A Roadmap to
The Patient Financial Experience of the Future

Part II of a Five Part Series

HIMSS Revenue Cycle Improvement Task Force
March 2017

EXECUTIVE SUMMARY

In March of 2016, we published the first of this five-part series, entitled ***A Roadmap to the Patient Financial Experience of the Future***. The initial paper considered the technology required to realize the HIMSS Revenue Cycle Improvement (RCI) Task Force's vision of the Patient Financial Experience of the Future. This paper looks at the Patient Financial Experience from the view of the physician and non-physician providers, collectively referred to as providers. For this analysis, the task force challenged itself to consider the back-office healthcare revenue cycle management (RCM) functionality required at the provider level to facilitate the task force's vision. Future papers will focus on the functionality required by hospitals, post-acute care settings, and payers to realize this vision.

This paper provides a detailed view of each component behind a new, improved RCM model for the industry. Though it follows the patient's journey from pre-care, treatment, and coordination of care, ending with patient satisfaction, the focus is on providers. The paper identifies suggested technical solutions, streamlined processes, and potential gaps in the current typical patient experience. Realization of the task force's vision of the Patient Financial Experience of the future will require widespread adoption of a full range of tools to support patient decision-making, scheduling, registration, administrative simplification, price transparency, and effective consumer payment methods.

As the RCI task force has worked to consider the implications of a more patient-centered approach to RCM and to articulate a proposed vision for improving the patient financial experience, the industry has realized the challenge to be even greater than originally expected and the solutions much more complicated. The changing landscape of healthcare, with uncertainty of the future of the Affordable Care Act, the marketplaces and the Medicare expansion – leaves many wondering what the future will hold for patients, providers and payers. What is certain is that there has been continued growth in consumer financial responsibility – through both direct increases in costs of plan premiums, and ever-increasing financial responsibility shifting to the consumer from the employer, particularly with the move to high deductible plans.

Increased patient financial responsibility is changing the dynamics of the patient-provider relationship and creating a need for greated shared decision-making tools.

This increase in patient financial responsibility is changing the dynamics of the patient-provider relationship. More and more frequently, patients must consider the financial implications of the treatment plan they choose as well as the treatment's medical efficacy. This necessitates a level of shared decision-making not seen since employer-sponsored healthcare coverage became the norm and

doctors stopped making house calls. **This shared decision-making requires real-time integration and access to a patient's clinical records, healthcare coverage, and financial information at the time treatment is considered.** A majority of patients will also benefit from having access to an individual who understands the interaction between each piece of this information, and is able to help the patient understand and make the best treatment choice based on their individual circumstance. The current models for accessing and sharing this information, and a general lack of interoperability between the systems that support this transfer of data are insufficient to support the level of shared decision-making envisioned by the task force.

There are already a number of examples emerging across the industry of significant efforts to improve components of the patient financial experience. However, even broader industry engagement in the envisioned goal and commitment to the level of secure data sharing and interoperability is essential to enable the optimal consumer-friendly revenue cycle and provide for the financial wellness of our healthcare delivery system.

Shared decision-making requires real-time integration and access to a patient's clinical records, healthcare coverage, and financial information at the time of treatment.

Our hope is that you will read this paper through the lens of a provider focused on creating a patient-centered financial experience. If you are an industry stakeholder, we hope you walk away inspired to leverage your engagement in the healthcare delivery system to help all of us realize the task force's vision for the Patient Financial Experience of the Future
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OVERVIEW

Since its inception in 2011, the Revenue Cycle improvement Task Force has been on a quest to address the patient financial experience as it relates to their overall satisfaction when they engage with the healthcare delivery system. In July 2015, the task force began focusing its energies on creating a vision for the next generation of revenue cycle management tools and processes that keep administrative cost containment, interoperability, and consumer engagement front and center. Membership in the task force includes representation from providers, financial institutions, payers, revenue cycle vendors, healthcare consultants, and professional associations, including the American Medical Association (AMA), the Healthcare Administrative Technology Association (HATA), and the Healthcare Financial Management Association (HFMA).

The HIMSS Revenue Cycle Improvement Task Force is focused on a vision for the next generation of revenue cycle management tools and processes that keep administrative cost containment, interoperability, and consumer engagement front and center.

These industry experts contributed their thoughts, ideas, and professional and personal experience to create a shared vision for improving the patient financial experience of the future. This vision was finalized in 2014. After socializing their vision through a white paper (***Rethinking Revenue Cycle Management***), infographic, and 2014 HIMSS Annual Conference listening session, the group turned its attention to encouraging the industry to realize its vision. In 2015, the task force completed the first in a series of five gap analyses, each aimed at identifying the technological functionality required for specific participants within an episode of care to facilitate the task force's vision of the Patient Financial Experience of the Future. The initial analysis focused on functionality required to support patient-facing activities. This paper will speak to the functionality required for primary care physicians to support those patient-facing activities. Future papers will address the functionality required for hospitals, post-acute care facilities, and, finally, payers.

This paper, and the analysis it represents, is intended to be a living document. It will change as solutions designed to fill the gaps identified through the task force's analysis are developed and adopted, and as revenue processes themselves evolve.

Guiding Principles

All work products delivered by the RCI task force demonstrate adherence to a specific set of Guiding Principles. Solutions promoted by the task force must:

- be patient-focused;
- support transparency of information;
- reflect process driven, non-duplicative business practices;
- leverage existing and emerging technologies;
- demonstrate a sustainable return on investment;
- have standards-based architectures;
- be intuitive and include simplified user interfaces; and
- be designed with the full revenue cycle business process flow in mind.

In 2016, the task force applied these principles to determine technical functionality gaps within a primary care provider setting that need to be addressed to realize the task force vision for the Patient Financial Experience of the Future.

Approach to Gap Analysis

Those familiar with the first paper in this series may recognize gaps and recommended solutions in this paper similar to those identified in that initial paper. This is a reflection of the critical role providers play in shepherding patients through an episode of care. Almost every interaction a patient has with the medical system is initiated by or flows through the provider's office. It makes sense that access to the tools that will facilitate these interactions is presented through the provider, which requires the provider to have technical functionality that compliments and supports the functionality required for patient action. However, complimentary and supporting technology does not necessarily mean the same technology, and readers will find additional gaps and solutions in this paper that were not identified in the patient perspective.

The patient financial experience of the future is a goal for the present.

Undertaking a project of this magnitude and scope requires engagement of stakeholders from every area of healthcare, and from the organizations that support them. Many of the team members have extensive knowledge and experience in hospital and physician practice revenue cycle management, a bonus when outlining current state processes, while others are more heavily involved in retail, finance and technology. The background differences in the group afforded a diverse and well-rounded approach to envisioning the technical functionality for future state success. Premier health care institutions are well represented with Kaiser Permanente, Mayo Clinic and Johns Hopkins Medicine volunteering their time and resources to the cause, as have smaller consulting firms, financial institutions, cyber security and mobile technology companies. Clinicians and administrators complete the cross-functional group; all

actively participating in a cause where shaping the patient financial experience of the future is a goal for the present.

Task force members are asked to suspend everything they believe to be true about what can or cannot be done as part of the revenue cycle process. The Patient Financial Experience of the Future must be viewed first through the eyes of the patient. With that vision crystalized in their minds, the task force members' next step is to think in terms of "what if" to identify the technology required to realize the vision. If healthcare services could be effectively priced in advance of receiving care, what technical functionality would be required to provide that information to the patient? What technical functionality would be required to facilitate real-time information exchange between payers, providers, and financial institutions?

To complete its analysis, the task force began with the same basic framework used to conduct the patient perspective gap analysis discussed in Part I of this series. The task force examined each step of the patient's journey, including pre-care activities, treatment, coordination of care, and patient satisfaction, considering specific activities involved in each of the steps as envisioned in the Patient Financial Experience of the Future. The group reviewed the technical functionality required to support these activities from the providers' perspective, and identified potential gaps between the functionality that exists today and the functionality that will need to be developed to fully realize the task force's vision. The following is an overview of the task force's findings.

The task force began with the same basic framework used in Part I of this series.

ROADMAP TO THE FUTURE

Category I: Pre-Care

The first step in every patient's journey is to choose a provider. To support this activity, providers need to provide visibility and accessibility to potential patients via a wide variety of electronic tools. Information needs include, but are not limited to: directories (payer, professional associates, etc.), multi-media advertising, links to provider website or self-scheduling tools, a list of services provided, language(s) spoken, hours of operation, geographic locations, hospital privileges, health plans accepted, billing and payment policy, quality & performance scoring information, and an indication of whether or not the provider is accepting new patients.

Patients tend to choose their provider based on their specific health plan. Tools that provide a technical connectivity solution with the ability to determine and match the details of the health plan, such as provider network, healthcare benefits, co-pay, and deductible with the patient's immediate healthcare needs and geographic location will simplify this task.

A solution that provides pertinent information such as hours of operation, languages spoken by the medical office staff, physician specialty, quality rating and charges for an initial office visit further enhances the provider's ability to attract patients.

In the Patient Financial Experience of the Future, the ability to schedule an appointment and complete a registration form on-line will streamline the registration process when the patient arrives at the point of care. A single point solution where the patient's medical information, including a complete medical history and list of medications currently being taken, and the name of the treating or prescribing provider, will be available to the provider with whom the patient is scheduling an appointment and auto-populate appropriate fields of the scheduling and registration forms. The customization of provider tools for patients and their information is an important shift in focus outward from the provider to the patient.

While there are progressive technology solutions available today that deliver pieces of this vision, none provide the full level of functionality described here.

As a part of scheduling and registration, the provider will capture the patient's authorization for all appropriate parties to provide the patient's medical records. This cannot happen without the adoption of national standards and uniform operating rules for patient matching and the secure transfer of this data.

Based on the health plan information and medical information (reason for visit) electronically collected during this process, the provider will make available a tool that estimates and communicates patient financial responsibility (or liability) in real-time at the moment the patient requests it, including information about payment options, payment processing prior to service, and access to financial counselors.

In situations where the patient is required to complete pre-visit activities, such as having lab work done prior to seeing the physician, patients will be given information about these requirements in advance of scheduling the associated visit. Information provided to the patient will include disclosure of the patient's anticipated financial responsibility, if any, for these pre-treatment services.

The provider's system will generate an automated appointment reminder for the visit. Today, there are technology solutions such as email, text and automated calling platforms for appointment reminders. Automated cancellation and rescheduling features are needed to increase the functionality and usefulness of these tools. Widespread adoption of these tools will help providers maximize their capacity for providing services to their patient population, and move the industry closer to realizing the task force's vision for the Patient Financial Experience of the Future.

All information captured and processed by the variety of tools identified in this section will be stored in the patient's electronic health record or other integrated data storage tool. The evolution of the EHR from a clinical repository only to a tool that also includes a data and information repository has essential implications, especially for population health and value-based delivery systems.

The table on the next page lists specific gaps in currently functionality that will need to be filled for pre-care activities to flow as seamlessly as described in this section.

Functional Components	Gaps	Identified Functional Solutions
Category I: PRE-CARE		
Robust marketing to potential patients about provider and services	Search functionality for mobile access; real-time updating of provider enrollment information	Specific search applications within certain large markets; provider websites
Provider linked mobile or other connectivity from provider and health plans for network information, benefits, price estimates and patient financial responsibility	Providers and patients not linked in a search function with health plans; lack of automated price estimation and financial responsibility tools customized to the specific patient need, provider and benefit status	Payer-based search solutions at the provider level; emergence of more service/procedure-based pricing tools
On-line access provided for patients or potential patients to access health records, schedule and pre-register via a secure method	Fully functional patient portals and EHR access from all electronic devices; interoperability across multiple providers	ONC pledge from the 4 major EHR providers to support interoperability; patient portals exist within individual systems ; demonstrated secure patient data transfer via encrypted, authenticated channels
Automated tool for required authorizations including obtaining records from disparate systems and/or providers	Deployment of automated pre-authorization processing despite existence of transaction standards	Demonstrated secure patient data transfer via encrypted, authenticated channels; organization and sharing of health data from disparate sources
Provider developed pre-visit instructions automatically provided; incorporation of telemedicine technology into pre-care process as provider designates	Robust deployment of smart phone telemedicine tools; ability to provide pre-visit instructions via patient's preferred method, including text and email	Monitoring via smart phones available but not widely deployed or incorporated into provider practices; tools for clinicians to customize push alerts at the patient or group level
Automated appointment reminders generated to solution identified by patient	Lack of choice given to patients	EHR support of text messaging and email messaging

Category II: Treatment

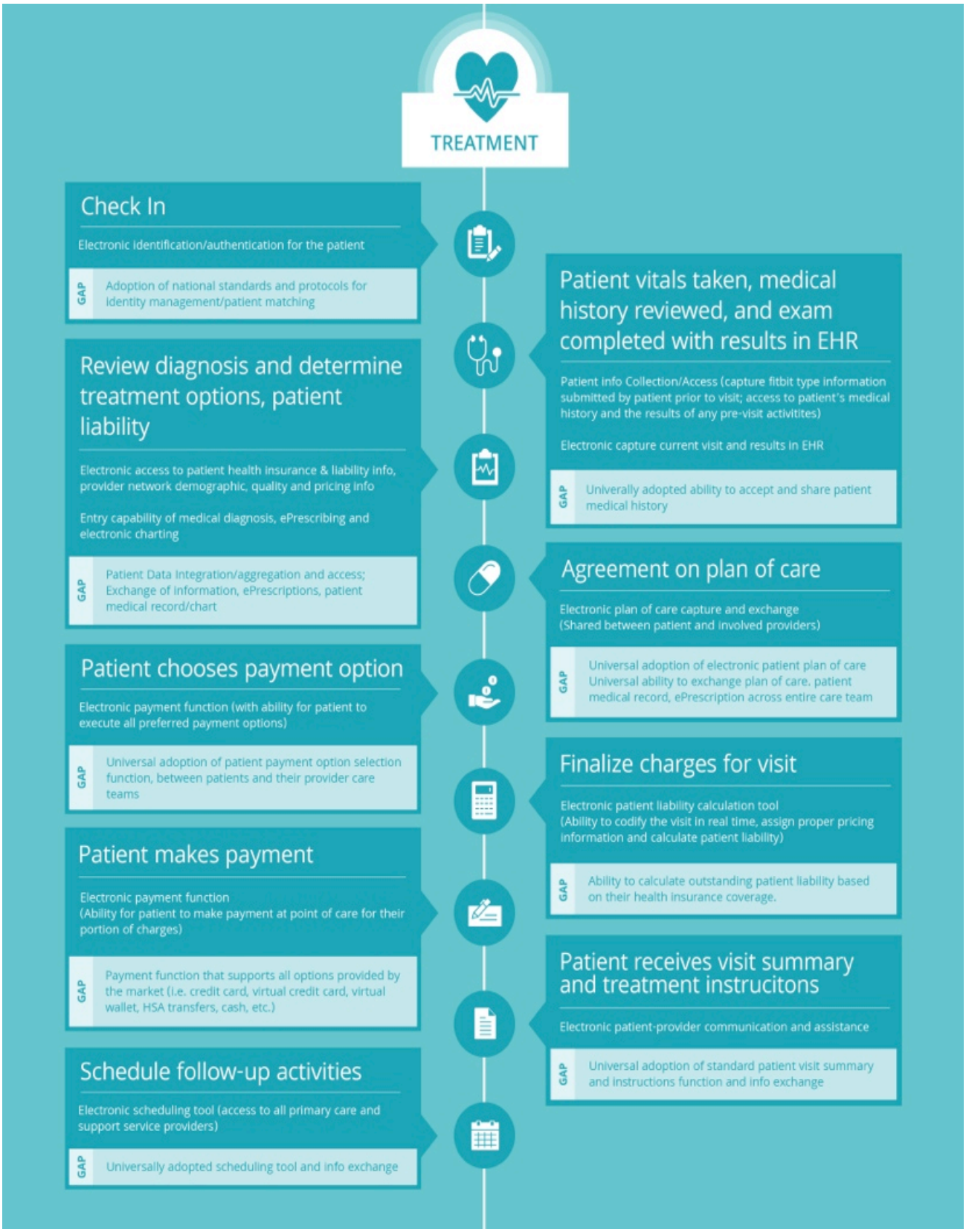
The task force envisions a future in which providers will utilize an automated arrival and check-in process. The task force is aware that there are a limited number of automated solutions available in the market today, but we are not familiar with one that provides a fully automated process for a new patient. As with the on-line registration process and sharing of information, developing this type of solution will require the creation and adoption of national standards and uniform operating rules related to patient matching to ensure that the right information is being associated with the right individual. Electronic awareness and connectivity by means of mobile phones and related applications is an opportunity that can increasingly be leveraged to achieve this functionality.

After the patient checks in and vital signs are taken, the medical history/reason for visit is reviewed. Providers may opt to expedite the vital sign capture with wearable technologies that could be programmed to transmit an individual's vital signs to a treating physician in real time. In spite of having some technological solutions in place today, there is still an inability to access and share patient medical history between multiple providers and multiple health systems.

It is the task force's vision that the provider's office will have real-time access to the patient's healthcare benefit information, including any patient financial responsibility associated with the current visit, such as co-pays or deductibles, the provider network associated with the patient's health insurance coverage, and pricing information for the services to be delivered. It is further expected that the provider will be able to share that information in a meaningful way with the patient to allow them to make the most informed treatment decisions possible. This will include the ability to compare both the efficacy and price of different treatment options. The provider will also be able to provide information about payment options for the patient's financial responsibility, and be able to facilitate payment arrangements at the point of care.

The challenges in realizing this vision for the future are two-fold. The current healthcare system lacks both the technical ability to share the level of detailed information identified herein and the business processes to support the scenario described. There are cultural challenges as well. Many providers are not accustomed to incorporating financial considerations in the discussion of treatment options with their patients. However, from a patient perspective, deciding on the best course of treatment may include consideration of their financial situation and the amount of social support available. The providers' challenge is to provide tools that facilitate the sharing of both clinical and financial information in an automated, real-time fashion with the patient.

Avoiding duplication of services and unexpected costs for the patient requires that providers document and capture a patient's plan of care electronically, and that that plan of care is shared with the patient and any providers involved in the execution of that plan. Although many providers are able to support such communications between themselves and their patients, fewer are able to extend this capability to include other providers involved in the patient's care, particularly providers who may not be directly affiliated with the primary physician's medical organization.



Providers will be able to provide patients with an interim or final bill, as appropriate, including an accurate statement of the patient's financial responsibility, before the patient leaves the office. Automated real-time revenue cycle management tools will support payment processing activities. Providers will have the ability to document charges, record payments, issue receipts and process deposits at the point of care. Payment methodologies will take a variety of forms, including mobile payments via a smart phone, credit card processing from a flexible spending account (FSA), health savings account (HSA), or regular bank account, electronic funds transfer (EFT) from the patient to the provider, or insurance payment via EFT to the provider.

Health plans must find a way to determine and communicate patient financial responsibility in real-time in order for this vision to be realized. This could happen through newly designed benefit structures created to support alternative payment models that make it easier to predict patient financial responsibility, through revised business processes related to claims adjudication, or through the development of technical solutions aimed at providing real-time claims information among all affected parties.

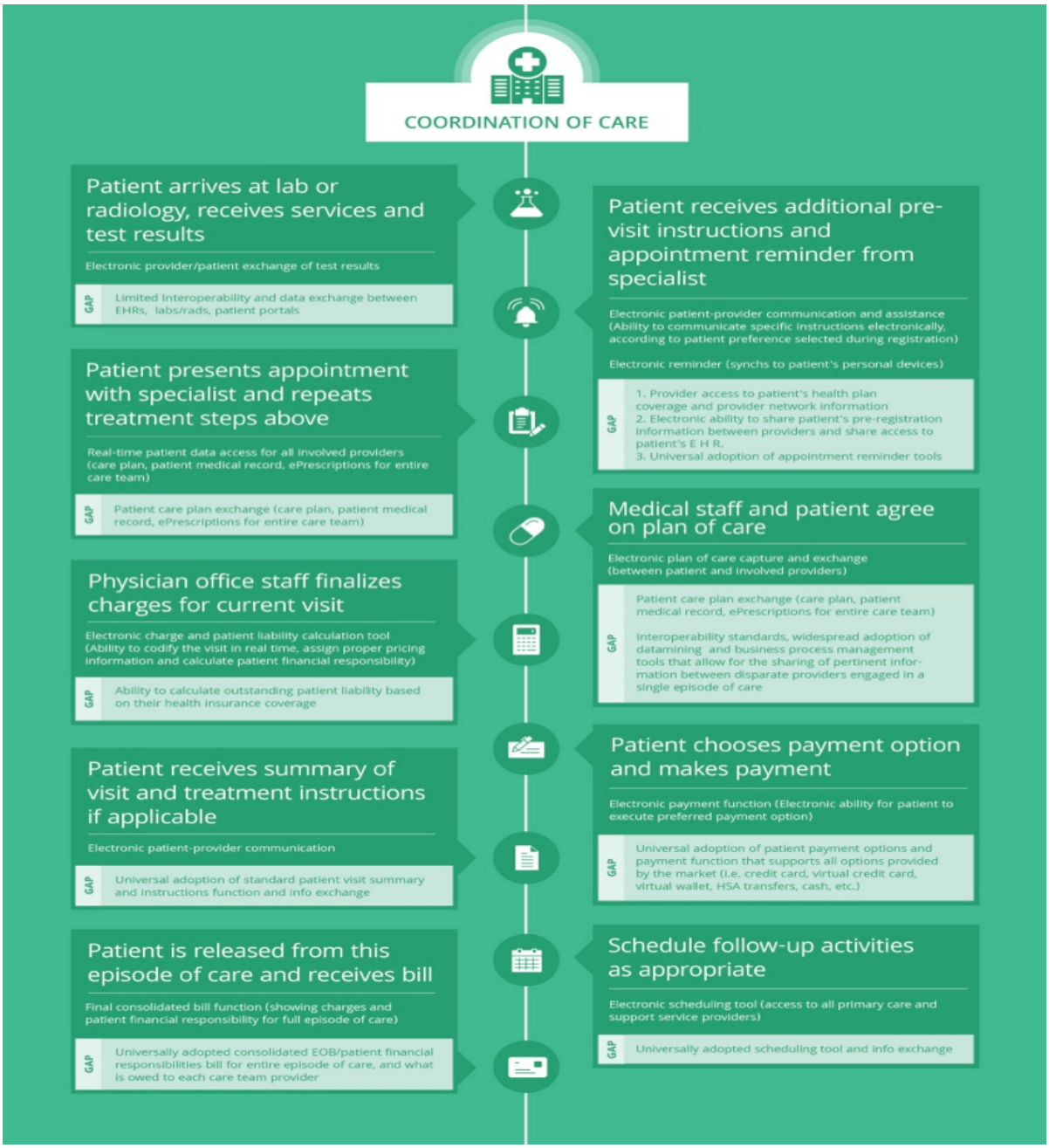
For those situations requiring follow up care or a referral to another provider such as a specialist, it will be the norm for care to be coordinated and appointments made before the patient leaves the referring physician's office. All applicable patient information will be automatically shared between providers without the need for patient facilitation. While the major EHRs assist with this functionality to some extent, there is still a lack of a universally adopted scheduling tool and wide spread information exchange, especially between non-affiliated providers.

The table on the next page lists specific gaps in currently functionality that will need to be filled for treatment activities to flow as seamlessly as described in this section.

Functional Components	Gaps	Identified Functional Solutions
Category II: Treatment		
Automated arrival check-in	Limited deployment of patient kiosks; no identified use of smart phone check-in	Use of iPads by limited number of organizations
Real-time automated updating of patient's insurance and price information	Fulltime automated access to payer records; ability to generate price information based on pre-service reason for visit/service	Insurance verification technology deployed but not necessarily utilized at time of service
Real-time capture of medical information; updating of EHR; development of patient's bill	Universal adoption of ERH and resolution of interoperability issues; lack of real-time billing function development	ONC pledge from the 4 major EHR providers to support interoperability;
Automated claim adjudication and financial responsibility resolution	Lack of real-time adjudication incorporated with ERH information at time of service	Limited real-time claim development and adjudication only in physician space
Automated referral(s) as required including transmittal of EHR information needed by the provider	Provider to provider information sharing not deployed across all providers and ERH platforms	ONC pledge from the 4 major EHR providers to support interoperability

Category III: Coordination of Care

Providers need the ability to receive all of their patient's pertinent personal health information (PHI) from other providers providing care to those patients. Thus, a full medical history will be available through automated means wherever and whenever the patient presents for services. The patient will not have to repeat their full medical history each time they are seen by a new provider or moved to a new setting. Sharing this type of information among all providers involved in an episode of care, including those who are not associated with the same medical facility or healthcare system, requires the establishment of national standards and uniform operating rules related to the sharing of PHI and widespread adoption of electronic health information exchange capabilities.



Many of the activities and gaps identified in the treatment category of activities, such as decision-making tools and payment options, apply to coordination of care as well. A major difference, however, will be the consolidation of financial information.

In today's world, a single episode of care involving multiple providers across a variety of settings results in multiple bills (and explanation of benefits). This adds enormous administrative costs, and creates a great deal of confusion and frustration for the patient, who simply wants to know, bottom line, who do they owe, how much do they owe them and what are their options for making payment.

In the Patient Financial Experience of the Future, providers will be using tools that ensure consolidated financial and clinical information will follow the patient throughout their episode of care and include real-time updates as they occur. The financial implication of this capability is that at the time the patient completes their final office visit and is released from care their provider is able to provide one final consolidated bill that includes charges from all providers involved in the episode of care, and clearly states the patient's total financial responsibility. Having provided an estimate of the financial responsibility at the time treatment was chosen, the provider will equip the patient to settle their portion of the bill at the time of care or automatically execute the payment arrangements made earlier in the process.

The following table lists specific gaps in currently functionality that will need to be filled for coordination of care activities to flow as seamlessly as described in this section.

Functional Components	Gaps	Identified Functional Solutions
Category III: Coordination of Care		
Real-time access to all medical information at any provider location	Limited to within a system	ONC pledge from the 4 major EHR providers to support interoperability; demonstrated secure patient data transfer via encrypted, authenticated channels
Consolidation of financial information and billing; bundled services billing; consolidated statements	Lack of systems to automate emerging service delivery models	Consolidated billing statements and combining of EOBs available as first step; demonstrated secure patient data transfer via encrypted, authenticated channels; clinical decision support tools deployed
Mobile payment application at time of service and post service	Limited automated payment solutions; lack of smart phone applications in traditional provider space	Retail mobile payment tools widely deployed and adaptable to healthcare space

Category IV: Patient Feedback

Providers realize the importance of patient satisfaction not only with their clinical care, but with the financial aspects of their care as well. In the future, it will be a standard component of the episode of care for patients to provide feedback regarding all aspects of their healthcare experience in real-time, or upon completion of the episode of care. Mobile technology will replace or supplement other feedback methodologies. Feedback collected will include comments regarding all elements of the experience, from ease of finding the provider, to the simplicity of the registration process; to how well the providers' tools delivered appropriate financial information, and how and when the patient's financial responsibility was addressed. This is not a new concept. The Centers for Medicare and Medicaid Services (CMS) has embraced this philosophy in practice through their Consumer Assessment of Healthcare Providers and Systems (CAHPS) program. CMS combines the results of CAHPS surveys with other quality measures to determine payment incentives for high performing healthcare physician providers.[1] On the hospital provider side, the CMS HCAHPS program is a parallel survey and data collection initiative. A significant difference between current state and the future envisioned by the task force is the inclusion of a consistent mechanism for the affected stakeholder group, whether it is the provider, the payer or the financial institution, to receive and acknowledge that feedback in a timely fashion, and in a way that makes the information received actionable.

Currently, individual providers and the industry as a whole lack a consistent approach to providing feedback to the providers regarding opportunities for improvement. The task force believes that for feedback mechanisms to be truly meaningful they must be easy and compelling for patients to participate in, consistent across the industry, constructive criticism must be acknowledged, and patterns must be tracked. Where patterns of extreme satisfaction exist, providers should be rewarded.

[1] AHRQ Program Brief "CAHPS: Assessing Health Care Quality From the Patient's Perspective." April 2014. https://cahps.ahrq.gov/about-cahps/cahps-program/14-p004_cahps.pdf

The challenge going forward is to create the required interoperability and connectivity, coupled with security and access that result in a healthcare system that includes a seamless clinical and financial experience for both providers and patients, while keeping administrative cost containment and patient engagement front and center, regardless of the payment methodology being applied.

The table below lists specific gaps in currently functionality that will need to be filled for patient feedback activities to flow as seamlessly as described in this section.

Functional Components	Gaps	Identified Functional Solutions
Category IV: Patient Satisfaction		
Real-time post patient satisfaction surveys sent to all patients via patient's selected method (email, mail, mobile)	Current survey methodologies generally limited to email or mail surveys	Automated surveys in other industries
Deployment of consistent survey tools and questions to enable identification of best practices	Medicare surveys and provider-deployed surveys not coordinated to create best practices information	Tools used in other industries and research platforms

Efforts Currently Underway

Not all of the functionality required to support the Patient Financial Experience of the Future will need to be created from scratch. There are numerous efforts already underway that may fill gaps identified above or that can be leveraged to do so going forward. The task force has done preliminary research to identify innovative solutions and initiatives based on the original Roadmap of the patient financial experience of the future; an overview of these findings can be found in the Appendix of the 2015 Whitepaper.

The 2017 grids associated with each of the major segments of the Roadmap identify technology gaps and emerging solutions to fill those gaps. The Office of the National Coordinator's (ONC) efforts as demonstrated through their "Consumer Health Data Aggregation Challenge"[2], the "Provider User Experience Challenge"[3], and the "Use of Block chain in Health IT Challenge"[4] include innovative solutions to many of the gaps identified in this white paper. The solutions/initiatives included in our grid are in no way intended to be a comprehensive inventory nor an endorsement of these solutions by HIMSS. Rather, this step is designed to illustrate movement already underway in the industry that can be built upon to realize the Patient Financial Experience of the Future and fill some of the functional technology gaps identified in this roadmap.

Call to Action

The findings presented in this paper represent the beginning, not the end, of the process. The HIMSS RCI task force needs your help to actualize its vision for improving the provider and patient financial experience. Achieving the task force's vision will require a paradigm shift among all participants – patients, providers, payers, vendors, and financial institutions. Will you join us and take action to make this vision a reality? Here are a few suggestions of how you can help.

[2] : https://www.hhs.gov/about/news/2017/01/12/onc-announces-winners-consumer-and-provider-app-challenges-improve-health-information-access-and-use#

[3] : https://www.hhs.gov/about/news/2017/01/12/onc-announces-winners-consumer-and-provider-app-challenges-improve-health-information-access-and-use#

[4] https://www.hhs.gov/about/news/2016/08/29/onc-announces-blockchain-challenge-winners.html

- ***Share your solutions***!
  Does your group have a solution to any of the issues identified in this paper? Are you working with a vendor or have a process in your organization that has solved for any of the challenges identified in this paper? Have you read about a new company that has solved these challenges? We are looking for authors to contribute thought leadership pieces on any of the topics raised in this paper. Has someone in your organization written an article for a professional journal, a master's program or perhaps a professional certification? Contact Pam Jodock, HIMSS Senior Director, at pjodock@himss.org to share what you know.

- ***Submit a case study***!
  The task force is aware that there may be tools or solutions available today, but not widely adopted, that could address specific gaps identified in this analysis. If you have such a solution, or are looking for a partner to pilot one, we encourage you to submit a case study to the HIMSS RCI task force. Criteria and application forms are found here.

  Accepted case studies will be promoted through a variety of HIMSS communication avenues, including professional publications, social media, and maybe even a chance to present at a HIMSS Annual Conference.

- ***Join the HIMSS Revenue Cycle Improvement task force***!
  The Revenue Cycle Task Force is always open to new members. The time commitment is only a few hours per month, but the benefit is much greater. Join your peers and share what you know, learn from like-minded colleagues and help advance the profession. We welcome your input and participation. The only requirement for participation is that you be an active HIMSS member. If you are an existing HIMSS member interested in joining the task force, please contact DonVielle Young at dyoung@himss.org. For more information on how to become a HIMSS member, please visit our website.

- ***Join the conversation***!
  Please visit the HIMSS Patient Financial Experience of the Future microsite. After completing the full journey, please share your thoughts and ideas through the link provided on the website, or by emailing Pam Jodock directly at pjodock@himss.org. Additional work products can be found on HIMSS Revenue Cycle Improvement web page. Join the HIMSS Revenue Cycle Improvement LinkedIn Group and contribute your ideas.

- ***Spread the word***!
  HIMSS encourages you to share this white paper and the links included herein with your friends and colleagues. HIMSS is honored when someone chooses to reference the work the RCI task force is doing when discussing his or her own contributions to revenue cycle management, such as Fifth Third Bank did in this example.

CONCLUSION

Healthcare is an ever changing, complex system that requires ongoing efforts to optimize the experiences of the patients and the providers. The work presented in this paper is an example of the need to continually challenge the status quo, to find more and better ways to streamline work and to connect the dots. The provider and patient share a similar desire to minimize and simplify the administrative tasks associated with revenue cycle management.

Imagine a day when automation and system interconnectivity eliminate the need for multiple administrative processes related to an office visit. No more filling out paper forms, or recounting your medical history and current concerns numerous times during the same visit or episode of care. Imagine having the information you need to partner with your provider in determining the best treatment option for your specific circumstance. Imagine never getting a paper bill, but instead having your account settled when you check out via an electronic payment authorized by you, with full understanding of what you and your insurance company are responsible for paying.

This vision of the future is possible, and we may be closer than we think. Systems are becoming more connected. National registries and interconnected hospital and physician medical records are becoming the norm. Connectivity across practices and hospitals is being more seriously considered than ever before as a way to reduce administrative costs and improve the overall patient experience.

The purpose of the HIMSS Revenue Cycle Improvement's Roadmap to the Patient Financial Experience of the Future series is to highlight the opportunities associated with realizing the task force's vision of the future, and to acknowledge the work already underway to realize this vision.

As we noted in the beginning of this paper, this is an ongoing effort. In Part III of our series, scheduled to be delivered in late 2017, we will address the functional technology gaps affecting hospitals' ability to support the Patient Financial Experience of the Future, and offer suggestions

for solutions to close those gaps. For now, we invite you to get involved. See the Call to Action section and give some thought to participating in building the future with us.

"Here's to the crazy ones. The misfits. The rebels. The troublemakers. The round pegs in the square holes. The ones who see things differently. They're not fond of rules. And they have no respect for the status quo. You can quote, disagree with them, glorify or vilify them. About the only thing you can't do is ignore them. Because they change things. They push the human race forward. And while some may see them as the crazy ones, we see genius. Because the people who are crazy enough to think they can change the world are the ones who do."

Ron Siltanen

HIMSS would like to thank the following authors for their contributions to this white paper:

Maureen Clancy, MBA, FACHE, CPC
SVP, Revenue Cycle Management
Privia Health

Lisa Tonkinson, CMRP
Senior Consultant, Revenue Cycle, Supply Chain, Pharmacy & Technology
e4 Services

Sandra Wolfskill, FHFMA
Director, Healthcare Finance Policy/Revenue Cycle MAP
Healthcare Finance Management Association (HFMA)

