How to Combat the High Cost of Alienating a Patient
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All physicians understand that as health care costs rise, patients demand a higher level of service. This expectation goes beyond the bedside to include every aspect of the patient encounter, from check-in to final statement. Every individual involved in the patient experience has an impact on satisfaction, from receptionists to medical staff.

According to the 2010 Consumer Impact Study from Waltham, Mass.-based Connace (http://connance.com/), the billing and collections process is no exception to this rule. This survey of patients found a strong correlation between the billing and collections experience and a patient’s loyalty to a provider. In fact, when a patient found the billing and collections experience favorable, about 99% of the time they reported being satisfied with the overall provider experience.

Negative Repercussions
While a patient’s loyalty can be severely affected by a negative post-care experience, what effect will that change in attitude have on a medical practice’s bottom line? Here are a few examples:

The lifetime value of a patient. Loss of a single patient’s lifetime household health care expenditure is estimated to be on average more than $1.5 million for hospitals and over $1 million for physician-related expenses, according to statistics from the U.S. Census Bureau.

Malpractice suits. When it comes to malpractice suits, it doesn’t matter whether a physician wins, loses, or settles. Being sued by a patient is one of the most stressful and expensive situations a hospital or physician can experience. The risk of being involved in a lawsuit raises from 0% for practices and hospitals with very good patient satisfaction ratings to 19% for those with a very poor rating. In more than 90% of cases that go to trial, physicians are found not to be negligent; yet more than $110,000 per case is spent defending those claims.

Lower reimbursement. Under the Centers for Medicare & Medicaid Services’ (CMS) value-based purchasing proposal, beginning in October 2012 as much as 1% of diagnosis-related group (DRG) Medicare payments will be at risk for hospital providers with low patient satisfaction scores. These satisfaction surveys will be conducted randomly with discharged patients, including patients who are too young to receive Medicare coverage. According to CMS, more than 3,000 hospitals will be affected, with potentially $850 million at stake. By 2017, this percentage is expected to increase to 2%.

Word-of-mouth advertising. Dissatisfied patients can do significant damage to a provider’s reputation when discussing their experience with other potential patients. This damage can occur whether or not a patient chooses to remain with their provider. The perception consumers have of service quality plays a disproportionate role in their choice of provider. On average, customers are twice as likely to talk about a good experience as they are to share a positive one, according to research presented in a 2009 white paper titled “Customer Satisfaction and the Success of Your Organization,” from Baltimore, Md.-based Carson Research Consulting, Inc. (www.carsonresearch.com). Conversely, patients who are highly satisfied with their providers’ billing processes are more than twice as likely to recommend the physician to a friend and more than five times as likely to recommend the hospital, compared with those who are less than satisfied, according to the 2011 Connance Consumer Impact Study.

Best Practices
Fortunately for health care providers, there are a number of techniques that can be employed to help preserve positive patient relationships while enhancing the provider’s bottom line. The techniques include:

Train nonclinical staff members on customer service. Every service representative communicating with a patient must know what they should do to keep the patient satisfied, especially...
those involved with the patient's money. The training should be aimed, from a patient-centered and patient-friendly perspective, at ensuring that the business end of the process meets the patient's needs and expectations.

Training for such nonclinical staff should include education on why patients expect and deserve more value as out-of-pocket expenses increase; how each employee contributes to customer service and affects patient satisfaction and loyalty; the lifetime financial value of a patient and the potential costs associated with patient dissatisfaction; and advanced patient communication techniques for revenue cycle staff, including rapport-building skills, how to avoid resistance, and influence and persuasion skills.

In addition, it is essential to train point-of-service staff on how to request payments from patients, since few people are comfortable doing so. Many untrained representatives often resort to passive inquiries like, “Would you like to pay your balance today?” Enquiries like this enable the patient to simply answer “no,” or provide an excuse. Ideally, the better approach would involve the representative stating the balance and then saying, “For your convenience we offer [list your payment options]. How would you like to take care of this today?” This is just one example of how modifying everyday communication techniques can make a difference and motivate patients to pay.

Examine all features of the billing process. At times, the billing process can be lengthy and complex, creating more opportunities for patient dissatisfaction. Every aspect of the billing process should be reviewed regularly to ensure patients receive clear, concise, and frequent communication about the payment collection process.

Focusing on patient satisfaction fulfills the essential mission of health care and makes business sense.

The Westchester, Ill.-based Healthcare Financial Management Association (HFMA; www.hfma.org) began the Patient Friendly Billing Initiative several years ago and is a great resource for best practices. Useful information can be found at the group’s website by searching the phrase “patient-friendly billing.” Designed to ensure that patients are made aware of their financial responsibilities in a clear manner, HFMA’s initiative is based on a central theme: Communicate information to patients in a manner that helps the patient understand what their financial obligations are and the ways they can meet those responsibilities, and then come to an agreement with the patient about how they will pay or otherwise resolve the financial obligation.

Assess Outside Providers

A commonly overlooked area is how patient satisfaction is affected by outsourced business process providers, particularly receivables management and bad debt recovery partners. These companies directly interact with your patients and play a critical role in their ultimate satisfaction. Here are some tips for assessing outsourced businesses and their processes:

- Include questions about your outsourced processes in your patient loyalty surveys.
- Check your vendor’s rating and complaint history with the Better Business Bureau (www.bbb.org/us) or contact your state’s Attorney General’s office to see if there are complaints about the vendors you are using. Keep in mind that what you find may only be

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AMA: PRACTICES HAVE NINE OPPORTUNITIES TO EDUCATE PATIENTS ON FINANCIAL RESPONSIBILITIES

According to research performed by the American Medical Association, health care providers have nine opportunities to educate their patients about their financial policies and patient responsibilities. These opportunities should be used to condition patients to think that it is normal and expected to take care of their out-of-pocket expenses at the time of service rather than to be billed for those responsibilities later.

Most of these education opportunities involve adding simple written communication at normal points of contact that a patient may encounter during their experience with the provider. They are:

1. Appointment scheduling
2. Provider website
3. Welcome letter
4. Insurance verification
5. Appointment reminder
6. Patient check-in
7. Patient check-out
8. Claim processing/patient invoice

At each step, the payment policy, payment method options, and the patient’s outstanding balances should be clearly stated. Doing so can mean the difference between a brisk cash flow for a practice and a large stack of accounts receivable.

—DM
the tip of the iceberg. According to the American Medical Association’s publication “The Case for Medical Liability Reform,” only about 5% of dissatisfied customers will lodge a formal complaint. That means that for every complaint that is filed, there are 19 more patients who are just as dissatisfied but don’t think it is their job to tell you.

• Communicate the expectations you have when it comes to treating patients with dignity and respect to your outside vendors. If these expectations are not being met, it may be time to reevaluate the relationship with the vendor.

Too often, providers select collection methods and processes based upon market trends as opposed to what works best for them. No two providers are alike. Two hospitals, for example, may appear to have similar characteristics on the outside but may have different patient demographics, staff competencies, account dispositions and information system capabilities. Each of these factors affects which collection processes will work best for a particular institution.

It is critical for providers to seek revenue collection partners with more expertise in collecting patient payments than their own staff. This expertise should include the ability to effectively communicate with patients during the billing process. Effective communication can easily eliminate the majority of issues that block providers from collecting what is owed in a timely fashion.

Providers should look for partners that have reputations for excellent communication, rapport-building and negotiation skills, or the providers will benefit only from cost reductions due to economies of scale. Revenue collection partners should be required to let the providers listen to some actual conversations between their personnel and patients and judge for themselves if they are handling patients with the dignity and respect they deserve and expect. The right partner will help a practice to preserve its reputation as well as sustain patient relationships—and ultimately ensure future opportunities to provide health care services.

The same goes for a practice’s technological and operations capabilities. A revenue collections partner should have technological and operations systems that are designed for the specific purposes they are contracted for, and should use proven methods that produce results that outweigh the provider’s capabilities. These include but are not limited to:

• Advanced dialing technology
• Call recording
• Real-time payment acceptance
• Online payment portals
• Automated payment plan follow-up
• Proactive charity care follow-up
• Analytical tools for process improvement
• Real-time reporting capabilities.

Focusing on patient satisfaction fulfills the essential mission of health care and makes business sense. There are costs associated with dissatisfied patients that have the potential to be disastrous given today’s shrinking margins for health care providers. Nonclinical employees have a significant effect on the perceptions patients form of a provider and their impact should be measured. Nonclinical staff, especially those involved with the revenue cycle, should be made aware of the importance of their role and be trained accordingly in customer service, patient loyalty, and advanced communication skills.

**RETAIN PATIENTS BY MEASURING SATISFACTION DURING BUSINESS, CLINICAL PROCESSES**

Any professional from any industry will say that satisfied customers yield repeat business, while dissatisfied customers are more likely to not return—and may even influence other potential customers’ decision not to patronize the business. Health care providers typically do a good job of measuring their patients’ levels of satisfaction at the bedside, but most satisfaction surveys ignore the bookends of the patient experience, scheduling and paying for services.

Patients should be surveyed after clinical services are provided about the care they received as well as on the scheduling and registration process. They should also be asked for their feedback after the final bill is paid. Surveys should be brief, no more than three to five questions, and should take place within two weeks after payment is processed. Key questions to ask include:

• Were you provided information on your responsibilities to pay and estimated costs?
• Was your bill easy to understand?
• Did you find the methods offered to pay your bill convenient?
• Was the accounts receivable staff easy to work with?
• Did you find our financial counselors helpful?
• If you worked with a third-party revenue collection provider, were they friendly and easy to work with?
• What are some ways that we could improve the billing process?

A complete picture of a practice’s patients’ level of satisfaction will enable it to improve on areas in which it is deficient, increasing the likelihood that patients will continue to return for care.

—DM