# How HIM Adds Value to Managed Care

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*Managed care offers many career opportunities to HIM professionals. If you're interested in making a transition to this area, the first step is understanding the ways HIM adds value to managed care processes. This article kicks off the first in a series on HIM opportunities in managed care.*

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The rapid metamorphosis in managed care directly correlates to the burgeoning demand for healthcare cost control, quality care delivery, easy access to healthcare, and the need for accurate information to manage these factors. The transformation of the industry, including the rapid expansion of communication, ongoing advancement of technology, new care delivery techniques, the well-informed patient, and regulatory changes all continue to bring about new focuses to the managed care arena.

It will be increasingly important for managed care organizations (MCOs) to consider the merit and inherent value of HIM professionals, including the multidimensional contributions they can make within this environment.

This article will identify four key functional areas of HIM, providing you with conceptual and practical examples of how HIM professionals can apply their skills toward building an effective HIM department in the evolving managed care environment. We'll also provide examples on data collection, management, and application for decision making within managed care.

This article is the first of a series intended to help stimulate thought and encourage HIM professionals to evaluate the value their background and experiences can bring to the world of managed care.

## HIM Stakes Its Claim

There are numerous ways the HIM can make a difference in MCOs as well as the associated constituency of managed care (that is, providers, payers, purchasers/employers, and others). MCOs are information driven, and as healthcare evolves, information becomes even more paramount. The move toward the virtual environment, i.e., e-health, brings the MCO constituency, including the consumer, together via the Internet. How the MCO manages its information becomes critical-even key-to its expected growth and evolution.

The HIM knowledge base is a key part of effective information use within an MCO. This includes our knowledge of clinical care classification systems and the supporting required documentation in paper or electronic media. HIM professionals are trained in data techniques that take advantage of both financial and clinical information. In managed care, the HIM profession's focus should be the realm of clinical information connectivity and communication across the continuum of managed care delivery.[1, 2]

As former AHIMA president Claire Dixon-Lee, PhD, RHIA, has put it, the HIM profession has "a universal view of the processes behind clinical data transformed to information that no other single discipline can claim. As health professionals, HIMs have a responsibility to step forward, question, evaluate, participate, and challenge today's manual and electronic clinical data capture methodologies if we want to improve health information management for the next millennium."[3]

The vision of "quality, cost-effective healthcare through quality information" is not limited to providers but spans all aspects of healthcare delivery and research. This vision clearly demonstrates the integral part HIM plays within the system, including managed care, as it has become an increasingly demanding area of focus.

## What HIM Can Do for Managed Care

The HIM discipline influences and benefits the MCO in several areas, including:

- effective management of **data quality**
- improved **provider profiling**
- **efficient employer reporting mechanisms**
- **clinical audit** of claims and medical records
- improved **claims processing and payment accuracy**
- feedback to utilization management areas for improved **case management prioritization**
- better aligned **incentives for provider funding, quality improvement, and overall utilization**

Like all healthcare organizations, MCOs need clean, accurate, and timely information. Issues like documentation, data quality, data retrieval, confidentiality, coding management, abstracting, and education are concerns for many MCOs just as they are for hospitals and clinics. There is also a need to convert information into applied knowledge, known outside the HIM domain as "knowledge mangement."[4]

Four key functions serve as the basis for an HIM process in an MCO by providing background to each area:

- **Data (Process) and Records Management**-Developing, implementing, and maintaining a health information management (compliance) plan for coding and reimbursement, medical documentation, and quality data in all divisions of a managed care organization. Providing leadership, direction, and technical expertise to ensure compliance with internal and external quality data, information, and documentation requirements.
- **Informatics**-Refining content and "value added" groupings; creating methods and methodologies (externally and internally) to classify managed care services spanning all divisions of the MCO.
- **Decision Support/Analytics**-Working with relevant divisions of the MCO to develop and implement a plan for analyzing information that is clinically relevant and actionable. (Here, clinical relevancy is key. The HIM division should interact with other departments for full clinical perspective.)
- **Quality Improvement**-Capitalizing on technical expertise by participating in decision-making and feedback loop processes based on results of analyses. This encompasses continuous quality assessment and improvement.

Regardless of setting, data needs to be appropriately and effectively managed-reliably enhanced, analyzed, validated, improved, and secured-to ensure that information is relevant and useable.

Managed care's evolution includes new and improved ways of sharing information between patients, providers, purchasers/employers, payers, and researchers. Increasingly, the vehicle for this transmittal is the Internet, allowing the patient or member to actually assist in making decisions regarding care. For example, in a preferred provider organization (PPO), a patient (or member or consumer) may select physicians, specialists, or other providers from the PPO network via a Web site. Conversely, patients or providers may also consult the Internet when a referral to another provider for specialty care is needed.

And that's only the beginning. Using the four key functions described above, one could conclude and begin to apply how some PPO-related functions are met through e-based methods. "The E-Frontier," provides an example.

## Using Our Influence

The breadth of HIM knowledge required in the MCO environment makes it inevitable that HIM professionals will move into considerably influential positions. HIM professionals will also become closely aligned with a number of other departments and will touch many others. Looking at the four key areas, we can see that departments influenced by HIM may well include:

- medical policy
- payment policy
- appeals
- clinical claims review
- HEDIS reporting
- data quality management[5]
- provider operations

- medical analysis
- IT liaison
- medical management liaison (utilization management, quality management)

As a way to evaluate both the scope of the HIM role and the impact that HIM-related knowledge bases will have within managed care, first we need to understand some of the dimensions of managed care. Let's look at examples of how a collaborative effort between patient and provider and support by the payer/purchaser combine with the HIM professional role to produce optimum results.

***Why Information Matters***

As with all industries, managed care requires information systems that support today's requirements yet are flexible enough to adapt to changes and trends. A critical motivating factor to effectively meet overall demands within healthcare is now focused with an eye toward achieving efficiencies-which some experts have referred to as achieving economy of scale.[6]

Related data and information initiatives might well be considered cyclic. For instance, paying a claim in a timely manner requires that the provider have current and valid eligibility and enrollment information. Having up-to-date eligibility information on the patient, including associated benefit plan details, creates a "clean claim" at the point of service. Optimally, an organization is able to electronically submit claims, allowing for immediate online payment as the claim is adjudicated (that is, pre- or repriced) and electronically paid by the payer organization.

The provider wants to have up-to-the-minute clinical information for use in making care decisions. This might include having evaluated past experiences to determine best-practice approaches to care delivery going forward. Patients or consumers may want methods for gaining more knowledge about a specific health concern, such as management of chronic illnesses or diseases such as diabetes. For example, a patient may want frequent or timely communication with a provider on home testing or monitoring blood glucose, foot care, dietary habits, weight, or blood pressure.

Collaborative linking of providers (specialists) and patients with a case/care manager has spawned such programs as disease and demand management in the recent past. In the example of the diabetic patient, the concept of linkage provides for use of disease manangement information in the form of practice guidelines and expands patient teaching with an orientation toward wellness and appropriate preventive care.

The clinical possibilities are endless; however, they require useful, reliable, and timely information, which helps ensure that good decisions are being made in the most efficient and cost-effective manner. To further understand this theory, let's look at the related concepts of quality and performance improvement using the PPO model of managed care.

## Quality and Performance Improvement: The Next Step

Quality measurement and continuous process improvement continue to be challenges for MCOs. For example, PPOs were not originally designed to collect the level of administrative (financial) and clinical data needed to measure and improve performance. Today, however, quality and performance strategies within PPOs are taking into consideration effective data strategies as they move to the next level-quality improvement. Liza Greenberg, vice president of research and quality at URAC, recommends the following strategies for PPOs as they move toward measuring and improving performance:[7]

- **accreditation**: Organizations such as the Joint Commission, National Committee for Quality Assurance, and the American Accreditation HealthCare Commission all provide PPO organizational standards to meet accreditation
- **focused reporting requirements**: The administrative claims data available in the PPO setting is a logical source for initial, basic measurement
- **improve enrollment information**: Not all PPOs use full enrollment information to process claims; therefore, it is difficult to conduct measurements on eligible beneficiaries. If enrollment information were accurate and updated regularly, then performance reports similarly used by HMOs would be possible
- **increase available and accurate claims data**: Linkages of data from all claim types (medical, pharmacy, and lab) is critical for any significant measurement and process (quality) improvement program within this delivery system
- **create data warehouses**: PPOs move toward defining standard elements, which leads to more effective analysis when measuring results and outcomes

- **participate in standard surveys**: Nationally accepted surveys are used to begin measuring customer service satisfaction levels. By using these survey tools, useful, comparative data becomes available to identify benchmarks in performance

***A Real-life Application***

Looking at a PPO member's level of satisfaction is one way to assess service quality and the PPO network's performance. A critical first step to gathering appropriate satisfaction data might come from industry examples through the use of the Consumer Assessment of Health Plans Survey (CAHPS) created by the Agency for Healthcare Research and Quality (AHRQ). The CAHPS tool is the most widely used tool that is publicly available (other similar tools developed by vendors are available for purchase). The CAHPS survey instrument is designed to measure a patient's experience in the physician's office as well as with the health plan's administrative processes.

Management of such a survey process is an ideal role for HIM professionals. Key steps in the implementation and application of the CAHPS survey tool includes:

- **design survey process**-What is the purpose and intended result in gathering this data?
- **gather eligibility data**-Without accurate eligibility data, a survey of this type cannot take place. A health plan should have this data anyway, as it is used to make referrals and process claims. Effective management of eligibility data can increase patient and provider satisfaction.
- **administrate survey tool**-Conducting the CAHPS survey requires the use of cover letters from the health plans to accompany the surveys mailed to patients. Use of follow-up techniques such as postcards and repeat survey mailings is necessary when there is no response.
- **report results**-Survey results should focus on how patients perceive their needs are met, satisfaction with provider communication, and factors such as office staff performance and customer service. Health plans can also address how claims are processed and complaints are managed. Accuracy of information provided by health plans to patients presents a significant issue, especially when directing patients to provider hospitals and physicians. A very significant issue for health plans is data integrity, especially when directing members to provider hospitals and physicians.

Unequivocally, purchasers of healthcare such as employers require information assistance in determining whether benefit plans are meeting the needs of employees. Purchasers may also need information about the ease of enrollment following plan selection and other issues. Currently, a number of large purchasers are beginning to evaluate how care is delivered, as alliances such as the recently formed Leapfrog Group illustrate. This new alliance, for example, has called for tougher patient safety standards within associated managed care plan contracts.8 As groups like this bring issues such as computerized ordering of medication and supplies and the use of evidence-based patient referrals to the healthcare debate, information management will continue to be in the spotlight.

## Want More Information? Stay Tuned

This article provides a high-level glimpse of how quality information can be used throughout managed care, with closer evaluation of how purchasers/payers and even patients and providers use information, further underscoring the inherent value-added role of HIM professionals within managed care.

Future articles in this series will focus on how HIM peers and healthcare colleagues view the value of information and the role of HIM professionals by providing practical examples from wide-ranging MCO dimensions.

This series will explore actual data processes and management methodologies, informatics with a clinical focus, analysis with decision support at its foundation, and finally, more about quality improvement techniques and opportunities within MCOs. Each article will provide sufficient knowledge and detail to help HIM professionals understand how they can make a difference in the world of managed care.

## Want More Information?

You can find more articles about managed care from the *Journal of AHIMA* at AHIMA's Web site. Go to www.ahima.org.

Welch, Julie. "Managed Care: The Dominant Paradigm in US Healthcare." *Journal of AHIMA* 69, no. 4 (1998).

Tercero, Wendy. "Managed Care in the Age of Accountability." *Journal of AHIMA* 70, no. 4 (1999).

Homan, Cheryl. "Choosing a Managed Care Information System." *Journal of AHIMA* 69, no. 4 (1998)

"So You Want to Work in Managed Care." *AHIMA Advantage* 3, no.1 (1999).

Other articles from the *Journal of AHIMA* are available through the National Information Center for Health Services Administration. Call (312) 422-2050 or go to www.nichsa.org. Here's a sampling:

AHIMA's Managed Care Task Force. "The Converging Roads of HIM and Managed Care." *Journal of AHIMA* 70, no. 4 (1999): 42-45.

Blumenthal, Jane. "Forging New Relationships: HIM and Managed Care." *Journal of AHIMA* 69, no. 4 (1998).

## The E-frontier

By applying the four key functions of HIM in the managed care environment, we see how HIM functions can affect a process such as selecting a specialist in the e-based environment.

| **Key Functional Area** | **Applying Key Concepts** |
|---|---|
| **Data (Process) and Records Management** | **Diagnosis/procedure**:<br>• Compile a listing of diagnoses and procedures that are commonly recognized (ICD-9-CM, CPT-4)<br>**Specialty**:<br>• Create a specialty table choosing a nationally recognized method (American Board of Medical Specialties)<br>• Account for primary and sub-specialties |
| **Informatics** | **Diagnosis/procedure**:<br>• Group diagnoses/procedures in specialty categories, where possible, allowing for overlaps, because diagnoses are not mutually exclusive, such as diabetic retinopathy<br>**Specialty**: |

| | |
|---|---|
| | • Link specialties to diagnosis groupings and forward to individual physicians based on their self-reported specialty (This is clearly not an all-inclusive method due to variability in how specialties are reported and variability in what certain specialists can or cannot do. For example, can all cardiologists perform a cardiac catheterization?) |
| **Decision Support/Analytics** | **Methods to analyze successful identification of specialist**:<br>• Successful hits, diagnosis/specialty<br>• Verification that all diagnoses are captured appropriately through clinical analysis<br>• Web-based customer surveys<br>• Claims analysis for office visits/treatments after identification of provider via Web-based method |
| **Quality Improvement** | **Quality improvement methods based on results of analysis**:<br>• Update diagnosis/procedure tables with new data items<br>• Update diagnosis/procedure groupings per specialty<br>• Apply improvements to process of identifying specialists based on results of customer surveys<br>• Provide episode based information to providers and patients to assist in improvement in clinical care |

## Notes

1. Can be defined as the linkage of all related methods of documenting and classifying patient care throughout an organization, not just through systems integration (which is an IT function), but through definitional alignment in collection and analysis of information (which is a business user and a health information management function).

2. Dixon-Lee, Claire R. "HIM's Contribution to Managed Care Documentation." *ADVANCE for Health Information Professionals* 8, no. 13 (1998): 14-17.

3. Ibid.

4. "So You Want to Work in Managed Care." *AHIMA Advantage* 3, no. 1 (1999): 5.

5. Kloss, Linda. "Quality Data Put the 'Managed' in Managed Care." *Managed Healthcare News* 15, no. 2 (1999): 35.

6. Kongstvedt, Peter R. *Essentials of Managed Health Care*, 2nd ed. Gaithersburg, MD: Aspen Publishers, Inc., 1997.

7. Greenberg, Liza. "State of the Art of PPO Quality and Performance Measurement." *Health Care Innovations* 9, no. 1 (1999).

8. Jackson, Russell A. *Managed Care Outlook: The Insider's Business Briefing on Managed Healthcare* 13, no. 14 (2000): 5.

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**Article citation**:
Valo, Carolyn, et al. "How HIM Adds Value to Managed Care." *Journal of AHIMA* 72, no.6 (2001): 41-46.

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