How to Cite:
Albalawi, R. A. S., Fallatah, G. A. H., Alamri, A. M. M., Alqahtani, H. M. H., Alharbi, A. S., Alherz, S. S., Alqasir, M. A. A., Alharbi, M. F. M., Alazkabsh, Barakat S., Ali, E. I. A., Alshehri, Nada S., Alzubidi, A. H. A., & Kabsh, M. A. A. (2024). The role of nurses and healthcare administrators in advancing value-based care models: Implications for integrated health administration, nursing, and pharmacy. *International Journal of Health Sciences*, *8*(S1), 1923–1948. https://doi.org/10.53730/ijhs.v8nS1.15446

The role of nurses and healthcare administrators in advancing value-based care models: Implications for integrated health administration, nursing, and pharmacy

Rakan Ahmed Saleh Albalawi
KSA, National Guard Health Affairs

Ghassan Abdullah Hassan Fallatah
KSA, National Guard Health Affairs

Abdulelah Mohammed Mubashir Alamri
KSA, National Guard Health Affairs

Hussain Muidh Hadi Alqahtani
KSA, National Guard Health Affairs

Ahmed Shahan Alharbi
KSA, National Guard Health Affairs

Sughra Salman Alherz
KSA, National Guard Health Affairs

Mohammed Abdulrahman Abdullah Alqasir
KSA, National Guard Health Affairs

Munirah Fayez Muhammed Alharbi
KSA, National Guard Health Affairs

Barakat Shumailan Alazkabsh
KSA, National Guard Health Affairs

Eman Ibrahim Alshaikh Ali
KSA, National Guard Health Affairs

Nada Sultan Alshehri
KSA, National Guard Health Affairs

International Journal of Health Sciences E-ISSN 2550-696X © 2024.
***Corresponding email**: akk29337@gmail.com*
Manuscript submitted: 01 Jan 2024, Manuscript revised: 09 Jan 2024, Accepted for publication: 15 Jan 2024

Abdullah Hzam Ali Alzubidi
KSA, National Guard Health Affairs

Dr Mohammad Ali Ahmad Kabsh
KSA, National Guard Health Affairs

***Abstract*---Background:** Value-based care (VBC) models, which focus on enhancing patient outcomes while reducing healthcare costs, represent a transformative shift in the delivery of healthcare. By prioritizing quality over quantity, these models align incentives with the achievement of health outcomes rather than the volume of services provided. VBC approaches, including Patient-Centered Medical Homes (PCMHs), bundled payment systems, and Accountable Care Organizations (ACOs), aim to address the rising burden of chronic diseases, escalating healthcare expenditures, and disparities in access to care. Despite their potential benefits, VBC models face challenges such as workforce readiness, compatibility with data management systems, and equitable implementation across diverse patient populations. **Aim:** This study explores the theoretical foundations, methods of implementation, and outcomes associated with VBC models, with a particular focus on the critical roles played by nurses and healthcare administrators in enhancing the planning, execution, and evaluation of these models. **Methods:** A comprehensive review of case studies, policy papers, and peer-reviewed literature was conducted. The analysis emphasizes the integration of technology, operationalization of VBC, and the contributions of interdisciplinary teams in improving care standards and reducing costs. **Results:** The findings indicate that VBC models lead to increased patient satisfaction, improved management of chronic conditions, and significant reductions in hospital readmissions. Key nursing contributions, including patient education and transitional care coordination, are vital to achieving these outcomes. Healthcare administrators play an essential role in workforce training, resource allocation, and aligning policies with VBC objectives. However, challenges related to data management, resistance to change, and equitable access to care persist. **Conclusion:** By aligning incentives with patient outcomes, VBC models have the potential to revolutionize healthcare delivery. To overcome existing challenges and fully realize the potential of these models, collaboration across nursing, health administration, and pharmacy disciplines is critical.

***Keywords*---**value-based care, patient-centered medical homes, accountable care organizations, nursing, health administration, pharmacy, healthcare transformation, interdisciplinary collaboration, equity in healthcare.

Introduction

The growing focus on patient-centered care, escalating healthcare costs, and the rising prevalence of chronic diseases necessitate a transformation in healthcare delivery systems. Central to this transformation is the concept of value-based care (VBC), a model designed to enhance patient outcomes while reducing overall healthcare costs. In contrast to traditional fee-for-service models, which reward the volume of services provided, VBC emphasizes rewarding outcomes, efficiency, and patient satisfaction. The Triple Aim framework, which prioritizes reducing healthcare costs per capita, improving population health, and enhancing patient experience, plays a crucial role in this paradigm shift [1, 2]. Moreover, the Quadruple Aim introduces a fourth goal—healthcare workforce well-being emphasizing that sustainable healthcare reform is contingent upon maintaining workforce satisfaction [3].

VBC is essential for addressing the inefficiencies inherent in volume-based healthcare systems, where increased utilization often leads to poorer patient outcomes and unnecessary expenditures. By incentivizing outcome-based care, VBC encourages healthcare professionals to focus on preventive measures, improve care coordination, and address the holistic needs of patients. This shift is especially pertinent given the rising prevalence of chronic conditions, such as diabetes, cardiovascular disease, and hypertension, which significantly contribute to healthcare costs [4, 5]. Furthermore, VBC fosters policies and programs aimed at expanding access to underserved populations, integrating social determinants of health (SDOH) into care strategies, and reducing healthcare disparities [6].

Over the past decade, the adoption of VBC has been propelled by regulatory changes, evolving patient expectations, and advancements in technology. A key feature of VBC is the development of Accountable Care Organizations (ACOs), which create collaborative networks of healthcare professionals dedicated to improving quality and reducing costs [7, 8]. The use of bundled payment models, which offer a single payment for an entire episode of care, has further supported cost containment and care coordination [9]. The integration of telehealth and remote monitoring technologies, particularly during the COVID-19 pandemic, has allowed for better management of chronic diseases and improved care delivery to rural and underserved populations [10]. Additionally, the increasing use of data analytics and artificial intelligence (AI) to identify high-risk patients, predict outcomes, and implement personalized interventions is enhancing the effectiveness of VBC models [11].

This paper begins by examining the theoretical foundations of value-based care, focusing on frameworks such as the Triple Aim and Quadruple Aim. The subsequent section explores key VBC models, including ACOs, bundled payments, and Patient-Centered Medical Homes (PCMHs), highlighting their design, implementation strategies, and impact on health outcomes. Following this, the paper delves into the role of technology and data in VBC, particularly the integration of telemedicine, electronic health records (EHRs), and predictive analytics. The contributions of health administrators and nurses in VBC are then discussed, emphasizing their roles in advocacy, policy alignment, and care coordination. The paper also addresses challenges related to workforce training,

data interoperability, and equity, which hinder the effective implementation of VBC. Finally, future directions for VBC are explored, focusing on innovative strategies, policy recommendations, and areas for future research.

Foundations of Value-Based Care Theory:

The value-based care (VBC) model is grounded in strong theoretical principles that guide its development, implementation, and evaluation. These foundational elements enable healthcare organizations to transition from volume-driven models to outcomes-focused care. Central to VBC are the Triple Aim and Quadruple Aim frameworks, which align cost control, staff well-being, population health improvement, and patient-centered care. Additionally, concepts like risk-sharing arrangements and realigning financial incentives are key to operationalizing VBC principles in real-world healthcare settings.

The Triple Aim framework, initially introduced by Berwick et al. in 2008, forms the backbone of value-based care initiatives [11]. It outlines three interconnected goals essential for healthcare transformation: improving population health, reducing per capita costs, and enhancing the patient experience. These goals collectively offer a comprehensive approach to addressing inefficiencies in healthcare delivery, advancing care quality, and ensuring cost-effectiveness [12]. The focus on improving population health while reducing unnecessary hospital admissions and emergency department visits aligns well with patient-centered policies that prioritize chronic disease management and preventive care.

Additionally, the Triple Aim's emphasis on patient experience is reflected in the inclusion of patient-reported outcomes in healthcare measures. By focusing on patient engagement, satisfaction, and shared decision-making, healthcare providers can meet the growing demand for personalized care. This approach is particularly vital in the management of chronic diseases, where patient adherence to treatment plans is crucial for achieving optimal outcomes [13].

The Quadruple Aim expands on the Triple Aim by incorporating workforce well-being as a fourth goal [14]. This addition acknowledges the critical need to address healthcare workers' challenges, such as burnout, excessive workloads, and lack of support, which can negatively impact the quality of care. Recognizing the importance of workforce satisfaction, the Quadruple Aim promotes initiatives that include training programs, equitable compensation structures, and fostering supportive work environments. These strategies are vital for developing a motivated and capable workforce that can deliver high-quality care.

The Quadruple Aim also highlights the relationship between physician satisfaction and patient outcomes. Research indicates that healthcare organizations prioritizing employee well-being see improvements in patient safety, care quality, and organizational effectiveness [15]. By addressing the systemic factors contributing to burnout, particularly in the face of increasing patient complexity and operational demands, the Quadruple Aim helps ensure healthcare systems remain resilient and adaptable.

Core Concepts: Aligning Financial Incentives with Outcome-Based Metrics:

One of the fundamental elements of value-based care is the realignment of financial incentives to reward outcomes rather than the volume of services provided. Traditional fee-for-service models incentivize the quantity of care, often leading to inefficiencies, fragmented services, and rising costs. In contrast, VBC models link reimbursement to key quality metrics, such as reduced hospital readmissions, improved chronic disease management, and enhanced patient satisfaction [16]. This shift encourages healthcare providers to focus on prevention and care coordination by addressing health issues early before they evolve into costly complications.

Adopting outcome-based metrics also requires the use of advanced data analytics to measure success and identify areas for improvement. Metrics such as cost savings, adherence rates, and patient-reported outcomes are essential for evaluating VBC effectiveness. For example, organizations utilizing risk stratification technologies can more effectively identify high-risk patients, allocate resources efficiently, and ultimately improve patient outcomes while reducing healthcare costs [17].

Agreements to Share Risk in Provider Payment Models

Utilizing risk-sharing arrangements, which match financial incentives between payers and providers, is another essential component of VBC. By taking on a portion of the financial risk related to patient outcomes, these agreements usually encourage the provision of effective and efficient care. Bundled payments, capitation, and pooled savings plans are examples of common risk-sharing strategies [18]. Bundled payment models, for instance, give clinicians a single payment for all services rendered during a certain episode of treatment, such hip replacement surgery. This framework preserves high-quality results while promoting care coordination and cost containment.

Additionally, risk-sharing agreements encourage cooperation between allied health workers, specialists, and primary care physicians. These models enhance patient outcomes and lessen care fragmentation by establishing financial incentives for integrated care. To guarantee fair risk sharing and long-term financial performance, such agreements must be implemented successfully, which calls for strong data systems, open communication, and an accountable culture [19].

Value-based care's theoretical underpinnings offer a thorough framework for overhauling healthcare delivery systems. The Triple Aim and Quadruple Aim frameworks set guiding principles for accomplishing systemic change by emphasizing patient-centered outcomes, population health improvement, cost containment, and worker well-being. Fundamental ideas like risk-sharing plans and outcomes-based financial incentives operationalize these ideas, guaranteeing the long-term viability and efficacy of value-based care models. Integrating these theoretical underpinnings will be essential to attaining significant and long-

lasting gains in healthcare quality and fairness as healthcare organizations continue to implement and develop these models.

Putting Value-Based Care Models into Practice

A thorough understanding of the structures, strategic implementation, and operational challenges associated with value-based care (VBC) models is essential for their successful deployment in integrated health administration, nursing, and pharmacy. VBC models represent a shift from volume-driven to value-oriented healthcare delivery systems and are based on fundamental principles of improving patient outcomes, enhancing care coordination, and reducing healthcare costs. This section examines the key types of VBC models and the important implementation processes that underscore the role of technology integration and stakeholder engagement in fostering sustainable healthcare transformation.

VBC Model Types

Accountable Care Organizations (ACOs): Objectives, Framework, and Outcomes

A central element of VBC is Accountable Care Organizations (ACOs), which focus on fostering provider collaboration to enhance patient outcomes while reducing costs. ACOs are networks of physicians, hospitals, and other healthcare providers who voluntarily collaborate to deliver high-quality, coordinated care to patients, particularly those with chronic conditions [20]. The main goal of ACOs is to eliminate medical errors and reduce unnecessary duplication of services while ensuring that patients receive the right care at the right time.

ACOs typically operate under shared savings agreements with payers, such as Medicare or private insurers, where providers are rewarded for meeting quality standards and reducing overall costs. For example, Medicare's Shared Savings Program (MSSP) has demonstrated that the implementation of ACOs can significantly reduce hospital readmissions and improve the management of chronic diseases [21]. ACOs are considered a key model in the VBC framework due to their positive impact on population health indicators, reduction in per capita costs, and improved patient satisfaction.

Bundled Payment Plans: Promoting Coordinated Care for Treatment Episodes

Bundled payment models are another critical component of VBC. Under this approach, healthcare providers are paid a single payment for all services rendered during a specific episode of care, such as heart surgery or joint replacement [22]. From preoperative evaluations to post-discharge follow-up, this model encourages providers to collaborate across the continuum of care, ensuring cost-efficiency and consistent quality.

By incentivizing cooperation among interdisciplinary teams, bundled payments help overcome the fragmentation inherent in traditional fee-for-service models. The Centers for Medicare & Medicaid Services (CMS) Bundled Payments for Care Improvement (BPCI) initiative has been successful in reducing costs for major

joint replacements and strokes while maintaining or enhancing quality of care [23]. However, challenges persist in managing financial risk and accurately predicting episode costs, particularly for patients with high levels of complexity.

Patient-Centered Medical Homes (PCMHs): Enhancing Access and Care Continuity

The Patient-Centered Medical Home (PCMH) model is designed to provide comprehensive, accessible, and patient-centered primary care, with a strong emphasis on improving patient engagement and care continuity. In this model, primary care physicians collaborate with nurses, care coordinators, and specialists to address the diverse needs of patients, especially those with chronic conditions [24]. Notable features of PCMHs include extended access to care, integrated mental health services, and robust care management programs.
PCMHs have been particularly effective in bridging gaps in chronic illness management and preventative care. Research shows that PCMHs improve chronic disease management, increase patient satisfaction, and reduce hospitalization rates [25]. Proactive outreach, coupled with the use of technology such as electronic health records (EHRs) to coordinate care and monitor patient outcomes, is essential for the success of PCMHs.

Implementation Procedures
Goal Alignment and Stakeholder Involvement

A crucial step in implementing VBC models is the active involvement of stakeholders across the healthcare ecosystem, including payers, providers, patients, and policymakers. Engaging stakeholders ensures alignment on the goals of VBC, such as improving equity in care delivery, reducing costs, and enhancing quality [26]. Early involvement promotes buy-in, facilitates the development of practical quality metrics, and ensures accountability throughout the implementation process.

Effective communication strategies, including regular stakeholder meetings and transparent reporting of performance indicators, are vital for maintaining alignment. For example, involving patients and community representatives in the design of care delivery models can increase the relevance and acceptability of VBC programs, particularly in underserved populations [27]. Similarly, collaborative partnerships with payers ensure that value-driven care is supported by appropriate payment structures.

Adoption of Enabling Technologies

The successful operation of VBC models heavily relies on the integration of advanced technologies, such as EHRs and health information exchanges (HIEs). These tools support evidence-based decision-making, improve care coordination, and enable real-time data sharing. EHRs are foundational to VBC, as they provide comprehensive patient records that facilitate chronic disease management, preventive care, and seamless communication between care teams [28].

Health information exchanges (HIEs) further enhance interoperability by enabling secure access and sharing of patient data across healthcare organizations. This is particularly important for managing care transitions, such as when patients move from hospital care to home or to skilled nursing facilities. Predictive analytics, powered by artificial intelligence (AI), is another critical tool for VBC, enabling healthcare providers to proactively identify high-risk patients and predict potential adverse outcomes, thereby improving care and preventing complications [29].

However, while these technologies offer substantial benefits, challenges such as data security, interoperability issues, and the digital divide must be addressed to ensure their successful implementation. Investment in technical support and training for healthcare staff is necessary to maximize the potential of these enabling technologies.

A comprehensive approach to implementing value-based care models requires the integration of collaboration, coordination, and technological solutions. Key VBC models such as ACOs, bundled payment plans, and PCMHs each contribute uniquely to the overarching goals of improving patient experience, reducing costs, and enhancing quality of care. The successful implementation of these models depends on aligning goals, engaging stakeholders, and integrating enabling technologies that support data sharing and evidence-based practices. As healthcare systems evolve, addressing challenges related to data interoperability and equitable access will be essential to realizing the full potential of VBC.

Technology and Data's Role in Value-Based Care

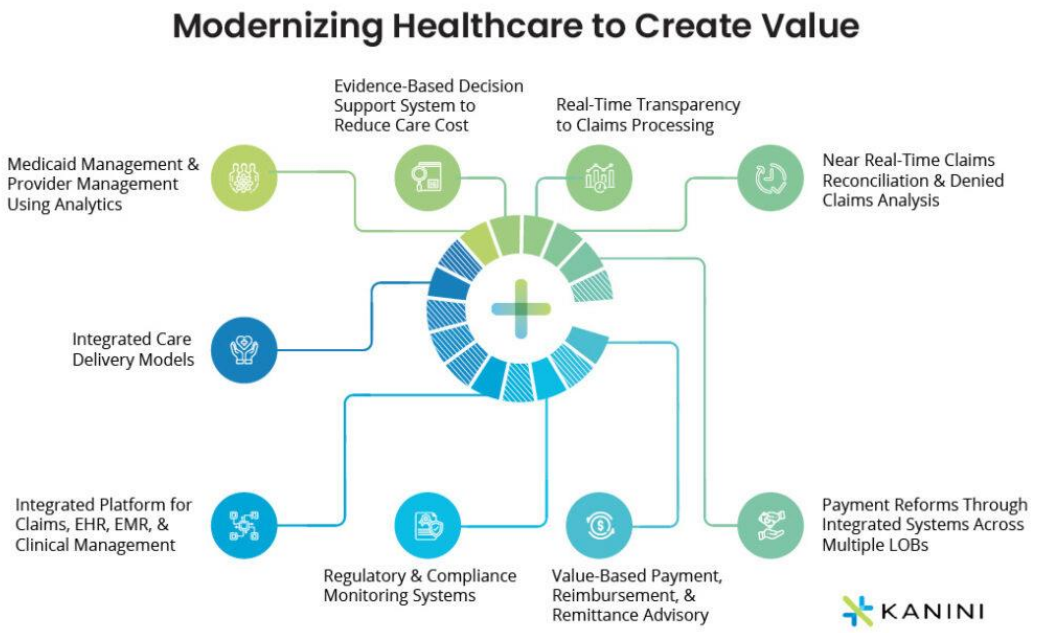

Figure 1 The strategic elements required to update healthcare systems in order to increase value through efficiency and innovation are depicted in this picture

The strategic use of technology and data analytics is essential to the shift to value-based care (VBC). In addition to helping healthcare professionals adhere to the fundamental tenets of VBC—improving patient outcomes, promoting population health, and cutting costs—these technologies also help them deal with the inefficiencies present in conventional healthcare models. Technology integration and data analytics have become important components in accomplishing VBC's objectives. Real-time monitoring, predictive modeling, risk stratification, and telemedicine solutions are some of their uses. To fully realize the potential of these breakthroughs, however, specific approaches are needed to address issues with interoperability, data security, and equitable access.

Using Predictive Modeling and Data Analytics Risk Stratification to Find High-Risk Groups

The foundation of VBC is data analytics, which gives medical professionals the ability to forecast future health outcomes and stratify populations according to risk. Risk stratification categorizes patient groups according to their propensity for negative health outcomes or excessive use of medical resources [30]. This procedure is essential for identifying high-risk patients and focusing interventions on them, such as those who have several chronic illnesses or are frequently admitted to the hospital.

This ability is further improved by predictive modeling, which forecasts health trajectories by utilizing both historical and current data. To forecast hospital readmissions or problems, for instance, machine learning algorithms can examine trends in claims data, electronic health records (EHRs), and socioeconomic determinants of health (SDOH) [31]. With the use of these insights, care teams can lower costs and improve outcomes by putting preventive measures like intense case management or early intervention programs into place. Predictive analytics has been shown in recent research to lower hospital readmissions by as much as 30% in specific patient cohorts, highlighting its usefulness in VBC systems [32].

Real-time tracking and assessment of patient outcomes

Monitoring and assessing patient outcomes in real time is another crucial use of data analytics at VBC. Finding care gaps or unfavorable trends is frequently postponed by traditional retrospective studies. On the other hand, providers may make prompt, data-driven decisions to improve patient care thanks to real-time analytics. Continuous glucose monitoring technologies, for example, provide real-time treatment plan modifications for diabetic patients, enhancing glycemic control and lowering complications [33].

Analytics platforms and dashboards compile information from various sources to give medical teams useful insights. Continuous monitoring of metrics including cost savings, clinical results, and patient adherence guarantees conformity with VBC objectives. Real-time analytics also facilitates performance benchmarking, which allows businesses to assess results against peer groups or industry norms [34]. One of VBC's core principles, continual quality improvement, is fostered by this dynamic approach.

Using Telehealth and Technology Integration to Improve Access and Continuity of Care

Particularly during the COVID-19 pandemic, which highlighted the necessity for accessible and adaptable care delivery models, telehealth has become a crucial tool in the VBC landscape. For underserved and rural communities, telehealth lowers obstacles to care by enabling remote consultations, monitoring, and follow-ups [35]. This capacity is consistent with VBC's focus on improving health outcomes and the patient experience.

Telehealth has proven to be quite beneficial in the management of chronic diseases. Healthcare teams receive continuous data from remote patient monitoring equipment, such wearable technology for heart patients, which allows for prompt actions. Additionally, by eliminating the need for in-person visits, virtual consultations improve patient convenience while preserving continuity of care. Telehealth has been shown to lower ER visits and hospital admissions, which lowers costs and improves the effectiveness of care [36].
Additionally, telehealth facilitates interdisciplinary collaboration by allowing care teams to easily exchange information across geographic boundaries. This is especially helpful for complicated instances that call for the opinions of several experts. However, resolving issues like digital literacy, reimbursement regulations,

and fair access to technology is necessary to realize the full potential of telehealth in VBC [37].

Overcoming Interoperability and Data Security Issues

Despite the enormous advantages of technology integration, interoperability and data security issues continue to be major obstacles to the effective use of VBC. The capacity of various healthcare systems and technologies to efficiently share, understand, and use data is known as interoperability. Care coordination is frequently hampered by fragmented health IT systems, which results in inefficiencies and service duplication [38]. For instance, insufficient or delayed information transmission between hospital and primary care EHR systems can jeopardize patient safety and treatment quality.

Overcoming these obstacles requires efforts to standardize data sharing protocols, such as the Fast Healthcare Interoperability Resources (FHIR) standard. Providers get real-time access to comprehensive patient data because to FHIR's smooth platform data sharing [39]. Federal programs that require the abolition of information blocking techniques, like the 21st Century Cures Act, further advance interoperability.

Another major worry is data security, especially as digital technology become more and more integrated into healthcare systems. Recent years have seen an increase in cyberattacks against healthcare institutions, endangering both patient privacy and the organization's reputation. Protecting sensitive data requires strict adherence to laws like the Health Insurance Portability and Accountability Act (HIPAA). Investments in cutting-edge cybersecurity tools, like as intrusion detection systems, encryption, and employee training, are also essential for risk mitigation [40].

For value-based care models to be successful, technology and data analytics must be integrated. Data analytics helps healthcare providers to identify high-risk populations and improve patient outcomes through risk stratification, predictive modeling, and real-time monitoring. In line with VBC's basic values, innovations like telehealth and health information exchanges improve access, continuity, and care coordination at the same time. To fully harness the potential of these advances, however, issues with data security, interoperability, and equitable access must be resolved. The strategic use of technology and data will continue to be a key factor in achieving value-based care objectives as healthcare systems change.

The Role of Nursing in Value-Based Care

Because of their proficiency in patient education, care coordination, advocacy, and leadership, nurses play a crucial role in the effective application of value-based care (VBC) models. Nurses ensure that value-based initiatives improve patient outcomes, lower costs, and promote holistic well-being by working at the nexus of organizational objectives and patient care. In order to ensure the sustainability of VBC frameworks, this section examines the critical

responsibilities that nurses play in lobbying, policy formulation, and care coordination and leadership.

Coordination of Care
Management of Transitional Care to Avoid Readmissions

Transitional care management, especially for patients transferring from the hospital to their homes or other care settings, is one of the main pillars of nursing's contributions to VBC. One important indicator in VBC models, the probability of hospital readmissions, is decreased by transitional care management [41]. Nurses make sure patients get the right medications, follow-up care, and community resources so they may successfully manage their diseases after being discharged. For example, by utilizing nurse-led interventions, evidence-based programs like the Care Transitions Intervention (CTI) have shown notable decreases in 30-day readmission rates [42].

During care transitions, nurses are also crucial in addressing social determinants of health (SDOH). Nurses make ensuring that obstacles to care are kept to a minimum by putting patients in touch with community-based resources like food aid or transportation services. By addressing both clinical and non-clinical factors that affect health outcomes, this holistic approach is consistent with the tenets of VBC [43].

Patient Education to Encourage Self-Management and Adherence

Another essential component of nursing's contributions to VBC is patient education. In order to enable patients and their families to actively participate in their health, nurses provide education on illness management, medication adherence, and lifestyle changes [44]. For instance, it has been demonstrated that nurse-led education programs enhance medication adherence and self-management abilities in the treatment of chronic diseases like diabetes or heart failure, leading to improved clinical results and reduced healthcare expenses.

Additionally, nurses employ telehealth platforms and other technological tools to educate and support patients, especially those who live in remote or underserved locations. This promotes long-term commitment to treatment plans and guarantees continuity of service. Nurses help VBC efforts succeed by bridging the gap between professional advice and patient behaviors through their emphasis on health literacy and patient participation.

Advocacy and Leadership
Initiatives for Quality Improvement Led by Nurse Leaders

Through quality improvement programs that match organizational procedures with value-based care concepts, nurse leaders play a crucial role in developing VBC. They are in a position to develop and put into practice initiatives that improve patient outcomes while cutting costs thanks to their clinical experience and operational insights [45]. For example, programs to improve care coordination, optimize resource usage, and reduce hospital-acquired infections (HAIs) are often led by nurse leaders. In addition to enhancing patient safety,

these initiatives help meet performance standards linked to reimbursement under VBC models.

By encouraging a culture of cooperation and communication across care teams, nurse leaders can help to promote interprofessional collaboration. This guarantees that everyone involved—from doctors to allied health specialists—is on the same page when it comes to providing patient-centered care. In order to ensure that healthcare teams are prepared to fulfill the needs of VBC, nurse leaders also support investments in staff education and professional development [46].

Contributions to Community Health Strategies and Policy Development

Nursing advocacy is not limited to clinical settings; it also encompasses community health and policy creation. Policies that address systemic obstacles to value-based care, such as disparities in health outcomes and access, are developed in part by nurses. Their firsthand knowledge ensures that legislative initiatives are based on clinical reality and offers insightful information about the real-world effects of healthcare legislation [47].

In order to create and carry out population health plans that support VBC goals, nurses are essential at the community level. Improved population health indicators, for instance, are a result of nurse-led initiatives aimed at preventative care, such as immunization campaigns or chronic condition checks. Additionally, nurses stress the significance of tackling SDOH as part of comprehensive VBC plans and push for financing and resources to assist community health efforts [48].

Nursing plays a variety of roles in value-based care, including advocacy, leadership, patient education, and care coordination. Key indicators including readmission rates, adherence, and patient satisfaction are directly impacted by nurses' proficiency in transitional care management and patient involvement. As leaders and advocates, nurses spearhead efforts to improve quality and have an impact on the creation of policies, guaranteeing the efficacy and equity of VBC frameworks. Their significance in accomplishing the objectives of value-based care is highlighted by their function in connecting clinical care with community health initiatives. The effectiveness and sustainability of value-based care models will continue to depend on the contributions of nurses as healthcare systems change.

Value-Based Care: Health Administration and Policy

Value-based care (VBC) models' operationalization and viability depend heavily on health administration and policy. To handle the challenges of implementation, the transition from volume-based reimbursement to value-based payment structures requires strong administrative frameworks and regulatory support. This section examines the function of administrative tactics and policy efforts, especially those spearheaded by Medicaid and Medicare, in coordinating organizational goals with VBC criteria. It also emphasizes how crucial personnel development and training are to meeting the needs of this revolutionary healthcare paradigm.

Policy Support VBC through Medicaid and Medicare Innovation Models

The growth of VBC models has been largely fueled by federal policy initiatives, especially those under Medicaid and Medicare. Initiatives to motivate providers to provide high-quality care while lowering costs include the Medicare Shared Savings Program (MSSP) and the Bundled Payments for Care Improvement (BPCI) program [49]. These models encourage healthcare companies to invest in preventative care and implement coordinated care strategies by promoting risk-sharing agreements and shared savings.

The concepts of VBC are further extended to underprivileged groups through Medicaid demonstration initiatives like Health Homes and state-level Accountable Care Organizations (ACOs). In order to enhance results for disadvantaged groups, these programs target social determinants of health (SDOH) and prioritize integrated care delivery. For example, the Medicaid Health Home program in New York has shown promise in lowering hospitalizations and ED visits among high-risk groups [50]. By improving population health measures and eliminating health inequities, these technologies support VBC's objectives.

Mechanisms for Reimbursement Promoting Preventive Healthcare

Additionally, policy changes have reorganized reimbursement systems to give preventive care precedence over reactive, sporadic care. Alternative payment models (APMs), which link reimbursement to quality and cost-efficiency criteria, are progressively replacing fee-for-service arrangements, which have historically been linked to fragmented and expensive care [51]. Capitated payment plans and performance-based incentives, which compensate providers for meeting predetermined quality standards like fewer readmissions to hospitals or better chronic illness care, are two examples.

The VBC agenda has been further strengthened by the Affordable Care Act's (ACA) preventive care reimbursement provisions, such as the requirement for cost-free coverage of preventive services. These regulations promote early illness identification and treatment, which lowers long-term medical expenses and enhances patient outcomes [52]. There are still issues, though, such as state-by-state differences in reimbursement rates and the requirement for consistent funding to support these programs.

Administrative Supervision Matching VBC Metrics with Organizational Objectives

It is the duty of health administrators to guarantee that organizational goals correspond with VBC's performance indicators. This necessitates a change in operational goals from generating revenue through volume to providing value-oriented care. Creating performance dashboards to monitor clinical results, patient satisfaction, and cost-efficiency measures in real-time is one of the key tactics [53]. Healthcare firms can use these dashboards to compare their performance to industry norms and pinpoint areas that need improvement.

Administrators are also essential in promoting an environment of responsibility and ongoing quality enhancement. This entails involving clinical and non-clinical personnel in decision-making procedures and making certain that all parties involved are dedicated to accomplishing VBC's objectives. For example, frequent training sessions and interdisciplinary discussions help foster cooperation and mutual understanding among care teams [54]. Additionally, administrators make ensuring that resources are distributed effectively, giving investments in enabling technology like data analytics platforms and electronic health records (EHRs) first priority.

Training and Development of the Workforce to Fulfill VBC Requirements

A key component of a successful VBC deployment is workforce preparation, and health administrators are responsible for providing staff with the abilities and information needed to function under this paradigm. Meeting VBC's expectations requires extensive training programs that emphasize population health management, patient participation, and care coordination [55]. Predictive analytics training, for instance, can improve nurses' and care managers' capacity to recognize high-risk patients and carry out focused treatments.

The lack of workers in vital fields like primary care and behavioral health, which are essential to VBC models, must also be addressed by administrators. Offering incentives like loan payback plans or competitive remuneration is one tactic to draw in and keep talented workers [56]. Additionally, encouraging interprofessional education and cooperation helps guarantee that care teams function as a unit, providing patient-centered and value-driven treatment.

In value-based care, health administration and policy play fundamental and ever-changing roles. A policy framework that uses alternative payment models to reward quality and cost-efficiency has been built by federal programs like Medicaid and Medicare innovation models. At the organizational level, health administrators are responsible for investing in workforce development, cultivating an accountable culture, and coordinating operational goals with VBC criteria. These initiatives guarantee that healthcare institutions are prepared to handle the opportunities and problems brought forth by the VBC paradigm. The interaction between administrative supervision and policy support will continue to be crucial in promoting value-based care as the healthcare environment changes.

Overcoming Obstacles in Value-Based Healthcare

In order to ensure successful implementation and sustainability, the transition to value-based care (VBC) poses substantial obstacles that call for strategic solutions. Even while VBC's advantages—better health outcomes, better patient experiences, and lower costs—are widely known, development may be hampered by operational and equity issues. This section examines the operational difficulties, such as resource constraints and opposition to change, as well as the equity issues involved in giving marginalized groups fair access to VBC programs. For VBC to fulfill its transformative potential in healthcare systems, these problems must be resolved.

Barriers to Operations

Opposition to Modifications in Provider Procedures

One of the biggest obstacles to moving from fee-for-service to value-based models is resistance to change. Traditional reimbursement schemes that put volume ahead of value are familiar to many clinicians. Hesitancy to implement new care delivery models or to align workflows with VBC metrics are common examples of this cultural inertia [57]. The greater emphasis on data collection and reporting, for example, can be seen by physicians as onerous or out of step with the priorities of patient care.

Effective change management techniques are essential to overcoming this obstacle. These include giving providers financial incentives to adhere to value-based initiatives, involving them early in the transition process, and providing unambiguous proof of the advantages of VBC [58]. A culture of accountability and cooperation is fostered by leadership, which guarantees that all parties involved are dedicated to accomplishing VBC's objectives. Programs for ongoing education and training can also give healthcare professionals the know-how and abilities they need to thrive in a value-driven setting.

Restrictions on Resources in Rural and Small Healthcare Systems

Adopting VBC can be particularly difficult for small and rural healthcare systems because of their limited financial, technological, and human resources. It's possible that these organizations lack the infrastructure required to implement population health management systems, care coordination platforms, or advanced data analytics [59]. These restrictions are further compounded by a lack of workers in rural regions, which makes it challenging to meet the expectations of VBC activities.

Targeted policy initiatives and cooperative collaborations are necessary to address resource restrictions. Rural providers can invest in enabling technologies such as telehealth platforms and electronic health records (EHRs) with the support of federal and state initiatives, including grants and subsidies [60]. Additionally, groups with limited resources can share data and benefit from collective experience through regional collaborations like health information exchanges (HIEs). Initiatives for workforce development, such as loan forgiveness plans for medical professionals employed in underprivileged regions, can also help alleviate staffing shortages and improve rural systems' ability to provide value-based care [61].

Aspects of Equity

Providing Underserved Populations with Fair Access to VBC Programs

Although obtaining equitable access to VBC programs continues to be a chronic difficulty, equity is a basic premise of VBC. Racial and ethnic minorities, low-income people, and those living in rural areas are examples of underserved populations that frequently encounter obstacles such poor health literacy, restricted access to healthcare facilities, and lack of transportation [62]. These

differences may hinder these groups' ability to fully benefit from VBC programs, hence sustaining gaps in health outcomes.

In addition to clinical care, social determinants of health (SDOH) must be addressed to guarantee equity in VBC. In order to link patients with community-based supports, screening methods can assist in identifying hurdles linked to SDOH, such as food insecurity or housing instability. Additionally, by acting as intermediaries between underprivileged communities and healthcare institutions, community health workers (CHWs) can promote trust and ease access to care [63].

In order to advance equity, policy measures are also essential. For instance, low-income communities now have far more access to VBC programs thanks to Medicaid expansion under the Affordable Care Act (ACA). In a similar vein, value-based payment schemes that include equity indicators, including the decrease in health inequalities, can encourage providers to attend to the needs of marginalized populations [64]. The accessibility and efficacy of VBC activities are further increased by making sure they are linguistically and culturally acceptable. A diversified strategy that blends operational enhancements with a dedication to equity is needed to address the issues surrounding VBC. Targeted interventions, such as financial incentives, leadership engagement, and investments in infrastructure and workforce development, are necessary because to provider resistance to change and resource constraints in small and rural systems. At the same time, addressing social determinants of health, utilizing community collaborations, and putting policy reforms that promote health equality into place are all necessary to achieve equitable access to VBC programs. Healthcare systems may realize value-based care's full potential and fulfill its promises of better patient outcomes, cost effectiveness, and satisfaction by addressing these obstacles.

Assessing Results in Value-Based Care Frameworks

To ensure that value-based care (VBC) models achieve their objectives of bettering patient outcomes, improving experiences, and lowering healthcare costs, evaluation of the models' results is essential to their implementation and scalability. The evidence required to improve VBC projects and guide policy decisions is provided by strong evaluation metrics. This section examines important evaluation topics, such as success measures including fewer readmissions to hospitals, better chronic illness management, patient satisfaction and participation, and cost-effectiveness attained through resource optimization and preventive treatment.

Success Metrics: Decrease in Emergency Visits and Hospital Readmissions

The decrease in ER visits and hospital readmissions is one of the main measures of VBC models' effectiveness. The efficacy of preventive interventions, transitional care, and care coordination is demonstrated by these indicators. For example, thorough discharge planning and follow-up treatment provided by Accountable treatment Organizations (ACOs) under the Medicare Shared Savings Program (MSSP) have shown a notable reduction in readmissions [65]. VBC models

enhance patient outcomes and cost-effectiveness by tackling the underlying causes of readmissions, such as improper drug administration and a lack of post-discharge support.

Additionally, physicians can identify high-risk patients and carry out focused interventions to avoid emergency visits by incorporating predictive analytics technologies. Research indicates that these data-driven strategies can lower acute care consumption by up to 25%, especially for patients with long-term illnesses like heart failure and diabetes [66]. These cuts improve the quality of care while also being in line with the financial incentives associated with VBC contracts.

Better Measures for the Management of Chronic Diseases

Given the substantial costs and morbidity associated with chronic conditions such as diabetes, hypertension, and chronic obstructive pulmonary disease (COPD), managing these diseases is a central element of value-based care (VBC) models. Improved metrics are vital indicators of VBC success, such as reduced hemoglobin A1c (HbA1c) levels in diabetic patients and enhanced blood pressure control in individuals with hypertension. Evidence demonstrates that patient education, care coordination, and nurse-led interventions significantly improve these metrics [67].

Furthermore, chronic disease outcomes can be substantially improved through population health management strategies, such as routine screenings and preventive care. For example, bundled payment plans incentivize providers to offer coordinated care for specific treatment episodes, ensuring that patients receive comprehensive management throughout their care continuum. The effectiveness of these strategies underscores the importance of aligning clinical objectives with financial incentives in VBC models.

Experience of the Patient
Assessing Contentment and Involvement

A critical aspect of VBC is the patient experience, as engaged and satisfied patients are more likely to adhere to treatment plans, which in turn leads to better health outcomes. Patient satisfaction is often measured through instruments like the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, which gathers patient feedback on care coordination, communication, and overall experience [68]. High CAHPS scores have been shown to correlate with improved outcomes, highlighting the importance of patient-centered care in VBC models.

Technological advancements, such as patient portals and telemedicine systems, significantly enhance patient interaction. These technologies support shared decision-making, give patients access to their health information, and enable real-time communication with healthcare providers. Research indicates that when patients actively participate in decisions about their care, they are more satisfied and achieve better clinical outcomes, especially in the management of chronic conditions [69].

Shared Decision-Making's Contribution to Better Results

Shared decision-making (SDM) is an essential element of improving the patient experience in VBC. By allowing patients to choose their treatment options based on their preferences, values, and goals, SDM ensures that care aligns with each individual's needs. Evidence shows that SDM enhances trust between patients and providers, reduces decisional conflict, and improves adherence to treatment plans. For instance, cancer patients who engage in SDM with their healthcare teams report fewer unmet needs and better quality-of-life outcomes [70].

Incorporating SDM into VBC models requires training healthcare providers to lead meaningful discussions and equip them with evidence-based decision aids. In doing so, SDM not only improves patient outcomes but also contributes to achieving the overall objectives of VBC by enhancing patient satisfaction and engagement.

Economicalness

Proving Cost Savings via Preventive Care and Reduced Service Duplication

Cost-effectiveness is a primary objective of VBC models, primarily achieved through the elimination of unnecessary services and the promotion of preventive care. Preventive measures, such as immunizations, cancer screenings, and smoking cessation programs, help reduce the prevalence of both acute and chronic illnesses, leading to significant cost savings [71]. For instance, every dollar spent on immunization programs has been estimated to save $10 in subsequent healthcare costs.

The economic benefits are further enhanced by reducing service duplication, such as unnecessary diagnostic tests. Health information exchanges (HIEs) play a crucial role in minimizing redundant tests by facilitating seamless data sharing between providers. Additionally, care coordination programs ensure that patients receive timely and appropriate services, thus preventing costly complications and hospital readmissions. Research shows that ACOs implementing VBC models have saved up to $1 billion annually, underscoring the financial sustainability of these models [72].

To ensure the effectiveness and long-term success of VBC models, it is essential to evaluate their outcomes using robust metrics, such as reduced hospital readmissions, improved chronic disease management, enhanced patient satisfaction, and overall cost savings. By leveraging tools like shared decision-making, patient engagement technologies, and predictive analytics, healthcare providers can achieve VBC goals while addressing operational challenges. Ultimately, a comprehensive evaluation process not only validates the success of VBC models but also guides continuous improvement efforts, ensuring that these models benefit payers, providers, and patients alike.

Conclusion

Value-based care (VBC) represents a paradigm shift in healthcare delivery, focusing on quality over quantity and prioritizing patient outcomes, cost-effectiveness, and holistic well-being. As highlighted by models such as Accountable Care Organizations (ACOs), Bundled Payment Programs, and Patient-Centered Medical Homes (PCMHs), VBC offers transformative potential for addressing the inefficiencies inherent in traditional fee-for-service systems. Through the integration of advanced data analytics, innovative technologies, and robust care coordination, healthcare systems can identify high-risk populations, personalize treatments, and achieve measurable improvements in clinical outcomes and patient satisfaction.

However, operational barriers, including provider resistance to change and resource limitations in underserved or rural areas, must be overcome for VBC models to be successfully implemented. Equally important is ensuring equitable access to VBC programs, particularly for vulnerable populations, through community partnerships and the integration of social determinants of health into care delivery. Nurses, with their leadership in advocacy, policy development, and care coordination, continue to play a pivotal role in bridging clinical and organizational goals within VBC models.

The multifaceted impact of VBC is exemplified by metrics such as reduced readmissions, improved chronic illness management, increased patient engagement, and cost savings. However, challenges related to workforce preparedness, interoperability, and access disparities highlight the need for ongoing administrative oversight and policy support.

In conclusion, while VBC has made significant strides in reshaping healthcare delivery, its long-term sustainability depends on continued innovation, collaboration across sectors, and an unwavering commitment to quality and equity. VBC will remain a cornerstone of efforts to develop a patient-centered, value-driven, and sustainable healthcare system. To address existing challenges and fully realize the potential of this transformative model, further research and enhanced policy initiatives are essential.

References

1. Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The Triple Aim: Care, health, and cost. Health Affairs, 27(3), 759–769.
2. Bodenheimer, T., & Sinsky, C. (2014). From Triple to Quadruple Aim: Care of the patient requires care of the provider. Annals of Family Medicine, 12(6), 573–576.
3. Porter, M. E., & Lee, T. H. (2013). The strategy that will fix health care. Harvard Business Review, 91(10), 50–70.
4. Centers for Disease Control and Prevention (CDC). (2021). Chronic diseases in America. CDC Foundation. Retrieved from https://www.cdc.gov
5. Marmot, M., & Allen, J. J. (2014). Social determinants of health equity. American Journal of Public Health, 104(S4), S517–S519.
6. Fisher, E. S., Shortell, S. M., & Savitz, L. A. (2016). Implementing accountable care organizations. New England Journal of Medicine, 374(11), 1045–1051.

7. Song, Z., & Fisher, E. S. (2016). The ACO experiment—Lessons for the next phase of Medicare reform. New England Journal of Medicine, 374(10), 993–994.
8. Mechanic, R., & Altman, S. H. (2009). Payment reform options: Episode payment is a good place to start. Health Affairs, 28(2), w262–w271.
9. Lin, C. C., Dievler, A., Robbins, C., Sripipatana, A., Quinn, M., & Nair, S. (2018). Telehealth in health centers: Key adoption factors, barriers, and opportunities. Health Affairs, 37(12), 1967–1974.
10. Obermeyer, Z., & Emanuel, E. J. (2016). Predicting the future—Big data, machine learning, and clinical medicine. The New England Journal of Medicine, 375(13), 1216–1219.
11. Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The Triple Aim: Care, health, and cost. Health Affairs, 27(3), 759–769. https://doi.org/10.1377/hlthaff.27.3.759
12. Porter, M. E., & Lee, T. H. (2013). The strategy that will fix health care. Harvard Business Review, 91(10), 50–70.
13. Doyle, C., Lennox, L., & Bell, D. (2013). A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. BMJ Open, 3(1), e001570. https://doi.org/10.1136/bmjopen-2012-001570
14. Bodenheimer, T., & Sinsky, C. (2014). From Triple to Quadruple Aim: Care of the patient requires care of the provider. Annals of Family Medicine, 12(6), 573–576. https://doi.org/10.1370/afm.1713
15. Shanafelt, T. D., & Noseworthy, J. H. (2017). Executive leadership and physician well-being: Nine organizational strategies to promote engagement and reduce burnout. Mayo Clinic Proceedings, 92(1), 129–146. https://doi.org/10.1016/j.mayocp.2016.10.004
16. Song, Z., & Fisher, E. S. (2016). The ACO experiment—Lessons for the next phase of Medicare reform. New England Journal of Medicine, 374(10), 993–995. https://doi.org/10.1056/NEJMp1513395
17. Mechanic, R. E., Altman, S. H., & McDonough, J. E. (2012). The ACA's payment and delivery system reforms: A progress report at year o ne. Health Affairs, 31(7), 1539–1548. https://doi.org/10.1377/hlthaff.2012.0402
18. Centers for Medicare & Medicaid Services (CMS). (2020). Bundled payments for care improvement initiative. Retrieved from https://www.cms.gov
19. McClellan, M., McKethan, A. N., Lewis, J. L., Roski, J., & Fisher, E. S. (2010). A national strategy to put accountable care into practice. Health Affairs, 29(5), 982–990. https://doi.org/10.1377/hlthaff.2010.0194
20. Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The Triple Aim: Care, health, and cost. Health Affairs, 27(3), 759–769. https://doi.org/10.1377/hlthaff.27.3.759
21. Fisher, E. S., Shortell, S. M., & Savitz, L. A. (2016). Implementing accountable care organizations. New England Journal of Medicine, 374(11), 1045–1051. https://doi.org/10.1056/NEJMp1513999
22. Mechanic, R., & Altman, S. H. (2009). Payment reform options: Episode payment is a good place to start. Health Affairs, 28(2), w262–w271. https://doi.org/10.1377/hlthaff.28.2.w262
23. Centers for Medicare & Medicaid Services (CMS). (2020). Bundled payments for care improvement initiative. Retrieved from https://www.cms.gov
24. Reid, R. J., Fishman, P. A., Yu, O., Ross, T. R., Tufano, J. T., & Soman, M. P. (2009). Patient-centered medical home demonstration: A prospective, quasi-

experimental, before and after evaluation. American Journal of Managed Care, 15(9), e71–e87.
25. Rosenthal, T. C. (2008). The medical home: Growing evidence to support a new approach to primary care. Journal of the American Board of Family Medicine, 21(5), 427–440. https://doi.org/10.3122/jabfm.2008.05.070287
26. Shortell, S. M., & Addicott, R. (2009). Collaborative care and the role of multispecialty group practice. Journal of Ambulatory Care Management, 32(4), 292–302.
27. Artiga, S., & Hinton, E. (2018). Beyond health care: The role of social determinants in promoting health and health equity. Kaiser Family Foundation.
28. Lin, C. C., Dievler, A., Robbins, C., Sripipatana, A., Quinn, M., & Nair, S. (2018). Telehealth in health centers: Key adoption factors, barriers, and opportunities. Health Affairs, 37(12), 1967–1974.
29. Obermeyer, Z., & Emanuel, E. J. (2016). Predicting the future—Big data, machine learning, and clinical medicine. The New England Journal of Medicine, 375(13), 1216–1219. https://doi.org/10.1056/NEJMp1606181
30. McClellan, M., Udayakumar, K., Thoumi, A., Gonzalez-Smith, J., Kadakia, K., & Kurek, N. (2017). Improving care and lowering costs: Evidence and lessons from a global analysis of accountable care reforms. Health Affairs, 36(11), 1920–1927. https://doi.org/10.1377/hlthaff.2017.0638
31. Obermeyer, Z., & Emanuel, E. J. (2016). Predicting the future—Big data, machine learning, and clinical medicine. The New England Journal of Medicine, 375(13), 1216–1219. https://doi.org/10.1056/NEJMp1606181
32. Kansagara, D., Englander, H., Salanitro, A., Kagen, D., Theobald, C., Freeman, M., & Kripalani, S. (2011). Risk prediction models for hospital readmission: A systematic review. JAMA, 306(15), 1688–1698. https://doi.org/10.1001/jama.2011.1515
33. Beck, R. W., Connor, C. G., Mullen, D. M., Wesley, D. M., & Bergenstal, R. M. (2019). The Fallacy of Average: How Using HbA1c Alone to Assess Glycemic Control Can Be Misleading. Diabetes Care, 42(6), 983–987. https://doi.org/10.2337/dc18-1580
34. Glance, L. G., Osler, T., Mukamel, D. B., & Dick, A. W. (2019). Impact of performance benchmarking on hospital quality, safety, and efficiency: A systematic review. Medical Care Research and Review, 76(2), 145–176. https://doi.org/10.1177/1077558717726850
35. Lin, C. C., Dievler, A., Robbins, C., Sripipatana, A., Quinn, M., & Nair, S. (2018). Telehealth in health centers: Key adoption factors, barriers, and opportunities. Health Affairs, 37(12), 1967–1974.
36. Smith, A. C., Thomas, E., Snoswell, C. L., Haydon, H., Mehrotra, A., Clemensen, J., & Caffery, L. J. (2020). Telehealth for global emergencies: Implications for coronavirus disease 2019 (COVID-19). Journal of Telemedicine and Telecare, 26(5), 309–313. https://doi.org/10.1177/1357633X20916567
37. Henry, T. A., & Pandit, A. U. (2020). Telemedicine after COVID-19: What now? The New England Journal of Medicine, 383(9), e87. https://doi.org/10.1056/NEJMp2021160
38. Kuperman, G. J., & McGowan, J. J. (2013). Potential unintended consequences of health information exchange. JAMA, 310(10), 1081–1082. https://doi.org/10.1001/jama.2013.276287

39. Mandl, K. D., & Kohane, I. S. (2017). A 21st-century health IT system—Interoperability and information blocking. JAMA, 317(15), 1533–1534. https://doi.org/10.1001/jama.2017.2595
40. Martin, G., Martin, P., Hankin, C., Darzi, A., & Kinross, J. (2017). Cybersecurity and healthcare: How safe are we? BMJ, 358, j3179. https://doi.org/10.1136/bmj.j3179
41. Coleman, E. A., Parry, C., Chalmers, S., & Min, S. J. (2006). The Care Transitions Intervention: Results of a randomized controlled trial. Archives of Internal Medicine, 166(17), 1822–1828. https://doi.org/10.1001/archinte.166.17.1822
42. Naylor, M. D., Aiken, L. H., Kurtzman, E. T., Olds, D. M., & Hirschman, K. B. (2011). The importance of transitional care in achieving health reform. Health Affairs, 30(4), 746–754. https://doi.org/10.1377/hlthaff.2011.0041
43. Artiga, S., & Hinton, E. (2018). Beyond health care: The role of social determinants in promoting health and health equity. Kaiser Family Foundation.
44. Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The Triple Aim: Care, health, and cost. Health Affairs, 27(3), 759–769. https://doi.org/10.1377/hlthaff.27.3.759
45. Shanafelt, T. D., & Noseworthy, J. H. (2017). Executive leadership and physician well-being: Nine organizational strategies to promote engagement and reduce burnout. Mayo Clinic Proceedings, 92(1), 129–146. https://doi.org/10.1016/j.mayocp.2016.10.004
46. Porter, M. E., & Lee, T. H. (2013). The strategy that will fix health care. Harvard Business Review, 91(10), 50–70.
47. Shortell, S. M., Addicott, R., Walsh, N., & Ham, C. (2014). The NHS five year forward view: Lessons from the United States in developing accountable care systems. BMJ, 349, g5322. https://doi.org/10.1136/bmj.g5322
48. Martin-Misener, R., Valaitis, R., Wong, S. T., MacDonald, M., Meagher-Stewart, D., & Kaczorowski, J. (2015). A scoping literature review of collaboration between primary care and public health. Primary Health Care Research & Development, 16(4), 351–364. https://doi.org/10.1017/S1463423614000495
49. Centers for Medicare & Medicaid Services (CMS). (2020). Medicare Shared Savings Program: Shared savings and losses and assignment methodology specifications. Retrieved from https://www.cms.gov
50. Bachrach, D., Guyer, J., & Levin, A. (2014). Medicaid accountable care organizations: State models and early results. The Commonwealth Fund, 1–16.
51. Berwick, D. M., & Hackbarth, A. D. (2012). Eliminating waste in US health care. JAMA, 307(14), 1513–1516. https://doi.org/10.1001/jama.2012.362
52. Sommers, B. D., Gawande, A. A., & Baicker, K. (2017). Health insurance coverage and health—What the recent evidence tells us. New England Journal of Medicine, 377(6), 586–593. https://doi.org/10.1056/NEJMsb1706645
53. Porter, M. E., & Lee, T. H. (2013). The strategy that will fix health care. Harvard Business Review, 91(10), 50–70.
54. Shortell, S. M., & Addicott, R. (2009). Collaborative care and the role of multispecialty group practice. Journal of Ambulatory Care Management, 32(4), 292–302.

55. Bodenheimer, T., & Sinsky, C. (2014). From triple to quadruple aim: Care of the patient requires care of the provider. Annals of Family Medicine, 12(6), 573–576. https://doi.org/10.1370/afm.1713
56. Health Resources and Services Administration (HRSA). (2020). Health workforce projections: Future demand for healthcare workers. Retrieved from https://bhw.hrsa.gov
57. Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The Triple Aim: Care, health, and cost. Health Affairs, 27(3), 759–769. https://doi.org/10.1377/hlthaff.27.3.759
58. Shortell, S. M., Addicott, R., Walsh, N., & Ham, C. (2014). The NHS five year forward view: Lessons from the United States in developing accountable care systems. BMJ, 349, g5322. https://doi.org/10.1136/bmj.g5322
59. Gale, J. A., & Heady, H. R. (2013). Rural health in rural hands: Strategic directions for rural, remote, northern, and aboriginal communities. National Rural Health Association.
60. Health Resources and Services Administration (HRSA). (2020). Health workforce projections: Future demand for healthcare workers. Retrieved from https://bhw.hrsa.gov
61. Porter, M. E., & Lee, T. H. (2013). The strategy that will fix health care. Harvard Business Review, 91(10), 50–70.
62. Artiga, S., & Hinton, E. (2018). Beyond health care: The role of social determinants in promoting health and health equity. Kaiser Family Foundation.
63. Marmot, M., Allen, J., Bell, R., Bloomer, E., & Goldblatt, P. (2012). WHO European review of social determinants of health and the health divide. The Lancet, 380(9846), 1011–1029. https://doi.org/10.1016/S0140-6736(12)61228-8
64. McClellan, M., Kent, J., Beales, S. J., Macdonnell, M., Thoumi, A., Shuttleworth, B., & Cohen, S. (2017). Accountable care around the world: A framework to guide reform strategies. Health Affairs, 36(11), 2096–2105. https://doi.org/10.1377/hlthaff.2017.0721
65. Medicare Payment Advisory Commission (MedPAC). (2020). Evaluating Medicare's Hospital Readmissions Reduction Program. MedPAC Report to Congress. Retrieved from https://www.medpac.gov
66. Naylor, M. D., Aiken, L. H., Kurtzman, E. T., Olds, D. M., & Hirschman, K. B. (2011). The importance of transitional care in achieving health reform. Health Affairs, 30(4), 746–754. https://doi.org/10.1377/hlthaff.2011.0041
67. Bodenheimer, T., & Berry-Millett, R. (2009). Care management of patients with complex health care needs. Robert Wood Johnson Foundation.
68. Agency for Healthcare Research and Quality (AHRQ). (2021). Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. Retrieved from https://www.ahrq.gov
69. Lupton, D. (2018). Digital health technologies and patient care. Social Theory & Health, 16(3), 332–347. https://doi.org/10.1057/s41285-018-0066-1
70. Elwyn, G., Frosch, D., & Thomson, R. (2012). Shared decision-making: A model for clinical practice. Journal of General Internal Medicine, 27(10), 1361–1367. https://doi.org/10.1007/s11606-012-2077-6
71. Maciosek, M. V., LaFrance, A. B., Dehmer, S. P., & McGr ee, D. A. (2017). Updated priorities among effective clinical preventive services. Annals of Family Medicine, 15(1), 14–22. https://doi.org/10.1370/afm.2017

72. Shrank, W. H., Rogstad, T. L., & Parekh, N. (2019). Waste in the US health care system: Estimated costs and potential for savings. JAMA, 322(15), 1501–1509. https://doi.org/10.1001/jama.2019.13978

دور الممرضين والإداريين الصحيين في تعزيز نماذج الرعاية القائمة على القيمة: تداعيات إدارة الرعاية الصحية المتكاملة والتمريض والصيدلة

الملخص

الخلفية :تمثل نماذج الرعاية القائمة على القيمة (VBC) تحولًا جذريًا في تقديم الرعاية الصحية، حيث تركز على تحسين نتائج المرضى مع تقليل التكاليف. من خلال إعطاء الأولوية للجودة على الكم، تتماشى هذه النماذج مع تحقيق نتائج صحية بدلاً من التركيز على حجم الخدمات المقدمة. تهدف نماذج VBC مثل المنازل الطبية المتمركزة حول المريض (PCMH) ونظام الدفع المجمع والمنظمات المسؤولة عن الرعاية (ACOs) إلى معالجة عبء الأمراض المزمنة المتزايد، والنفقات الصحية المتصاعدة، وعدم المساواة في الوصول إلى الرعاية. ورغم إمكاناتها، تواجه هذه النماذج تحديات مثل استعداد القوى العاملة، توافقها مع أنظمة إدارة البيانات، وتنفيذها العادل عبر مجموعات سكانية متنوعة.

الهدف :تستعرض هذه الدراسة الأسس النظرية وطرق التنفيذ والنتائج المرتبطة بنماذجVBC ، مع التركيز بشكل خاص على الأدوار الحيوية التي يلعبها الممرضون والإداريون الصحيون في تعزيز تخطيط وتنفيذ وتقييم هذه النماذج.

المنهجية :تم إجراء مراجعة شاملة لحالات دراسية، أوراق سياسات، ومقالات بحثية محكمة. يركز التحليل على دمج التكنولوجيا، تطبيقVBC ، والمساهمات التي تقدمها الفرق متعددة التخصصات في تحسين معايير الرعاية وتقليل التكاليف.

النتائج :تشير النتائج إلى أن نماذج VBC تؤدي إلى زيادة رضا المرضى، وتحسين إدارة الأمراض المزمنة، وتقليص كبير في حالات إعادة إدخال المرضى إلى المستشفيات. وتعد مساهمات الممرضين مثل التعليم الصحي للمرضى وتنسيق الرعاية الانتقالية ضرورية لتحقيق هذه النتائج. كما يلعب الإداريون الصحيون دورًا أساسيًا في تدريب القوى العاملة، تخصيص الموارد، ومواءمة السياسات مع أهداف .VBC ومع ذلك، ما زالت التحديات المتعلقة بإدارة البيانات، والمقاومة للتغيير، والوصول العادل إلى الرعاية قائمة.

الخاتمة :من خلال التوافق بين الحوافز والنتائج الصحية، تتمتع نماذج الرعاية القائمة على القيمة بإمكانات كبيرة في إعادة تشكيل تقديم الرعاية الصحية. للتغلب على التحديات الحالية وتحقيق أقصى استفادة من هذه النماذج، يعد التعاون بين التمريض، إدارة الرعاية الصحية، والصيدلة أمرًا بالغ الأهمية.

الكلمات المفتاحية :الرعاية القائمة على القيمة، المنازل الطبية المتمركزة حول المريض، المنظمات المسؤولة عن الرعاية، التمريض، إدارة الرعاية الصحية، الصيدلة، التحول في الرعاية الصحية، التعاون متعدد التخصصات، العدالة في الرعاية الصحية.