

## HEALTHCARE TRANSFORMATION: GETTING THERE

/// VIEWPOINT PAPER



### Examining the possibilities of a 360-degree healthcare continuum

Healthcare reform has been on the American agenda for decades. Through the years, the nation's policymakers, payers and providers have worked to expand insurance choice and coverage and improve care access and delivery. But today, it's clear the U.S. healthcare system needs systemic changes to improve care and control costs. In this paper, EDS, an HP company, examines how government agencies can address the issues and opportunities facing consumers, providers and payers, as viewed through the lens of *The 360-Degree Healthcare Continuum*.

## TABLE OF CONTENTS

Introduction	1
Moving from transaction processing to collaboration	1
The future U.S. healthcare system	3
Exploring <i>The 360-Degree Healthcare Continuum</i>	4
Knowledge distribution	7
Consumer empowerment	7
Performance improvement	8
Streamlined, standardized business processes for providers and beneficiaries	9
Leveraged, modernized infrastructure and applications	10
The path ahead for government payers	10
Realizing tomorrow's healthcare system	11

## Introduction

Healthcare is one of the biggest issues on the U.S. national agenda. Who receives it? How good is it? And who pays for it?

Today, we spend 16 percent of our gross domestic product (GDP) on healthcare, and our spending has risen faster than in other countries. Yet, on key health outcome measures, U.S. performance is at best average. The nation ranks 15th among 19 countries in mortality from conditions preventable or treatable with timely, effective medical care.<sup>1</sup>

Meanwhile, the cost of care continues to climb. The federal government predicts that healthcare spending will almost double by 2017 to \$4.3 trillion a year, one-fifth of GDP.<sup>2</sup> This spending is driven by a complex set of factors, including the use of medical technology, inflation, patterns of care seeking, delivery and demographics. Concern about the sustainability of such increases over time has led to a national conversation about how best to optimize, organize and incent the health insurance and delivery system to increase value and control costs.

Whatever direction this conversation takes, states are in the unique position to use their assets – systems, processes and stakeholder relationships derived from Medicaid, State Children’s Insurance Program, and other health and human services programs – to drive systemwide change. This paper presents a perspective on healthcare transformation that we call *The 360-Degree Healthcare Continuum*. This continuum provides a framework for states and other participants in the healthcare system to think about how their solutions and assets can be connected and organized to address the critical goals of lower costs, improved care and greater efficiency.

Healthcare transformation isn’t going to take place overnight. It’s not one solution or one program, one change, or one initiative. We’re unlikely to see change successfully driven as a big bang, rip and replace, do-it-all-at-once proposition. Those who lead the change agenda will promote real solutions and not slogans, tear down silos instead of creating new ones, promote collaboration and shared investments at an enterprise level, and embrace an expansive view of stakeholders and contributors to the health mission.

### Moving from transaction processing to collaboration

To date, the bulk of operational and technology investment by government payers has gone to payment and transaction processing. At the state and federal levels, payment processing and eligibility systems have needed to handle massive volumes of data. The ability of these systems to process data efficiently and support accurate payment, coverage and eligibility determinations has been the primary focus of attention of these investments.

Government payers have built, bought and maintained these systems to handle a plethora of detailed programmatic functionality embedded in and required by state and federal health insurance programs. Billions of federal and state dollars have been spent on applications and operations to process the transactions that have formed the backbone of the program: determining benefits eligibility, enrolling participants and providers, and administering fee and payment schedules. However, in carrying out these activities, we have built systems and processes focused on the integrity and validity of transactions within the business silo - to ensure the dollar we spend conforms to reimbursement rules - rather than on optimizing how care is actually delivered at a systemwide or provider level - to ensure we get the most out of the dollar we spend.

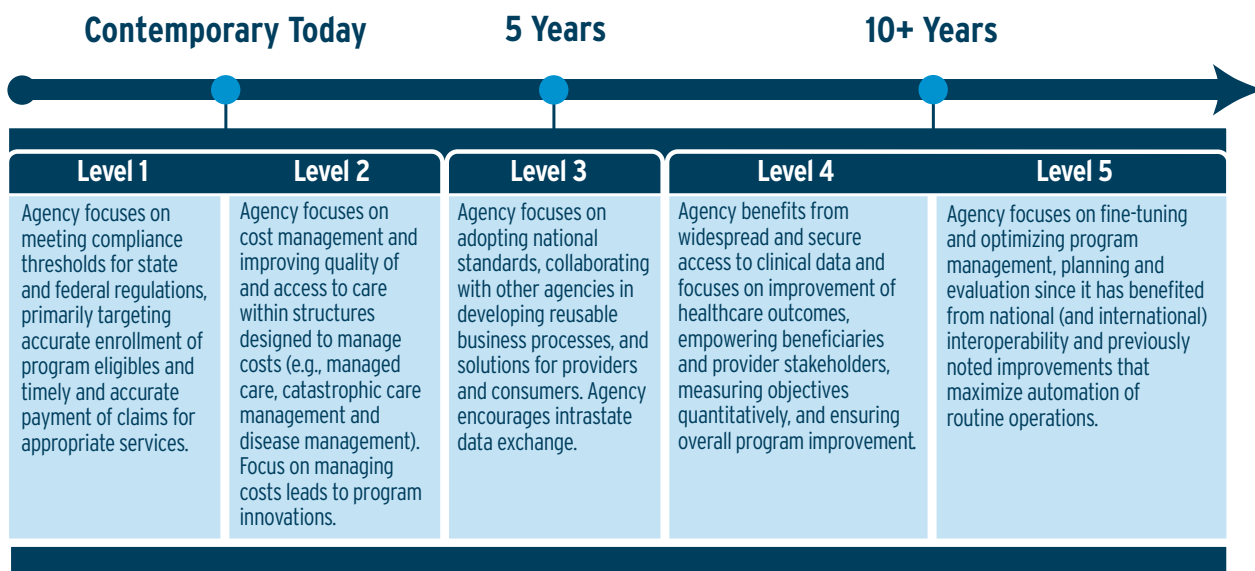
As payers have built their systems to administer programs, providers have had to deploy the processes and technology to input information into these transaction-processing machines. Providers have seen their administrative time and costs of compliance increase and have expressed deep concern about the diversion of resources from direct care, representing a source of continuing friction with the payer community.

The industry is recognizing the need to alter the conversation among payers, providers and patients to align incentives and practices in a different way. This new view embraces social and economic relationships and expectations, as well as business models and technology.

For payers, as well as for providers and consumers, repackaging old business models will not suffice. It is not enough to simply sprinkle patient education programs, Web front ends, electronic health records or care management programs onto the existing structure and believe that transformational change will take place as a result. The underlying business of administering a public health plan - what we think that entails or involves, where we spend our time and money - must change at its core.

This shift is reflected in Version 2 of the Medicaid Information Technology Architecture (MITA) of the Centers for Medicare & Medicaid Services (CMS). MITA is a national framework to support improved systems development and healthcare management for the Medicaid enterprise. Through MITA, CMS has clearly articulated a vision to transform Medicaid from a program focused on transactions to one that effectively manages, mines and exchanges information to improve healthcare outcomes (Figure 1).

Figure 1. MITA Maturity Model



Each level is further refined by various qualities, such as timeliness, accuracy and efficiency.

Advancement along the MITA maturity path will require that payers, providers and patients share a common vision for working together and sharing responsibility to improve health. Providers must spend less time billing and more time delivering evidence-based care supported by systems that reduce errors and promote quality. Payers must spend less time processing bills and more time providing feedback and information on care and health to both providers and patients. Patients must take ownership of their health, participate in care decisions and help drive the healthcare system to greater efficiency and effectiveness.

Although there are deep political divisions on how best to drive change, we see healthcare consumers, providers and payers beginning to coalesce around a desire for collaboration; for shared information and responsibility; for improved care and outcomes; and for the promotion of wellness and prevention.

Fundamentally, the challenges before us are not technology-oriented or driven. The acceleration of technological advances in the past decade gives us confidence that the hardware and software necessary to support change is available now or will emerge as we are ready for it. The most important challenge we face is in reconstructing relationships in the healthcare system – operating outside of siloed organizational charts and working in active collaboration with patients, including the family and community resources on which they depend, and their care providers.

### The future U.S. healthcare system

What kind of future can we envision if we are successful in establishing those new relationships, redirecting our energies and capturing the value of new technology? We will see change in many critical dimensions of the healthcare system, which will increase consumer involvement and satisfaction:

- **A range of choices for healthcare insurance.** Consumers will choose from a variety of options to cover their healthcare costs and protect themselves against risk. They will have opportunities to customize benefits, cost sharing, provider networks and financial exposure to suit their individual and family circumstances. Trusted advisers in the family and community will play key roles in assisting and advocating for patients as they enroll and make care choices.
- **Multiple entry points into care and consultation.** Consumers will utilize different channels into the healthcare system. Someone feeling ill might go to a clinic set up in a local retail store for a quick consultation and blood pressure reading, or schedule an appointment with his or her regular physician. Appointment requests will be made online through a text message or video feed from a personal computer or handled by a sophisticated interactive voice response (IVR) telephone system that also delivers customized information and education. Biometric scans, magnetic stripe cards and personal ID numbers will validate identities.
- **Electronic practice environments.** Practice settings increasingly will use automated processes to manage appointments, communications and recordkeeping. Physicians will have tools to automatically feed data into work and documentation streams. They will enter menu-driven and free-form data using both a keyboard and image capture to document patients' physical conditions and complaints. Instrumentation readings and images will be captured automatically. Physicians might be alerted to potential treatment options based on test results and prior readings, family and personal history, evidence-based clinical protocols, or standardized state population health results (for example, 80 percent of individuals with similar profiles were successfully treated using a combination of diet, exercise and a certain class of medication). After a patient and physician choose a course of treatment and referrals, care instructions and education will be transmitted to the patient's e-mail address and into an individual health record. Prescriptions will be electronically transmitted to the local pharmacy of the consumer's choice to be filled by mail or in person.
- **Virtualization of care.** Outside the four walls of a physical provider setting, patients and providers will interact virtually to exchange information and limit the need for physical presence. Patients will take their own blood pressure readings or test insulin levels using remote devices and transmit them to personal health records and to payers and providers. Alerts will be generated if readings indicate concern. Phone, e-mail, text messages and the Internet will be used to communicate about issues or concerns. For patients in remote rural areas

and those with specialized needs, Webcams, kiosks and other telemedicine tools will be available for virtual consultations and discussions with providers; such consultations will be mediated, if necessary, by trusted advisers in the community and family.

- **Personalization of information, care and benefits.**

Just as a video rental company warns us that a movie is about to be overdue, a patient who hasn't picked up a new medication after 24 hours will receive a communication (phone, e-mail, text message, as preferred) reminding him or her it is ready. Notice will be provided that new information is waiting in the patient's health record or e-mail inbox about local health groups focused on managing certain conditions or on relevant clinical trials. The patient's payer will communicate benefit information changes. For example, a patient with a family history of high blood pressure and heart disease, genetic markers increasing heart disease risk, and three recent high blood pressure readings might be offered enrollment in a new program that encourages proper management of the condition. Some benefits that may not be considered traditional healthcare services - such as nutrition counseling, gym membership and support groups - will be offered, because they promote healthy lifestyles, with patients able to sign up through their health record or a Web portal.

- **Incentives for better health decision-making.**

Patients, payers and providers will share in the rewards of optimizing healthcare treatments and decisions. Compliance with prescribed treatment or participation in weight-loss, stop-smoking and other wellness programs will enhance quality of life by improving health and providing financial rewards for members. Providers and payers will share in the cost savings from delivery of optimal care through pay-for-performance programs.

- **"Always connected" healthcare community.**

Information on health, wellness, treatment options and provider performance will be organized and accessible through social networking sites, Web portals and search engines.

- **Consumers confident in the protection of data.**

Continued vigilance and protection against identity theft are absolute essentials in this market. At the same time, just as they confidently use ATMs and online banking today, all parties will develop trust in the security and privacy of the information exchange. Use of biometric and other technologies to validate identity will promote consumer confidence and control.

- **Integration of clinical and financial systems.** The electronic system that has captured all the clinical services, activities and results from an office visit will automatically convert those data points into a defined payment request. The request will be posted and routed based on predefined preferences and insurance coverage, and electronic payment back to the provider will occur in real time.

The vision of a healthcare system that puts the patient at the center and uses information to control costs and improve outcomes has been widely articulated by industry participants, analysts and academicians.<sup>3</sup> Still, the transformation discussion should proceed with full acknowledgement of the challenges involved - a multiplicity of stakeholder interests and incentives, the economic and cultural costs of change, the fragmentation of the healthcare system, and the substantial intersection and interaction of public and private organizations involved in the financing, oversight, regulation and delivery of healthcare.

### Exploring The 360-Degree Healthcare Continuum

Both public and commercial healthcare payers must assume leadership in promoting and managing change. For government healthcare programs such as Medicare, Medicaid and the State Children's Health Insurance Program, complex political environments complicate the challenge. Nonetheless, we believe it is imperative that these government programs not only embrace the change agenda but help shape and lead it. The beneficiaries they serve - often the most vulnerable in our society - have the most to gain.

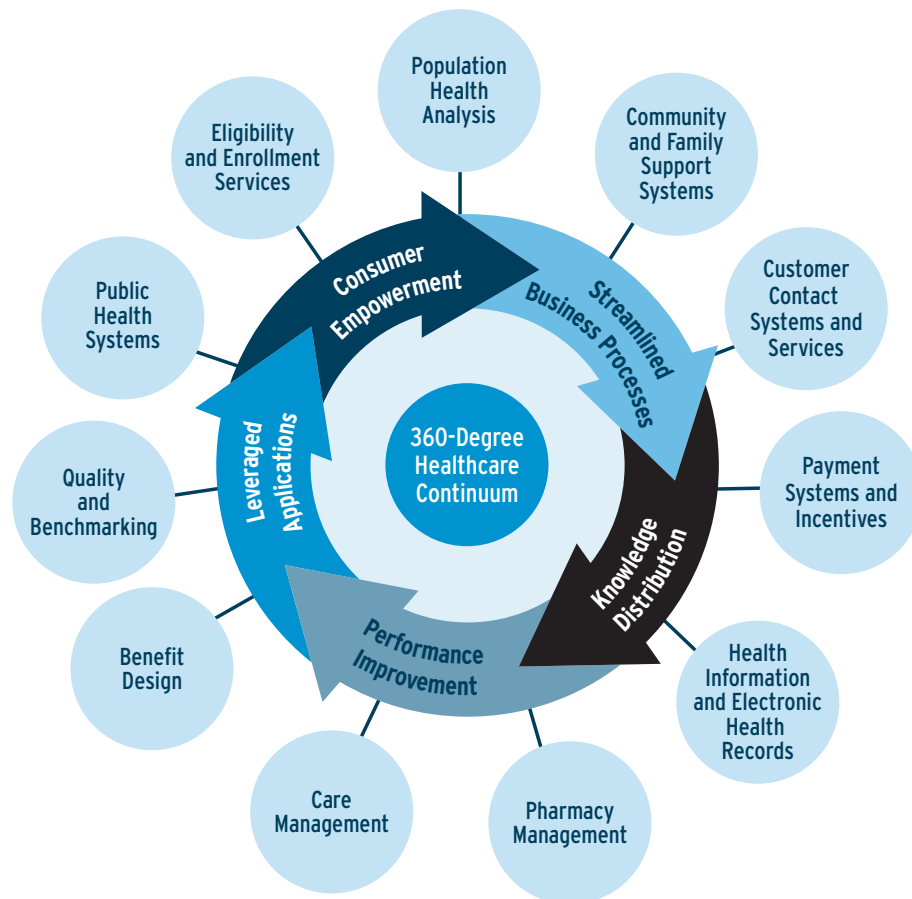
In leading change, government programs must keep a number of moving pieces working effectively together, deliver measurable results, manage the intersection of public and private interests, stay flexible and take appropriate risks. Most importantly, government must set priorities or risk implementation failures, communication breakdowns and lack of stakeholder trust. We believe the potential for innovation, impact and breakthrough return on investment is greatest when we focus on achieving progress through these methods:

- **Improving the distribution of knowledge:** Turning data into information and information into knowledge for use by consumers, providers and payers
- **Consumer empowerment:** Giving patients and their families and advocates the knowledge and ability to make choices

- **Performance improvement:** Working in collaboration with patients and providers to promote safety, quality and value
- **Streamlined business processes:** Deconstructing the way we do business to reduce administrative costs and effort, and promote efficiency and effectiveness
- **Leveraged, modernized infrastructure and applications:** Using the investments we make to support multiple reuse by a variety of stakeholders and programs, and to reduce the costs and maximize the value of modernization

These five keys to progress lie at the core of *The 360-Degree Healthcare Continuum* (Figure 2). The Continuum expresses the need for solutions and services in the health and human services field to contribute to, and then receive value from, the advances we seek.

Figure 2. *The 360-Degree Healthcare Continuum*



## Healthcare Solutions and Services

### Population Health Analysis

Interpreting and shaping claims and clinical data enable us to identify gaps in care, predict future care needs and costs, and assess the impact and relative value of services. Predicting which groups or individuals will drive costs in the future is a key to managing costs and focusing program efforts for the greatest benefit.

### Community and Family Support Systems

A beneficiary's community and family provide social, financial, emotional and physical support, and assistance to patients in need. In effect, these resources act as extensions to the public enterprise, whether in providing direct care in a family home, conducting outreach and education around health and other living challenges, or actually taking on responsibilities to advocate for and interact with other parts of the enterprise on behalf of the beneficiary.

### Customer Contact Systems and Services

These systems and business processes provide the enterprise a direct line of communication with beneficiaries, providers and other stakeholders. They represent the face of the enterprise and provide an avenue for all types of information, in multiple forms, on subjects such as eligibility, program features, payment, administrative controls and requirements, rights and responsibilities, clinical care, and education and resources.

### Payment Systems and Incentives

Payment and financial systems include all the ways in which providers are reimbursed for care, and all the supporting elements necessary to enable accurate payment according to program rules (such as coding and editing, risk adjustment, pay for performance, technology incentives, and payment integrity). Also included are those financial obligations assessed on beneficiaries (in the form of premiums, deductibles and cost sharing) or in limiting risk exposure (limits on coverage) and payment obligation on behalf of the insurer.

### Health Information Exchange and Electronic Health Records

This arena represents the secure, confidential information exchange and presentation of personal, financial, clinical and other data among a beneficiary's trusted network of caregivers, providers and payer.

### Pharmacy Management

Because of the importance of pharmaceutical treatment in the health system, payers have focused special attention on solutions that help them negotiate and manage price, coverage terms, product selections and utilization.

## Healthcare Solutions and Services

### Care Management

Payers must ensure they pay only for medical necessary care, while promoting wellness and health habits in covered populations. Tools available to meet these goals include applications and services to manage chronic illnesses and promote wellness. Utilization review helps ensure appropriateness of care and conformance to coverage rules.

### Benefit Design

Public insurance programs must respond to legislative direction and are sometimes required to quickly make substantial changes in program direction or approach. Public programs must produce budgets and allocate resources consistent with legal guidance, court orders and authority. Commercial payers have long offered multiple products to their members, and government payers are now providing similar choices in their portfolios, including managed care options, custom programs for specific populations and patient profiles, premium support programs, and traditional fee-for-service programs with varying levels of coverage and focus. Within those parameters, programs also exercise administrative discretion to interpret and operationalize benefit structure and design.

### Quality and Benchmarking

Payers participate in and drive the collection and reporting of data to assist providers in improving the safety and quality of the care they provide, in ensuring adherence to clinical standards and best practices, and in reporting data to the community. Government also acts in these arenas, outside of its role as payer, in facilitating improvements and reporting within the healthcare delivery system.

### Public Health Systems

At both the federal and state levels, governments collect, analyze and monitor public health data, organize responses to threats, provide education and training, and deliver care.

### Eligibility and Enrollment Services

Solutions and services in the dimension of eligibility and enrollment include outreach and education to potentially eligible populations, collection of information to support enrollment and determinations, and provisioning of identification cards.

## Knowledge distribution

Today's healthcare system can be characterized as data rich but information poor due to dispersion, limited context, lack of timeliness and presentation problems. Payers see data on encounters and claims data but lack detailed clinical or beneficiary information. Providers see information relating to their own direct patient encounters but do not have easy access to a patient's full history. Patients have limited information on their own care and services.

Beyond the obvious problem of data dispersion, there is often a lack of context. Standards and analytics to support understanding of how patient care compares to clinical guidelines, or to analyze and predict potential risks and outcomes based on conditions and treatment decisions, may be inadequate or nonexistent.

On a population basis, we haven't yet harnessed the power of data in systems to look at groups of individuals and patients to understand a population's health challenges or the outcomes from interventions. In those instances where data is consolidated, analyzed and put in context, it often lacks the timeliness to promote effective action and improve decision-making in the course of patient care.

Even when those problems are solved, knowledge may not be presented in a form and manner that allows easy access and understanding by patients, providers or payers. Too much effort is required to access the information or to sift through it to find the pieces of interest and relevance to a particular user.

Solutions that can help solve these challenges will return dollars to healthcare payers by eliminating costs associated with avoidable hospital admissions, suboptimal care, and unnecessary and redundant services. In this last category alone, savings estimates are substantial. One estimate, for example, places the cost of unnecessary high-tech imaging at \$16 billion.<sup>4</sup> Other research suggests that information exchange between providers and laboratories could save almost \$32 billion in elimination of duplicative and unnecessary tests.<sup>5</sup>

### Eligibility and enrollment: It can be more than just getting people on the rolls

Eligibility and enrollment activities traditionally focus on administrative requirements such as determining income levels, verifying Social Security numbers and issuing member IDs. In *The 360-Degree Healthcare Continuum*, the intake process can be the first step in collaborating with beneficiaries around their care needs. For example, at enrollment, a participant receives a health risk assessment that identifies a problem such as asthma or diabetes. This information is populated into an electronic health record. A care management or health education program is initiated. And the participant is enrolled in a health education program for the condition.

## Consumer empowerment

Consensus is growing among health system experts that healthcare consumers should take greater control of health decisions and care in several ways:

- Take steps to maintain and improve their own health
- Drive the market to greater price and service sensitivity
- Make choices about insurance coverage and care to maximize their financial and personal well-being in light of health needs and status, cultural and personal preferences, community resources and environment, risk tolerance, and health history
- Drive delivery models for care, expressing preferences for the social and medical services needed to keep them in their homes and communities rather than in more expensive settings

However, serious challenges stand in the way of unleashing consumer power in the healthcare marketplace. These hurdles, which are particularly evident in government healthcare programs such as Medicare and Medicaid, include the following:

- Giving consumers adequate information they can absorb and use in navigating a complex healthcare delivery system
- Providing appropriate support to consumers in finding and accessing quality care and services
- Balancing personal responsibility and accountability with the need to support and maintain access to care and quality of life
- Providing sufficient flexibility and choices to patients so they can customize medical and social support systems to their personal circumstances and conditions
- Promoting prevention and healthy lifestyles when changes in economic conditions, living arrangements, employers and insurance offerings cause consumers to enter and leave different provider networks and plans
- Promoting consumerism in a multicultural, multiliteracy level, multiage and multiability environment

Solutions that help address these problems can return dollars to healthcare payers by reducing unnecessary or inappropriate healthcare consumption and redirecting patients from more expensive to less expensive care settings.

Although turning to healthier behavior and self-care might actually increase total costs in the healthcare systems as people consume healthcare resources over longer lifetimes, the economic impact can be offset by more productive and higher quality of life, as well as redirection of healthcare investments from treatment for avoidable injury and illness.

## Performance improvement

Payers historically have focused their efforts on individual financial transactions with providers and beneficiaries. Key questions they have asked have revolved around what price to pay for a service and what services are covered.

To the extent that payers have focused on the appropriateness of care, this emphasis has been more closely linked to utilization review than to optimizing a patient's care program in light of his or her medical needs and circumstances. To the extent they have focused on efficiency, the emphasis has been more on price and quantity controls than on ensuring best value.

Care management programs that include predictive modeling and effectively engage providers and beneficiaries can have positive impact on costs and outcomes by helping providers identify patients with the highest risks and biggest gaps in care. Payers and providers can then collaborate to address the highest-risk, highest-cost patients, benefiting all parties.

Delivering the right care to the right patient, at the right time, by the right provider is a key to controlling costs and improving outcomes. Payers that act as information brokers and data stewards can differentiate themselves through a focus on patient health and well-being and active cooperation with providers and beneficiaries.

Today's healthcare system also fails to reward the highest-performing providers adequately and to effectively address low-performing providers. Payment controls (price or utilization) can actually perpetuate this imbalance. Providers who deliver high-quality, effective patient interventions can find themselves receiving fewer financial rewards than those who provide a higher volume of services but with suboptimal patient outcomes.

Solutions that can help improve the performance of the healthcare system will deliver returns in the form of better cost and care management in serving seriously ill, high-risk patient populations, as well as improved outcomes from the delivery of more timely, high-quality care.

Vulnerable populations suffering from chronic conditions may particularly benefit from active care management and early intervention. A study by the Agency for Healthcare Research and Quality found that individuals in lower-income communities were significantly more likely to be hospitalized for preventable causes, including diabetes, hypertension and asthma.<sup>6</sup>

### **Streamlined, standardized business processes for providers and beneficiaries**

As noted above, payers must view themselves as operating in partnership with providers who actually deliver high-quality, appropriate care to their insured populations. And they must work in conjunction with their target populations to ease entry into and facilitate use of the resources available to support their health.

As part of this equation, payers must ensure their business processes and systems do not introduce unnecessary tension or complexity for providers and beneficiaries. Providers may not want to participate in government programs because payments are not set at a level they consider adequate, or because the populations covered by government programs are seen as particularly difficult to serve or manage. Plus, administrative complexity, specialized requirements, paperwork demands and claims auditing procedures can be as much of a deterrent to participation as payment rates or patient compliance issues.

For beneficiaries, the challenges of enrolling in programs, understanding and evaluating coverage and care options, and absorbing and acting on information can be overwhelming. Families in government-funded state programs must navigate complex eligibility requirements and numerous program rules to access coverage to which they are entitled.

Efforts to improve partnership between payers and providers should include the following:

- Moving government programs to business and technology industry standards
- Creating better, more convenient methods for communicating and sharing information
- Reducing paperwork
- Employing sophisticated tools to focus on unscrupulous and fraudulent providers, while easing burdens on legitimate and honest providers

Streamlining processes and systems that assist families and individuals in applying for and receiving accurate eligibility determinations, as well as enrolling those families in appropriate plans, will allow for earlier engagement with beneficiaries with regard to health and wellness.

Reengineering business processes and supporting technology to make engagement with providers and beneficiaries more efficient, convenient, understandable and collaborative will increase provider participation rates, reduce inappropriate expenditures and unnecessary costs, improve uptake in enrollment of eligible populations, and improve program integrity.

A small example of streamlining and automating business processes indicates the potential savings in efficiency from changes in how payers and provider interact. In about 60 percent of all U.S. healthcare claims payments, payers print and mail checks to the providers, which manually reconcile the claims and deposit the checks. With an annual volume of 2.5 billion claims payments, the majority reimbursed by check, the system costs \$15 billion to \$20 billion a year in postage, item processing and accounting. Increasing the rate of electronic penetration to 90 percent from the current 40 percent would save \$6 billion or more across the industry.<sup>7</sup>

### Leveraged, modernized infrastructure and applications

In our current healthcare system, commercial and government payers, as well as providers, operate in competitive silos with duplicative infrastructure. In contrast, a shared services or utility environment with systems leveraged to benefit a larger community could help achieve these results:

- Spread technology adoption to those with limited resources
- Leverage sunk costs to free up future revenue streams for more productive uses
- Drive investment dollars to best performing units of experience and expertise
- Reduce contract and program management costs

Enterprisewide applications and infrastructure approaches also eliminate duplicative effort that does not contribute to innovation and competitive differentiation in the marketplace.

We expect to see unique partnerships begin to emerge in the healthcare market among commercial and government payers and within state agencies for the shared use of applications and infrastructure for common work elements (document management case coordination, intake and referral, etc.). Solutions that can help solve these challenges will reduce investment and capital expenditure for payers, as well as ongoing administrative expense.

We also see significant opportunity for payers to drive service improvement, efficiency and effectiveness through the modernization of legacy applications. The U.S. healthcare system is heavily dependent on decades-old applications that are expensive to maintain and difficult to change, and the work force with knowledge needed to maintain them is aging rapidly. As new technological advances rapidly become available, the rework necessary to integrate old and new systems adds more complexity. This situation is of grave concern to government payers anticipating a significant surge in demand, expectations and sheer numbers as the baby boom generation ages into eligibility for Medicare and Medicaid.

Solutions that can help address these problems will return investment to payers through reduced maintenance costs, less time between policy changes to implementation, easier plug and play to new technologies, and cheaper upgrades.

### The path ahead for government payers

So where are we in the journey to *The 360-Degree Healthcare Continuum*? As we view the landscape in the context of the five keys to progress, we can see ways in which government payers can work within a total healthcare system framework to drive significant advances. We might envision that maturity path as having the stages and characteristics reflected in Figure 3 below.

Figure 3.

	Current Stage	Next Stage	End Stage
Knowledge	Disorganized	Accessible	Embedded
Consumers	Affected	Active	In control
Performance	Variable	Improved	Optimized
Administrative	Complex	Simplified	Automated
Systems and Applications	Rigid, siloed	Flexible, componentized	Shared

In assessing where to make business and technology investments, government payers should explore solutions in the 11 capability realms of the continuum that achieve the following:

- Support demonstrable progress in the five focus areas, with the understanding that leading solutions may support directional progress in more than one arena
- Are consistent with and support the overall market direction, including industry standards
- Allow for continual refresh and integration with new products and capabilities in the private sector
- Provide flexibility as future healthcare financing and delivery decisions are made on the national and state levels

### **Realizing tomorrow's healthcare system**

Government payers operate in a complex, fragmented, organizational, political, economic and cultural environment. Because of this, change and progress will necessarily come in fits and starts subject to competing demands, interests and concerns of disparate stakeholder groups. The transition may significantly strain government leadership and systems. However, by working to address the priorities outlined here: knowledge distribution, consumer empowerment, performance improvement, streamlined business processes and leveraged, modernized infrastructure and applications, states can lead the way. By applying the framework of *The 360-Degree Healthcare Continuum*, states can be in the forefront of transforming U.S. healthcare to a value-driven, integrated enterprise.

---

## Notes

- 1 "Learning from High Performance Health Systems Around the Globe," Karen Davis; The Commonwealth Fund, January 2007; [http://www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=441618](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=441618)
- 2 U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services, National Health Expenditure Projections 2007-2017, <http://www.cms.hhs.gov/NationalHealthExpendData/>
- 3 For example, the Center for Healthcare Transformation has talked about a transformation of today's disease-focused, paper-intensive, knowledge-disconnected, process-oriented and price-oriented system to a prevention focused, electronic, outcomes-focused, knowledge-rich, and value-focused system. ("Paper Kills: Transforming Health and Healthcare with Information Technology," edited by David Merrit, Center for Health Transformation, [http://www.healthtransformation.net/cs/paper\\_kills\\_info](http://www.healthtransformation.net/cs/paper_kills_info)). Lynn Etheredge and others have spoken of the need to use the data representing current services and outcomes being delivered in the healthcare system today as a vast natural experiment from which we can draw and distribute knowledge about the healthcare outcomes. (*Health Affairs*, 26 No. 6 (2007), Technologies of Health Policy)
- 4 "Right Image, Right Time," Gregg Allen, M.D.; *Health Management Technology*, April 2007; [http://www.healthmgttech.com/features/2007\\_april/0407right\\_image.aspx](http://www.healthmgttech.com/features/2007_april/0407right_image.aspx)
- 5 "The Value of Healthcare Information Exchange and Interoperability," Jan Walker, Eric Pan, Douglas Johnston, Julia Adler-Milstein, David W. Bates, and Blackford Middleton; *Health Affairs*, January 2005; <http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.10/DC1>
- 6 U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project, Preventable Hospitalizations Fact Book, [www.ahrq.gov/data/hcup](http://www.ahrq.gov/data/hcup)
- 7 "Overhauling the U.S. Health Care Payment System," Nick A. LeCuyer and Shubham Singhal, *The McKinsey Quarterly*, June 2007.

## ABOUT THE AUTHOR

### **Penny Thompson**

Penny Thompson is the director of Government Health and Human Services Strategy and Portfolio for EDS. She provides forward-looking strategic and solution direction for EDS' substantial book of business in the government health and human services market, particularly focusing her attention on electronic health records, medical management, informatics, eligibility and program integrity. In this capacity, Thompson works closely with federal and state clients and accounts.

Thompson has 20 years of direct experience within government, working on Medicare and Medicaid program issues, including more than 12 years in the U.S. Department of Health and Human Services. She previously served as deputy director and acting director for the Center for Medicaid and State Operations in the Centers for Medicare and Medicaid Services and director of Program Integrity for CMS. She has held senior management positions at the U.S. Department of Health and Human Services' Office of Inspector General, where she conducted program and organizational evaluations on Medicare and Medicaid programs.

## Contact us

### EDS Headquarters

5400 Legacy Drive  
Plano, Texas 75024  
USA  
1 800 566 9337

### EDS Regional Headquarters

#### Asia

36F, Shanghai Information Tower  
211 Century Avenue  
Pudong  
Shanghai, SHA  
China 200120  
86 21 2891 2888

#### Australia & New Zealand

Level 1, The Bond  
30 Hickson Road  
Millers Point  
New South Wales 2000  
Australia  
612 8965 0500

#### Canada

33 Yonge Street  
Toronto, Ontario  
M5E 1G4  
Canada  
1 416 814 4500  
1 800 814 9038  
(in Canada only)

#### Europe, Middle East & Africa

2nd Floor  
Lansdowne House  
Berkeley Square  
London W1J 6ER  
44 20 7569 5100

#### Latin America

Estrada Samuel Aizemberg, 1707  
Tower C - 4th Floor  
São Bernardo do Campo, SP  
Brazil 09851-550  
55 11 4399 8875

### HP Worldwide Corporate Headquarters

3000 Hanover Street  
Palo Alto, California 94304-1185  
USA  
1 650 857 1501

## About EDS

EDS, an HP company, is a leading global technology services provider, delivering business solutions to its customers. EDS founded the information technology outsourcing industry more than 46 years ago. Today, EDS delivers a broad portfolio of information technology, applications and business process outsourcing services to customers in the manufacturing, financial services, healthcare, communications, energy, transportation, and consumer and retail industries, and to governments around the world.

EDS and the EDS logo are registered trademarks of Hewlett-Packard Development Company, LP. HP is an equal opportunity employer and values the diversity of its people.  
© 2008 Hewlett-Packard Development Company, LP. 09/2008 rev 11/2008 8GCPH1220

