

HFMA's Patient Friendly Billing



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Hospital Rating Systems What You Need to Know

Hospital quality ratings might seem to be one thing that CFOs can leave for other leaders to worry about. Don't do it. Although most patients are not using the ratings for decision making yet, quality ratings are becoming more ubiquitous, more public—and more important.

"A hospital's reputation and the clinical care quality provided by the hospital are what keep it in business," says Michael L. Millenson, president of Health Quality Advisors in Highland Park, Ill. "You're not going to have too many patients unless people think they are going to get better when they come to your hospital—no matter how good your food court is, no matter how beautiful the atrium you build."

Why Ratings Matter

More than 100 rating systems for hospitals and physicians are circulating, and new ones are introduced every year. Yet very few patients are using the ratings to

choose their healthcare providers (see the upper exhibit on page 2). Nonetheless, healthcare report cards—regardless of whether they are right, wrong, or too hard to understand—are key to any hospital's own health status.

"Hospital leaders who ignore these ratings do so at their own peril," says Rick Wade, senior vice president for strategic communications at the American Hospital Association.

Historically, patients had no hard data on which to choose a hospital. But now patients hear a constant drumbeat telling

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them to become savvy shoppers for their healthcare services—and quality information is being actively pushed to them from the federal government, health insurance plans, advocacy organizations, and hospitals touting their own performance.

The cacophony may be too much for consumers at the moment, but they will eventually start using the information, says Wade. A survey by Thomson Healthcare found that the majority of consumers studied said they would change hospitals if their preferred hospital received a below-average rating for clinical quality (see exhibit below right).

For that reason, no hospital leader should look at report cards and say “not my job.” “There’s got to be a core of people at the top of the organization committed to seeing this through over the long term, and that includes the people in the finance office where the resources are,” says Wade. “If that kind of commitment doesn’t go from the boardroom right to the bedside, you’re never going to improve the processes that make a difference in quality.”

Physicians and nurses are likely to check out a hospital’s report cards before making career decisions, and news reporters can find an easy story in the latest Hospital Compare data for their community. Hospitals may check on their competitors’ scores to find competitive advantage, and hospital trustees do not want to be associated with an organization that has quality problems to explain.

While patients may be slow to use quality reports for decision making, people closer to the healthcare industry are not. Physicians and nurses are likely to check out a hospital’s report cards before making career decisions, and news reporters can find an easy story in the latest Hospital Compare data for their community. Hospitals may check on their competitors’ scores to find competitive advantage, and hospital

trustees do not want to be associated with an organization that has quality problems to explain.

“We’re not yet at the tipping point where everyone is using these data, but we’re clearly moving there,” says Millenson. “And once the tipping point is reached, you can’t go back and get a make up.”

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Online Ratings Get Scant Attention—So Far

Quality ratings for	Percentage who saw ratings online	Based on ratings, percentage who considered a change	Based on ratings, percentage who made a change
Hospitals	23%	2%	1%
Health plans	26%	4%	1%
Physicians	22%	5%	2%

Source: Reprinted with permission from the California HealthCare Foundation 2008.

A survey of 1,007 Californians conducted in late 2007 found relatively low awareness of online quality ratings—and very little use of ratings for decision-making.

Hospitals Are Vulnerable to Poor Ratings

	Percentage of respondents
Would change hospital if preferred hospital received a below-average rating for clinical quality	57%
Would not change hospital if preferred hospital received a below-average rating for clinical quality	43%
Would change physician if preferred physician received a below-average rating for clinical quality	24%
Would not change physician if preferred physician received a below-average rating for clinical quality	76%

Source: Thomson Reuters

What Are Your Statements Telling Your Patients?

It's no secret that complicated billing statements frustrate patients and their families because these statements create insecurity around two of their most important concerns: *their health* and *their finances*. Ineffective statements also increase the perceptions of excessively high costs and overcharges. As the impact of consumer-driven health care becomes more entrenched, it becomes more important that patients understand the information in their billing statement.

What's In it for You?

Patients who feel confident that their statements are clear and accurate typically are more likely to pay their bills in a timely manner. Providing clear, concise billing statements not only encourages prompt payment, but also educates patients on their financial responsibilities. Easy-to-read statements can proactively provide patients with pertinent information about their outstanding account and can result in reduced customer service calls and a higher bill payment rate.

Principles to Follow

Here are a few principles you can follow when making your billing statements more effective.

Be clear. Use a minimum amount of medical terminology. Whenever possible, avoid abbreviations, acronyms, codes, and other elements that patients will not easily identify.

Be accurate. Items on the statement should represent the care the patient received. Also, include tips on where the statement recipient can turn for further explanation and instruction.

Be concise. Include enough details to clearly communicate important account information, such as services rendered and financial responsibility. Include information on how the patient can obtain further information.

Be patient-friendly. In addition to being easy-to-read, patient statements should reflect what the patient's insurance is covering and what the patient's responsibility is moving forward.

Creating a Billing Philosophy

Implementing the principles to provide patients with clear, concise billing statements can be a

from creating a clear, concise billing philosophy. Intuitive billing statements educate patients on treatments rendered and their financial responsibilities while encouraging prompt payment. ☎

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complex process. With the rise of consumerism in health care, organizations such as the HFMA have developed recommendations to help organize the movement to patient-friendly billing formats. Both providers and patients can benefit

A Clear, Concise Bill

Account Summary		Summary of Charges	
Patient Name	John Q. Patient	Description	What We Billed Insurance
Account number	0123-4567-89	PHARMACY	\$333.75
Service date(s)	July 11, 0000	CLINICAL LAB	129.00
What we billed to Aetna	\$9,883.03	OR SERVICES	3,770.00
What Aetna paid	6,577.00	RECOVERY ROOM	362.00
What we billed to Anthem BC	3,306.03	ANESTHESIA	680.00
What Anthem BC paid	2,852.00	MED-SURG SUPPLIES	3,944.28
Total insurance payments	-\$9,429.00	RADIOLOGY	98.00
Patient payments	0.00	THERAPY SERVICES	270.00
What you owe now	\$454.03	PATHOLOGY	296.00
		TOTAL	\$9,883.03
		Insurance payments/adjustments	-9,429.00
		Adjustments	0.00
		Amount patient owes	\$454.03
Insurance Information		Message	
Primary Insurance	AETNA	If you have any questions or concerns regarding your account, or need to discuss arrangements for payment, please call us at (800)555-5554 or (321)555-9876, Monday through Friday, between the hours of 8:30 a.m. and 5:00 p.m.	
Secondary Insurance	ANTHEM BLUE CROSS		

Source: Emdeon Business Services. Reprinted with permission.

This excerpt from a hypothetical patient bill spells out the patient's financial obligation in a simple, concise manner. The entire sample bill can be found at www.patientfriendlybilling.org.

Insurer Increases Access to Physicians

The Hawaii Medical Service Association (HMSA), a member of the Blue Cross and Blue Shield Association and the dominant insurer in Hawaii, has arranged for caregivers in its network to make themselves available to their patients for online and phone consultations at their discretion, any time, from any location.

Consumers will have immediate live access to care providers in the HMSA network without scheduling appointments or leaving home. Via the online service, physicians and other caregivers will be able to review patient information, speak with and see patients, prescribe medications, and suggest follow-up care.

“We are committed to providing our community with the most convenient and effective care possible. By providing immediate, secure, and private access to primary and specialty care, we are improving access to care for our members and extending care to nonmembers, including remote, underinsured, and uninsured populations,” says Michael Gold, chief operating officer of HMSA.

A study of Hawaii physicians found that 45 percent of physicians said they are extremely or very likely to deliver care using the service. They cited convenience, improved patient care and satisfaction, and increased income as key motivators. For more information, visit www.hmsa.com.

Employer Medical Costs to Rise 9.6 Percent

Although medical costs have increased steadily for decades, the rate of growth has been slowing in each of the past five years. No more, however: In 2009, the downward trend is expected to level off, and actual medical costs are expected to grow 9.6 percent, according to a new PricewaterhouseCoopers Health Research Institute (HRI) report, *Behind the Numbers: Medical Cost Trends for 2009*.

The report is based on the institute’s analysis and a survey of more than 500 employers and provider-based health plans.

Problems Mount for Under- and Uninsured

	Insured all year		
	Insured, not underinsured	Underinsured	Uninsured during year
<i>Access problems</i>			
Did not fill prescription	21%	41%	46%
Skipped test, treatment, or follow-up care recommended by doctor	14%	30%	43%
Had a medical problem but did not visit doctor	17%	35%	55%
Did not get needed specialist care	11%	20%	35%
At least one access problem	31%	53%	68%
<i>Medical bill problems</i>			
Had problems paying medical bills	15%	36%	45%
Changed way of life to pay medical bills	10%	27%	30%
Contacted by collection agency for bills	10%	17%	24%
Had some type of bill problem	21%	45%	51%

Source: Collins, S. R., et al., *Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families: Findings from the Commonwealth Fund Biennial Health Insurance Surveys, 2001-2007*, The Commonwealth Fund, August 2008

Multiple factors are expected to help drive medical cost increases in 2009, including booming healthcare construction and increased cost-shifting to private payers from the uninsured, Medicare, and Medicaid. Also, a recession in 2009 could result in higher costs, since medical price growth has historically risen faster during recessions. For more information, visit www.pwc.com.

Number of Underinsured Up 60 Percent in Four Years

The number of underinsured adults rose by 60 percent between 2003 and 2007, from 16 million to more than 25 million, according to a new Commonwealth Fund study. Middle- and higher-income families were hit the hardest by the steep increase: Underinsurance rates nearly tripled for those with incomes above 200 percent of the federal poverty level (annual income of \$40,000 or higher for a family).

In *How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007*, Commonwealth Fund authors use 2007 survey data to provide a

national estimate of the number of adults who are underinsured, updating a 2003 study. The analysis finds that 25.2 million insured adults ages 19-64 were underinsured based on their out-of-pocket costs relative to their incomes.

Including those who had any time without insurance during the year, the study estimates that 42 percent of adults age 19-64, or 75 million people, were either uninsured or underinsured during the year as of 2007, up from one-third in 2003.

Despite the fact that the underinsured have health insurance all year long, they are at high risk of access problems and financial stress—with experiences often similar to those of the uninsured. The study authors conclude that benefit designs that reduce cost sharing for high-value, cost-effective care and lower cost sharing for families with low and modest incomes will be necessary to achieve high-quality care and better health outcomes rather than just coverage. For more information, visit www.commonwealthfund.org.

Most report cards reflect data that are at least a year old, so a hospital that receives a bad quality rating may find that correcting the problem, earning a better score, and educating the public about the improvement is a challenge.

“It’s a lot easier to lose trust and to lose a reputation than it is to win it back,” says Millenson. “Ultimately, trust is what keeps any hospital in business.”

Which Ratings Matter?

When quality report cards first emerged, many hospital leaders dismissed them on the grounds that their methodology was faulty or their reports were misleading. Over time, data quality and analysis methods have improved and report cards are showing up in more places.

“What may have seemed a pesky distraction at first has evolved and deserves a reexamination,” says Millenson.

Some of the oldest ratings, including those produced by HealthGrades and The Leapfrog Group for Patient Safety, are getting new life as health plans post their reports on their own web sites and encourage plan members to study up. Meanwhile, the federal government continues to add new content to its Hospital Compare report cards and, earlier this year, bought newspaper advertisements to encourage patients to compare their hospital options. Consumers Union, the well-known publisher of *Consumer Reports*, is now publishing hospital report cards using the *Dartmouth Atlas of Healthcare’s* analysis, while dozens of other private and public organizations are launching ratings that reflect their own priorities.

Although hospitals may not choose to buy quality reports from vendors, no rating should be dismissed out of hand. “You have to look at every one of these

“If you haven’t talked to your public about what you’re doing on the quality front, then you’ve made yourself vulnerable. That’s where many hospitals are falling down. They’re not talking to the public about what they’re doing.”

and think, ‘Is this relevant to how we’re doing quality improvement inside this institution?’” says Wade. “‘Can we use these for benchmarks? Do they tell us and the community something about how we’re doing?’”

How to Use Ratings

Indeed, Wade sees report cards not as a threat but as an opportunity. “Many of these ratings are very useful internally for benchmarking purposes,” he says. He believes report cards are best used to keep hospital leaders and staff members focused on their quality improvement initiatives and appraised of the quality of care their organization is providing.

Beyond that, using report cards requires careful thought.

Understand the risk. Using positive quality ratings in marketing messages is risky business, says Wade. “All of these are a snapshot in time based on data that are old at the time the ratings are released, so you may look absolutely wonderful in one set of ratings and absolutely dismal in another set of ratings,” he says.

While many hospitals cannot help themselves from buying “We’re No. 1” billboards, Wade says he sees no evidence that they are effective. “I don’t think anybody has seen the marketing of these ratings make an enormous difference in what the public knows about their institution,” he says.

Know what you’re saying. Any hospital that brags about a report card gives up the right to complain later about how the score was tallied, says Millenson. “If the quality rating is good enough to adver-

tise, and it’s good enough to hang banners in your hospital to motivate staff and congratulate people on a job well done, you need to at least have a deep understanding of what you’re doing,” he says.

He encourages hospital leaders to understand exactly what a report card measures, what data are used in the calculation, and how the hospital’s performance can change over time. What is worse? Taking down the “Top Hospital” lobby banner when your score falls? Or keeping the banner up with a qualifier that says “Top Hospital in 2005”?

Create your own message. “If you simply wait for somebody to put out data that tell your patients something about you, and you haven’t talked to your public about what you’re doing on the quality front, then you’ve made yourself vulnerable,” says Wade. “That’s where many hospitals are falling down. They’re not talking to the public about what they’re doing.”

He believes every patient that enters the hospital—and their family members—should receive information about the quality improvement work under way in that hospital. In addition to reporting how the hospital is working to reduce infections, for example, some hospitals are publicly posting report cards. This type of transparency may position the hospital as a knowledgeable and trustworthy source of information about its own performance.

“Are you going to let somebody else talk about you?” asks Wade. “Or are you going to get the information out there yourself, whether it’s good or bad?” ☞

Geisinger Pioneers a New Way to Charge for Services

Many hospitals are looking for ways to prove they provide value—high quality at low cost—to their patients and payers. Geisinger Health System, a large integrated healthcare delivery system in Pennsylvania, may have found a way. Since early 2006, we have been providing elective coronary artery bypass graft (CABG) surgery via a new approach: Our health system charges Geisinger Health Plan—which provides coverage to about one-third of our CABG patients—a single rate for a package of inpatient and outpatient CABG services. Most significant, we do not charge extra if the patient has complications or requires readmission.

At a Glance

- > Geisinger offers payers a single rate for a package of inpatient and outpatient CABG services.
- > Four major teams and a steering committee were formed to launch the initiative. The clinical work groups identified best practices for providing CABG services. The financial team was charged with defining and pricing CABG services.
- > The package was priced to the insurance plan as a “guaranteed price” based on the assumption that readmissions would be reduced.
- > Results to date include: A reduction in variable costs of 3.6 percent, a 16.9 percent increase in the contribution margin, a 45 percent reduction in readmissions within 30 days, and a 20 percent decrease in complications, including infections and reoperations.

Another novel component of this program: Patients are required to sign an agreement in which they accept their role as a partner in Geisinger’s “ProvenCareSM Heart Program.”

How It Started

Geisinger Health System’s president and CEO, Glenn Steele Jr., MD, PhD, along with the board of directors, established a vision that articulated Geisinger’s intent to strive for perfection. This was a systemwide strategic effort to address issues and gaps in healthcare delivery as identified in the Institute of Medicine report. We wanted a more activated, empowered patient at the center of care. We thought there were opportunities for more highly reliable care processes. We wanted to commit to evidence- or consensus-based best practices and eliminate some of the inappropriate variation in care. We knew we needed to develop programs that would have continuous improvement in acute care outcomes, as well as with chronic disease management.

Geisinger Health System set out to fundamentally realign reimbursement

incentives and, at the same time, support quality initiatives. Because the Geisinger Health System is fully integrated (physicians, hospitals and health plan), we knew this provided a unique opportunity to promote quality while partnering with employers and their employees, and hopefully, expand our market leadership and increase volumes.

Planning Phase

The basic premise of the ProvenCare model is that Geisinger will simply not get paid for doing additional work. Therefore, we were willing to go at risk for complications.

With that as our goal, we felt we needed to get patients more activated and involved in the process. That’s why we developed the ProvenCare CABG Patient Compact, which spells out the patient’s responsibility (see the exhibit on page 7). This is an important component to making the program work, both from Geisinger’s perspective and the patient’s perspective.

The initial goal was to deliver value—defined as the combination of cost and quality, as measured by patient outcomes—to four constituencies: patients, physicians, hospitals, and purchasers (including employers, government, and private payers).

The CABG procedure was chosen as the first target in part because best practices are derived from evidence-based guidelines in scientific literature. We began with a group of willing physicians who were already demonstrating great value as reported by the Pennsylvania Health Care Cost Containment Council. They were all employed in a group practice in

three different settings within the Geisinger system.

Geisinger's electronic health record (EHR) system, which provided baseline data about expected volume levels and practice patterns, turned out to be a critical asset in this initiative. The fact that Geisinger employed physicians and a health plan as part of its integrated system was also key to making this initiative work. The financial relationships among the hospital, physicians, and insurer are closely meshed here.

The Financial Team's Role

Four major teams and a steering committee were formed to launch this initiative:

- > The best practice work group, including all the cardiac surgeons, which determined the guidelines that ProvenCare would follow and identified the elements of care that needed to be included in the program
- > The clinical effectiveness work group, which established an ideal workflow that incorporated all the best-practice elements and the mechanism for documenting and tracking adherence
- > The patient activation work group, which developed the Geisinger patient agreement
- > The financial work group, which included clinicians, finance staff, administrators, and representatives of Geisinger Health Plan

The financial team was charged with defining and pricing CABG services. The first step was to conduct a retrospective examination of volumes, costs, and services rendered. The team then defined the CABG episode of care to include any related service preadmission through 90 days post surgery. This included:

- > The preadmission cardiovascular surgical clinic examination and other testing
- > The actual bypass surgery

- > Post-discharge home health services
- > Cardiac rehabilitation services
- > Other related outpatient services

The financial work group priced out the technical and the professional
continued →

ProvenCareSM: CABG Patient Compact

My Role in Proven Heart Care

The Geisinger heart surgery team has your health and safety as its chief concerns. That is why we established the ProvenCareSM Heart Program. The ProvenCare Heart Program includes all of the care steps necessary to ensure the highest quality care before, during, and after your heart operation. Your active participation is one of the most important parts of the Geisinger ProvenCare Heart Program. Medical research has shown that the more involved you are in your own care—and the stronger the partnership between you and your caregivers—the better your results will be. Even though the Geisinger heart surgery team always strives to provide all of the elements of the ProvenCare Heart Program, you will get the best result when you, your family, and your Geisinger heart surgery team are all active partners in your care.

Commitment to Communicate as a Team

- > I will alert my heart surgery team when I don't understand something, when anything worries me, or if anything unexpected occurs, knowing that my heart surgery team will work with me until I am satisfied.
- > I will discuss all of my current medications, nonprescription products, vitamins, or herbs, as well as all of my current and past medical programs, recognizing how important this information is in guiding my care and making me safer.

Commitment to Involve My Family and Loved Ones

- > I will have a trusted family member or loved one present with me during my hospitalization and clinic visits—to help support me during my care.
- > I will work with my heart surgery team to develop a sensible plan for my transition from the hospital back to my home.

Commitment to Complete Important Care Steps

- > I will alert my heart surgery team before I stop or start any of my medications so that we can discuss how any change might impact my care.
- > I will work with my heart surgery team to develop a sensible schedule for my after-surgery care, follow-up visits, and rehabilitation.

Commitment to Improved Heart and Prevention

- > I will complete a cardiac rehabilitation program, understanding that it will give me a better, quicker, and more lasting recovery.
- > I will work with my heart surgery team to stop my use of any tobacco products—forever.
- > I will discuss with my heart surgery team the important role that life-long nutrition, weight management, exercise, and medications play in keeping my heart healthy.

I realize that my decisions and behavior have a significant positive impact on my long-term health. Because I want to become and stay healthy, I fully accept my role as a partner in the ProvenCare Heart Program.

Sincerely,

Insert Name

Date

components for 18 preadmission services, as well as the surgery and inpatient services, home health, and follow-up outpatient testing.

Of course, the real risk was on complications and readmissions. So the package was priced to the insurance plan as a “guaranteed price” based on the assumption that readmissions would be reduced by 50 percent.

Results to Date

Geisinger has seen a 16 percent reduction in the average length of stay since 2006—from 6.3 days to 5.3 days—and a reduction in variable costs of 3.6 percent. Geisinger has also seen a 16.9 percent increase in the contribution margin.

There has been a 45 percent reduction in readmissions within 30 days. That is not quite at our goal of a 50 percent reduction, but it has still proven to be more financially beneficial than prior arrangements.

But that's not the real value. The real value is in the clinical outcomes. Complications dropped by more than 20 percent, even though Geisinger's complication rate was low before ProvenCare was introduced. The amount of blood products used decreased by 22 percent. The amount of reoperations caused by bleeding was reduced by 55 percent. The number of deep sternal wound infections was reduced by 25 percent.

We have passed along value to others, too. I think we've accomplished our goal when you consider the value provided to patients or to employers who get their workers back sooner and in a more productive state. And we've given insurers a more predictable financial arrangement, which they are able to pass on to their customers when pricing their product.

Our physicians have benefitted as well. Within the Geisinger Health System, we offered financial incentives to each surgeon, and they earn financial rewards based upon these outcomes.

Coming Up Next

We have expanded the ProvenCare model to include cataract surgery and hip replacement and plan to add bariatric surgery, percutaneous catheter intervention, as well as other procedures.

We have received many requests from other health systems interested in this approach, and we recently began a year-long consulting contract with another large system. The key is to redesign care processes and use the EHR system to embed the new processes into daily work. It's not just about sitting down with a group of surgeons and getting an agreement on how things should be done. It's also about being able to guarantee that care can be provided in a way that improves outcomes, and then be willing to be financially at risk for that care.

To date, the only payer that is taking advantage of the guaranteed price is our own health plan; however, all elective CABG patients treated at Geisinger Health System get the exact same standard of care. Will other payers go along with this idea? We have three major Blues plans and one large, for-profit insurer in our service area, and we are in early discussions with them.

We are early in the game, but we are prepared to demonstrate value for our patients and payers, and we are going to share the gains with our physicians who lead these initiatives. ☎

Kevin F. Brennan, CPA, FHFMA is the executive vice president and CFO of Geisinger Health System in Danville, Penn.

Mayo Clinic Health Policy Center

Who? The Mayo Clinic Health Policy Center, established in 2005 in Rochester, Minn., is convening providers, payers, purchasers—and patients—through dozens of events to identify solutions to America's healthcare crisis and gather strength to push for change.

What? Earlier this year, the center convened 400 patients and healthcare leaders at its second symposium on national healthcare reform. “I have never before been in a room in America where people could really change health care,” said Donald Berwick, MD, founder of the Institute for Healthcare Improvement. “Today, I am.” Since then, the center's activities have ranged from small-group meetings on “pay for value” concepts and an IT forum to a symposium on reforming medical education.

Significance to healthcare consumerism.

The Health Policy Center, the Kaiser Medical Foundation, and the American Hospital Association are jointly sponsoring “Your Voice, New Vision,” (www.yourvoicewision.org), a national initiative to make patients' perspectives an integral part of the healthcare reform debate. To help understand consumers' perspectives, the Health Policy Center commissioned a survey of more than 1,000 individuals responsible for making healthcare decisions for their households. The survey found that consumers favor three reform options the most:

- > Patients should be able to obtain accurate and complete information on their own health.
- > Patients should have freedom of choice when they select physicians, hospitals, and insurance.
- > No one should be denied health insurance due to a preexisting condition.

For more information. Visit www.mayoclinic.org/healthpolicycenter.

Georgia Health System Pioneers Patient Kiosks

Self-serve kiosks allow patients at the Medical Center of Central Georgia (MCCG) to whisk through the registration process in less than half the time needed in the traditional process—while improving patient satisfaction, increasing registration accuracy, and making life easier for front desk staff.

Jane Gray, CPA, assistant vice president for MCCG's patient business services, and Kim Whitley, RN, director of patient access, tell why the 603-bed medical center introduced patient kiosks in two busy locations in 2007—and plan to install additional kiosks elsewhere in the medical center. "My dream is to have a kiosk at every registration site," says Whitley.

What prompted you to introduce patient kiosks?

Whitley: The space configuration of our new heart services tower was going to require additional staff members to handle registration. There had been some reluctance to move to kiosks because senior management worried how patients would react. Our second attempt to consider a kiosk solution was more readily accepted because it was compared with an investment of five new staff members.

Have your patients benefited from the kiosks?

Gray: In the old system, staff members could check in only two patients at a time. So patients sometimes waited 20 or 25 minutes just to see a registration person, and the registration process could take 10 to 20 minutes. The kiosks allow 10 patients to be checking in simultaneously, so there is no wait to start registering. Patients go immediately to a kiosk or to get a tablet (similar to a laptop computer) if they prefer to sit.

Whitley: Assuming the patients have preregistered, which is our goal, the registration process at the kiosk primarily is verifying data on a few screens, making changes if necessary, and

writing their electronic signature. They can also pay upfront for services, if they owe money. The registration process takes an average of six to seven minutes for Medicare patients and three to four minutes for non-Medicare patients.

Because we started in our heart services unit, where our patients tend to be somewhat older, their willingness to accept the kiosks was a concern. Generally, it has been very well accepted. Some people need a little more assistance than

others. People who are technology-savvy really don't need much assistance at all.

Gray: We are very concerned about patient satisfaction with these kiosks, so we use an on-screen satisfaction survey at the end of the kiosk check-in process. Responses have been positive, and patients report that the technology is easy to use, even though a high percentage of our patients are senior citizens. We monitor these surveys closely and immediately respond to any negative feedback.

How have kiosks affected your staffing?

Gray: We have a staff person who monitors the kiosk activity and is available for assistance

continued →

Sample Screen from MCCG's Patient Kiosk

The Medical Center of Central Georgia

ModiiKiosk

Patient Information

? I NEED HELP

CANCEL CHECK-IN

Please verify that all of the information is correct:

YES NO Is the PATIENT information listed below correct and complete?

Name: Chanel Hicks

Address: 3250 Happy Times

City: Macon State: GA Zip: 31208

County: Bibb

Date of Birth: 12/02/1962

Race: Caucasian

Sex: Female

Social Security Number: 321-23-4567

Home Phone: (478)558-3455

Other Phone: (478)558-3456

Marital Status: Married

Religion: Catholic

Source: Medical Center of Central Georgia. Reprinted with permission.

Cardiac patients at the Medical Center of Central Georgia use a kiosk to register when they arrive for services. Patients who have preregistered simply verify data on a few screens, make any needed changes, and write their electronic signature. They can also pay upfront for services, if they owe money.

as needed, but instead of having that 1:1 staff-to-patient ratio, we can have 1:4 or 1:6 ratio. This allows our registration staff to spend their time preregistering patients by telephone, which is what makes the kiosk check-in go so quickly.

The change in workflow improves the accuracy of our registration information since patients seem to review and correct the information we gathered during the preregistration process more vigilantly on the kiosks than they do in rote responses when the same questions are asked verbally in the traditional face-to-face model.

Instead of managing paperwork behind a desk, the role of our staff members has become friendlier—providing support, direction, and assistance, as needed. Having the staff side-by-side with the patient has helped to enhance our rapport with our customers and has served to improve both patient and staff job satisfaction.

Do patients have the option of registering the traditional way?

Whitley: When we researched how other hospitals had been successful with kiosks, we learned that kiosks should not be offered as an option. If a patient comes in and absolutely refuses to use the kiosk, then our staff person will do it, with the patient providing the information needed to move through the screens. But that is rare. Generally speaking, when you come to our site, the only option for registration is via self-service through the kiosk.

How do kiosks affect your workflow?

Gray: We went from registering two patients at one time to registering 10 patients at one time. On the first day that we used kiosks, our clinical staff went from having to wait on their patients to get through registration to telling us, "Wait a minute—you're going too fast."

Reducing registration waits has helped improve patient throughput. We were able to move patient arrival times closer to the actual case time, instead of batching arrivals up to two hours in advance to ensure the physicians had enough patients ready to stay productive in the cath labs. Once the volumes in our new heart tower stabilize, it will be

interesting to review our case load to see if the reduced wait times have actually translated into increased capacity and increased revenue.

What advice do you have for hospitals who are considering kiosks?

Whitley: Make sure that you budget for enough development hours to address the unanticipated updates that will allow you to make the most of the technology. This requires reengineering the registration process totally. As you move through the design phase of creating storyboards—which determine what information will be on each screen and how the screens will be ordered—and building the new work flow, you will probably find things you want to do that were not in the original scope of the project.

You need to have very strong project managers with experience on the vendor's side and a staff person who can organize internal tasks, keep things going, and meet deadlines. You want to have somebody who is going to keep everybody focused through testing and implementation. Starting from scratch, it took us about six months to design, develop, test, and implement our first kiosk site. The next site was much quicker—less than two months—because the initial look and feel of the kiosks had been established.

Gray: If your executive team is hesitant to invest in an enterprisewide solution initially, a pilot license targeting one key area will give you the opportunity to try the technology on your patient populations without making a gigantic software investment up front. In our case, the ROI was favorable when comparing the pilot purchase price to the potential salary and benefit expense associated with adding five new FTE's to do the work. You might ask your vendor to apply the cost of the pilot license to the cost of an enterprise implementation, if your trial is successful and you decide to move forward with kiosk registration across the organization. ☞

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"Using the estimation methods published by the Institute of Medicine, and recently updated by the Urban Institute, more than 24,000 Americans will die as a result of uninsurance next year."

—Arnold Milstein, MD, medical director at the Pacific Business Group on Health, the *Health Affairs* blog, June 2, 2008

"Having health insurance does not mean you will receive health care when you need it. Insurance companies may promise you the moon and a thousand doctors, but if you really need your medical care, you can bet they will be looking for a way to deny treatment or cancel your policy."

—Richard Frankenstein, MD, president of the California Medical Association, *Los Angeles Times*, July 17, 2008

"There is very little concrete rigorous evidence that the medical home will do all those wonderful things they want it to do."

—Mark V. Pauly, PhD, health policy economist at the Wharton School of the University of Pennsylvania, in *The New York Times*, July 21, 2008

"Our driving philosophy is to contact the patient only as a very last resort [about billing issues] because if we do a second search, we usually find an internal error, eligibility timing issue, or payer pattern."

—Lyman Sornberger, executive director of patient financial services, Cleveland Clinic, in HFMA roundtable *Your Strategies for Improving Patient Registration Processes*

"Hospital price information is of little interest to members...we run deductibles of maybe \$1,000 to \$3,000, and every inpatient stay blows through that deductible."

—A health plan executive quoted in *A Health Plan Work in Progress: Hospital-Physician Price and Quality Transparency*, an August 2008 research brief published by the Center for Studying Health System Change ☞

CDHP Savings Are Positive but Small—So Far

Many hospital executives hope that consumer-driven health plans (CDHPs) are a fad that will soon fade. In one of the first independent, actuarial studies of CDHPs, the consulting firm Milliman found that, when all factors are considered, CDHPs produce just 1.5 percent in savings compared with non-CDHP plans. But future projections appear rosier. After studying six employer programs, the report's author believes the theory that CDHP design will change consumer behavior and generate substantial savings is likely to be true—eventually.

Jack Burke, lead author of Milliman's study, gives his forecast for a future filled with CDHP.

Some reports suggest that CDHPs are generating much larger savings than you found. Who's correct?

Burke: You have to take some reports about CDHPs with a grain of salt, and employers who are reading those studies need to be careful about what they're reading. The savings reported are often overstated because the studies do not adjust for and explain that the cause of the savings might be the lower risk enrollment.

When you adjust for all the relevant factors, you see moderate savings like you would expect from a plan that incentivizes members not to be wasteful. So it's not bad news (for CDHP proponents); it's moderately good news.

I do support CDHPs and I believe they work, although I would argue that they're not yet delivering big savings because the availability of quality and cost data is not there yet. Significant savings will only be realized when that data is available to the consumer (patient) at the time they make healthcare purchasing decisions.

Your analysis attributes some of the CDHP savings to reduced utilization, which is sometimes criticized and sometimes praised. What is your take?

Burke: I would congratulate CDHPs for limiting the use of healthcare services. That's a key part of the theory for consumer-driven plans, and we did indeed see some savings. I don't think that

employees have foregone needed care. I have more faith in patients, consumers, and employees than to think they would give up significant needed care.

The employers who were included in this study lamented that their workers do not have access to information on provider costs and quality. Do you think cost and quality information will ever get good enough that consumers will use it for rational decision making?

Burke: I do expect meaningful quality information to come. If you look five years back, you will notice the difference in quality and cost data from what is now available. It feels like it's slow when you're living in it day to day. But in a

decade, we will be significantly further along in measuring and presenting cost and quality data to consumers at the point where they can use it to make a decision.

Currently, when consumers see cost data, they choose the most expensive provider, assuming that higher cost implies better quality. I think consumers need to see quality information at the same time as cost data in order to feel comfortable choosing a lower-cost provider for some types of services. In addition, as cost information becomes more public, it will provide incentives for providers who are outliers to come in line.

Where is the CDHP movement headed—up or out?

Burke: I think the CDHP movement will advance. More employers will offer it and more employees will sign up. There will be more full replacement (of other plan designs).

Consumer-driven plans create better incentives for the healthcare system and for patients' careful use of health services than low copayments, which essentially offer incentives to use more services. ☞

Key Findings of Milliman Study

The analysis of claims data from six employers that offer their employees a choice of consumer-directed health plans (CDHPs) or nonCDHPs was designed to answer the following question: Do consumer-driven health plans (CDHPs) help reduce costs? Here's what the study found:

- > Total claims per member per month paid are about 41 percent lower for CDHP plans than the claims paid via nonCDHP plans. However, most of this big reduction is explained by the health status of the people who choose CDHP.
- > CDHP members are younger and healthier than their peers in other plan designs. After adjusting for these and related factors, CDHP total paid claims are about 4.8 percent lower than for nonCDHP designs.
- > The higher cost-sharing of CDHP design discourages members from using healthcare services. Adjusting for reduced utilization brings savings associated with CDHP design to 1.5 percent.

The employer programs studied in the Milliman study covered approximately 225,000 members with more than 30,000 enrolled in a CDHP. The CDHP penetration of the six employers ranged from less than 5 percent to 76 percent.

Source: Burke, J., and Pipich, R., *Consumer-Driven Impact Study*, Prepared by Milliman, Inc., April 2008.



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