INCREASING HOSPITAL POS COLLECTIONS Project for the Lean Six Sigma Green Belt course

Description

Holistic Health Systems (HHS) operates 39 hospital facilities and clinics. The executive team has been reviewing key metrics over the last year and identified a need to improve Point of Service Collections, or simply known as POS (pronounced "P-O-S"). POS is a patient payment that is received within 7 days of discharge. Increasing POS is important for HHS because hospitals are 60% less likely to receive payment once the patient leaves the hospital. The cost of collecting on the patient’s account continues to go up while the chance of actually collecting payment goes down if there is a delay in collecting the payment after the patient’s discharge. Therefore, it is better to not delay collecting the payment. Increasing POS reduces bad debts, provides a better cash position, reduces expenses, and increases patient satisfaction when conducted properly. POS is calculated by dividing POS payments by the total patient cash collected. HHS has identified the industry median benchmark for POS as 13.6% and the top 10% POS benchmark as 41.4%. HHS’s current POS performance is 35.6%, and the executive team has determined that a 5-percentage point increase is needed to stay competitive (target = 40.6%). A Lean Six Sigma team was formed.

POS is a metric that heavily relies on the Patient Access team, or PA. PA is responsible for several tasks—patient scheduling, registration, and financial clearance. The "scheduling" tasks are typically completed by a centralized PA team for multiple hospital facilities. During scheduling, PA reps receive a doctor’s order for a patient. The order is like a permission slip for specific medical services the doctor deems necessary. The doctor or even the patient related to the order can call scheduling to reserve an appointment for the services that correspond to what is written in the order. PA reps need to verify that the order is complete and accurate, coordinate time for services, and provide patients with pre-service instructions. After the patient’s information is logged into the scheduling system

it will be queued up for the PA registration team to complete the registration process. The PA will call the patient and confirm their identity and collect demographics such as address, family, emergency contact, etc. The patient's health insurance provider(s) will also be confirmed as part of the PA registration process. PA registration can be completed at a hospital facility or by a centralized team. Lastly, PA Financial Clearance will verify patient health benefits to ensure they exist and to determine if the procedure or service for the patient is covered. If authorization is required, the PA Financial Clearance will request authorization for services from the patient’s health insurance provider. Services performed without authorization lead to rejected claims. Also, during PA Financial Clearance, the PA rep will counsel the patient about their liability (how much their insurance provider says they need to pay for the services) and collect the payment. Any payment received is considered POS since it’s before 7 days post discharge. Financial clearance can also be performed at the hospital facilities or by a centralized team. Summary patient cash data for HHS’s 39 hospital facilities for a year is presented in Table 1. The table also indicates if the PA team for each facility is centralized or not. Table 2 provides an overall monthly trend for POS performance. The team identified the facilities with POS performance above the target and researched the activities they have in place, hoping to find commonalities or key drivers. They are: • ensure proper patient education on benefits and liability • ask for payment • have a financial counseling policy • reduce number of patients that leave without financial clearance • have accurate tools to help estimate patient liability or responsibility • utilize devices that allow patient collections at the patient’s bedside



