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Reimagining Utilization Management

# **Amplifying Human Expertise** with Automation and AI

# Table of **Contents**



# Introduction

## DEFINITION OF UTILIZATION MANAGEMENT

Utilization Management (UM) in healthcare is a collaborative process between payers and providers to assess the necessity and efficiency of medical services.

It aims to ensure patients receive appropriate, timely, and cost-effective care. By aligning treatments with established guidelines, UM enhances patient outcomes while controlling healthcare costs. In an era of rising expenses and increasing demand for quality care, effective UM has become indispensable.

## IMPORTANCE OF UTILIZATION MANAGEMENT IN HEALTHCARE

Utilization management is essential in today's healthcare landscape for several critical reasons. First and foremost, it fosters evidence-based decision-making, ensuring that treatments are clinically necessary, as well as aligned with the latest research and guidelines. This alignment improves patient outcomes by reducing the risks of unnecessary procedures or medications, enhancing safety and quality of care.

Further, effective UM addresses the pressing issue of cost containment within the complex American healthcare system. As healthcare expenditures continue to rise, UM is a proactive strategy to identify inefficiencies and eliminate wasteful practices. By prioritizing necessary care and discouraging needless interventions, UM helps mitigate the burden on payers and providers alike.

UM also effectively enhances communication between payers and providers, building collaborative relationships aimed at the shared goal of patient well-being. In an era of value-based care, where the focus is on improving patient outcomes while managing costs, utilization management processes are essential. Navigating today's challenges requires both parties to embrace a collaborative approach, leveraging UM as a vital tool to drive efficiency, enhance patient experiences, and deliver higher-quality care.

# Overview of Current Pressures Facing **Healthcare Stakeholders**

The healthcare landscape is marked by a litany of pressures impacting both payers and providers. One of the most pressing challenges is the rising cost of care, which has escalated dramatically over the past decade. According to the Centers for Medicare & Medicaid Services, national health expenditures are projected to exceed $5 trillion for the first time in 2024, rising to $7.7 trillion by 2032 (CMS, 2024). This financial strain puts immense pressure on payers to control costs while maintaining adequate coverage and access for patients.

Providers frequently find themselves caught in the crossfire of these funding challenges, often facing reduced reimbursement rates from payers. This trend has led to an increased reliance on utilization management strategies as providers strive to maintain their financial viability without compromising care quality. According to the American Medical Association, Medicare payments have declined by 26% from 2001 to 2023 when adjusted for inflation, impacting physicians' ability to provide timely care, and increasing wait times for patients (AMA, 2024).

In addition to cost pressures, the ongoing shift toward value-based care necessitates a recalibration of care delivery models. As provider accountability shifts from the number of services provided to patient outcomes, the need for data-driven decision making becomes critical. However, many healthcare systems struggle with integrating the necessary technology and analytics capabilities.

Moreover, regulatory demands and administrative burdens add to the challenges experienced by both payers and providers. The increase in prior authorization processes has faced criticism because it often delays necessary treatments, increasing the possibility of negative patient outcomes. According to a survey by the American Medical Association, nearly one in four physicians report that prior authorization has led to a serious adverse event for a patient, including hospitalization, permanent impairment, or death (AMA, 2024).

These pressures underscore the urgent need for innovative solutions in utilization management to balance the integrity of patient care with the realities of a strained healthcare system. Addressing these challenges requires a concerted effort to foster collaboration and leverage data-driven insights for sustainable healthcare practices.

# Understanding the Pressures **in Utilization Management**

## INCREASED REGULATORY REQUIREMENTS

Regulatory requirements heavily influence the healthcare landscape, which directly impacts both payers and providers. These regulations, designed to safeguard patient care and ensure financial accountability, have become more stringent, creating added pressure on stakeholders to adapt. Notably, the Interoperability and Patient Access final rule by the Centers for Medicare & Medicaid Services (CMS, 2020) mandates the sharing of patient data to improve transparency in care delivery. This operational shift requires providers to invest in technology and training to meet the new standards, complicating their existing workflows and potentially diverting resources from direct patient care.

Compliance with state and federal mandates involves intricate processes and documentation practices that can overwhelm healthcare teams. For instance, regulations surrounding prior authorization have been tightened, leading to increased scrutiny of treatment plans before approval. Failure to comply with these regulations can lead to severe consequences, including financial penalties and reduced reimbursement rates.

According to a survey by the American Medical Association (AMA, 2024), more than **90% of physicians** reported that prior authorization delays access to necessary care, **significantly** impacting patient outcomes and increasing liability.

Physicians spend **16 hours** per week on paperwork and administrative duties (AMA, 2024).

Striking a balance between stringent documentation requirements and the need for **efficient care delivery** remains a critical challenge in the ongoing evolution of UM.

## Administrative Burden of Utilization Management

The administrative burden associated with utilization management presents significant challenges for healthcare providers, particularly in the context of manual, time-consuming processes. These processes often require extensive coordination between multiple stakeholders, including payers, care teams, and administrative personnel. Whether it's the manual entry of treatment authorization requests or the back-and-forth communications required for clarifications, these activities consume valuable hours that could otherwise be dedicated to patient care.

The problem of excessive paperwork compounds this issue, leading to inefficiencies and delays in patient care. Healthcare providers are often burdened by heavy documentation requirements mandated by regulatory bodies and payers. This burden is exacerbated by frequent requests for clarification from UM departments, which require physicians to justify extended stays or specialized care (such as ICU placement). These clarifications must be added to patient notes, ensuring proper documentation to prevent future claim denials and secure payment from payers. This cycle of documentation, clarification, and additional note taking not only diverts resources from direct patient interactions, but also increases the likelihood of errors and misunderstandings throughout the review process, further delaying care delivery and complicating the UM workflow.

## Rising Healthcare Costs

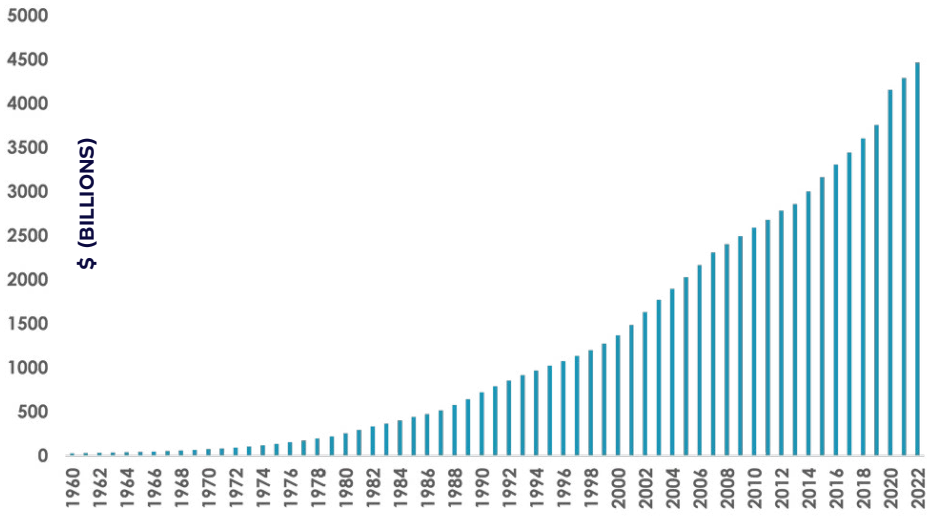
The escalating cost of healthcare in the United States exerts significant pressure on utilization management practices for both payers and providers. Several factors contribute to this upward trajectory, including the increasing prevalence of chronic diseases, advances in medical technology, and rising pharmaceutical prices. As the population ages and chronic illness grows, the demand for healthcare services naturally follows the same path, prompting an urgent need for more effective resource management. This presents a daunting challenge for healthcare systems already grappling with tight budgets and constrained reimbursement models.

For payers, the rising costs impose a dual challenge: ensuring sustainable financial practices while maintaining accessibility and quality of care for their members. Insurers are compelled to implement stricter UM policies to control expenditures, often resulting in greater scrutiny of treatment plans and necessitating pre-authorization for a wider range of services. Such policies create hurdles for providers, often disrupting treatment continuity and patient satisfaction.

On the other hand, providers are facing rising operational costs and tighter reimbursement rates. With the need to invest in advanced technologies and robust administrative infrastructures to comply with emerging regulations, many healthcare facilities find their profit margins increasingly squeezed. This financial strain may discourage providers from accepting certain insurance plans or accepting new patients, leading to further complications in patient access. Addressing the pressures stemming from rising healthcare costs is essential, as it affects organizational viability and has profound implications for patient outcomes.

**The Cost of Healthcare** in the US

Centers for Medicare & Medicaid Services, 2024



## Evolving Patient Expectations in a Value-Based Care Landscape

In the U.S., the average wait time for a primary care visit is approximately 20.6 days.

(Schibell, N., Wilson, K., 2024)

As healthcare shifts towards value-based care models, patients increasingly expect not only high-quality treatment, but also a personalized and accessible experience. Today's informed and proactive patients require a different approach to care delivery. They demand transparency in treatment options and expect their input to be considered in care planning. This is especially important in chronic disease management, where tailored solutions lead to better outcomes.

Accessibility is a top priority for patients. Long wait times for authorizations or treatments can cause frustration and disengagement, undermining the patient-centered principles of value-based care. For example, in the U.S., the average wait time for a primary care visit is approximately 20.6 days (Schibell, N., Wilson, K., 2024). This wait time can vary significantly across regions, with some areas experiencing even longer delays. Such prolonged waits can lead to decreased patient satisfaction and poorer health outcomes, as patients may experience anxiety and worsening of their conditions while waiting for care. Healthcare providers face challenges, such as staffing shortages and outdated technology, further contributing to delays.

**PATIENTS RECEIVE INPATIENT LEVEL CARE IN AN INPATIENT SETTING**

Utilization management plays a crucial role in determining whether patients are classified under inpatient (IP) or observation status, impacting hospital reimbursement, patient costs, and resource allocation. Providers continually strive to optimize the ratio of IP to observation stays, as improper classification can lead to financial penalties and increased scrutiny from payers. Best practices suggest employing evidence based criteria, such as InterQual and MCG guidelines, to make informed decisions on patient status. For instance, studies indicate that utilizing these criteria can reduce observation rates by up to 30%, ensuring appropriate care while minimizing unnecessary costs (Healthcare Financial Management Association, 2023).

Additionally, regular training and audits can help providers maintain accurate status determinations, supporting compliance and financial performance (American Hospital Association, 2022). Optimizing inpatient versus observation status enhances operational efficiency and patient outcomes while navigating complex regulatory requirements.

## The Two Midnight Rule

as established by CMS in 2013

Inpatient admissions are considered appropriate for patients whose stays cross two midnights. Stays expected to span less than two midnights are considered outpatient or observation status.

# Insights from **the Stakeholders**

## PERSPECTIVES FROM HEALTHCARE PROVIDERS

Healthcare providers face numerous challenges when implementing utilization management practices, primarily due to the balance required between administrative efficiency and quality of patient care. Providers often express frustrations regarding the stringent pre-authorization processes that delay necessary treatments. This sentiment reflects a broader concern about administrative burdens distracting healthcare professionals from patient-centered care.

Despite these challenges, many providers have successfully adopted strategies that streamline their UM processes and enhance patient satisfaction. One such innovative practice is the use of electronic prior authorization tools. These tools streamline operations by reducing manual workloads and minimizing the time spent on administrative tasks. By automating the authorization process, healthcare providers can ensure quicker communication with insurers, reducing delays in care provision and improving overall patient satisfaction.

The integration of technology in UM has broader implications for patient care and provider relationships. For instance, automating the authorization process not only expedites service delivery, but also enhances the accuracy of patient data management. This precision helps in reducing medical necessity denials and ensures that patients receive appropriate care levels promptly.

Additionally, aligning goals with payers creates a collaborative environment that prioritizes patient outcomes. Regular meetings and shared data analytics help minimize unnecessary hurdles while ensuring high-quality care. Not only do these strategies benefit patient care, but they also support providers in mitigating burnout.

## Perspectives from Healthcare Payers

As with providers, payers face significant challenges implementing utilization management strategies, focusing primarily on the balance between cost management and patient access to care. Payers are under intense pressure to control costs while meeting the growing demand for services. Stricter UM policies, aimed at curtailing unnecessary spending, can inadvertently lead to barriers for providers and patients alike.

**58%**

of insured adults have **experienced a problem using their health insurance** in the past year – including claims denials and pre-authorization problems.

**50%**

of those with insurance problems **say the problem was satisfactorily resolved.**

### Of the problems that remained unresolved:

17%

report being unable to receive care.

15%

experienced a decline in health.

28%

paid more than they expected for care.

(KFF, 2023)

**One of the foremost challenges for payers is the need to develop UM practices that are both effective in managing healthcare costs and perceived as fair by providers and enrollees.** For instance, the delays in care accompanying extensive pre-authorization practices often result in dissatisfaction among both providers and patients. Such delays in treatment reflect poorly on a payer's perceived commitment to quality care.

## PERSPECTIVES FROM HEALTHCARE PAYERS, CONT.

To address these challenges, payers have successfully employed collaborative approaches that foster partnerships with healthcare providers. Collaborative UM protocol development and data sharing between payers and providers create refined processes that prioritize patient needs. For instance, an exception-based UM strategy with "gold carding" streamlines pre-authorization by exempting high-performing providers, based on their adherence to evidence-based practices and approval history. Implementing this type of system offers several advantages:

**Operational Efficiency:** By reducing the volume of pre-authorization reviews, administrative overhead is significantly decreased for both payers and providers.

**Enhanced Care Delivery:** The streamlined process minimizes delays in patient care, facilitating more timely interventions and treatments.

**Resource Optimization:** UM teams can focus their efforts on reviewing truly exceptional cases or providers with lower performance ratings, ensuring improved allocation of resources.

**Quality Assurance:** Continuous monitoring and periodic reassessment of provider performance maintains high standards of care and appropriate resource utilization.

This strategic approach mitigates administrative burdens and fosters a collaborative relationship between payers and high-performing healthcare providers, contributing to a more efficient and patient-centered healthcare system.

By leveraging Automation and AI technology to automate aspects of UM and enhance communication channels, payers can not only reduce their operational burdens, but also facilitate access to care. For example, the integration of artificial intelligence to support real-time decision-making during care authorizations can expedite approvals while ensuring compliance with clinical guidelines.

# Solutions for **Effective Utilization Management**

## PART A: AMPLIFYING HUMAN EXPERTISE WITH AUTOMATION AND AI

Modern utilization management allows payers, providers, and patients to realize their healthcare goals by partnering human expertise with digital workers (AI and automation). This transformation begins with a thorough analysis of existing workflows, identifying tasks best suited for digital handling, and recognizing those requiring human judgment. By deconstructing and reconstructing these processes, healthcare organizations can significantly enhance efficiency and decision-making.

### Simplifying the Workflow

After deconstructing and analyzing the workflow, tasks suitable for automation and AI are identified and delegated accordingly. These typically include repetitive manual tasks such as routine documentation and initial case screening. Predictive analytics is employed to identify high-risk patients, enabling timely interventions. Tasks that no longer add value are eliminated entirely.

A regional payer exemplifies this approach in handling prior authorization requests. AI automatically reviews and sorts requests based on clinical guidelines, approving routine cases like maternity care and flagging complex ones for human review. This process ensures that nurses and clinicians intervene only when their expertise is necessary, resulting in timely and accurate medical necessity determinations.

### Integrating Advanced Analytics, AI, and Automation in Decision-Making

The integration of advanced analytics, AI, and automation in UM workflows significantly enhances decision-making. Predictive analytics examines large datasets to identify individuals at high risk for adverse outcomes, such as unexpected hospital readmissions or complications, prompting timely, proactive care interventions like personalized care plans or additional monitoring.

AI algorithms analyze complex patterns within vast datasets, providing real-time insights that assist healthcare professionals in making more informed decisions. This collaboration between human expertise and AI improves outcomes, optimizes resource allocation, and streamlines approval processes, improving the efficiency of UM.

### Reconstructing the Workflow

The reconstructed UM workflow seamlessly integrates automation and AI with human expertise after tasks have been analyzed and simplified. AI-powered systems automatically handle routine tasks, analyze clinical data in real time, and provide evidence-based recommendations to guide decision-making. These systems can approve or deny prior authorization requests for standard procedures like maternity care while flagging complex or high-risk cases for human review. Human professionals, in turn, focus on cases requiring clinical judgment and experience. They perform patient-centered tasks, interpret AI-driven recommendations within patient specific contexts, and make final decisions in challenging or unique cases. This integration allows for efficient resource allocation, with human experts contributing to ongoing process improvements while technology handles repetitive tasks.

## DECONSTRUCT

+ Process discovery workshops, Process mining, and Reverse Demos to **deconstruct** work to tasks - **Why/Who/Where/ When/ How**
+ **Value Analysis** - Leverage Task Mining an AI-powered tool that automatically captures and analyzes user desktop activities.

## SIMPLIFY

+ Identify **parts of the work that is repetitive and time-consuming tasks** suitable for automation and AI.
+ Identify **variability** in the process to standardize
+ **Simplify** the number of steps – No change, New, Delete.

## RECONSTRUCT

+ **Reconstruct the work while offloading elements to automation and AI.**
+ **Workforce Transformation** – Redeploy/Reskill/Upskill
+ **Governance** for a culture of accountability.

**The Role of EHRs in Integrated Transformation**
Electronic Health Record (EHR) systems also play a crucial role in supporting this transformation. EHRs facilitate seamless communication and data sharing among healthcare stakeholders, providing accurate documentation, standardizing data entry, and offering real-time access to patient information. When integrated with AI, data analytics, and intelligent automation, EHRs can further streamline UM operations.

For example, AI algorithms can analyze EHR data to identify high-risk patients and suggest optimal treatment pathways. Automation handles routine tasks like pre-authorization, while predictive analytics uncovers valuable insights to inform UM strategies.

**A Harmonized Approach**
By combining the strengths of human expertise with the power of AI and automation, UM processes become more proactive, efficient, and personalized. Nurses, clinicians, and AI systems work together to ensure that both routine and complex cases are handled appropriately.

**Automation** handles routine tasks like pre-authorization, while **predictive analytics** uncovers valuable insights to inform UM strategies.

## PART B: BEST PRACTICES FOR COLLABORATION

Effective collaboration between payers and providers is essential to UM processes and enhances health outcomes. Building effective communication channels is pivotal in fostering transparency and trust, ensuring both parties remain aligned in their goals of delivering high-quality care.

One effective method to enhance communications is the establishment of regular collaborative meetings. These forums can facilitate open discussions regarding UM guidelines, patient care pathways, and feedback on existing processes. Additionally, integrating technology platforms that allow real-time data sharing can bridge the gap between payers and providers. Such technology can include shared dashboards that display metrics related to patient outcomes, cost-effectiveness, and adherence to treatment protocols, allowing both sides to address concerns proactively.

**When Collaboration Works**
Humana and local healthcare providers launched a collaborative initiative in 2019, focusing on personalized care through an integrated delivery model. This "payvider" approach aligns insurance and healthcare services, enhancing coordination and efficiency.

By sharing patient data, the program developed tailored care strategies, improved care management, and boosted patient satisfaction, demonstrating the effectiveness of strategic partnerships in modern healthcare.

(Fierce Healthcare, 2019)

## PART C: TRAINING AND EDUCATION

Continuing education and fostering a culture of adaptability are critical components for the success of effective UM. Staff must remain abreast of the latest technologies, protocols, and regulatory changes. By investing in ongoing training programs, organizations can ensure that their personnel possess the skills necessary to successfully implement innovative UM strategies. These programs should focus not only on technical competencies, but also on critical thinking, decision-making, and patient-centric care approaches.

Creating a culture of adaptability within healthcare organizations is equally vital. Encouraging a mindset that embraces change can significantly enhance a team's ability to respond to new challenges and technologies with agility. This can be cultivated through regular workshops, seminars, and collaborative projects that expose staff to diverse perspectives and novel problem-solving methods. Leadership plays a pivotal role in this transformation by recognizing and rewarding adaptive behaviors, setting the precedent for a dynamic and flexible organizational ethos.

# Technology Based **Solutions**

## PAYER CASE STUDY:

### Automating Medical Necessity Review Records Search

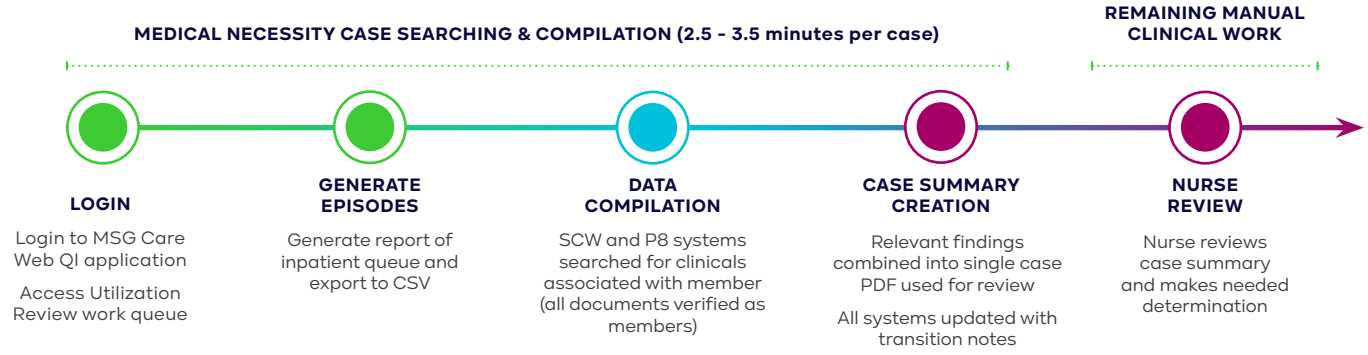
**Introduction** Technological breakthroughs are driving the transformation of the healthcare industry, allowing for unprecedented levels of operational efficiency and effectiveness. Among these advancements, intelligent automation stands out as a game-changer, particularly in addressing the challenges faced by healthcare payers. This case study focuses on the automation of a major healthcare payer's medical necessity review records search, a traditionally manual and time-consuming process, and highlights the substantial benefits of transitioning to an automated solution.

**The Challenge of Manual Medical Necessity Reviews** Medical necessity is a crucial element of healthcare, ensuring that the services provided to patients are suitable and necessary based on their medical condition. However, reviewing medical necessity is often labor-intensive and susceptible to human error. Determining medical necessity requires following strict guidelines and proving the need for specific medical services through comprehensive documentation. For healthcare payers, this means nurses and other clinical staff devote considerable time to compiling and reviewing records from various systems to make informed decisions, leading to inefficiencies and high operational costs.

**The Solution: Intelligent Automation** To address these challenges, a major healthcare provider worked with Naviant Solutions to automate their Medical Necessity Review Records Search process. An unattended bot now performs several critical tasks previously handled manually by clinical staff:

**The automation process significantly reduced the time required for search and compilation to 2.5 to 3.5 minutes per case, compared to the manual procedure, which demanded 16,000 hours of labor annually.**

| AUTOMATION | ANNUAL HOURS SAVED | ANNUAL LABOR SAVINGS |
|---|---|---|
| **70%** | **11,760** | **$847,600** |




### BUSINESS CHALLENGE

Nursing team spending over 16,000 hours annual compiling records needed to make medical necessity determination for inpatient cases.

### AUTOMATION SOLUTION OVERVIEW

Unattended bot logs into needed systems to generate report, analyze outputs, and make appropriate system notes. Medical records are found in numerous systems, compiled, and saved to a single file nurses use to make determinations.

### APPLICATIONS

- **MCG**
- **CSW**
- **P8**
- **MS Excel**

## ADDITIONAL BENEFITS OF AUTOMATION FOR HEALTHCARE PAYERS

### Improved Accuracy

Automation minimizes the risk of human error in medical necessity reviews, ensuring that determinations are based on accurate and comprehensive data. This enhances the reliability of the review process and reduces the likelihood of errors that could lead to claim denials or payment recoupments.

### Enhanced Compliance

With automated processes, healthcare payers can ensure consistent adherence to regulatory guidelines and standards for medical necessity. This reduces the risk of noncompliance and associated penalties, fostering a culture of accountability and precision.

### Future-Proofing Operations

With automated processes, healthcare payers can ensure consistent adherence to regulatory guidelines and standards for medical necessity. This reduces the risk of noncompliance and associated penalties, fostering a culture of accountability and precision.

### Conclusion

The automation of Medical Necessity Review Records Search is a compelling example of how intelligent automation can transform healthcare payer operations. By delivering significant cost savings, efficiency gains, and improved accuracy, automation proves to be an invaluable tool for healthcare organizations.

# Technology Based **Solutions**

## PROVIDER CASE STUDY:

**Saving Time and Costs: The Potential Impact of Automationon Healthcare Admissions**

**Introduction**

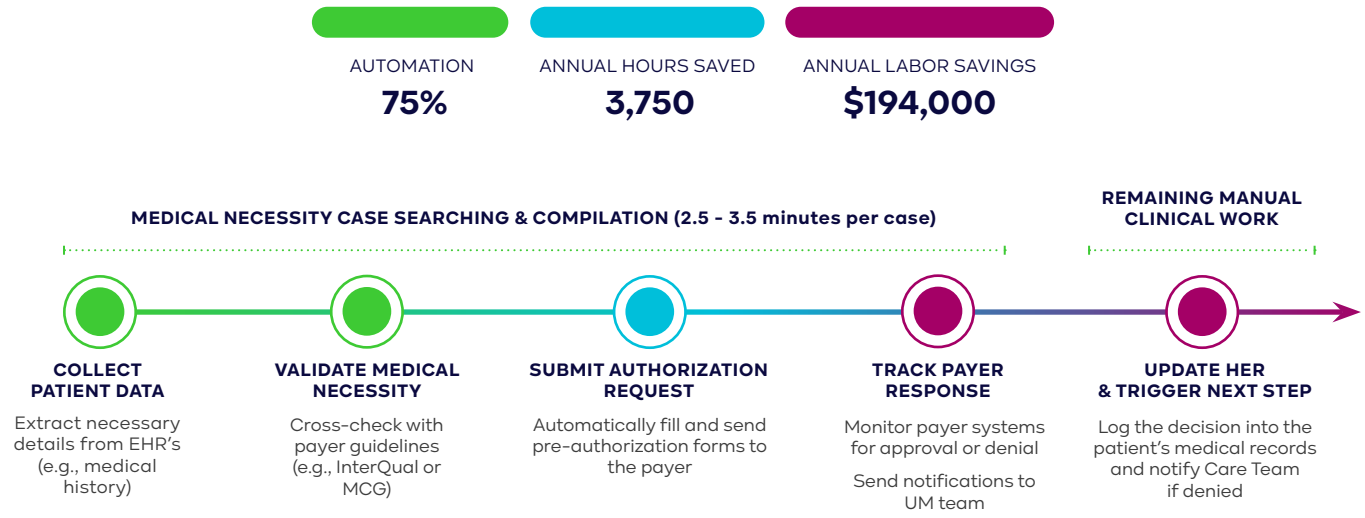
Today's clinical staff face increasing demands, particularly in the domain of hospital admissions. The pre-authorization phase is notably time-consuming, requiring extensive effort and attention. Clinical personnel are tasked not only with the initial submission but also with providing clarifications and supplementary documentation necessary to justify patient admissions. This labor-intensive process can lead to inefficiencies, adversely affecting both patient care and operational expenditures.

**The Challenges in Manual Processes**

The process of securing hospital admission hinges on pre-authorization, which requires thorough attention to detail. Clinical staff must meticulously compile comprehensive medical data, navigate intricate payer requirements, and ensure compliance with regulatory standards. This complex process often necessitates multiple rounds of clarifications and additional documentation, each consuming valuable time and resources. In fact, 52% of physicians report spending 10 or more hours per week on pre-authorizations (Medical Economics, 2023). The manual execution of these tasks leads to delays, errors, and increased administrative burdens, ultimately compromising the quality of healthcare delivery.

**Automation Solution Overview** To address these challenges, an intelligent automation solution should be implemented, incorporating several key technologies and processes:

- Data extraction from EHRs and documents using Document Understanding.
- Form submission using APIs and unattended bots.
- Tracking payer responses with a dashboard and email notifications.




### BUSINESS CHALLENGE

25% of UM team time is spent on submitting authorizations. This process causes delays and administrative bottlenecks, leading to inefficient resource use and patients in observation status longer than ideal.

### AUTOMATION SOLUTION OVERVIEW

Data extraction from EHR and documents using document understanding, form submission using APIs and unattended bots, and tracking payer responses with dashboards and email notifications.

### APPLICATIONS

+ **EHRs** (Epic, Cerner)
+ **Payer Portals** (Optum, Change Healthcare)
+ **Outlook**

## Results

Results from automating this workflow for an organization processing 10,000 annual admissions is expected to be:

+ **Automation Rate**: 75% of the pre-authorization process is automated.
+ **Work Hours Saved:** 3,750 annual work hours saved.
+ **Cost Savings:** $194,000 saved annually.

## Conclusion

The introduction of intelligent automation in the pre-authorization submission process has proven to be a game-changer for healthcare providers. By automating 75% of the process, an organization can expect to save considerable time and money, while also improving the efficiency of their Utilization Management team. This case study demonstrates the profound impact that intelligent automation can have on healthcare provider administration.

# Conclusion

Addressing utilization management challenges is crucial for meeting industry standards and enhancing patient outcomes and satisfaction. The integration of innovative solutions, like automating auditing processes, can lead to significant improvements in operational efficiency, cost savings, and resource allocation.

Navigating UM's complexities requires a unified approach among stakeholders— payers, providers, technologists, and regulatory bodies. Open discussions and collaboration are key to fostering data sharing and innovation. Embracing technology and continuous learning equips organizations to adapt to new challenges. Stakeholders must actively design and implement strategies that align with the overarching goals of quality care and sustainability. By working together, we can usher in transformative healthcare management that benefits patients and the entire healthcare ecosystem.

## CONTRIBUTORS

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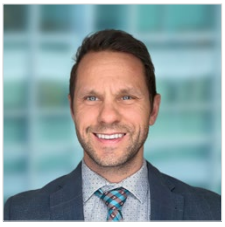
**Katie Oliva** | Previously, SVP of Operations

*As the Senior Vice President of Operations at Naviant, Katie Oliva plays a pivotal role in upholding our commitment to delivering top-tier AI, analytics, and automation solutions to our clients. Katie has spent over 27 years cultivating her expertise in nursing and healthcare operations. In the past 13 years, she further specialized in executive roles within nursing and operations. She brings more than 15 years of experience driving data-driven strategies and delivering valuable insights to optimize business performance.*



**Jacob Rouse** | VP of Innovation, Healthcare

*Jacob has a passion for population health and lowering the total cost of care. He has spent the last 15 years working in financial and operational leadership roles (executive, department, process) and as a strategic consultant. He has an expert knowledge of healthcare finances and revenue cycle and is a frequent HFMA and Epic conference speaker on financial and improvement topics. Additionally, he has been nationally recognized by both organizations.*

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Our mission is to improve the lives of people giving and receiving care. With a single-minded focus on value, we combine people, process, culture, and technology to drive real and lasting change. We partner with our customers to deliver data, analytics and automation strategies and solutions to make healthcare more proactive, higher quality, and less expensive for everyone.

**Contact our team** to explore tailored agentic AI solutions for your public sector organization. Schedule a consultation today and let us be your guide.

Contact Our Team