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How healthcare IT is busting old myths to help you achieve the "impossible trifecta."

MYTH #1

"You can't have your cake and eat it too."

REALITY

The clinically-driven revenue cycle has the potential to deliver win-win-win results.

Having technology in place that makes revenue cycle a byproduct of clinical activity creates an opportunity to automate workflows that previously required human intervention. This has been demonstrated to improve metrics in every area from Patient Experience to Clinical Outcomes—to Revenue and Cash Collections, a true "trifecta."

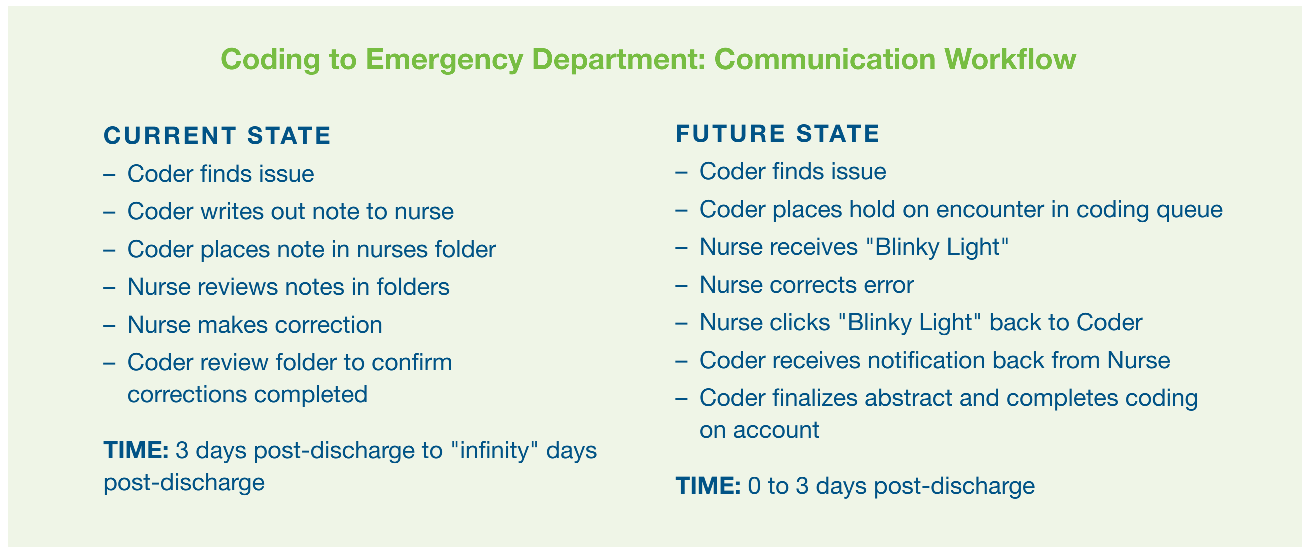
For HIT organizations, supporting the clinically-driven revenue model means establishing a comprehensive unified system that includes Patient Access, Electronic Medical Record (EMR), Health Information Management (HIM), Patient Accounting, Case Management and Electronic Document Interchange (EDI) Services.

So why move toward the clinically-driven revenue cycle? For starters, to achieve huge gains in efficiency and financial health. Current charge-capturing, coding, reconciliation and collections processes result in countless errors, duplication of effort, and lost or delayed revenue. Further, these antiquated systems are not on-track to meet tomorrow's regulatory demands.

Today's HIT solutions—when combined with strategic implementation planning—allow for complex workflows, which are automated to ensure efficient communication between patient financial

services staff regarding clinical denials management. For example, some organizations have implemented decision-support technology that enables denial/variance indicators to automatically notify clinicians that key information is needed to avoid a denial before it happens. This kind of centralized, efficient method of communication reduces a previously fragmented approach to interdepartmental communications and delays in reimbursement. (See Figure 1)

Figure 1. Example of how an improved communications workflow (e.g. Emergency Department) can reduce revenue collection efficiencies.



MYTH #2 "It's too difficult to implement shared risk models."

REALITY

Existing systems can be adapted to accommodate event-driven reimbursement and new models like ACOs, bundles, and narrow networks.

As payer arrangements evolve from event-driven models to other innovative models, changes in the way your HIT solutions work will also be required. The good news is that much of this functionality can be achieved today, when vendor-provided solutions are fitted to the specific strategies and practices of your particular organization.

Functions such as integrated eligibility, medical necessity, and claims management have been embedded into the core workflow for end users, reducing the need for "bolt-on" workarounds to accomplish key revenue cycle tasks.

And, as these capabilities and insights become available, administrators can negotiate and plan with greater confidence, while clinicians understand how to better manage patients for optimal outcomes.

MYTH #3 “Population health management is just for administrators.”

REALITY

Real impact comes from proactive patient engagement—at point-of-care.

As organizations take on a higher level of financial risk through various population health delivery models, it becomes essential for everyone to play a role in keeping patients as healthy as possible.

With some of today’s newer revenue models, frontline providers and clinicians are freed from the transactional, event-based mindset, as they undertake more proactive patient engagement. Metrics are no longer focused on procedures and precisely-calibrated visits, but on quality-based outcomes and healthy-population incentives. Critical to the success of these new programs is your HIT solution’s ability to measure utilization trends such as unplanned care, gaps in care, out-of-network services, and so forth—and to deliver that knowledge to caregivers in an accurate and timely way.

Driving adoption by clinicians to these forward-thinking programs can be dramatically assisted when your HIT strategies are informed by IT professionals who are also experience clinicians—physicians and nurses—who understand the daily realities of interfacing between technology and human patients. Unified clinical and financial solutions provide for the capabilities to manage these changing delivery models and financial environments.

MYTH #4 “It’s smarter to wait for the dust to settle before we do anything.”

REALITY

Concrete steps taken today can give you a competitive edge no matter what happens to healthcare regulation down the road.

Most indications are that the Medicare program will continue to implement payment rule changes to incentivize quality and cost-effectiveness in healthcare services. In January 2015, The U.S. Department of Health and Human Services (HHS) announced its goal of tying 30% of traditional, fee-for-service Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (“ACOs”) or bundled payment arrangements, by the end of 2016, and tying 50% of payments to these models by the end of 2018.

HHS also announced a goal of tying 90% of all Medicare payments to quality or value by the end of 2018, through programs such as the Readmissions Reduction Program and Hospital Inpatient Value Based Purchasing Program.

With passage of MACRA in 2015, the Centers for Medicare and Medicaid Services ("CMS") was directed to develop and implement a Merit-Based Payment System ("MIPS") and alternative payment models ("APMs") for physicians, and to accelerate or at least maintain the "path to value" in Medicare payment rules for hospitals. Since history suggests that private payors and state Medicaid programs follow the lead of the Medicare program with respect to payment policies and programs, these developments in the Medicare program suggest that quality and "value" are likely to become increasingly important focal points as healthcare evolves from this point.

MYTH #5

"Implementations are complex and unpredictable."

REALITY

An experienced partner can anticipate and eliminate the lion's share of common—and uncommon—pitfalls.

At S&P Consultants, we have seen multi-million dollar implementations either be abandoned entirely—or fall far short of expectations due to an inability to bind an organization's strategy to the agile execution required for implementation under real-world conditions. That's why we have worked hard to create systems and structures (like our InTegrity℠ implementation blueprint) that keep the most complex implementations on-strategy, on-track and on-budget.

Clients are desperate to make real progress—in time to meet pressing goals like MACRA or to meet their aim in achieving a clinically-driven revenue cycle. S&P fills critical gaps in experience and personnel with a 100% objective perspective to help clients succeed.

ABOUT S&P CONSULTANTS

S&P Consultants enjoys a 20-year reputation for "doing the right thing" in healthcare IT, facilitating realistic interactions among all parties in HIS implementations. Our InTegrity℠ approach provides a solid "genetic roadmap" and adaptive framework to organizations looking to assure the success of complex projects.

S&P World Headquarters
15 Braintree Hill Office Park, Suite 102
Braintree, MA 02184
781.428.3497 | info@spconinc.com

www.spconinc.com

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