

# Profiles in Excellence

## Using Best Practices to Create Better Financial Experiences for Patients



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healthcare financial management association

## Patient Financial Communications Best Practices Steering Committee

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The following national policymakers advised the project: Sen. Tom Daschle (D.-S.D.), Sen. Bill Frist (R.-Tenn.), former U.S. Secretary of Health and Human Services Donna Shalala, Gov. Michael Leavitt (R-Utah), and former U.S. Deputy Attorney General Jamie Gorelick.



## Dear Healthcare Leader:

As consumers have started paying more out-of-pocket for their health care, the healthcare industry has come to realize the importance of creating a good financial experience for patients. That experience must start with the fundamentals—that is, with ensuring that all financial communications with patients reflect respect and compassion while incorporating education and patient advocacy.

Until recently, it was difficult to assess the extent to which those “soft skills” are built into an organization’s business processes. With the development of HFMA’s Patient Financial Communications Best Practices®, which are based on industry consensus, that changed. By adopting the Best Practices, you can be assured that your organization has a solid foundation for building and maintaining the trust of your patients and community members.

The organizations profiled here have all achieved recognition as Adopters of the Patient Financial Communications Best Practices. Through their commitment to improving financial communication with patients, they have discovered many ways that finance leaders can make a difference in the lives of patients and in the well-being of their communities, while improving outcomes for all concerned.

Each organization has a different story to tell. I hope that in reading their stories, you will gain insight into ways that you can better serve your own patients and community members. Other organizations have also achieved Adopter status. For an up-to-date list, visit [hfma.org/adopterorganizations](http://hfma.org/adopterorganizations)

To learn more about the Best Practices and becoming an Adopter, please visit [hfma.org/communications](http://hfma.org/communications). We look forward to welcoming you to the Adopter community.

Very best,  


Joseph J. Fifer, FHFMA, CPA  
*President and CEO*  
*Healthcare Financial Management Association*





After a financial counselor at Carolinas HealthCare System (CHS) helped a patient qualify for 100 percent financial assistance, the health system was surprised to receive a check in the mail from the family.

“They sent us a letter saying they appreciated the financial assistance and explaining they had fallen on hard times,” says Chris Kiser, vice president, patient financial services. “They believed it was their job to contribute what they could and they sent us a check for \$100.”

Since the patient’s account had been cleared by charity care, the health system could not accept the money as payment. But Kiser’s staff helped the patient make a \$100 donation to the health system’s foundation to help other patients who struggle with bills.

“Sometimes working in patient financial services can be a thankless job, but this is a heartwarming story for all of us,” he says. “We use it as an example of “connect-to-purpose” for our financial counseling team and our registrars.”

## Getting Ahead of the Curve

Based in Charlotte, N.C., CHS owns or manages hospitals in North and South Carolina. The system earned recognition as an Adopter of the Healthcare Financial Management Association’s Patient Financial Communications Best Practices® as it seeks to proactively address the rise of consumerism in healthcare.

Price-shopping is still in its infancy in CHS’s markets; the health system’s financial representatives field about 300 requests per month from consumers, primarily those who want to make a smart decision about imaging procedures.

“We are hearing people say, ‘I am going to have an MRI and what is that going to cost at one of your hospitals versus a freestanding center?’” Kiser says. “We are seeing more of it with radiology than surgery.”



**“In our patient registration area, we say ‘the party starts with us.’ Patient registration is just as important as the clinical services and everything else. Success is really about getting it right at the very beginning.”**

### Chris Kiser

Vice President, Patient Financial Services  
Carolinas HealthCare System

## CAROLINAS HEALTHCARE SYSTEM

Despite the relatively low number of shoppers, Kiser and his colleagues know patients are concerned about prices. The local media are focused on price transparency, and the North Carolina legislature passed a law requiring price transparency in 2013.

In response, CHS has invested in technology needed to automate out-of-pocket estimates and beef up its financial counseling department to help patients know what services will cost. About 30,000 out-of-pocket estimates for scheduled services are prepared each month; CHS staff calls patients to discuss their financial responsibility, when possible—or notifies them when they present for service if they have not been called.

In some cases, CHS asks patients to pre-pay part of their bill. Payment plans and financial assistance are also offered. The system has avoided outsourcing its financial counseling function because it wants counselors to provide a “human touch” when they help patients apply for Medicaid, charity care, or other payment support, Kiser says.

### Taking a “First Face, Last Face” Approach

The system uses a “first face, last face” customer-service training program that underscores the importance of front-end staff.

“In our patient registration area, we say ‘the party starts with us,’” Kiser says. “I think patient registration is the most important part of any healthcare system—just as important as the clinical services and everything else. Success is really about getting it right at the very beginning and ensuring you have good quality people either calling patients pre-service or when they walk in the door to make sure things get kicked off in the right way.”

Working through the Adopter application process helped Kiser and his colleagues recognize a training gap.

“We do a great job when we get a new hire, but we probably have some opportunity to circle back to our existing employees who have been here for a long time,” he says.

Beyond that, CHS found the Adopter process to affirm the direction his department is moving.

“This helped us see that, in some areas, we are really doing a great job with these best practices,” he says. “So we patted ourselves on the back. We are really proud.” ✕

The patient knew his health plan carried a very high deductible and co-insurance, but he assumed his savings could cover the out-of-pocket costs for an upcoming orthopedic surgery.

“Unfortunately, the patient wasn’t aware of the health plan coverage limitations for that surgical procedure and the device that was implanted,” says Rodney Williams, senior manager of Patient Revenue Management Organization at Duke University Health System.

Williams and his colleagues helped the patient out in two ways. They provided an upfront estimate that let him know his share of the cost, and they offered him a zero-interest payment plan that allowed him to proceed with his doctor’s recommendation.

“The surgery was initially considered elective but his physician felt that his condition would deteriorate rapidly without the surgery,” Williams says. “The surgeon believed a better and longer lasting outcome would result from performing the surgery before the need became acute and further significant damage had been done.”

Those two services—out-of-pocket estimates in advance of service and payment plans—are among the nearly 100 criteria that Duke University Hospital, a 957-bed hospital in Durham, N.C., met to earn recognition as an Adopter of the Healthcare Financial Management Association’s Patient Financial Communications Best Practices®.

## Seeking Excellence

Duke pursued the recognition as a way of living up to the institution’s international reputation for excellence. “As a healthcare provider, we are always striving to do everything we can to improve medical and surgical outcomes and improve the overall patient experience,” says Jeff Neisen, director of revenue management, customer service, payer relations, and self-pay collections. “Duke is one of the nation’s leaders in clinical excellence and we want to ensure that our administrative practices are consistent with that level of high performance.”



Shawn Rocco, Duke Health

**“It’s important to take a holistic approach in understanding how the cost of a procedure or hospitalization is going to ultimately impact your patients. We perform a comprehensive analysis to make sure that patients are not going to be surprised by the costs they are responsible for on the back end.”**

### Jeff Neisen

Director of Revenue Management,  
Customer Service, Payer Relations, and  
Self-Pay Collections  
Duke University Health System



## DUKE UNIVERSITY HEALTH SYSTEM

Comparison price-shopping is just beginning at Duke—Williams estimates maybe 30 consumers call for prices each month—but high insurance plan deductibles are common. That is why provider organizations must give patients the information they need to manage their increasing out-of-pocket costs for healthcare services, he says. Good patient financial communications means proactively providing information that patients may not realize they need.

“It’s important to take a holistic approach in understanding how the cost of a procedure or hospitalization is going to ultimately impact your patients,” he says. “We perform a comprehensive analysis—from scheduling and pre-service to point-of-service—to make sure that patients are not going to be surprised by the costs they are responsible for on the back end.”

### Adopting Patient-Friendly Policies

In addition to knowing how much they will owe, patients need to know how a provider organization can help them manage high medical bills. Duke offers upfront information about payment plans, financial assistance, and help in applying for Medicaid or other forms of assistance outside the organization.

One particular challenge in the North Carolina market comes from the rapid rise of narrow network health plans. Consumers are attracted to the plans because they generally have lower premiums, but they often do not realize the limits of the coverage and the costs that might result.

Duke has seen a spike in patients coming to its emergency department, assuming that their health plan would cover the majority of charges, only to learn that Duke is not in the plan’s network. This is likely the result of an increased number of patients selecting a narrow network plan without fully understanding or researching the facilities and physician networks that those plans cover.

“Insurance plans will pay for part of out-of-network emergency services, but if we are not part of their plan, contractual payment adjustments for any balances are, unfortunately, the responsibility of the patient,” Neisen says.

Recognizing that patients are unwittingly caught in the middle, Duke adopted a patient-friendly policy for patients who seek services in its ED even though Duke is not in their network. “They receive the benefit of a discount that is equal to what would be extended to a patient that is coming to Duke through the ED in a contracted plan,” Neisen says. “That’s one of the things that consumerism and the era of high-deductible health plans has led us to do out of consideration for the patient and the financial burden the patient bears.” ✕



Working as a financial counselor for a health system can be an emotional burden, seeing one patient after another struggle with their medical bills. Or it can be a fulfilling opportunity to help people when they need it most.

When Dan Trustem, vice president of revenue services at Essentia Health, asked his financial counselors to share stories of their interactions with patients, one sent her own testimony: “I am so happy to work for Essentia and help our patients. I’m able to offer interest-free extended payment plans, financial assistance, screen for HPE (hospital presumptive eligibility), or refer patients to MNsure navigators. I feel empowered with the tools that are available to help our patients, and I feel I make a difference in a patient’s life almost every day.”

One example: An uninsured patient arrived at her office in tears because he was unable to afford his medication. The financial counselor sought HPE—in Minnesota, hospitals can temporarily enroll patients in Medicaid with a few basic pieces of information—and connected him with a vendor to pursue disability status.

“HPE covered his inpatient stay, and the disability coverage took care of his pharmacy,” Trustem says. “She sent him out to the pharmacy to get his prescriptions, and he came back two hours later and said, ‘Thank you—no one has ever taken the time to help me like that.’”

## Benchmarking Performance

Essentia Health, based in Duluth, Minn., is an integrated health system serving patients in Minnesota, Wisconsin, North Dakota, and Idaho. Trustem and his colleagues applied for recognition as an Adopter of the Healthcare Financial Management Association’s Patient Financial Communications Best Practices because they wanted to benchmark against other top-performing health systems.

“It takes some time and effort to go through the application process—we had to gather a lot of statistics and metrics and policies,” he says. “But it really gives you a sense of what the best practices are.”



**“I feel empowered with the tools that are available to help our patients.”**

**Financial counselor  
Essentia Health**

The process gave a boost of confidence to the entire department.

“When we were responding to the questions, we could see ‘Hey, we’re doing this stuff and I think doing it well,’” Trustem says. “And it confirms that we are doing the right things for the patient to create a positive financial experience.”

### Supporting, Informing, Solving Problems

He considers Essentia’s pre-service financial clearance department to be a best practice that most health systems should replicate.

“It really helps create informed consumers,” he says. “They now know before the service what it’s going to cost them out-of-pocket.”

The department serves, on average, more than 2,300 consumers each month. Staff members provide the estimated charge for a scheduled service, verify the patient’s insurance benefits, and calculate the deductible and coinsurance to come up with an estimate of the patient’s total out-of-pocket expense.

Some patients call Essentia seeking the information, but the department also proactively contacts scheduled patients who are uninsured or likely to have a large out-of-pocket liability. The service helps patients plan for the expense—and it also helps the health system.

“I’ve seen a decrease in bad debt, and we also see a decrease in denials, because we are verifying the patients’ insurance benefits upfront,” Trustem says.

When the financial implications of an upcoming service are known, Essentia staff can help its patients problem-solve in advance.

For example, a patient scheduled for a procedure was thought to be eligible for full coverage from the Indian Health Service (IHS). However, IHS requires patients to apply for Medicaid and be denied before it will assess a patient’s eligibility.

“So one of our financial counselors got creative,” Trustem says. “She thought, ‘If I can approve temporary Medicaid for 30 days, I should be able to deny it.’ So she determined that the patient would not be eligible for Medicaid, the Indian Health Service accepted the denial, approved her for full coverage—and the patient got the procedure.” ✕

Geisinger Health System in 2015 set a new bar for patient-friendly financial policies when it announced ProvenExperience™, an official promise to refund money to patients who feel they were not treated with the kindness and compassion they expected.

Like the “no-questions-asked” refund practices used by Nordstrom and Starbucks, Geisinger’s policy lets patients decide if they are satisfied with their experience. For certain surgery patients, Geisinger invites unhappy patients to use an app to choose the amount of refund they want based on their copayment. A surgery patient who paid a \$1,000 copayment, for example, could request from \$1 to \$1,000—and have the refund processed in less than a week.

## Raising the Bar

Geisinger’s next move: replacing the upfront estimate of a patient’s out-of-pocket costs with a guaranteed price. Barbara Tapscott, vice president-revenue management for Geisinger, believes that patient estimates are sufficiently accurate so this does not represent a big financial risk to the health system. But moving from “estimate” to “guarantee” is a way to find out.

“We will learn where the opportunities are to satisfy our patients and to tighten up our processes,” she says. “And this will also improve the patient experience.”

The initiatives are the latest to spring from Geisinger’s ongoing commitment to improve its patient financial communications. That effort started several years ago, when the health system decided to focus on three priorities:

- Communicate in patient-friendly terms that patients can understand
- Provide upfront estimates, including physician and hospital charges, in advance of services being rendered
- Address patients’ primary question: What will I have to pay? For insured patients, this means providing the out-of-pocket responsibility based on deductible status and benefit design. For uninsured patients, this means helping patients access resources, such as Medicaid coverage or financial assistance, for which they are eligible.



**“We don’t have to start with a blank slate all the time. We want to improve, and we can look to the research that HFMA has already done—just like we did a decade ago when we implemented the Patient-Friendly Billing project and when we signed up for the Adopter program. Going through those exercises shows us where our opportunities are.”**

**Christy Pehanich**  
Assistant Vice President, Revenue Management  
Geisinger Health System

## GEISINGER HEALTH SYSTEM

“It has been a journey—a journey Geisinger has been on for a long, long time,” Tapscott says.

The improved services directly support Geisinger’s goal of providing an outstanding patient experience. “One of our patients was so touched by the help that she received from one of our coordinators in our incoming call center that she sent two thank-you cards and she sent her a care package,” says Christy Pehanich, assistant vice president-revenue management. “She was just in awe of what this coordinator had done to help her navigate the billing process and help her to obtain the resources that were available to help her with her bill.”

Seeking recognition as an Adopter of the Healthcare Financial Management Association’s Patient Financial Communications Best Practices was a next logical step to keep Geisinger, a 12-hospital campus integrated health system, at the forefront of the industry.

“This is just the natural progression,” Tapscott says. “We were doing many of the things that are outlined in the patient financial communications blueprint that HFMA put out for our industry.”

### Being Proactive

Geisinger’s emphasis on patient financial communications came just at the right time. High-deductible health plans are prompting consumers in many of its markets to start shopping for healthcare services. The system receives nearly 200 incoming calls a day from consumers seeking price quotes. That call volume increased by 70 percent between April 2015 and March 2016, Tapscott says.

“I think it’s very telling of the environment with folks having to pay a higher share of healthcare costs,” she says. “They are looking for where they can find the convergence of price and value that matches what they can afford.”

Meanwhile, Geisinger financial counselors proactively contact patients who have scheduled services to discuss their out-of-pocket responsibility as part of the system’s MyVisit pre-service program. About 65 percent of scheduled patients are financially cleared before service, meaning that registration, insurance verification, authorizations and financial counseling, including payment plans or other arrangements, have been completed.

To prepare its application for HFMA’s Adopter recognition, Geisinger’s staff conducted a gap analysis that revealed an opportunity to take that pre-service financial clearance rate even higher.

“I learned that there were some departments that we have not yet covered with our MyVisit financial clearance, so we reviewed our resources to expand our reach to those departments,” Tapscott says. “Out of that came MyVisit 2.0, the next iteration of this program, so as to leave no stone unturned.”

The Adopter application process also revealed a need to bolster the training program for patient financial services staff. “We recognized that we have diverse generations of people that we need to reach, and not everybody can pull away to attend an in-person class,” she says. “So we developed computer-based training modules that everyone completes on an annual basis.”

Pehanich encourages other provider organizations to use HFMA resources, which she thinks contribute to Geisinger’s revenue cycle success.

“We don’t have to start with a blank slate all the time,” she says. “We want to improve, and we can look to the research that HFMA has already done—just like we did a decade ago when we implemented the Patient-Friendly Billing project and when we signed up for the Adopter program. Going through those exercises shows us where our opportunities are.” ✕



A diagnosis of gallstones in the Henry County Health Center (HCHC) emergency department led to surgery and a patient's discovery that he would owe more than \$5,300 in medical bills.

"He had not been sick prior to this episode so he had not used his insurance up to this point," says Sara McClure, HCHC's director of patient financial services. "He had no idea that he had a large out-of-pocket deductible and copay which he would be responsible for."

The patient lost work time during his recovery from surgery and fell behind on his payments to the hospital. When he called McClure to say he was going to have to file for bankruptcy, she referred him to a bank loan program for HCHC's patients.

"He was so appreciative that there was another option and felt the payments were affordable within his budget," McClure says. "We were glad it worked out for him."

## Building on Past Successes

HCHC pursued recognition as an Adopter of the Healthcare Financial Management Association's Patient Financial Communications Best Practices® because participating in HFMA initiatives has led to good success for the 25-bed critical access hospital in Mount Pleasant, Iowa.

It jumped aboard the Patient-Friendly Billing initiative years ago and, in 2009, was one of just 13 hospitals nationwide to receive the HFMA High Performance in Revenue Cycle Award. In 2013, it earned a MAP Award in recognition of its excellent revenue cycle performance.

All staff members in HCHC's patient access and patient financial services departments have completed the online modules of HFMA's Patient Financial Communications Training Program, and some staff are pursuing certification through HFMA's Certified Revenue Cycle Professional Program.



**"A patient's mother told me that [our financial communications process] relieved her of a lot of stress so she could focus on her son and his care. It was the first time in my career that I felt that I had made a difference in someone's life."**

**David Muhs**  
CFO  
Henry County Health Center

## HENRY COUNTY HEALTH CENTER

“Where we are today has a lot to do with HFMA,” says HCHC CFO David Muhs.

So when HFMA introduced the financial communications Adopter program, he checked it out.

“Financial transparency is just a natural progression for us,” he says. “What we learned from the application process is that we had a lot of things in place, but we never put it all together. We just needed to get to that next step.”

### Shopping for Selected Procedures

That next step required some work. Although HCHC was already following many of the nearly 100 best practices covering financial interactions in various settings, its ability to produce accurate upfront estimates of a patient’s out-of-pocket expense was lagging. The hospital addressed that by acquiring point-of-service technology that provides timely estimates that reflect each patient’s deductible status and cost-sharing responsibilities.

And consumers are using it. HCHC used the patient estimate tool to field 27 requests in the fourth quarter of 2015, 96 requests in the first quarter of 2016—and 58 requests in the month of April 2016 alone.

“There’s three things that consumers are calling for—colonoscopies, cataracts, and deliveries,” Muhs says.

In the case of colonoscopies and newborn deliveries, Muhs thinks consumers are comparing HCHC prices to decide where to receive the services. As for cataracts, consumers are already planning to come to HCHC—a well-known eye surgeon attracts patients from a wide geographic area—and want to know in advance how much the surgery will cost.

Regardless of why consumers are seeking price information, Muhs is glad to see them engaging with the hospital. He and his colleagues are working to educate patients about how to become smart healthcare consumers. They are participating in the Iowa Hospital Association transparency initiative, which is based on the HFMA Price Transparency Task Force recommendations; and they have placed articles in the local newspaper, appeared on a local radio program and published a new brochure, *The Patient’s Guide to Paying for Services*.

Their efforts are paying off. Earlier this year, an acquaintance approached Muhs in the hospital cafeteria to say thanks.

“She proceeded to tell me that her son was having surgery and how relieved she was that she knew what her out-of-pocket cost would be prior to the service and that we had a loan program she could participate in,” he says. “She told me that these programs relieved her of a lot of stress so she could focus on her son and his care. It was the first time in my career that I felt that I had made a difference in someone’s life.” ✕

When a Novant Health access manager was rounding with patients in the emergency department, he met a patient who said she was alone and scared to death. Her son was rushing to be with her, but he lived in another city at least 90 minutes away.

The manager got a blanket for the patient and sat down to talk with her. When she protested that he had better things to do, he said: “There is nothing more important to me right now than being here with you.”

The patient’s family members were so appreciative that they wrote a letter to the hospital leadership to commend the staff member.

“These are the things we are focusing on from the human side of health care,” says Craig Pergrem, senior director for pre-service/onsite access at Novant Health. “We may be revenue cycle, but we all would want our loved ones to be treated this way if they were alone waiting for family to arrive.”

## Reinforcing a Culture of Continuous Improvement

Novant Health, a four-state integrated network of physician clinics, outpatient centers and hospitals based in Winston-Salem, N.C., sought recognition as an Adopter of the Healthcare Financial Management Association’s Patient Financial Communications Best Practices to reinforce its culture of continuous improvement.

“We tend to get to a goal we have established and then continue on to even improve further,” Pergrem says. “This is the drive throughout the revenue cycle and one of which we are proud.”

One example: Novant Health is replacing the concept of “patient experience” with “human experience.” That perspective helps an access manager recognize that sitting with a frightened patient in the ED is just as important as making sure the copayment is collected properly.



**“We may be revenue cycle, but we are focusing on the human side of health care.”**

**Craig Pergrem**  
Senior Director for Pre-Service/Onsite Access  
Novant Health

## NOVANT HEALTH

The system's "human experience" initiative launched this year. "It will not be a project that has an end, but one we will continue to grow through the years so our patients are informed, educated and cared for from a financial side as well as a clinical side," he says. "At the same time, we are keeping it very personal so patients are not feeling like they are just a number."

In another push to continuous improvement, Novant Health established a Revenue Cycle University program that, beginning in summer 2016, is preparing its staff members to pursue HFMA's [Compliance Recognition Program](#). Building on the Adopter Recognition Program, the compliance program provides an objective performance assessment conducted by revenue cycle experts and HFMA's revenue cycle team.

Going through the Adopter application process identified some areas that warrant additional education for staff members, Pergrem said. On the other hand, it also highlighted Novant Health's leadership in patient financial communications—and inspired Pergrem and his colleagues to share their experience with their peers.

"We were able to realize some of the things that we have done that are outstanding and we did a full-day presentation to [a state-based group] on our education, collection, and best practices," he says.

## Taking a Team Approach

Novant Health operates in a region where healthcare consumerism has gained traction as many patients have high out-of-pocket cost-sharing. Pergrem sees patients asking for convenience and transparency in quality and price information.

The system receives several hundred requests from price-shopping consumers each month. "We are able to offer them pricing on all our lines and to let them know where (a service) can be done at less cost—for example, freestanding radiology center vs. the hospital setting," he says.

Even as patients become savvier consumers, many need help understanding their insurance benefits and their patient statements. That is why Pergrem sees additional opportunities to improve patient financial communications.

For example, billing statements that detail what the insurer is contracted to pay and what the patient owes do not signal a patient-centered focus. "The spotlight seems to always be on the provider or facility, when in fact it should be on a combination of the patient, insurance, provider and facility," he says. "With a team-type approach, I think we can make health care much more understood." ✕



To support patients' ability to manage and obtain a better understanding of their healthcare costs, UAB Medicine has added infrastructure to become an Adopter of the Healthcare Financial Management Association's Patient Financial Communications Best Practices.

"We know this is the right thing to do for our patients, and this is the direction our industry is progressing," said UAB Medicine Clinical Operations CFO Mary Beth Briscoe. "Our success in adapting to changes in the healthcare environment has always been predicated on our ability to be proactive. We approach the need for transparent patient financial communication no differently."

In 2014, UAB Medicine's revenue cycle team began work to improve transparency and patient financial communications. They invested in software that allows staff to create estimates of patient out-of-pocket financial responsibility for scheduled services based on their individual insurance benefits.

## Demystifying Patient Responsibility

Introduced in 2015, UAB Medicine financial counselors launched a program to contact patients scheduled for elective surgical procedures by phone to confirm clinical expectations and discuss estimated financial liability. Patients have expressed appreciation for having this information in advance. The increase in collections prior to service and enhanced patient satisfaction demonstrates this approach works for the patient as well as the health system.

"Revising how our frontline, patient-facing personnel approach the conversation of financial obligation has begun to de-mystify the concept of patient responsibility and contributed to a more positive overall patient experience." Briscoe said.

Briscoe called the Adopter application process an "eye-opener" and a learning experience for the organization.



**"The first 'best practice' we adopted was to acknowledge the organizational opportunity to improve the overall patient experience."**

**Mary Beth Briscoe**  
Clinical Operations CFO  
UAB Medicine

## UAB MEDICINE

“The first ‘best practice’ we adopted was to acknowledge the organizational opportunity to improve the overall patient experience,” she said.

As insurance deductible levels increase, patients are often confused by their personal financial responsibility for healthcare services, and that confusion can impact the patient’s experience and satisfaction. Briscoe’s staff found the Adopter application process helped both define effective financial communications and provide an overall framework for improvement.

“Large-scale change initiatives do not come with a prescriptive vision,” she says. “The application questions provided a roadmap that allowed the organization to measure strengths and weaknesses of processes to develop a work plan for achievement.”

### Learning from Others

Briscoe, a former HFMA national chair, encourages other organizations to seek input from their Patient and Family Advisory Council on the strengths and weaknesses of current

patient financial communications processes. She also encourages organizations to reach out to benefit from the experience of others.

“Don’t try to do it on your own,” Briscoe said. “Take full advantage of available thought leadership. Contact those early adopters and recognized best practice facilities to understand what has worked and lessons they have learned on their respective journeys. This will contribute to the successful transition of a culture built upon passive partnership to one predicated upon active partnership between the organization and the patient.”

Briscoe advises against waiting until consumers start comparison-shopping in your market, if they are not already, and recommends finding out what your competitors offer. “Our industry is moving at an accelerated rate, and if transparent patient financial communication is not one of your top initiatives—you’re already behind.” ✕

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With more than 40,000 members, HFMA is the nation's premier membership organization for healthcare finance leaders. HFMA builds and supports coalitions with other healthcare associations and industry groups to achieve consensus on solutions to the challenges the U.S. healthcare system faces today. Working with a broad cross-section of stakeholders, HFMA identifies gaps throughout the healthcare delivery system and bridges them through the establishment and sharing of knowledge and best practices. The Association's mission is to lead the financial management of health care.

Visit [hfma.org/dollars](http://hfma.org/dollars) for more information about the Patient Financial Communications Best Practices, the Adopter recognition program, and HFMA's Healthcare Dollars & Sense® initiative.

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