Accountable Care Organization Solution

A.C.O. SOLUTION - Triple AIM SOLUTION

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# Introduction

Universal Medical Record (UMR) is a proprietary technology that seamlessly integrates data streams from multiple electronic medical record (EMR) systems through an innovative telecommunications hub designed to provide a single comprehensive repository for patient medical history that is updated real time in a user friendly dashboard. UMR simplifies aggregation of Healthcare Effectiveness Data and Information Sets (HEDIS) measures and specificity coding allowing for tangible improvement in health care delivery and cost.

# Business Case

Healthcare providers have a growing need to share data, identify where patients have obtained clinical care, meet HEDIS clinical pathways criteria, and to perform specificity coding thereby enhancing reimbursement and preparing for ICD10 implementation.

Hospitals as well as other Healthcare institutions are being challenged to better manage the care provided to patients, to analyze quality indicators such as readmissions, and to manage co-morbidities.

Payers including insurance companies are now being driven to streamline case management and reduce over utilization of services due to the changes in legislation and reimbursement mandates.

Patients are now being provided the ability to actively participate in their health care by monitoring their utilization, provide information to physicians that they may not otherwise have access, and reduce erroneous payer charges by providing an additional layer of review.

# Problem Statement

The case for electronic medical records is compelling: They can make health care more efficient and less expensive, and improve the quality of care by making patients’ medical history easily accessible to all who treat them.

But as health care providers adopt electronic records, the challenges have proved daunting, with a potential for mix-ups and confusion that can be frustrating, costly and even dangerous.

Some doctors complain that the electronic systems are clunky and time-consuming, designed more for bureaucrats than physicians.

Reliable data about problems in the electronic systems is hard to come by, hidden by a virtual code of silence enforced by fears of lawsuits and bad publicity. A recent study commissioned by the government sketches the magnitude of the problem, calling for tools to report problems and to prevent them.

Another increasing problem faced by the growing shift into the electronic medical systems is that the records the providers use at their office may not connect or interact with different software used at the same organization. Seventy-percent of doctors cited the lack of interoperability as a frustration with electronic records in a recent Bipartisan Policy Center survey. This in turn has created a need for a universal collaborative system for the sharing and management of electronic medical records.

The lack of organization of the electronic medical record has raised questions about whether electronic records actually increase costs. By making ordering a test as easy as one click of the mouse, some expect that the technology might ultimately contribute to a higher volume of care than would be delivered in a non-digital environment.

# Proposed Solution(s)

## Introduction of Solution

Universal Medical Record (UMR) technology provides a real-time clinically organized dashboard that provides a comprehensive medical record accessible by multiple users before or during patient encounters. UMR integrates a continuum of captured electronic sources generated by provider EMRs from hospitals, out-patient providers including nursing homes, ambulances, pharmacies, etc. which can be easily provided to entities in need of analyzing a large volume of encounters for a single patient or multiple patients – like insurance companies. This dashboard recognizes all medical codes [CPT, ICD, NDC, CDT, MDS and OASIS] and translates them into a unique genealogy of remarkable and unremarkable medical disciplines [Patented], for example a chest x-ray has the genealogy of radiology, cardiology, and pulmonology medicine. This database allows a comprehensive algorithm for evidence based HEDIS clinical pathways and specificity coding to stratify disease risk. The simple list of Unremarkable Disciplines saves time while maintaining ongoing integrity of data. An Emergency Information section maintains updated information.

A comprehensive databank of all Medical Codes’ genealogy is our unique approach to care coordination between different medical providers’ overlapping fields of practice, and allows mutual support for HEDIS clinical pathways, specificity coding, predictive modeling, utilization management and quality assurance reporting. Thus, this data of Remarkable Disciplines becomes the collective consciousness of applied patient care shared by all participants.

Access to the UMR record (patient identification and insurance verification) provides compliance data about patient utilization of medications, appointments to providers and diagnostic studies. Secure mobile device messaging provides further integrated real time data update to the shared clinical dashboard. Our Prescription and Medication discipline provides a comprehensive drug-laboratory and drug-disease interaction analysis to improve patient safety, effect centralized drug data updates including pharmaceutical market recalls. This record also evaluates compliance of each patient’s medication (re)fills and utilization, which impact disease response. In addition, response of measureable clinical parameters can be evaluated by medication therapies.

UMR through its analytic capability can identify patients for clinical trials and can provide research coordinators the information needed to comply with clinical research protocols. This system is designed to be a real time interface that provides a one stop solution for medical record retrieval and analysis for the health care community.

## Application of Solution

Utilizing the UMR system insurance companies (payers) will lower utilization, reduce costs, and streamline case management. Through the use of technology UMR improves the coordination and quality of care, improving outcomes while reducing the time to treat and diagnose. The UMR system will also enable the insurance companies to perform predictive modeling.

Additionally, Providers benefit from a provider friendly workflow that brings to the surface the information necessary to manage a patient’s care. Through the UMR system providers will meet the HEDIS criteria of clinical pathways and the specificity coding will allow them to increase reimbursement. Health outcomes benefit by provider UMR utilization that leads to a complete understanding of patient health records when treating and diagnosing conditions.

# Future Direction / Long-Term Focus

Insurance Companies are the initial stepping stones to our process as they have the complete data record of who (patient and provider), what (services performed through CPT and ICD coding), when (service dates), and where (location of service provided). The data is then uploaded into the UMR system which will then aggregate and genealogically categorize the data and be available to providers, hospitals, payers, and patients. Information obtained through the insurance companies provides a road map of the care provided. This road map will indicate the services performed and direct providers to simultaneously manage care and cost in an unprecedented fashion. The UMR system is also able to link directly with EMRs and HIEs so CCD data can be shared.

UMR’s long term target market is the health care community at large; we believe UMR is a real time communication pathway for Providers, Healthcare Organizations, Payers, and Patients. The UMR system brings value to those connected by improving the management and quality of care, tracking utilization, reducing redundancy, and ensuring patient safety.

# Results / Conclusion

The UMR system complements and/or replaces any HIE allowing UMR to act as a bridge across multiple electronic records. This would expedite UMR’s exposure to multiple EMRs and demonstrate to a larger audience - the enormous benefits gained by the system’s ability to reach across multiple providers’ EMRs and produce a single expansive standard record that enables better clinical care and cost control by providing a single meeting place for a patient’s data, regardless of origin.

# Appendices

## Appendix A – Authors

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## Appendix B – References

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