HEALTH CARE EXECUTIVE TOOLKIT

OPTUM®

UNLOCKING THE RELATIONSHIP BETWEEN QUALITY AND COST

Health care is changing. Spurred by delivery and payment reform and changing patient expectations, providers face the daily struggle of continually elevating their care quality while still controlling costs. New care delivery models place all hope of growth within the ability to realize the benefits of population health management like improving quality measures, strengthening the care delivery network, cultivating the right health plan relationships and improving patient engagement.

To unlock value and achieve growth, these strategies depend on a foundation of accurate, comprehensive and actionable data. Yet health care executives are often unable to see a complete picture of their operations. Data exists in silos, more than half of patient care is delivered outside the primary care system, and patient outcomes are often tied to social determinants of health that seem beyond a physician's control.

The resources within this toolkit are designed to help you take immediate action to assess, refine and expand your organization's ability to deliver improved care quality while controlling costs.

INTERACTIVE PDF

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FOUR PILLARS OF POPULATION HEALTH MANAGEMENT

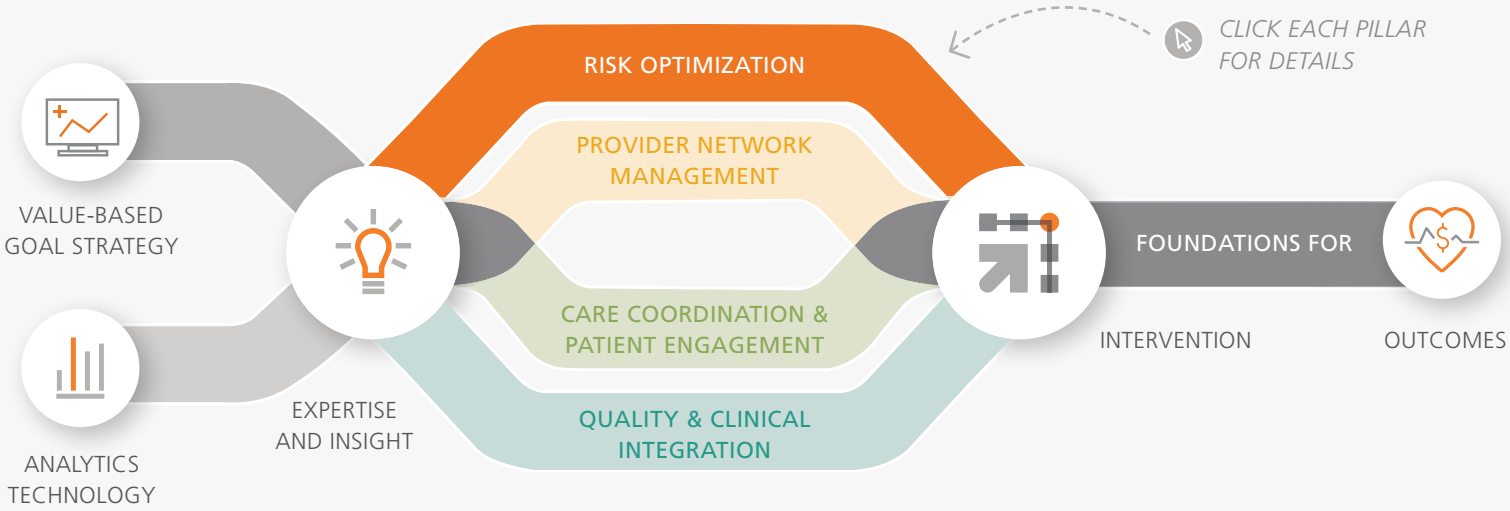
THE FOUR PILLARS OF A STRONG PHM FOUNDATION

Want to build an effective population health management (PHM) strategy? Focus on these four pillars.

Succeeding in a value-based world results from:

- Organizations embracing all aspects of population health
- Delivering necessary clinical and financial interventions to make the ecosystem work better

Source: Frost & Sullivan 2016 PHM Report



A complete PHM solution will need to analyze disparate patient data, highlight care improvement opportunities, manage delivery through coordination and engagement, serve up insights at the point of care, benchmark performance and mitigate financial risks.

RISK OPTIMIZATION

Managing value-based models requires a cohesive balance of population health management activities supporting a high-performance network with contracts that allow for value to be created and rewarded.

- **Evaluate** network performance against payer contracts.
- **Focus** on improved utilization, cost management and clinical outcomes.
- **Support** payer contract negotiations and risk-based operations.

RISK OPTIMIZATION

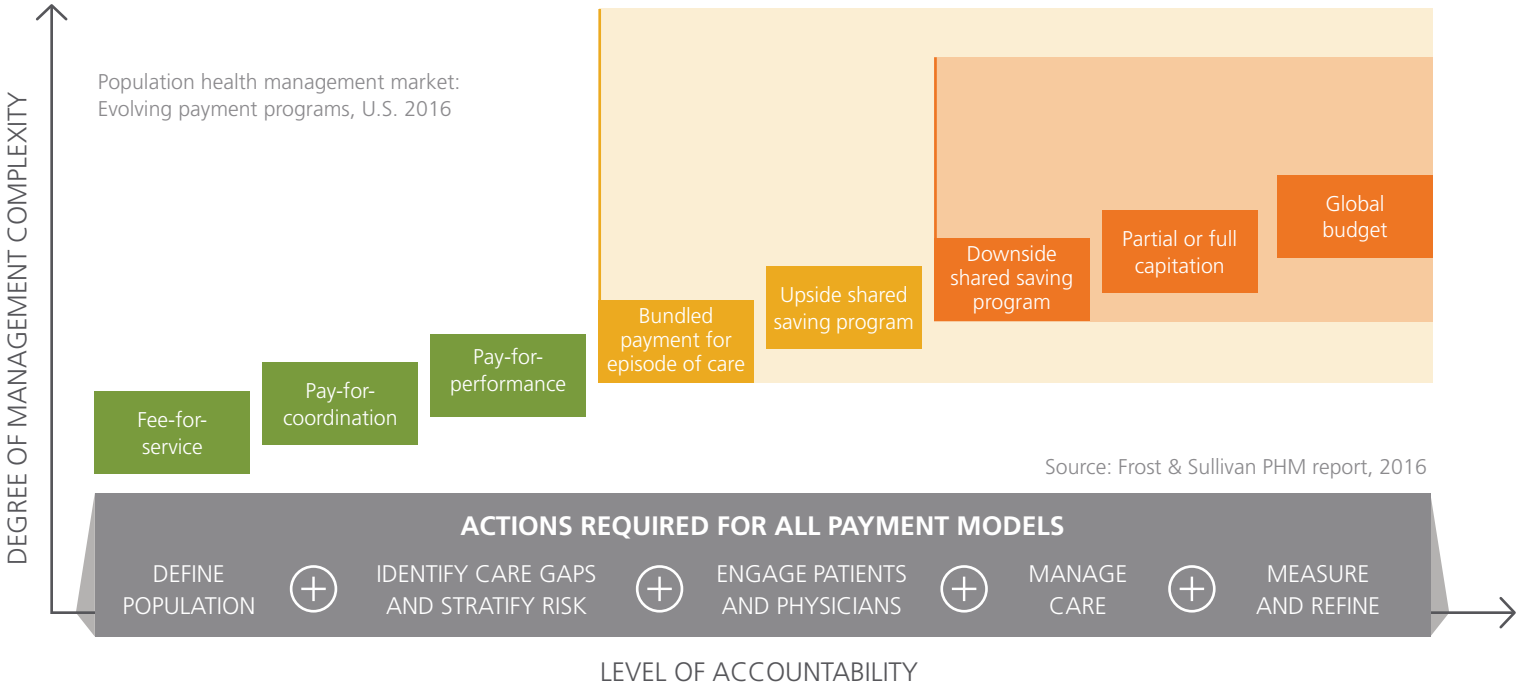
VALUE-BASED CARE: RISK VS. REWARD

Value-based care (VBC) is a payment environment that rewards clinicians who deliver the highest-quality, most-efficient care. There are a variety of value-based-care models with escalating levels of accountability.

THE REWARD OF VALUE-BASED CARE

CLICK HERE TO SEE LIST

VALUE-BASED REIMBURSEMENTS TIE PROVIDER REVENUE TO PERFORMANCE



Source: Frost & Sullivan PHM report, 2016

REQUIREMENTS

CLICK HERE TO SEE THE CHART

PAYMENTS UNDER MACRA

CLICK HERE TO SEE THE CHART

SOLVING THE HEALTH CARE PERFORMANCE CHALLENGE

THE TREND

CHANGES IN PATIENT EXPECTATIONS, REIMBURSEMENT AND TECHNOLOGY ARE ALTERING THE COURSE OF HEALTH CARE

VOLUME — REIMBURSEMENT | TECHNOLOGY | PATIENT EXPECTATIONS — VALUE

94%
OF HEALTH CARE EXECUTIVES say they're moving to value-based care.[1]

50%
AI HAS THE POTENTIAL to improve outcomes by 30–40% and cut treatment costs by 50%.[2]

50m
PATIENTS
50 million price- and quality-conscious consumers will enter the health care market by 2020.[3]

$555B
OUT-OF-POCKET EXPENSES are expected to rise from $350B to $555B by 2027.[4]

THE GOAL

Quality, cost and consumer experience are the focus of the new health ecosystem.

COST-EFFECTIVE, HIGH-QUALITY CARE AND HEALTHY COMMUNITIES

PATIENT SATISFACTION
Patients will expect satisfaction, from the care they receive, its cost and its responsiveness to their needs and preferences.

HEALTHY POPULATIONS
Preemptive, coordinated approaches for managing the health of all patient populations.

PREFERRED NETWORKS
Patients (and payers) will make low-cost, high-quality networks their provider of choice.

THE POWER OF EXPERTISE

Bridge the performance gap with data and analytics capabilities.

Standardize and integrate disparate data

Apply leading analytics

Transform care and payment models

"Providers need to be very deliberate as they begin to transform towards alternative payment models. A great place to start is in analytics, to be able to analyze data and put it into action. At the same time, providers need to understand where the riskiest patients are and develop systems that reach those patients to keep them healthier for the long term."
— Aric Sharp, Vice President of Accountable Care, UnityPoint Health

THE DESIGN

INTEGRATED DATA DRIVES EVIDENCE-BASED DECISIONS AND BETTER ACTIONS

Combining and mining clinical claims and financial data sources reveals the strategic insights to optimize network, care and quality and forecast population health initiatives.

Strategic insights

90% EMR adoption by providers has created a rich foundation upon which clinical and financial data can be layered and analyzed to produce actionable insights for quality and cost management.[5]

THE ALIGNMENT

EXPERTISE, INSIGHT AND ACTION

ACHIEVE HIGH-QUALITY OUTCOMES AND FINANCIAL SUSTAINABILITY

Risk and Contract Optimization
- Enable use of specialty networks and secondary referrals
- Benchmark regional contractual performance
- Evaluate network quality, efficiency and utilization

Provider Network Management
- Monitor patient volume/utilization
- Understand referral patterns
- Evaluate physician performance for quality bonuses and incentives

Care Coordination and Patient Engagement
- Reduce admissions and manage transitions of care
- Ensure patients are able to make informed health decisions
- Build data-driven population health strategies

Quality and Clinical Integration
- Track, report and benchmark performance
- Identify opportunities to improve care and deliver value
- Understand implications of payment reform

LEADING ANALYTICS AND SERVICE SOLUTIONS

THE RESULT

SUCCESS IN A CHANGING HEALTH CARE ENVIRONMENT

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FOUNDATION FOR SUCCESS

THE PITFALLS OF POOR ANALYTICS

While health care executives agree that aggregating data with analytics is important, not all analytics are equally valuable. Relying on poor analytics can leave care delivery systems without the meaningful insights necessary to have a positive effect on quality and cost.

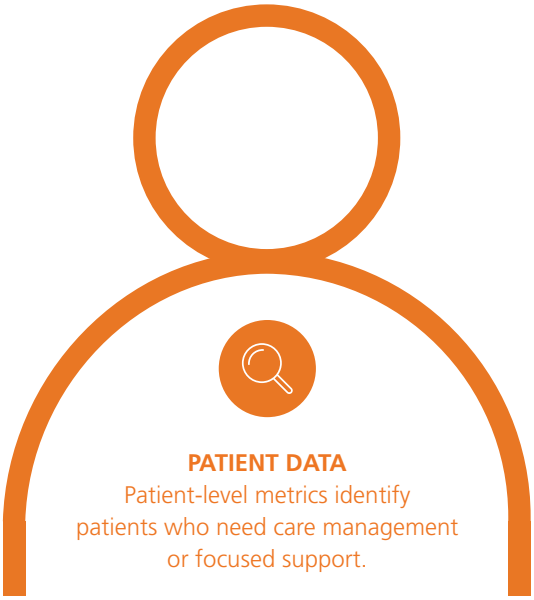
CLICK ON ICONS BELOW TO REVEAL RISKS AND MITIGATIONS

RISK: Treating your population as one homogeneous group

All patient populations are different. Treating them as one puts you at risk of missing high-acuity patients, leading to higher costs and inappropriate utilizations.

MITIGATION: Proactively identify which patients will become high risk

Risk analytics sort patients by tiers of risk — high, medium and low — based on their diagnoses, treatment, utilization and cost of care.



PATIENT DATA

Patient-level metrics identify patients who need care management or focused support.

POPULATION DATA

Population-level metrics help providers identify and address broader population health trends within the attributed population.

SOCIAL DETERMINANTS OF HEALTH

Social factors like joblessness, illiteracy and social isolation affect clinical outcomes. The most useful patient-level social data helps redirect caregiver focus when serious nonmedical problems create barriers to care.

There are many sources of data you can and should pull from to better manage population health and improve your quality metrics.

"Analytics absolutely drives better care. It allows us to focus on our patients as a population, find who are the most vulnerable within our populations and address them in real time. Data analytics allows us to be proactive."
— Mark DeRubeis, CEO, Premier Medical Associates

RISK OPTIMIZATION

MAKE RISK CONTRACT NEGOTIATING LESS RISKY

Transitioning to risk-based contracts can be stressful. The process itself can be overwhelming, and providers are often at a disadvantage in the discussion. Make sure you're prepared for successful contract negotiations with these tips.

CLICK ON ICONS BELOW TO REVEAL DETAILS

Arm the provider side of negotiation with payer negotiation experience

Obtain actuarial assistance

Understand the type of risk managed

Evaluate provider network adequacy

Collect claims data

Determine a target pmpm cost for services

Negotiate with confidence

Arm the provider side of negotiation with payer negotiation experience

Including someone on the provider negotiating team with payer experience can **IMPROVE** the negotiation process, as well as the outcomes.

Ideally, this individual would know the language, perspectives, biases and contingencies a payer would use and be an **INVALUABLE** strategist.

LISTEN TO A PODCAST ON NEGOTIATING RISK-BASED CONTRACTS

RISK OPTIMIZATION

STEPS TO VALUE-BASED READINESS

All providers need to drive greater value and innovation to survive in this ever-changing health care landscape. Both economics and practicality prevent the journey to value-based care from being accomplished in a single step. Rather, providers will find it easier to gradually enhance their data and care delivery capabilities to reflect the changing needs of their contracts. The "next step" will depend upon where you currently sit on the journey. How prepared is your organization, and what should your next goal be?

	ABILITY TO DELIVER ON VALUE-BASED-CARE RESPONSIBILITIES			
	STEP 1: BUILDING	STEP 2: OPTIMIZING	STEP 3: PERFORMING	STEP 4: INNOVATING
PATIENT ENGAGEMENT	Ad hoc provider interactions and patient outreach	Patients access simple decision aids; static portals	Automated patient outreach/scheduling; patient-enabled wellness programs	Fully bi-directional communication; complex patient decision support; interactive tools
CLINICAL PERFORMANCE	Episodic care	Standardized management of chronic and high-risk populations	Wellness-focused care; automated gaps-in-care alerts	Personalized medicine; remote care delivery
RISK & CONTRACT OPTIMIZATION	Enterprise financial reporting; fee-for-service models	Advanced cost accounting	Contract forecasting and modeling	Contract monitoring and optimization
PROVIDER NETWORK	Patient volume and utilization monitoring	Care delivery and performance gap analysis; enterprise physician reporting	Referral pattern analysis; physician quality incentives tied to performance	Vertical integration of patient care across regional provider organizations
DATA	Isolated interactions captured in EMR	Data aggregation and governance; increased data auto-throughput	Data interoperability across acute, ambulatory and specialist care	Complete data interoperability across all providers
ANALYTICS	EMR-based reporting; basic segmentation; cost-of-care reporting	Population health analytics; physician scoring; risk stratification	Predictive and prescriptive analytics; pattern identification	Real-time behavioral, social and environmental data with predictive care decisions; real-time operational analytics

> *Those who are most successful often deploy innovative delivery models; analyzing data and trends in a population's health, quality, and costs; and bearing financial risk. Value-based payment contracts reward providers for successfully executing these processes.*
>
> — Deloitte, Deloitte 2017 Survey of U.S. Health System CEOs

A range of value-based contracts

Value-based care can refer to a variety of contracts that require providers to positively influence quality of care. Most providers will operate under multiple value-based models simultaneously, including:

- Focused risk-based contracts
- Formalized VBC delivery models (ACO/patient-centered medical home (PCMH))
- High volume of shared-risk contracts
- Fully capitated care models

PROVIDER NETWORK MANAGEMENT

BUILD YOUR PROVIDER NETWORK TO REFLECT YOUR VALUE-BASED-CARE VISION

For your organization to improve quality measures and reduce cost, your provider network has to align with your payer and care management strategies. These six steps can help your organization identify your best-performing physicians and refine your provider network strategy.

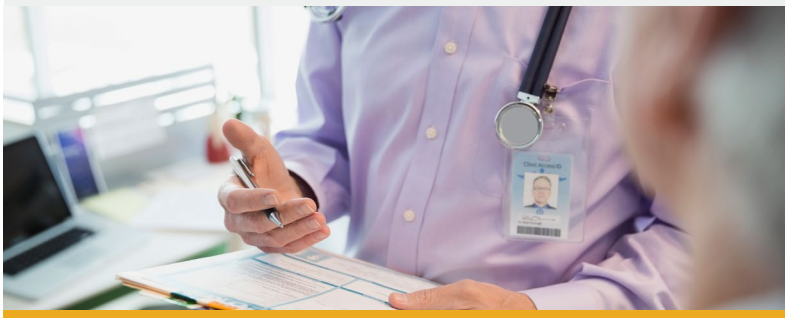
> *We have a whole team that's dedicated to revamping our entire referral process. High quality at the best cost is really another important responsibility that we have, especially the primary care providers.*
>
> — Stephanie Copeland, Chief Quality Officer, USMD Health System

BE AWARE OF THE CHALLENGES

Value-based care will drive providers to continually improve outcomes and lower costs. Common challenges include:

- **Incompatible data:** Most provider organizations lack a common EMR or platform to aggregate patient data.
- **Insufficient analytics:** Many analytic tools lack the ability to identify specific actions necessary to implement data insights.
- **Nationwide shortage of skilled specialists.**
- **Referral disconnects:** Quality and cost of care become more difficult to manage when patients visit specialists beyond a hospital's visibility.

CLICK TO NAVIGATE THROUGH THE 6 STEPS



STEP 1: IDENTIFY YOUR TOP-PERFORMING PROVIDERS

Analytics can identify those providers who have a track record of collaborating for better cost efficiency and quality outcomes. Shifting services to these top-performing physicians will reduce overutilization and cost while improving overall patient outcomes and quality measures.

CLICK ON + TO REVEAL THE ANSWER

What **principles of contracting** are consistent no matter the types of contracts a provider has? +

Should the provider network strategy change with the **level of risk** organizations take on? +

As providers assume both upside and downside risk, **where should your provider network be**? +

What is the **first step providers should take** when entering into value-based contracts? +

What **kinds of capabilities** should providers cultivate when establishing value-based contracts? +

What is the connection between **value-based contracting and PHM**? +

Are health care providers expected to **invest in this capability** without any reimbursement? +

How does managing population health support both **existing and emerging** care delivery models? +

THE DUAL FOCUS:

Delivering on today's FFS needs while preparing for the value-based future

Providers don't have the luxury of closing, restructuring, retraining and then reopening under a new care delivery model. They must prepare for the value-based future while still delivering on the obligations of today. The provider network's strategy — and the population health management (PHM) strategy that underpins it — must focus on both the present and the future at the same time.

6 STEPS TO DELIVER ON THE PROMISE OF CARE COORDINATION

A clear care coordination strategy allows care delivery systems to achieve success in value-based care. Enabling clinicians to work at the top of their licenses allows them to make the greatest contribution possible with their time, raising care team satisfaction and cost efficiency. Follow these steps to help make care coordination work for your facility.

CLICK EACH NUMBER BELOW TO NAVIGATE THROUGH THE 6 STEPS

1 2 3 4 5 6

Identify your PHM goals and choose the right care team model.

Identify internal changes needed to support your care team model.

Define your key measurement criteria and how you will report on progress.

Mandate team documentation requirements.

Set internal expectations and create a culture of transparency.

Reduce obstacles that accompany change.

STEP 1: IDENTIFY YOUR PHM GOALS AND CHOOSE THE RIGHT CARE TEAM MODEL.

- **Review your payer contracts to identify key quality measures to improve.**
- **Identify top provider performers and pursue additional network partnerships that complement your existing capabilities.**
- **Select a care team model that can meet your population health management objectives.**

BENEFITS

- Reduces resource waste
- Reduces utilization cost
- Empowers and retains workforce
- Allows you to develop VBC capabilities at your own pace

> *Spending some time to give a patient a relatively inexpensive vaccine may prevent a very costly hospitalization down the line. Making an investment in getting more patients screened for colon cancer will lead to the result that you will have fewer patients in your practice who suffer the devastating effects of late-stage colon cancer and the costs that are associated with that.*
>
> — Frank Colangelo, Chief Quality Officer, Premier Medical Associates

CARE COORDINATION & PATIENT ENGAGEMENT

COMBATING THE OPIOID EPIDEMIC

Opioids are a useful and necessary part of treatment for pain and other medical conditions, but these powerful drugs come with a high risk of misuse and dependency. Opioid abuse and misuse is now a national epidemic, impacting lives with no regard to age, race, wealth or region. Providers can take steps to prevent opioid abuse, provide effective treatment for those affected and support long-term individual recovery.

VIEW: CDC MAP BY COUNTY OF OPIOID-PRESCRIBING RATES

The opioid situation

CLICK THE NUMBERS BELOW TO REVEAL OPIOID USE BY THE NUMBERS

80% 70% 16 minutes 5+ million 301,315 1:1

Strategies to Manage

- PREVENTION OF POTENTIAL OPIOID MISUSE
- TREATMENT FOR THOSE AFFECTED
- SUPPORT FOR LONG-TERM RECOVERY

CLICK TO NAVIGATE THROUGH THE 3 STRATEGIES

FINANCIAL COSTS

CLICK HERE TO SEE OPIOID COSTS

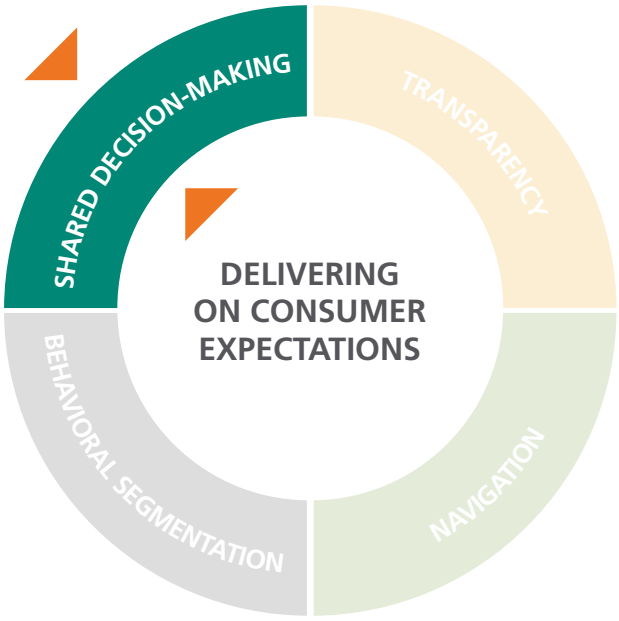
CARE COORDINATION & PATIENT ENGAGEMENT

HARNESSING CONSUMERISM TO ENGAGE PATIENTS

Historically, consumers have been shielded from the true cost of health care, but high-deductible plans and health exchanges have resulted in a wave of increased consumer interest and involvement in their health care coverage, treatment and lifestyle decisions.

> *More than ever before patients have more skin in the game, they have higher deductibles, they have more choice than ever before. If you don't have a good patient experience in your health system, someone else will take those patients.*
>
> — Donn Sorensen, President, Mercy Health

CLICK ON CIRCLE TO NAVIGATE THROUGH THE EXPECTATIONS



Shared decision-making:

Help consumers understand all of their treatment options and connect them with high-quality, cost-effective providers. Example: A provider walks a patient through the risks and benefits of different treatments and the quality performance measures for the specialists who would provide them.

ENGAGING PATIENTS TO IMPROVE QUALITY

Helping consumers navigate the complex health care system allows providers to harness the consumerism trend and influence factors affecting quality measures that are typically beyond their control.

Payers increasingly offer higher-deductible health plans. *AND* **Health exchanges raise consumer awareness of costs.** *WHICH LEAD TO* **Patients increase their expectations as a result of increased choice and control.** *WHICH LEADS TO* **Providers must deliver a positive patient experience to remain competitive.** *WHICH LEADS TO* **Providers deliver on patient expectations and provide positive experience.** *WHICH LEADS TO* **Patients view health activity as an investment and become more vested with positive outcomes.** *WHICH LEADS TO* **a) Improved quality measures b) Reduced costs c) Engaged patients**

WILMINGTON HEALTH

CLICK HERE TO LEARN THE FULL STORY OF THE ACO THAT INSPIRED THESE BUDGET-FRIENDLY TIPS

FOUR BUDGET-FRIENDLY TIPS FOR POPULATION HEALTH MANAGEMENT

LESS COMPLEX AND COSTLY INVESTMENTS CAN DELIVER AN ROI. As more risk shifts from payers to care provider organizations, indicators are pointing to the expense and complexity of practicing medicine increasing to match that risk. Estimates on preparing for value-based care range in the millions, with many care provider organizations responding by pouring resources into their operations, often without measurable improvement in quality or satisfaction to show for it. However, that doesn't have to be the outcome. Below are some effective PHM efforts that can bring a return — without the high price tag.

CLICK EACH TIP FOR DETAILS

TIP 1

ESTABLISH A SHARED VISION OR PURPOSE

TIP 2

IMPLEMENT A ZERO-BASED EXPENSE MODEL

TIP 3

TRANSPARENCY IS FREE — AND IT WORKS

TIP 4

REINVENT PATIENT INTAKE AND ONBOARDING PROCESSES

A shared vision. Thoughtful technology investments. Critical cultural shifts. Modern patient relationships.

Modern providers invest in what matters. Considering the strategic importance of population health, connecting EMRs and advanced analytics empowers and enables efforts to improve the quality and completeness of care. However, aiming for patients who are happier and allowing physicians to remember why they got into medicine doesn't always require large monetary investments.

QUALITY & CLINICAL INTEGRATION

THE EMR IS A FOUNDATION — NOT A SOLUTION — FOR PHM

Effective population health management — as well as the uncovering of insights and the clinical interventions needed to achieve specific quality goals — depends upon having analytic tools that extend beyond the electronic medical record (EMR).

> *[EMRs] are great repositories of the critical patient data necessary to make PHM work, but few are equipped with the proper data analysis functionality needed to support risk stratification and produce actionable information based on predictive analytics.*
> — Becker's Hospital Review

SCOPE OF EMR

- Patient encounter data
- Database of isolated transactions
- Limited analysis
- Documentation improvement
- Clinician access to complete PHI
- Better PHI privacy and security
- More-effective diagnoses

OUTSIDE SCOPE OF EMR

- Social determinants of health data
- Claims data
- Clearinghouse data
- Population stratification and health cohort data
- No interoperability with different systems and other EMRs
- Operational reporting
- Financial ramifications of care decision patterns
- Care coordination insights
- Decision support
- Predictive analytics based on post-treatment efficacy analyses
- Identification of specific clinical interventions
- Patient engagement
- Measure adherence to protocols and variability of care

A BRIEF HISTORY OF EMRs

"Meaningful use" regulations drove care delivery systems to adopt EMRs.

However, these EMRs were designed to fulfill existing regulations, not provide care coordination or analytics.

Now providers need robust analytics to improve quality measures and control costs as the market moves toward value-based care.

To respond to the need, EMR companies are scrambling to bolt analytics tools onto their base EMR.

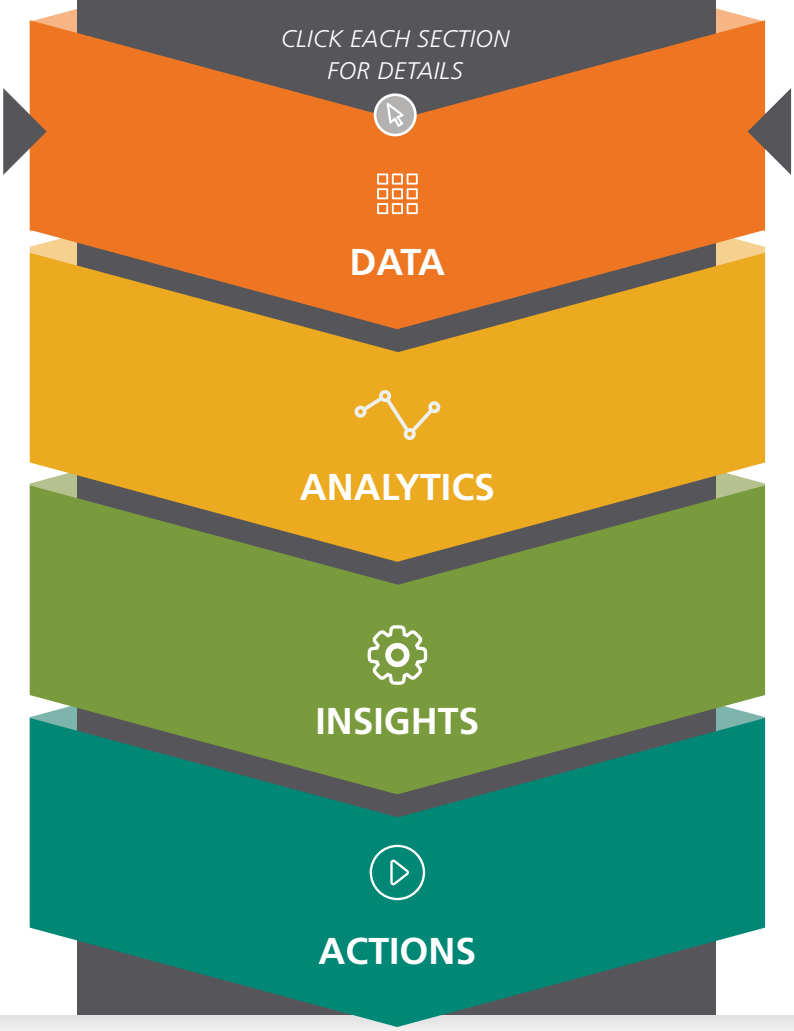
Ultimately, EMRs are repositories of isolated health care transactions and were never intended to serve as longitudinal analytic tools to meet the needs of modern risk-sharing entities.

QUALITY & CLINICAL INTEGRATION

DATA VS. ANALYTICS VS. INSIGHTS VS. ACTIONS

Value-based care requires analytics that identify specific clinical actions that apply meaningful insights to positively influence quality measures. Let's explore what each of these elements really means and how you can achieve them.

CLICK EACH SECTION FOR DETAILS



DOWNLOAD: SEE HOW NYUPN LEVERAGES DATA, ANALYTICS AND INSIGHTS TO IDENTIFY THE ESSENTIAL ACTIONS NEEDED TO MANAGE THEIR POPULATIONS.

- Electronic medical record (EMR)
- Clearinghouse data
- Claims data
- Social determinants of health
- Specialist provider EMRs
- Patient-reported outcomes

QUALITY & CLINICAL INTEGRATION

NATURAL LANGUAGE PROCESSING: AI WITH AN ROI

Many vendors make bold claims about artificial intelligence (AI), but innovation for the sake of innovation isn't enough.

Health care providers need to see a return on any analytic investment they make. Natural language processing (NLP) is one way AI can help providers convert the potential within their health data into quality improvement and cost savings.

Natural language processing is an AI technology that actually makes sense for health care.

ARTIFICIAL INTELLIGENCE LANDSCAPE

CLICK HERE TO SEE DIAGRAM

BENEFITS

CLICK HERE TO SEE BENEFITS

WHAT
is natural language processing?

- Computational linguistics technology within the field of artificial intelligence.
- Using NLP, the computer can read, interpret and organize important health data that is buried in unstructured FREE-TEXT fields, such as physician's notes.
- Converts complex clinical narratives into actionable data points and insights.

WHY
is NLP important?

- 80% of health record content is unstructured (such as descriptions, text fields and narrative notes) and doesn't fit into easily actionable categories.
- Extracting valuable information from this unstructured data is done manually and is time-consuming.
- NLP enhances the return on hospitals' electronic medical record (EMR) and analytic investments by improving the amount of usable data and enhancing analytic insights.

HOW
does NLP work?

- NLP takes this large variety of source documentation and organizes it into actionable and indexable data.
  - NLP preserves the context of medical information, paving the way for in-depth analysis.
- Insights gleaned from NLP-augmented clinical data, adjudicated claims data and other data sources provide new ways for organizations to respond quickly and with material impact on care quality and cost.

WATCH A VIDEO OF MARK MORSCH DISCUSSING NLP FOR HEALTH CARE.

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