Patient Financial Communications: Implementing the Best Practices

HFMA Joint Spring Conference
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Director – Healthcare Finance Policy
HFMA
Every day, healthcare professionals conduct sensitive financial discussions with patients. But there have been no accepted, consistent best practices to guide them in these discussions—until now.
Patient Financial Communications

Best practices for healthcare providers:
– Emergency Department
– Time of Service (Outside the ED)
– In Advance of Service
– Patient Financial Communications – All Settings
– Measurement Criteria Framework
  ▪ Training
  ▪ Process compliance evaluation
  ▪ Technology evaluation
  ▪ Feedback and response evaluation
  ▪ Executive level metrics reporting
When and Where to Have Patient Financial Discussions

Discussions at the time of service

- In the ED
- Outside the ED setting

Discussions in advance of service
Who Participates in Patient Financial Discussions

Routine scenarios
Non-routine or complex scenarios
Topics Addressed in Patient Financial Discussions

Provision of care
Registration, insurance verification, and financial counseling
Topics Addressed in Patient Financial Discussions

Patient Share
Prior balances (if applicable)
Balance resolution

Value = \frac{Quality}{Payment}
Parameters for Patient Financial Discussions

Compassion
Patient advocacy
Education
Compliance Framework

Training program
Process compliance
Metrics reporting
Compliance Framework

Technology
Feedback process and response
HFMA’s Programs

Education Products – Available now
Adopter Recognition – Available now
Compliance Recognition – Announced February, 2014

Vendor Peer Review Program for consulting firms working in the patient financial communications area – just announced!
What We Dare Not Do!
Patients Benefit

Understands Out-of-Pocket Liability

Focus on clinical care at time of service

Reduces back end problems (denials, etc.)

Engaged

Single point of contact for finances

Knows how account will be resolved
Providers Benefit

• Opportunity to encourage patients to talk with financial counselor about any financial concerns
• Identify opportunities to locate additional or alternative insurance coverage
• Secure how accounts will be resolved through conversation
• Identify patients who fall under the 501r regulations
• Benefit from the PR value of a satisfied consumer vs. an unhappy consumer
Implementation – In the Beginning …

• Someone has to lead the charge
• C-Suite leadership is critical
• It takes a team
• What is your current performance
• What are your opportunities
It Takes a Team

• The cast of the obvious – patient access
• The cast of the less obvious – clinical leaders, ancillary department personnel
• The cast of the lesser obvious – volunteers (Pink Guys and Gals, et.al.), physicians, physician office managers, marketing/public relations personnel, members of the Board
Gap Analysis

• Comparing best practices to current practices
  – Observation of current activities
  – Documentation of gaps
• Identifying the degrees to which our organization is willing to commit to the Best Practices
  – No “one size fits all”
  – Think BIG!
  – Uses Gap analysis to identify potential policy and procedure changes
## Sample Gap Analysis Worksheet

<table>
<thead>
<tr>
<th>Best Practice – TOS (Outside ED)</th>
<th>Observed Compliance</th>
<th>Defined Gap</th>
<th>May Require Policy change</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Discussion participants-properly trained registration or discharge rep; supervisor or FC for complex cases; patients have opportunity to request advocate, designee or family member to assist</td>
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<tr>
<td>2.2 Setting – during registration or discharge; during medical care as long as does not interfere and with patient consent</td>
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<tbody>
<tr>
<td>2.3.1 Registration – demographic information collected</td>
<td></td>
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<tr>
<td>2.3.1 Insurance coverage information collected</td>
<td></td>
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<tr>
<td>2.3.1 Determine potential need for financial assistance</td>
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<tr>
<td>2.3.2 Insurance verification - review insurance eligibility details with patient to ensure accuracy</td>
<td></td>
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<tr>
<td>2.3.2 If uninsured patient, explain goal of collection information is to identify paying solutions or financial assistance options for this visit</td>
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<tr>
<td>2.3.3 – Financial counseling – if appropriate, refer patient to financial counselor or offer information regarding provider’s financial counseling service and assistance policies</td>
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<td>2.4 Provision of care-provider will have clear policies on how to interact with patients with prior balances choosing to have elective or non-elective services. Clear definitions of elective and non-elective services.</td>
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<tr>
<td>2.4.1.1 – Elective services - patients have obligation to make satisfactory payment arrangements before receiving care</td>
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<tr>
<td>2.4.1.2 – Elective services-prior balances – patients will be informed if provider’s policies regarding prior balances mean the service will be deferred</td>
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<td>2.4.2 – Non-elective services</td>
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<tr>
<td>2.4.2.1 – Patients will be informed that ability to resolve patient share or prior balances will not affect provision of care</td>
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<td>2.5 Patient share and prior balance discussions – will not interfere with patient care; will focus on patient education</td>
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<tr>
<td>2.5.1.1 Patient share: list of participating providers</td>
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<tr>
<td>2.5.1.2 Costs may vary from estimates and why</td>
<td></td>
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<td>2.5.1.3 If appropriate, provide payment options if patient is interested in them</td>
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<td>2.5.1.4 If appropriate, provide financial assistance program information</td>
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<tr>
<td>2.5.2 Prior balance discussions</td>
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<tr>
<td>2.5.2.1 Discuss services that led to prior balance, including DOS and $; provide list if requested</td>
<td></td>
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<td>2.5.2.2 If appropriate, discuss payment options</td>
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<td>2.5.2.3 If appropriate, provide financial assistance program information</td>
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<td>2.5.2.4 Proactively attempt to resolve prior balances through insurance and financial assistance</td>
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<td>2.6 Balance resolution, including how and timing of collection activity</td>
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<td>2.7 Summary of care documentation: written financial assistance information, financial implications of services provided; telephone number</td>
<td></td>
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hfma healthcare financial management association
Next Steps

• Summarize gaps by service area
• Identify potential policy changes and present to C-Suite sponsor
• Finalize policy changes!
Next Steps - Strategies

• Hire, train and motivate compassionate, service-oriented staff

• Equip staff with tools to succeed:
  - Charge estimation
  - Insurance verification
  - Prior balances
  - Financial assistance applications, process
  - Scripting
  - Ongoing refresher classes
Next Steps - Strategies

• Best Practices Training Recommendations
  - Annual program
  - Documented and shared with C-suite annually
  - Variety of methodologies may be used
  - May use internal or externally sourced program(s) and faculty, subject to review by designated quality officer
  - HFMA materials available now:
    - [www.hfma.org/pfcprogram/](http://www.hfma.org/pfcprogram/)
Next Steps - Strategies

• Best Practices Training Recommendations
  - Content
    o Match best practices to specific staff roles
    o Financial assistance policies
    o Available patient financing options
    o Alternative solutions for the uninsured
    o Standard language to be used in patient discussions
    o Laws and regulations specific to staff role (EMTLA, FDCPA, TCPA, etc.)
Next Steps - Strategies

• Education
  - Revenue cycle staff: change the vocabulary
  - Patient access staff: establish where, when and how to have what conversations with patients
  - Provider clinical staff: why financial conversations represent best practices; why financial care is a component of patient care
  - All other provider staff: how these best practices help our patients first
HFMA’s Education Program

- Developed by HFMA with input and field testing by provider organizations
- Customizable to make it easy for providers to insert provider-specific policies and procedures
- Train the trainer materials
- Three webinars covering the three major service areas:
  - In advance of service
  - Time of service-outside ED
  - Time of service ED
Next Steps - Strategies

• Education (continued)
  - Physicians: non-interference with clinical care; why financial conversations represent best practices; why financial care is a component of patient care
  - Navigators or Certified Application Counselors (CACs): keep their conversations with patients in sync with provider’s philosophies and requirements
  - Volunteers: share why and how the best practices are helping patients understand the financial part of their care
  - Others
Next Step - Strategies

• Patients
  - Create tools and materials to help patients understand:
    o Insurance verification results, especially high deductible plans, in vs. out of network plans, open enrollment period, etc.
    o Cost to the patient
    o Financial options
    o Financial assistance options
Next Step - Strategies

• Patients (continued)
  - Use website materials to help guide patients through the pre-service and time of service activities
  - Recognize when a patient needs help to understand the conversation—patient advocate, family member, etc.
  - Conduct patient satisfaction surveys to measure impact of best practices
  - Document everything (IRS 501r rules applying to uninsured and underinsured)
Prescription for Success – Implement!

• Make it happen – just do it!
• Never forget the importance of managing by walking around – listen to your staff; listen to your patients
Next Steps - Metrics

• What we measure, staff treat as important!
• Create the before and after picture
  - Patient satisfaction-HCACPS, etc.
  - Pre-registration
  - Insurance verification
  - Focus group results
  - % of patients participating in financial discussions
  - POS collections
  - Net A/R days
Next Step – Reporting Results

• Feedback and response protocols
• Escalation process for patient complaints
• Reporting to C-Suite on an annual basis
• Annual overall compliance report to C-suite team
From Compliance to Culture Change

Effective patient financial communications are critical

- For patient satisfaction
- For financial health of organizations

Integral part of their culture
And Then …

• Apply for HFMA Adopter recognition
• Participate in HFMA’s compliance program for Patient Financial Communication Best Practices
Questions and Resource Information

Questions!

For more information about the Patient Financial Communications Best Practices:

www.hfma.org/communications
Appendix

Patient Financial Communications Adopter Recognition Program Application
Step 1 - Provider Information

1. Organization
   *Organization Name: Corporate Name:
   *Medicare Number:

2. Address
   *Address1:
   Additional Address Line:
   *City:
   *State:
   *Zip:

3. Chief Revenue Cycle Official reviewing this application
   *Name:
   *Title:
   *Telephone:
   *E-mail:

4. Person completing this application
   *Name:
   *Title:
   *Telephone:
   *E-mail:
   *Required

Step 2 - Demographics and Background Information

*Provider Region
Rural
Urban

*Hospital Type
Children's Hospital
Critical Access Hospital (CAH)
General Medical/Surgical Hospital
Other (Please specify)
Other Provider Type - Specify:

*Provider Control
Government
Private Not for Profit
Investor Owned (for profit)
Physician Owned
Other (Please specify)

*Subsidiary of System
Yes No

*Disproportionate share hospital (DSH)
Yes No

*Number of Staffed Beds:
*Number of Employed Physicians (if Physician Provider):
*Annual Inpatient Discharges:
*Annual ED Visits:
*Annual OP Visits:
*Annual Patient Encounters (physician providers):
*Annual Net Patient Service Revenue:
*Required
**Step 3 - Process Compliance Evaluation and Checklist**

**Patient Financial Communications in the Emergency Department**

Please tell us about your patient financial communications in the Emergency Department; select the appropriate frequency or N/A if it does not apply.

1. We appropriately trained provider representatives conduct these conversations with the patient or guarantor; patients are given the opportunity to request a patient advocate, designee or family member to assist.

<table>
<thead>
<tr>
<th>Frequency</th>
<th>90%+ of the time</th>
<th>70-89% of the time</th>
<th>Less than 70% of the time</th>
<th>N/A</th>
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</table>

2. We conduct conversations with patients considered emergent during the discharge process.

<table>
<thead>
<tr>
<th>Frequency</th>
<th>90%+ of the time</th>
<th>70-89% of the time</th>
<th>Less than 70% of the time</th>
<th>N/A</th>
</tr>
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</table>

3. We conduct conversations with patients who do not have an emergency medical condition following the medical screening or as late as the discharge process.

<table>
<thead>
<tr>
<th>Frequency</th>
<th>90%+ of the time</th>
<th>70-89% of the time</th>
<th>Less than 70% of the time</th>
<th>N/A</th>
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4. We inform patients that their ability to pay will not interfere with treatment of any emergency medical conditions.

<table>
<thead>
<tr>
<th>Frequency</th>
<th>90%+ of the time</th>
<th>70-89% of the time</th>
<th>Less than 70% of the time</th>
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5. Once the medical screening has occurred and the patient is stabilized, we review insurance eligibility information with the patient to ensure information accuracy.

<table>
<thead>
<tr>
<th>Frequency</th>
<th>90%+ of the time</th>
<th>70-89% of the time</th>
<th>Less than 70% of the time</th>
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6. If appropriate, we refer the patient to a financial counselor or offer information regarding our financial counseling services and assistance policies.

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<th>Frequency</th>
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<th>70-89% of the time</th>
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7. We provide our patients as much information as possible about their estimated financial obligations.

<table>
<thead>
<tr>
<th>Frequency</th>
<th>90%+ of the time</th>
<th>70-89% of the time</th>
<th>Less than 70% of the time</th>
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8. If applicable, we conduct a prior balance conversation on balances that are being pursued for collection.

<table>
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<th>Frequency</th>
<th>90%+ of the time</th>
<th>70-89% of the time</th>
<th>Less than 70% of the time</th>
<th>N/A</th>
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9. We routinely inquire about how the patient would like to resolve the balance for the current service and any prior balance the patient may have, if applicable.

<table>
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<tr>
<th>Frequency</th>
<th>90%+ of the time</th>
<th>70-89% of the time</th>
<th>Less than 70% of the time</th>
<th>N/A</th>
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10. During the discharge process, we routinely provide written information regarding our financial assistance programs and a summary of the financial implications for the services rendered, including a phone number to call with questions.

<table>
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<th>Frequency</th>
<th>90%+ of the time</th>
<th>70-89% of the time</th>
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Patient Financial Communications at the Time of Service (Outside the ED)

Please tell us about your patient financial communications at the time of service (outside the ED); select all that apply and indicate frequency:

*1. We appropriately trained provider representatives conduct these conversations with the patient or guarantor; patients are given the opportunity to request a patient advocate, designee or family member to assist.

90%+ of the time    70-89% of the time    Less than 70% of the time    N/A

*2. We conduct conversations with patients during the registration or discharge process in a location that does not disrupt patient flow; the conversation may also occur during the medical encounter so long as patient care is not interfered with and with the patient’s consent.

90%+ of the time    70-89% of the time    Less than 70% of the time    N/A

*3. We routinely conduct patient financial conversations during the pre-registration process and do not repeat those conversations during the registration or discharge process.

90%+ of the time    70-89% of the time    Less than 70% of the time    N/A

*4. We routinely gather basic demographics, insurance coverage(s), and determine the potential need for financial assistance.

90%+ of the time    70-89% of the time    Less than 70% of the time    N/A

*5. We routinely review insurance eligibility details with the patient to ensure accuracy.

90%+ of the time    70-89% of the time    Less than 70% of the time    N/A

*6. We routinely inform uninsured patients that our goal is to collect information to identify paying solutions or financial assistance options that may assist them with their obligations for the visit.

90%+ of the time    70-89% of the time    Less than 70% of the time    N/A

*7. If appropriate, we routinely refer patients to a financial counselor and/or offer information regarding our financial counseling services and assistance policies.

90%+ of the time    70-89% of the time    Less than 70% of the time    N/A

*8. We have clear policies on how to interact with patients with prior balances choosing to have elective and non-elective procedures as well as clear policies defining elective and non-elective procedures which we make available to patients and the public.

90%+ of the time    70-89% of the time    Less than 70% of the time    N/A
**9.** We routinely provide as much information as possible about the patient’s estimated financial obligations both verbally and if requested, in writing.

<table>
<thead>
<tr>
<th>Percentage</th>
<th>90%+ of the time</th>
<th>70-89% of the time</th>
<th>Less than 70% of the time</th>
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**10.** We routinely inform the patient that the actual costs may vary from estimates depending on the actual services performed or timing issues with other payments affecting the patient’s deductible.

<table>
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<tr>
<th>Percentage</th>
<th>90%+ of the time</th>
<th>70-89% of the time</th>
<th>Less than 70% of the time</th>
<th>N/A</th>
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**11.** If appropriate, we ask the patient if they are interested in receiving information regarding payment options and/or financial assistance programs.

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<th>Percentage</th>
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**12.** If applicable, we conduct a prior balance conversation regardless of the size or age of the balance and provide the patient a written list of the services provided, dates of service and the resulting prior balance.

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**13.** We routinely inquire about how the patient would like to resolve the balance for the current service and any prior balance the patient may have, if applicable.

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**14.** During the registration or discharge process, we routinely provide written information regarding our financial assistance programs and a summary of the financial implications for the services rendered, including a phone number to call with questions.

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**Patient Financial Communications in Advance of Service**

Please tell us about your patient financial communications in advance of service; select all that apply and indicate frequency:

*1. We appropriately trained provider representatives conduct these conversations with the patient or guarantor; patients are given the opportunity to request a patient advocate, designee or family member to assist.

90%+ of the time  70-89% of the time  Less than 70% of the time  N/A

*2. We conduct conversations with patients using the most appropriate means of communication for the patient, which may include outbound contact to the patient in advance of service, inbound contact from the patient inquiring about an upcoming service or from the scheduling/contact center when the patient’s appointment is made.

90%+ of the time  70-89% of the time  Less than 70% of the time  N/A

*3. We routinely gather basic demographics, insurance coverage(s), and determine the potential need for financial assistance.

90%+ of the time  70-89% of the time  Less than 70% of the time  N/A

*4. We routinely review insurance eligibility details with the patient to ensure accuracy.

90%+ of the time  70-89% of the time  Less than 70% of the time  N/A

*5. We routinely inform uninsured patients that our goal is to collect information to identify paying solutions or financial assistance options that may assist them with their obligations for the visit.

90%+ of the time  70-89% of the time  Less than 70% of the time  N/A

*6. If appropriate, we routinely refer patients to a financial counselor and/or offer information regarding our financial counseling services and assistance policies.

90%+ of the time  70-89% of the time  Less than 70% of the time  N/A

*7. We have clear policies regarding the handling of patients with prior balances choosing to have elective and non-elective procedures as well as clear policies defining elective and non-elective procedures which we make available to patients and the public.

90%+ of the time  70-89% of the time  Less than 70% of the time  N/A

*8. We routinely provide as much information as possible about the patient’s estimated financial obligations both verbally and if requested, in writing.

90%+ of the time  70-89% of the time  Less than 70% of the time  N/A
9. We routinely inform the patient that the actual costs may vary from estimates depending on the actual services performed or timing issues with other payments affecting the patient’s deductible.

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<tr>
<th>Percentage</th>
<th>90%+ of the time</th>
<th>70-89% of the time</th>
<th>Less than 70% of the time</th>
<th>N/A</th>
</tr>
</thead>
</table>

10. If appropriate, we ask the patient if they are interested in receiving information regarding payment options and/or financial assistance programs.

<table>
<thead>
<tr>
<th>Percentage</th>
<th>90%+ of the time</th>
<th>70-89% of the time</th>
<th>Less than 70% of the time</th>
<th>N/A</th>
</tr>
</thead>
</table>

11. If applicable, we conduct a prior balance conversation regardless of the size or age of the balance and provide the patient a written list of the services provided, dates of service and the resulting prior balance.

<table>
<thead>
<tr>
<th>Percentage</th>
<th>90%+ of the time</th>
<th>70-89% of the time</th>
<th>Less than 70% of the time</th>
<th>N/A</th>
</tr>
</thead>
</table>

12. We routinely inquire about how the patient would like to resolve the balance for the current service and any prior balance the patient may have, if applicable.

<table>
<thead>
<tr>
<th>Percentage</th>
<th>90%+ of the time</th>
<th>70-89% of the time</th>
<th>Less than 70% of the time</th>
<th>N/A</th>
</tr>
</thead>
</table>

13. During the registration or discharge process, we routinely provide written information regarding our financial assistance programs and a summary of the financial implications for the services rendered, including a phone number to call with questions.

<table>
<thead>
<tr>
<th>Percentage</th>
<th>90%+ of the time</th>
<th>70-89% of the time</th>
<th>Less than 70% of the time</th>
<th>N/A</th>
</tr>
</thead>
</table>

**Step 4 - All Patient Financial Communications and Technology Evaluation**

**Best Practices for All Settings: Patient Financial Communications**

Please check each of the practices below that accurately describe the current practices in your facility:

- Compassion, patient advocacy, and education are a part of all patient communications.
- Standard language is used to guide staff on the most common types of patient financial communications.
- Face-to-face communications are used whenever possible to facilitate one-time resolution.
- Availability of supportive financial assistance is always communicated to patient and the community.
- Communication with the patient is initiated by the provider.
- The patient’s perspective is included in the development of the standard language used for patient financial communications.
- Communications are understandable by the patient.
- Communications include verification of patient information and the patient’s preferred methods for future communication.
- Patient privacy is respected in all patient financial communications.
- A toll-free number is widely publicized that patients can call to receive assistance in financial matters and concerns.
- All patient financial communications focus on steps toward amicable resolution of financial obligations.
# Technology Evaluation

For each technology solution listed below, indicate the usage in each major setting for patient financial communications and the percentage of total visits processed using the identified technology:

## Emergency Department

* Insurance verification eligibility
  - Yes
  - No
  If yes, what percentage of total visits processed?

* Estimator of patient responsibility for services provided
  - Yes
  - No
  If yes, what percentage of total visits processed?

* Tool to identify prior balances due
  - Yes
  - No
  If yes, what percentage of total visits processed?

## Time of Service

* Insurance verification eligibility
  - Yes
  - No
  If yes, what percentage of total visits processed?

* Estimator of patient responsibility for services provided
  - Yes
  - No
  If yes, what percentage of total visits processed?

## In Advance of Service

* Insurance verification eligibility
  - Yes
  - No
  If yes, what percentage of total visits processed?

* Estimator of patient responsibility for services provided
  - Yes
  - No
  If yes, what percentage of total visits processed?

* Tool to identify prior balances due
  - Yes
  - No
  If yes, what percentage of total visits processed?

* Required
### Step 5 - Feedback Process and Training Program Evaluation

**Feedback Process and Response Documentation**
Please describe the processes used to measure compliance with the best practices for patient financial communications as implemented in your organization. Include patient satisfaction survey results from internal and external sources, including HCAHPS scores. Provide tracking information used to monitor customer service complaints related to the areas included in the best practice standards, including annual volume, types of complaints and most common resolutions implemented by your organization. Finally, please provide a copy of the most recent report provided to the executive team on customer service and the patient experience for your organization.

**Training Program Evaluation**
Please tell us about your training program for new and existing staff in Emergency Department, Patient Access, Financial Counseling and Customer Service who deal with patient financial communications. At a minimum, please list the specific courses provided, duration, type of delivery (web-based or in-person) and the differences between training for new vs. existing employees. Please include a copy of your training policy and procedures, the annual training plan, and annual requirements for staff and managers.

<table>
<thead>
<tr>
<th></th>
<th>Emergency Department</th>
<th>Scheduling/Pre-Service</th>
<th>Time of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Number FTE's Trained (Annualized):</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>Total Hours of Training Provided (Annualized):</strong></td>
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<td></td>
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<tr>
<td><strong>Number of Distinctly Different Courses:</strong></td>
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<tr>
<td><strong>Delivery Method(s):</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Live Presentation</td>
<td>Intranet Course(s)</td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Self-Study</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please provide the following statistical summary for your most recent fiscal year:

**Emergency Department**

Total Number FTE's Trained (Annualized):
Total Hours of Training Provided (Annualized):
Number of Distinctly Different Courses:
Delivery Method(s):
Live Presentation | Intranet Course(s) | Other
Self-Study

**Scheduling/Pre-Service**

Total Number FTE's Trained (Annualized):
Total Hours of Training Provided (Annualized):
Number of Distinctly Different Courses:
Delivery Method(s):
Live Presentation | Intranet Course(s) | Other
Self-Study

**Time of Service**

Total Number FTE's Trained (Annualized):
Total Hours of Training Provided (Annualized):
Number of Distinctly Different Courses:
Delivery Method(s):
Live Presentation | Intranet Course(s) | Other
Self-Study
Financial Counseling (ONLY if separate from above areas)

Total Number FTE's Trained (Annualized):
Total Hours of Training Provided (Annualized):
Number of Distinctly Different Courses:
Delivery Method(s):
Live Presentation Intranet Course(s) Other Self-Study

Customer Service (separate from above areas)

Total Number FTE's Trained (Annualized):
Total Hours of Training Provided (Annualized):
Number of Distinctly Different Courses:
Delivery Method(s):
Live Presentation Intranet Course(s) Other Self-Study

Total

Total Number FTE's devoted to developing this training:

*Required

Step 6 - Performance Metrics

Basic Performance Metrics Data Requirements
Please provide the following data based on the standard HFMA definitions. Use the most recent year-end audited financial statements and relevant system reports to calculate the metrics. At the end of the data sheet, you will find a link to attach your supporting documentation to validate the individual numbers provided. Please compile all supporting materials into one PDF file and attach.

For the most recent fiscal year (annualized data):
Audited/Final Financial Data Source: Most recent audited fiscal year data or preliminary most recent fiscal year data if audited data is pending.

Net Days in A/R
*Net A/R:
Click Here for Definition/Source

*Net Patient Service Revenue:
Click Here for Definition/Source

POS Cash as a Percentage of Total Patient Cash

*POS Cash Collected:
Click Here for Definition/Source

*Total Patient Cash Collected:
Click Here for Definition/Source
Insurance Verified Encounters as a Percentage of Total Encounters
*Total Number of Insurance Verified Encounters(Visits):
Click Here for Definition/Source

*Total Number of Registered Patient Encounters(Visits):
Click Here for Definition/Source

Pre-registered Encounters as a Percentage of Scheduled Encounters
*Total Number of Scheduled Encounters(Visits):
Click Here for Definition/Source

*Total Number of Scheduled Encounters(Visits) Pre-Registered:
Click Here for Definition/Source (Note: Encounters/visits include inpatient, outpatient, ED and clinic visits)

Electronic Certification
Must be provided by the CFO or CEO

I hereby attest to the accuracy of the information provided in this application

*Name:
*Title:
*Date:
*Email:
*Required