Value-Based Care—The Future of Healthcare

By LeRoy E. Jones, Founder and CEO, GSI Health

In the real world, patient care is not a one-size-fits-all model. Each patient's needs are unique, and the cost to keep patients healthy can vary widely based on medical condition and a variety of non-medical factors such as behavioral issues, economic status, and even living situation. To address these needs, the healthcare industry is evolving to value-based care, a model in which care is no longer delivered only by doctors and nurses treating patients independently, but by care teams that treat the "whole patient" across the community. In this model, providers are paid for keeping patients well. Rather than being incentivized to do more procedures, they are rewarded for improving patient outcomes and maintaining the quality of care for their population—in other words, delivering value rather than delivering services.

Value-based models deliver care through entire communities who "touch" the patient, an approach that is especially important for patients with one or more chronic diseases, because these patients are the costliest to treat. It truly "takes a village" to treat these patients—a range of providers, including social services, medical and behavioral health, and more must come together to make sure the entirety of a patient's needs is addressed. This means that communication and care plans no longer live within the four walls of a doctor's office or hospital. To be successful, organizations must work toward a new model for care delivery that focuses on a number of key factors:

- ***Collaboration and care management***—Success requires interdisciplinary care teams that collaborate across organizational boundaries, and proactively identify what they should be doing *together* to achieve better outcomes. This includes identifying non-medical factors that reduce care effectiveness, such as housing instability, lack of transportation, and behavioral issues. Care must be managed across disparate care providers and life circumstances to ensure that resources are allocated, assignments are known and understood, and each provider is contributing to a coordinated set of actions that lead to a common goal. No longer can individual efforts remain unreconciled with the bigger picture of care.

- ***Analysis and measurement***—Identifying and managing the highest utilizers of care and "rising risk" patients can make a big difference to patient outcomes and an organization's bottom line. A little intervention can go a long way in improving patient health and keeping them "out of the red."

- ***Interoperability***— Effective analysis can be extremely difficult when most providers are working in a silo. Providers need to securely aggregate data, using technology to remove boundaries to care and enable information exchange and transparency across the entire community.

Today, delivering care to individuals isn't enough—you need to do it in an informed way, and

with measurable outcomes. We believe that care coordination and analytics need to be together—just one in isolation isn't enough to get the job done. Bringing them both into a single platform maximizes synergies through sharing information within a unified framework. By establishing this close linkage, care coordination and analytics reinforce one another, delivering a total package of functionality that helps you achieve your goals in a more effective way.

This approach has achieved excellent results in the real world. In a recent study, GSI Health's population health management platform was implemented as the technology solution in a unique team-based healthcare delivery model to address the high total cost of care for patients with severe mental illness. This population is typically one of the most expensive to care for, with treatment distributed among many providers. The program successfully used our insight-driven population health management technology to improve patient care efficiency and effectiveness across multiple care settings, reduce psychiatric and medical hospital admissions, and reduce total cost of care—plus addressed social determinants of health such as housing instability and transportation that can be barriers to care delivery. This pioneering program was so successful that it is being scaled and extended to other populations and conditions, including the organization's entire Medicaid population.

At GSI Health, we believe that having the right teams assembled to address each patient's unique needs—and getting the right information to them at the right time—can have a tremendous benefit to reducing healthcare costs, and more importantly to improving individual patient and population health. Our technology bridge between care coordination and analytics integrates information from across the care continuum and brings the insights to the people delivering care, empowering care teams to address individual needs at the patient level and make decisions about how to best spend their scarce time and resources for the entire population. We are working toward a future where data-driven technology creates insight that can optimize overall care delivery, significantly improving the coordination, collaboration, and financial efficiency among providers and improving the health of entire populations.