Coordinating care in a value-based world
Today’s presenters

Ken Botsford, MD
Chief Medical Officer,
naviHealth, a Cardinal Health company

Jay LaBine, MD
Senior Vice President and
Associate Chief Medical Officer,
Spectrum Health
1. Why is care coordination more critical than ever for health systems?

2. What are the elements of successful care coordination?

3. Best practice spotlight: Spectrum Health

4. What steps can I take to improve transitions of care at my health system?
Why is care coordination more critical than ever for health systems?
CMS stepping on the gas to shift to value-based care

“In a historic announcement, HHS\(^1\) sets clear goals and timeline for shifting Medicare reimbursements from volume to value”

*First time in the history of the Medicare program that HHS has set explicit goals for alternative payment models and value-based payments*

\(^1\)HHS = United States Department of Health and Human Services
CMS stepping on the gas to shift to value-based care

HHS timeline for transition to value (% Medicare payments)

- **2014**
  - 20% Alternate payment models (e.g., bundled payments, ACOs)
  - 60% Fee-for-service (FFS) linked to quality or value (e.g., readmission penalties, value-based purchasing)
  - 20% Traditional FFS payment

- **2016**
  - 30% Alternate payment models (e.g., bundled payments, ACOs)
  - 55% Fee-for-service (FFS) linked to quality or value (e.g., readmission penalties, value-based purchasing)
  - 15% Traditional FFS payment

- **2018**
  - 50% Alternate payment models (e.g., bundled payments, ACOs)
  - 40% Fee-for-service (FFS) linked to quality or value (e.g., readmission penalties, value-based purchasing)
  - 10% Traditional FFS payment
80% of health systems are evaluating value-based care efforts

What is your organization’s status regarding making the transition from providing care on a fee-for-service basis to providing value-based care?

- Not pursuing: 8%
- Investigating: 25%
- Underway with pilot efforts: 35%
- Pilot efforts complete, full roll-out not scheduled: 7%
- Pilot efforts complete, full roll-out underway: 12%
- Full roll-out nearly complete: 4%
- Full roll-out complete: 4%
- Don’t know: 5%

Base = 471
Value-based Care (VBC) requires a transition toward provider-assumed risk.

- **Risk**
  - Traditional fee for service
  - Pay for performance
  - One-sided shared savings
  - Bundled/episode payments
  - Two-sided shared savings
  - Partial capitation
  - Global capitation

**Payer takes full financial risk**  **Provider takes full financial risk**

**Increased provider risk = Increased need for care coordination**
Meet Dutch
Two critical challenges in care coordination

Medication management

30 percent of patients have at least one medication discrepancy upon hospital discharge

1 in 5 patients discharged to their home from the hospital experienced an adverse event within three weeks of discharge

60 percent of these events were medication related and could have been avoided

Care transitions

$100+ billion in annual post-acute care (PAC) spending

Utilized by nearly 1 in 2 Medicare patients

Accounts for 73 percent of total variance in Medicare spending

Readmissions cost the healthcare system $30-$40 billion annually
What are the elements of successful care coordination?
## Three factors to drive success

<table>
<thead>
<tr>
<th>The right care</th>
<th>Medication management</th>
<th>Care transitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensuring patients understand their doctor’s orders and medication instructions</td>
<td>Addressing patient-centered discharge planning by risk, condition, and ability to self-manage</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>The right place</th>
<th>Medication reconciliation is key to optimal transitions of care (CMS Star Measure)</th>
<th>Choosing the right setting and practicing “warm” handoffs enhance value and safety to improve outcomes</th>
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</thead>
</table>

| The right time | Missed medication doses alone account for 10 to 25 percent of hospital and nursing home admissions | Variation in discharge planning leads to poor transitions, lower patient satisfaction, and eventually readmissions |
A high performing network is essential

43 percent of Medicare patients utilize post-acute care (PAC) after discharge and there is wide variation in costs across each setting.

1 Other inpatient facilities (acute and psychiatric) and death
2 Represents average cost to Medicare per case, or discharge in 2013 (Source: MedPAC June 2015 Data Book)
Best practice spotlight: Spectrum Health
Partnering to Manage Care Transitions

Jay LaBine, MD
Senior Vice President and Associate Chief Medical Officer
How Spectrum Health addresses these challenges
Results

<table>
<thead>
<tr>
<th></th>
<th>June 2013</th>
<th>June 2014</th>
<th>June 2015</th>
<th>June 2016</th>
<th>YoY +/-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total PMPM</td>
<td>$28.09</td>
<td>$25.38</td>
<td>$22.33</td>
<td>$19.55</td>
<td>-12.4%</td>
</tr>
<tr>
<td>SNF Admits / 1,000</td>
<td>42.3</td>
<td>41.5</td>
<td>42.7</td>
<td>40.1</td>
<td>-6.0%</td>
</tr>
<tr>
<td>SNF ALOS</td>
<td>22.8</td>
<td>21.2</td>
<td>17.6</td>
<td>15.9</td>
<td>-9.2%</td>
</tr>
<tr>
<td>SNF Days / 1,000</td>
<td>966</td>
<td>879</td>
<td>750</td>
<td>640</td>
<td>-14.6%</td>
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Post-acute Care High-Performing Network

Spectrum Health Clinical Consortium
- 21 facilities, representing 8 PAC entities
- Charter, October 2015
- Executive Steering Committee; Clinical Operations Workgroup

<table>
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<tr>
<th>PH Data, Rolling 12 mos. Apr. 2015-Mar. 2016</th>
<th>ELOS</th>
<th>Discharge Score</th>
<th>Therapy Hrs/Day</th>
<th>30D Re-admit Rate</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Target</td>
<td>Var.</td>
<td>Actual</td>
</tr>
<tr>
<td>Consortium Facilities</td>
<td>15.0</td>
<td>14.4</td>
<td>4%</td>
<td>50.9</td>
</tr>
<tr>
<td>Other Facilities</td>
<td>17.4</td>
<td>14.3</td>
<td>21%</td>
<td>50.8</td>
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</table>
What steps can I take to improve transitions of care at my health system?
What does a best-practice transitions of care program look like?

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<th>What it’s not</th>
<th>What it is</th>
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<tr>
<td></td>
<td>Simply having a case manager to oversee discharge</td>
<td>Assuming ownership of the patient before, during, and after an inpatient stay</td>
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<td>A directory of available post-acute care facilities</td>
<td>Ensuring your technology is able to identify patient outcomes, functional status and needs, and monitor network performance</td>
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<td>Assuming your existing ACO network will cover all of your organization’s needs</td>
<td>A strong network based on outcomes data that connects with patients in order to conduct timelier, better and “warmer” handoffs</td>
<td></td>
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</table>
How do you get started?

1. Establish multi-disciplinary planning teams

2. Use technology to support informed decisions

3. Build high-quality post-acute care networks
Interested in learning more about best-in-class approaches?

To learn more about how you can achieve better results under value-based care through effective care transitions, contact us at:

caretransitions@cardinalhealth.com
Thank you.