Beyond the Curve of Health Care

The health executive’s guide to organizational reform
Presented by Optum™
The Journey to Better Health Care

Every health company in the United States has been impacted by health care reform. However, no two health care organizations feel that impact in the same way. Each one must evolve uniquely, challenging their own history of success against shifting mindsets as well as evolving revenue and delivery models. It is here where leadership can drive change within their department and their organization. Each day, health care executives search for opportunities to advance their organization’s journey from past archived standards of providing care to the modern paradigm of managing health.

On this journey, the health care organization can pass through three distinct stages. First, it will optimize to ensure they are efficient – in care, documentation and revenue – to take on risk as it moves forward. Second, the organization will prepare for the transition, ensuring its delivery model matches perfectly with its patient population and the population’s needs. Finally, it will invest in the shift, taking advantage of new approaches and technologies to manage and measure its care capabilities as well as increase care quality and population health while also reducing costs.

If you are an executive prepared to help your organization progress along this journey, you now have the ability to pinpoint where your organization falls on the risk continuum and gain key actionable insights that you can act on during each phase of the journey.
Every Executive Supports Their Organization’s Growth

Executives who create impact today and for years to come typically focus on one or more of these five core categories:

- **ADMINISTRATIVE**
  They find connections between patient care, operations and analytics to pinpoint the best opportunities for sustainable growth.

- **CLINICAL**
  They focus on the patient and the care they receive throughout their stay as well as their transition to other care facilities or their home.

- **COMPLIANCE**
  They check every aspect of operations against local and national government standards to ensure maximum rewards and legal agreement.

- **FINANCIAL**
  They track billing and reimbursements, negotiate contracts and review financial analytics to ensure a positive growth outlook.

- **TECHNOLOGY**
  They build and maintain patient documentation, analytics, coding and intranet systems that work seamlessly across staff and caregivers.

Look for your icon throughout the eBook to see curves in the road that you might face. View others’ icons to understand where your curves cross and the pathways your colleagues must navigate.

However, each type of executive must take their own path through the journey to help their company reorganize and respond to new initiatives. It is in their unique differences – all pushing toward the same goal – that they can create long-term, sustainable success for their organization.
Exploring the Journey to a New Health Care World

See the challenges faced and how to use them to find success

PHASE 1: OPTIMIZE PERFORMANCE

Within the shifting health care industry, each organization has been tasked with a massive goal - to leave volume-based care behind and shift to a value-based care system. According to a study by ORC International, 90% of health plans already include some value-based reimbursement in their contracts. This, in turn, is accelerating the shift in medical organizations’ view of health care as well as helping push it away from providing care and toward managing patient health.

While this shift can be seen as resting solely on the shoulders of the income and profits needed to thrive, a closer look reveals that managing health is supported by the work across all departments in an organization. Through optimization, the organization can ensure every element of their operations is on-target and working efficiently. This allows providers to spot opportunities to optimize as they analyze their current structure and streamline in five key areas – patient access, clinical care, medical necessity, coding and documentation, and reimbursement – to support the whole of the organization as it approaches the shift.

Each executive views these categories differently. Their understanding and ability to apply their knowledge as well as determine how they directly or indirectly impact their department can help them pass cleanly around the curve. The following pages will help take you through each area of focus.

The Coordination of Patient Access

Patient access spans across a patient’s entire care continuum and impacts the patient’s life well before they ever enter the hospital door and for years after they leave. Each organization can make unique choices about how they manage patient information, make services available and coordinate care and information across the full continuum.

Patients’ expectations around access and convenience are growing and they will continue to seek out providers who improve their ability to integrate care and health information. Patient access includes a consideration of every touch point now and in the near future. Plus, it works seamlessly across several important aspects.

**24/7 ACCESS**
Via Internet, phone or in the hospital, patients want support and information from medical experts who can provide feedback based on their specific needs.

**DATA CONSISTENCY**
Many patients, especially those with chronic conditions, have multiple doctors. To ensure proper care, information must move seamlessly between medical staff.

**OPERATIONS/TRANSITIONS**
As patients move from one care format to another, they want their health to remain a top priority throughout the transition. Using technologies that support patient access work flow can help improve communication.

**FACILITIES**
From location to staffing to utilities, medical facilities and their staff must be able to serve the patient population without interrupting or hindering its care.

While streamlining and connecting all the above can clearly improve the patient experience, it may also improve your quality of care, lower readmissions and help reduce overall expenses during optimization.

**AMA Health Insurer Report Card**
Lack of Eligibility  ➞  Increased Claims Denials

Clinical Care Is More Than Patient Care

While excellent patient care is the end goal, clinical care applies to everyone involved in patient care, including the patient as well as their physicians, nurses, caregivers, family and friends. It also ranges from the emergency department to hospice care, and every element an organization touches within their system and through their partnerships. So what must leadership do to achieve efficient and effective clinical care? Streamline everything.

CREATING EFFICIENCIES IN CLINICAL CARE

- Implement electronic medical records (EMR) for more streamlined communication
- Use its data tools and reporting to minimize medical redundancies and drug interactions
- Improve the care overview of patients who enter through the emergency department
- Put into practice preventive methods and care plans that can help prevent initial admissions and readmissions

Clinical care, when achieved, walks hand-in-hand with quality patient care, putting the patient and the physician in control of each unique health situation.

18.6% of patients are readmitted to the hospital.

The Importance of Medical Necessity

Medical necessity is the law of the United States and must be followed exactly to ensure an organization is operating legally within the limits of the law. It is also an important way for a health care organization to gain medical and tax benefits that support their financial shift to a value-based revenue model. For many organizations, Medicare and Medicaid represent a significant portion of operating revenues. And, because Medicare and Medicaid are a standard income source for many hospitals, the CMS is increasing audits, and the scope of them, to ensure each organization is in compliance with their standards. It is here where leadership can play a vital role.

EXECUTIVES CAN EXAMINE THREE DEFINING ELEMENTS:

1. **Understanding compliance standards** as they evolve to ensure that the organization can consistently operate under them correctly. Additionally, staff ranging from a nurse to a specialist can be trained on how to maintain those standards within their patient care and medical decisions.

2. **Facing huge financial swings** that can shift between receiving benefits to being hit with substantial penalties when standards are not met. These penalties can come from several areas that can be tracked and monitored throughout operations. Using proper data tracking, smart and logical medical decisions, and avoiding waste or abuse found in improper care can eliminate these errors.

3. **Discovering areas of opportunity** can provide added financial and care benefits. With a shifting health care model, there are often overlooked or unused standards that may begin to come into play for an organization as they optimize for a new future.

By working through these key areas of expertise, executives can give their organization financial assurance on their journey.

**$7.89B** Overpayments to hospitals identified by Medicare Recovery Auditors since 2011.

http://www.cms.gov
Coding and Documentation Is More Than Data

By properly tracking, filing, documenting and billing, a health organization can limit missed opportunities for care and revenue, while also ensuring each patient receives the attention they deserve. In this curve, data becomes more than an organizational checkpoint and begins to serve as a resource for every element of care. The data, properly documented and coded, turns into the dollars that support your organization, the management of health and the treatment of patients.

Additionally, this data is not simple to manage. With the looming implementation of ICD-10, and its drastic increase of variables, executives must keep coding and documentation top-of-mind at all times. This presents a long and challenging curve in which constant education and implementation for staff is essential. From coding to compliance to billing, leadership can find multiple opportunities to support their team and provide the best resources to support their growth.

**Data is valuable only if it is good data. Proper coding and documentation can help shift your organization from missing out on unanswered queries to gaining greater financial advantages.**

**BE A FIRST-TO-MARKET ORGANIZATION:**

- **KEEP UP WITH MEDICAL CODE UPDATES**
- **INTEGRATE REGULATORY CHANGES**
- **REVIEW COMPLIANCE ISSUES**

**100%-200%** CMS’s estimated increase in claims denials during the early stages of ICD-10.
Reimbursement Is the Narrowest Curve on the Journey

Reimbursement requires consistent and accurate steps to carefully navigate the challenges it presents for success. It is vital for executives to pinpoint and correct each error before they occur. That effort can help drive reimbursement rates, support claims and reimbursement compliance requirements, and reduce overall operating expenses for the long term.

This impact can be re-created day after day to continually widen the gap between errors and profits, giving the organization breathing room for future efforts as well as managing risk within the patient population. Health care leadership can now focus on reducing claims denials, staying current with regulatory guidelines and complying with regulations to receive timely and accurate payment.

UNDERSTANDING THE CLAIMS EDITING PROCESS

<table>
<thead>
<tr>
<th>CLAIMS MANAGER FACILITY</th>
<th>HOSPITAL INFORMATION SYSTEM</th>
<th>EDI CLEARINGHOUSE</th>
<th>PAYER</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Claims Manager Clinical Edits</td>
<td>• Charge Entry</td>
<td>• Technical Edits</td>
<td>• Claims Adjudication</td>
</tr>
<tr>
<td>• Knowledgebase Claim History</td>
<td>• Charge Entry Work Queue</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Charge Postings/Claims Processing</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

REMITTANCE INFORMATION, DENIALS, REJECTIONS

110,000
Number of current appeals in the Office of Medicare Hearings and Appeals (OMHA) queue.


Reimbursement isn’t as simple as an invoice and payment. Based on cuts since 2010, mastering this complicated process is now vital to your organization’s financial success.
PHASE 2: PREPARE FOR VALUE-BASED CARE

As a health care organization begins to realize the benefits of optimization, their executives can prepare for new shifts in their pathway. Leadership may be moving forward on a more streamlined route and it can begin to make the required adjustments needed to serve a broader patient population. Healthy patients are the fuel to success, and the health care organization’s services can be the engine to drive them toward stronger and more successful health management. To maintain momentum, patients and services must move together in unison.

An organization must know their patients better than they ever have before. They must understand ages and ailments, projections and likelihoods, and every element of the population as if it were their own family. It takes every executive, oftentimes crossing paths during preparation, to learn, adjust and meet the patient population’s needs without negatively impacting the organization’s own financial incentives.

Staffing, data and care solutions can shift based on upcoming partnerships, expansions and patient population demographics. It is valuable for all of leadership to carefully take on the curves of the care delivery model and develop the insights and information to ensure your organization has aligned incentives for the long term.
Re-create Your Care Delivery Model

This is no easy feat, even for the most knowledgeable executives, but it is a curve they all must pass through together. It will intertwine patients and care with finances and facilities, both today and for the long term. Leadership can begin to develop baselines to work against and spotlight new opportunities to adjust as they move forward. It takes everyone’s knowledge and ability to learn from one another to succeed. And there are four key steps executives can take to get there.

IDENTIFY
Begin by taking a structured approach to identifying, stratifying and prioritizing clinical interventions. Each intervention should strive to fit the model of lowering costs while also improving care quality and patient satisfaction.

ENSURE
As the organization predicts the outcomes of their care delivery model transformation, executives may also consider taking a multi-disciplinary approach that delivers care vertically (within the care delivery) and horizontally (across the system of care).

REDESIGN
The executive team can assess the needs of its population and match it against their provider network and care management resources to provide for the local market and their segment in it.

PLAN
A structured approach may be key to completing the curve. From physician engagement to enhanced capabilities to top quality clinical care, executives can match their efforts against the previous three steps to create a sustainable model.

These steps can help executives create a care delivery model that not only serves the patient population but also reduces wait times, hospitals stays and costs for long-term growth.

While financial success is key to an organization’s long-term sustainability, it’s important that your care delivery model match your resources and the growth of your patient population as well as their evolution within the Affordable Care Act.

EXECUTIVES WHO FACE THIS CURVE:

PHASE 2: PREPARE

Patients: Wait up to 39 hours to see a primary care physician

Physicians: Need to work 22 hours a day to meet guidelines

Yarnall KSH, Østbye T, Krause KM, Pollak KI, Gradison M, Michener JL, 2013 MMS Patient Access to Care Study
Family physicians as team leaders: “time” to share the care.
Ensure Aligned Incentives

As an organization continues to prepare, leadership should target win-win situations where no department of their organization is left behind. A collaboration that aligns goals can help ensure a continual feedback loop and properly incentivized care quality standards. This loop measures and manages improvements as the executives find the long-term balance between payer/employers/patients and hospitals/providers that are structured to create innovation.

The value of innovation is now becoming as important as, and at times more important than, than revenue. This value can be found where the risk applied in all directions – payer, provider and patient – improves health beyond the cost of care. At this point cost is minimized while health management of the patient or patient population is increased. This model can create ongoing opportunities to evolve with the care delivery model, match shifts in the patient population, and reach financial growth projections year after year.

WHY WIN-WIN MATTERS:

- Improved care quality
- Reduced readmissions
- Improved patient satisfaction and adherence to care directions
- Lower costs for ongoing care
- Improved accountability
- Improved ability to provide the right care at the right time
- Fewer disputes over care options, billing and collections

As your organization begins to take on risk to reach improved care, patient satisfaction and lower costs, every incentive and every dollar can make a difference toward creating a sustainable future.

EXECUTIVES WHO FACE THIS CURVE:

CLINICAL
FINANCIAL

$210 Billion

Amount wasted on the delivery of unnecessary care by U.S. Health care system.

PHASE 3: INVEST IN MANAGING RISK

When a health care organization is optimized and its preparation is complete, their leadership can see a new world of health care on the horizon. Their determination to evolve the past and their preparation to continue transforming their care delivery model into the future leaves executives on the precipice of completing a historic transition. They can now invest the time and resources to fully commit to quality-driven, cost-effective care.

By reaching this point in the journey, organizations have created an opportunity to define their future. Leadership has the ability to put financial support behind their evolution and build upon opportunities they envisioned earlier in their travels. They can consider what they witnessed during the transition, apply patient and financial knowledge they gained, and put data behind every decision they make. And with each step they can further analyze every element, from patient to income, to ensure they stay on the path to a sustainable future of managing health.

Health care executives may face these final curves in their journey head-on and be relied on to create new pathways that are completely unique to their position and their organization. It is through continual learning, leadership, governance and vision that the whole organization can continue to move toward the new world of health care.
Utilizing Clinical and Financial Diagnostics

Health organizations can benefit greatly from streamlining management by converting health information to health intelligence with analytics. Valuable analytics provide the organization with the opportunity to study the past and create accurate prospective insights about their future. These results also create previously unseen value as important as any other step on the journey. There are two categories in which this can be done:

1. **FINANCIAL ANALYTICS PROVIDE THE ABILITY TO:**
   - Optimize risk, underwriting and pricing
   - Analyze reimbursement, network contracting and payments
   - Illustrate cost drivers and key performance indicators

2. **CLINICAL ANALYTICS PROVIDE THE ABILITY TO:**
   - Identify high-risk populations and individuals
   - Pinpoint opportunities to improve care quality while lowering cost
   - Understand patient utilization “leakage”

These areas and the ability to cross-reference their findings provide executives with the right information at the right time. By integrating analytics with care management, they can help physicians stratify risk and effectively manage the care of individuals and populations. It can help build treatment and care management guidelines in clinical work flows and avoid costly hospitalizations for patients with chronic illnesses. Additionally, it supports leadership’s ability to look across facilities and partners to find opportunities for better care quality and reduced wait times and it can have a positive impact on organizational and patient expenses.

**$55 BILLION**

The amount wasted annually on missed prevention.

Population Health Management: A Holistic Approach

The premier goal of population health management is to shift away from population care, or even predictable care, and live in the world of health management and prevention. This curve must be taken by streamlining all information to all parties, including the patient, to ensure everyone is working off the same knowledge base at the same time. By encouraging a proactive approach of management in a population, executives can create results including improved health quality and patient experience as well as reduced departmental and organizational costs.

THE FOUR ASPECTS OF A HOLISTIC APPROACH:

1. **Optimize Your Network** – Share cost and quality reporting with all referring parties
2. **Manage Care Transitions** – Track patients across their entire care continuum
3. **Champion Interventions** – Manage progress and outcomes at the population and patient level
4. **Expand Management** – Manage all patient populations, not just your high-risk cohorts

Population health management, much like the care delivery model, can involve all of leadership listening to, learning from and working with others in health care. They learn from precise data – combining clinical, claims and patient knowledge – to gain a comprehensive, real-time view of their organization as well as growth and patient health projections. This cohesive model can ensure that work flow, economics, technology and physicians are all in alignment. In turn, it may create a community that stands behind their goals and is open to transformation as the health care industry continues to evolve.

5% of patient population drives nearly 50% of health care spending.

Welcome to the New World of Health Care

The journey that leadership has faced was peppered with shifts and curves, challenges and successes, but they took them all on and moved through one of the most momentous shifts in the history of health care. They have joined the pioneers in an amazing new world, but their adventure is hardly over. In fact, it is just beginning.

Each executive, who worked diligently to apply his or her knowledge and provide an educated and unique piece of the puzzle, has helped his or her organization position itself to grow and serve patients for years to come.

THE THREE ASPECTS OF A HOLISTIC APPROACH:

1. Take on risk to lower costs and ensure your organization can continue to move forward.

2. Pay attention to the little details, helping the patient population be happier and healthier, while encouraging their future retention.

3. Place quality at the top of the priority list, improving it to a new level, and in turn reducing unnecessary procedures, readmissions, and missed health care opportunities each and every day.

Executives have done these things to allow their organization to thrive in the new health care world. And their organization has all the resources needed to transition to a new business model that demonstrates the ability to provide improved outcomes while also reducing cost. The organization has the potential to grow and solve the ever-changing health concerns of its patient population in innovative, measureable and comprehensive ways. And in the end the organization, the patients and the community can all progress together, creating a new world of managed health.
About Optum

Optum is a leading information and technology-enabled health services business dedicated to helping make the health system work better for everyone. With approximately 80,000 people worldwide, Optum delivers intelligent, integrated solutions that help to modernize the health system and improve overall population health. Optum is part of UnitedHealth Group (NYSE:UNH).

To learn more about the journey from providing care to managing health, please visit Optum.com/MyJourney or call 866-386-3404.