IT'S TIME FOR AN EVIDENCE-BASED APPROACH TO COMPLAINT MANAGEMENT IN THE REVENUE CYCLE

Suzanne Lestina

If a patient complained so vehemently about an unpleasant collection encounter that it reached the CEO's office, is that an indication that the hospital's Patient Financial Experience is terrible? What if the same CEO, on the same day, gets a letter from a different patient raving about the registrar who brightened her day while collecting a $25 copay? Should you take it as a sign that the financial experience you offer is extremely high quality?

Of course, neither the complaint nor the compliment tells anything close to the full story about The Patient Financial Experience. In fact, both of these examples could well be related solely to the amount the patients owed. Yet this kind of feedback—where the loudest voices, either very pleased or very unhappy that somehow make it through all the background noise---is often what drives change in the revenue cycle.

This reactive, piecemeal approach is contrary to everything we know about best practices in complaint management for any industry, healthcare included. And the way the clinical world manages complaints is quite different from their revenue cycle counterparts. In this blog, I'm going to examine some of these differences and what they mean for revenue cycle leadership.

First, clinical protocols affecting all hospital patients are not based on a handful of "outlier" cases. That's because no two patients are alike, and an isolated poor clinical outcome could have happened for any number of reasons. That's why a root cause analysis, if appropriate, is done--so that clinicians can determine the underlying causes of the unfortunate incident.

But clinical practices for the general patient population wouldn't necessarily be changed because of a single bad outcome. Similarly, if a particular patient's outcome was far better than anyone on the clinical team expected, it might indeed result in a letter of gratitude to the hospital and entire clinical team. The letter might even be used for marketing purposes, as an example of the excellent care the hospital provides. But standing on its own, the great outcome and feedback from a grateful family isn't enough to base clinical practice changes on. So how and why are clinical practice changes made? They're made based on evidence-based recommendations which stem from a large amount of data looking at care provided to all kinds of patients---not just a handful whose outcomes were particularly great or very poor.

In my experience, hospitals tend to weigh "outlier" revenue cycle complaints too heavily. I've known revenue cycle leaders who have made changes in their processes after just a single complaint reached the CEO's office. The problem with basing quality improvement on complaints or compliments is that we know that patients who give feedback, especially if it's unsolicited, are typically either the most or least satisfied. Any complaint should be appropriately addressed, of course, but that doesn't mean changes in the revenue cycle should be driven by it.

Wouldn't it be much better to take *all* revenue cycle interactions into account? Lack of this data puts the revenue cycle at a big disadvantage. Quality assurance as it's typically done in the revenue cycle is based on very limited data. It's also labor-intensive, when every hospital is doing more with less. Auditors typically look for things such as whether the employee greeted the patient by name, obtained certain pieces of information, and closed by asking, "Is there anything more I can help you with today?" or thanking the patient. That's all fine and good, but does it really tell the whole story about that patient's entire financial experience? It doesn't take into account any of the other calls or in-person encounters that particular person had. For patients, satisfaction depends not on an isolated encounter but on the entirety of their health care financial experience.

And what does it say about the Patient Financial Experience the revenue cycle is delivering in general? Just consider all of the information that's missed if only a handful of interactions are looked at. It means the revenue cycle is making decisions based on only a small percentage of the information that's out there. It's true that auditors might discover some really poor encounters that signal the need for an individual employee to be trained, or for department-wide inservicing to be done. But a needle in a haystack approach to complaint management is fraught with risk. It can conceal some pervasive problems that are occurring with financial conversations, or it can falsely reassure you that things are great.

An evidence-based approach to complaint management is possible only if you get the whole story. Imagine if surgeons knew their mortality and infection rates for just a small group of patients. Such limited data could be very misleading, not to mention dangerous. Likewise, the revenue cycle should be getting information about all interactions, not just a select few, in order to meet its mission. Basing action plans and process changes on limited information such as complaints is no way to do business, but in many ways that is how revenue cycle departments are operating today.

Another big difference in complaint management between clinical areas and the revenue cycle involves ***prevention***.

There is a growing shift in the clinical world toward preventing health conditions from occurring in the first place, and preventing bad outcomes in the hospital setting, giving rise to such quality metrics as hospital-acquired infections and hospital readmissions within 30 days. And patient-reported outcomes are giving even more data to improve care. The revenue cycle has no comparable performance metrics to drive improvement.

Another way clinicians prevent bad outcomes, of course, is with specialized training, such as that required of radiology technicians, emergency nurses and phlebotomists, for example. All of these health care professionals are expected to meet the standards of their fields and have the appropriate certifications.

It's worth noting that some revenue cycle employees don't have any certifications indicating they're meeting current standards in their field. Further, they often have no specialized customer service training for the revenue cycle, even though their roles are extremely important to many key organizationwide priorities--The Patient Experience and the hospital's financial solvency, to name two. Today's registrars have a complex role that calls for specialized training and expertise, including some very complex financial conversations. It all requires an in-depth knowledge of insurance and benefits and clinicals and financials. Just imagine the number of poor experiences, some of course escalating to complaints, that could be prevented altogether if revenue cycle employees obtained training on par with their clinical counterparts?

Clinical areas also use evidence-based approaches to predict which patients are at high risk for having poor outcomes and do something about it. Those patients are treated differently from other patients. A patient with a concerning medical history, for instance, might be kept for observation. Since no two patients are alike, clinical care is adjusted accordingly. If that wasn't the case, the high-risk patients would be likely to have poor medical outcomes, with the "complaint" likely to come in the form of a malpractice suit or a report to the state medical board. Major repercussions would follow, not just for the individual clinicians involved in the case, but the entire organization.

Similarly, if a patient is at high-risk for a poor financial outcome, the cost in terms of revenue and reputation could easily rival that of a malpractice lawsuit if the situation is well-publicized. Yet in contrast to the clinical side, revenue cycle are not designed to proactively prevent complaints. In part that is because the revenue cycle can't tell which patients are at high risk of escalation. But just as on the clinical side, where there are certain symptoms or medical history putting patients in high-risk categories, there are well-known factors that put patients at risk for a poor financial outcome. The problem again, is lack of data. If the entire array of patient interactions were analyzed for signs of escalation, it could be a game-changer for complaint management in the revenue cycle.

At Avadyne, for example, we know a great deal about what makes it likely a patient encounter will escalate. Risk factors include tone or volume of voice and use of certain key words or phrases. Certain situations are high-risk, too, such as high-dollar liability amounts discovered much too late in the process, or problems with coverage (such as claims getting denied due to the insurer claiming they're not medically necessary, because they have no authorization, or because the payer is out-of-network, to name just a few!)

Yet typically, in the revenue cycle, many are not doing enough to weed out these high-risk interactions and do something about them. No action is taken until after someone complains. Imagine how many revenue

cycle complaints were clearly identifiable, in plain sight, and allowed to escalate? That's dissatisfaction that didn't need to happen.

Going back to the example of the patient who complained to the CEO's office about an unpleasant collection encounter, the call seemed to come out of nowhere. But it couldn't have. For certain, there was at least one encounter (and there were probably several) where that patient gave clear warning signs that things were escalating. If the very first time it happened, the encounter was identified as likely to escalate, something could be done. A supervisor or customer service specialist could get involved and do service recovery, either at the time of the encounter or very shortly afterward. The patient doesn't have to take the time out of their day to write a letter, make phone calls or post on social media, since the issue was resolved.

If the revenue cycle doesn't have a way to monitor all interactions before things escalate, someone else might be the one fielding the complaints. By the time it reaches the CEO, things are already bad. The patient has already posted publicly with their version of events, damaging the hospital's reputation. The hospital must adopt a defensive position of damage control--because it's too late to do anything else.

Let's take the example of a social media post made by a patient: "Layoffs announced at Hospital A this morning—but they're making me wait 2 weeks for my MRI. You'd think they'd want revenue!" The clever post gets its point across. Anyone who sees it probably can't help but sympathize and shake their heads, wondering why the hospital's operations are so inefficient and inconsiderate of patients' needs. Complaints like this one, if they come to the attention of administrators, might even be dealt without revenue cycle input. Perhaps a decision gets made to advertise that all MRIs get scheduled within a week—without realizing that a major payer recently increased timeframes for authorization requests to seven business days. Patients getting quick appointments would be very pleased—but only until the day of service when they find out their diagnostic test was not authorized—and that they took off work for nothing because the test must be rescheduled. Or worse, when the claim gets denied weeks later due to "no auth" obtained. This well-meaning change in response to a vocal complaint would only wreak havoc with productivity and satisfaction, with many more angry social media posts likely to follow.

Let's back up in time, a few days before the posted complaint. There were surely signals that things were escalating. If detected, a conversation in real time or shortly after the encounter could explain the reason for the scheduling being done a week out: Because it was the only way to avoid a denied claim and a very large bill for the patient. The patient would probably have been relieved to know the revenue cycle employee was working behind the scenes, using their insurance know-how to avoid a large bill.

We also need to consider how many people are unhappy with their financial experience, but do not take the time and effort to complain. According to our market study, more than half of patients are not satisfied

with the hospital's ability to give financial help and guidance. There's a lot of dissatisfaction out there, to be sure. All of those people are surely telling others about their poor financial experiences, whether on social media or just their own circle of acquaintances, friends and family. It's impossible to know how this affects revenue. But if even one person decides to choose another hospital due to the perception of a poor Patient Financial Experience, millions in revenue are potentially lost.

Click Here to Get the Market Study >

The bottom line is: Patients expect financial care to be on par with the clinical care they receive. It's time to change the way we manage complaints in the revenue cycle to reflect this reality. We need technology to tell us which encounters will probably turn into complaints, and we need to look at every patient financial encounter. The revenue cycle needs a preventative, data-driven approach to complaints—the same way things have been done on the clinical side for decades.

To learn more how to manage financial dissatisfaction, check out our eBook ***We Know How Our Patients Feel About Us!" (Or Do We?): Putting Financial Dis-Satisfaction Under the Microscope in Search of New Cures***