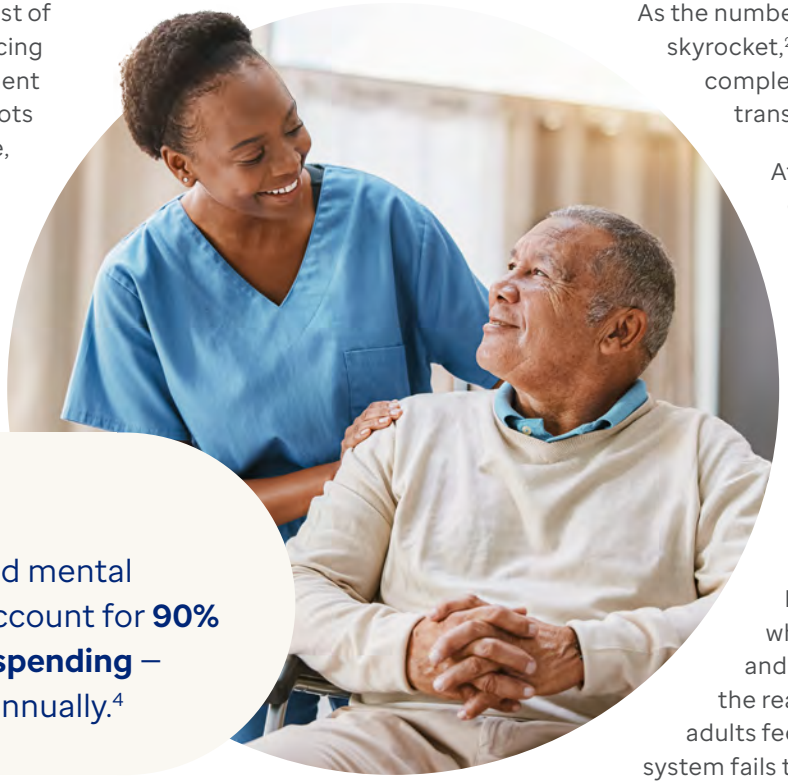
Optum

Fragmented, Integrated or Somewhere in the Middle?

A guide to reimagining complex care delivery in 2024 and beyond

Care delivery in the U.S. is evolving as payers look to deliver improved consumer experiences and on-demand accessibility, but this shift will take time

How can payers make the most of the messy middle? By embracing sophisticated care management programs that connect the dots between distinct sites of care, providers, specialties and resources. New research confirms what payers and providers already know – patients today need more complex care than they did 20 years ago.[1]



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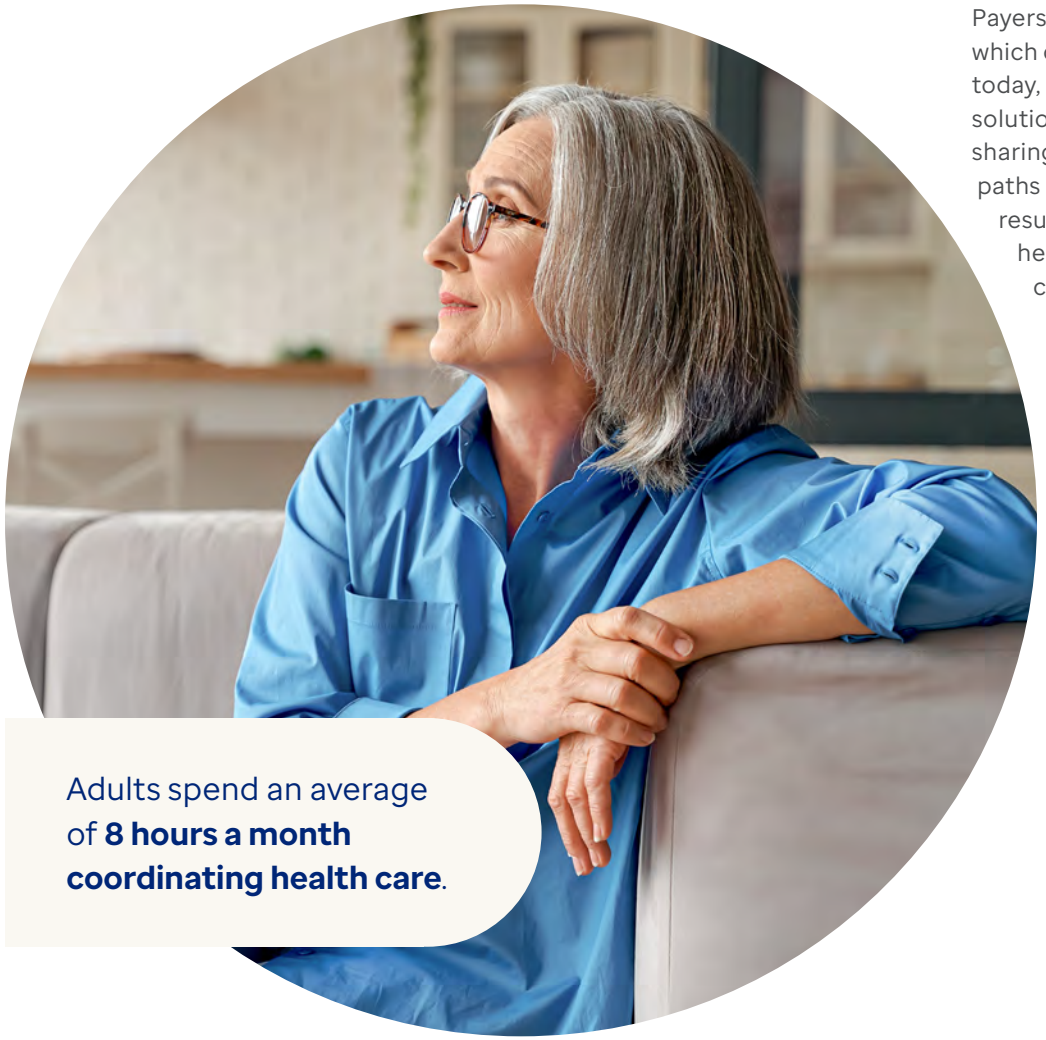
Chronic diseases and mental health conditions account for **90% of U.S. health care spending** – nearly **$4.1 trillion** annually.[4]

As the number of Americans with chronic health issues continues to skyrocket,[2] both the quantity of diagnoses and cost of care related to complex needs – from cancer treatment and kidney disease to organ transplants – are growing at an untenable rate.

At the same time, individuals with conditions that are not generally considered complex, such as pregnancy, are also experiencing more complications due to a significant increase in the prevalence of chronic physical and behavioral health conditions before becoming pregnant.[3]

To respond to these and other challenges, the health care industry has been trying to transform for years. Payers, employers and providers understand that fragmented care delivery increases costs and lowers quality while leading to poor patient experiences.[5,6] They know that the old fee-for-service model, with its misaligned incentives, has contributed to rising costs without creating better health. Health care has come a long way in recent years, especially when it comes to electronic health records (EHRs), virtual care and emerging models for delivering better value-based care. But the reality is that there's still a long way to go. Today, 65% of U.S. adults feel managing health care is overwhelming, and 73% say the system fails to meet their needs in some way.[7]



Adults spend an average of **8 hours a month coordinating health care**.

Payers and employers don't have time to wait for a far-off future in which care is perfectly digitized and integrated. The good news is that today, even in the middle of this bumpy journey, technology can enable solutions. Within a still-siloed system, robust coordination and data-sharing capabilities can harmonize clinical care and smooth patients' paths across sites, providers, and emerging start-up services. This can result in a personalized, efficient and ultimately more successful health journey for the many millions of Americans struggling with complex conditions.

This style of care depends on **4 central pillars**:

- Moving beyond hospital walls
- Maximizing specialty impact
- Smoothing the patient experience
- Putting data to work

Here's how to start building.

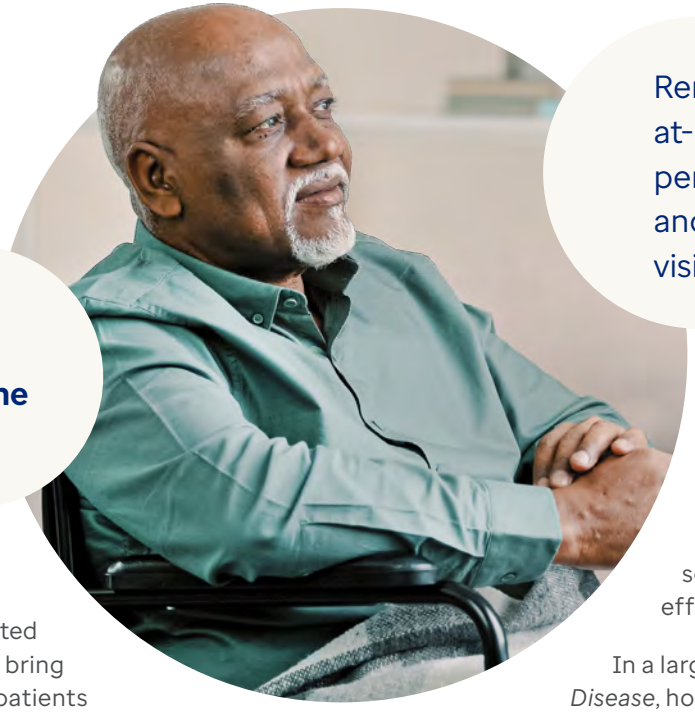
Pillar 1

Optimizing where care is delivered

Too often, patients with complex conditions experience gaps in care that trap them in a cycle of hospitalizations and emergency department (ED) visits. What's behind these frequent visits?

Research shows a few factors are likely at cause:[8]

1. Medication side effects or other adverse events
2. Fragmented care due to visiting multiple providers



Patients prefer to **receive care at home** rather than in a medical facility.[9]

To break this expensive, inefficient cycle while continuing the shift to patient-centered care, the health care industry is leveraging pandemic-accelerated advances in telehealth and other remote services to bring care inside patients' homes. At-home care benefits patients and payers alike. Patients prefer to receive care at home rather than in a medical facility,[9] and research indicates that at-home care can improve quality while lowering costs.[10]

Remote patient monitoring and at-home care can augment in-person care, **empowering patients** and creating continuity between visits to their PCP and specialists.

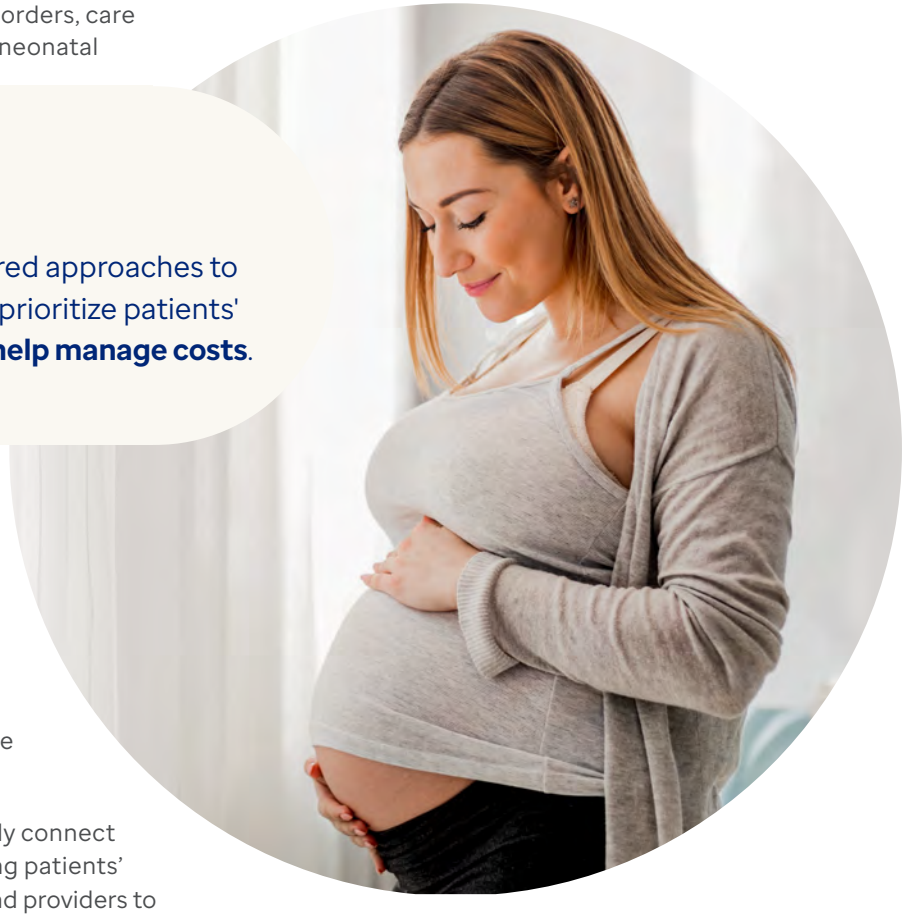
Consider hemodialysis for patients with end-stage renal disease (ESRD). Shifting this critical treatment to the home can dramatically improve patients' quality of life by saving them scheduling and travel time and allowing more frequent treatment sessions. All of which can lead to fewer side effects and better outcomes.[11]

In a large study in the *American Journal of Kidney Disease*, home hemodialysis was associated with an 8% lower risk of hospitalization and a 20% lower risk of all-cause mortality.[12] It's not surprising that more than 90% of nephrologists said they would choose a home therapy for themselves.[13]

At-home prenatal care for women with high-risk pregnancies is another way to improve outcomes while managing costs. By sending nurses into women's homes to administer medication, manage nausea and vomiting, and address issues created by diabetes and hypertensive disorders, care management can lessen the likelihood of preterm births, birth complications and neonatal intensive care unit (NICU) stays.[14]

The best complex care programs leverage technology that allows providers to administer home dialysis and other proven at-home interventions, as well as remotely track patients' vital signs and biometric data to help them manage their conditions at home.

Patient-centered approaches to complex care prioritize patients' **comfort** and **help manage costs**.



But the goal is not to fully replace in-office doctor appointments or hospital procedures. Instead, remote patient monitoring and at-home care can augment in-person care, empowering patients and creating continuity between visits to their PCP and specialists. New types of provider relationships — in-home primary care, care managers who make house visits, specially trained paramedics — are emerging to further assist patients with complex needs while blurring the line between hospital and home.

Given improvements in health apps and online portals, complex care programs can also seamlessly connect at-home care with a patient's network of providers, so everyone has access to the patient's data. Improved data sharing allows the entire care team to better understand patients and their environments while making decisions that impact care. It also improves the ability to catch problems or change care management plans before a patient lands in the ED.

By creating a patient-centered approach, complex care programs can meaningfully connect care across a variety of providers and settings while managing costs and prioritizing patients' comfort. An increased focus on in-home care plays a crucial role, allowing payers and providers to work together toward better outcomes, lower costs, improved service and higher satisfaction.

Pillar 2

Building a sophisticated approach to maximize the impact of clinical expertise

When business executives want to accelerate performance and improve customer service, they often simplify operations

But massive simplification is more challenging in the world of complex health care. Today, many patients have multiple comorbidities, require care across multiple clinical specialties, and may benefit from new, experimental or genetically personalized treatments that bring ever-changing protocols and considerations.

Optimizing and managing, rather than eliminating, complexity is critical to successfully identifying at-risk patients and helping them **navigate their condition and the care system**.

Rather than trying to streamline these cases with a one-size-fits-all care management approach, complex care management teams should lean into the details.

Just as complex patients benefit from many medical specialists with years of condition-specific experience, the best complex patient management brings the same level of expertise to address distinct practice patterns and evolving treatments.

For example, patients with chronic kidney disease (CKD) benefit far more from experienced CKD care managers and advocates who have the specific knowledge necessary to best manage this progressive condition. This includes an understanding of the best resources, providers and sites of service, including kidney transplant centers of excellence.

Sophisticated complex care management also uses predictive modeling and specialized data to further tailor treatment. These precise approaches can improve patient outcomes, including enabling early diagnosis of CKD and opportunities for preemptive living donor kidney transplants. Take the example of a project funded by the National Science Foundation (NSF). The initiative is attempting

to address the shortfall of available kidneys for the 110,000 people waiting for one by developing algorithms that can better match organs with recipients and address racial and economic inequities in the organ transplant field.[15]

Beyond CKD, cutting-edge specialized data is critical to oncology management, especially when patients and providers can benefit from credible reports on in-progress research rather than wait for the results of multiyear clinical trials. There are also an overwhelming number of evidence updates annually detailing which drugs may be appropriate for which patients. Having a dedicated oncology nurse who understands and keeps up to date on these intricacies can be crucial.

All told, well-designed care management aims to optimize the high-performance, incredibly detailed machine that is specialty care. Optimizing and managing, rather than eliminating, complexity is critical to successfully identifying at-risk patients and helping patients navigate their condition and the care system. This approach also supports specialists and other clinicians by streamlining data transmission and reducing administrative headaches.

Predictive modeling and specialized data can **help diagnosis CKD earlier** and **benefit oncology management**.

Pillar 3

Creating a holistic model to remove barriers and build hope

Beyond the inherent challenges of living with a complex disease, many patients also struggle to access affordable, high-quality care for their conditions

When care is complex, the risk of barriers to that care grows. The result of these barriers is that patients may:

- Need help understanding their treatment plan
- Miss appointments due to financial or transportation concerns
- Slip through the cracks during care transition

Comprehensive care management for complex patients aims to remove these barriers by focusing on whole-person health, including physical, mental and financial well-being. Experienced care managers can help patients:

- Go over the details of their clinician visits and care plans
- Access manufacturer coupons or other discounts to make prescriptions more affordable
- Actively assess new treatment options
- Find providers best positioned to deliver the precise care required

About 20% of all Medicare, Medicaid, commercial outpatient, ED and home health spending could be **virtually enabled**.[16]

Additionally, the work of these managers can be complemented by digital tools, such as virtual pharmacy consults, personalized educational videos, texting programs and specialty patient portals. These tools can also assist patients in accessing resources, managing their condition and staying adherent.

Let's look at the impact of this approach on a specific disease like cancer. Often, a cancer diagnosis is an emotional event that is quickly followed by the need to make care decisions and begin treatment, an understandably overwhelming scenario. Care management that includes center of excellence networks can ease the decision process by identifying top-performing cancer centers and facilitating second opinions. Similarly, care management led by one contact, such as a specialized cancer nurse, can smooth the decision-making journey while helping to prevent and manage symptoms and side effects, manage prescriptions, and access additional resources and specialists as needed.

Pillar 4

Integrating data to continuously track performance and outcomes

Major improvements in data analytics have enabled payers and providers to drill deeper into complex care management

Today, advanced care management programs can continuously monitor everything from program use and medication adherence, to changes in hospital admission and readmission rates.

By leveraging data analytics software that integrates EHR, claims data and third-party data about social and behavioral factors, these management programs can offer deep insights to patients. This can help optimize program participation and performance while driving data-driven care decisions that improve treatment outcomes.

A sophisticated data approach can be just the bridge between fragmentation and integration that today's complex care patients need. When data is easily collected, transferred and shared, it connects the dots and creates a bigger picture that can otherwise be obscured as patients move across physicians, facilities and supportive services.

By sharing data through an advanced care management platform, payers and providers also enable a scalable approach that can lead to advances in care protocols while empowering providers to prioritize the most important interventions and effectively allocate resources for complex care patients, leading to better clinical and financial outcomes.

A **sophisticated data approach** can be just the bridge between fragmentation and integration that today's complex care patients need.

Conclusion: The future is now

As the fragmented U.S. health care system continues to make incremental progress toward integration, payers and providers must take a proactive approach and use technology to create a holistic, efficient care management approach for complex patients.

Optum can help unlock the power of data and enable continuous coordination to improve care, access and outcomes while creating a more sustainable future.

Learn about Optum solutions for **kidney**, **transplant**, **oncology** and **women's health**.

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