Health Insurer Success In The Era Of Value-Based Care

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Suzanne Cogan - Healthier Populations Sales
Dr. Chris Hobson - Chief Medical Officer
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Advanced analytics build a foundation for new care models

The post-ACA era is a time of enormous challenge in the healthcare industry. For health insurers, the pressures center on member choice, millions of newly insured, and the shift toward population health and value-based care. Health insurers are tasked with re-architecting care delivery infrastructures in order to enable patient-centered care models that improve quality and outcomes while achieving affordability.[1] Data plays a key role as care coordination programs are created, and data is more freely shared between healthcare entities.[2]

Although claims-driven data models are still relevant, it has become clear that they must be combined with clinical data in order to produce timely data feedback loops, improve care coordination, advance disease management, and enable population health.[3]

There is little question that this innovation, which will involve substantial structural changes, is needed. Currently, our healthcare system consumes 17 percent of U.S. gross domestic product[4] and is expected to increase to 20 percent by 2021.[5] Improved care coordination is needed to decrease healthcare costs for patients with multiple chronic conditions, which account for more than 66 percent of total healthcare spending.[6]

Better care coordination can also reduce wasteful healthcare spending, which was estimated at $25 to $45 billion in 2011,[7] and lower unnecessary readmissions. Currently, almost 20 percent of Medicare patients return to the hospital within 30 days of discharge, costing $12 billion per year.[8]

Steps to enable population health management and empower members

Successfully integrating claims data with clinical data to provide the support needed by providers and engage patients is a complex undertaking. Full integration is likely to take several years, but health insurers can begin preparing now by recognizing both the functions that will be necessary and the technologies likely required to achieve them.

Health insurers must first be able to combine data from a wide variety of sources, including clinical and claims systems, genomics data and even data from wearable devices, a task made significantly more complex by security and regulatory considerations. And much of the data will be information not traditionally shared between health insurers and providers.

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[1] Karen Ignagni, CEO, AHIP, Healthdatapalooza keynote speech, Washington, DC, June 2, 2014.

[2] Ibid.

[3] Ibid.

[4] The Future of Healthcare Delivery, Dr. Stephen Schimpff, 2012.

[5] "National Health Expenditure Projections," Keehan, et al., Health Affairs, July 2012.

[6] "Chronic Care: Making the Case for Ongoing Care," Gerard Anderson, Robert Wood Johnson Foundation, 2010.

[7] "Health Policy Brief: Reducing Waste in Health Care," Health Affairs, December 2012.

[8] "Readmissions: The Cold Hard Facts," eQHeath Solutions, http://louisianaqio.eqhs.org/PDF/Care%20Transitions/Care%20Transitions%20Facts.pdf, accessed July 9, 2014.

The following is a list of top 5 emerging best practices and the technologies needed to support changing healthcare payment models:

1. Normalize data and store it securely. This will require semantic layer technologies that can normalize diagnoses and other clinical values expressed differently across multiple systems. It will also require a clinical data repository that serves as the fundamental store of normalized data.

2. Analyze the data to create robust population health management workflows and care plans. This function will require business intelligence tools that allow both analysts and non-technical users to mine data. The tools will also need to automatically generate core reports and dashboards that deliver data to the point of impact.

3. Facilitate active member management through provider access to clinical data and care guidelines at the point of care. Providers will need direct access to longitudinal records across the entire care continuum in a way that complements their existing workflow and technologies. Care managers will need workflow integration that includes secure single sign-on to multiple systems. They will also need workflow tools that let them deploy evidence-based, consistent care plans based on patient and population data.

4. Engage and empower members with tools that educate and allow them to view, download and transmit their electronic records (the standard for meaningful use stage 2). This will require portals that include a personal health record, mobile access, and secure messaging and can be accessed by both patients and their designated caregivers.

5. Streamline communications and transactions to ensure secure clinical information sharing and timely pre-authorizations and reduce duplicative or unnecessary procedures. This will involve secure information exchange and transport (e.g., Direct exchange and eHealth Exchange), as well as identity management and enterprise master patient/master provider indexes.

Advanced member engagement

As health insurers form partnerships with providers, using bundled payments, capitated agreements, or an ACO model, they require effective and efficient technology to meet their data needs and achieve care and revenue goals. Often, this involves connecting applications and solutions from disparate systems.

Even when the health insurer-provider partnership is successful at integrating disparate systems to communicate with one another, it's just a single step in using technology to coordinate care. A holistic, fully integrated solution must:

- Combine relevant historic and timely data
- Normalize and aggregate data
- Find useful, actionable insights
- Deliver the information and recommendations to caregivers, administrators and members
- Monitor the ongoing implementation of those recommendations

Such a system allows for the type of care coordination and member engagement that ACOs and other value-based payment models must achieve. Consistent member outreach is also essential for effective patient engagement—without it, the overall goal of lowering costs while improving outcomes cannot be achieved.

When a patient and their circle of care is a central part of the healthcare team, rather than just a recipient of care, they are active participants who can help manage their own chronic diseases and tend to remain compliant with their treatment plan after diagnosis. Additionally, as members try to get more from their healthcare dollars and manage their benefits as well as their care, member satisfaction is becoming increasingly important to success for health insurers.

Among the healthcare stakeholders, members are perhaps the most underutilized resource. With the shift to data exchange and analytics, health plans are realizing the need to focus on long-term cost control and enhanced outcomes rather than short-term cost savings by limiting access to services and medication, which can cost more in the long run.

Summary

As partnerships strengthen between health insurers, providers, and members, it is important that value-based payment initiatives align with strategic initiatives, demonstrate value, and manage care toward a state of wellness. Achieving these goals involves:

- Real-time data acquisition from disparate systems
- Aggregating and securely storing that data
- Analyzing data to create robust population health management workflows and care plans
- Providing data access to clinicians and members
- Facilitating community-wide stakeholder engagement
- Performing sophisticated analysis on the data
- Managing continuous cycles of care improvement

It's a challenging operation, but one that can be achieved with an IT foundation designed to create a learning health system that benefits all and helps create a healthier population.

Karen Ignagni, CEO of AHIP, emphasized many of these points in a recent keynote, "We're overhauling the benefit structures to create more value for patients. We've done it by understanding [that] we are the only entity in the delivery system that has a line of sight in to where patients go and when they go there through all their encounters. We're the only entity that has the ability to link these encounters and provide data to physicians to help them provide care in context, not care in a vacuum."[1]

[1] Karen Ignagni, CEO, AHIP, Healthdatapalooza keynote speech, Washington, DC, June 2, 2014.