Implementing Automated Appointment Reminders to Reduce No-Show Rates

In an era of fiscal challenges, research indicates that many healthcare providers are seeking to leverage automation as a way to expedite revenue cycle processes and extend limited resources. As examples, Academy research shows 77% of surveyed providers now offer online bill pay, and more than 40% have employed technology to assess patients' propensity to pay. Furthermore, a number of surveyed providers have adopted an automated dialing system to remind patients of upcoming appointments and reduce staff workloads.

For Charles Cole Memorial Hospital, a critical access facility with 11 affiliated rural health clinics, automated call reminders have saved the system approximately $75,000 in reduced no-shows over a year.

Charles Cole Memorial Hospital
Coudersport, Pennsylvania

- Number of Hospitals: 1
- Number of Clinics: 11
- Bed Size: 25 licensed beds
- Net Patient Revenue: $66 million

The Academy recently spoke with Janice Walters, Executive Director of Revenue Systems and Primary Care Services, who discussed how using such technology to remind ambulatory patients of appointment dates and times has enhanced the patient experience and allowed scheduling staff to focus on identifying and communicating patient responsibility prior to service—supporting the medical group's ability to collect 70% of co-pays upfront

Standardizing Reminder Processes

Prior to utilizing an automated solution, Charlies Cole had a decentralized, manual appointment reminder process. "Some offices were very diligent and [took time each day to contact their patients] to remind them of their office appointments," Walters explains. "However, some had no processes for appointment reminders in place at all ... Sometimes patient
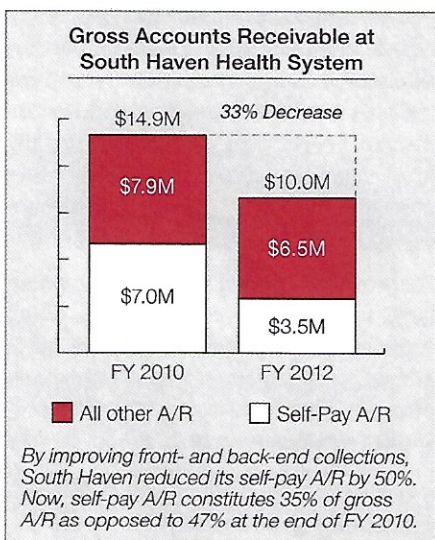
Analyzing Accounts Receivable to Drive Revenue Cycle Improvement Initiatives

For patients, recent years have brought steep healthcare costs along with high out-of-pocket financial responsibilities—ultimately leading to substantial self-pay accounts receivable balances for hospitals and health systems. In order to adequately

Gross Accounts Receivable at South Haven Health System

$14.9M — *33% Decrease*

$7.9M | $10.0M
$7.0M | $6.5M
| $3.5M

FY 2010 | FY 2012

■ All other A/R   ☐ Self-Pay A/R

By improving front- and back-end collections, South Haven reduced its self-pay A/R by 50%. Now, self-pay A/R constitutes 35% of gross A/R as opposed to 47% at the end of FY 2010.

address such high balances, it is essential for healthcare leaders to closely analyze the makeup of their A/R (e.g., percent self-pay, percent over 90 days aging, etc.) in order to identify specific opportunities for improvement.

For smaller hospitals, however, revenue cycle improvement initiatives are often hindered by constraints in technology, budget, and staffing. While these resources can certainly prove useful, providers often overlook the enhancement of fundamental concepts like patient communication and staff accountability as viable options for reducing A/R.

South Haven Health System, a 25-bed organization in Michigan, is one organization that recently focused its improvement efforts on building staff accountability and elevating patient communication. Mark Gross, the health system's CFO, recently shared his experience in working with the organization's revenue cycle team to

increase point of service (POS) collections, improve patient satisfaction regarding billing practices, and enhance denial tracking—ultimately reducing gross A/R by 33% within two years.

Improving POS Collections

When Gross was first appointed as South Haven's CFO in 2011, he immediately identified the opportunity to reduce the organization's gross A/R from $14.9 million. "One of the things I noted first was that our POS collections was really low," Gross explains. "So we started focusing on that, and have put processes in place during this fiscal year."

To provide South Haven's front-line staff members, or clerical medical assistants, the resources and confidence needed to consistently request payment from patients, they are given scripting for various scenarios. As an example, when a

Responding to RAC Exposure at a Smaller Facility

With the RAC program currently conducting a demonstration for prepayment reviews in addition to steady retrospective reviews, providers nationwide are taking measures to minimize audit exposure and optimize RAC coordination practices.
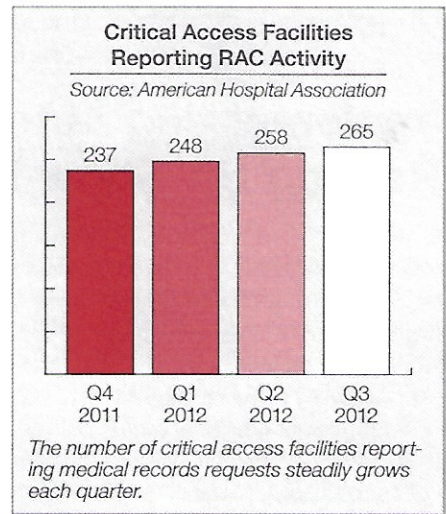
To gain further insight into actionable approaches smaller organizations can take to effectively manage RAC requests, denials, and appeals, The Academy recently spoke with Constance Harris, Manager of Health Information Management (HIM) at Silverton Hospital in Oregon. By developing standardized response strategies, as well as identifying and educating staff regarding root causes of payment discrepancies, the provider was able to reduce financial risk while improving workflow efficiency.

Employing Fundamental RAC Response Strategies

While many larger organizations dedicate additional FTEs to external audits to help effectively track and manage the various stages of each research request, smaller organizations have found systemic response practices to achieve similar aims. For example, recognizing budgetary constraints, Silverton Hospital began evaluating long-term strategies for handling

Critical Access Facilities Reporting RAC Activity

Source: American Hospital Association

Q4 2011	Q1 2012	Q2 2012	Q3 2012
237	248	258	265

The number of critical access facilities reporting medical records requests steadily grows each quarter.

---

volume just didn't allow for call reminders to happen." In response, the organization implemented an automated dialing system with the primary goal of standardizing the appointment reminder process across the ambulatory network—and achieved reduced no-shows as a result.

Selecting a vendor to develop and install the software, as well as provide continued IT support, Charles Cole was also able to integrate scripting software; according to Walters, the combined use of these solutions has expedited the appointment reminder process. "We simply download patients' schedules through the scripting software; the automated calling system pulls that data file and loads it, then calls each patient two days before their scheduled appointments," Walters explains. "Patients can confirm or cancel their appointments with the touch of a button … [Resulting] reports are then put out on our network, allowing the physician offices to pull and use that data on a daily basis."

Leveraging Added Capabilities

Charles Cole has expanded the use of the software to raise awareness of community health issues and educational events as well as for emergency response, disaster planning, and to initiate call trees. "We had a whooping cough outbreak not long ago, as did many other parts of the country, and we were able to use this system to encourage our pediatric patients to obtain vaccinations and take certain precautions," Walters states. "We had one purpose in mind when we purchased this software, but we learned it could yield many additional benefits."

The software has been further leveraged to evaluate patient perception; accompanying the dialing system is the ability to conduct automated telephone surveys. Developed internally, the survey has five questions—answered on a four-point scale—and takes approximately four minutes to complete. Patients are contacted automatically following appointments to take the survey, and results are shared quarterly across the ambulatory network to highlight satisfaction scores at each location. "We had nothing in our primary care network gauging patient satisfaction prior to this tool, but now we instantly have data on hand and can share the information with the entire physician network," she says.
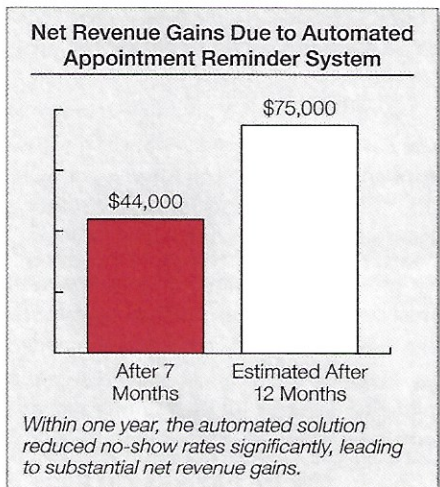
Fostering an Automated Culture

Although the dialing system assisted Charles Cole in expediting appointment reminders, increasing patient satisfaction, and automating a previously time-consuming task—there was initial pushback, as some clinic locations preferred to continue manual processes.

As a critical access hospital with limited financial means, transitioning to a culture of automation has been essential to the health system's financial viability; according to Walters, this realization helped secure buy-in system-wide. "We're not foregoing personal touch," she states. "We're just trying to offer a service to ensure patients receive the healthcare they need."

Although Walters emphasized the need to be cautious with how often calls are placed, she also noted the significant return on investment Charles Cole has received by using such software. "Any time you can hardwire a process and remove manual intervention, you can ensure the process is being conducted efficiently and effectively and that there is consistency across the organization," she states.

For providers seeking to expedite appointment reminder processes, Charles Cole's experience offers insight into how automation can reduce no-show rates and promote quality customer service—providing significant contributions to the financial well-being of physician offices and the satisfaction of the patient community. ✚

Net Revenue Gains Due to Automated Appointment Reminder System

After 7 Months	Estimated After 12 Months
$44,000	$75,000

Within one year, the automated solution reduced no-show rates significantly, leading to substantial net revenue gains.

Medicare audits without adding an additional FTE—ultimately determining that Harris, in addition to her existing responsibilities, would act as the organization's RAC coordinator.

At a basic level, Harris employs RAC coordination and management as a small portion of her daily operations. She checks the contractor's website and CMS home page routinely to identify outstanding records requests and investigate any RAC policy changes or new audit targets. "If you're willing to take a little bit of time out of your normal schedule, you can get a lot done," Harris says. "You just have to be proactive." In fact, Harris notes that her audit coordination duties have constituted only a small fraction of her time.

When Silverton receives a request, she time stamps each record before sending it to the facility's regional contractor. Additionally, to ensure CMS receives requested information and that mandated deadlines are being met, the organization also obtains certified return receipts. Harris also uses the American Hospital Association's free claim-level tracking tool—an Excel spreadsheet available for download off the organization's website—to continually log the progress of items such as claim reviews, denials, underpayments, and overpayments.

To assist in managing denials, Silverton Hospital has established a response workflow organized by specialty. For instance, Harris handles denials resulting from inpatient coding errors, while denials resulting from medical necessity issues are forwarded to a designated care manager who reviews the affected record and gives feedback to help determine if the appeals process needs to be initiated. In the event that a denial reaches a higher

---

Common Reasons for Complex Denials

- Short stay medically unnecessary
- Medically unnecessary inpatient stay longer than three days
- Incorrect MS-DRG or other coding error
- No or insufficient documentation in the medical record

---

level of appeal, the facility has a physician advisor as well as an attorney who are available to guide them through the process. As Harris explains, an audit coordinator—whether dedicated solely to the role, or simply taking on related duties—does not necessarily require extensive regulatory knowledge, but rather a strong network of pre-established resources and reliable contacts who can work together to ensure optimal outcomes.

Educating Clinicians and Revenue Cycle Staff to Mitigate Risk

In addition to establishing core processes and procedures for dealing with RAC audits, it is essential for organizations to proactively educate staff members and perform root cause analysis on all incurred denials. As such, Harris has also previously dedicated some of her time to educating staff members across the organization on how they can influence a timely response and protect the organization against future requests and potential takebacks.

For example, by integrating brief educational sessions into monthly clinical staff meetings, Harris and clinical documentation improvement staff have grown the understanding of physicians, hospitalists, and nurses regarding the importance of complete and accurate documentation.

Harris and other revenue cycle leaders have also been able to identify opportunities for improvement by conducting internal audits on proposed RAC targets. As an example,
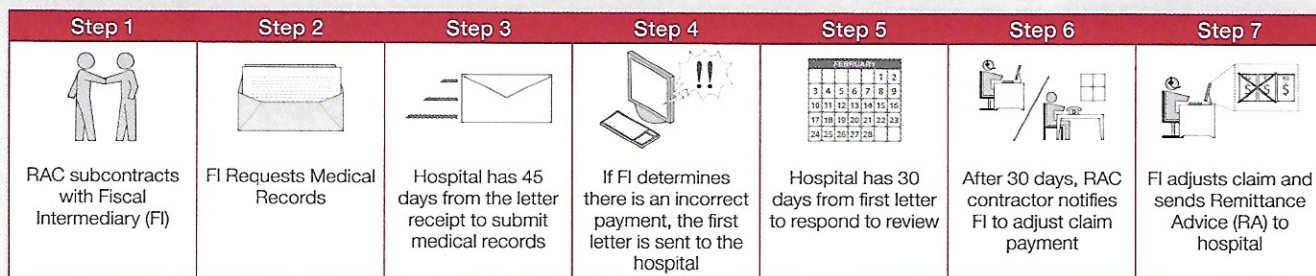
Harris performed an audit on admission orders, leading the provider to update its order sets, and case management continues to track one-day stays. "We knew that we had some one-day stay issues, so we looked at those on our own, and we looked at our admission orders and made sure that they said 'admit' instead of 'refer for inpatient observation'. It worked," Harris explains. She then worked with a care management leader to educate physicians and care managers on necessary documentation regarding medical necessity. Furthermore, because considerable audit risk often stems from coding errors, coding audits are also conducted regularly and leaders attend several coding seminars.

Benefits and Results

Overall, Silverton has experienced a greater degree of staff collaboration. "It has actually been really nice to have the responsibilities of the insurance and RAC audits because it's given me a chance to connect with other departments in the hospital," Harris explains. The most vital result of the facility's RAC management efforts, however, is the fact that exposure to RAC at Silverton has remained low since 2010; under- and overpayments have remained relatively even in terms of dollar amounts, and requests that do come in have been handled in a timely and efficient manner.

By staying up-to-date on current RAC trends, developing uniform response processes, and educating physicians and staff on pre-emptive measures, smaller facilities have the opportunity to adjust and improve coding, documentation, and other impactful processes even prior to the receipt of an audit. In doing so, providers may also benefit from more refined workflows, strengthened collaboration between revenue cycle departments, and an overall positive financial outlook. ✚

An Overview of the RAC Request Process

Step 1	Step 2	Step 3	Step 4	Step 5	Step 6	Step 7
RAC subcontracts with Fiscal Intermediary (FI)	FI Requests Medical Records	Hospital has 45 days from the letter receipt to submit medical records	If FI determines there is an incorrect payment, the first letter is sent to the hospital	Hospital has 30 days from first letter to respond to review	After 30 days, RAC contractor notifies FI to adjust claim payment	FI adjusts claim and sends Remittance Advice (RA) to hospital

Tracking RAC requests by date allows organizations to dedicate proper attention to aging audits and avoid automatic claim adjustments.

patient indicates that he or she does not have a purse or wallet, staff are instructed to still ask the patient how he or she was planning on paying. The staff member then attempts to secure a commitment to pay in full by mail-in check with verbiage such as, "Will you be sending a check as soon as you get home? Here is a self-addressed envelope for your convenience," and "Will that be for the entire balance?" In all cases, scripts aim to gather information about each patient's particular financial situation while securing full, partial, or commitment for payment.

To hold these staff members accountable, they are required to document payment requests within the billing system. Additionally, each staff member's collections are measured and tracked on a patient access scorecard that is leveraged in determining scores within annual performance evaluations.

Individual collections totals are also posted at the end of every month—fueling even greater motivation to consistently request payment and reach collections goals. Overall, these efforts have resulted in a 34% increase in POS collections.

Improving Billing Transparency

During his analysis of South Haven's A/R, Gross also identified that self-pay A/R—approximately $7 million in fiscal year 2010—made up nearly half of the organization's gross A/R. Therefore, Gross and the revenue cycle team at South Haven also worked to further reduce self-pay balances by embarking on a billing initiative

South Haven Health System
SOUTH HAVEN HEALTH SYSTEM
South Haven Health System
South Haven, Michigan
• Number of Hospitals: 1
• Number of Physician Practices: 9
• Bed Size: 25 staffed beds
• Net Patient Revenue: $37 million

meant to improve patient comprehension. "We're making sure that patients are aware, whether it's on the front end or back end, of all the options that are available to them," he says.

As part of this approach, South Haven has recently updated its patient billing statements to be easier to navigate and more informative of available financial assistance options like interest-free payment plans and an uninsured prompt-pay discount. The statement also encourages patients to call if they are concerned about paying their bills. "We really have gotten some positive feedback," Gross says. "It's more understandable, and it lays out the options that patients have when it comes to paying their bills."

The updated statement also uses straightforward verbiage to guide patients through the document. For example, the new form includes a box that reads, "What You Owe Now" in large font—eliminating confusion regarding the actual balance. Furthermore, to provide additional clarity on charges incurred, the statement guides the patient to a back-page "charge summary" that breaks down the total into individual charges and clearly informs the patient that physicians bill seperately for their time and services.

Improving Denial Management and Tracking Efforts

Another important component of realizing full reimbursement is effectively managing and tracking denials. Although South Haven's current billing system is not equipped with an automated tracking mechanism, the organization has been able to leverage a denial management system through its clearinghouse vendor that tracks denials and loads them into a worklist for resolution. South Haven's business office director oversees the denials and forwards them onto the responsible departments.

While the tracking system does not contain historical data, the tool has proven useful in comparing performance from month to month as well as in providing valuable visibility into the root cause of denials. "It's really helped us to identify we have the greatest opportunity in the registration process," Gross says. "So we're really focusing on explaining to registration staff that what they enter into the system when they register a patient has a huge impact on the dollars that we're collecting." In this way, South Haven is able to resolve denials more quickly while creating educational opportunities that ultimately prevent similar denials in the future.

For many small organizations facing large A/R balances, investing in additional staff and new IT solutions is not always an option. However, by taking steps to implement fundamental strategies that improve patient interactions and staff training, providers hoping to improve POS collections and billing processes can better position themselves to increase patient satisfaction as well as their overall financial health. ✚

Sample Scripting Utilized by South Haven Health System	
Potential Patient Scenario	**Staff Member Response**
"This is ridiculous!"	"I am sorry you feel that way. This is a business that needs money to keep it going. When do you plan on paying this account?"
"I was involved in an auto accident."	"When you receive the bill from the clinic, forward it to the responsible party or his or her insurance company as soon as possible. Until then, we must still hold you responsible for the bill."
"I have $20 to put down."	"Thank you, and here is your receipt. When will you be paying the remaining balance?"
"I have no money/no job."	"Do you receive unemployment benefits?" If yes, "Please call customer service so that something can be worked out regarding your situation."