Access to Better Information can Drive Revenue and Patient Satisfaction

By Dan Buell

Long recognized as patient registration experts, Patient Access is now tasked with a new vantage point in the healthcare continuum. Seemingly routine responsibilities, such as registering patients, checking eligibility and verifying identity, are more than they seem. They affect all aspects of the revenue cycle and, more importantly, the healthcare organization’s bottom line. Some processes can even impact patient safety. In addition, patient experience and satisfaction have become a critical part of the job, challenging staff to approach traditional Patient Access processes with a new mindset.

In fact, Patient Access is quickly becoming the gatekeeper of the patient experience and critical patient information. Staff conversations, interactions and efforts not only act as the first patient encounter, but they also have a significant impact on the overall revenue cycle more than ever before.

Not only is it important to input accurate demographic data that ensures patients receive the right services, but staff also must begin critical conversations about financial responsibilities that lead to improved collections. Furthermore, this must be done in a way that demonstrates respect and concern for patients. The linchpin in this process is information now gathered or provided by Patient Access.

The result? Patient Access staff must have the skills and technology to handle new revenue-related activities such as pre-service collections. They must also be able to answer patient questions related to financial counseling and insurance benefits — something traditionally referred to other departments.

Complicating the equation, however, is the growing need to verify patient identity at pre-registration or registration to avoid fraud and to improve patient safety. Clinical care may not start at registration, but as today’s Patient Access staff is acutely aware, data entered before service can affect patient care and satisfaction, as well as an organization’s financial health.

Ensure Better Reimbursement and Patient Care

The movement of traditional back-end processes to Patient Access Services is now a “best practice” because it can serve dual purposes. On one hand, Patient Access staff members are best suited to focus on patient needs from the first contact. On the other hand, they are in a unique position to ensure that the financial and clinical needs of the organization get addressed at

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the beginning of the care process. Even though each activity might initially occur in different segments of the Patient Access continuum, the availability of updated information to all staff facilitates ongoing conversations and provides patients with best information and important options.

Technology secures and leverages valuable data and analytics throughout the process, and it enables meaningful interactions between staff and the patient. Some technology-enabled Patient Access best practices include:

- Verify patient identity: Taking this step at initial access ensures the patient is linked to the proper medical record and enhances patient safety because clinical providers have accurate medical information. At the same time, a verified identity provides access to accurate financial information, which increases the creation of clean claims and faster reimbursement. Just as important, it also helps safeguard hospitals and healthcare systems from fraud and medical identity theft. Tools that search a comprehensive database to confirm the patient’s name, Social Security number, date of birth and other demographic information result in more accurate registrations upfront.

- Determine eligibility and benefits from all payer sources for accurate patient estimates: Patients don’t always understand their benefits or know the status of their deductibles; they often rely on Patient Access staff to provide this information. The ability to share information before service gives patients time to ask questions so they understand their responsibilities. Easy connection to this information at each point in the Patient Access process enables staff to accurately resolve issues for patients as they arise.

- Having complete information about patients’ eligibility and benefits either before arrival or at the time of service enables meaningful financial conversations. It is also important that verification go beyond primary insurance and include secondary and tertiary insurance coverage to ensure accurate estimates and to reassure patients that all financial sources have been identified.

- Assess a patient’s ability to pay: Accurate eligibility and benefits information becomes more valuable when paired with an assessment of the
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patient’s propensity to pay. Every patient’s financial situation is unique so determining the likelihood of payment is critical before beginning any financial discussion. The best course of action is to discuss all options in the very first conversation.

- It is important to review all open balances for a patient and his or her guarantors when determining total responsibility and ability to pay. When staff has a complete picture of the patient’s situation, the conversation can quickly move in the right direction with the patient participating in decisions about the most effective payment approach based on their unique situation and needs. As a result, the patient is typically more satisfied by this positive, informative and collaborative encounter, while hospitals and healthcare systems experience higher collections rates, both pre-service and after service.

- Evaluate all financial options:

Sometimes the best financial strategy for both the patient and the organization is to evaluate the patient’s qualification for financial assistance, such as Medicaid or a hospital charity program. When Patient Access staff have this information, their conversations with patients are more productive because patients know that every option has been explored, and those in need are paired with programs to help lessen the financial burden. Even if a patient does not qualify for financial assistance, a thorough overview of patient’s financial obligations enables staff to offer customized payment plans.

With effective strategies and solutions in place, Patient Access is even more empowered with the knowledge it needs to comfortably embrace its new role in healthcare. Access to accurate, up-to-date information provides the starting point for all meaningful conversations with patients but is even more supported with tools that provide scripts and conversation prompts to guide staff through discussions. This additional support gives staff the confidence to talk with patients about financial responsibilities and payment options as well as provides guidance when referral to another person is appropriate.

This is a transformative time for Patient Access professionals who are on the front lines in contending with such challenges as increased patient financial responsibilities, medical identity fraud, patient safety and a heightened focus on outcomes. The use of technology to determine patient responsibility and ability to pay — as well as to identify financial assistance and offer payment options — gives all Patient Access staff the tools needed to meet the demands of this new role. With a strategic approach in place, healthcare facilities are certain to improve patient safety and quality care as well as improve collections efforts in the process.

Dan Buell is the general manager of Experian Healthcare, a leader in providing revenue cycle products and consultative services to health systems, hospitals, medical groups and specialty organizations, helping them to optimize payment processes, reduce bad debt and make better-informed business decisions.