The Journey to Integrated Care

Orion Health White Paper
Pam Stout
Nurse Executive
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ORION HEALTH

The Building Blocks for Population Health Management

Integrated care—healthcare that crosses organisational boundaries and different care settings—is the goal of health systems worldwide. So, too, is achieving that goal within the confines of scarce resources. Many of the challenges facing healthcare globally—aging and expanding populations, the proliferation of chronic diseases, heightened consumer expectations, increasing focus on care quality and value-based care, and changing financial and quality regulations—are underpinned, or driven by, fragmented healthcare services.

For example, take my friend who has Type 1 diabetes (only developed in her 20s, which is rare). She deals with multiple specialists to help manage her condition—her PCP, her endocrinologist, her physician, her diabetes nurse specialist, her cardiologist, her podiatrist, her eye specialist, and her dietician, not to mention the specialist diabetes clinic she visits to check the operation of her insulin pump. While each of these specialists shares information the old-fashioned way—by faxing and emailing notes—it's a very manual process that leaves gaping holes. And at no point is any real-time data captured about her fitness regime or the stresses she faces caring for two young children without any family support, while also trying to manage her condition. In her words, "managing diabetes is a full-time job."

Tackling the challenges facing healthcare requires re-architecting care delivery models. One of the most complex and critical aspects of this is building an IT infrastructure that enables all participants in the healthcare system to access and share the information they need, and to streamline and automate their processes to ensure the most efficient clinical and administrative workflows—all with the result of improving outcomes and reducing costs.

The Status Quo: Drivers for Integrated Care in the United States

The current structure of healthcare delivery has been sustained for decades by several mutually reinforcing factors: siloed primary care practices, measurements of "quality" defined and incentivised as process compliance, care delivery systems with duplicative service lines and little integration, and fragmented patient populations. And all of this is underscored by siloed IT systems with little or no sharing of information.[1]

Globally, health systems are reaching a breaking point because of burgeoning costs. Health expenditure per capita in the US$ sits at $9,146, one of the highest in the OECD.[2] This compares with US$ 5,718 per capita in Canada, US$ 5,827 in Australia, and US$ 3,598 in the United Kingdom.[3] Despite spending upward of 18 percent of GDP on healthcare, comparative analyses consistently show that the U.S. underperforms relative to other countries on most dimensions of performance—such as efficiency, access, equity, and outcomes.[4] Also, an estimated 34 million people in the U.S. still lack health insurance and, therefore, access to care outside of emergency departments.[5]

In the U.S., as in other parts of the globe, a fundamental shift in emphasis from acute in-hospital care (which is costly and not very efficient) to coordinated care across

[1] The Strategy That Will Fix Health Care, by Michael E. Porter and Thomas H. Lee, MD, Harvard Business Review: https://hbr.org/2013/10/the-strategy-that-will-fix-health-care

[2] Healthcare Outlook Infographic, Deloitte, 2016

[3] Idem

[4] http://deloitte.wsj.com/cio/2016/01/26/2016-health-care-providers-industry-outlook/

[5] Ibid.

the community is required. More than this, the focus must shift from reactive to preventative care—identifying signs of chronic conditions well in advance of them developing, and putting in place plans for prevention. Yet, to date, health systems globally have been slow at investing in the building blocks to implement transformative change.

There are many drivers behind a shift to an integrated healthcare system, as mentioned in the opening.

Aging Population

Population aging is accelerating worldwide. On average, life expectancy is projected to increase from 72.3 years in 2014 to 73.3 in 2019, which would bring the number of people over 65 to more than 604 million, or 10.8 percent of the total global population.[6] In higher-incomecountries such as the U.S., increasing life expectancy is largely due to declining mortality among those who are older.

An expanding, aging population places additional burdens on a country's healthcare system—but not only due to increased demand for services that are the result of chronic conditions. Increasingly, active, well-informed, affluent seniors are demanding new healthcare services, drugs, and technologies to prolong their good health.

Increase in Chronic Conditions/Disease

Globally, obesity, cardiovascular diseases, hypertension, mental health, and dementia are becoming persistent and widespread health problems. They are challenging public health systems to meet increasing demand for medications and treatments. Chronic conditions are the leading causes of death and disability in the U.S. and account for most healthcare costs.

The most prolific chronic conditions in the U.S.—heart disease, stroke, cancer, Type 2 diabetes, obesity, and arthritis—are among the most common, costly, and preventable of all health problems. While the statistics available from the Centers for Disease Control and Prevention are not very up to date, they still paint a grim picture, one that has likely become worse in recent years:[7]

- 86 percent of all healthcare spending in 2010 was for people with one or more chronic medical conditions.
- The total cost of heart disease and stroke in 2010 was estimated to be $315.4 billion. Of this amount, $193.4 billion was for direct medical costs, not including costs of nursing home care.
- In 2010, cancer care cost $157 billion.
- The total estimated cost of diagnosed diabetes in 2012 was $245 billion, including $176 billion in direct medical costs and $69 billion in decreased productivity. Decreased productivity includes costs associated with people being absent from work, being less productive while at work, or not being able to work at all because of diabetes.
- The total cost of arthritis and related conditions was about $128 billion in 2003. Of this amount, nearly $81 billion was for direct medical costs and $47 billion was for indirect costs associated with lost earnings.
- Medical costs linked to obesity were estimated to be $147 billion in 2008. Annual medical costs for people who are obese were $1,429 higher than those for people of normal weight in 2006.
- For the years 2009-2012, the economic cost due to smoking was estimated to be more than $289 billion a year. This cost includes at least $133 billion in direct medical care for adults and more than $156 billion for lost productivity from premature death estimated from 2005 through 2009.

[6] 2015 healthcare outlook, Australia, Deloitte, 2015

[7] https://www.cdc.gov/chronicdisease/overview

- The economic cost of drinking too much alcohol was estimated to be $223.5 billion, or $1.90 a drink, in 2006. Most of this cost was due to binge drinking and resulted from losses in workplace productivity, healthcare expenses, and crimes related to excessive drinking.

Consumer Expectations

An aging population and chronic conditions are not the only drivers for integrated care. Consumers also have a big part to play. Today's consumers are used to having information at their fingertips. In this connected world and smartphone ecosystem, we're never more than a few seconds from our banking information, chat conversation with friends, or checking our flight schedule. Increasingly, consumers are defining their ideal healthcare experience to be more like what they experience from other industries. They want more than a traditional patient-doctor experience: they expect convenience, amenities, service, and access to their own healthcare information. They want digitally connected health with access "anytime and anywhere."

Consequently, payers and healthcare providers are evolving their offerings and focusing on consumer engagement strategies, cost transparency, and improved service/product quality. Changing consumer attitudes and behaviors are prompting sector stakeholders to invest more in new and expanded customer engagement capabilities. For example, if healthcare providers wish to retain existing patients and engage new ones, then they should at the very least invest in a patient portal, but ideally also offer a mobile application. Implementing functionalities that patients find useful, such as appointment scheduling, billing, and the ability to contribute data to their own health record, are likely to increase adoption of those offerings.

Additionally, data captured by wearable devices, mobile health apps (mHealth), and social media are being used to transform aspects of healthcare. Around the world, nations with a critical lack of healthcare resources are exploring the use of digital-based care delivery models, such as offering online video consultations and triaging patients using pre-visit questionnaires delivered via mobile applications.

Financial

There are also financial drivers for integrated care. Current statistics (or as current as is available) show that almost US$ 1.2 trillion of the $2.2 trillion spent globally on healthcare is wasteful.[8] There are different buckets of wasted spend—money spent on preventable conditions related to obesity and weight, unnecessary emergency room visits, duplicate medical testing, and inefficiencies in the system.

To address this, traditional payment and service models are being deconstructed. Around the world, healthcare delivery models are shifting from a traditional fee-for-service (FFS) model to a value-based care (VBC) model. The focus is moving from volume of services toward delivering improved outcomes. The premise of VBC payments is to align physician and hospital bonuses and penalties with cost, quality, and outcome measures.

The U.S. is leading the charge on value-based care initiatives to drive efficiencies into the healthcare system with the objective of achieving the "Triple Aim" of improved healthcare outcomes, improved patient experiences, and overall reduced healthcare costs. Several significant

[8] PricewaterhouseCoopers' Health Research Institute, "The price of excess: Identifying waste in healthcare spending," 2013.

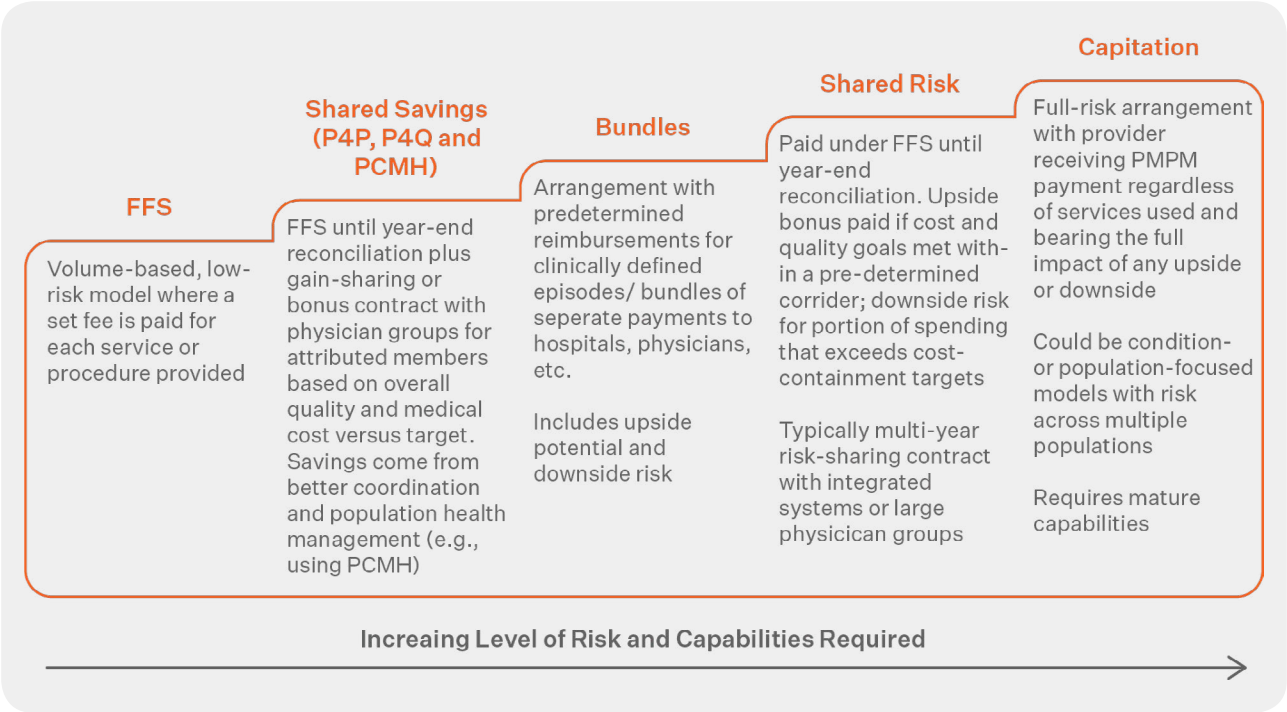


FIGURE 1: Range of VBC payment models being applied in the U.S. that can be considered in different markets.

pieces of legislation have been introduced in the past 10 years, most notably the Patient Protection and Affordable Care Act of 2010—commonly referred to as the Affordable Care Act or "Obamacare." This brought in several measures that prompted private health insurers (payers) to increase health insurance coverage and affordability, resulting in payers being required to cover all insurance applicants within new minimum standards and offer the same insurance premiums regardless of pre-existing conditions or gender. At the same time, the legislation introduced incentives through the government insurers, Medicare and Medicaid, for healthcare providers to operate more efficiently through the establishment of accountable care organisations (ACOs), and for those ACOs to have the ability to benefit from a "shared savings program." More complex payment models have also emerged from bundled payments to pay for performance (P4P), with significant reporting requirements around quality measures needed to qualify for payments.

The post-election landscape in the U.S. leaves the future of Obamacare uncertain, and there isn't any clear consensus as to how things are likely to turn out. But regardless of legislative change, healthcare cost containment should remain high on the agenda.

In 2013, McKinsey & Company estimated that the U.S. alone could generate an upside of $1 trillion in savings if the entire system switched to integrated healthcare delivery.[9] And change is afoot globally. In France, responsibility for the coordination of healthcare delivery is being devolved to Regional Health Authorities (Agences Regionales de Santé), with an emphasis on coordination of care for the population across logical geographical regions around hospitals, called territoires de santé. In the United Kingdom, some of the new models of care being developed under the National Health Service's (NHS) Five Year Forward View will trial alternative financial models and a range of initiatives to promote more integrated care.

[9] Latkovic, T (2013). Claiming the $1 trillion prize in US health care, McKinsey & Company.

Legislative

There are two additional factors that are likely to accelerate consolidation in the U.S. healthcare provider industry and the adoption of value-based payments propelling the healthcare system toward integrated care: the Medicare Access and CHIP Reauthorisation Act of 2015 (MACRA) and the Cadillac tax.

MACRA establishes a new way to pay physicians who treat Medicare patients and is the largest-scale reform in the U.S. since Obamacare came into force. Among other things, it changes the way Medicare doctors are reimbursed, ending the Sustainable Growth Rate formula that was designed to specify the yearly growth rate targets for physicians' services under Medicare, with a view to control the aggregate growth in Medicare expenditures for physicians' services. Under MACRA, physicians can choose a Merit-based Incentive Payment System (MIPS) or an Advanced Alternative Payment Model (APM).

Although Congress recently delayed the Cadillac tax, the excise tax on high-cost, employer-sponsored health coverage (which will now come into effect Jan. 1, 2019), employers and health plans are likely to continue to consider its impact on their offerings. The result is that there will continue to be a proliferation of high-deductible plans and a growth of private exchanges with a direct impact on health providers.

MACRA and the Cadillac tax are likely to accelerate consolidation in the provider industry and the adoption of value-based payments.

Achieving Integrated Care: The IT Strategy to Support a Coordinated Model of Care Delivery

Integrated care purports to bring together all parties involved in delivering healthcare, coordinating their services through sharing information and transforming healthcare into a seamless experience for the patient. Increasingly this care is moving away from emergency department visits and lengthy hospital stays to more accessible and less costly settings—home, school, and work. This is, in essence, "connected health," and technology adoption is critical to deliver this.

In 2013, Michael E. Porter and Thomas H. Lee expounded the six critical elements to deliver coordinated care: organise into integrated practice units, measure outcomes and costs for every patient, move to bundled payments for care cycles, integrate care delivery systems, expand geographic reach, and build an enabling information technology platform.

If you haven't read it already, the article is well worth your time. And while all six points warrant further discussion, it is the sixth point that brings us to the heart of this paper: "Build an Enabling Information Technology Platform." In fact, it is only through a robust IT solution that Porter and Lee's previous five elements can work. Despite being published in 2013, their theory holds true today. Healthcare systems globally are at different stages of maturity, but all need to follow a similar path to achieve the holy grail of population health management—where integrated care includes analysis and patient engagement such that everyone has an actionable patient record, improving both clinical and financial outcomes across the population.

Porter and Lee identify that a value-enhancing IT platform has six essential elements:

- It is centered on patients. The system follows patients across services, sites, and the full cycle of care. Data is aggregated around patients instead of departments, units, or locations.
- It uses common data definitions. Interoperability (the exchange of information between different software systems and applications) is an ongoing challenge for healthcare organisations. Terminology and data fields related to different types of health data need to be standardised so that everyone is speaking the same language and data can be exchanged and understood.
- It encompasses all types of patient data. Health is complex and involves data from clinicians, health insurers, patients themselves, lab tests, social information, and genetics.
- The medical record is accessible to all parties involved in care. All parties involved in a patient's care, including the patient, should be able to see the other parties' notes. Patients should only have to provide information once, and it should be stored in a central repository accessible by the entire circle of care.
- The system includes templates and expert systems for each medical condition. Standardised procedures for treating certain conditions ensure that those involved in delivering that care follow the correct next steps required to ensure thorough examinations and identify possible risks. For example, drug interactions may be overlooked if data is simply recorded in free text.
- The system architecture makes it easy to extract information. Value-enhancing systems make the data needed to measure outcomes, track costs, and control patient risk factors easily extractable.

The Porter and Lee strategy is on point with how Orion Health organises its technology to support the journey to integrated care as the building blocks for population health management and precise health. We call it the 7 A's.[10]

[10] A full examination of the 7 A's can be found in a white paper, "The Path to Population Health Management," at orionhealth.com

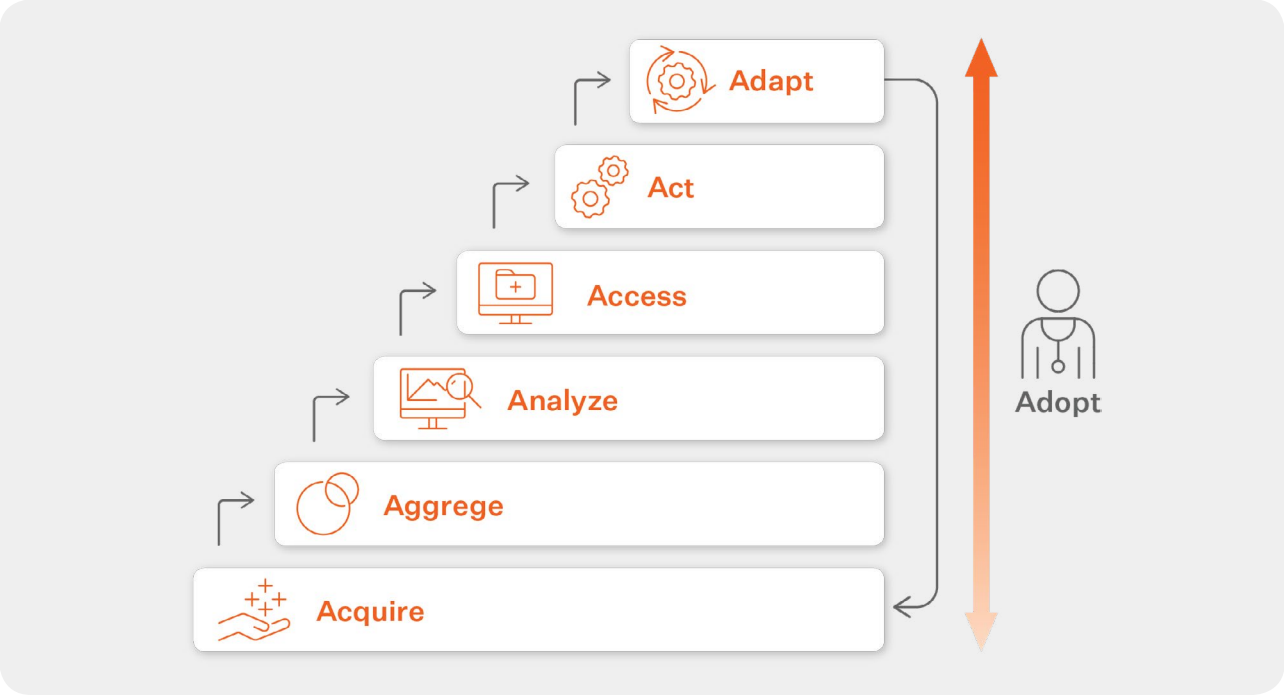


FIGURE 2: Acquisition Diagram

Acquisition: Acquiring Data from Disparate Information Systems and Care Location

Multiple EHRs and other clinical systems format, store, and share data in many different ways. To get the complete picture of an individual's health; protect the privacy and security of patient information; ensure secure exchange and information transport; and enable accurate, reliable interoperability with a wide array of systems, an IT system needs to support effective data acquisition and feature integration-engine technology.

Aggregation: Secure Storage of Structured, Normalised, and Identified Data

Each of the systems contributing data to a healthcare network has its characteristics and conventions for formatting and sharing data. Even common EHR and other healthcare information system (HIS) platforms can alter their data formats from version to version of the software. The data that needs to be aggregated includes clinical information—clinicians' and nurses' notes, medical images (X-rays and scans), lab tests, and discharge letters—and additional types of data, such as health insurance claims (to reconcile interventions with payments made), medication adherence, social information, and genetics. It also needs to include systems for identity management and terminology services to ensure normalisation of data across multiple systems.

Analytics: Tools for Risk Identification, Management, and Quality Improvement

Mining data for views into population health, finding the actionable insights that can drive improvements to quality and efficiency, and keeping up with the ongoing and ever-increasing regulatory reporting requirements—these issues and many more drive the need for analytics as a fundamental component of a successful integrated health network. Leveraging data-driven intelligence to improve care delivery is also something that a well-constructed IT infrastructure is uniquely able to do. With solid data acquisition and aggregation come the ability to learn from and act on data in very powerful ways.

Access: Fast, Easy, and Convenient Access to Information for the Entire Circle of Care

Several different types of stakeholders will need secure access to various aspects of a healthcare network's data, such as clinicians, administrators, health information management (HIM) professionals, patients, family members, health insurers, and many others. Each constituency has its own unique set of priorities, ermissions, and levels of technical and clinical sophistication to consider. But for all of them, the access to data must be as frictionless as possible to support initial and ongoing adoption. Healthcare providers will typically be best served by giving them access to information within the EHR itself, whereas patients and family members in their circle of care will need a web-accessible secure patient portal.

Action: Turning Information and Insights into Activities and Outcomes

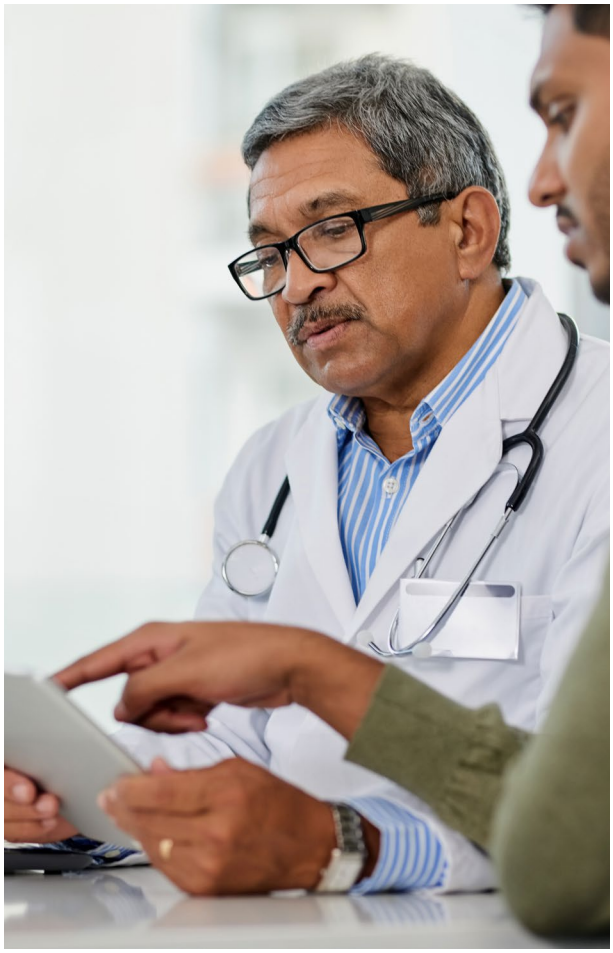
Coordination workflow tools are a key technology requirement that enable care managers to deploy consistent care pathways based on patient and population data, and to document and communicate progress with the healthcare providers and patients they support.

Adapt: Creating a Big-Picture View of Medical Decision-Making

Once the population has been stratified and cohorts of interest have been identified via analytics, customised action plans can be put in place for each patient and care can be coordinated across facility lines accordingly.

Adoption: User Engagement and Adoption of Tech

Adoption is as much an issue of technical prowess—making the data seamlessly easy to get to and impeccably accurate—as an emotional and behavioral one, and those two sides of the challenge are inextricably linked. If clinicians and care coordinators fail to adopt, key information will not be used for decision-making and outcomes will suffer. Both effects are potentially devastating to the success of any integrated care delivery system.



Orion Health's Approach to Integrated Care

Orion Health is investing heavily in an IT solution that delivers to the needs of a healthcare system—not just a single healthcare provider or payer.

Our offering for integrated care, as the foundation of population health management, delivers an end-to-end solution with seamless data integration and visualisation built on a massively scalable open platform—the Orion Health Amadeus platform. Clinicians need only log in once to see the longitudinal patient record, perform analytics queries over huge data sets, and turn insights into clinical workflow—from individual care plans to customised care pathways. Real-time data integration means that patient information is always up to date and notifications trigger actions at a specific moment in time, ensuring that patients are receiving optimal, and timely, care.

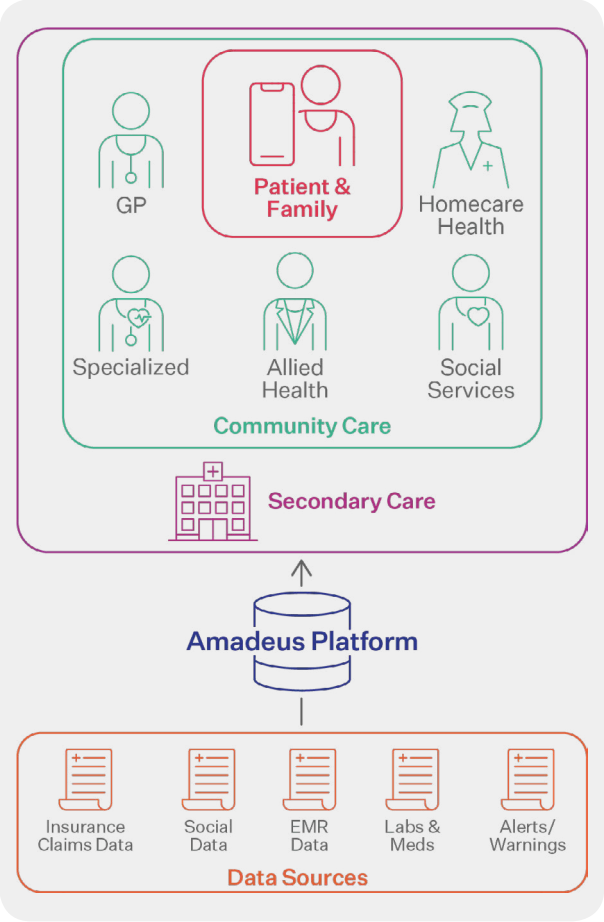


FIGURE 3: The Orion Health model for integrated care

To deliver integrated care in a health system that has evolved enough for EMRs to be commonplace, such as in the U.S., the next critical step is to support care coordination. Addressing the underlying system problems that create silos, gaps in care, and patient exclusion is the ultimate goal.

The Amadeus platform can integrate with multiple data sources across both health and social providers and payers, generating a centralised and complete view of a patient's record. Systems can take advantage of this rich data and manage individual patients and entire populations more effectively using the Orion Health Coordinate and Orion Health Amadeus Analytics applications. A virtual multidisciplinary care team approach enables a true patient-centric view and way of working—making sure that social, behavioral, and genetic data are considered when creating care plans or considering interventions. This model supports proactively addressing the social determinants of health in conjunction with immediate health needs. It also supports prioritising resources across care settings and, most importantly, prioritising the needs of the patient.

Achieving integrated care requires more than just technology. We must be clear on our objectives and empower the people involved through the right processes. We must have a clear goal to unify disparate organisations—putting the patient at the center of the health system. Only then will individuals and communities have a better experience of care—and improved support—by experiencing less inequality and achieving better outcomes.

Real-World Application

To understand integrated care and how it can work to its full effect, it's useful to look at a couple of examples from different parts of the globe.

Canterbury Tale

In 2013, The King's Fund in the U.K. published a case study about Canterbury in New Zealand and the region's quest for integrated health and social care.[11] The entire study makes for interesting reading, but the key point to note is that Canterbury has proven that it is possible to provide better care for patients, reduce demand on acute and primary care, and reduce demand generally across health and social care by improved integration—particularly around the interface between the hospital, primary care, and community services.[12]

From the early 2000s, the Canterbury District Health Board, New Zealand's second largest DHB, devised a vision for an integrated health system that would keep people healthy and well in their own homes. In 2007, the Canterbury Health System was almost $17 million in deficit on a turnover of just under $1.2 billion, and by 2010/2011 was on track to make an $8 million surplus.[13] Then tragedy struck and a devastating earthquake caused immense damage to the city, killing 185 people and injuring close to 7,000 more.

The earthquake somewhat disrupted Canterbury's journey. Repairs were required to every one of Canterbury DHB's 200 buildings. More than 630 rest-home beds and 105 acute inpatient beds were lost. Many GP clinics and pharmacies were also severely disrupted. The earthquake and subsequent aftershocks caused a loss of paper records and disrupted access to electronic records. When a displaced population signed up to a new GP, some did so without any medical history.

Canterbury approached its goal of integrated care with new vigor. An electronic shared care record, coined HealthOne, was commissioned by a partner alliance involving the Canterbury DHB, PHO Pegasus Health, and Orion Health. Pegasus Health hosts the general practice, pharmacy, and community care databases, taking the primary care information from the various systems to a central repository to be viewed as a "single source" of up-to-date patient information. Additionally, many pharmacists across Canterbury using the two main pharmacy systems in New Zealand (LOTS and Toniq) have contributed pharmacy data to the patient record. HealthOne consolidates the GP record, community pharmacy dispensing information, and community care coordination referrals into a centralised store. The patient's healthcare providers in the hospital, and a number of community providers, can access a summary of their patient's demographics, medications, encounters, allergies, alerts, and observations. They can also view past visits, admission data, and discharge information (unless the patient has opted out of the system).

The HealthOne solution also integrates with Health Connect South, a revolutionary web-based EMR portal which provides a unified view of the complete patient electronic medical record in hospitals across the South Island. These two solutions combined enable clinicians to view and contribute toward a single shared electronic record.

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[11] https://orionhealth.com/global/knowledge-hub/reports/the-quest-for-integrated-health-and-social-care/

[12] Ibid.

[13] Ibid.

The results: HealthOne has had a significant impact on the workflow of primary and community healthcare providers by giving them access to up-to-date and relevant information and allowing timely, safe, and more informed decision-making.

As of April 2016, there were some excellent adoption results:

- More than 57 million patient data items (e.g., a diagnosis, a prescribing, a dispensing) are contained within HealthOne. More than 1.7 million new items are received every month.
- The rollout to community pharmacies began in February 2012, and now more than 450 pharmacy staff have HealthOne access.
- The first 12 general practice sites were rolled out as a pilot in June 2012. As of July 2016, nearly 1,500 general practice doctors, nurses, and practice staff across three health districts have access.
- Canterbury community nursing organisation, Nurse Maude, was granted access to HealthOne data via Health Connect South in December 2012. The Laura Fergusson Trust was on-boarded at the start of 2015. More community nursing, emergency services, and private hospitals are to follow.

While out-of-hospital services in Canterbury have increased, the region is currently undertaking work to measure the outcomes of the integrated care initiatives.

Scottsdale Savings

Innovation Care Partners (ICP)—formerly known as Scottsdale Health Partners (SHP), and now a wholly owned division of HonorHealth—is a physician-led clinical integration network (CIN) and accountable care organisation (ACO) in Scottsdale, Arizona. As an ACO, it participates in the Medicare Shared Savings Program (MSSP) referred to earlier. The organisation focuses on the "Triple Aim" of healthcare: improving patient health and the patient experience while reducing costs. It contracts with seven major insurance companies, covers more than 40,000 patients, uses a pluralistic model to represent a broad spectrum of medical specialties, and empowers providers to remain independent and entrepreneurial.

After a thorough review of available solutions, ICP partnered with Orion Health to leverage its flexible open platform technology in the Amadeus data platform, providing a common interface to facilitate the seamless exchange of crucial health information between ICP's 62 practices. It then went on to work with Orion Health to develop an application for the MSSP.

The MSSP, which is administered by the Centers for Medicare & Medicaid Services (CMS), rewards participating ACOs that lower their healthcare delivery costs and meet specified quality-of-care standards. While ICP managed to satisfy all the MSSP requirements in their first year in the program and achieve cost savings of $3.7 million, the reporting process proved to be extremely challenging and labor intensive. The approach used in the first year of quality reporting—copies of a customised Microsoft Excel spreadsheet that was distributed to ICP's 62 practices so that they could fill it out with reporting data—was fraught with problems. It was consistently rejected by many of the practices' email applications, often incompatible with older versions of Excel, and plagued with column-offset issues, which required ICP to provide constant technical support. Further, it provided ICP no visibility on their practices' progress, which left ICP blind to performance shortcomings and gaps in care, and, therefore, unable to take timely corrective actions and make ongoing benchmark adjustments.

In their first year in the MSSP, and with a timeframe of only six weeks to collect data, ICP's practices managed to report just 60 percent of their data by the end of the fourth week. This predicament would be unacceptable in ICP's second year, when a large portion of their metrics would become P4P and the data would be scored for quality. ICP would need to be able to make supplemental requests for missing data throughout the six-week reporting period in real time. Further challenges in the first year included the fact that even once the spreadsheets were collected from all 62 practices (i.e., 62 separate spreadsheets), it was still up to ICP to extract the data, ensure that the column-offset and other Excel-based issues didn't create errors, and post it to a central database—an onerous, time-consuming task that required many quality-assurance reviews to ensure the data was reported completely and accurately.

To streamline the MSSP quality-metrics reporting process and improve their overall quality scores, ICP worked with Orion Health to develop the MSSP Management application. Featuring an analytics engine capable of creating a payer registry, a patient registry, and a managed database, the application consumes data from clinical data repositories, enterprise master patient indices, ACO files, and EMR imports, while providing a real-time dashboard for monitoring and tracking performance against the MSSP clinical quality measures.

The implementation of the Orion Health MSSP Management application marked a watershed moment in ICP's MSSP journey, simplifying the reporting process, reducing the demands on their practices' staff, and eliminating regulatory risk. Not only did the application immediately free ICP from the limitations, frustrations, technical-support demands, and regulatory pitfalls created by the first year's spreadsheet tool, it also gave them immediate visibility into their practices' reporting progress. By the end of the first week, 50 percent of the data had been collected; by the end of the fourth week, 84 percent had been collected.

These improvements all contributed to a dramatic year-over-year improvement in cost savings and care quality: ICP's quality score increased from 60 to 93 percent. This—coupled with ICP demonstrating cost savings of nearly $10 million, a $6.3 million increase over their first year in the MSSP—led to ICP being awarded $4.7 million.

You can read a full case study about ICP on Orion Health's website: orionhealth.com/us/knowledge-hub/case-studies/innovation-care-partners-mssp-earns-a-huge-payout-from-cms/

Conclusion

We have entered a new era in healthcare where we are orienting our health system around the patient (or consumer). To deliver care that best serves individuals, we must promote more integrated care—bringing together services and systems across the health spectrum. Now is the time to accelerate systems that empower people, keep them well longer, and prevent the onset of preventable chronic disease. Healthcare IT has a huge part to play in the seamless integration of our healthcare systems. Adopting the right strategy—and making the right investment—is crucial to generating improved clinical and financial outcomes.