# Coordinating care in a value-based world

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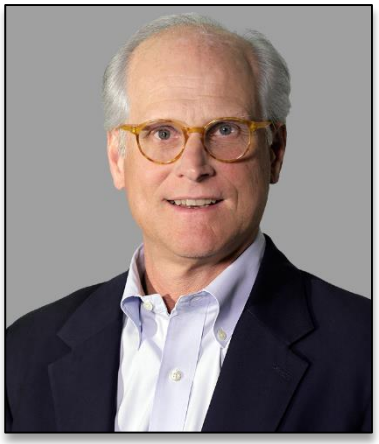
# Today's presenters



## Ken Botsford, MD

Chief Medical Officer,
naviHealth, a Cardinal Health company

## Jay LaBine, MD

Senior Vice President and
Associate Chief Medical Officer,
Spectrum Health





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# Agenda

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?





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# Why is care coordination more critical than ever for health systems?

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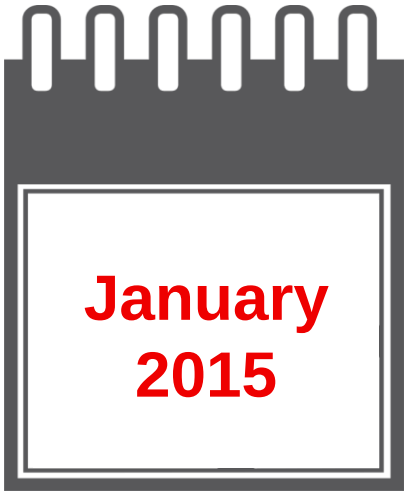
# CMS stepping on the gas to shift to value-based care




"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





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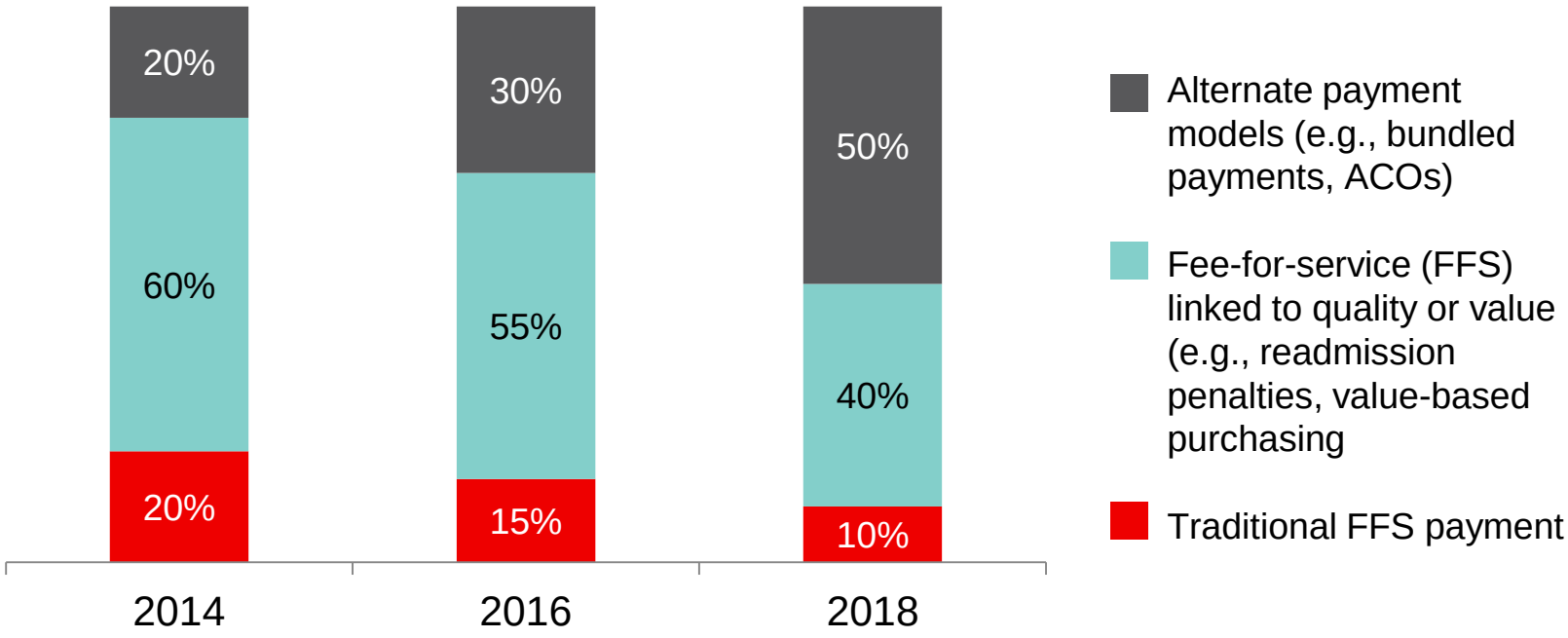
# CMS stepping on the gas to shift to value-based care

## HHS timeline for transition to value (% Medicare payments)





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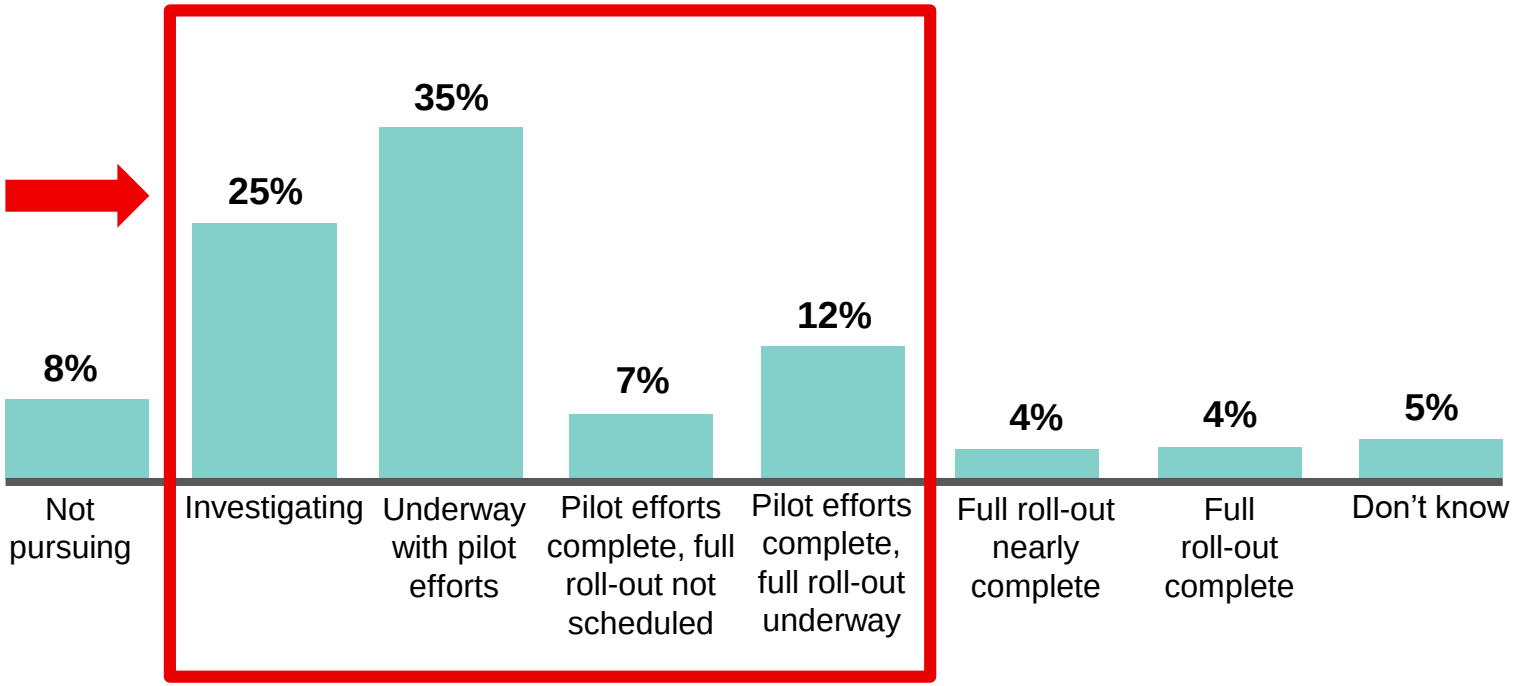
# 80% of health systems are evaluating value-based care efforts

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




**Base = 471**







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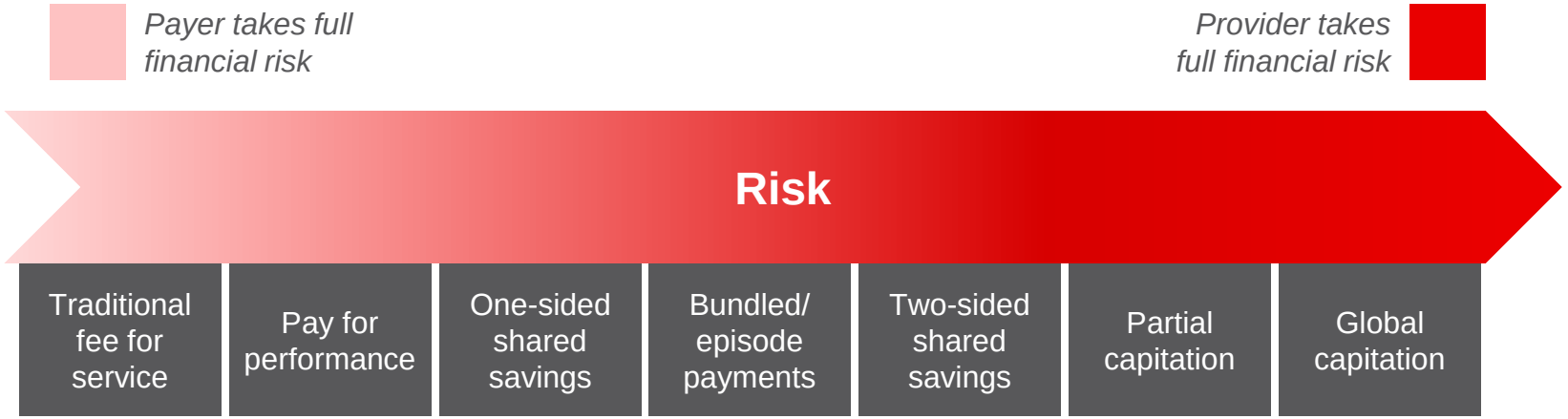
# Value-based Care (VBC) requires a transition toward provider-assumed risk




**Increased provider risk = Increased need for care coordination**





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# Meet Dutch





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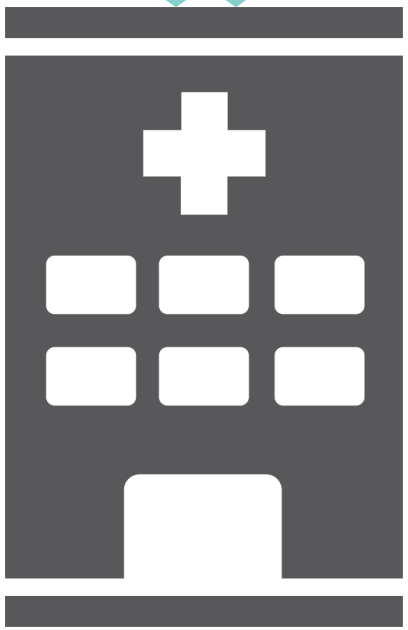
# Two critical challenges in care coordination

## 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





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# What are the elements of successful care coordination?

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# Three factors to drive success

| | Medication management | Care transitions |
|---|---|---|
| **The right care** | Ensuring patients understand their doctor's orders and medication instructions | Addressing patient- centered discharge planning by risk, condition, and ability to self-manage |
| **The right place** | Medication reconciliation is key to optimal transitions of care (CMS Star Measure) | Choosing the right setting and practicing "warm" handoffs enhance value and safety to improve outcomes |
| **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 |





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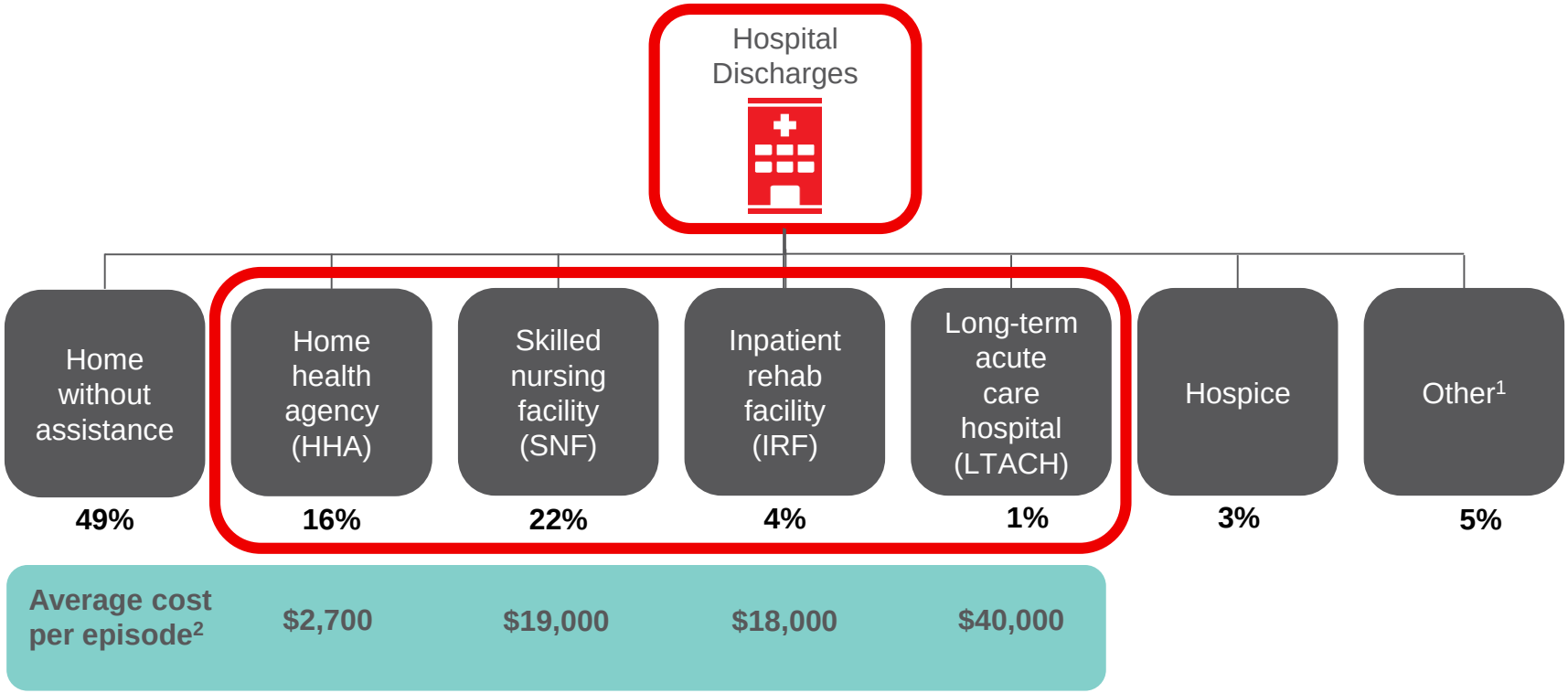
# A high performing network is essential

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




Notes & Sources: MedPAC, "Healthcare Spending and the Medicare Program," June 2014
[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)





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# Best practice spotlight: Spectrum Health

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# Partnering to Manage Care Transitions

Jay LaBine, MD
Senior Vice President and
Associate Chief Medical Officer

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## Spectrum Health

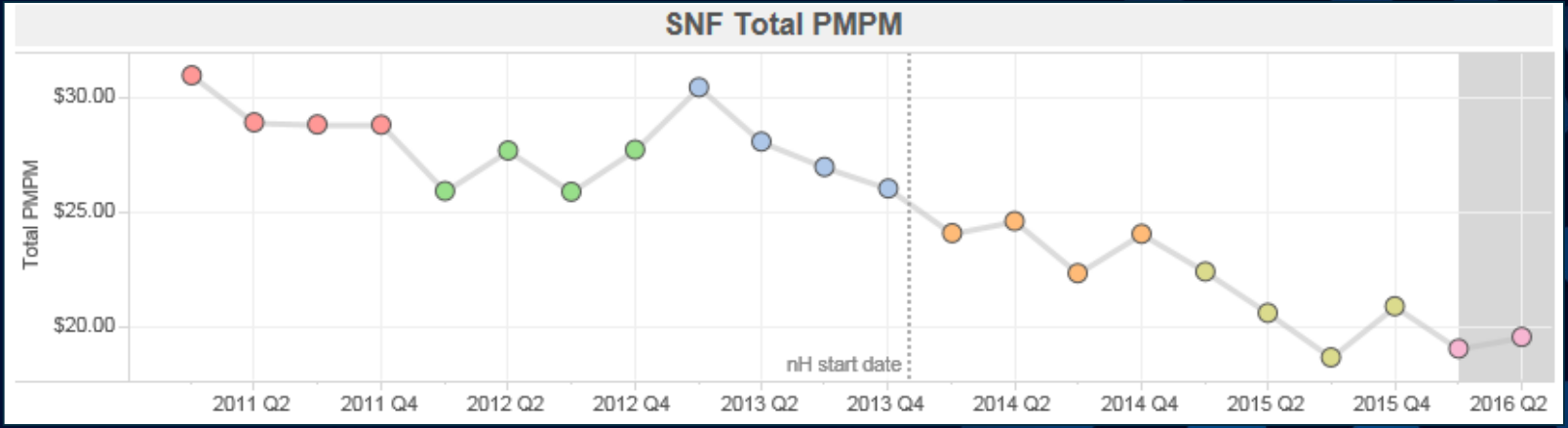
- **$5B** Enterprise Revenue
- **12** Hospitals
- **178** Ambulatory Sites
- **750,000** Member Priority Health Plan
- **24,000** Employees in West Michigan
- **3,400** Physicians & Advanced Practice Providers
- **1,400** Members of Spectrum Health Medical Group
- **5x Top 15** Health Systems in Nation

## naviHealth

- **21%** of U.S. Care Transitions Managed
- **6.8M** Discharges per Year
- **2M** Medicare Patient Lives Managed
- **20+** Clinical Service Areas in **48** states
- **650+** Connected Hospitals
- **40,000** Active PAC Providers
- **$6B+** Annual PAC Medical Spend Impacted
- **18 Combined Years** Experience Managing PAC
- **21** - Cardinal Health's Fortune 500 Rank

# How Spectrum Health addresses these challenges


# Results




| | June 2013 | June 2014 | June 2015 | June 2016 | YoY +/- |
|---|---|---|---|---|---|
| Total PMPM | $28.09 | $25.38 | $22.33 | $19.55 | -12.4% |
| SNF Admits / 1,000 | 42.3 | 41.5 | 42.7 | 40.1 | -6.0% |
| SNF ALOS | 22.8 | 21.2 | 17.6 | 15.9 | -9.2% |
| SNF Days / 1,000 | 966 | 879 | 750 | 640 | -14.6% |

SPECTRUM HEALTH

# 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

| PH Data, Rolling 12 mos. Apr. 2015-Mar. 2016 | ELOS | | | Discharge Score | | | Therapy Hrs/Day | | | 30D Re-admit Rate |
|---|---|---|---|---|---|---|---|---|---|---|
| | Actual | Target | Var. | Actual | Target | Var. | Actual | Target | Var. | |
| Consortium Facilities | 15.0 | 14.4 | 4% | 50.9 | 53.0 | -3.8% | 1.61 | 1.35 | 19% | 11.3% |
| Other Facilities | 17.4 | 14.3 | 21% | 50.8 | 54.6 | -6.9% | 1.38 | 1.36 | 1% | 13.4% |

# What steps can I take to improve transitions of care at my health system?

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# What does a best-practice transitions of care program look like?

| | What it's not | What it is |
|---|---|---|
| **The right care** | Simply having a case manager to oversee discharge | Assuming ownership of the patient before, during, and after an inpatient stay |
| **The right place** | A directory of available post-acute care facilities | Ensuring your technology is able to identify patient outcomes, functional status and needs, and monitor network performance |
| **The right time** | Assuming your existing ACO network will cover all of your organization's needs | A strong network based on outcomes data that connects with patients in order to conduct timelier, better and "warmer" handoffs |





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# 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**





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# 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**





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# Q&A

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# Thank you.

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