

EXECUTIVE INSIGHTS

RESILIENCY + RECOVERY



CREATING A SUSTAINABLE HEALTH-FIRST MODEL WITH VALUE-BASED CARE

Strategies and best practices for transitioning to risk-based models

Creating a sustainable health-first model with value-based care

Strategies and best practices for transitioning to risk-based models

Value-based care relationships among providers, payers and employers are evolving in response to a health care economy that is under pressure from escalating costs, an aging population, rising consumer expectations, delivery disruption and increased regulatory requirements. The shift is moving slower than anticipated but roughly 61% of all health care payments are tied to value and quality in some way. Yet even though many providers have experience with risk-based programs, their respective performance on quality, cost reduction and shared savings can vary. This executive dialogue examines the current state of value-based care, the value-based care initiatives providers are prioritizing and best practices to excel in these programs.

7 LESSONS FROM THE FIELD ON VALUE-BASED CARE

- **1 DATA MINING**

Getting experience with the value journey helps to know the patient population and the issues around social determinants. It's an advantage to dig into the data and understand the trends.
- **2 GOVERNMENT PROGRAMS**

Hospitals and health systems participating in Medicare Advantage and Medicaid accountable care organization (ACO) programs have been able to drive value and savings by reducing admissions and emergency department (ED) utilization. During the pandemic, being involved in the Medicaid risk track or state programs for the uninsured and underinsured helped to provide needed care navigation, counselors and community-based services.
- **3 TECHNOLOGY**

Organizations are deploying technology to streamline care management strategies and care retention strategies for high utilizers or people with complex conditions.
- **4 DETERMINING SUCCESS**

Success in value-based care models varies among health systems and their patient populations, payers and employers. By using data to identify who's using services and what the issues are, providers are able to deliver person-centered care that meets people where they are and target care coordination to improve outcomes; reduce admissions and ED utilization; and improve health status.
- **5 CAPITATION MODELS**

It may be time to look at full-risk capitation models to promote the best interests of patients and health outcomes. With a more predictable cash flow, the incentives are to explore preventive care and cost-effective care processes and help patients overcome barriers to health and change lifestyles.
- **6 RISK-AVERSE**

Risk-based arrangements are a small percentage of value-based care among hospitals. In many markets, payers evaluate providers on quality measures, but aren't as far along in risk-based payments. Many providers are engaging with employers in direct contracting and bundled payment arrangements. However, they are finding that employers are still working through the right balance of health care options that will help them attract talent.
- **7 MARKET SHARE**

Some providers participate in value-based care arrangements to gain market share — not only to get stickier with the consumer and engage patients as a hedge against current competition within their market, but also as a protection strategy against new entrants.

PARTICIPANTS



Bruce Bailey

/ PRESIDENT AND CEO

TIDELANDS HEALTH | GEORGETOWN, SOUTH CAROLINA



Tim Charles

/ PRESIDENT AND CEO

MERCY MEDICAL CENTER | CEDAR RAPIDS, IOWA



Sally Dowling, M.D.

/ VICE PRESIDENT OF MEDICAL AFFAIRS

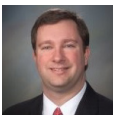
ATLANTIC GENERAL HOSPITAL AND HEALTH SYSTEM | BERLIN, MARYLAND



Lori Herndon, MBA, BSN, R.N.

/ PRESIDENT AND CEO, BOARD CHAIR, NEW JERSEY HOSPITAL ASSOCIATION

ATLANTICARE | EGG HARBOR TOWNSHIP, NEW JERSEY



Bryan Jackson

/ VICE PRESIDENT AND CHIEF ADMINISTRATIVE OFFICER

JEFFERSON REGIONAL MEDICAL CENTER | PINE BLUFF, ARKANSAS



J. Stephen Jones, M.D., MBA, FACS

/ PRESIDENT AND CEO

INOVA HEALTH SYSTEM | FALLS CHURCH, VIRGINIA



Charlton Park

/ CHIEF FINANCIAL OFFICER AND CHIEF ANALYTICS OFFICER

UNIVERSITY OF UTAH HOSPITALS AND CLINICS | SALT LAKE CITY, UTAH



Kevin Seabaugh

/ VICE PRESIDENT AND HEALTH NETWORK GENERAL MANAGER

ORACLE CERNER | KANSAS CITY, MISSOURI



Shawn Tester, MSOL

/ CEO

NORTHEASTERN VERMONT REGIONAL HOSPITAL | ST. JOHNSBURY, VERMONT



Denise Webber

/ CEO

STILLWATER MEDICAL CENTER | STILLWATER, OKLAHOMA



MODERATOR Lindsey Dunn Burgstahler

/ VICE PRESIDENT, PROGRAMMING AND MARKET INTELLIGENCE

AMERICAN HOSPITAL ASSOCIATION | CHICAGO, ILLINOIS

CREATING A SUSTAINABLE HEALTH-FIRST MODEL WITH VALUE-BASED CARE

MODERATOR (*Lindsey Dunn Burgstahler, American Hospital Association*): **In what types of value-based arrangements is your organization involved and what has been the impact on your organization? What improvements in quality of care and cost reductions are you seeing?**

SALLY DOWLING (*Atlantic General Hospital and Health System*): Maryland is a unique rate-regulated all-payer state, which makes things different on a lot of bases, but we have been involved with Maryland's Medicare program, the Maryland Primary Care Program (MDPCP) and our primary care offices in Delaware have been involved with the Primary Care First program. We've seen a lot of improvements in quality and costs, mainly around readmissions. We've had a vast improvement in readmissions through robust care coordination.

One of our struggles has been unsupported ED utilization. We've had difficulty affecting that number, even though we have availability and access in primary care and urgent care.

SHAWN TESTER (*Northeastern Vermont Regional Hospital*): Northeastern Vermont Regional Hospital is a 25-bed, nonprofit, independent, critical access hospital in a rural part of Vermont. The state had negotiated a waiver with the Centers for Medicare & Medicaid Services (CMS) six years ago to implement an accountable care (ACO)-based, all-payer model that would drive us toward value-based care. We've been on that journey for about five years. You could opt into three risk tracks: a Medicare risk track, a Medicaid risk track and commercial insurances. For a critical access hospital, nobody knew how to make the Medicare risk track work effectively because of our cost-based reimbursement. All the critical access hospitals have opted out of the Medicare risk track. That's a hole in the model that needs to be addressed.

For the last three years, we've been on the Medicaid risk track, which we were trying to pilot while we

also navigated the global pandemic. Because of the pandemic, it's been helpful to be in that Medicaid risk track. We have been able to drive down our avoidable ED visits by about 17% to 18%.

MODERATOR: **What is accelerating or hindering your organization's adoption of value-based care initiatives?**

LORI HERNDON (*AtlantiCare*): We started our ACO about 12 years ago and it's been a journey. As a registered nurse, I believed it made sense to provide the right care in the right place. We are in southeastern New Jersey and Horizon Blue Cross Blue Shield is the dominant player in our market. We're involved in a lot of bundles and smaller engagements with self-funded companies in Atlantic City.

With the orthopedic bundles, we saw dramatic quality improvements and lower costs per case. And in our market, post-acute care utilization was high so we started to look at best practices and work to decrease utilization.

A lot of our competitors in our market never got on the value journey. They dabbled a bit. During the pandemic surges, it was great to see some money flow in because of the reduction in utilization.

TIM CHARLES (*Mercy Medical Center*): Our journey began well before this topic was introduced. We employ about 140 providers. We've had our primary care physicians engaged in achieving quality metrics for 15 years, where a portion of their compensation was linked to measurable quality improvement outcomes. It was a way of stepping into value-based care as we believed that was the direction health care was going. Compared to the rest of the nation, Iowa is a low-cost state and our quality outcomes tend to be good.

Today, we're involved in risk relationships with Medicare, Medicare Advantage and Wellmark. We've

CREATING A SUSTAINABLE HEALTH-FIRST MODEL WITH VALUE-BASED CARE

done well and it's been beneficial. We've had good pickups every single year.

The health care field is changing quietly behind the scenes, but radically, and it has little to do with the opportunities associated with value-based care. The locus of health care delivery is leaving our hospitals: it's moving into entirely different settings. That's tough for us to wrap our heads around because we love our assets. We love our hospitals. Our growth, however, is all outpatient. It's in our ambulatory surgery centers. It's post-acute. It's in the clinics. It's the procedures the payers and consumers are driving into our specialty clinics.

Our attention, time and resources are being re-directed to address the social determinants of health. We are being positioned to become the social safety net for the communities served by our institutions. We are being called upon to right systemic inequities.

Taken together, these trends and increasing expectations will intensify the efforts to redesign payment structures. As health care providers are positioned to be accountable for not only achieving the Triple Aim but also the health of their communities, they will seek to step well beyond incremental risk-sharing models to ones with maximum access to the full premium dollar, in other words capitation.

DENISE WEBBER (*Stillwater Medical Center*): We started into this space in 2012 as part of the Medicare Comprehensive Primary Care Initiative (CPCI) program and built tremendous infrastructure, had great success and lowered the cost of care. That program was the best program that Medicare put out because it helped you invest the infrastructure dollars to get the savings. Consultants were engaged to help you learn in this space. We were a

part of that program for nine years.

From a clinical point of view, we were out of the ballpark on quality measures and reducing ED visits. It didn't happen on the front end. We learned that it's social issues when you have a lot of high utilizers and sometimes it's just loneliness. We had to tackle it differently than the clinical side.

We are also independent. We joined part of a network of other hospitals to try to become a larger player in this space. Throughout the pandemic, when operating margins are challenged, you realize that how the payment models are stacked up currently can't go on forever. We do think things are moving in the direction of value-based care.

BRUCE BAILEY (*Tidelands Health*): Tidelands Health serves a big retirement community with Medicare being the largest payer and 70% of the revenue coming from outpatient services. We're probably one of the largest providers of acute rehab services.

South Carolina chose not to expand Medicaid, but it created the Healthy Outcomes Plan (HOP) to manage the underinsured and uninsured in our community. We take on the risk for those who aren't insured. We jumped

on that, and we have great results. We wrap our arms around the uninsured and underinsured with care navigators, counselors and community-based services. We were able to push ED visits down 30% for that group and admissions down 16% to 20%. Nobody's asking us to do it. We do it because it's the right thing to do for the uninsured.

MODERATOR: Kevin, you have a unique role within Cerner. Tell us about yourself and share some high-level observations on top priorities when

"Throughout the pandemic, when operating margins are challenged, you realize that how the payment models are stacked up currently can't go on forever. We do think things are moving in the direction of value-based care."

— Denise Webber —
Stillwater Medical Center

CREATING A SUSTAINABLE HEALTH-FIRST MODEL WITH VALUE-BASED CARE

implementing value-based care initiatives.

KEVIN SEABAUGH (*Oracle Cerner*): I run our health network business. There are two verticals in that business: One is our population health management business, which is anchored by our data and insights platform, called Cerner HealthIntent, and the other is our continuum of care business. It's the behavioral health, mental health, home, rehabilitation, long-term care — those types of facilities that are increasingly part of the networks that you're operating. It's been said a couple times: value-based care has been a long time coming and we keep talking about it, but it hasn't received sufficient traction either because we haven't seen enough in our local market or we can't get the per-panel density for providers. It's kind of a distraction from fee-for-service. We think, based on our client conversations, that the current market environment lines up well to be a catalyst for a more rapid move to create a path to value. This includes opportunities to mature existing value-based care capabilities and to accelerate development of new capabilities.

We've heard some common themes that emerged today. Some providers are looking for a revenue-diversification strategy — the idea of a capitated payment model and recurring predictable revenue that acts as a buffer against the dramatic change in demand that happened with COVID-19 during which fee-for-service business dropped to nearly zero. Increasingly, it's also a competitive advantage as you think about consumer engagement. Leaders from some organizations say, 'I think I've stitched together enough density within a market so that I can manage the total cost of care across a network.' They want to participate to gain market share — to get stickier with their consumers, which they view as a hedge against current competition within their market, but also as a protection strategy against new entrants. In many markets, private equity and other organizations like insurance companies are aggressively buying up provider practices and

creating a network that doesn't include a hospital.

When health system leaders talk about the path of value, conversation centers around 'The cause is noble, but the path is tough because any move to value requires a business and practice transformation.' The question becomes: How do you manage the stress of the workforce when it already has as much stress as it can handle? But even with the challenge of practice redesign and transformation, we have been seeing some success.

We've seen initial success with clients that have started in Medicare ACOs and Medicare Advantage. Benchmarks can be a challenge, but it's clear how you are paid for that. There are some good developments in organization governance models and provider alignment, which helps organizations think through a panel-density, change-management perspective.

Increasingly, organizations are deploying technology to streamline care management and retention strategies for high utilizers, or patients with a high cost of care. We think we can help advance value by applying technology to allow you to generate insights, identify high utilizers and do it in a way that is less burdensome on an already stressed workforce.

MODERATOR: What current care delivery arrangements are concentrated in value-based models? What areas might grow in the next two to three years?

BRYAN JACKSON (*Jefferson Regional*): We're located in southeast Arkansas, we're rural, and agriculturally and economically challenged. We started looking at value-based care and the Medicare Shared Savings Program as a way to work together without mergers and acquisitions, because everybody in each of these communities wants their hospital to remain locally controlled. We formed our clinically integrated network in 2018

CREATING A SUSTAINABLE HEALTH-FIRST MODEL WITH VALUE-BASED CARE

and entered into shared savings in 2019. Several critical access hospitals chose not to participate because they felt that it didn't make financial sense. We achieved savings in our first two years by looking at high ED utilization and using our care coordinators to call those patients to ask why they are going to the ED so often and work with them to get a primary care provider (PCP), if they didn't have one.

We employ around 75 physicians and nurse practitioners. Where most hospitals and health systems pursued PCPs over the last 12 years, most of our physician practice acquisition has been specialty care to keep that service available in the market. Today, we have a handful of PCPs and most of them in southeast Arkansas are still independent. It's been a challenge to get a dozen independent hospitals and several independent physicians to all move to value-based care.

This year is our last year without downside risk. We also entered into a shared savings agreement with Arkansas Blue Cross and Blue Shield, the largest commercial insurer in the state. That's just getting started. The executive director of our clinically integrated network is our hospital's chief quality officer. It's a personal passion for her to look at readmissions and quality measures to figure out how we can address those issues in the network. We've found a few things that work, but we got started in it from the perspective that we'd rather try to learn this while it's optional rather than waiting until it's forced on us and find ourselves behind the game. We feel that we're learning things that will be helpful down the road.

CHARLTON PARK (*University of Utah Hospitals and Clinics*): There's not enough value-based care going on in Utah. Being in an academic environment, our

physicians and teams are eager to get involved with value-based care. We had a great experience with the BPCI program. We also have 80,000+ lives in a Medicaid ACO arrangement in Utah that we care for through our own health plan. The Medicaid ACO population has been our primary focus regarding value-based payment models.

Beyond that, our focus has been on our own hospitals and clinics and the university's employees. We are self-insured and, with nearly 60,000 lives, we have an opportunity to provide value-based care with potential to reduce our costs. Our commercial market has been hesitant to get into these types of arrangements. Payers continue to be apprehensive about moving away from traditional methods of payment toward value-based care arrangements.

MODERATOR: What systems and processes do you need to deliver on value-based care arrangements?

PARK: We've had incredible success with the Medicaid ACO. About 10 years ago, we started what we call an intensive outpatient clinic and used data to identify those who may be overutilizing services or not accessing services before conditions worsen. We focus on those with chronic conditions,

which is a smaller percentage of the population, but drives much of the spend. We've been able to create value and savings by reducing admissions and ED utilization, as well as improving the use of pharmacy services.

There's a strong desire to take what we've learned and apply it to different populations. We have made tremendous investments in infrastructure and data so we can manage populations and understand how to drive value. We will continue to make these investments and look for payers and populations with whom to partner to create value.

"We achieved savings in our first two years by looking at high ED utilization and using our care coordinators to call those patients."

— Bryan Jackson —
Jefferson Regional

CREATING A SUSTAINABLE HEALTH-FIRST MODEL
WITH VALUE-BASED CARE

MODERATOR: What was the most acute pain point as you've tested these models or if you are trying to do more of them?

HERNDON: I think the value journey has helped us because we were faced with all the social determinants of health as barriers to care. They just hit you in the face, whether it's a lack of food, housing, transportation — fill in the blanks. If you're not focusing on value, you might overlook social determinants.

And it might be a competitive advantage for those of us who got in on this early because of the data. As you get to know the member, you discover what their issues are. I would say data derived from Cerner HealthIntent works well. It has been an advantage for us to be able to dig into the data and understand the trends. But at the end of the day, if you're not willing to go on the journey of health with me, where are we going?

WEBBER: When we tried to go directly to employers, we realized there is a very high demand for broad choice in a network model. The commercial insurance networks in our area are not highly active in risk-based contracts. We have many contracts that pay us to hit quality measures, but not risk-based. Ensuring the care of our patient is very important. It allows them to have better outcomes. Our business is about the patient and their well-being, but this needs to be sustainable for us. One of the upsides is our patients and families continuing to seek care from us because of their trust and knowing that we care.

SEABAUGH: The change in patient behavior comes up a lot as well as the link to social determinants of health, because most providers can manage within the four walls and even within their network.

We experience a fair amount of, "I need to get into the home," and then you start to hit the business models and send them home with various devices. Where's the business model that aligns with that approach?

HERNDON: I'm fascinated by the move to patient care at home, but it requires lots of staffing and trying to find the perfect patient who can be managed at home.

BAILEY: Do they have good support at home? If they're relatively affluent, they might.

WEBBER: Most families wouldn't have the family support. It's not easy. I don't know how they would do it, because a lot of these cases are so complex, especially when they have delayed their care. Those we see in the hospital are in bad shape. How could you ever take care of some of them in their home? We struggle to do it sometimes in the hospital.

HERNDON: We can do so much more in the out-patient surgery setting. I have 700 joint patients going to a musculoskeletal surgery center. The financial hit to our organization was huge, but if we didn't do it, somebody else would. So that's going to keep changing.

WEBBER: What really worries me about all this is whether we are going to have enough critical infrastructure spread throughout the country for when people really need it.

HERNDON: We don't have it now, let alone in a future where there's less and less truly acute care. Truth be told, we don't make money on half the things we do, right?

I'm convinced that in New Jersey, we are headed to

"We've been able to drive value and savings by reducing admissions and ED utilization, as well as improving the use of pharmacy services."

— Charlton Park —
University of Utah
Hospitals and Clinics

CREATING A SUSTAINABLE HEALTH-FIRST MODEL
WITH VALUE-BASED CARE

a capitation model of some sort. It seems to work. It's painful in the beginning, but once you figure it out, you figure it out.

DOWLING: In certain ways, the regulated and capitated environment in Maryland is more conducive to small independent hospitals. We have an easier time than in traditional payer models.

TESTER: I think it's going to be tougher in a state like Vermont, because we have an aging demographic; we're the second-oldest state. That means the tax base has essentially flat-lined. If you look at our payer mix, we're more than 25% Medicaid.

With any system transformation, whether it's the ACO shared savings model or capitation, there's only so much money to go around and we have an aging demographic that needs more care.

We've done a good job at improving outcomes for our aging population, and I'm proud of that. However, that brings on new challenges in continuing to care for that population — for example, historically someone who may have passed away at 75 because of a heart attack is now 85 with four comorbidities and is spending more days being treated in the hospital.

MODERATOR: For the hospitals, the financial insecurity and challenges with COVID-19 might have been a catalyst to take on risk. Would this be a catalyst to make a more significant shift in two to three years? I'm hearing that advancing value-based care initiatives with private payers and employers has been a challenge. Is that an accurate summary of our conversation?

HERNDON: In New Jersey, we haven't seen com-

mercial payers being incentivized to engage. In other states, some payers are becoming providers.

MODERATOR: Is anyone in a market where that has been an issue?

SEABAUGH: We see pockets of markets where United Healthcare or Optum have come in and bought physician practices. Recently, there was a large acquisition in Massachusetts. We see some activity that is raising awareness about new competition — a competitor who could also be the provider's largest commercial payer. The other one that is drawing interest in certain markets is CVS Aetna — where CVS is pushing into primary care and leveraging its physical infrastructure on the CVS stores to create the HealthHUB. It's in pockets. Other than full capitation, is there a way that CMS could force value that wouldn't be a math game?

STEVEN JONES (*Inova Health System*): I think they have tried that with all these experiments. They tried to reduce both admissions and rehabilitation. I will become the chair of the board of the AMGA (American Medical Group

Association), which is committed to value-based care. Those member groups tend to be the ones who have been pushing furthest. Consider that Cornerstone Health Care, which was among the first to invest in the technology to do value-based care, has been out of business for almost a decade because it spent so much money on infrastructure, and the reimbursement system didn't reward them for their meaningful work toward the goal of real value.

WEBBER: I don't think there's anyone in this room who doesn't anticipate that CMS is going to have to make huge changes. We all know it's coming. We just don't know what it's going to look like. When

"We think we can help advance value by applying technology to allow you to generate insights, identify high utilizers and do it in a way that is less burdensome on an already stressed workforce."

— Kevin Seabaugh—
Oracle Cerner

CREATING A SUSTAINABLE HEALTH-FIRST MODEL
WITH VALUE-BASED CARE

you look at the cost of our aging population that is living longer, you know that we spend the most money on complex medical conditions and end-of-life care.

TESTER: That, and lifestyle issues and mental health.

MODERATOR: Is there ever a scenario in which increased costs get so bad that employers would consider value-based programs sooner than the federal government?

HERNDON: In our market with recruitment of employees, I think employers are becoming more generous. They don't want to hurry up. There's going to be a wave of additional choice options. One employee doesn't want health insurance, the other one needs the Cadillac plan. It's going to run the gamut. Until the workforce stabilizes, there will be less appetite for change. Options such as a narrow network that we've tried are going to be on hold for a while.

JONES: The test case was when the Affordable Care Act was enacted in 2010 and employers could have switched everybody over to one of those plans. Few employers told their employees, 'Here's a check. Go spend it on whatever plan you want,' which I thought was going to happen.

WEBBER: I was shocked at how wide open they wanted their networks to be.

MODERATOR: I think we all agree that we'll move there, but slower than we may have thought five or 10 years ago. But many of you have had success in the small programs, some pilots and some larger models. What are some big insights or lessons learned?

BAILEY: Social determinants of health — what we have learned is that we have so little to do with someone's health outcome. Once they're sick, we'll get them well again, but preventing them from needing our services is all about what's going on in the community. With the Medicare population, you can try to reduce the redundant care, the unnecessary care, but their health status is their health status. We're not changing it at 68. You can manage it to a lower number through care navigation, but you're not going to make them healthy. You have to focus on the 18-year-old and convince them that eating what you want, whenever you want and taking a pill for it later will not make it better. To help fix this, you must involve others to structurally change the trajectory of where we're headed.

"The value journey has helped us because we were faced with all the social determinants of health as barriers to care. They just hit you in the face, whether it's a lack of food, housing, transportation."

— Lori Herndon —
AtlantiCare

I come back to our uninsured. It is amazing the difference we have made in the lives of the uninsured patients we are care managing, and it's to our benefit. If they show up in our ED, we get paid nothing. ED doctors are expensive. If we can keep them out, we win. We buy air conditioners. We'll pay for a cab. We will take you to your doctor, whatever it takes, but that's the blocking and tackling of care navigation and care coordinators that really matters. I think that will work with the Medicare population if we can intervene so they don't go to the ED. If somebody would pay us to do that, I think we could change things.

HERNDON: That's been the value. All of us in health care learned that we helped people improve their lives.

SEABAUGH: This has been a valuable discussion. There are many ways for provider organizations to approach the shift to value, and that's reflected in the diversity of strategies and tactics we've talked through today. The entry point into value-based

EXECUTIVE INSIGHTS

CREATING A SUSTAINABLE HEALTH-FIRST MODEL WITH VALUE-BASED CARE

care and the rate of change are influenced by a variety of national, state and local factors. That said, across the room, there really has been tangible progress in developing a robust strategy for value-based care, adopting value-based models, and aligning incentives across your stakeholders — including payers, providers, employers and patients. At the same time, we still have work to do to increase adoption of value-based models and to shift the mindset of stakeholders towards outcomes and total cost of care. We talked about several of those opportunities today — including increased collaboration with payers and employers and incorporating social determinants of health into care plans. We are working to accelerate the pace of the move to value. It is critical for our communities.

I'm excited about the near-term potential. We have the systems in place to use data to activate a connected health care ecosystem. We can create actionable insights to aid clinical decision making. And we are focused on the patients. We can engage them in their care — whether that's in our facilities or at home — and we can use this increased engagement to improve satisfaction, loyalty and total cost. We at Oracle Cerner are proud to be working on these initiatives with our clients. We look forward to continuing this journey by helping organizations connect and leverage clinical, payer, social, and environmental data, and to translate this data into actionable insight to address the operational, clinical, financial components of value-based care.

SPONSOR

ORACLE Cerner

Oracle Cerner health technologies connect people and information systems at thousands of contracted provider facilities worldwide dedicated to creating smarter and better care for individuals and communities. Recognized globally for innovation, Oracle Cerner assists clinicians in making care decisions and assists organizations in managing the health of their populations. The company also offers an integrated clinical and financial system to help manage day-to-day revenue functions, as well as a wide range of services to support clinical, financial and operational needs, focused on people.

With over four decades of experience connecting healthcare ecosystems, Oracle Cerner help organizations accelerate their VBC efforts while still supporting their current fee-for-service business. By streamlining operational changes that can enhance quality, impact patient satisfaction, provider satisfaction and financial outcomes, together we can work to support a more sustainable, health-first model.

FOR MORE INFORMATION VISIT:
cerner.com/vbc

