Information Builders

A White Paper

Getting the Most From Your Clinical Data

Making Clinical Data Actionable With Omni-HealthData™ Payer Edition

WebFOCUS iWay Software Omni

Information Builders helps organizations transform data into business value. Our business intelligence, integration, and data integrity solutions enable smarter decision-making, strengthen customer relationships, improve performance, and drive growth.

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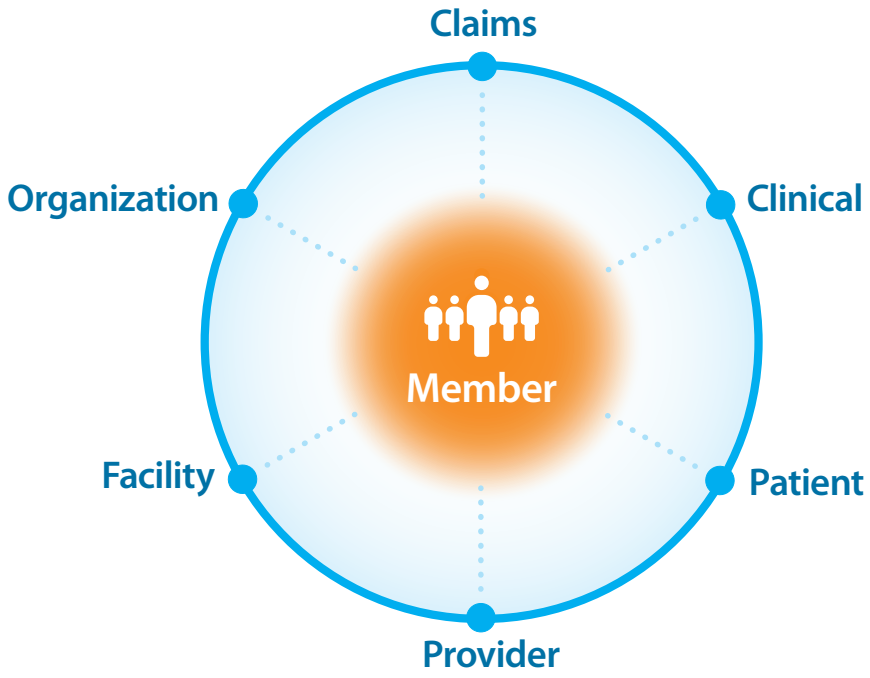
Introduction

The global healthcare landscape is enduring unsustainable upward costs, gaps in information, lack of care coordination, and high readmissions. Payers and providers, challenged to deliver quality care at a reasonable cost, are shifting from fee-for-service to value-based care, where providers are reimbursed by payers based on patient outcomes, rather than services delivered.



Value-based care requires member-centric information.

Formerly, payers' business was driven by claims data. To support care-based operations and optimize revenue, payers need to efficiently tap into external clinical data from provider practices, laboratories, hospital systems, immunization registries, and other sources to get a holistic view of care. The Healthcare Effectiveness Data and Information Set (HEDIS), the Centers for Medicare and Medicaid Services' (CMS) STAR rating system, and other programs that drive reimbursements create a greater need for improved payer access to clinical records.

These changes require effective clinical data exchange: the process of gathering and leveraging clinical data from providers, combining it with claims details and other operational information, and sharing it among all stakeholders. This broader access to information increases the efficiency of the healthcare supply chain (for example, by reducing redundant clinical procedures or unnecessary laboratory tests), while enabling precise measurement of provider performance in key areas such as member outcomes, patient satisfaction, and provider trust.

Doctors use this information – when they have it – to make better care choices that benefit patients, providers, and payers. "Physicians desire a broadening of available clinical protocols, quality measures that align with their specialties and emphasize outcomes rather than processes of care, and detailed data on their own performance and on those to whom they refer patients. Our survey findings suggest that many physicians currently lack these tools, but when made available, they impact performance." [1]

Harnessing so much data from so many sources presents tremendous challenges. It's difficult to collect clinical data from siloed, incompatible systems and unify it with claims and operational data from internal sources – and, at the same time, optimize the consistency, completeness, and accuracy of that information.

This paper discusses the obstacles healthcare payers experience when planning and implementing a strategy for collecting, managing, and exchanging financial, clinical, and operational data. It highlights the benefits of having timely, actionable data and introduces Omni-HealthData™ Payer Edition, a robust and comprehensive member information management solution for health insurers.

[1] Morris, Mitchell Morris; Abrams, Ken; Elsner, Natasha; Gerhardt, Wendy. "Practicing Value-Based Care: What Do Doctors Need?", Deloitte University Press, October 2016.

The Value of Improved Clinical Information Management for Payers

Health plan systems are evolving, and Medicare enrollment will grow at an average rate of 3 percent per year through 2020.[2] HEDIS, CMS STAR, and other initiatives, such as population stratification, risk profiling, and coordination of care, require payers to bring timely and comprehensive clinical data in-house and unify it with claims details and information from diverse internal sources as part of a broad information management strategy.

A solid strategy for managing clinical data offers providers a single, consistent, accurate view of member care outside their practice. Payers can quickly identify gaps in care and alert providers to promote better outcomes. This new relationship paradigm, however, can only be successful if it is data-driven.

Improving information management and promoting clinical data exchange makes information more actionable and drives enhancements in the following key payer operations:

Cost and Profitability Optimization

By harnessing clinical data and improving its accuracy and consistency, payers can eliminate deficiencies in information and leverage outcomes-based data to boost their network performance. This may lead to higher quality ratings, such as CMS STAR, and bigger incentive payments. Furthermore, a higher-quality network would attract more members across different lines of business, increasing revenue and profitability.

Provider Partnership and Care Coordination

Bi-directional data exchange empowers providers with information to make better decisions at the point of care. Payers can provide valuable feedback to improve documentation of clinical encounters at point of care, especially in electronic medical records (EMRs); share cost and quality metrics, to evaluate provider performance against peers; and deliver automated alerts to better coordinate care amongst providers and caregivers. According to HIMMS, "Combining the two data streams could result in a powerful source of information to improve care, quality, and value."[3]

Population Health Analytics

Payers can perform deep, timely, and sharp analytics from claims and supplemental data by managing it in a standard format and refining it to ensure quality. Integrating disparate data into a single repository will supplement existing analytics. Payers can then pull visit information from claims and EMR data to define and analyze their member population using cohorts, create and validate algorithms such as member-provider attribution, perform risk analysis to reduce resource utilization when analyzing data about potentially preventable adverse conditions, and identify at-risk members to proactively target them for outreach.

[2] "Projected Average Annual Growth in Medicare Enrollment From 2010 to 2050," Statista, 2017.

[3] "About Health IT & Payers," HIMSS, 2017.

Claims Adjudication

Accurate claims adjudication is achieved through improved management of clinical data. Accelerated claims turnaround, with fewer errors, enhances operational efficiency, while boosting provider and member satisfaction. Automated data feeds from EMRs reduce manual chart chases and associated overhead.

Member Engagement

The view of a member's health across the continuum of care dramatically improves both the member-provider relationship as well as member satisfaction. A trusted data repository can create unprecedented levels of transparency, which allows payers to create incentive programs that motivate lifestyle changes and lead to better overall well-being. The relationship between payer and member is changing too. Consumers want to interact with their own care-related data, and health plans are expected to provide a trustworthy way for them to track data about their healthcare services.

Program/Product Development

Better information empowers payers to proactively target members as they move from one program to another. A single member view also improves a payer's ability to create and maintain Medicare and other programs, as well as to provide exceptional service, which opens up new revenue streams by drawing in new members.

Managing Chronic Conditions

Nearly one-third of Americans have two or more chronic conditions, and individuals with chronic diseases account for more than 75 percent of healthcare costs.[4] This represents a significant cost driver for payers and demonstrates one of the reasons for the shift to a value-based model. In the absence of granular clinical data, coordinating care between multiple providers is difficult. This causes preventable conditions to be overlooked and significantly impacts resource utilization and, ultimately, claims payments.

[4] "Multiple Chronic Conditions Chartbook," Agency for Healthcare Research and Quality (AHRQ), 2010.

Data Quality Improvement

Healthcare payers are reaching out to their members in new ways, leveraging multiple channels to interact with consumers and share information in different population segments. This creates data quality risks that can jeopardize relationships with provider groups and/or members. For example, invalid, incorrect, or incomplete information about members or claims can diminish trust among these stakeholders, resulting in lost business. Payers must ensure the accuracy of member information, so they can confidently create superior multi-channel experiences.

Regulatory Compliance and Reporting

With rigid rules governing healthcare and driving improvements in care quality, the need to provide quality data to regulatory bodies is growing. Sending incomplete or inaccurate data to a HEDIS Grouper, for example, adversely impacts a payer's CMS STAR rating and jeopardizes reimbursement to both payer and provider. Wider access and better control and management of member data at the payer level improves the quality of data included in annual HEDIS reporting, and boosts the plan's CMS STAR rating – which could translate to millions of dollars in incentive payments. Mandatory reporting requirements and associated payments are also accelerated when comprehensive member information is consolidated in a single location.

Onboarding provider data facilitates better analytics, HEDIS scores, and provider relations.

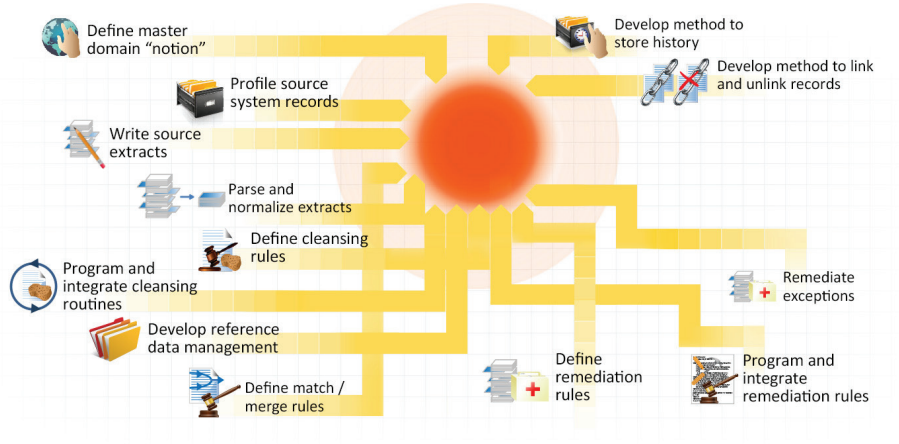
The Challenges of Making Clinical Data Actionable

Harnessing data to support member-centric strategies presents tremendous obstacles such as:

Accessing and Gathering Clinical Data

Detailed clinical information ensures that high-risk members with chronic conditions get access to certain services and programs. However, it can take months to report a visit to a hospital, and those reports often lack clinical details, such as historical medical records or vital signs, that would help identify these high-risk members.

Payers access data by receiving claims information from providers. Problems occur when the variety and volume of data is overwhelming and payers succumb to technical burdens and resource strains. Payers are also familiar and comfortable with HIPAA X12 transactions compared to HL7 transactions, ADT messages, and CCD and CCD/A documents.



Onboarding clinical and other data is usually manual, brittle, and expensive.

Consolidating Clinical Information With Other Sources

A member-centric strategy requires more than just patient data. "The clinical-based patient record is richer than claims-based patient records, but only includes data from one HCO and does not go far back in time," states advisory firm Chilmark Research. "In contrast, the claims-based patient record is sparse, but more longitudinal across providers and deeper historically. A much more complete integrated patient record can be created by combining the two."[5]

Furthermore, patient information is no longer confined to EMR records and claims transactions. Digital health solutions, such as diagnostic, therapeutic, and monitoring software, now use the Internet to move data across multiple treatment settings including hospitals, clinics, physician offices, and the home. When leveraged strategically, these solutions give healthcare payers fresh insight into member treatment and outcomes.

Many payers find it difficult to retrieve, consolidate, manage, and share this data, which comes from incompatible formats and siloed sources.

Mastering Data to Make It Actionable and Trustworthy

Once information is collected and aggregated from various sources, its accuracy, completeness, and consistency must be ensured. This requires a plan, and supporting solutions, that promote data quality management and master data management.

Stakeholders must have complete confidence that their data is trustworthy and accurate. Furthermore, data is not truly actionable until it can be retrieved and shared in a meaningful way among all stakeholders, including payers and providers.

[5] Sharma, Cora. "Haunted by the Past: The Legacy of Claims Data Continues," Chilmark Research, August 2013.

Introducing Omni-HealthData Payer Edition: Member Information Management for Health Insurance

Omni-HealthData Payer Edition from Information Builders is a member information management solution that enables the integration, optimization, and bi-directional exchange of complete, trusted, and timely clinical data across providers and facilities. Payers get a 360-degree view of their members, giving them the insight they need to optimize the payment efficiency and foster collaboration with provider groups, while helping to manage risk, drive quality improvements, and minimize costs.

With Omni-HealthData Payer Edition, health insurers can tap into unified clinical data from physicians' offices, hospitals, nursing homes, laboratories, Health Information Exchanges (HIEs), telemedical services, and more to:

- **Improve provider partnerships** by enhancing management of the provider network, understanding how practice groups operate and relate to each other, increasing the speed and accuracy of provider onboarding, and benchmarking and comparing outcomes and performances of provider groups
- **Produce effective program development** by tracking information about preventable conditions to encourage proactive approaches, engaging in effective population health management, driving improvements in care quality and efficiency with feedback, and increasing adoption of value-based payment models
- **Ensure compliance** with regulatory guidelines and improve plan performance ratings, such as HEDIS and CMS STAR
- **Improve the patient experience** by providing a single version of the truth across the spectrum of care, and creating faster and better targeted member outreach campaigns
- **Optimize operations** by identifying and reducing medically unnecessary utilization, enhancing care coordination, and adopting new care delivery settings, such as Patient-Centered Medical Home (PCMH)

Key features include:

- Match-merge capabilities that link clinical data to member populations
- Comprehensive data quality management, including cleansing, standardization, and enrichment to create a single, trusted source for clinical data
- Terminology management, including code set look-up, validation, standardization, and relationships
- Seamless integration of data into critical workflows
- Pre-built business domains that offer faster time to market

Faster Time-to-Value With Seven Pre-Built Business Domains

Omni-HealthData is a complete solution for onboarding and integrating data to provide a 360-degree view of members. By including mastered subjects, Omni-HealthData provides an accurate, integrated view of a domain. It also includes transactional subjects, which offers a 360-degree view of a member and his or her history across multiple domains.

Omni-HealthData Payer Edition organizes all data into seven **business domains**, sets of topics that represent key business entities integral to running your business (e.g., member, provider).

Five business domains contain mastered subjects with **golden records** – the results of properly mastered data, in which all the information you need to know about a given member, patient, provider, facility, and organization is unified. Two other domains contain **transactional subjects** related to the mastered subjects (claims and clinical). They include predefined data quality rules, match/merge rules, process rules, consumption rules, and remediation rules for each domain. **Transactional information** is individual events that happen with respect to any business domain.

Omni-HealthData's Seven Business Domains

- **Clinical** – Includes a set of transactional subjects that cover patient care, such as diagnosis, encounters, episodes, and care plans. This domain enables analysis of clinical events, patient movement, and diagnosis, and provides details on orders and procedures
- **Claim** – Includes transactional claim-related data, containing attributes related to healthcare services coding. This domain provides a financial history as it relates to clinical, patient, and other domains
- **Member** – Contains mastered data specifying the member's relationship with the payer, including attributes related to demographics and plan information. This can be used for marketing and contact purposes when it relates to information in the patient domain
- **Patient** – Contains mastered data for a patient, including attributes such as clinical disposition, habits, allergies, and demographic data. This information, when combined with the clinical domain, gives a 360-degree view of treatments and outcomes for a specific patient
- **Provider** – Contains mastered data related to providers and includes attributes such as contact information, education, and credentials. This domain helps users identify highly successful providers, as well as those that need additional guidance
- **Facility** – Includes mastered data to describe where patient care was delivered and in what setting it took place (inpatient, ambulatory, outpatient, home, etc.). This helps a payer uncover any abnormalities or gaps in care for a particular member, or identify issues at specific facilities or facility types
- **Organization** – Contains mastered data about an organization, including attributes such as contact information, identifiers, and relationships. With this information, payers can map a complete organizational hierarchy

Conclusion

To move towards a more member-centric business model and develop collaborative relationships with provider groups, health insurers need fast, efficient, economical ways to tap into clinical data. Programs intended to ensure better outcomes, such as HEDIS and CMS STAR, add additional incentives for payers to engage in open, bi-directional clinical data exchanges to get an accurate and broad view of every member and provider.

Omni-HealthData Payer Edition from Information Builders combines powerful features and capabilities with pre-built business domains to empower health plans to efficiently create robust, complete data integration and mastering applications. Health insurers can rapidly gather, unify, and master clinical, claims, and other information, for comprehensive data management that promotes coordinated care, minimizes risk, improves care quality, optimizes costs, and drives better business performance.

About Information Builders

Information Builders helps organizations transform data into business value. Our software solutions for business intelligence and analytics, integration, and data integrity empower people to make smarter decisions, strengthen customer relationships, and drive growth. Our dedication to customer success is unmatched in the industry. That's why thousands of leading organizations rely on Information Builders to be their trusted partner. Founded in 1975, Information Builders is headquartered in New York, NY, with offices around the world, and remains one of the largest independent, privately held companies in the industry. Visit us at **informationbuilders.com**, follow us on Twitter at @infobldrs, like us on Facebook, and visit our LinkedIn page.

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