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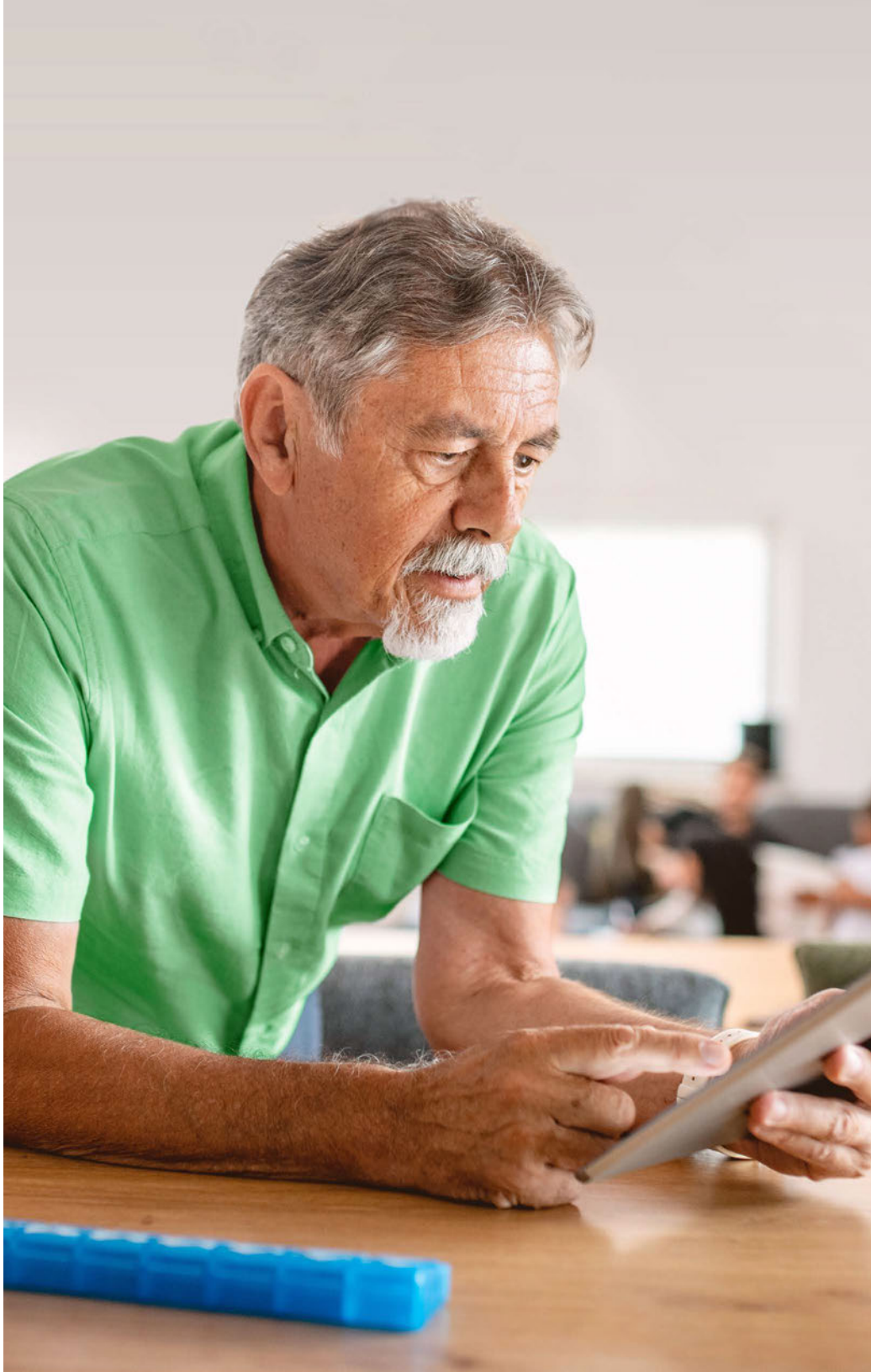
Collaborative strategies to optimize complex care management

As costs and requirements related to caring for complex patients skyrocket, payers and providers must come together with the shared goal of providing better, more accessible, lower-cost care.



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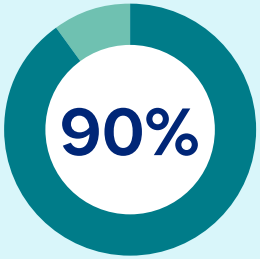
Introduction

For years, payers and providers have recognized the need to better coordinate care and improve outcomes for patients with complex health and social needs.



of the **$4.1 trillion** spent annually on health care in the U.S. goes toward treating people with chronic and mental health conditions.[1]

The fact that 5% of the U.S. population accounts for nearly half of all health spending has been widely publicized, making clear the difficulties faced by patients with multiple chronic conditions, which are often exacerbated by unmet social needs.[2]

As the industry refines its approach to providing high-quality care while controlling costs, health plans and health care systems alike recognize that standard, 15-minute primary care visits simply aren't sufficient to comprehensively address these needs.[3] What should take their place? An integrated, team-based approach that focuses on frequent communication, continuity of care and broader support to address social determinants of health (SDOH), such as income insecurity and access to safe housing, healthy food and reliable transportation.[4] Accordingly, a robust base of best practices, core competencies and quality measures have emerged to guide this new approach.

Still, as costs to treat complex medical conditions continue to rise, even high-performing health systems lack the scale and resources to single-handedly invest in the capabilities required to transform the complex care landscape. Therefore, payers and providers must accelerate collaboration to improve patient outcomes, control costs and drive health equity. This need has only increased in recent years, as the health care industry faces growing financial and operational challenges in the wake of COVID-19.

Research shows that providers increasingly want to partner with payers to improve operations, make better use of data and analytics and boost patient engagement.[5] This growing desire for collaboration has created a window of opportunity for players across the health care spectrum.

The following strategies can help you maximize the potential of payer-provider partnerships to positively impact spend, outcomes and quality of life for people seeking complex care.

Partner with leaders in high-cost care

Successful collaboration requires alignment in strategic objectives, culture and resources. This takes significant time and investment, so it's not realistic to hope to address every health condition and every provider at once.

Instead, payers should first focus on conditions that are relatively rare yet carry a disproportionate cost burden — including kidney disease, complex cancer, congenital heart disease, organ transplants, and cellular and gene therapies — and target providers who have already shown a commitment to value-based care.

Research shows that more than a quarter of health care costs are associated with 4 complex condition categories: heart disease, musculoskeletal conditions, cancer and kidney disease.[6] Because these diseases are so closely tied to comorbidities and lifestyle factors, they offer clear opportunities to create significant impact in patient outcomes and cost reduction. Doing so requires highly integrated care models that improve care management and ensure patients receive the right care in the right setting at the right time. By joining forces, payers and providers can smooth complex patients' journey by connecting them with high-quality care that reduces the risk of complications and hospital readmissions.

For example, value-based care partnerships demonstrate particular promise for kidney disease management, a complex and expensive condition that affects 15 million U.S. adults — including a disproportionate number of people of color.[7] However, most people with chronic kidney disease (CKD) don't know they have it, creating barriers to early intervention that can slow or stop the disease.

By banding together, payers and providers can leverage sophisticated health data analysis to identify patients at risk of CKD and improve awareness and screenings in primary care settings. Because unmanaged hypertension and diabetes are the leading causes of kidney failure,[8] early interventions and improved disease management may render a transplant unnecessary. CKD patients who need advanced care, meanwhile, can make informed decisions about options that improve outcomes while decreasing costs.

Sometimes, preemptive transplantation is a better solution than dialysis — a long-term, demanding and costly treatment. When a transplant is the best choice, payer-provider collaboration through a Centers of Excellence (COE) approach ensures that patients find their way to the very best transplant centers that perform the most surgeries with the highest patient survival rates and lowest wait times, based on information from the Scientific Registry of Transplant Recipients and other third-party data.

One collaborative, evidence-based kidney care program resulted in[9]:

- A **24.7%** reduction in inpatient admissions
- An **11.3%** reduction in ER visits
- A **2.5x** preemptive transplant evaluation rate

It's not just kidney care and transplantation that benefits from this approach. More generally, organ transplants of any kind require specialized care and coordination. A cohesive program that helps patients navigate this process and provide education and resources can lead to significantly better outcomes, including[10]:

- Lower rejection rates
- Lower pneumonia rates
- Less time in the hospital after transplant
- Fewer readmissions
- Lower mortality rates

Similarly, partnerships can also transform cancer care. Today, the disease kills more than 600,000 Americans each year, and another 1.9 million are diagnosed annually.[11] What's more, the financial cost of cancer is expected to balloon to $246 billion by 2030.[12]

At the same time, new and advanced treatments are rolling out at an astonishing pace. In fact, 8 new biological therapies — a class of treatment including immunotherapies — are expected to be approved in 2023.

That's the same number that have been approved to date since biologics launched in 2017. Similarly, cell therapy is growing rapidly as applications move beyond leukemias and lymphomas to also target multiple myeloma, sickle cell disease, metastatic melanoma and more. As a result, these low-incidence but very costly treatments will become much more common over the coming years.

Payers, providers and industry solution providers can partner to facilitate access to these life-saving therapies and reduce barriers for patients. A collaborative, patient-centric approach can also help prevent and manage symptoms and treatment side effects, leading to fewer inpatient admissions and emergency department visits; manage treatment costs by ensuring alignment with evidence-based standards; and provide patient support to help individuals navigate care and make informed treatment decisions.

Taking control of ballooning care complexities and their costs can feel overwhelming. But by carefully identifying stakeholder needs and areas in which partnerships can create the most impact, payers and providers can move quickly to create an integrated strategy that blends better care and utilization management with improved access to evidence-based, high-quality treatments — and succeed in driving improved outcomes at a lower cost for complex patients.

Important questions to ask when considering a payer-provider partnership around complex care:

- Are both parties willing to share clinical and financial data to stratify clinical priorities?
- Are your cultures and quality standards compatible?
- Do you both have the infrastructure to support sophisticated clinical and care management?

Partner on clinical, claims and other third-party data

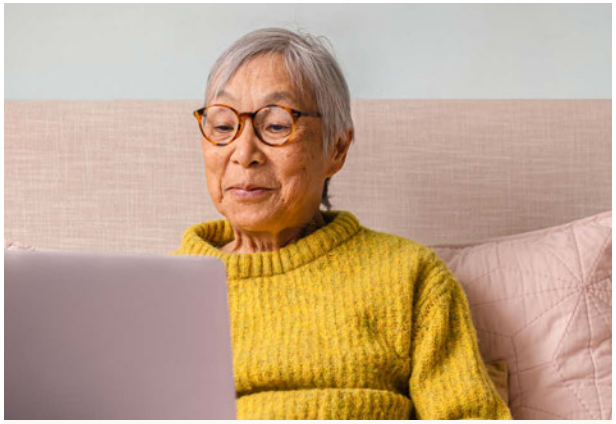
Health care stakeholders can't manage what they can't measure. Clunky, disparate data depositories make it harder to surface insights and collaborate on care management.

That's why, after agreeing on specific disease targets and an SDOH-informed approach, payers and providers need to ensure that they have the right analytics to implement effective care. By sharing actionable intelligence, partners can make fast decisions that benefit everyone — especially the patient.

Simply sharing data across organizations isn't enough. Instead, payers should consider investing in jointly managed data analytics software that integrates electronic health records (EHR), claims data and third-party data about social and behavioral factors.

A unified data repository paints a clear picture that improves health plans' and providers' understanding of patients at risk of poor outcomes. The right data and analytics platform — one that brings together disparate clinical, financial and socio-economic data — can drive health outcomes by targeting and assessing medical interventions more accurately while also lowering costs and reducing barriers to care by improving care coordination, efficiency and patient outreach.

> "Payers and providers "need to move toward having a common view for data analytics and information in order to make sure that all parties have timely access to appropriate clinical information."
>
> **— David Chennisi,** Vice President, System Integration, Optum Payer Consulting[13]



When data and analytics serve as the foundation of a payer-partner relationship, they can:

- Reduce unnecessary costs
- Offer critical insights at the point of care to reduce variation
- Create a delivery model that enhances patient satisfaction

Take a holistic, whole-patient approach

The evidence linking SDOH with chronic and complex disease is overwhelming. Determinants including income, education, racial discrimination, smoking and alcohol consumption can both cause disease and directly impact its progression and outcome.[14]

Specifically, SDOH are strongly correlated with cancer prevalence, outcomes and survivorship,[15] as well as kidney failure and transplantation rates.[16]

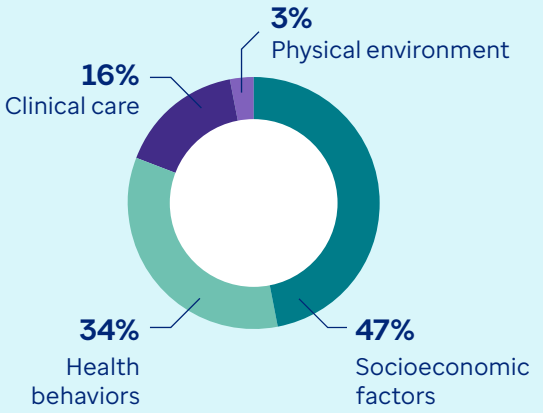
Moreover, studies show that SDOH and behavioral factors account for a large majority of health utilization. So-called "super utilizers" who make frequent trips to emergency departments are far more likely to struggle with adverse SDOH than other patients, and account for an outsized percentage of ED costs.[17]

To improve outcomes of complex conditions, payers and providers need to move beyond a generic, population-level understanding of health challenges. Together, they can create a proactive approach that identifies patients living with these issues, casts light on the specific economic and lifestyle barriers that prevent them from successfully managing their disease, and better connects health care to social services that can address these factors.

For example, when patients struggling with housing insecurity receive housing assistance, they have fewer ED visits, hospital admission and inpatient days – resulting in significant reductions in health care costs and clear returns on the housing investments.[18] Accordingly, health systems and local governments across the country are increasingly providing housing to people experiencing homelessness in order to improve their health and reduce inappropriate use of health care resources. In Los Angeles, the Department of Health Services runs a program called Housing for Health, which works with 100 community-based partners to provide housing – as well as care management and other wraparound services – to more than 20,000 individuals.[19]

Facilitating transportation to and from provider appointments, "prescribing" fruits and vegetables that are provided for free, and connecting individuals to employment resources can create similarly profound results in complex patient populations. By working together to analyze SDOH, payers and providers can build effective value-based care models and investment strategies to better serve high-need patients – and benefit their communities at large.

Factors driving health outcomes[20]:



Adults who are food-insecure have annual health care expenditures that are $1,834 higher than those who are food secure.

Prioritize care coordination

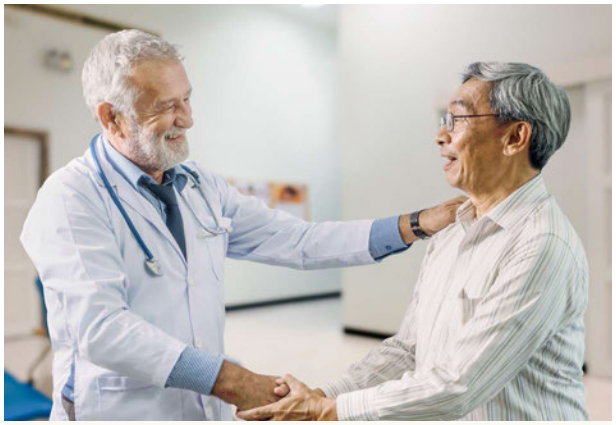
Above all else, effectively managing patients' complex conditions requires providing the right care in the right setting at the right time.

But achieving this long-standing care delivery goal across complex patients is nearly impossible when medical, behavioral and social services are fragmented. To truly move the needle on outcomes for patients with complex needs, payers and providers must partner to create a sophisticated care coordination approach that offers individualized support and integrates medical, behavioral and social services to improve quality of life and minimize unnecessary utilization. The best care coordination leverages a platform that manages patient relationships, drives engagement and ensures continuity across the care continuum.

Successful care coordination begins with properly identifying the patients you're trying to help. Advanced analytics can create a registry of patients with a specific targeted condition. Next, those analytics are applied to specific patients' longitudinal health histories to determine risk factors and health barriers, from SDOH to stress management. This approach allows providers to pinpoint not only the most significant risk factors, but also those that can benefit the most from intervention.

Then it's time to develop, executive and evaluate a care plan performed by specialists. Armed with a thorough understanding of an individual's situation and risk factors, payers and providers can work together to create programs or partner with existing options provided by companies like Optum that include patients in their own care planning and coordinate with caretakers to develop a plan that addresses clinical needs. This plan should use a mix of specialized team members, from physicians and nurse managers with specific expertise in the patients conditions to therapists, social workers and health coaches. Together, this team works with a patient every step of the way, serving as advocates, problem-solvers and guides.

Finally, stakeholders should evaluate outcomes by comparing a patient's post-intervention status to their baseline through a care management platform. At scale, this approach empowers providers to prioritize the most important interventions and best allocate resources for individuals with complex needs, leading to better patient experiences and clinical and financial outcomes.



With the right care coordination platform, patients can:

- Review and complete tasks to improve care
- Access educational materials
- Send their providers health questions

Care coordinators can:

- View the full patient record to determine a timeline and task list for the provider and patient
- Coordinate appropriate care by sending messages to other care resources, including nurses, social workers, pharmacists and others

Conclusion

The idea that payers and providers are inherently at odds is outdated.

As value-based care initiatives continue to gain steam, all parties are incentivized to invest in collaborative solutions that improve the quality and efficiency of care while prioritizing care coordination. Everyone succeeds when payers and providers come together to address complex conditions through a patient-centered strategy.

Learn about Optum Transplant Solutions and Optum Kidney Solutions.

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