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# Better Data: The Value-based Care Differentiator

## How to get physicians the insights they need to improve outcomes and lower costs

To say physicians are tired and frustrated is an understatement. Research shows primary care providers need an average of 26.7 hours to carry out guideline-recommended care and administrative tasks on a given day, three hours of which are needed for documentation and inbox management alone. Morale is much lower than in years prior. And in 2021, nearly 63 percent of physicians reported at least one manifestation of burnout — characterized by exhaustion, depersonalization and a lowered sense of accomplishment.

These factors encompass only a fraction of what's contributing to current healthcare staff shortages. Today's hospital, health system and physician leaders must find ways to better support clinical teams, especially amid greater demand for complex care for patients with multiple chronic conditions. Industry groups like the American Hospital Association are urging organizations to use technology to bolster staff and achieve better patient outcomes, lower costs and improve health equity — the pillars of value-based care — while being careful not to add to physicians' already steep administrative burden.

Effectively shifting to value-based care requires better clinical information that reaches physicians at the right time, easily. *Becker's Hospital Review* spoke with Paul Gentuso, MD, chief medical officer for Nashville, Tenn.-based Heritage Medical Associates, and Becky Trotter, vice president of population health solutions at CareAllies, to learn how the proper technology, processes and expertise can support physicians' access to better data and improve outcomes for patients and healthcare organizations alike.

## The rise of chronic conditions and the need for patient centricity

More and more Americans are living with multiple chronic conditions. This presents challenges for patients, physicians and the broader healthcare system. In fact, patients living with multiple chronic conditions account for 64 percent of all clinician visits, 70 percent of all inpatient stays, 83 percent of all prescriptions, 71 percent of all healthcare spending and 93 percent of Medicare spending. These patients also require more complex care, which presents additional challenges amid severe staff shortages and financial pressures.

"Polypharmacy is one of the biggest issues we face," Dr. Gentuso said. "Patients are on so many medications right now that our doctors really need to be very familiar with drug-to-drug interactions." Moreover, there's the cost factor. "We have to help our patients be on safe sets of medicines, but also affordable sets of medicines," he added.

Caring for patients with multiple chronic conditions also requires enhanced communication and coordination, often between specialists, which places operational strain on hospitals and health systems. "When we have more specialist engagement, that's when we really start needing health information exchange," Dr. Gentuso said. "We really need to be communicating well between primary care doctors and specialists."

Additionally, Dr. Gentuso noted how increased incidence of chronic diseases underscores the need for patient centricity and multiple pathways for engagement — whether it's reaching out to patients to schedule regular preventive screenings or clinic visits, or activating patients to participate in their own care via the patient portal or physician-patient education.

But even when patients with multiple chronic conditions are actively engaged in their care plans, it is often difficult for them to keep track of every issue. This is especially risky when patients are receiving care outside of their primary care physician and communication and data-sharing between facilities is limited.

"Patients are not always what we would consider the best 'historians,'" Ms. Trotter said. "So when a patient is coming in for one particular problem, they may not realize how important it is to mention that they also have diabetes, congestive heart failure, COPD, chronic kidney disease or a history of seizures." When a physician has little to no context and is relying only on the patient's perspective, Ms. Trotter said this often results in facilities spending undue time and resources performing duplicative workups and evaluations, which can frustrate patients — or in worse scenarios, providers might prescribe medication or treatment plans that adversely interact with others the patient is already following.

Amid growing financial pressures and limited staff, healthcare organizations striving to administer value-based care successfully must find ways to identify patients' chronic conditions sooner, improve outreach, activate patients in their own care plans, and lower costs via better health outcomes. To achieve these aims, physicians need actionable, real-time insights at the point of care.

## The right data at the right time: challenges and solutions

Physicians' need for actionable patient data is clear, but *when* they access this information is just as essential.

"Doctors really need data at the point of care to help them take care of the person in front of them," Dr. Gentuso said. "And they want something that's going to help them decide if this person has a need for cancer screening or the need for preventive steps like immunizations, or if there's a chronic disease management need."

But getting data to physicians during patient interactions is challenging for many reasons. For one, aggregating data from multiple, disparate sources often is not possible or requires additional steps, logins or complicated data-sharing agreements. Like many facilities, Dr. Gentuso's multispecialty physician group uses an EHR system that differs from systems of other local hospitals and clinics where patients also receive care. Sometimes, his physician teams can access data from hospital interfaces — information exchanges they have with local hospitals — but accessing this information requires more manual steps and logins to separate data systems, which most physicians don't want to do or don't have time to do while caring for a patient. "They want the information to be right there, in the EHR," said Dr. Gentuso.

Aggregating data from multiple sources and making it *usable* is where CareAllies steps in. As part of its population health strategy, CareAllies acquires clinical, commercial payer and CMS data on behalf of providers, which is then delivered through local people resources to help physicians turn insights into clinical actions. "We do the work on the back end to aggregate it for them, so it takes the burden off their plates," Ms. Trotter said. Over 4,000 clinical end users, from those at integrated health systems to independent physician practices, are taking advantage of these analytic insights today.

CareAllies also offers an option for practices to integrate actionable analytics in their existing EHR, making it easy for physicians to access the data they need on one platform as opposed to switching between systems and logins. "This is not intended to replace their EHR," Ms. Trotter said. "It's meant to supplement the data that they have sitting in their office in the easiest, most efficient way possible."

Streamlined access to better data also gives time back to physicians to prepare for in-person patient visits. "It really makes a big difference," Dr. Gentuso said. "When a patient comes into a room and the doctor has taken the time to gather their recent hospitalization information, information from specialists and understands what the patient's experience has been between visits with the PCP — those patients just feel cared for and attended to and are much happier."

CareAllies also offers physician training and education on topics like care transition management and advanced platform access to empower physicians to leverage these data-driven insights — an important, complementary feature for patient-centric care and improving outcomes, Ms. Trotter noted. "If the patient is having a good experience and getting their needs met, their behaviors start to change and the dominoes start to fall in terms of quality outcomes supporting lower costs," she said.

In addition to point-of-care data and insights for physicians, CareAllies recognizes how other provider types require access to patient information outside of the physician-patient interaction. For example, population health teams need access to lists of patients due for preventive care, preventive screenings or chronic disease management. Dr. Gentuso shared how he previously tasked his physician team with reaching out to patients on these care gap lists, but saw little success. “No doctor or their staff who’s taking care of patients in front of them really has time to think about the patients who are not scheduled for the day,” he said. That’s when Heritage Medical Associates tapped CareAllies for a dedicated team of patient liaisons to attend to care gap lists and help with collecting and reporting quality data.

Heritage Medical Associates’ 10-year partnership with CareAllies — which has involved services ranging from data and analytics to medical management and quality improvement efforts for the group’s Medicare patients — has yielded better care for the patients. Dr. Gentuso said the partnership has enabled higher rates of preventive screenings for depression, breast cancer, colorectal cancer and closer monitoring of patients’ A1C levels. They’ve also seen boosted CAHPS scores. “I think patients are having a better experience,” he said.

Much like its clinical partners, CareAllies strives for continuous improvement and is on to the next innovation that will support value-based, patient-centric care. Ms. Trotter previewed an upcoming point-of-care offering, CareAllies’ Next Best Action tool. This solution is designed to guide physicians through a set of individualized, quality-focused actions they can take to ensure patients receive the preventive services they need. It will also help to ensure physicians are documenting chronic conditions appropriately, and will prompt them to collect social insights like patients’ transportation needs, enabling a more thorough understanding of patients’ barriers to care.

## Giving physicians time: the key to success

Actionable data at the point of care — where physicians need it — can help clinical teams deliver better care to patients, especially those with multiple chronic conditions. When hospitals, health systems and physician organizations commit to adding the right technology, processes and expertise, they relieve physicians of administrative burden and give back time for meaningful patient interactions that can support better outcomes.

“Now, there is time for those other conversations: ‘Do you have access to food? Do you have access to stable housing? Do you have a way to get to your PCP?’” Ms. Trotter said. “Those are the conversations that, quite frankly, don’t otherwise happen because physicians have a limited amount of time with a patient and they’re trying to address and track down everything else.”

Reflecting on Heritage Medical Associates’ long-time partnership with CareAllies and the growing number of organizations embracing value-based care, Dr. Gentuso offered clinical leaders some parting advice: “Don’t ignore what’s coming,” he said. “Get into a relationship with a partner who knows what they’re doing, who will stay engaged with you, who will listen to you and adjust their plans. You need a trustworthy partner to navigate value-based care.”