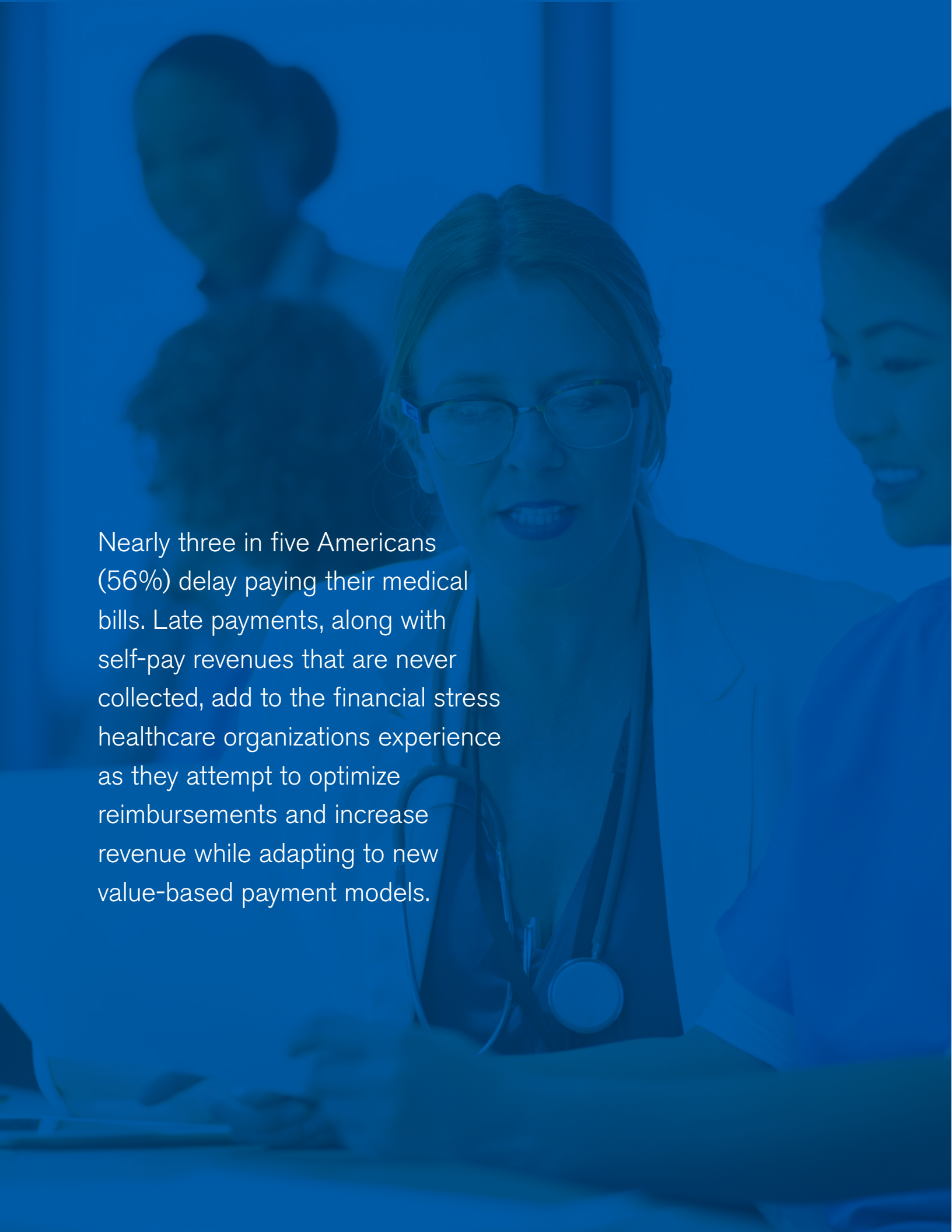




Optimizing Revenue

*Solving Healthcare's Revenue Cycle Challenges
Using Technology-Enabled Communications*





Nearly three in five Americans (56%) delay paying their medical bills. Late payments, along with self-pay revenues that are never collected, add to the financial stress healthcare organizations experience as they attempt to optimize reimbursements and increase revenue while adapting to new value-based payment models.

West's report *Optimizing Revenue: Solving Healthcare's Revenue Cycle Challenges Using Technology-Enabled Communications* found that 56 percent of patients' payments are delayed at least some of the time. The report also revealed that high insurance deductibles are the most common reason cited for missing payment deadlines.

An analysis of the cost of insurance policies purchased through the Healthcare Marketplace during the 2017 open enrollment period showed that the average annual deductible was \$8,232 for a family policy.¹ That same analysis reported that between 2016 and 2017, the average annual deductible for family plans increased by \$249, or three percent. It is partly due to this trend of rising deductibles that patients are delaying paying their medical bills and providers are finding it more difficult to collect payments and reduce bad debt.

According to West's survey results, optimizing reimbursements is another top revenue-related challenge that weighs on providers. Value-based payment programs that financially reward healthcare organizations based on performance are growing in numbers. The Centers for Medicare and Medicaid Services (CMS) has already succeeded in tying 30 percent of Medicare provider payments to value, and it is continuing to advance alternative payments as it drives toward the goal of tying 50 percent of payments to value by the end of 2018.² The introduction of these new payment programs is forcing healthcare providers and organizations to seek out solutions that will enable them to maximize reimbursements.

While healthcare organizations have always focused on retaining and increasing revenue, that has become more difficult now that three-quarters of patients' decisions about whether to see their provider and receive healthcare services are impacted by high deductible health plans. *Optimizing Revenue: Solving Healthcare's Revenue Cycle Challenges Using Technology-Enabled Communications* shares findings from two West surveys related to revenue cycle management. The first survey, conducted in partnership with Kelton Global, was administered to 1,010 nationally representative Americans ages 18 and over. The second survey was administered by West and captured viewpoints from 236 healthcare providers.

ANALYSIS OF THE SURVEY FINDINGS REVEALED:

- Managing overdue payments is one of the top challenges facing healthcare organizations.
- Patients are struggling to pay medical bills, and more than half of patients are delaying payments.
- High insurance deductibles and confusion regarding insurance coverage are the primary reasons patients delay healthcare payments.
- Providers are missing opportunities to increase and retain revenue.
- Healthcare providers can maximize reimbursements by prioritizing chronic disease management.

Getting Paid and Reducing Bad Debt

Rising deductibles and growing healthcare costs are contributing to delayed payments and uncollected self-pay revenues that threaten the financial viability of medical practices and hospitals. Healthcare providers across the U.S. struggle daily to collect payments from financially stressed patients who cannot or will not make timely payments.

Nearly four in five patients (79%) say affordability is the biggest problem—ahead of insurance coverage, care quality, provider availability—with healthcare in America. In fact, when asked about their general opinions of healthcare in America, nine in ten healthcare consumers (93%) said it is too expensive. Attitudes surrounding cost may stem from the fact that two-thirds (67%) of patients say their financial situation makes it difficult to pay their medical bills on time.

Twelve percent of patients say their payments are “always” delayed. Another 16 percent of patients admit they “frequently” delay paying their medical bills.

Healthcare Costs Fuel Payment Problems

Nearly all Americans feel healthcare is too expensive.

79% of patients say affordability is the biggest problem with healthcare.

93% of healthcare consumers believe healthcare is too expensive.

67% of patients say their financial situation makes it difficult to pay medical bills on time.

56% of patients delay paying their medical bills at least some of the time.



Younger adults in particular confirm that they have missed payment deadlines. Millennials are more likely than non-millennials (70% vs. 50%) to delay paying their medical bills. Younger working adults are not only more likely to miss payment deadlines, but they also have on average lower annual salaries than older working adults. According to data from the Bureau of Labor Statistics, the median weekly income earned by people between the ages of 25 and 34 was \$778 during the first quarter of 2017.³ During that same period, 45- to 54-year-olds earned a median weekly income of \$1,001. Based on these figures, the average annual difference in earnings between these two age groups is \$11,596. The fact that the group with significantly less income is more likely to delay medical payments emphasizes the burden of high healthcare costs.

Young Adults Are Missing Payment Deadlines

Extra effort is required from providers to remind and encourage millennials to pay on time.

7 in 10 young adults (millennials) have missed payment deadlines for medical bills.

Millennials are more likely than non-millennials (70% vs. 50%) to delay paying their medical bills.



Patients cite high insurance deductibles as the top reason behind delayed medical payments. In fact, 42 percent of patients state that they delay payments for medical bills because of unexpectedly high deductibles.

Healthcare providers understand that patients are having difficulty affording the self-pay portion of medical expenses. Nearly all (95%) providers recognize that patients may delay bill payments because their financial situation makes it challenging to pay on time.



Patients Are Struggling To Pay Medical Bills

Patients cite high deductibles as the top reason behind delayed medical payments.

42% of patients delay payments for medical bills because of unexpectedly high deductibles.

95% of providers recognize that patients may delay bill payments because of their financial situation.

High deductibles are not the only factor preventing patients from paying medical bills on time. Patients say other factors that contribute to payment delays include:

- Confusion about how much insurance will cover vs. what patients owe (30%).
- Receiving bills for services patients don't think they should have to pay for (30%).
- Waiting to receive the final bill so they are sure of the amount owed (25%).
- Uncertainty about what payment method to use (11%).

Finally, more than one-third (36%) of patients report that they find it difficult to remember to pay their bills on time. This is no surprise to providers—more than half (53%) recognize that patients delay payments because they don't remember to pay their bill.

Forgetfulness Leads To Payment Delays



Patients admit they have forgotten to pay their medical bills on time.

36% of patients find it difficult to remember to pay their bills on time.

53% of providers recognize that patients delay payments because they forget to pay their bills.

Millennials are twice as likely as non-millennials (54% vs. 27%) to feel that it is difficult to remember to pay their bills on time.

Providers Can Drive Timely Payments

Sending patients strategic engagement communications helps reduce payment barriers.

85% of patients feel there are strategies providers could use to encourage on-time payments.





Solving Payment Problems

Everyone agrees that more measures are needed to help patients make timely payments. Providers know that they need to strengthen and expand efforts to solve payment issues. Eighty-five percent of patients feel there are strategies that providers could use to encourage and help them pay their medical bills on time. Opportunities exist for providers to assist patients in making payments by simply leveraging technology-enabled communications, the very same technology used to deliver appointment reminders. Here are some ways providers can leverage this technology.



Engage patients in conversations about healthcare costs.

More than one-third (36%) of providers say they never discuss a patient's ability to pay for healthcare prior to delivering services, or they only discuss affordability if patients raise the topic. Only 23 percent of providers make it a habit to always discuss each patient's ability to afford healthcare prior to delivering services. By initiating conversations about cost, providers can identify payment barriers and help patients overcome those challenges. This practice also has the added benefit of reducing patient anxiety, making patients less likely to put off receiving treatment.

Reminder notifications can serve a dual purpose and be used as an icebreaker for financial conversations. The 77 percent of providers who do not discuss cost with each of their patients can open the door to payment conversations by using double-duty appointment reminder messages. A healthcare practice could use the automated voice message, email or text message appointment reminders they are already sending in advance of scheduled appointments to inform patients of

potential copayments and out-of-pocket costs. Patients would receive a message stating the date and time of the appointment, as well as a reminder to be prepared to pay their copayment upon arrival. The message may also encourage patients to discuss payment concerns with their healthcare team during the appointment. Giving patients advance warning of their financial obligations reduces the likelihood of payment delays stemming from financial strain, allowing more time to plan for healthcare expenses prior to payment deadlines.

Discussing Costs Can Help Reduce Delayed Payments

36%

of providers say they never discuss a patient's ability to pay for healthcare prior to delivering services.

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of providers who do not discuss cost with each of their patients can open the door to payment conversations by using double-duty appointment reminder messages.



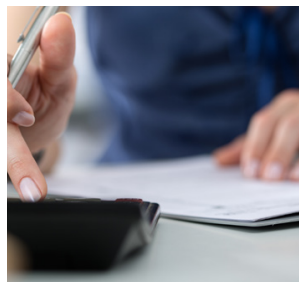
Improve transparency by communicating costs prior to billing.

Thirty percent of patients delay bill payments because they are confused about what expenses insurance covers and what they owe. Thirty percent of patients also delay payments when they believe they have been billed for something that they don't think they should have to pay for. By using appointment reminder technology to deliver patient payment communications, providers can answer questions and clear up confusion that is prohibiting payment.

Three in four patients (75%) do not know the cost of healthcare services until they receive a bill. Sharing cost information prior to sending out bills makes patients more aware of self-pay responsibilities, improves transparency and helps patients plan for medical expenses. Yet less than one-quarter (24%) of providers plan to implement a price transparency program within the next 12 months. This data shows there are opportunities for providers to do more to improve transparency and remove payment hurdles.

Providers can use appointment reminder technology to send patients post-appointment messages containing follow-up clinical instructions and a pre-billing alert. The messages could be customized with a brief explanation of the amount owed along with care plan reminders or follow-up instructions to reaffirm what was discussed during the appointment.

A mere 15 percent of providers currently send messages—either by phone, text or email—to explain bills and let patients know what portion of the cost is covered by insurance. By sending patients pre-billing messages, providers can ensure patients know when to expect a bill, what portion of the bill is covered by insurance and the amount the patient is responsible for paying out of pocket. This strategy of preparing patients for bills helps reduce confusion and prevent late payments.



Patients Are Confused about Cost of Healthcare Services

30%

of patients delay bill payments because they are confused about what expenses insurance covers and what they owe.

75%

of patients do not know the cost of healthcare services until they receive a bill.

23%

of providers make it a habit to always discuss each patient's ability to afford healthcare prior to delivering services.

24%

of providers plan to implement a price transparency program within the next 12 months.

15%

of providers currently send messages—either by phone, text or email—to explain bills and let patients know what portion of the cost is covered by insurance.



Send patients proactive payment reminders.

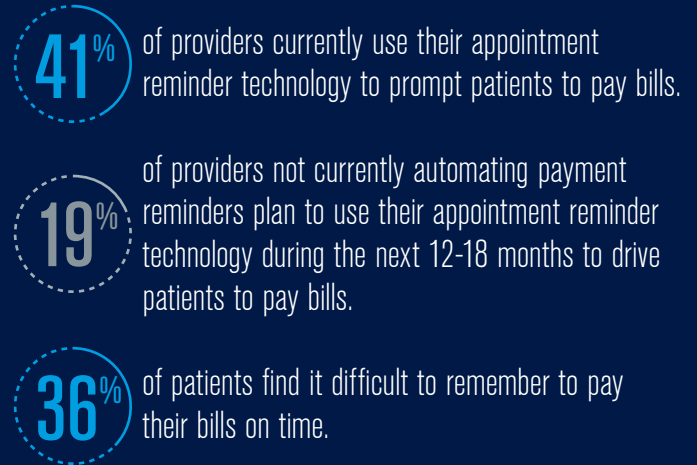
Although many providers already have technology in place to automate payment reminders, just four in ten providers (41%) currently use their appointment reminder technology to prompt patients to pay bills. Only 19 percent of providers not currently automating payment reminders plan to use their appointment reminder technology during the next 12-18 months to drive patients to pay bills.

For 36 percent of patients, it is difficult to remember to pay their bills on time. These patients are prime candidates for proactive payment deadline reminders.

These findings reveal that providers could do more to communicate with patients and remind them of payment deadlines, but that they may not realize they can leverage their appointment reminder technology to do so.

In the same way providers use appointment reminder notifications to alert patients of upcoming appointments, medical teams can send messages to patients who are in danger of missing a payment deadline.

Reminder Communications Prevent Delayed Payments



For example, staff can pull a list of patients who have an approaching payment due date and set up an automated payment reminder for anyone on the list whose payment has not processed. These reminder messages let patients know they have an upcoming payment deadline and invite them to make an immediate one-time payment to avoid delinquency. The communications can be designed so that patients can respond immediately by pushing a button on their touch tone phone to make a payment. By making the payment process simple and convenient, providers increase the likelihood that payments will be made.





Notify patients when payments are overdue.

Only 31 percent of providers make phone calls to patients who have missed payments. Even fewer providers use automated communications such as voice messages, texts and emails—which require fewer resources and have lower costs than staff-initiated outreach—to contact patients with outstanding balances.

Just 21 percent of providers send reminders to notify patients when payments are past due and provide an immediate payment option. When MU Health Care (The University of Missouri Health Care) began sending automated payment reminder calls to patients with delinquent accounts, they reduced outstanding A/R by more than \$463,000 annually. The healthcare provider delivered voice messages that transferred patients to their self-pay team to make a payment. Through these efforts, MU Health Care was able to collect \$115,941 in the first three months after implementation—proving that technology-enabled communications can successfully drive payments and reduce bad debt.

Appointment reminder technology offers providers opportunities to collect past-due payments by sending automated messages. Friendly automated messages that are sent soon after missed due dates, encourage patients to pay their bill and offer immediate and convenient payment options can help providers collect more payments sooner.

Delayed payments, or those that are never received, contribute to bad debt and financial stress for healthcare providers. Medical teams are aware of the difficulties that are causing patients to delay payments and not pay their bills. To collect payments and reduce bad debt, providers must work to address patients' payment challenges. By leveraging technology-enabled communications, providers can significantly minimize these payment obstacles.

Past-Due Notifications Solve Payment Problems

31%

of providers make phone calls to patients who have missed payments.

21%

of providers send reminders to notify patients when payments are past due and provide an immediate payment option.





Increasing and Retaining Revenue

Patients' financial concerns about healthcare costs impact providers' ability to increase and retain revenue. Around three in four patients (77%) disclose that higher insurance deductibles affect how often they see their provider. Seventy-five percent of patients say higher insurance deductibles are a factor in their decisions about whether to receive healthcare altogether.

Patients are currently opting out of preventive care because they believe it is too costly. Three-quarters (75%) of patients admit that high insurance deductibles impact how often they get preventive screenings or tests. Unfortunately, more than one-third (37%) of adults in the U.S. say they would not be able to afford an unexpected medical bill for more than \$100 without going into debt. As many patients are reluctant to take on extra expenses, this leads to avoidance of what they view as non-essential healthcare services.⁴ Providers agree that high deductible health plans influence patients' willingness to seek preventive care. Seventy-seven percent of providers claim that large deductibles have a very high or high impact on patients' decisions to get preventive screenings or tests. For providers who need to maintain a full schedule of appointments to produce revenue, these numbers are troublesome.



Patients Forego Healthcare Due to Cost



Providers may miss opportunities to book appointments because of patients' concerns about healthcare costs.

75% of patients say high deductibles impact their decisions about whether to receive healthcare.

77% of patients say high deductibles impact how often they see their provider.

75% of patients admit high insurance deductibles impact how often they get preventive screenings or tests.

Preventive Care Revenue Opportunities

Patient participation in preventive care generates revenue for providers and is beneficial to patient health. However, Americans currently use routine care at only half the suggested rate, which means that providers are missing out on potential revenue opportunities from preventive care.⁵

To make preventive care more attractive to patients, providers need to educate them about the actual costs of routine services and screenings. Sixty-three percent of providers say promoting necessary preventive care services to drive new revenue is at least a high priority, and 17 percent say it is their top priority.

Numerous opportunities exist to increase this revenue stream by driving better patient communications through technology to teach patients about the advantages, availability and affordability of preventive services. Providers who take advantage of these opportunities can help patients understand the importance of preventive care, and potentially realign priorities by highlighting preventive care's benefits vs. actual costs.





Women's Health

Women make up a large patient demographic that underutilizes preventive care. In fact, only 26 percent of women strongly agree with the statement, "I get all necessary preventive screenings." Seventy-seven percent of women report that high deductibles at least somewhat impact how often they get preventive screenings or tests. Forty-five percent of women say high deductibles impact how often they postpone or delay recommended or necessary treatments either by "a lot" or "very much." U.S. Census Bureau estimates from 2015 show that nearly two in five people (39.5%) living in the U.S. are women age 18 or older.⁶ So even a slight increase to the rate at which this demographic uses routine care would result in a significant increase in the number of preventive services and screenings conducted by U.S. healthcare providers, thereby increasing preventive care revenue for providers. To promote preventive care to this demographic, healthcare providers can send women messages to educate them about the availability and importance of preventive screenings such as mammograms, notify them when they are due for preventive services and encourage them to make appointments for services that carry no out-of-pocket costs. Under the Affordable Care Act, the standard coverage for mammography screenings by private plans allows for women age 40 and over to receive a screening every 1-2 years. Data analyzed from the Center for Disease Control and Prevention (CDC) indicates that approximately 80 percent of eligible women received a mammogram in the past two years.⁷

Scottsdale Medical Imaging conducted an outreach campaign to drive more patients to schedule mammograms. The healthcare provider identified every patient who had ever been seen for a mammogram and was 30 days past due for their next one. By sending these overdue patients an automated voicemail asking them to schedule their preventive screening, the practice booked approximately 1,200 mammograms year-over-year, a strategy that translates into a quarter of a million dollars in additional revenue.



Women Not Taking Advantage of Preventive Care



Financial concerns are partly to blame for women delaying or postponing preventive care.

Only 26% of women strongly agree with the statement, "I get all necessary preventive screenings."

77% of women say high deductibles at least somewhat impact how often they get preventive screenings.

Men's Health

Like women, men admit to skipping or delaying preventive care. Less than one-third (28%) of men say they strongly agree with the statement, "I get all necessary preventive screenings." Seventy-two percent of men admit a high deductible at least somewhat impacts how often they get preventive screenings or tests. Four in ten men (40%) report that high deductibles impact how often they postpone or delay recommended or necessary treatments either by "a lot" or "very much." To increase the rate at which male patients receive preventive care, and in turn increase revenue, healthcare providers can communicate using technology to educate male patients about the availability and affordability of preventive services like colorectal cancer screenings.

Ochsner Health System increased revenue by using automated appointment reminders to book preventive screenings for colorectal cancer. Over the course of two months, Ochsner delivered automated phone notifications to patients with recent orders for a colonoscopy. The strategy was to let patients know they were due for the preventive screening and remind them to schedule the test. This effort paid off for Ochsner, delivering \$685,000 in additional appointment revenue.



Men Delay Preventive Care

Providers miss opportunities to earn revenue when men do not get recommended preventive screenings.

40% of men say that high deductibles impact how often they postpone or delay recommended treatments either by "a lot" or "very much."

Only 28% of men say they strongly agree with the statement, "I get all necessary preventive screenings."





Childhood Immunizations

Eighty-four percent of parents say a high deductible at least somewhat impacts how often their children get preventive screenings or tests, while 49 percent say high deductibles impact decisions—“a lot” or “very much”—to postpone recommended or necessary treatments. Many parents are unaware that childhood immunizations are a covered service available at no cost, regardless of insurance status or the patient’s deductible. Using appointment reminder technology, providers can easily send parents automated communications when children are due for immunizations. These text messages, emails or voice messages can inform parents that there are no out-of-pocket costs for immunizations, and provide an option to automatically schedule an appointment for their child.

One large healthcare organization used this strategy to message parents of adolescents who were due for immunizations. Utilizing West’s technology-enabled communications, parents were sent texts and automated voice calls that encouraged them to get their child vaccinated. Messaging costs for the outreach equaled less than one percent of the gross revenue generated from additional appointments; every dollar invested in the outreach generated \$115 in gross reimbursements.

A previous West study confirmed that when providers reach out to patients and encourage them to schedule routine exams or services, the results are very favorable. According to the study, *Patient Engagement: Improve Communication, Improve Care*, for 45 percent of physicians, outreach converts into appointments at least half of the time.⁸ That means at least one out of every two messages sent results in a patient visit for those providers. Another 38 percent of physicians report being able to convert around 20-50 percent of outreach attempts into appointments. Ultimately, nine out of every ten physicians gain increased patient visits and increased revenue when they perform even a minimal amount of outreach to promote routine care.

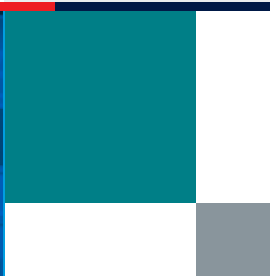
Parents Weigh the Cost of Care



Financial concerns impact parents' decisions about their children's healthcare.

84%

of parents say a high deductible at least somewhat impacts how often they get preventive screenings or tests for their children.



Retain Existing Revenue

Efforts to increase revenue by booking additional appointments and services are futile if providers do not have strategies in place to ensure those revenue-producing appointments are kept. Eliminating unused appointments in schedules caused by last-minute cancellations and patient no-shows is both challenging and necessary for retaining revenue. To reduce no-shows and protect revenue, providers can send traditional automated appointment reminders that ask patients to either confirm that they will be at their upcoming appointment, cancel the appointment or reschedule it. For example, a provider might send an automated text message to each patient several days prior to their scheduled appointment. Those messages offer patients an option to immediately speak to scheduling staff if they need to reschedule. When an appointment is cancelled, staff can reach out to waitlisted patients and offer the time slot to those individuals until it is filled.

By proactively contacting patients and giving them a simple way to notify their provider if they need to cancel or reschedule an appointment, providers can retain expected revenue, keep the schedule full and reduce the financial burden of cancellations.

Patients' perceptions and concerns about the cost of healthcare affects providers financially. When patients perceive preventive services as costly and unnecessary, they are likely to pass on opportunities to receive valuable screenings or tests. These same patients often fail to show up for scheduled appointments. Healthcare teams that encourage patient participation in preventive care and keep full appointment schedules will be better positioned to retain and increase revenue. In addition to confirming appointments and filling appointment cancellations with waitlisted patients, providers can use their existing appointment reminder technology to deliver messages to patients about the affordability and availability of preventive care, driving more appointments and revenue.



Optimizing Reimbursements

Value-based payments are increasing in number and have reached a point where they are significantly impacting provider revenue. Unless providers take steps to maximize reimbursements, they will experience substantial revenue challenges.

As providers evaluate their care and operational strategies to best align with value-based payment models, chronic care emerges as an ideal area for consideration due to the opportunities it presents for providers to earn reimbursements. For example, Medicare's Chronic Care Management program allows providers to be reimbursed \$40 per month for each patient they enroll. A monthly fee of \$8 per patient is required for participation in the program. Moreover, 66 percent of chronic patients surveyed would be willing to pay their provider up to \$10 per month for between-visit support from their medical team. Enrolling just those two-thirds of patients would enable providers to deliver ongoing support to chronic patients and earn \$480 in additional reimbursements per chronic patient annually.

Healthcare providers recognize that chronic care offers reimbursement opportunities and deserves attention. Twenty percent of medical practice providers and 18 percent of hospital and health system providers report that CMS' Chronic Care Management program is the top care program they are focusing on currently.

Providers Are Adopting Chronic Care Management

Healthcare providers recognize that chronic care offers reimbursement opportunities.



20%

of medical practice providers report that CMS' Chronic Care Management program is the top care program they are focusing on currently.

18%

of hospital and health system providers say that CMS' Chronic Care Management program is the top care program they are focusing on currently.

Patients Desire Chronic Care Support



Chronic patients want support and are willing to pay for services that will help them manage chronic conditions.

66%

of chronic patients would be willing to pay their provider up to \$10 per month for between-visit support from their medical team.





Chronic Care Program Enrollment

Chronic diseases are the leading cause of death and disability in the U.S. Half of adults in the U.S. have a chronic condition, and one in four Americans has two or more chronic conditions.⁹ Enrolling as many patients as possible in chronic disease management programs not only allows providers to improve patient experiences and the health of many Americans, it also enables providers to maximize chronic care reimbursements.

Before providers can maximize reimbursements, they need to leverage their EHR system to identify eligible patients (those with two or more chronic conditions) and then enroll them in the Chronic Care Management program, leveraging their appointment reminder system to send an enrollment email, as an example. The email could include details about the program, outline the patient benefits of participation and offer easy methods (such as links) for patients to enroll or get further information.

Providers underestimate patients' interest level in chronic care and their desire to receive support, stating that they are not confident patients would be willing to pay for chronic care support. When asked if their patients would agree to pay \$10 per month for additional chronic care support, only half (53%) of providers answered "yes." However, two-thirds of patients say they would agree to this arrangement. This misperception about patients' eagerness to receive chronic care support—and willingness to pay for it—is causing providers to miss out on reimbursement opportunities.





Scheduling Chronic Care Management Services

Participation in Medicare's Chronic Care Management program requires providers to ensure patients receive preventive services, manage and reconcile patient medications, conduct electronic person-centered care plan tracking, use a certified EHR to record and share information and designate a care team member to provide continuous care. Providers can use their patient communications technology to help them accomplish many of these tasks.

For example, providers are allowed to bill Medicare if they provide at least 20 minutes of support per enrolled patient in a calendar month. The assigned care team member should schedule a recurring monthly call with each patient to provide support and fulfill billing requirements. Care managers can use their appointment reminder system to automatically schedule those patient calls. This strategy would enable providers to earn a \$40 reimbursement for every enrolled patient each month.

The Chronic Care Management program also mandates that patients receive recommended preventive services. Care managers can send patients automated text, emails or voice messages to notify them when they are due for preventive screenings and tests. Like other patients, chronic patients admit they are electing to not receive some healthcare services because of concerns about cost. Nearly half (47%) of patients with a chronic condition say high insurance deductibles impact how often they go to see their healthcare provider either by "a lot" or "very much." High deductibles also impact

Chronic Patients and Preventive Care

Chronic patients admit they do not always receive healthcare services because of concerns about cost.

47% of chronic patients say high deductibles impact how often they go to see their healthcare provider.

46% of chronic patients confirm high deductibles impact how often they postpone recommended or necessary treatments.

42% of chronic patients admit high deductibles impact how often they get preventive screenings or tests.

how often chronic patients postpone recommended or necessary treatments (46%) and how often they get preventive screenings or tests (42%) either by "a lot" or "very much." When care managers send patients automated messages to encourage them to schedule preventive screenings, they can ease financial concerns by letting patients know which of the preventive services are available at no cost.





Monitoring Patient Health with Surveys

Healthcare teams can use survey check-ins as another way to monitor the health of chronic patients. Distributing surveys is simple—providers can use their appointment reminder technology to automatically send messages that encourage patients to complete a survey about their immediate state of health. Then, patients simply need to respond using a touch tone phone. Surveys can be used to ask patients about things like medication adherence or symptoms they are experiencing.

Automated surveys give healthcare teams patient information between visits to help them understand how well chronic conditions are being managed. For example, a patient with COPD might be given a survey that prompts them to:

- Press 1 if they can eat without being out of breath.
- Press 2 if they are slightly out of breath when eating.
- Press 3 if they are breathless when eating.

The patient's response to this question and others about weight, appetite, energy and sleep helps the care manager assess the patient's needs and inform them of potential problems. Proactive patient monitoring lets providers recognize issues and intervene earlier. This helps reduce the need for acute care and limits hospital admissions and readmissions.

Readmissions hurt providers' ability to optimize reimbursements, as hospitals receive payment penalties, rather than reimbursements, if they reach an excessive threshold for preventable readmissions. During the 2016-2017 payment period, half of U.S. hospitals were penalized for readmissions.¹⁰ To avoid penalties and optimize reimbursements, providers need to prioritize activities that will help prevent readmissions. Sending automated surveys to chronic patients in order to proactively identify and address problems before they become critical can help prevent readmissions and penalties.



Sixty-nine percent of providers report that managing chronic diseases is a high priority. Participating in Medicare's Chronic Care Management program is an effective way for healthcare providers to manage chronic diseases and maximize reimbursements. Providers can use their technology-enabled communications to get patients enrolled in the Chronic Care Program, monitor patients' health and provide the support services that are required for chronic care billing, all of which will help them maximize reimbursements.

Conclusion

The financial impact of value-based payments is becoming more evident. Collecting payments and reducing bad debt, increasing and retaining revenue and maximizing reimbursements are challenges that define the financial well-being of medical practices, hospitals and other healthcare organizations. By not prioritizing improvements in these areas, healthcare providers are missing out on many of the opportunities that would benefit their organization financially. The providers who are seeing the most success now, and who will continue to achieve the best financial outcomes in the future, are those who understand how to use their existing resources—like technology-enabled communications—to solve revenue cycle challenges. By applying the capabilities of their existing appointment reminder technology to deliver automated messages, providers can increase the revenue they earn from patient payments and reimbursements and thrive financially.





About West

West's Engagement Center Solutions help organizations effectively activate and engage patients beyond the clinical setting. West's unique combination of technology-enabled communications and clinically managed resources are designed to improve patient engagement by solving complex communication challenges in four key areas along the care continuum: Patient Access, Routine Care, Chronic Care and Transition Care. By providing innovative technology and delivering meaningful and relevant communications, West enables healthcare organizations to optimize the patient experience, improve quality, maximize revenue and reduce costs.

West is a leading provider of technology-driven communications, serving Fortune 1000 companies and clients in a variety of industries, including: healthcare, telecommunications, retail, financial services, public safety, and technology.



Learn more about how
West is changing healthcare:

west.com/healthcare

televox.com



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