

Mary Wickersham

Sure. I've got two things to share in that space. One is our patient advocate program that we have on our acute side. We do it all in house with various staff, and these folks are meeting with our uninsured patients that are either inpatient or high dollar outpatient to really figure out what are they eligible for. Can we get them on some sort of payer source? Can we help them fill out a charity care application? And they really go above and beyond to make sure that that patient has someone kind of holding their hand through their journey. And so that's been very successful for us to be able to have those advocates in-house. From a collection standpoint, we also do all of our own self-pay collections in-house, and for some of our smaller communities, that's been very effective because people want to know who they're talking to. Not to say that outsourcing is a bad thing. I think there's a lot of value in outsourcing, but for us, we've been able to keep our costs low, hire our own staff and really give the patients a Avera experience when it comes to collections and not have them feel like we're handing them off to another vendor to figure out how to manage their bills.

Alexandra Pecci

And Sarah?

Sarah Hartwig

Along those lines, again on the front end, what I can speak to is again organizing teams up front, so having a pre-arrival team focused on readying the patient for care. So it is having that financial conversation explaining benefits when there is situations such as short term insurance or a higher out of pocket, making sure that they're ready and expect that. That goes with estimates, as well as having those difficult conversations and giving them their options. So in line again with what Mary's talking about. And again, making sure that we're normalizing a financial conversation. A lot of times we avoid that. It's easier to avoid and and skip over that piece, but really trying to lean into those conversations with patients so they feel ready and they also feel engaged with the whole experience.

Alexandra Pecci

And Lisa?

Lisa Schillaci

Ah, well, they kind of halfway stole my thunder, but I want to add add a little bit more to it. We, over the last couple of years, we have greatly expanded our financial assistance from a policy perspective and also an execution. We wanted to also create a better, seamless, frictionless process for applying for financial assistance. And what we found is is we were swimming in applications and we really weren't doing the patient a service by delaying a response to them, you know, 20, 30-some days. So we fully automated our financial assistance process. We basically do presumptive charity for all of our self-pay patients where we use a paid subscription electronic scoring mechanism. We do not want money to be a barrier to care. Most recently, one thing that we're super proud of is for balance after insurance, you know, for those high deductibles or, you know, a deductible co-insurance, we were really putting the patients to the mat and asking them to complete a full application with documents. And we said, hey, what are we really, what are we really trying to do here? If there is a need, let's go ahead and use our electronic scoring. So we just switched for balance after insurance to also use the electronic scoring method to try to ease the patient from having to provide all those documents and delay getting a response back to the patient. Now, of course, this is all in our policy, and so we're super proud of that. On a gross basis, we will do over a million dollars in charity in 2021. We've actually already exceeded a million dollars, now mind you, that's gross.

Lisa Schillaci

And then I also want to share back to what Sarah and Mary were saying. In 2020, we engaged in a full blown redesign of our patient collection, starting from vendor to insourcing. Mary, I love that we're going back to insourcing. I appreciate what you said. Other vendors can't do what we do. There are patients and it all needs to be... What I found that what we were doing is, is we were doing cookie cutter and we were doing random acts of collections. Nothing was coordinated. So with the with the vendor that we used to help us with not only just our statement redesign, but we we used their technology, we use their scoring, we use their infrastructure to be able to create a tailored collection event to the patient that drives off of their ballots, the age of the account, how they want to be communicated with via paper or electronic, phone, etc. and also their financial ability. We are really relying on the vendor to supply all of that knowledge, all of that technology to coordinate the collection event for the life of the balance with that patient. So there's no random collections, there's no random letters going out. We use all of their intelligence from a perspective of outbound IVR, inbound IVR. So with that said, we endeavored into this redesign and we'll share with you. It took a year for us to go live. We went live in early 2021, January of 2021 and we are... In addition to that, they've covered the cost with all of the expenses that we save from all the various individual vendors that we were utilizing. We actually reduced cost by about $250,000. And from a net cash, patient cash collections pick up, we'll expect a $3.4 million increase just on patient collections this year. We had to... For an innovative project, we had to calculate the return on investment for this project alone, and it was, it was heavily scrutinized.

Lisa Schillaci

So those just aren't PowerPoint savings. And those aren't just fluffy numbers. Those were quantitative analysis on the increase in cash collections. Moreover, I want to share my final point on this. We're so proud of it. I could talk about it forever is we're now starting to see a reduction in some of the phone

calls that we were getting prior to going live. With this new with this new strategy, we're seeing reduction in phone calls for people wanting to set up a monthly payment plan because that's part of the strategy. And that's part of the electronics and technology that's provided. We're seeing reduction in phone calls: "What is this balance for? I made a payment. Where did you apply my payment?" Some of the, I guess, some of the basic blocking and tackling as it relates to billing and collections on the patient side. We're starting to see a reduction in those phone calls. So I'll stop my remarks there. And if you guys have any questions about that, I think we'll have some question and answers later.

Alexandra Pecci

Absolutely. Ward, I saw you agreeing with all of our speakers. Anything you'd like to add before we move on?

Ward Svavari

No, I think what Sarah and Mary are doing in Avera and certainly what Lisa has been doing at Houston Methodist has echoed kind of what we've seen with our with our partners across the country and the one thing we obviously don't have ourselves at CommerceHealthcare, the patient financial experience, but I've partnered a lot with some of our other organizations and they've done much like what Sarah did, where we've helped them kind of reconstruct and redesign that front end process, right? It's really about educating the patient on what their options are when they, you know, whether it's to seek coverage and then to seek charity. And then finally, what is the financial options for them to pay their patient liability or their patient obligation? And I think the one thing that that I'm kind of proud of what we've done at CommerceHealthcare is that over the last six years, we've been able to provide over $1 billion in patient financing for that third category if coverage wasn't going to cover all the options and then charity wasn't.

Ward Svavari

But one thing that we've been able to do that I'd like to highlight for everyone is that being a bank, we have a lot of payment data for loans and everything. And what we've been able to find is that if you can keep the payment under $200, if you start thinking of the psychology of payments that our patients have to deal with, mortgage number one, you know, utilities, car payments, medical bills tend to fall down to that bottom of that list, around eighth on priority. But what we found is that if you can keep a patient's payment under $200, the ones that want to pay their bill will make that payment, right? So working with our partners to find out a combination strategy of what do they want to do: in house payments and leverage their own balance sheet or leverage a banking partner or a financing partner that has further extended options? You know, if you look at just 24 months and keeping that $200, some of our patient bills that are there are greater than $4,800 or $5,000, what are the options for that segment of your patient population? So we've been able to greatly increase the financial access for some of those particular patients and our partners.

Alexandra Pecci

Thank you. So Sarah, let's start with you with this question. Where are some areas of the patient financial experience that you think still need improvement?

Sarah Hartwig

I mean, I think we're in a constantly changing environment that won't go away. So when we talk about change and readying both patients as well as our internal teams, that's one area we need to continually address. We are growing quickly. Many organizations are to try to meet the changing demands of our patients and our communities. So an area for continued improvement is keeping our finger on the pulse of that growth and maintaining some level of revenue integrity. Knowing what we're going to provide with changing services, how does that align with our pre-services? What can patients expect as they try to segue into care because we want to get that growth up and running as quickly as possible. So keeping our teams at the table for those conversations is an area of continued focus. Also that continued communication with their care teams. Again, I already said the patient access is really an extension of the care team. We're really trying to bridge that patient experience from financial to that, that place of care. So how are we keeping communication clean and clear? And also the care teams drive the next step, right? So making sure that we have continued collaboration so we know what the patient's next steps in care are, so we can help to ready for that and get them prepared, get prior authorizations in place.

Sarah Hartwig

And that kind of leads to my final piece. Prior authorization is complex and it's continuing to be complex. And so for those patients who do have coverage, there's still additional steps when we have to go through that prior authorization process. We we need to rally around supporting unification of those processes among our payers and make sure we have some consistency there because without that consistency, it remains manual. We we have the need to continually learn and understand the changing environment with our peers. And so that just creates that complexity. And as I already said for high deductible plans making sure that we create the needed avenues for patients to know how to pay their bill. And Mary can speak to that piece as well.

Alexandra Pecci

Mary?

Mary Wickersham

Thanks very much. One thing that I do want to add, and I don't necessarily have a solution for it is we see a lot of patients that don't understand their benefits. They don't understand why something wasn't covered. They don't understand that they signed up for some sort of limited plan or some ministry program that isn't necessarily going to always provide coverage. And so I feel like employers and insurance agents and the marketplace too need to do a better job of explaining to the patient what they

are signing up for so that there isn't a surprise on the back end. And then we have the surprise, surprise billing legislation that we're dealing with. And again, I don't know really how to solve for that, but I do see it as a huge gap in just patients not understanding their coverage or things like prior auths. If that was their responsibility at times to get that prior auth. So I think there's a lot of work that could be done there to help patients know what is included in their plan, what's excluded and where they're going to have coverage.

Alexandra Pecci

And Lisa, this is a great question for you, since you're in the midst of a revamp.

Lisa Schillaci

I couldn't agree with Mary and Sarah more, and I believe that some of the legislation that's already out there as it relates to pricing transparency is not going to, that's not the answer. However, it's a start. So yay for that. But what we're... and I agree with everything that they've said. What we are finding is one of our greatest challenges for Houston Methodist revenue cycle again, is what I mentioned is really just access to care. And as I mentioned in my opening remarks, we are heavy in technology. We are heavy in innovation. And we bought all the all the tools. And now what we're doing is we're saying, OK, we've bought this. We bought this technology from a scheduling, you know, automatic scheduling a, you know, we've bought the EHR. We bought all these add ons. We're partnering with an authorization... automating our authorizations again. We're not shy to partner and we're not shy to buy. So now what we're dealing with is, well, what are the barriers to making these systems work, sing and dance seamless, frictionless with each other so that we can open up that access for the patients to self schedule, self-serve, self register? And what we have found is, is that there are barriers, that there's clinical barriers. Well, for patient safety purposes, we don't want the patient to do this or there were there were other barriers, maybe in the build.

Lisa Schillaci

And so we are going to start internally and we're going to... we've got a vision, a strategic vision that includes innovation and senior, senior leadership strategy that we're trying to create the vision for. What what is hospital access going to look like for 2030? So we're calling that our access 2030 vision, and it is breaking down the barriers on why these computer systems and this technology can't do what it's supposed to do and really start breaking the barriers down. While we can appreciate patient safety and clinical protocols, for example, just to give you guys an example, and I know you all are there and you're probably going to appreciate this example, but if someone wants to go and schedule a radiology, you know an X-ray, well, is it with contrast or is it without contrast? You know, and and and and. And so now we're putting the patient in the middle of doing these niche things that we have staffed up to do. We want to start trying to break those barriers down, and it's not going to... and it's not going to become easy. But again, we bought all this technology. We've got to now find innovative ways on really engaging the patient for those patients that want to engage in self-service. And the population is such that I think Mary said it. Everybody wants the Amazon experience. Click, click, click. Boom. I'm there. I'm doing it. We've got to be able to meet that for those patients that want that while still keeping the other

populations warm with soft touch, hand-holding, etc. So just to share with you along, that is... We are, you know, again, we bought all the systems kind of looking at my notes here, all the electronics... we've got, we've got a big bite. We just are going to change clearinghouses to most specifically for the return, the eligibility return, that RTE, the real time eligibility we've got to have, we've got to have reform. Agree with you, Sarah, on the authorization insurance companies giving back information. Not all the information, giving us information that looks all cryptic. We absolutely have to have reform in that, but we also need to have the best partners.

Lisa Schillaci

So we're changing clearinghouse specifically for the RTE. We just partnered with a vendor to help us with our authorizations. So essentially what we're doing is we're trying to get all the pieces as optimized as possible so that as we're breaking barriers down, all of these systems and technology can work together for the good, for the patients that want to self-serve, self-schedule self-help. I could really talk about this forever. I don't have the answers. Would love to get your guys's, see what you guys are doing. But I think now it is just beginning to rub out the rough edges and understand the barriers and start knocking those barriers down. And where we are our own internal barrier, we've got senior, senior executives that says, I'll be your bulldozer. And I'll tell you when I heard our senior, senior executives say that, it renewed my hope in this project.

Alexandra Pecci

That's great. Ward?

Ward Svavari

Yeah, I agree, I absolutely agree with what Mary was saying around patient education and a lot of the work and putting the pieces together that Lisa's been doing. But when I think of the overall patient financial experience, I kind of study and take a look at some other industries. And Mary and Lisa both mentioned it right? With we want to have an Amazon type experience, but, and so part of that, what is that Amazon experience? It's predictable and it's standardized, right? And so I don't have to tell all you guys on the phone with M&A and the massive growth that we've seen, right? That presents a lot of challenges because no matter your entry point into a provider system, be it at an ambulatory physician or the queue coming through the ED. Right? We need to standardize what that patient financial experience is going to be. And if you look at other industries, I like to look at hospitality and travel, right? So obviously travel has been curtailed for the last two years, but you can go and... I can book my flight on Southwest. I like to do it all on my phone, right? So I do it Southwest. I can book my hotel room and my rental car, and I can do it on my phone without actually ever interacting. And that's standardized no matter what Marriott Hotel I go to, whether it's in the Pacific Northwest or New York City or down in Atlanta or Houston. So that's a standardized process, but also recognizing that you need to have multichannel as part of that. It's not just one standardized patient financial experience because we have different cohorts or segments, however you want to call it, of people, right? So my my grandparents may want to interact with your health system one way. I want to interact another. And then you have

millennials that may want to do it all on their phone. So that in looking at other industries and how they've standardized and had a multichannel kind of interaction is where we need to go.

Ward Svavari

And I understand the complexities. All of you on the phone are living that and even, you know, it's hard to take a step back when we're just trying to get cash in the door. But that, to me, is kind of where I think we can go, and some of that starts with the standardization and then even backing that up, that has to go to the org structure, right? So I think one of the trends that we saw the last five years was the consolidation on the back end, right? And a lot of larger organizations. I know Mary and Lisa, I know you guys have with centralizing the CBOs right. Well, now it's we need to kind of do that effort on the front end with the patient access, as we've seen a lot of those activities shifting more up front in the patient financial with authorizations, eligibility coverage and whatnot. We got to really standardize those processes across the entire organization before we can have, you know, a standard, seamless patient financial experience, though. That's... And again, like Lisa said, we could spend a whole summit just talking about how to tactically go employ those different strategies.

Alexandra Pecci

Well, let's talk about those strategies and action. Have you seen KPIs improved by improving the patient financial experience and what other soft metrics are you paying attention to when it comes to this effort? Lisa, would you like to start?

Lisa Schillaci

Sure. Related to our, as I mentioned earlier, to our total revamp of patient collection, starting with the statement and using the tools that this vendor has provided, I've seen a question in the comments. Yes, we are, I guess, through our subscription fee to this vendor, we're paying for some type of propensity to pay scoring model there. They're using it. They're... I'm not receiving it, but the vendor is utilizing it and is utilizing it in their in their collections, tailored collections, efforts to the patient. But we're looking at, of course, we're looking at patient cash. And as I mentioned to you, with all things being equalized for our price increases, rate increases, volume increases, etc. after we've neutralized all of that, we are up $3.4 million. I'm looking at, related to the patient journey, I'm looking at what are... what are the patients calling in for? We have every phone call that comes into our call center. We've got about 35 agents. We take about 6,000 calls a week. We organize all of those phone calls with just a little tag. We've got a drop down menu. I'm really looking to see why the patients are calling. And while we are seeing some reductions in some of the basic questions, they still are our top reasons. So we definitely have our work still to do on those. But again, they are decreasing, but they're still our top, our top calls. I'm looking at what's our lead time on a days to authorization from date, from days to authorized from the date of service. We call those lean days or days out. We want it... we need to increase that because what we don't want to get into a situation with, is that we've got to do last minute cancels or last minute reschedules because we didn't get this, we didn't get the service authorized, specifically looking at imaging and surgery. Keep a tight, tight eye on that. Patient refunds on days on work queue. We did

some automation in that where we were very, very conservative, where we would not let a patient refund go out the door without having eyes on it.

Lisa Schillaci

And we have slowly through some innovation and some automation in our EHR is we now are doing some automated refunds all the way up to $2,500. That has tremendously helped that metric. And I hope that that also helps the patient experience. Again, repeating a little bit about what we've done. Financial assistance, days on work queue. Of course, with all of our automation, that's really, really gone down. We're looking at point of service collections, denials, specifically eligibility denials, authorization denials. Let's see here. Also, in our whole system, all the patients can definitely call in, we also have an opportunity for the patients to send in, I don't know, I'll call it like an email through our whole system. We keep a close eye on that. I'll go ahead and stop there. Basic, these are basic KPIs and with everything that I've shared with you that we've done, financial assistance increased our patient refunds, our revamp of our collections event. All of our KPIs are moving in the right direction. Now, mind you, we still have a lot of room to go. Some of these initiatives are new, but I am seeing it going in the right direction and I'm going to give all the credit to our innovation, the vendor partners that we've chosen and the talent on the team to make all this happen.

Alexandra Pecci

Thanks. Mary?

Mary Wickersham

Yeah, just a couple of things to add to that we've implemented a lot of technology and automation in order to drive our KPIs in the right direction, and so examples of those would be our auto claim statusing. So, you know, a few days after a claim goes out where auto statusing that and affecting our workflow by deactivating and activating accounts so that we can get that claim paid as quickly as possible. And if a patient has a balance, then we can get them a statement in the mail as soon as possible. No one wants to receive a bill six months after their date of service. And so by doing that, we've seen our days in AR go down. We've seen our agings go down because we're getting paid faster. We also use a built-on system to Meditech for all of our collections workflow. So it really allows our collectors to work smarter and not harder through the use of the technology. We also implemented an IVR, which is where patients can pay over the phone and bypass a representative. And so as we've implemented those, we've seen our self-pay collections go up and our drop rates of our calls also go down. And I'll let Sarah comment on some of her KPIs that she's monitoring.

Sarah Hartwig

Sure. So for patient access, we've taken just a renewed effort toward accuracy and quality. We have this finite amount of time to get it right before the claim marches on. So it really is about tracking, in a timely way, accuracy around our basic workflows. So in the pre services world, as well as that pre-registration but also up to the point of registration, are we getting complete and accurate information? So we have

taken a renewed effort toward that point of service collections again. How often are we getting cash in the door? That's pretty basic. Our estimate accuracy is one that we've taken again, a renewed effort when, with surprise billing coming in January, we really are looking at if we're spending all this time and effort toward estimates, how close to the mark are we getting? So we're keeping track of that. In addition to some of those other metrics that were already mentioned, I can't, I guess, state enough how important the turnaround time that Lisa mentioned to our authorization. And that's just important, I would just add, we look at the date of the order to the scheduling when it's actually scheduled in the system, when it's performed in the system from the order date, as well as that authorization because we do allow scheduling to happen at the time of authorization. So we really keep a close eye on, is anything scheduled that still needs authorization and then holding accountabilities with our peers if we have a certain turnaround time for those authorizations and those expectations, we have to keep a close eye on that.

Sarah Hartwig

And then just timely reporting. All of these metrics are important. And so a lot of our efforts are around getting timely information, especially up front, so that we can avoid the chaos that can happen on the back end. So we're really trying to focus our efforts on that quality component.

Alexandra Pecci

Thank you. So when thinking about the entire patient financial experience from start to finish, where do you think it's strong and where do you think it could be improved? And that's both for your organizations and the industry as a whole. So Sarah, could you start?

Sarah Hartwig

I think we've kind of spoken to this, I think the strengths are that, you know, as difficult as regulations and catching up to regulations can be and that quick expectation, I think there's realization overall that patients need to be informed that having clear, transparent information upfront is important to the overall patient experience. But I also think it's that double edged sword. That's the difficulty. For us, really trying to, Mary already said, explain complex benefits. Patients don't always have the understanding. So that's where that constant improvement is needed. How do we really raise the bar on understanding in our communities so that patients know what to expect, they know what their responsibilities are and they're ready to engage in those conversations. We already mentioned meeting patients where they are. I think tools and technology have worked to catch up to the ever changing needs. We have to be more digital. We have to engage in those tools and those multiple channels, so there's more options for patients. So I think it's again a strength and a little bit of a weakness is trying to employ them in a way that's meaningful. I'll pause there and let the others add to that.

Sarah Hartwig

Thank you. Mary?

Mary Wickersham

Yeah, I agree with everything that Sarah has said and at Avera, as we kind of do the revamp that Lisa has done in her organization around, you know, single bill, better online bills, bill space, getting to that Amazon world is definitely something I'm super excited about. I feel like the industry struggles with kind of the bad press around pricing. Price transparency has obviously been a huge part of our world and all organizations this last year, and I think in the industry, you know, the price is always out there, right? That's the sticker shock. But what patients don't understand is what we call contractuasl, right? When we bill insurance, you don't ever get 100% of your bill charges, ever. So I think, you know, I don't know how you solve for that, but I think there's just a misunderstanding out there around price transparency and what it was really meant to do. I think the other area that we struggle is that at Avera and this probably happens in some of your organizations, too, you have outside providers coming in to see patients. They do their own billing and the patient feels like they're being seen by an Avera doctor, but it's actually someone coming from the outside. And I know the surprise billing has some solutions for that, even though they're pretty operational heavy and will take a lot to implement. But I don't think patients understand that when they're sitting in a bed or they have an anesthesiologist come in, it might be a separate provider that they're going to get a separate bill for. And so something I think we just all need to be aware of and figure out how to solve for it. If any of you have figured out how to manage that, I would love to hear from you.

Alexandra Pecci

Thank you. Lisa?

Lisa Schillaci

Yeah, me too, if you guys have got the silver bullet, please let me know. I agree with Mary and Sarah in spades. But what I what I am hopeful for is what I'm seeing a strength in the industry. And I am hopeful at this point in time is that we've got a lot of, I guess, capital being thrown in the health care and we've got vendors and capital investors and new niche technologies that are trying to overcome all the barriers that we just mentioned. If the payers can't come to the table, if the patients don't understand, we've got technology and capital investors out there that are wanting to step in that place.

Lisa Schillaci

And so I look at from a strength is health care is getting a lot of attention, a lot of capital investment being poured in. However, the flip side of that is we've got to vet it. Does it really hit the mark? Does it really do what it needs to do? And how does this one niche thing play in the kaleidoscope of everything else that we have? As I mentioned to you guys, we've got a lot of technology. We've got a lot of, you know, we've invested in, you know, an EHR. And then how do we make that one niche thing play well with everything else. So it's kind of a blessing and a curse. I think we've got a, along with the capital investment, I think one thing that I'm super impressed with and hopeful for is just the the innovation, the robotics, the RPA, the machine learning we are... Now again, everything promises the moon. And if

you can kind of get, you know, three feet off the ground, you know, you're doing pretty good. But we've bought into the automated robotic processing. So we've got a team here and I'm an executive sponsor for that. After we can get... I think there's a place for it, and we are seeing that we are making strides. Again, it's a blessing and a curse. RPA came in and everybody was beating the drum that this was going to take, you know, 50% of the people out of the revenue cycle and it was going to save XYZ billions of dollars in health care. It's not that, but it is something and I'm thankful to see that my hospital is not fearful to try. Again, We're not fearful to fail. But if we're going to fail, let's go ahead and fail fast and not keep trying to force it to work.

Lisa Schillaci

I think a lot of the... A lot of what we're talking about with patient finance and most specifically is there are vendors and there's technology out there where people are amassing these big, huge databases on people. We are everywhere, our footprint is everywhere, and everything that we do is being organized into a nomi experience. And the more information that we can get about the patient to know their financial ability, and to tailor the collection experience around them, I think we're going to be in a better position. That information is out there and we've got to be able to harness it and we've got to be able to use it for good. So I am from a patient financial perspective, I am pleased with what I'm seeing with the technology, the amassing of tailored data on people. What are their preferences, what type of medium do they use? What time of day are they using computer technology? Do they use computer technology at all? What's the response times between they get some stimulus that they're responding? What are they... Who are they spending their time and money? Everybody has gotten a profile and we've got to be able to tap into that and to be able to use it for good. And I believe what we've done with our renovation of patient collections and that patient experience over the last year, we've just tipped of the iceberg of this, of utilizing these profiles on patients. I'm not going into a CRM specifically related to clinical care. I'm not there, but I am looking at that patient profile from a payment perspective. So I think everything has a blessing. Everything is a blessing and a curse, a strength and a weakness. If it becomes perverted or if you... or if we as as health care workers... We've got to be wise, we've got to be... We've got to use some discernment on everything that's being offered to us. But then we also have to be not afraid to go into it. And I'm actually very, very hopeful and looking forward to what these next, you know, we've got the vision for patient access for 2030. We're looking at all of our areas in our hospitals. What are all these areas going to look like in 2030? I'm very hopeful, but we've also got to be prudent.

Alexandra Pecci

And we have just a couple of minutes before Q&A, but Ward, do you want to add anything?

Ward Svavari

I think Lisa and Sarah and Mary, you know, hit most of it. If I if I could summarize it, I think it's really the core investments that we've been making in EMRs, ERPs and even now CRMs, right? Lisa mentioned. Eventually - we're not there. It's at the very cusp, but providers are going to start building those patient profiles because that's how they're going to know how to interact. So I think a lot of that investment has been going on. One of the silver linings, if there could be one from COVID is that it forced a lot of

automation that was slow coming, right? I mean, we moved the back offices to a complete remote working environment where we thought previous to COVID that that had to be butts in chairs in our CBOs, right? So that's one silver lining that I've seen is it's forced probably by five years, maybe more the automation of a lot of those tasks that that were manual previously. And I think that's key to improving the patient financial experience. And some of that where we struggle, and I certainly don't have the answers and I don't know that anyone does, but Mary hit on it. And Lisa did earlier where with price transparency and no surprise billing, health care's complicated. It's not as simple as that as a transaction on Amazon or booking a hotel room in a flight on Southwest and Marriott, right? You have four different stakeholders between the patient provider, the payer and then even the government with regulations.

Ward Svavari

So I think some of those regulations are an attempt by the government to take the first two steps in the twelve step journey. But really getting to the payers are going to have to get involved. And Mary hit on it, right? You can post your CDM online. But for those of us in the industry that CDM is essentially meaningless, right? I mean, those prices, you could actually operate without a CDM, it's the contractual prices that you get from a payer that truly matter. And until we can get that figured out and say, Hey, why don't we just have a flat fee for a particular DRG and not worry about the variation, right? I think that's where the industry struggles right now, and I don't know what that answer is. If we simplify that down to just the least amount of stakeholders, or if we can get to some sort of contractual flat rate, that's a little bit of what we're trying to do with the movement towards value based care. But, that's... I'll wrap it up, right? Those are some of the summarizing thoughts, automation and then kind of getting to the payers in the contractual amounts to be able to better predict what the costs of care are going to be.

Alexandra Pecci

Great. Well, thank you all again for an excellent presentation. This brings us to the Q&A portion of the program, so we'd like to ask the audience to ask live questions of our speakers. As a reminder to submit a question, click on the Q&A widget at the bottom of your screen. It may be open already and appear on the left side of your screen. Please note that your questions will remain anonymous and will not be viewable by other audience members. So first, this is a question about outside providers.

Alexandra Pecci

We have signage and having discussion with patients at times of service, speak about separate billing, our referral team will discuss benefits and discuss separate billing for interpretation, for radiology as an example and ask the patient directly if they don't understand. Communication up front with the patient is so important. That's more of a comment than a question. Anyone want to weigh in on that before we move on to the next question?

Sarah Hartwig

And I'll go ahead and just comment, I think that was in response to, you know, what can we do for outside providers? And so I think it's great feedback and again points to where we want to get that information up front and maybe do more of that collaborative work with those external providers. So that's that's great feedback.

Alexandra Pecci

Next question, have you established a propensity to pay model to focus on collections that patients will pay?

Mary Wickersham

This is Mary. We today do not have propensity to pay in place, but that is part of the revamp that we're doing. I would mention, too, that we own our own bad debt agency, which is very unique for a health system to do so. They do use propensity to pay analytics at time of listing the account, which that propensity to pay really drives workflow when it comes to outbound phone calls as well as inbound. It really gives you a line of sight on that patient situation, and it's going to drive the conversation. The propensity to pay tools that we'll be using with our new kind of revamp will be able to do the same from a collection standpoint and the phone calls, but it can also drive what is actually printed on that patient's statement. It can drive, do we send a charity care application automatically? It will drive when they log in to the website to to pay us what presents for payment plan options. So someone with the high propensity to pay it may first present a payment plan option of three months instead of the whole 24 months that we would, we would still give them. So it's really going to, I guess, drive the patient experience. And the analytics aren't just a credit score, it's really taking history from previous patients. So we'll give them two years of our data and they'll study that. And so when Mary Wickersham has a visit, if I've always paid you in full, that's going to drive my patient experience. When I go online, I'm not going to be one that would get a charity care application, so I'm really excited for those tools and how they're going to help drive our collections.

Alexandra Pecci

Thank you. Next question: How do we standardize patient experience when the process of different codes and office leveling prevents it?

Lisa Schillaci

We are battling that. Lisa, Houston Methodist, we're battling that right now, and we have come to the conclusion that it is going to be a top down decision. It is going to have to be the senior executives and those mid-level vice presidents are going to have to make the decision and help us enforce it.

Alexandra Pecci

Anyone else like to weigh in on that? All right, we'll move on to the next question. Do you have a coverage discovery tool in place for patients who don't present with coverage?

Lisa Schillaci

Real quick, I have two of them, I call them my safety net programs, and I've got two vendors that do that.

Mary Wickersham

Yeah, at Avera I talked a little bit earlier about our patient advocate program, and so those advocates are focused on reviewing the uninsured inpatient and high dollar outpatient population. And then we actually have coverage discovery built in prior to, I think it's 60 days before our patient goes to bad debt. And so I know that's kind of part of what Sarah is looking at too. Do we move that up? Do we keep it in place? Is there a better strategy for it? But we've been really successful with those advocates and scrubbing those accounts to help keep our vendor costs low.

Sarah Hartwig

Yeah, just want to add, that is an area that we're looking to move up front, so it's supported dually, both at the point of pre services when it's identified as uninsured and then maintaining what we have in place with Mary's team.

Alexandra Pecci

Thank you. Well, that's all the time we have for questions today. In closing, please note that if you've registered for the next webinar of the summit, titled "Panel Discussion: A Revolutionary Approach to Stopping Missed Revenue," a live clickable link will appear at the close of this session to take you directly over to that program. If you've not registered for that program and wish to attend, you'll need to click on the link and fill out the registration form to gain access. I want to thank our speakers once again for an excellent discussion. I'd also like to thank our platinum sponsor, CommerceHealthcare, for making this morning's program possible.

Alexandra Pecci

Finally, thank you to you in our audience for participating this morning. We hope you enjoyed the session and look forward to seeing you during other webinars for this summit.