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Executive Summary

Amid move to value-based care, health plans can drive change

As healthcare in the United States moves from a fee-for-service (FFS) model to a value-based one, better communication and collaboration with care providers, especially in post-acute care settings, will be key for health plans to be successful.

That shift comes as health plans face an aging population with a system already running into capacity issues, Allan Brand, product leader with PointClickCare, said during "How Health Plans Can Drive Value-Based Transformation for an Aging Population," a recent webinar discussion on improving patient transitions to skilled nursing facilities.

"The result is you're just piling more and more load onto the provider, onto the payer, to try to manage in a system that's not actually designed to scale effectively," Brand said. "And that's where a lot of these new plans come in."

So why should payers be focused on improving care transitions? Because it is at this point when the patient has an increased risk of becoming clinically compromised due to lost data, medication errors, and lack of care coordination.

The move away from the FFS model also presents an opportunity to address the current incomplete circle of care, which has led to higher costs, suboptimal outcomes, and, in some cases, harm to patients.

Communication is critical

"Case managers often don't have adequate information," said Gary Owens, president of Gary Owens Associates, which specializes in medical and pharmacy management consulting.

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>
> Allan Brand, product leader with PointClickCare

For instance, it's not uncommon for a skilled nursing facility to accept a patient with an orthopedic issue but receive no communication about underlying comorbidities that may cause complications if they go unaddressed, explained Ian Strand, vice president of sales and business development with Patient Pattern, a technology company that provides care management and clinical documentation solutions to payers and providers.

"Our medical system is very fragmented right now in terms of connectivity on the technology and medical records side," Strand said.

That lack of communication and collaboration drives a high risk for readmissions. This means payers could be looking at paying bills twice, essentially, for high-risk patients who end up back in the emergency department (ED) or end up being readmitted for an inpatient stay.

While a Continuity of Care Document is a good start for sharing critical patient information, leveraging technology offers a much better solution to keeping health plans, providers, and others in the care continuum in the loop on a patient's status and needs.

For example, ensuring real-time information exchange allows for greater awareness of a patient's current health status, better planning for that patient post-discharge, lower costs to the plan, and ideally, better opportunities to identify interventions that could prevent that patient from needing to return for additional care, Brand said.

It can also help providers gain visibility into social determinants of health that may be playing a role in patient outcomes, such as access to food or stable housing.

Longitudinal information about a patient needs to reach across the care continuum. However, not everyone needs the same data points. Overburdened primary care physicians don't need to be overwhelmed with claims data, analytics, and readmission rates. They need the most up-to-date clinical data that will support them to be most effective in their jobs, particularly when providing follow-up care for patients after an acute care encounter.

PointClickCare's integrated platform with embedded workflows and an expansive clinical network creates a real-time connection to patient data for providers and health plans managing care. Having that targeted data sent directly to provider workflows is especially helpful when managing post-acute care coordination as a patient moves through the care continuum.

What success looks like

There are already success stories of health plans using the value-based care model. Success for health plans means shorter inpatient stays and fewer emergency visits, readmissions and penalties, and a significantly reduced risk of reputational harm.

"Value-based care and other types of plans that focus on outcomes are going to be driving what it looks like going forward," Brand said.

Owens noted research shared with him by Dr. Maria Lopes on patients transferred from Geisinger. When Geisinger's staff worked closely with primary care providers, the collaboration yielded drops in readmission rates by 27%, ED visits by 35% and hospital admissions by 40%. It also resulted in a savings of $8,000 per patient, per year. Collaboration with providers is crucial for payers to help improve outcomes and reduce expenditures.

Value-based care is growing in pharmacy

Value-based care is expanding in the pharmacy space, as well. A recent survey by Avalere Health found that about 58% of health plans had at least one outcomes-based contract for prescription drugs in 2022. More than 35% had at least 10 outcomes-based contracts that year.

Payers are taking what was learned on the pharmacy side and using that to help develop their value-based arrangements with providers and others in those care transitions, Owens said.

Payers that successfully transition to the value-based care model will see improvements in the patient care experience, population health, and even the work-life balance of their partner providers. And they'll enjoy a better bottom line with reduced costs.

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