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Care Coordination: What's in it for my Organization

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Innovations

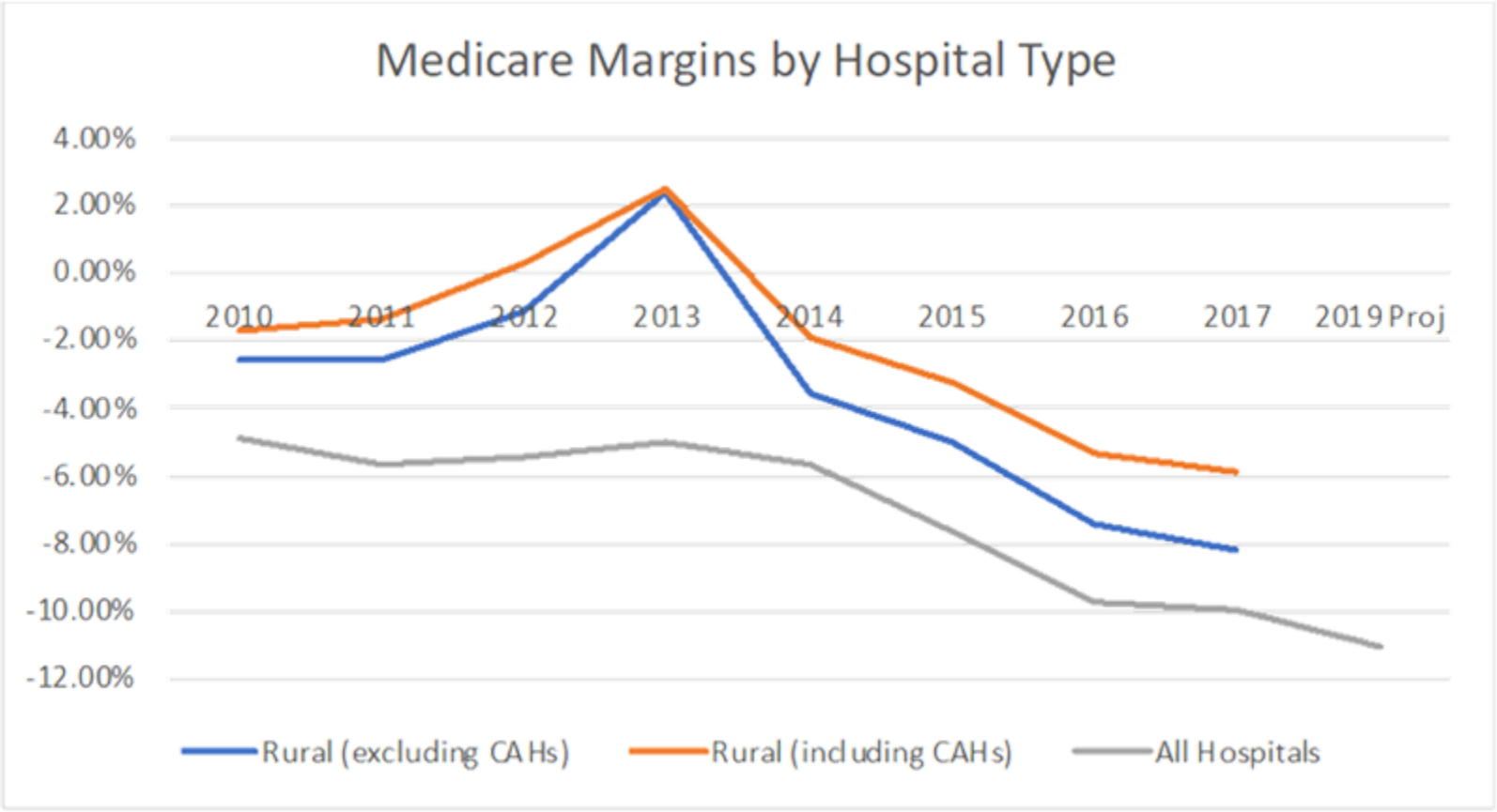
Thoughts & Questions

- When are we going to be done transforming?
- Aren't population health and value-based care just new terms for managed care, and didn't we try that already?
- My hospital only has the energy to deal with the pandemic.
- RISK!
- Isn't operating a rural hospital already risky enough?
- Maybe if we don't do anything this will all go away.
- My hospital is too small to move into value-based care.

Declining Medicare Margins

Call to Action: Declining Medicare Margins

STROUDWATER



Source: MedPac Report to Congress, March 15, 2019

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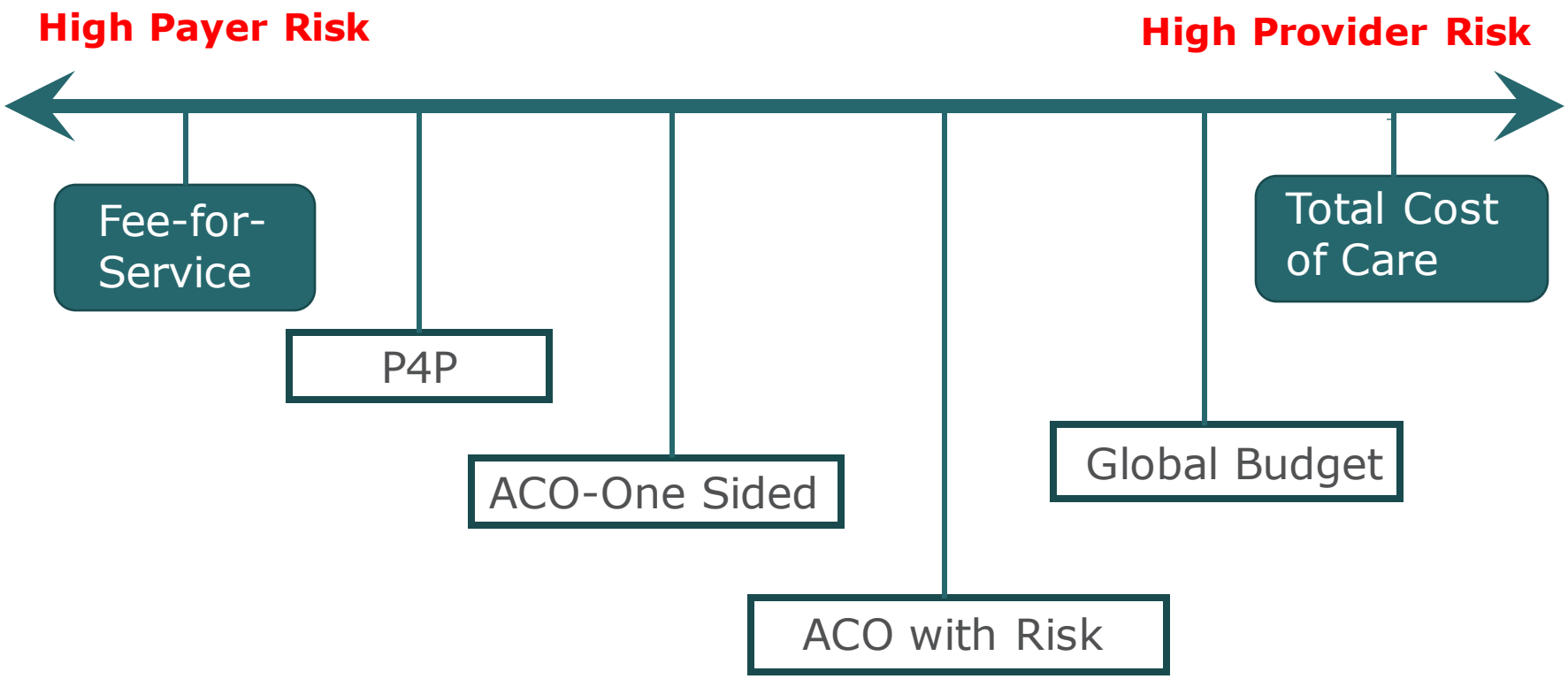
Value-Based Continuum



Current Advanced Payment Models

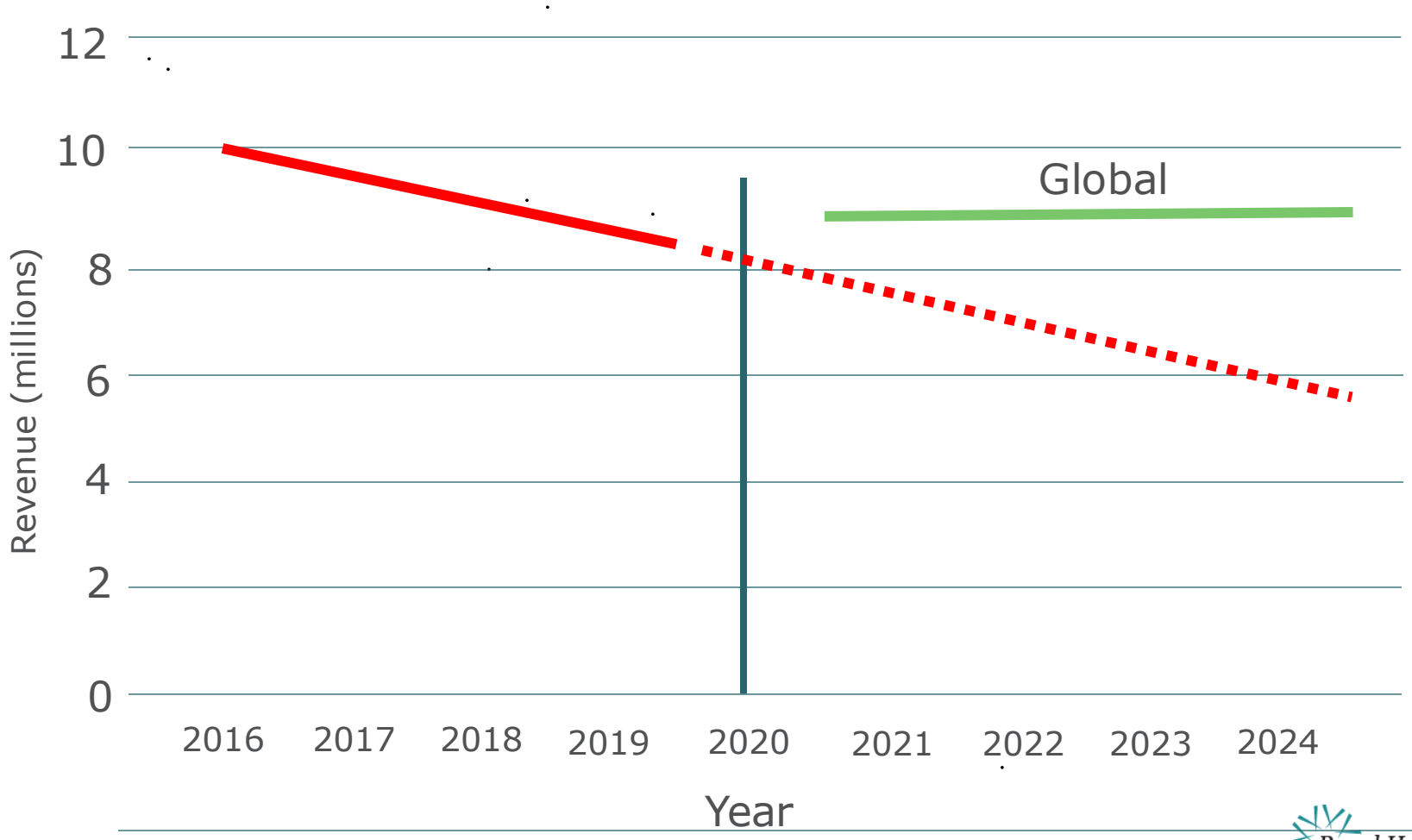
1. Accountable Care Organizations
2. Bundled Payments
3. MACRA and MIPS
4. Global Budget
5. Medicaid & Insurance Co ACOs

New CMS CHART Models

- CHART Aims:
  - Increase hospital financial stability
  - Remove regulatory barriers
  - Enhance access

- Community Transformation Tract
  - Organize communities
  - Develop transformation plans
  - Change to capitated payments
  - Include all payers
  - Semi-monthly payments to hospitals

Historic Trend Versus Global Budget



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Pennsylvania Rural Health Model

- Goal: Improve quality and address community health needs in 54 rural hospitals in six years
- Hospital global budgets: for all outpatient and inpatient services
- Hospitals will redesign patient care across the service delivery continuum
- All payers will pay the same in monthly payments

New CMS CHART Models

ACO Transformation Tract

- Based on previous AIM model (2016)
- Up to 20 ACOs receive funding
- Up front $200,000 & $36 per person
- $8 PBPM advanced payments
- Maximum of 10,000 beneficiaries
- Scheduled to begin in 2022

Future Hospital Financial Value Equation

$$\text{Value Payment} = \frac{\text{Quality}}{\text{Cost}} \times \text{Population}$$

Accountable Care Organizations (ACO's)

- A mechanism to monetize value by increasing quality and reducing cost
- A group of health care providers that takes responsibility for the cost and quality of care for a group of patients or individuals

Update on ACO's Presence

- Growth of Medicare ACO/Shared Savings
  - August 2012: 220
  - January 2015: 404
  - January 2016: 433 (41 new in rural)
  - January 2018: 649
  - January 2020: 558
  - January 2021: 477
- Both hospital and physician led
- Rural hospitals are outperforming urban

Source: CMS - Medicare Shared Savings Program Fast Facts

Rural ACOs: What Have We Learned

1. Develop care coordination programs.
2. Pay attention to post-acute care
3. Provide behavioral health support.
4. Improve HCC (Hierarchical Conditioning Coding).
5. Expand clinic hours, implement pre-visit planning and focus on prevention quality processes and metrics.
6. Reduce out-migration & increase outpatient volume.
7. Increase use of telehealth & technology.
8. Engage and enlist physicians as partners.
9. Manage, analyze and act on patient information.
10. Manage downstream costs of patient care.

Long Term and Post Acute Care

- Substantial variation in post acute care costs
  - Mean for non-swing $647 ($421)
  - Mean for home health $449 ($367)

- Significant variation in Long Term Care quality

- Longer hospice stay = less end-of-life cost
  - 0-7 days = $37,524
  - Over 30 days = $30,646

How Do You Win in the MSSP?

Managing your patients better than fee-for-service

- ✓ Wellness
- ✓ Prevention
- ✓ Chronic Care Management
- ✓ Behavioral/Mental Health Support
- ✓ Post-Acute Care

Accurately coding chronic conditions every year

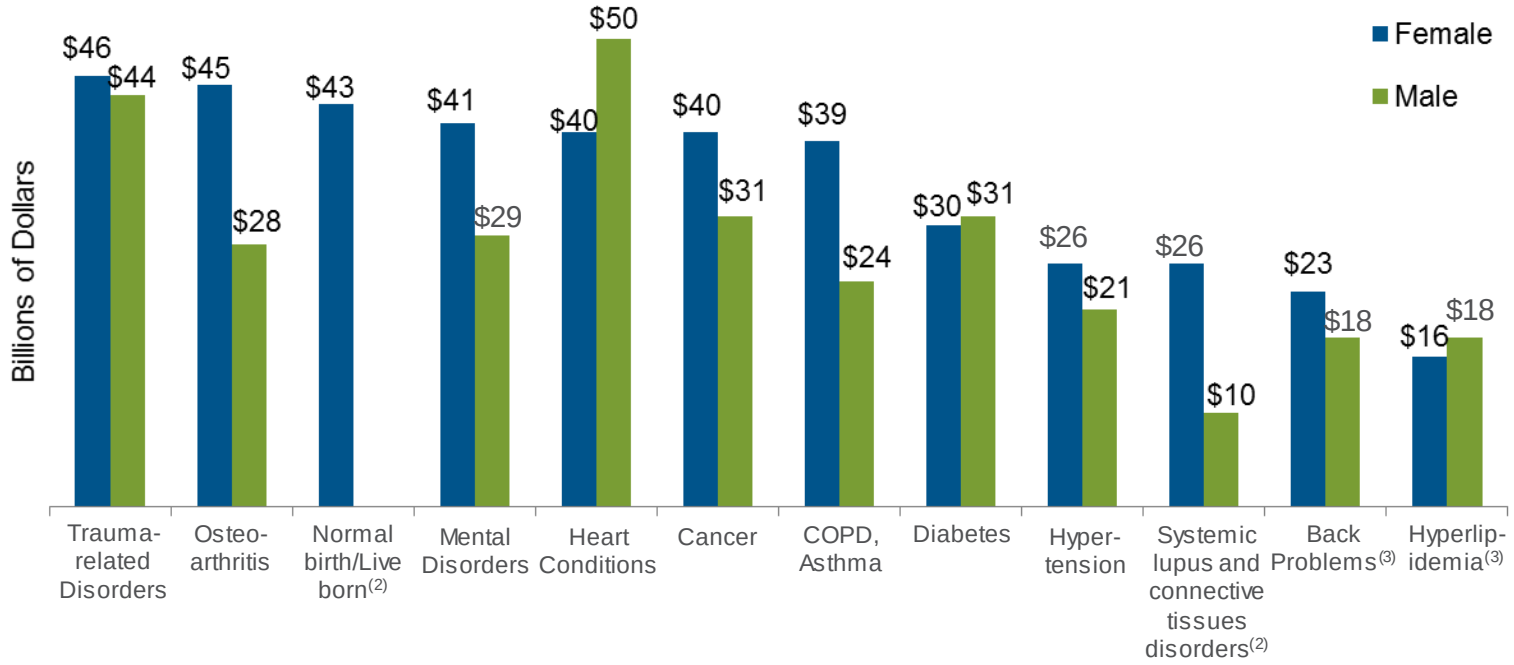
Having enough lives to reduce statistical variation

Your path to... ***... Shared Savings***

caravanhealth
bringing population health to life

Drivers of Cost

Chart 7.24: Total Expenses on Top 10 Most Costly Conditions Among Adults[1] by Sex, 2013



Source: Agency for Healthcare Research and Quality. Center for Financing, Access, and Cost Trends. Household Component of the Medical Expenditure Panel Survey, 2013. Available at: https://meps.ahrq.gov/mepsweb/.

(1) Only includes adults ages 18 and older.

(2) Normal birth/live born and systemic lupus and connective tissues disorders are not included among the top ten most costly conditions for males.

(3) Back Problems and Hyperlipidemia are not included among the top ten most costly conditions for females.

Chart added in Chartbook 2016.

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Growth of Telehealth

- Expanding 65% a year
- Payment & regulatory obstacles are being removed
- Impressive quality & cost:
  - In person psych cost: $5,103
  - Tele-psych cost: $2,000
- Key to chronic illness mgt, LTC & home monitoring
- Growing acceptance by providers & patients
- Virtual medicine is increasing rapidly and could provide competition from new "disrupters"

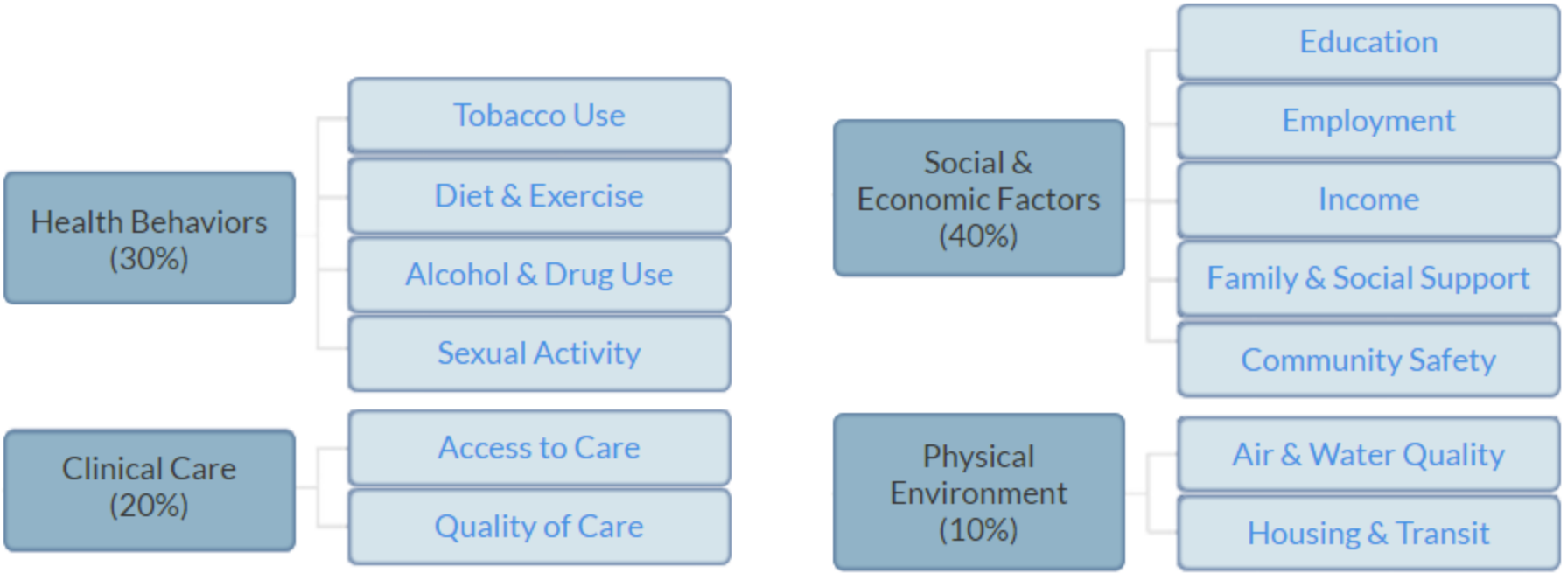
What This Could Mean for Health Care

Social Determinants of Health

The conditions and circumstances in which people are born, grow, live, work, and age. These circumstances are **shaped by** a set of forces beyond the control of the individual: economics and the **distribution of money, power, social policies, and politics….**

Source: WHO and CDC (adapted)

Population Health has Many Determinants



Source: County Health Rankings: What Works for Health

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Unmet Social Needs Lead to...

- Nearly twice the rate of depression.
- 60% higher prevalence of diabetes.
- More than double the rate of ED visits.
- More than double the rate of missed medical appointments.

High Prevalence of Chronic Conditions

½ adults

one or more chronic condition

Arthritis

23% of all adults, often a comorbidity

Heart Disease and Cancer

46% of all deaths

Obesity

$147B on obesity-related health care costs each year

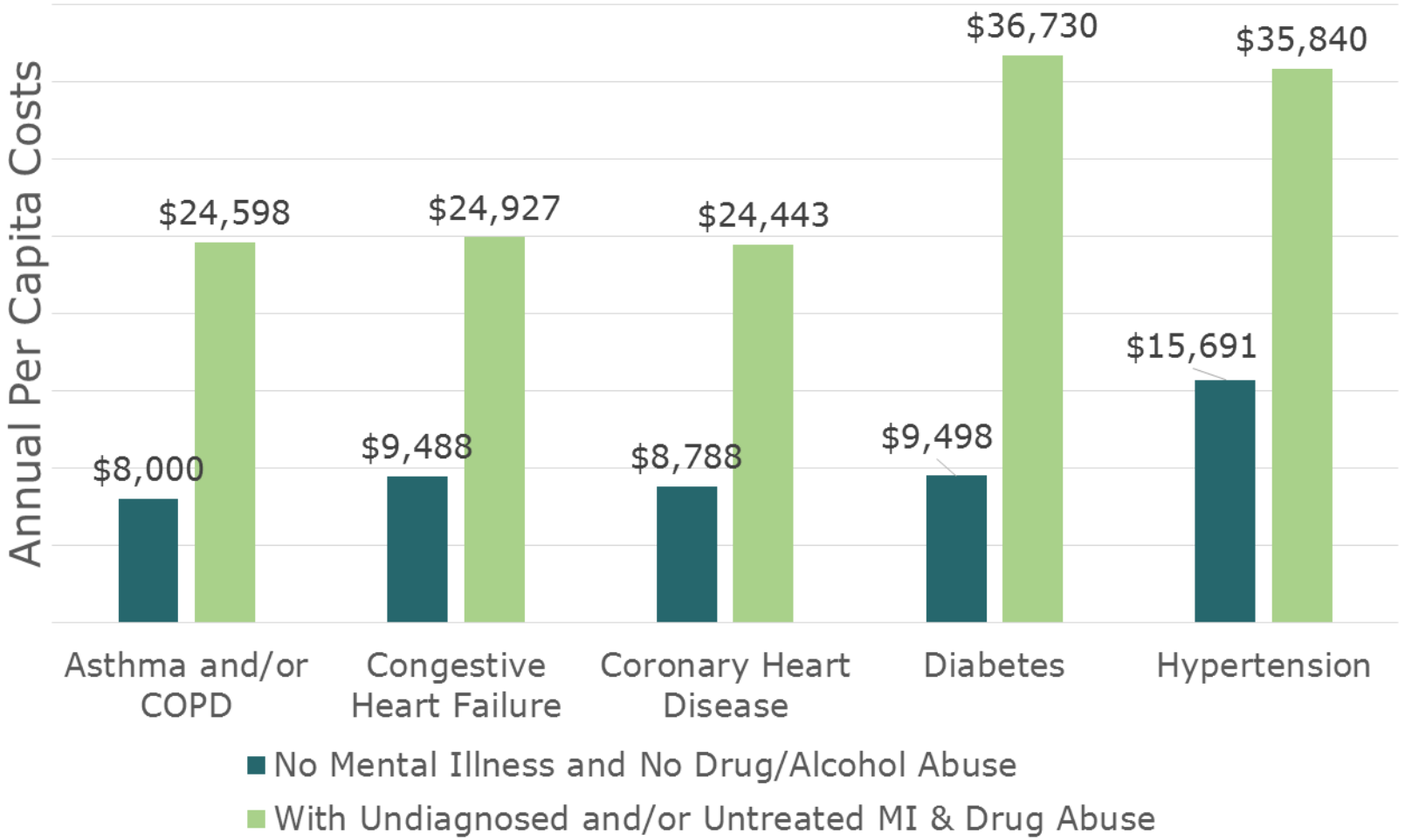
Diabetes

1 in 3 adults are prediabetic
9 in 10 don't know it

Mental Health

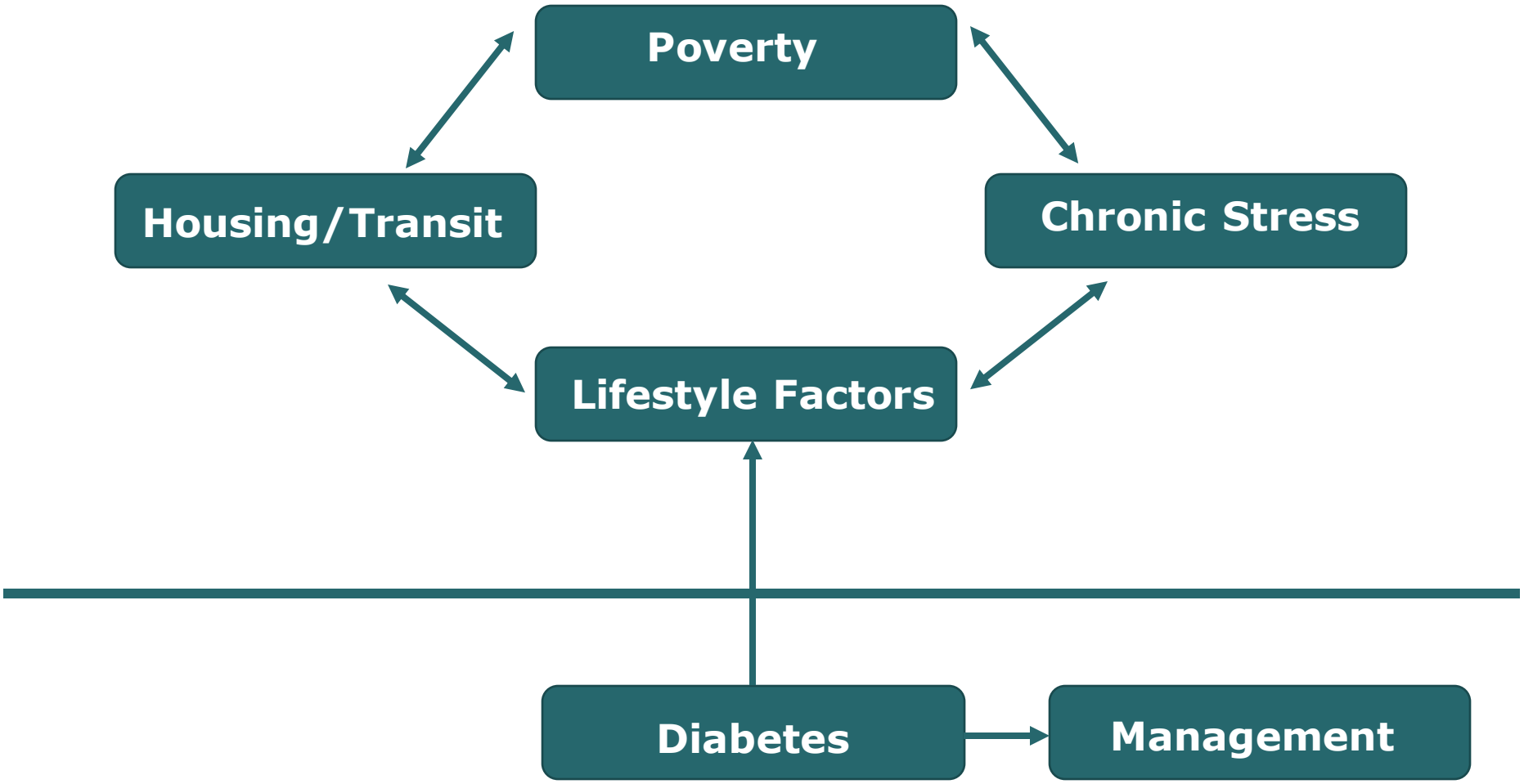
https://maps.communitycommons.org/viewer/?action=open_map&id=33674

Impact on Chronic Health Care Costs



Data source: Epstein Becker Green

Social Determinants & Diabetes



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Population Health has Many Partners

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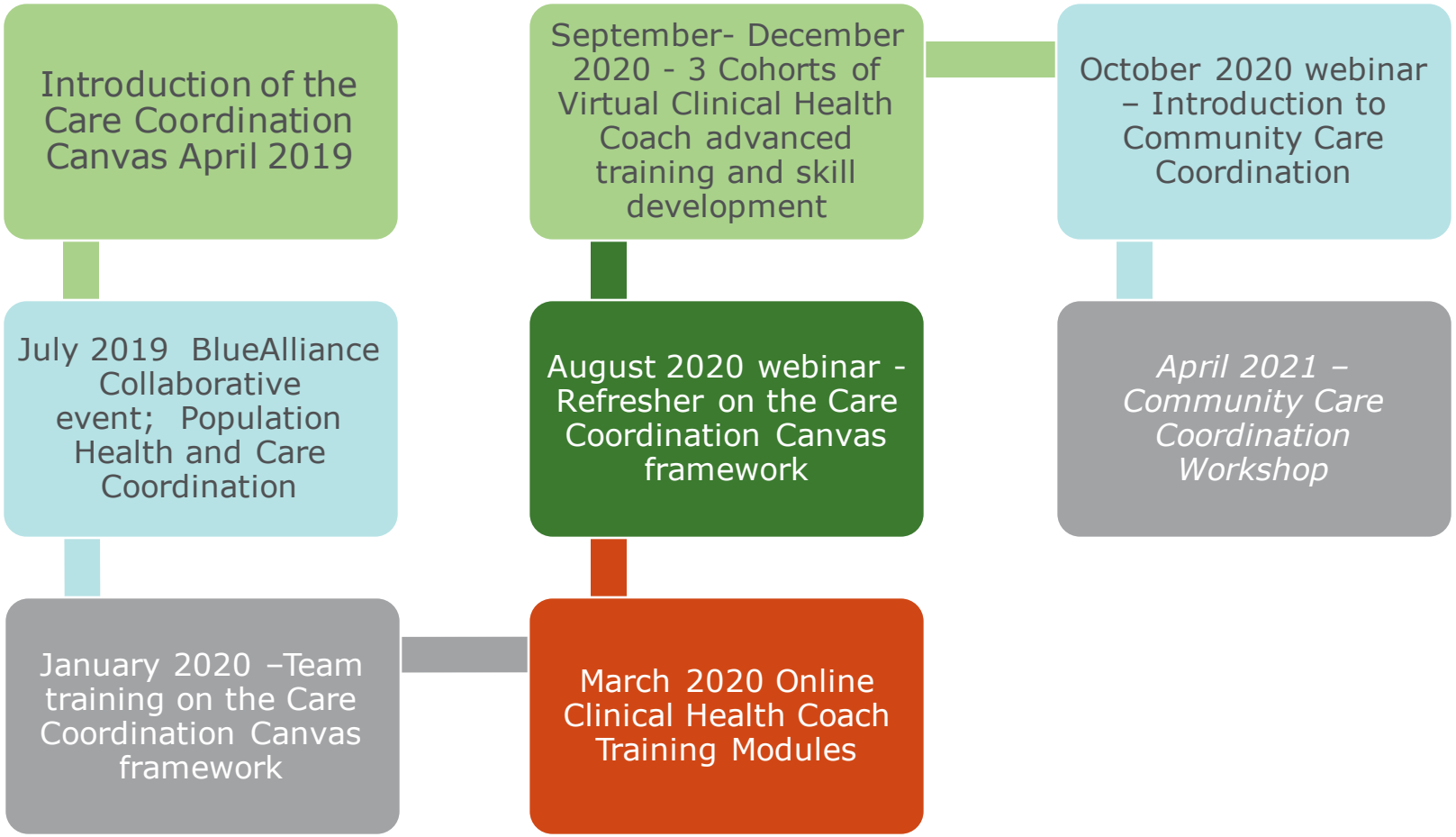
Community Care Coordination: Benefits

ND Care Collaborative



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Care Coordination is the Heart

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Definitions

Care Coordination

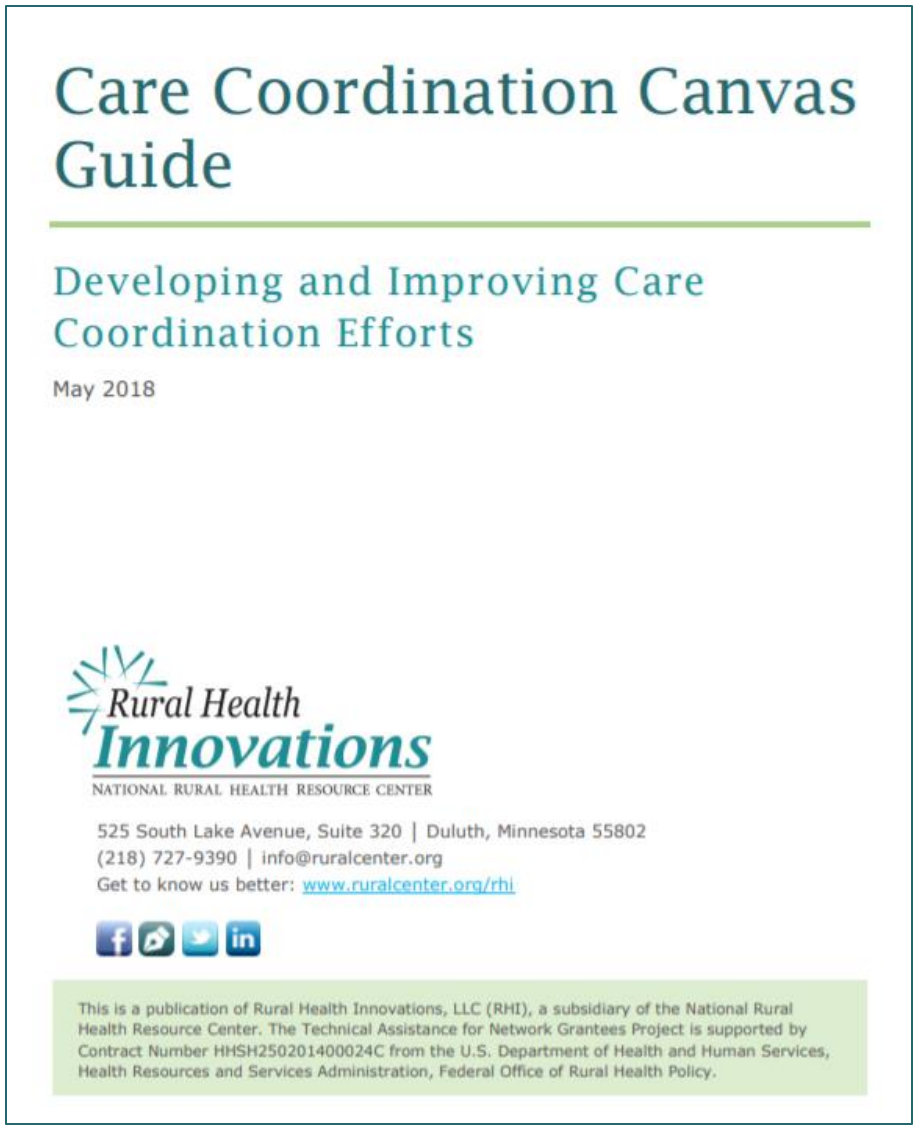
"Community-based and integrated primary care, behavioral health, oral health, local health and community resources to provide **person-centered**, coordinated **services**."

"An opportunity to supplement the diagnosis and treatment priorities of medicine with **clinical and non-clinical** prevention and management in a system that also supports the **social aspects** of patients' lives that contribute to health."

Community Care Coordination

"A **collaboration** among health care professionals, clinics, hospitals, specialists, pharmacies, mental health, community-services, and other resources working together to provide person-centered coordinated care."

Care Coordination Study



Care Coordination Canvas materials include:

- Guide
- White paper
- Case studies
- Worksheets
- Canvas tool

Care Coordination Canvas Materials

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Keys of Care Coordination

Target population

Assessments

Care plan

Care team

The Care Coordination Canvas

CARE COORDINATION CANVAS TEMPLATE			
1. What is your Target Population?		**2. What Assessment Tool(s) is your organization using?**	
1a. Is it specific enough? Further refine if needed.	**1b. How will the target population be identified?**	**2a. Is one needed?**	**2b. What is the type or how will it be used?**
1c. How will you communicate with and engage the population?		**2c. How will you communicate the results to who needs it? Store it?**	
1d. How will technology be used to perform these functions?		**2d. How will technology be used to perform these functions?**	
Collaboration:			
3. What is the focus of your Care Plan?		**4. Who is a part of your Interdisciplinary Care Team?**	
3a. What approach to developing the Care Plan is being taken?	**3b. What is included (components of)?**	**4a. Who is the coordinator?**	**4b. How will you build collaboration with the provider or partners of the Care Team?**
3c. How will the Care Plan be communicated to engage the chosen population and include the Care Team?		**4c. How will the Care Team communicate with the chosen population, coordinator and amongst themselves?**	
3d. How will technology be used to perform these functions?		**4d. How will technology be used to perform these functions?**	
5. Leadership next steps?		**6. What is your Business Model?**	
Social Determinants of Health (SDOH):			

Common Language

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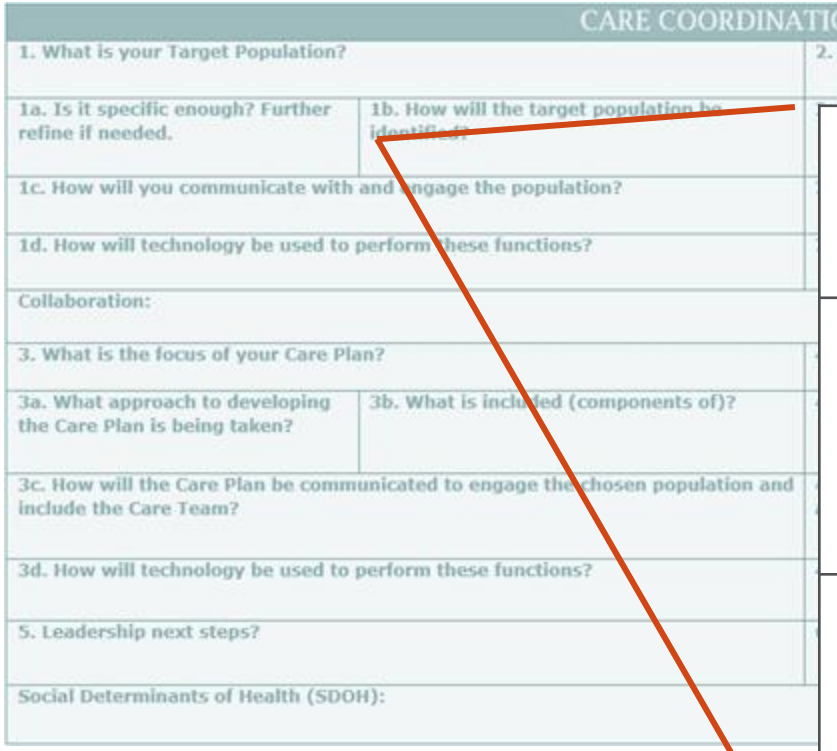
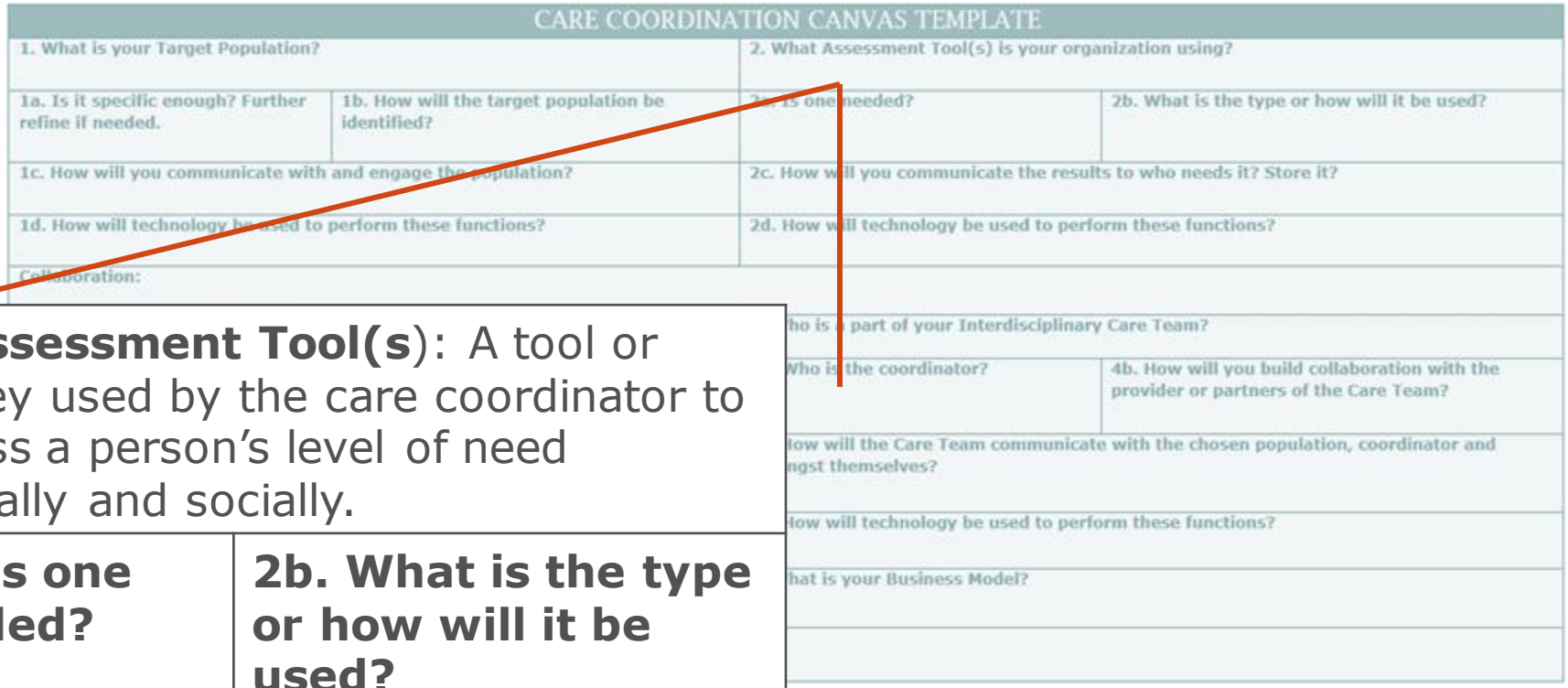
Target Population



1. Target Population: Improving the care, health and reducing costs for a specific group of people.

1a. Is it specific enough?	**1b. How will the target population be identified?**
1c. How will you communicate with and engage the population?	
1d. How will technology be used to perform these functions?	

Assessment Tools



2. Assessment Tool(s): A tool or survey used by the care coordinator to assess a person's level of need clinically and socially.

2a. Is one needed?	**2b. What is the type or how will it be used?**
2c. How will results be communicated?	
2d. How will technology be used to perform these functions?	

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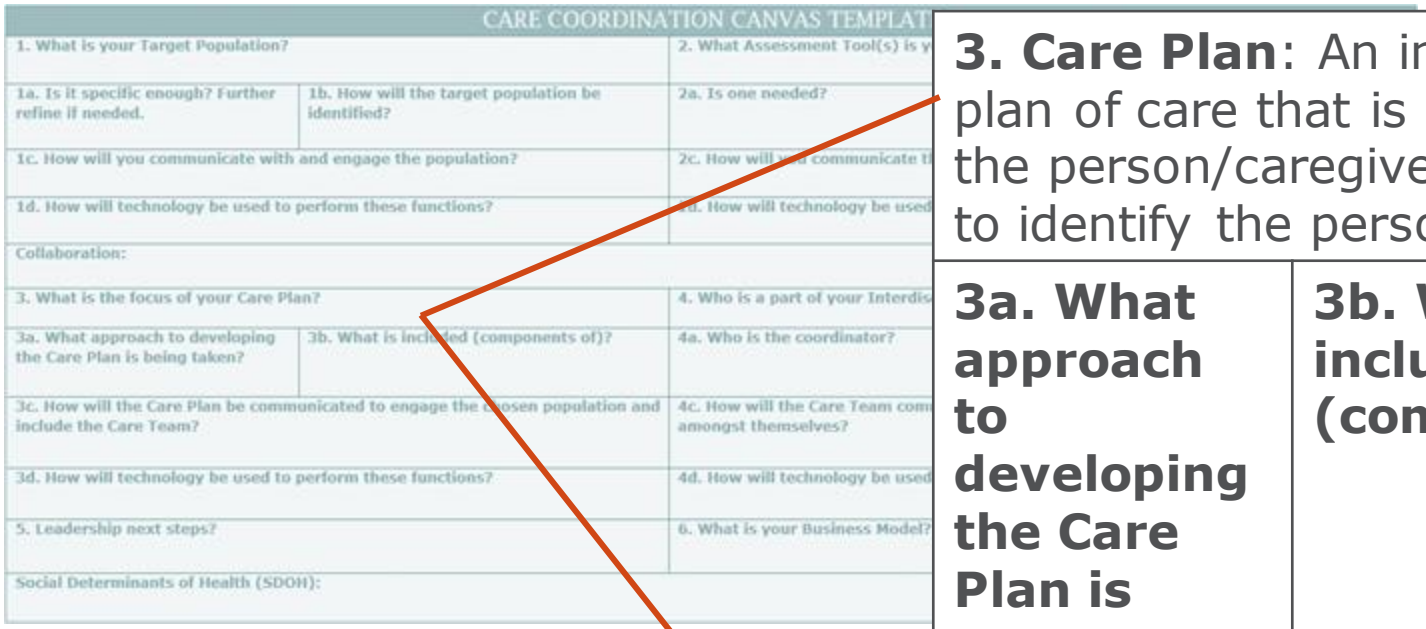
Care Plan


CARE COORDINATION CANVAS TEMPLAT

1. What is your Target Population?

2. What Assessment Tool(s) is y

1a. Is it specific enough? Further refine if needed.

1b. How will the target population be identified?

2a. Is one needed?

1c. How will you communicate with and engage the population?

2c. How will

1d. How will technology be used to perform these functions?

2d. How will technology be used

Collaboration:

3. What is the focus of your Care Plan?

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3a. What approach to developing the Care Plan is being taken?

3b. What is included (components of)?

4a. Who is the coordinator?

3c. How will the Care Plan be communicated to engage the chosen population and include the Care Team?

4c. How will the Care Team com amongst themselves?

3d. How will technology be used to perform these functions?

4d. How will technology be used

5. Leadership next steps?

6. What is your Business Model?

Social Determinants of Health (SDOH):

3. Care Plan: An individualized plan of care that is developed with the person/caregiver and providers to identify the person's needs.

3a. What approach to developing the Care Plan is being taken?	**3b. What is included (components of)?**

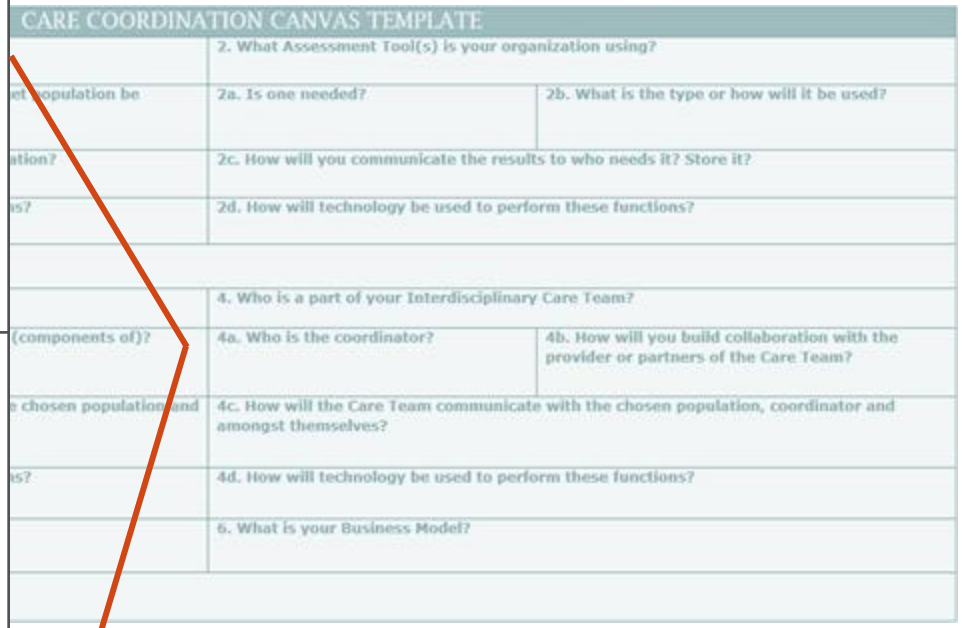
3c. How will the Care Plan be communicated to engage the chosen population and include the Care Team?

3d. How will technology be used to perform these functions?

Care Team

4. Care Team: Providers identified with the person and/or caregiver that represents the clinical, behavioral health, social services, long-term care and community resources needed to help meet the person's goals and outcomes.

4a. Who is the coordinator?	**4b. How will you build collaboration with the provider or partners of the Care Team?**
4c. How will the Care Team communicate with the chosen population, coordinator, and amongst themselves?	
4d. How will technology be used to perform these functions?	



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Integrated Components

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Social Determinants of Health (SDOH):			

How will you communicate with…
How will technology be used…

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Other Considerations

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Social Determinants of Health (SDOH):			

Collaboration…
Social Determinants of Health…

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Social Determinants of Health (SDOH):			

"Even if you're on the right track, you'll get run over if you just sit there."

-Will Rogers

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