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# Help Wanted: A Chief Outcomes Officer

## A new role leads a human-centered approach to improve outcomes

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Few health care organizations feel they've achieved their targets of improved outcomes, lower cost, and higher satisfaction. Meanwhile, COVID-19 has increased the imperative to take a proactive, holistic approach to patient needs. The onus is often now on CMOs to become more proactive and consumer-centric, especially if moving toward value-based care models. The answer may lie in the creation of a new role — Chief Outcomes Officer — that would consider the factors of providers, health plans, and patients.

Few health care organizations feel they've achieved their targets of improved outcomes, lower cost, and higher satisfaction. Meanwhile, the coronavirus disease (COVID-19) has increased the imperative to take a proactive, holistic approach to attend patient needs — a more human-centered approach for all involved. The onus is often now on Chief Medical Officers (CMOs) to become more proactive and consumer-centric, especially if they are steering their organizations toward value-based care models.

Pursuits of value-based reimbursement arrangements have been rolled out with requirements that have led to unintended consequences. Volume and variability spring from every health plan program, and it can sometimes overwhelm providers with variety and complexity. This growing demand can steal time away from patient encounters and challenge provider organizations with a seemingly infinite number of requests to accommodate. And the patient lives at the tail end of this confusion — coping with illness, uncertainty, and perhaps a challenging care plan.

The problem of administrative burden is not going away. In fact, as we'll explain in this article, it's getting worse. Removing administrative burden requires answering three questions:

- How can CMOs help their organizations achieve better outcomes without burdening clinicians with administrative variability and documentation demands?

- Even with interoperability streamlining information, how can the specifics of each health plan program come to life in each provider organization?

- How can we help ensure that each patient receives the best and most complete set of services that their health plan and provider team can offer?

The answer may lie in the creation of a new role — Chief Outcomes Officer. This position would consider the factors of providers, health plans, and patients to help ensure that the exchange of data is productive, requirements are streamlined, and consumers can access all available health and support services.

This new role could reduce costly administrative variability and redirect resources and workflows to deliver and document improved outcomes. In the form of a centralized position or strategic partner, a Chief Outcomes Officer could engage providers to standardize, simplify, and streamline the needs of various quality programs — increasing the time physicians have to spend with patients.

A CMO could help establish, lead, or even step into the Chief Outcomes Officer role, removing administrative burden and linking the goals of disease/care management programs to risk adjustment and quality programs.

## Increasing the focus on outcomes

The motivations for moving from fee-for-service to value-based care are fundamentally correct. Value-based care seeks to provide a more holistic, preventive approach that takes a more complete, human-centered view of the patient into account. This focus on treating the person rather than the condition should ultimately lower administrative costs while improving outcomes and increasing consumer satisfaction.

Unfortunately, the increase in positive patient outcomes has yet to meet industry expectations. Under value-based care, 30% to 50% or more of individual patients still do not receive the care or achieve the outcomes set by group performance measures.[1] The approach has become too fragmented and diverse. To succeed with physicians and consumers, it needs to be streamlined, standardized, and made simple.

> *"77% of health systems experience moderate to serious problems with staff capacity to support health plan risk adjustment and quality programs.[2]"*

### *How a Chief Outcomes Officer could help*

- Educate providers about the variety of benefits that each patient can access.
- Follow up to ensure that clinical programs are being fully utilized to treat the complete health picture of the patient.
- Follow up with patients to direct them to the proper site of service or plan benefit for evidence-based preventative care and chronic condition management.
- Make sure that patient transitions out of the hospital are coordinated and that they get the post-acute care they need.

#### ***The human-centered approach in action***

*A patient wasn't taking their medication. Through engagement with a social program, it was discovered that the patient could not read and was therefore unable to follow the instructions. A representative from Optum (acting as a Chief Outcomes Officer) connected with the health plan and discovered that they had resources available through a community-based program. This program then sent a home worker out to meet with the patient to teach them how to read the bottle. The patient became compliant and happy after that, always checking in. The provider, seeing the complete turnaround in outcome, has become an advocate for these resources.*

## Alleviating administrative burden

Despite good intentions, health plan programs can create excessive administrative burden for providers.

On average, providers contract with about 10 health plans.[2] If each health plan has unique expectations, data requirements, forms, and incentive programs, that multiplies the number of processes a provider has to manage in order to receive value-based reimbursement. As a result, provider organizations are having to invest in technology and staff just to manage the various health plan administrative processes.

> *"Over 50% of large provider organizations experience moderate to severe financial impact arising from the various demands on staff, processes and technologies from health plan risk adjustment and quality programs.[2]"*

The time spent on documentation and follow-up is also cutting into the time that clinicians can spend on patients, with about a quarter of physicians spending less than 12 minutes per patient visit.[3]

Clinicians can also be frustrated when they are asked, via their EMR, to treat patients differently based on their coverage and the unique requirements of each health plan. In fact, 74% of providers say they are challenged by variation in health plan processes, changing processes and adding to clinician workloads to participate in programs.[2] While the front office cares about proper billing, and rightly so, the clinician needs to know about the patient. The variance in authorization, required documentation, and order sets flows from the business side of the organization right into the patient/clinician encounter. Unfortunately, it is dominating the exercise and reprioritizing clinician time and attention away from the patient.

### *How a Chief Outcomes Officer could help*

- Standardize the exchange of data and program parameters.
- Standardize workflows so that multiple parties aren't fighting for the attention of clinicians when they're seeing the patient.
- Clearly lay out gaps and complexity to raise awareness of issues and identify solutions.
- Work with the health plan to take stock of every piece of data that is being introduced to a provider, and every piece of data that's being sent back.

#### ***The human-centered approach in action***

*The health plan began to sponsor customized provider training a few years ago, and it has since been established as a regularly occurring event. The programs have become popular with providers and their clinical and coding/billing staff as the number of attendees has grown, adding new participants to those individuals returning year over year to be informed of documentation and coding guidelines, code set, and payment year changes.*

## Variability is created by a desire to be unique

As health plans strive to differentiate, they may develop a variety of programs that they believe will help them achieve their business goals, improve the health outcomes of their members, and set them apart in the market. And they can launch from two sources — the ability to anticipate risk from the financial side and the ability to improve population health, which is driven from the clinical side.

> *"To gain consistency, health plans will need to put down the desire to be unique."*

But to gain consistency, health plans will need to put down the desire to be unique. They can instead differentiate by developing an exceptional ability to understand providers and the challenges faced at the point of care. They can take a more nuanced approach to what providers need, how they work, and what tools are truly usable for them.

However, there are other ways for CMOs to help their organizations differentiate right away. More are addressing the holistic set of member needs. Many offer transportation, benefits, prescription delivery, home care, and nutrition support. Health plans have invested in improving health and lifestyle standards for their members. And yet, that information is often not shared with providers. Putting that information at their fingertips would help providers educate patients on the benefits they can access to support their health outcomes.

### *How a Chief Outcomes Officer could help*

- Take inventory of risk adjustment, quality incentive, and outcome-based programs. Determine how much common data can be shared and how much unique data is required.

- Seek input from network providers to identify pain points of variability and look for opportunities to facilitate a common provider experience to reduce variability and the associated costly administrative burden.

- Dialogue with program developers to illuminate the volume of documentation they request and work directly with individuals doing the documentation to brainstorm ways to streamline these requests.

## Assessing opportunities to streamline, simplify, or retire programs

### *What health plans can do*

First, health plan CMOs can evaluate the impact of the programs. Which ones produced actionable insight or opportunity that prompted a provider or patient to do something new? This confirms if the activities are causing new outcomes or are simply using the administrative work to track evidence of what already occurred.

Health plans can also track which providers are staying in their programs, and which are opting out. If they're opting out, they may have already recognized the returns aren't there. If they stay, that can indicate what is working.

### *What providers can do*

Provider CMOs can help track program engagement — especially in preventive care like annual visits, screenings, and managing chronic conditions. They can quickly tell if programs are working as designed because ER visits and readmissions should likely decrease. There should be fewer cases of patients with complex comorbidities seeing their conditions spiral out of control — in other words, fewer super-users.

When these indicators move in the right direction, organizations can see the benefits of a value-based approach. But if the focus and the man-hours are constrained by administrative demands, the opportunity to achieve better clinical outcomes is equally diminished.

*A Chief Outcomes Officer could:*

- Release clinicians from administrative burden.
- Increase focus on a patient's unique need(s).
- Inform and advocate for use of the full range of available benefits.

***The human-centered approach in action***

*An Optum employee working on behalf of the health plan sat with groups for countless hours on multiple days — holding their hands, working side-by-side, until she exhausted her efforts to ensure that everything was done to help the groups earn available incentives and properly document. Her engagement has providers wanting more education so that they can ensure members have the resources for proper care.*

## Unlocking the potential of the Chief Outcomes Officer

One of the primary factors slowing down the transition to value-based care that CMOs must contend with is administrative variability. It wastes time, wastes money, and hampers clinical outcomes. And this variability is often due to the disjointed relationship between health plans and providers.

A new Chief Outcomes Officer role could exist between all parties, facilitating data exchange, working with programs to meet their goals, and helping patients find the human-centered care they need and desire. By eliminating these gaps and disconnects, the Chief Outcomes Officer could help health care organizations deliver on the ultimate promise of value-based care.

*For more clinical leadership insights on the approaches and trends shaping health care, visit* optum.com/vitalviews.



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