GUIDE:

The four keys to a successful, technology-enabled payer-provider partnership

Fueled by changes in payment models, advances in technology, and shifting marketplace demands, payer-provider partnerships are becoming more collaborative than ever. Indeed, the success of any health care organization in today's world is largely influenced by healthy and productive partnerships among payers and providers. What exactly ensures a successful partnership? Technology plays a primary role in bringing together these two entities that have traditionally operated from either side of a digital divide.

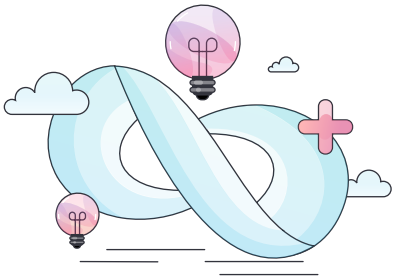
Read on to learn more about the keys to ensuring successful partnerships among payers and providers. →

1 Portals and spreadsheets do not equal connectivity

Payers must be willing to share clinical and claims data with providers, but the status quo of provider facing spreadsheets and portals has not solved for true provider-enabling connectivity. Provider-facing spreadsheets or patient-specific lists, often delivered through secure email, are manual, time intensive, and error-prone to work with. Many payer portals, though designed with best intentions, add to an already cumbersome administrative workload for providers by requiring an out-of-workflow login and query process that can drain valuable time from patient care activities. Standard single payer portals have struggled with provider engagement, and even multi-payer portals add clicks and time to clinicians and care team staff days.

Whether relying on portals or lists, payer-to-provider data transfer efforts that exist outside of existing workflows require substantial time and effort from provider teams and thus often leave performance targets unmet. Instead of relying on portal and static lists, payers should look for solutions that drop patient insights into the point of care so providers can gain valuable data without having to shift their focus or leave their existing workflows.

2 Surface insights within clinical workflow for better outcomes



If patient information isn't readily available where and when providers need it, it might as well not exist. Providers need contextually relevant data at the point of care, not before or after. This will lead to better outcomes and improved patient experience, as provider teams will be able to spend more time supporting patients and less time hunting down data from disparate sources.

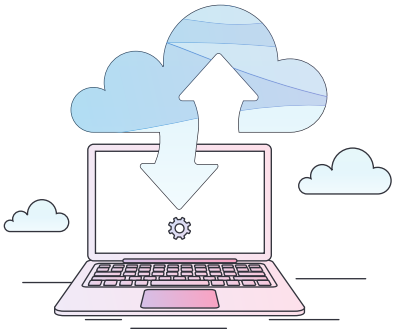
Given that current clinical workflows take place almost entirely within EHR systems, health plans should integrate data directly into those environments whenever possible. When insights are surfaced within existing EHR workflows, providers can quickly and easily refer patients to high performing specialists and address quality and diagnosis gaps, while payers can take advantage of bidirectional connectivity to get point of care data faster and more effectively. Through responsive write-back functions, providers can document or dismiss diagnoses with one click.

3 Shared incentives and clear goals bring both parties to the table

As payers and providers shift from fee-for-service to value-based reimbursement, both parties must align on incentives and share accountability to achieve shared upsides and succeed financially. This may result in different financial arrangements depending on providers' readiness to manage risk, which can require a greater level of collaboration than in traditional fee-for-service models.

Health plans seeking to support more of their network providers in the journey to risk and value based care must provide clear targets and supportive infrastructure to enable success under more advanced contracts. Historically, support for primary care networks has taken the form of manual data transfer, some limited performance visibility, and on-the-ground clinical performance consulting. Progressive health plans are increasingly taking these strategies digital by offering their networks performance enablement technology with enhanced data, workflow support, and greater performance visibility.

4 Respect implementation fatigue by moving on from time intensive IT projects



Traditional integrations between payers and providers have relied on legacy data transfer connections that require significant investments of time from already stretched provider IT teams. Months-long implementations get slotted into priority queues, and rollout calendars seem to extend endlessly. Payers should respect provider IT constraints by rethinking their approach to integration and implementation. A new generation of integration technology, powered by agent-based connections, robotic process automation, and dynamic API interactions, is expanding what's possible and dramatically reducing timelines and implementation effort required. When used effectively, the result can be direct clinical workflow connections for payers, radically lower burden for providers, and measurably accelerated performance across value-based partnerships.

Providers are looking to move quickly and get back to helping their patients. Be a conduit for change by enabling adoption of the latest technology to establish true connectivity between payers and provider partners.

Next Steps

Primary Care Organizations

Power providers' in-EHR workflows and close more quality and diagnosis gaps with ease using Vim's point-of-care engagement and connectivity platform.

Visit getvim.com/quality_and_risk_adjustment/ for more information on how Vim automates in-EHR workflows at scale.

Health Plans/Insurers/Data Sources

Get streamlined and scalable digital connectivity to provider EHRs for your member panels through a single integration point using Vim's point-of-care engagement and connectivity platform suitable for any practice size or EHR. Let Vim surface relevant member data for providers during in-EHR workflows for improved quality and risk-adjustment performance.

How Vim is Powering the Future of Healthcare

Vim Diagnosis Gaps embeds suspected diagnoses directly into provider EHRs for enhanced awareness and increased provider engagement, and it digitizes workflows such as automated EHR write-back for accurate capture.

Vim Enhanced Eligibility offers at-a-glance confirmation of active insurance eligibility status and details on plan design - from plan coverage dates to out-of-pocket costs when available - saving pre-visit time and reducing visits to portals or calls to payer contact centers.

Vim Order Assist helps care teams select high-performing, in-network referral destinations during an EHR order with real-time data - this means fewer steps and more confidence in patient care plans.

Vim Patient Health History expands care team awareness of a patient's health journey with payer claims-based data summaries.

Vim Prior Authorization streamlines prior authorization processes through direct connections to payer rulesets and systems including automated prior auth checks and quick code lookup to case submission and status search and update – all without leaving the EHR.

Vim Quality Gaps places quality data, such as HEDIS, directly into EHR workflow for improved quality performance.

For more information, please visit getvim.com or contact info@getvim.com.