

Streamlining the business of caring

Evolving models have added complexities to the business side of healthcare; HIT solutions can help manage this strain

By Wayne Pan, PhD, MD, MBA

Rarely has the healthcare industry been buffeted by winds as powerful as those blowing today. The rapid emergence of health information technologies (HIT) combined with unprecedented advances in therapeutic and diagnostic protocols, sweeping healthcare reform policies, and an increasingly sophisticated patient population has created a degree of turbulence seldom seen before.

Groups are embracing patient-focused models of care such as patient-centered medical homes (PCMH) and accountable care organizations (ACO) at unprecedented rates, and are trying to hold steady in the face of significant challenges. It has become alarmingly clear that the healthcare business model must adapt – and adapt quickly – for stakeholders to survive and thrive in the coming years.

Another of the pressing issues the payer community faces is the medical loss ratio (MLR), which dictates the percentage of premiums insurers must apply to medical expenses as opposed to the amount paid for administrative overhead. The 2010 health reform bill – Patient Protection and Affordable Care Act (PPACA) – has set the MLR at 85 percent medical to 15 percent administrative for individual and small-business plans. For larger plans, medical costs must represent 80 percent of expenditures. Clearance to apply only 15 or 20 percent of revenue to administrative tasks leaves payers with little wiggle room – and great motivation to operate as efficiently as possible.

Balancing quality, access and cost

Coordinated care management – involving patients, providers and payers both within an organization and beyond its walls – is emerging as the preferred solution to balancing the often-opposing forces of cost, access and quality. In fact, this concept

of collaboration and communication is the genesis for clinical integration, the fundamental underpinning of PCMHs and ACOs. Within these models:

- Patients take greater responsibility for their own health and engage in self-care activities;
- Providers utilize emerging technologies that offer an integrated, community-wide view of patient data – far beyond what has been available through electronic health records (EHR) and health information exchange (HIE) platforms to date – to communicate, confer and coordinate with colleagues and patients throughout the continuum of care; and
- Payers or delegated third parties rely upon case and utilization management capabilities to facilitate care and wellness management that is effective, timely, reasonable and fully integrated into the continuum of care delivery.

As they coordinate care, these stakeholders are now challenged to:

- ensure patients and plan members receive timely care and are not inconvenienced or harmed by “process” delays;
- serve patients at the right time with the right services; and
- see that expenses are wisely managed in the pursuit of quality outcomes.

Health plans play a unique role in this coordinated care management equation. Theirs is the sensitive responsibility to control costs outlays, especially for those patients with multiple diagnoses, chronic and complicated medical conditions, co-morbidities, or diseases that require expensive treatment. Likewise, payers must closely monitor and manage patients at risk for catastrophic events and those struggling with socioeconomic pressures that threaten health and safety.

So, what does all this have to do with gale-force industry changes, escalating administrative costs and restrictive medical loss ratios?

Stakeholders along the continuum are discovering that coordinated care management, for all of its benefits, is an intense process with multiple touch points. This means that the entire care team bridging payer and provider is involved in the process – some with divergent points of view – and they require ready access to greater volumes of information.

Let's face it: Seldom do circumstances like those described above lend themselves to lower costs and greater returns, whether measured in cost or patient outcomes.

On the other hand, increased reliance on HIT, particularly in the clinical setting, is nudging the industry towards greater efficiency and timely communications. Healthcare payers likewise are adopting technologies to help trim the workflow process and optimize resources – particularly for administrative functions, which cost the payer community more than \$90 billion in 2009. Leading the way are auto-adjudication tools designed to streamline the time-consuming practice of manually reviewing all pre-authorization and referral requests for low-risk, routine medical services and procedures. With the adoption of these highly sophisticated tools, payers are then able to invest diminishing administrative resources in the efficient management of high-risk, high-cost patient conditions.

Automation reduces administrative expenses

Referrals and approvals are critical to moving the patient effectively along the care continuum. Unfortunately, many healthcare payers continue to perform these tasks manually, creating an unnecessary and costly administrative burden for both payer and provider. As ACOs are formed, some with payer involvement and some without, varying levels of sophistication in the management of costs will be the starting point. Regardless of the sophistication each partner brings to these new care delivery models, employing innovative IT solutions that can automate these processes and can allow managers to focus only on the most critical and complex patient cases, ensuring their care plans receive the appropriate level of oversight, will be essential.

Many referral and authorization requests can be considered “routine” – such as when an ED physician refers a patient to a pulmonologist after treating an acute asthma attack, when a pediatrician sends a teenager who has crushed several fingers in a car door to an orthopedic surgeon or when a dermatologist

requests precertification for surgery for a patient with a benign neck lesion. In many cases, these are straightforward requests for conditions that require standard treatment.

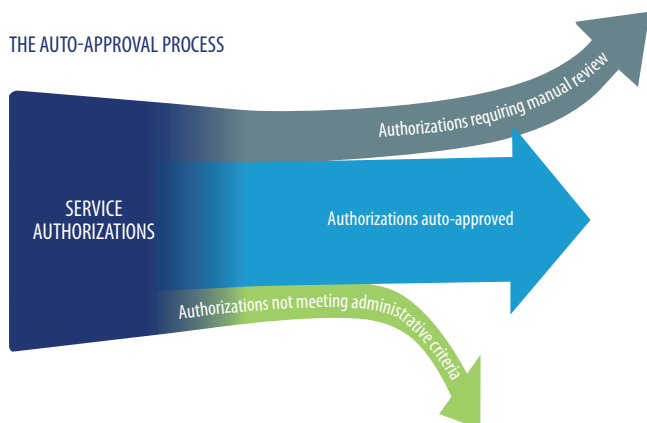
Because requests like these are uncomplicated, healthcare group administrators are implementing solutions that allow approvals to be automated. Emerging applications enable payers to establish highly specific rules and protocols that allow requests to bypass human evaluation when certain parameters are met, thereby reducing the time and resources invested in common or uncontroversial protocols.

These same algorithms can be programmed to identify those cases which, conversely, require human involvement and divert them into a defined queue for review. Cancer diagnoses, for instance, typically involve a complex series of treatment modalities that might include surgery, chemotherapy, radiation or any combination thereof. It is important for administration to evaluate a provider's proposed care plan for a patient with such a diagnosis and provide case or utilization management as appropriate. Similar situations might include the treatment of patients with multiple conditions like diabetes and congestive heart failure, those seeking mental health care, or individuals undergoing infertility treatments.

Furthermore, the rules inherent to these innovative software solutions can be refined not only to channel specific types of medical cases, they can be adjusted by provider as well. Perhaps Dr. Jones historically has “over-treated” patients, ordering extensive tests and studies that typically fall outside of generally accepted evidence-based care guidelines and protocols. The automated system can “kick out” all of this physician's referral and authorization requests for evaluation by the payer for a defined period of time, no matter how routine or straightforward the case may seem. Likewise, the system can automate all requests made by another physician who has proven consistently conscientious based on past performance metric tracking.

As a result, service authorizations travel much more smoothly through the approval process and with less human intervention. The vast majority, as seen in the illustration below, speed through automatically according to customized sets of rules and protocols. A minority is diverted for manual review and an even smaller number are denied if they don't meet preset administrative criteria.

THE AUTO-APPROVAL PROCESS



Access Express: Streamlining approval and referral processes

Among the most effective auto-adjudicating applications available is Access Express™, developed by Health Access Solutions, which combines intelligent and customizable functionality to help group administrators streamline the approval process for referral and authorization requests. The solution has facilitated MSOs, IPAs and healthcare payers in their efforts to support high-quality care at a reasonable, controlled cost. In addition, it will be fully transferable to the new ACOs under development today. Access Express also enables HIPAA-compliant, secure messaging to the patient and provides collaborative features supporting all stakeholders.

Access Express can be delivered as an integrated care management solution complete with case management, utilization management and clinical care coordination. However, modules also can be deployed independently for organizations preferring separate products to fit their unique situations. The flexibility of Access Express and its individual components allow users to define rules, objectives, barriers and assessments to meet the changing needs of a specific organization. Access Express is built on a Microsoft SQL Server database that enables responsive reporting capabilities that can be easily customized to extend beyond standard applications.

Delivered on a Software as a Service (SaaS) basis, Access Express integrates easily with existing systems. Interoperability is not an issue, as it accepts data in multiple formats. And, because of the SaaS delivery model, users are not required to purchase additional equipment or software. A computer and internet connection are the only components needed.

Access Express features

- All case activity for a patient is captured in a single case record
- On-line, user-defined assessments
- Linked to Milliman Care Guidelines® to track standard treatment guidelines
- User-defined tables allow customization of problems, goals, barriers, interventions, status codes and acuity levels
- Outcomes tracking for each case
- Unlimited personal contacts with the ability to generate and deliver letters to patients and their caregivers
- Ability to auto-assign a member to case management when referral authorization requests are received
- Unlimited notes intelligently linked to all areas of case management
- Audit logging of important data changes and end-user performance tracking
- P4P provider dashboards for easy performance monitoring and incentive tracking
- Linked to Ascender HCC module to streamline Medicare Advantage Health Plan risk-adjusted payments

Case Study: Results achieved by SCCIPA

The Individual Practice Association Medical Group of Santa Clara County, Inc. (SCCIPA) – a risk-bearing IPA representing a network of 800 physicians, eight community hospitals and more than 65,000 plan members – implemented Access Express in the late 1990s. As regulations are provided, SCCIPA will continue its evolution towards an ACO-style environment, where administrative cost control is paramount to the success of the organization. Whether an ACO or some other model, clinical integration through use of advanced HIT will be instrumental to bending the cost curve and reducing variability of quality across the country.

Deploying the platform's case management and utilization management modules, SCCIPA has achieved 100% adoption of the solution and maintains an effective and enviable case manager to patient ratio of 1:50. Many industry experts, including the Case Management Society of America, state that the average case manager to patient ratio is 1:20. Patient-centric and physician-focused are essential themes for any HIT solution – attributes absent from most technologies widely available today.

The SCCIPA care management program is centered on a commitment to ensure that medically appropriate care is delivered in the most efficient setting for members with complex and chronic care needs.

Through its use of Access Express, SCCIPA has:

- Reduced certain staff by 50% over a three-year period because comprehensive information is easily accessible to stakeholders all along the care continuum.
- Increased compliance by 30% because all activities leave an audit trail available to case managers and payers.
- Reduced unnecessary hospital admits by 25% by alerting case managers so they can take proactive steps to ensure patients receive appropriate care after discharge (i.e., ride home, home help, DME, follow up visits, etc.).

In addition, SCCIPA now automates 70 percent of all referral and authorization requests.

Operating within California's capitated payment system, SCCIPA was able to customize Access Express to meet its needs. The solution's flexibility likewise can accommodate other care delivery environments as evidenced by deployments in more than 15 full-risk delegated medical groups, supporting 26,000 physicians caring for three million Californians. In addition to its case and utilization management functionality, Access Express offers clinical care and disease management tools that integrate seamlessly to offer a one-of-a-kind comprehensive solution for coordinated care.

Conclusion

Automated approvals and e-referrals are important vehicles that help healthcare payers reduce administrative costs while managing access and quality. As the winds of change alter the course of medicine in the United States, a focus on coordinated care management technologies will assist industry leaders as they balance quality, access and cost. Integrated solutions, such as Access Express, can advance the spirit of healthcare reform by minimizing expenses and offering collaborative features to facilitate quality care.

About Health Access Solutions

Founded in 2000, Health Access Solutions delivers a patient-centric care coordination platform that enables physicians, hospitals, payers and patients to collaborate across the care continuum – throughout an enterprise and beyond organizational boundaries. Access Express™ and Excelicare™ together provide

clinical and care management solutions to organizations in the U.S., Puerto Rico, Canada and the U.K., accounting for more than 31,000 healthcare providers as well as eight million patients and health plan members. The company's integrated care coordination platform was designed from its inception to support patient-centric care collaboration models such as the medical home and Accountable Care Organization. Marketed under the Access Express Care Management and Excelicare Clinical Management brands, the transformative Web-based platform enhances clinical decision making through evidence-based clinical decision support and treatment reminders; gaps-in-care alerts; medication and care plan adherence notifications; and real-time quality dashboards, analytics and reporting for individual and patient populations. In addition, it enables secure patient access to summaries of current medical record information, while offering patients the ability to easily communicate online with care providers and office staff for appointment and refill requests or other secure communications.

For more information, visit www.HealthAccessSolutions.com.

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Dr. Pan serves as Chief Medical Informatics Officer for Health Access Solutions, bringing more than 20 years of broad healthcare industry experience to the organization. His background spans clinical medicine as an orthopaedic hand surgeon; basic science research in the field of molecular biology; and executive leadership in managed care and health information technology.

After earning his bachelor's degree in biology from Johns Hopkins University, Dr. Pan completed his MD and PhD degrees concurrently as a recipient of a Medical Scientist Training Program grant at Mount Sinai School of Medicine in New York City. He completed his orthopaedic surgery residency at Thomas Jefferson University Hospital and Clinics, and continued with a post-graduate clinical fellowship in hand and microsurgery at the Philadelphia Hand Center. Subsequently, after five years of clinical practice, Dr. Pan transitioned into administrative medicine, holding positions as Medical Director and Chief Medical Officer at several San Francisco Bay Area Medicaid managed care plans, and as CMO of a small local IPA. He is also a member of the adjunct faculty at the Wharton School of the University of Pennsylvania.