PHYSICIANS PRACTICE

Communication: The Key to Better Patient Collections

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W hile the business of healthcare is somewhat in flux, the average medical practice continues to render medical services under the existing framework of health insurance. This can be a particular challenge these days due to high deductible health plans where patients are responsible for a larger portion of their healthcare bills.

Additionally, patients are starting to pay more attention to the value and quality of the healthcare they are receiving and are more likely to question their bills than ever before. What does this mean for your practice, and how can you improve the manner in which you are handling your patients and your patient billing and collection process?

The average person feels obligated to pay for items and services she has received. However, healthcare is intangible and, unlike a piece of clothing or a car, once a patient leaves the doctor’s office (empty-handed but feeling better, hopefully) she can begin to feel separated from the value of the services received. This means practices must be diligent about collecting payment or establishing effective payment options as close to the time of service as possible.

How do you collect money from your patients? Making it more convenient makes it more likely your patients will pay quickly, if not on the spot. Does this mean offering credit card payments? Setting up automated payment plans?

Practices also need to adjust their collection approach to meet the expectations of their patients. Younger patients expect to pay...
electronically and may not even look at paper invoices arriving in the mail. Older patients may still prefer paper invoices and/or payment by check. Most patients are willing to provide a credit card for the practice to keep on file and/or establish a payment plan, though too many practices fail to even ask for a card to be provided. There is no reason a variety of approaches cannot be offered at the same time as long as they are spelled out clearly.

ELIMINATE THE MYSTERY

Another issue that often makes it challenging to collect from patients is when the cost of the services/bill comes as a surprise. Patients, like any consumer, can become angry when the cost of what they “bought” is more than expected. Unlike going to the store, patients often have no idea upfront what they will be spending on healthcare and whether they even can afford the service.

This lack of information also makes it difficult for patients to shop around for comparable services. While it is not always clear exactly what a patient’s bill will be before services are rendered/tests are run, most of the time, my practice clients can offer at least an estimate of costs and are usually quite accurate in their estimates. Practices that are upfront about potential costs find that their patients are more cooperative in making payment arrangements and following through on such payments. The same patients are often willing to choose a practice that is more transparent with its costs over a competitor that is not. This is also an important factor for practices to consider.

Most importantly, whatever your practice policy may be regarding pricing, payments, and collections, every practice must have a sound financial policy that explains the process by which services are billed and how payments can be made. The more information shared with patients—and the more often it is shared—the greater the chance that patients will fully understand and comply with the policy.

Some additional tips to help patients better understand the practice’s financial policies:

1. Break down the policy into parts and have the patient initial their understanding of each part. Lengthy policies with long paragraphs are rarely read or understood.

2. Have the staff review the policy with patients. This can be especially helpful for older patients or those who do not speak English as well.

3. Ask for the policy to be signed each time a patient visits the office. I find this annoying myself as a patient; however, my practice clients have reported that patients who visit often and are asked to review and sign the policy each time are more familiar with the policies as a result.

4. Review the policies regularly to be sure they are clear, accurate, and still reflect the practice’s policies. Be sure your practice is also billing and collecting in compliance with the law.

Addressing a patient’s ability and willingness to pay for services upfront can go far towards a practice’s financial health. Think about how your practice can make some changes to develop a better relationship with its consumers and improve its bottom line at the same time.

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Statistics show it no longer makes sense to attempt to collect from patients using in-house resources.

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Traditionally, practices have focused on the front desk collecting co-payments and have left co-insurances and deductibles to patient billing after the claim has been processed.

This creates a lengthy revenue cycle and less cash flow for the practice. With more responsibility being placed on the patients for these deductibles and co-insurances, practices can no longer survive with traditional billing processes. Many are starting to deploy new methods, such as requiring patients to pay up-front for services when deductibles have not been met.

Modifying collection practices is a systematic change for your business with many factors to consider and processes to work through. It is essential to plan and prepare to launch new policies.

**DETERMINE GOALS**

Use data to determine if there is a need to modify your collection procedures. You may find there is no need to implement an entire new process for collections but may want to consider new technologies to improve efficiencies or payment options to your patients.

Review your current policies and procedures. Does your process already include collecting deductibles and co-insurances? Perhaps there are policies in place that are not being enforced and simply require retraining staff and reinforcing the plan with your patients.

Review patient aging reports for accounts receivable (A/R) days and outstanding balances. If patients have balances that appear to be the entire cost of the visit, large balances, or have a high number of days in A/R, chances are there is a significant amount going towards unmet deductibles.

If you feel changes are necessary, it’s time to decide on an implementation date and which policies are you going to implement for your practice.

**REVIEW WORKFLOW**

List out the steps for collecting at the time of service. Note what processes are already in place that will need to be altered, and which can remain.

Identify all the people who will be involved in the workflow and what they will need to manage their responsibilities.

Involve key staff in developing the new workflow. No one understands the job more than the people who are doing it each day. Having them become part of the implementation team will help them be more supportive of the program when it is rolled out.
If you are already verifying benefits prior to the visit, most of these systems will provide you with deductible information. Determine where this obtained information will be maintained in your management system.

If the desire is to collect co-insurances, obtain fee schedules for each plan and create a spreadsheet outlining your evaluation and management codes and top procedure codes.

**CREATE PATIENT POLICIES**

Communicating the expectations to your patients ahead of time is an essential part of implementing new workflow and strategies.

Making payment policies part of your registration packet assures every patient will have been made aware of your office process from the start. Rather than create matter-of-fact policies, craft a brief message that explains the reasoning behind the policy whenever possible.

For existing patients, typically a letter from the medical director explaining the need for change and any plans for assisting patients can go a long way in the patient’s acceptance of new policies.

**EDUCATE STAFF**

Prepare for the change by arming your staff with the tools they need to communicate the new plan. Make sure they know where to find the information they need, are comfortable with answering questions from patients, and can navigate the policy for every-day workflow.

Provide scripting for the staff so messaging is consistent and is crafted with the tone you want to convey as they communicate with your patients.

Role play with your staff to alleviate their tensions in rolling out the new process. This makes learning fun while showing them the best way to handle an uncomfortable situation or question from the patient. It also may uncover some areas you haven’t thought about addressing with the new polices.

**DETERMINE PAYMENT OPTIONS**

Requesting payments upfront is likely to be an unpopular policy for patients, but a necessary one for your practice. Developing options to assist patients with these payments can do a great deal to bridge the gap to meet everyone’s needs.

Payment plans only work when patients adhere to their responsibilities and the staff can manage the complexities of overseeing the plans. Keeping credit cards on file with written agreements permitting specific dollar amounts or processing limits gives both the practice and the patient some control over the payment plans.

**USE TECHNOLOGY**

Consider using technology to assist you by implementing an electronic credit card on file program.

There are several secure systems on the market that do not display the credit card information and instead, store key information in the cloud. This provides a level of comfort that personal information is inaccessible to anyone on staff.

Charges are made automatically for dates and amounts that have been agreed upon during the initial set up with the patient. Systems can provide a multitude of services, including one-time payments, automatic payment plans, payment limitations, and automatically sending receipts to the patient’s email.

Modifying traditional collection policies is becoming more of a necessity and is gaining more popularity in the changing world of healthcare. Taking the time to review your process is an essential piece of keeping adequate cash flow moving through your practice.

Kathleen Adams is president and founder of MD Practice Partner, a national independent consulting firm that helps launch, develop, and grow private medical practices.
High-deductible health plans have become the standard in healthcare. Patients feel this impact greatest at the beginning of the year when deductibles reset. Higher deductibles result in doctors billing and collecting directly from patients for a greater share of a typical annual healthcare expenses.

According to a recent study in the *Annals of Internal Medicine*, physicians spend only 27 percent of their time caring for patients face-to-face, with the balance of time involved in administrative and billing activities. This time imbalance can have serious implications for patients and their healthcare providers. Many providers are looking to reduce their time spent on administrative and billing activities to spend more time with patients.

Effectively communicating about medical costs has become increasingly important in the age of Yelp! and Vitals, when a patient’s frustration over the handling of a bill, fee, or insurance coverage can quickly spread on social media. Below are three strategies to consider for a thorough approach to financial conversations with patients.

**OVER-COMMUNICATE NEW POLICIES**

Patient no-shows significantly affect delivery, cost of care, and resource planning. No-shows cost the U.S. healthcare system more than $150 billion a year, according to a 2017 report by SCI Solutions. Understandably, more physicians may be implementing fees for late or missed appointments.

Patients may be sensitive to this policy change, especially when the fees come as a surprise. It’s important to clearly communicate a new policy before it goes into effect. Have patients acknowledge that they understand a new policy during

27%:

**AMOUNT OF TYPICAL WORKDAY PHYSICIANS SPEND FACE-TO-FACE WITH PATIENTS**

Source: *Annals of Internal Medicine, 2016*
Office check-in and include reminders in waiting room signage, phone “hold” messages, and on your website. Keep a log of when patients signed an acknowledgement in their electronic file. Incorporate reasonable exceptions for unavoidable situations.

By communicating your policies to patients clearly and often, you’ll demonstrate transparency and reinforce trust.

**Implement Additional Payment Options**

Regardless of practice or specialty, all healthcare professionals share one common goal: improving the health of their patients. But patients may have different preferences when it comes to paying for their healthcare. With that in mind, you may want to consider adding alternative payment options to your current financial policy.

There are a number of products that offer payment solutions that are easy for your office to manage and provide more flexibility for patients than a traditional in-house payment plan. These products may also have resources that help staff have the financial conversation with patients.

One such option is a credit card designed specifically for health and wellness needs. This type of card can be used to pay for treatments and procedures, and it allows patients to make convenient monthly payments. The benefit for your office is that it takes the process of collection management off your hands, allowing your staff to focus on patients’ health needs.

**Communicate Payment Options to Patients**

Once you’ve decided on the various payment options you’ll make available to patients, utilize your existing communication channels to promote these alternatives. Add a tab to your website with this information—and any appropriate payment site links. Email your patients important and cost-saving changes that are available to them. Prominently display brochures or information about your various payment and financing options.

With healthcare spending at an all-time high, your patients will appreciate your help and guidance as they plan how to pay for their medical services.

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With healthcare spending at an all-time high, your patients will appreciate your help and guidance as they plan how to pay for their medical services. Not only could these three strategies improve the financial health of your practice, they can also assist your patients in gaining access to care.

**Dave Fasoli** is the chief executive officer of CareCredit, a leading health and wellness credit card in the U.S. which is accepted at more than 200,000 health and wellness providers nationwide, and executive vice president at Synchrony Financial.
Nearly 45 percent of physicians consider patient no-shows to be the biggest challenge in their medical practice, according to a recent poll conducted by the Medical Group Management Association. No-shows cost practices time and money, with an average of 60 minutes wasted and $200 lost per appointment, according to a report by SCI Solutions.

For patients, no-shows can lead to illness getting worse, missed diagnoses and forgotten prescription refills.

Plus, they inconvenience other patients in need of more immediate care who would have gladly filled the slot. With no-show rates as high as 30 percent, missed healthcare appointment costs in the U.S. total a whopping $150 billion each year, as reported by Health Management Tech.

WHY ARE PATIENTS MISSING THEIR APPOINTMENTS?
While healthcare is a personal matter for patients, a study conducted by Annals of Family Medicine identified three major reasons why patients didn’t keep their scheduled appointment:

- They suffered from personal issues and emotions.
- They felt disrespected by their doctor or practice staff.
- They did not understand the practice’s scheduling system.

Improved wait times, patient engagement efforts and updated systems can deter them from missing their appointments.

A 2017 survey conducted by MGMA reported 52.4 percent of patients simply forgot to attend or cancel the appointment, while 41 percent were unaware of their doctor’s no-show policy. Most said practices can help them remember by sending appointment reminders and educating them on reschedule and cancellation procedures.

It pays to implement efforts to alleviate the cost and frequency of no-shows.

CANCELLATION FEES
Some practices choose to charge patients a cancellation fee when they miss an appoint-
ment. While it doesn’t cover all the revenue lost, it’s intended to discourage patients from missing additional appointments.

The fee usually ranges from $20 to $50, depending on the practice, patient and type of appointment. The fee for a new patient appointment might be higher than a routine check-up for an existing patient. Most practices establish a 24-hour cancellation policy, but this is based on the clinic’s preference.

It’s important to keep in mind that sending these bills can get tricky without automated payments. They can also give your practice a bad reputation for surprising patients with extra fees.

To implement cancellation fees, the staff should request patients keep a credit card on file for automatic payments. More importantly, they should make sure patients understand and acknowledge the policy before collecting their payment information.

**APPOINTMENT REMINDERS**

It’s best practice to contact patients at least a day or two before their appointment. Once they’re reminded, patients can confirm if they will be attending the appointment. The reminder also serves as a great opportunity to confirm benefits, highlight changes in coverage, and provide price estimates. If patients confirm they won’t be able to make it to the appoint-

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mean practices should give up traditional communication methods if they are working well. The idea is to meet patient needs. It’s important to ask how they would like their doctor’s office to send important notifications, as patients will be most responsive to the messages they receive via preferred platforms.

**CONVENIENT SCHEDULING**

Online booking is the basic standard for making appointments easy to schedule and cancel.

Patients want fast, automated services that give them more control over their healthcare decisions.
This is true especially in younger patients. Jefferson Health conducted a survey that reported 92 percent of patients under 40 expect full electronic communication with their providers. Online scheduling allows them to change their appointment as soon as a conflict arises. Additionally, many online booking platforms will send automated email or text confirmations and reminders, which alleviates the pressure from office staff.

MINIMIZE WAIT TIMES
If doctors want patients to value their time, they should try to return the favor. Efforts to cut down wait times are extremely important in increasing patient satisfaction with the practice, and improves the chances of them coming in for their appointment. If they have a busy day and know they’ll have to wait almost an hour to even see the doctor, they might be inclined to skip the appointment all together. This is a reason to stray from double-booking, and try other efforts to combat the negative effects of no-shows.

PRE-PAID APPOINTMENTS
While not all patients will opt for pre-paid options, it can be beneficial to offer them. They’ll be more likely to show up for their appointment when they know they’ve already committed the money. Some practices provide incentives to encourage prepayments, such as small discounts on the service.

FILL THE SLOT
When a patient doesn’t show up for an appointment, it affects other patients who could have been treated instead. When it’s possible, always try to fill an open slot. Keep a list of the patients who would like to be alerted when last-minute appointments are available. When you fill the cancellation, you’ll increase revenue, as well as another patient’s satisfaction with the practice.

A good connection with their doctor always gives patients more incentive to attend their appointments. They feel committed to the physicians and office staff, and might even experience guilt in letting them down. Send birthday and holiday wishes, and keep them updated with newsletters and healthcare alerts. Patients want to be engaged in their healthcare, so make them feel involved with shared decision making and open communication.

When they keep showing up for appointments, make sure to show your appreciation

FOLLOW UP
Always follow up with patients who missed an appointment. Often times they simply forgot or didn’t realize they missed the appointment, and the message will encourage them to reschedule the appointment.

It’s also a good opportunity to refresh them on the cancellation policy, and alert them if they will be charged a no-show fee.

SIMPLIFY THE PROCESS
The right technology can help practices with the automated messaging, patient engagement and cancellation management needed to alleviate the cost of no-shows. Practice management software helps clinic optimize scheduling, enrollment and workflow. Revenue cycle management services can help improve practice profitability, including dealing with the financial burden of no-shows.

With fewer no-shows and more productive workflow, practices can benefit from increased revenue and satisfied patients.

Matt Seefeld is executive vice president at MedEvolve.
Managing the money tied to patient encounters at each step along the way is critical, but in an era of high deductibles and tightening payer reimbursements, revenue management is an increasingly complex task.

Patients are more commonly required to pay something out of pocket. Insurers require more data. How can practices improve their revenue cycle management (RCM) process in the midst of all this change?

For some, it may take support from vendors, revisions to internal processes, the deployment of additional technology tools, or a combination of all three, according to experts.

**THE EVER-CHANGING HEALTHCARE MARKETPLACE**

Many of the challenges practices encounter throughout the RCM cycle are outside their control. The current shift in patient payment obligations is one such issue.

“We have a lot of people choosing low-premium health plans for economic reasons,” says Timika Lucas, MBA, president and chief executive officer of Lucas RCM Consultants Inc. in Hazel Crest, Ill.

Magnifying the effects of that trend is the move toward high-deductible plans as consumers seek to more closely manage their healthcare expenses and usage. “That’s resulting in insurance companies making patients responsible for a higher percentage of their care costs,” Lucas says. As patients see their out-of-pocket expenditures climb, an increasing number are finding it difficult to pay, or to pay on time.

Recovering payments from patients is a challenge Lucas sees across the private practice spectrum, particularly when the dollar amounts are higher. Working with a multitude of payers—a portion of the industry also undergoing significant changes in the current environment—presents its own difficulties.

“A lot of reimbursement is regional, so it depends on payers in your area and what kind of programs they have and their level of sophistication,” says Drew Borland, chief technology officer at Alpharetta, Ga.-based Philips Wellcentive, a population management and revenue growth platform provider.
Navigating through compliance requirements that are still maturing adds to the complexity for practices. “The issues are evolving as we go from an incentive-based world to a value-based penalty world, where if you don’t do things with a certain level of quality, then you can get dinged,” Borland says.

The practice’s lack of time, a phenomenon that seems to be getting worse rather than better, is another factor hindering practices’ efforts to recover the highest possible reimbursements. Moreover, physician burnout sometimes keeps providers from focusing on RCM and the components that go into it.

“They don’t always have good knowledge of the revenue cycle, and they don’t have the time to look at it,” says Ginny Shipp, professional services consultant at revenue cycle technology firm Waystar, in Duluth, Ga. Shipp says she doesn’t believe it’s necessary for providers to directly manage the RCM process, but too few have a working familiarity with how the cycle works or what a solid RCM strategy looks like if they do oversee it.

IN-HOUSE MISTAKES PRACTICES MAKE
Lucas points to common internal work flow issues as another potential barrier to maximizing revenue. She says staff already have a full plate when it comes to complying with payer requirements.

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“[Practices] need to make sure that preapprovals are obtained, or they need to make that call to the insurance company to find out if it’s necessary or not,” she says. Insurers may change policies and requirements for certain procedures, and staying abreast of each update is difficult and time consuming.

“Support staff may not have that ability, or they may have staff multitasking and doing more than one job,” Lucas says. Newer practices just starting out often find themselves in this position most frequently, but if staffing is too lean to make RCM a priority, physicians could leave money on the table.

Practices trying to brighten their financial picture sometimes head in the wrong direction because of incorrect assumptions made on a limited amount of data. “They will look at a canned report out of their practice management system, and it shows them something but it doesn’t get to that granular level of what those numbers really mean,” Shipp says.

It’s important that a physician identify very clearly where and why their RCM strategy is lagging before they chart a course forward toward a solution. Without that insight, they may end up addressing only the symptoms of an inefficient process, and Shipp says, “They’re not actually fixing the root cause of the problem.”
GETTING A HANDLE ON RCM
Efficient protocols on the front end can help practices improve their revenue picture. Lucas suggests calling to verify patient information a day or two in advance of a visit whenever possible.

“Make sure the patient demographic information is accurate and updated, along with any insurance information,” she says. “That information being incorrect can cause a ripple effect and have reimbursement delays more than anything else.”

A number of EHR and practice administration platforms provide tools to help track patient eligibility and assist in capturing the necessary RCM data. Some also offer practices “warning signs which can help their current staff catch things before they go out to clearinghouses to be processed,” Lucas says.

Back-end processes factor heavily into a practice’s success with revenue improvement. Clinical documentation, for example, must be clear and concise if services are to be accurately coded.

It’s also vital that physicians be responsive to inquiries about their documentation. “Coders may need to ask questions about what the provider has documented for that patient visit,” Lucas says. “[The coders are] making sure they’re capturing everything so they can be reimbursed correctly.”

An experienced consultant can be a useful resource for examining existing workflows and identifying where internal processes should be improved to secure better reimbursement levels.

Coding protocols are an important area of focus when it comes to RCM improvement efforts. Incorrect and missing codes are frequently the cause of diminished and delayed reimbursements.

“You don’t have technology just for the sake of technology, but you don’t kick it out the door just because the patients may not like it.”

“Maybe a person is diabetic and hypertensive but you only coded them diabetic,” Borland says. “Comorbidity pays better than a single chronic condition.”

An experienced coding specialist can often spot these potential errors or omissions, whether that means in-house staff working on RCM-related efforts or partnering with a vendor that can provide that service. New technologies focused on coding optimization—often powered by artificial intelligence engines and vast databases of coding patterns and commonalities—can also help a practice be more accurate and thorough. The results are a higher reimbursement rate and fewer missed dollars.

Simply taking a more prominent role in the revenue process may help physicians maximize reimbursements. Shipp encourages physicians to learn about RCM and gain a better understanding of the process.

“They would be significantly more comfortable participating in helping to maximize that revenue cycle,” she says. “They need to know what the revenue cycle looks like and what the steps are. And it starts when the patient is scheduled.”
Knowing that the patient experience plays a heavy role in determining where consumers spend their healthcare dollars, physicians—as the care providers and revenue producers—need to be familiar enough with the revenue cycle to engage in reviewing RCM performance and targeting opportunities to improve. More knowledge may also provide a better footing to make process and technology decisions for the practice.

“You don’t have technology just for the sake of technology, but you don’t kick it out the door just because the patients may not like it,” Shipp says. Practices need to commit to an educational process and making the necessary adjustments when it comes to implementing any new software platform.

CLEARING THE PATIENT PAYMENT DISCUSSION HURDLE
Developing workable protocols for handling the patient side of the payment equation is an important step. Begin by being open with patients on their likely financial obligations.

“With some insurance companies, you can go online and see how much the patient may have to pay out of pocket,” Lucas says. She adds that discussing payment arrangements and agreeing to a timeline is also a useful strategy. “Give them options, such as payment plans that fit their budget.”

How patients pay, whether it’s by phone, through the patient portal, or even via automated billing if the practice has the technology to support it, should be discussed, along with when payments will be made and the amount of each installment. Throughout the process, practices need to be diligent in maintaining open communication with the patient. Their out-of-pocket estimate may need to be adjusted, or the payment terms amended to keep the financial picture on track.

Some practices will need to take a step back and establish a more formal financial policy when it comes to patient payment responsibilities. “Even if they do have a policy, not every practice is transparent about it,” Shipp says. It isn’t that practices intentionally hide their protocols, but many are hesitant to communicate them openly.

“There’s still a huge discomfort around talking about money with patients,” Shipp says. Taking a look internally at the different types of patients, such as those on Medicare or with high-deductible plans, can help put some structure around the payment options that make sense for each type. Accepting a healthcare financing credit card or similar program is one point to consider, and if the practice has any other kind of support it can offer the patient, the staff needs to be aware of that and have information ready to hand to patients.

Even as physicians work to improve their revenue management processes, inertia and human nature may still stand in the way. For instance, relying on meeting the various benchmarks popular in the industry can sometimes lead to complacency.

“It’s good data, it’s real data,” Shipp says. “But by just meeting those benchmarks, [practices are] not pushing as far as they could go to capture all the revenue they’re owed.”

If a practice has a 9 percent denial rate when the benchmark is 11 percent, for example, that figure should be seen as offering room for improvement rather than being good enough.

“You have to capture every penny,” Shipp says. “The days are gone where you can afford to write off with insurance companies or patients.”

Julie Knudson is a freelance healthcare writer located in Alexandria, Va.
Most physicians and their practice staff consider themselves to be in the healthcare delivery business. However, healthcare is very much considered a service industry by patients and consumers. But while other service industries have transformed the way they meet customer demands, healthcare lags years behind.

Consider how customers book airline flights. Customers can simply go to the internet, select an airline or aggregator like Travelocity, browse the many flight options available, and make a choice based on the time and price that suits them best. The same is true for making restaurant reservations or booking a hotel room or rental car. Customers can select from a range of choices that best suit their needs, right from their devices, and at a time that is most convenient for them.

Now consider how patients interact with most medical practices. While some information may be online—such as practice details and patient education materials — patients typically have to call during business hours to schedule appointments, receive test results, and communicate with their doctors.

Practices need to provide resources to service patients in that way, and patients need to take time out of their busy schedules. It is inconvenient, costly, and inefficient for all.

So what can practices do to better meet the needs of their patients?

**UTILIZE A PORTAL.**

If you have an EHR, chances are that the EHR vendor has a portal that can be added to your current system (or set up and switched on). Most portals allow patients to request prescription refills, access visit notes, and communicate securely with the office. Not only will making these functions available better service patients, it will also reduce call volume by putting these requests online. And while you need to ensure that staff check for messages regularly throughout the day, it creates a smoother workflow than constant calling.
So talk to your EHR vendor and see what options are available to you.

**CONSIDER AN ONLINE SCHEDULER.**
We have seen several practices add “schedule an appointment” options to their websites, but these are merely e-forms that allow patients to request times and still require that the office staff call the patient to set up the appointment.

A better solution is to actually allow for real-time online scheduling by patients themselves. In some cases, that scheduler can be built right in to an EHR or through a portal. In other cases, you may need to add on third party software.

**MAKE INFORMATION AVAILABLE ONLINE.**
Put as much information as possible online so that it is at patients’ fingertips. Your website can contain everything from new patient forms to instructions for visits to tips on conditions and patient education materials. Using your website as a reference tool allows you to refer patients to the site to “self-serve” rather than use time and resources within your practice to educate patients. It reduces calls to your office and develops a place for patients to return to time and again.

**USE PREFERRED METHODS OF COMMUNICATION.**
Ask patients how they would like to interact with your office. Do they prefer to receive visit reminders via text? Email? Or by automated call? Capturing the preferred method should help to reduce no-show rates, and it also makes for a more pleasant interaction from the patient’s point of view. Many practice management systems allow for this information to be captured and to create automated reminders using multiple methods easily. Ask your EHR vendor.

“Capturing the preferred [communication] method should help to reduce no-show rates, and it also makes for a more pleasant interaction from the patient’s point of view.”

**UPGRADE YOUR ONLINE PRESENCE.**
There are many companies now offering end-to-end “patient engagement” and help with online reputation management, online scheduling, website search engine optimization, and multichannel patient engagement. However, these all-in-one solutions can be expensive.

You can start by bringing tools to your site, such as embedding your physicians’ Healthgrades.com reviews within a page on your site and displaying your social media accounts on a page within your site using some easy code (for example, [https://developers.facebook.com/docs/plugins/page-plugin/](https://developers.facebook.com/docs/plugins/page-plugin/)).

And if you do not yet have a social media presence, get one.

**Susanne Madden** is founder and CEO of The Verden Group, a consulting firm founded to help practices navigate through the increasingly complex business of healthcare.
Work **smarter**, get paid **quicker** and improve staff and patient experiences.

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