Southern Regional Medical Center (SRMC), of Riverdale, GA, three years ago embraced new technology to move its patient access department to the frontline of effective revenue cycle management. The 376-bed facility implemented an automated system that allows the hospital to improve its registration processes and, in turn, generate many positive outcomes, including, among others, improved registration data integrity, increased point-of-service collections, and early identification of patients eligible for charity care.

The impetus driving improvement through an automated solution was the need to identify charity care in a more timely way at the front-end, prior to sending outstanding accounts receivable (A/R) to a collection agency when, in fact, the balances due were uncollectible, says Tracey Frederick, a senior systems analyst with SRMC and, at the time, the organization’s patient accounts director. The benefits of implementing an automated revenue cycle management solution, through the Chicago-based TransUnion, went far beyond identifying and accounting for charity care.

Pre-Automation
Before implementing the TransUnion solution through its health care revenue cycle platform (HRCP) system, SRMC was “behind the times,” according to Frederick. For example, she says, “our point of service collections were very low... because we were not having anybody except patient accounting staff ask for money. Registration never asked.”

The ability to electronically verify information provided by patients was nil. For example, if patients said they had no insurance and no ability to pay, notes Frederick, “We had to take the patient’s word that they were who they said they were, and that they could not pay.” The facility, located just south of the Atlanta airport, serves a large indigent population, with well more than half of patients potentially eligible for some type of financial assistance. Thus, the likelihood that self-pay patients could not pay for their medical care was high, although that was not always the case for all patients who claimed an inability to pay.

Prior to implementing the automated solution, if a patient was self-pay and indicated an inability to pay, a financial counselor would meet with the patient in care units. Patients were required to substantiate their claims of being unable to pay with “W-2 Forms and all different kinds of bills and back reports, to prove they were indigent and charity care eligible.”

Completing the necessary paperwork was timeconsuming, as the forms were long and the process, like many other processes in place at the time, was manual. Verifying information provided by patients through such a manual process was hit or miss. Often, Frederick says, “if a patient said he or she couldn't pay, he or she automatically headed down the charity care track. There was no way to say if someone was not being truthful.”

In addition, although the facility had policies in place for charity care, patient indigence, legal options, and catastrophic cases, consistency in how each employee...
applied and/or carried out those policies was lacking, Frederick says. Plus, the bulk of self-pay issues were handled on the back-end, in patient accounting, which was too late.

**Post-Automation**

In 2004, SRMC executives brought in TransUnion representatives for a demonstration of the firm's health care revenue cycle platform system and were convinced the system could address the immediate need to identify early, at registration, patients who were eligible for charity care. It proved to be a tool that would result in many other positive outcomes, as the facility paired the implementation of new technology with a commitment to improve processes, which eventually led to culture change, according to Frederick.

With training on the new automated decision system response (ADSR) technology and the implementation of new processes, SRMC was poised to realize significant benefits. A major reason: with automated verification of the patient demographic and insurance information gathered at registration, a critical outcome achieved was improved registration data integrity. This improved registration data integrity opened the door to early charity care identification, among many other benefits realized in an automated environment. Among the additional benefits were the following:

**Improved Point-of-Service Collections**

Prior to implementing an automated system, monthly point-of-service collections ranged from less than $80,000 to about $100,000. Since implementation of the TransUnion system, monthly point-of-service collections have pushed to nearly $120,000 or better, and, at times, have climbed as high as $190,000 in total monthly point-of-service collections. Such improvement is possible as patient access employees are able to identify early patients’ financial obligations and initiate payment requests for patient-pay balances.

The increase in point-of-service collections also is due, in part, to involving more employees in the collections process, Frederick adds. For example, she says, in addition to front-end registration staff pursuing collections from patients at the time of service, customer service representatives also were trained to pursue payment from patients when handling queries from patients with balances due.

**Improved Consistency in Employee Performance**

The technology provides automated prompts for data-gathering, which allows for greater consistency in individual employee performance.

For instance, for potential charity care patients, an employee follows an automated financial screening process, entering patient demographic data along with a patient’s income, based on statements from the patient, while an automated credit check runs in the background. The result: employees gain an automated guide, based on responses to registration queries and automated verification of data provided. Examples include:

- If what the patient says and what the system finds about the patient’s financial situation are a match, the employee proceeds with a short-form charity care application.
- If the system surfaces a different income level for the patient, however, employees will be prompted to complete a long-form charity application. The patient may still be eligible for charity care, Frederick notes, but the discrepancy in what that patient says and what the automated credit check turns up will lead the employee to an automated prompt, with scripted questions, for the employee to complete a more thorough, long charity care form rather that the short form.

**Reduced Paperwork**

Information now is stored electronically in the new system or in an optical system.

**Timely Verification of Patient Data and Patient Credit Worthiness**

The system allows for automated verification of patient information, including, among other data elements, address, Social Security number, and credit worthiness. With complete and verified information, employees can determine which path to take with self-pay patients in making financial arrangements.

The payment paths for self-pay patients will vary. It may be that patients are eligible for full charity care, or that patients are eligible for some form of financial assistance plus charity care. With the new system in place, a recent review of 8,681 accounts revealed that:

- Nearly 75 percent of patients were eligible for state or local funding;
- 12.6 percent of patients had some ability to pay;
About 4 percent of patients had moderate credit worthiness; and

Nearly 9 percent of patients had a significant ability to pay.

As revealed in the data cited above, there are self-pay patients who claim an inability to pay, and properly so, as they truly are unable to pay. At the other extreme are patients who are able but unwilling to pay. As the above data reveal, some self-pay patients claim an inability to pay, although they may, in fact, have the financial ability to pay for their health care, with nearly 13 percent of patients possessing either “respectable” creditworthiness or a significant ability to pay.

For patients who truly are unable to pay, SRMC employees, through the automated TransUnion system, are able to initiate the necessary processes for these patients to apply for and receive medical coverage benefits through local or government financial assistance programs, such as Medicaid, and/or charity care.

For self-pay patients who claim an inability to pay but actually can pay, in part or in full, an automated system alerts front-end employees to that fact at registration.

With such timely information, working with patients to make financial arrangements to plan for payment and/or to collect patient-pay balances can then begin at patient access.

Reduced Patient Identity Theft and/or Fraud

The system also stems patient identity theft and/or fraud through real-time, automated verification of patient data. This benefit reduces the number of instances in which patient accounts employees meet with dead-ends while attempting to collect on accounts, resulting in bad-debt write-offs once the patients are gone and the information provided at registration is inaccurate.

For example, Frederick cites an incident in which a self-pay patient presented for care, with photo identification and a Social Security card. When the information was entered into the system, the employee informed the patient that the Social Security number did not appear to be a match with the person’s name and identity. “We did our scripting,” Frederick explains. “We said this does not look like a Social Security number assigned to you. This was a foreign patient, and (the patient was) very upset because the patient had just purchased the Social Security card at a nearby flea market.”

Training for Change

Training for the transition to an automated environment and new processes was comprehensive, ranging from hands-on training on the new system and its capabilities, through to scripting and role-play of the various possible registration scenarios. Training is essential to provide employees with the needed skill and knowledge to make the best and highest use of the new technology. Frederick notes that scripting and role-play are also essential in order to gain consistency in job performance and in how employees carry out their responsibilities.

As part of training, scripts were developed so that employee responses and handling of various registration scenarios all meet the same performance standards. Some scripts are built into the system, through prompts based on the information entered. Some scripts were developed to help create consistency for queries and responses that are not system driven, such as one-on-one, point-of-service payment requests.

For instance, Frederick says, if a patient provides a Social Security number that the system is unable to verify, a series of scripts and prompts are initiated and displayed in the system. An employee might inform the patient that the system indicates the Social Security number is not a match, and patients often then “start to change numbers, and they go back and forth.” Employees never accuse a patient of being untruthful, and the automated verification of such data prevents employees from registering patients with a Social Security number that later may end up proving to be nonexistent or perhaps a Social Security number for a person who has died.

Once the automated system was in place, training on point-of-service collections soon followed, Frederick says. Additional scripts were developed for point-of-service collections, a process that is enabled and enhanced through automation, but the actual collections process—a one-to-one request for payment—is not system driven. The automated environment led to improved registration data quality, so that employees could identify and collect patient-pay balances based on reliable data. Standardized scripts, however, were developed for employees on how to ask for and collect money from patients.
Automating Patient Access
As technology continues to develop and is implemented on the front-end, patient access is poised to provide even greater contributions to health care provider organizations’ revenue cycle management process. With the TransUnion system, the electronic capabilities to improve front-end processes are significant. The system offers a depth of applications, notes Marty Callahan, vice president of TransUnion’s health care division, and facilities that tap into all those capabilities are realizing the greatest benefits of its implementation.

The importance of electronic solutions in an increasingly complex health care industry that is continuously plagued with major financial challenges cannot be underestimated, according to Callahan. Electronic solutions are essential for facilities regardless of patient populations, as the ability to automatically verify and use accurate data, real-time, while the patient is at a facility, can only enhance a facility’s ability to best serve indigent patients—by early identification of patients’ eligibility for charity care or other financial assistance, as well as insured patients who increasingly must pay a greater portion of their health care bills.

“It is not getting any easier,” Callahan says. “The number of the uninsured is only going up. The advent of more high-deductible plans is only going to make the overall patient (financial) responsibility higher, even for the insured population.... The problem has not gotten any better. It is more a need of segmenting it properly, so we know who is who, and what they owe, and how they can pay.”

As the health care industry continues to evolve and consumer-directed health plans, among other changes, gain ground, the need for automation only grows, according to Callahan. Through increased use of automation, starting on the front-end at patient access, health care provider organizations can function with the most effective health care revenue cycle management processes, to the benefit of the institution and the patients it serves.

In the current health care environment, Callahan underscores, “hope is not a strategy. A lot of the consumer-directed health plans make our buying public feel like at least they have some coverage and, when they need health care, all of a sudden, they do not have adequate coverage.”

As the health care industry continues to evolve, automated solutions—those that allow health care provider organizations to identify early on the level of coverage, or lack thereof, and to identify patients’ financial obligations as well as their ability to meet those obligations—are essential, for the institution’s financial viability and for its ability to deliver superior customer service. For example, Callahan recalls the story of how the automated TransUnion solution did just that—secured reimbursement while delivering superior service that went beyond delivering quality care—for an uninsured pregnant patient.

A young, pregnant woman presented for care at an emergency department. She was uninsured and, to that point, had had no prenatal care. The patient’s information was entered into the system, and financial counselors quickly verified her eligibility for public assistance and related medical coverage. Not only did the patient benefit from access to medical coverage—which created an incentive for her to seek and receive covered prenatal care—she also learned of and gained access to other important public assistance programs, for herself and, in time, for her newborn, such as those that ensure proper food and nutrition for newborns and their mothers, so that they have a better chance to remain healthy.

“We help a number of people receive the kind of care they should have, and all kinds of other things that help patients,” Callahan explains. “There is a patient safety aspect that springs from this (focus on financial issues) as well...and all kinds of good things can happen to help patients if we have the right patient ID.”