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What Happens to the ROI Calculation as We Move Forward

Bedford, TX – In the past, we've carried a number of stories about call center ROI, the calculation of the numbers and also how it can be communicated to upper management. A decade or two ago, it may have been a simple figure that the call center manager might want to give to express just how successful the call center was in its mission. "We have a return on investment of eight to one, or we have a return on investment of five to one" might have been typical responses in that era.

As our health system transitions from one focused on sick care to one oriented toward keeping patients well, there are changes in store for call center ROI. "I don't believe the Revenue Reconciliation process will change, we'll still be matching callers to patients, but what will change is how we interpret and utilize the output," says Ellen Faw, vice president of strategic customer relations for the Bedford, Texas-based offsite contact center provider Beryl.

David Marlowe, principal with the Ellicott City, Maryland-based Strategic Marketing Concepts, says that health organizations will still want to capture patients. Even if there is some form of capitation or global payments, call centers can still assist in bringing patients into the network.

Understanding the amount of business brought to the healthcare organization through the call center will still be important from a macro level, but, Faw says, it will also be important to understand call center activity through a number of different lenses. One of those lenses is, "more in-depth analysis of campaigns driving primary care activity and outpatient activity including educational opportunities, vehicles and community outreach."

Another element, she says, is focused around service inefficiency, including such things as analysis of scheduling for patients, tracking no-show rates, monitoring patient, employee and provider satisfaction, and evaluating first available appointment metrics.

The latter is especially important as, for example, if callers are consistently told they may have to wait weeks for an appointment, then service levels slip and eventually those patients may be lost to the system.

This issue becomes particularly important under the Patient Centered Medical Home initiatives that are rolling out within our health system. Faw says that it does not serve patient continuity well if patients get so frustrated with their medical home that they leave and find another office and then leave that too.

Then there are the efficiencies created by the call center in extending the physician referral conversation to include other related potential medical needs such as referrals for family

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members and scheduling relevant diagnostic tests such as mammograms.

The efficiencies that the call center brings to the table have to be considered a part of the return on investment calculation as we move forward, she says.

Another change could mean an expanded analysis to account for the growing integration in healthcare organizations. Faw says that this expansion of facilities/departments for call center reconciliation includes employed physician practices, outpatient, extended care, skilled nursing, and inpatient and outpatient rehab.

Then, there is the clinical side of the call center. That's where telephonic disease management and telephone nurse advice and triage can play a big role in truly understanding the ROI concept in our new system. Catch a diabetic problem early through a disease management program, and perhaps that individual won't show up as an inpatient for an expensive stay, she says. Redirecting unnecessary ER visits through a telephone nurse advice and triage application can save the health system money, as previous stories in this publication have indicated.

ROI in the clinical arena may include more utilization and measurement of all things nurse triage. They include, Faw says, "How we successfully keep inappropriate patients out of the ED; how we can impact and decrease readmission rates via post-discharge calling; how we manage chronic conditions and how we impact call center touched patients versus overall hospital patients. Is their length of stay shorter? Is their utilization of the ED lower? Are their readmission rates lower? Is their satisfaction higher?

Indeed, Marlowe calls this notion a "reverse ROI." It is still a return on investment, but rather than looking at how much money the call center makes for the health organization, it is focused on how much money it can save.

He says that there are a variety of scenarios where a reverse ROI could come into the picture. One of those is if the health organization is operating in a capitation-risk model whereby it receives payment streams based on the number of "members" rather than health events. In this model, what the call center may contribute in terms of redirection of care to less expensive settings and early interventions is certainly ROI. Another example is in looking at the looming penalties for readmission of Medicare patients.

While the call center can get some credit for its efforts to reduce readmissions through things like post-discharge calls, it may be difficult to attribute how much credit ought to be given as there may be other initiatives the hospital may be doing that also play a big role. So, for example, let's say that to avoid readmission penalties the hospital beefs up home visits, places a stronger focus on discharge communication before release and does post-discharge follow up calls through the call center, what percentage allocation should each activity get?

Marlowe cautions that no matter what goes into your ROI calculation, whether it's strictly the traditional ROI or incorporates other features such as cost avoidance, the calculation will not have the credibility you desire unless you get upfront buy-in from finance (and other relevant powers that be) regarding assumptions and pieces of information that will be used. Indeed, he points out, these underlying assumptions of the ROI calculation may be different from hospital to hospital but they are each correct as they reflect each hospital's particular milieu.