Atrius Health and AAAs: Partners in Accountable Care:

ACL Learning Collaborative
July 16, 2013
Today’s Discussion

• Atrius Health: Who We Are

• Atrius Health’s Pioneer ACO Strategy

• Atrius Health - ASAP Partnership

• Lessons Learned and Next Steps
Atrius Health Core Competencies

- **Corporate Data Warehouse** integrates single platform, electronic health record data with multi-payer claims data to manage quality and cost
- Long history with and majority of revenue under **Global Payment** across commercial and public payers
- Widespread **Population Management** tools including disease-based and risk-based rosters
- Sophisticated development and reporting of **Quality and Performance Measures**
- **Patient-Centered Medical Home** foundation, achieving level 3 NCQA
- Newest Addition to Atrius Health: home health care, private duty nursing and hospice care through VNA Care Network & Hospice
Why Participate in Pioneer ACO? “Reason for Action”

- High quality, high-value care for all Medicare-eligible patients across the care continuum with spillover for commercial risk
- Unique opportunity to be accountable for quality and costs for a PPO population
- Further Atrius Health position as a market leader in payment reform, moving towards 100% global payment

Achieving Triple Aim Goals
Key Features of Pioneer & Performance Measures

- Three year contract effective January 2012; accountable for all Medicare A and B benefits
- Partnership with Center for Medicare and Medicaid Innovation
- Medicare FFS beneficiaries aligned with ACO based on their historical claims data
- Global budget and performance measured against national benchmark
- Upside and downside risk sharing with CMS
- Incentives rewards to achieve high quality performance measurements
- Accountable to Pioneer ACO obligations
Quality Measures: Key Features

- Patient/Caregiver Experience, measured by CG-CAHPS
- Meaningful Use (double weighted)
- Care Coordination/Patient Safety, measured by claims data
  - Ambulatory Sensitive Condition Admissions
  - Readmissions
- At Risk Population/Preventive Health, measured with EMR data
  - Diabetes
  - IVD
  - CAD
  - Heart Failure
  - Hypertension
  - Immunizations
Atrius Approach to Pioneer

Outcome

High Value Care for Medicare Patients

Primary Drivers

- Stratified, population-based, geriatric model of care
- Aligned hospital relationships
- Coordination of post-acute care and care transitions

Secondary Drivers

- Tight coordination of 5% highest risk patients
- Integration of home-based care and community supports
- Longitudinal management of chronic conditions
- Population-based outreach and preventative care
- Discharge process that includes standard Atrius Health elements
- Bi-directional access to medical records
- Concurrent reporting of admissions, discharges, ER visits
- Collaborative care improvement and performance incentives
- Effective network of facilities and providers
- Consistent and appropriate documentation and information exchange
- Shared SNF coverage with other Boston Pioneers

Outcome: High Value Care for Medicare Patients
Addressing the Gaps in Home-Based Care

Accountable for managing care, cost and quality of Medicare services in the home setting.

- Costs are substantial across dozens of post-acute providers.
- Patients have choice and are geographically distributed.
- Poor transitions result in unnecessary readmissions and other wasteful costs, harm, and errors.
- No standard model of home-based care across Atrius Health, no standard measurement

ASAPs, while not currently Medicare providers, can be an important resource in closing these gaps.
ASAP Strategy: *Link Primary Care to Community Home Care Services*

**Achieve triple aim objectives** by linking primary care practices to community resources

- Reduce costs through **prevention** and/or **reduction of unnecessary utilization** of health care services

- Improve health outcomes through **better care coordination** and **patient education**

- Improve patient experience and satisfaction by **aligning with goal of remaining functionally active at home**
Atrius Health – ASAP Collaboration

- Expansion of the “Care Team” to include the patient’s home and community-based networks

- Requires: effective communication for timely and efficient referrals, hand offs, and “closing the loop”

- Results in: patient centered care plans with realistic goals and resources for implementation

- Collaboration through:
  - Practice-based Pilots
  - Population-based Interventions
Atrius Health/ASAPs Practice-Based Pilots

1. HVMA Chelmsford & Elder Services of Merrimack Valley
2. Southboro & BayPath
3. HVMA West Roxbury & Ethos
4. HVMA Wellesley/Watertown & Springwell

Currently expanding to new sites
OUR PARTNERSHIPS

- Practice-based pilots and population-based interventions of varied intensity
- Creation of **patient centered care plans with resources** for implementation
- Development of **standard work processes for optimal care coordination**

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<td>Enhanced care coordination to “close the loop” on services provided</td>
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<td>On-site ASAP Social Worker integrated into the practices</td>
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<td>Direct communication between practices and ASAPs with secure e-mail</td>
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PROGRESSION OF SERVICE DELIVERY

Community Care *Linkages*™
Mass Home Care
Opportunities & Challenges

• **Opportunities**
  
  • Build sustainable relationships beyond individuals
  
  • Continuous learning together => innovation
  
  • Demonstrate Value => Clinical and Financial Commitment

• **Challenges**
  
  • Slow Start Up
    – Hard to scale
    – Building as we go
  
  • Data timing
    – Utilization & costs
    – Quality measures
  
  • Integration into primary care protocols
    – Work flow changes
    – Education
Value Proposition for Southboro Medical

**ASAP as Authentic Member of Care Team**

- Quicker and "more economically feasible" to buy
- Better access to ASAP services through embedded staff in practice (vs. standard I&R)
- Improved care management that reduced duplication of handoffs
- More patients access ASAP network services through relationship
- Opportunity to focus on prevention, develop innovative model for best practice
- Align with ACO measures
- Reduces burden on MD practices

“wish she was here 5 days per week”

“Our staff can focus more on care management and less on the details or making arrangements”
Lessons Learned

ASAP Collaboration
- Build relationship with one point of contact and spread
- Allow time for MD practice staff to experience value of ASAP, one patient at a time
- Participation in case “roster” review is powerful

Internal Atrius Health
- MD engagement drives change
- Care Managers are key to everything
- New opportunity to spread pilots across Atrius Health

External
- Potential conflicts AND/OR opportunities with other initiatives
  - CCTP, MSSP ACOs, Bundled Payment Pilot
What’s Next?

• For Pioneer and ASAP work
  – Spread the good work
  – Track the results

• For Atrius, More “O”s…. 
  – SCO – Existing MA duals plan, 65+
  – ICO – New MA plans, < 65
Questions?

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