How ACO’s Are Thinking of Home Care: the Atrius Health Experience

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May 29, 2014
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Overview of Atrius Health

Overview of Pioneer ACO & Atrius Health Goals

ACOs and Post Acute Care

VNA Care Network & Hospice Partnership

ACO Initiatives with VNACNH
Atrius Health

Non-profit alliance of six leading independent medical groups in Eastern Massachusetts and home health agency and hospice

- Granite Medical
- Dedham Medical Associates
- Harvard Vanguard Medical Associates
- Reliant Medical Group
- Southboro Medical Group
- South Shore Medical Center
- VNA Care Network & Hospice, including VNA of Boston

Providing care for ~ 1,000,000 adult and pediatric patients with 1000 physicians, 2100 other healthcare professionals across 35 specialties
Atrius Health Core Competencies

**Corporate Data Warehouse** integrates single platform, electronic health record data with multi-payer claims data to manage quality & cost

Widespread **Population Management** tools including disease-based & risk-based rosters

Long history with & majority of revenue under **Global Payment** across commercial & public payers

Sophisticated development & reporting of **Quality and Performance Measures**

**Patient-Centered Medical Home** foundation, achieving level 3 NCQA at all 37 adult primary care practices

Newest Addition to Atrius Health: home health care, private duty nursing & hospice care through VNA Care Network & Hospice (VNACNH)
The root of the problem in health care is that the business models of almost all US health care organizations depend on keeping these aims separate. Society on the other hand needs these three aims optimized (given appropriate weightings on the components) simultaneously. Tom Nolan, PhD.
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 (CMMI)
- Medicare FFS beneficiaries aligned with ACO based on their historical claims data
- Global budget: performance measured against national benchmark
- Upside & downside risk sharing with CMS
- Incentives rewards to achieve high quality performance measurements
- Accountable to Pioneer ACO Obligations

Atrius Health
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 & 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
Pioneer ACO Strategies Addressing Multiple Gaps

Hospital Strategy

Medicare/Medicaid Dual Population Strategy

Geriatric Care Model

Care Management Strategy

Post-Acute Strategy

Electronic Health Records & Health Information Exchange

Quality & Safety

Data Analytics & Reporting

Regulatory

Internal Communication & Structure

PATIENT-CENTERED MEDICAL HOME

Costs: Beat the trend

Quality: 100% Reporting (2012)

90th Percentile (2013)
Key ACO Initiatives

Geriatric Care Model
• Patient Risk Stratification
• Multidisciplinary Roster Reviews
• Advance Care Planning
• Chronic Kidney Disease
• Home-based primary care program

Care Management Strategy
• Stronger Collaboration with VNA Partner
• Expand VNA geographical coverage
• Integrate Local Elder Services Agencies
• Preferred Hospital strategy
• Programs for Dual-eligibles
• Preferred ambulance strategy

Post-Acute Strategy
• Preferred SNF Network
• SNF Service Standards/provider expectations
• SNF Provider Expectations
• Total joint replacement home rehab

Data Analytics & Reporting
• Ongoing Support for Workgroup Initiatives

Electronic Health Record and Health Information Exchange
• Tools to Support ACO Quality Metrics & Workflow

Quality & Safety
• ACO Quality Metric Reporting
Achieving Triple Aim “Right Care - Right Place - Right Time - Right Team”

- Acute Hospital: 32%
- Inside Atrius Health Services: 30%
- Skilled Nursing Facility: 20%
- Homecare: 10%
- Acute Rehabilitation: 5%
- Other: 5%

Atrius Health: Medicare Advantage Expenses
Achieving Triple Aim goals requires Work in the “Neighborhood”

• 20% of all Medicare beneficiaries are hospitalized at least 1x/year

• About 35% of them will be discharged to post-acute care:
  – 41.1% to SNF
  – 37.4% to Home Health
  – 10.3% to In-patient rehab facility
  – 9.1% to outpatient/ambulatory therapy
  – 2.0% to long term care hospital

Source: Gage et al (2009). Examining post-acute care relationships in an integrated hospital system, ASPE.
Savings Opportunities – Site of Service

There is also opportunity to shift post acute site of service to more appropriate, lower cost settings.

Site of Service Opportunity

Dollars in Millions

Post Acute Cost per Case by Site

<table>
<thead>
<tr>
<th>Site of Service</th>
<th>Cost per Case</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTACH</td>
<td>$37,455</td>
<td>612</td>
</tr>
<tr>
<td>SNF</td>
<td>$21,781</td>
<td>15,082</td>
</tr>
<tr>
<td>IRF</td>
<td>$21,760</td>
<td>2,367</td>
</tr>
<tr>
<td>HHA</td>
<td>$4,054</td>
<td>48,459</td>
</tr>
</tbody>
</table>

Savings Opportunity Ranges

<table>
<thead>
<tr>
<th>% Sos Shift</th>
<th>$ Savings (M)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10%</td>
<td>$28.6</td>
</tr>
<tr>
<td>20%</td>
<td>$57.2</td>
</tr>
<tr>
<td>30%</td>
<td>$85.8</td>
</tr>
</tbody>
</table>

Atrius Health
Hospital and physician providers must address how to optimize performance in the current environment while also preparing to “jump” from Curve #1 to Curve #2.

Curve #1: FEE-FOR-SERVICE
- All about volume
- Reinforces work in silos
- Little incentive for “real” integration

Curve #2: VALUE-BASED PAYMENT
- Coordinate care
- Shared Savings Programs
- Bundled / Global Payments
- Value-based Reimbursement
- Rewards integration, coordination, quality, outcomes and efficiency
- Blurring lines between payors and providers?

Natural Trajectory
Atriuis Health & VNA Care Network & Hospice

- A strategic partnership between non-profit MD practice group and non-profit VNA and Hospice designed to foster improved clinical outcomes, improved patient experience and reduction of per capita cost.

“They have helped make every day of this illness easier.”
- Russell Brett
VNA Care Network & Hospice: Experienced

- 120 years of experience caring for residents in more than 200 Eastern and Central Massachusetts communities

- First Medicare-certified home health agency in the Commonwealth of Massachusetts

- Pioneer in end-of-life care as first Medicare-certified hospice in Massachusetts with first hospice residence in the state

- Co-owner of Home Staff a private duty agency serving much of the service area with nursing assistance, personal care, cleaning, household management, and errand services
VNA of Boston & Affiliates Joins VNA Care Network & Hospice

- Expands geographic coverage within and around Boston
- Oldest organized VNA in the U.S., established 1886
- Nearly 177,000 certified home health care visits in 2012
- Services include skilled nursing, home health aides, rehabilitation, hospice care and private pay care.
- Special programs for Fall prevention, Heart failure avoidance, Homesafe case management, Orthopedic care, Wound care and Telehealth home monitoring
VNA Care Network & Hospice: Key Partner in Accountable Care

Long-standing, trusted referral relationship within the Atrius Health system of care

Aligned coverage area, single point of contact

High Quality

- Evidence based practice & programs
- High Home Health Compare scores
- High patient satisfaction
- Consistency across providers
Key Atrius Health Initiatives with VNA Care Network and Hospice

Four Major Areas of Focus:

1. Communication
   - Seamless
   - Electronic
   - Expedite Work Flow

2. Team Work
   - From nameless faces to face and names
   - Integrated

3. Program Design
   - Meet true care needs regardless of payment

4. Metrics
   - Accountability
Key Atrius Health Initiatives with VNA Care Network and Hospice - Communication

Current

– Daily electronic exchange of ACO reports which consists of:
  • Falls Risk Assessment
  • Medication Review
  • Depression Screening

Automatically distributed to Atrius Health Information Management Department

– Weekly Active patient clinical data sent which consists of:
  • Progress towards goals
  • Response to Teaching
  • Discharge Planning
  • Hospice Team meeting notes

Extracted & e-mailed to case managers at each site
Key Atrius Health Initiatives with VNA Care Network and Hospice - **Communication**

- **Current**
  - Encrypted email connection to all medical groups
  - Reliant practice group pilot referrals - Intake retrieves patient information directly from eRecord Link
  - EPIC accounts established for Clinical Managers, Coordinators and Hospice MD’s for care coordination – Read Only; able to extract clinical information for RN assigned to a case
Key Atrius Health Initiatives with VNA Care Network and Hospice - **Communication**

• **Future**
  - Investigating EPIC Home Care software for future full integration
  - All Atrius groups developing similar referral process to Reliant through eRecord Link
  - Researching ability to create Face to Face document in EPIC for PCP’s to use and automation of Plan of Treatment Orders creation (485’s) through MD Portal
Atrius Health Initiatives with VNA Care Network and Hospice – Team Work

Team Work begins at the top:

The charter of the Atrius Health, VNACN & H Clinical Collaboration Steering Committee (“CCSC”) is to oversee all clinical integration and referral transition work:

- CCSC will define policies and procedures which will be used to implement the relevant care coordination and collaboration programs.
- CCSC will define the process for CCSC review of cases and the process for making recommendations.
- CCSC will recommend new program design and innovative activity and function as the oversight body for all development.
- CCSC will propose alternative funding requirements to support programs as necessary, i.e. under or unfunded services.
Atrius Health Initiatives with VNA Care Network and Hospice – Team Work

Primary Care Practice

Primary Care Medical Team
PCP, NP, RN, PA, IHNBP, HRNP,

Consultation Team
• Palliative Care
• Geriatric Care
• Pharma Consults
• Social Worker

Primary Care Case Managers

VNACN&H Dedicated Home Care Field RN, LPN, PT, OT, ST, MSW

Consultation Team

VNACN&H Dedicated Transitional Care Liaison Nurse

VNACN&H Transitional Intake RNs/Staff

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Atrius Health Initiatives with VNA Care Network and Hospice – Team Work

Transformation from vendor relationship to a partnership as part of Atrius Health:

• ED coverage at identified hospitals
• High Risk Geriatric Roster review participation at some sites
• Home Health Liaison Navigator services provided to Nurse Case Managers at each practice site
• Liaisons assigned to Network ECFs and hospitals
## Geriatric Care Model: Multidisciplinary Roster Reviews

<table>
<thead>
<tr>
<th>Adopted common standards for High Risk Patient Roster Reviews</th>
<th>Review and confirm accuracy of diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Review appropriateness of medications</td>
</tr>
<tr>
<td></td>
<td>Perform a care needs assessment</td>
</tr>
<tr>
<td></td>
<td>Create a clinical summary of the patient</td>
</tr>
<tr>
<td></td>
<td>Perform a social assessment</td>
</tr>
<tr>
<td></td>
<td>Review applicable diseases related quality measures</td>
</tr>
<tr>
<td></td>
<td>Confirm existence and need for advance directives</td>
</tr>
<tr>
<td></td>
<td>Update the patient’s care plan and document next steps</td>
</tr>
</tbody>
</table>

Early adopters saw greater reductions in total medical expense – mostly from reduced hospital and SNF admits.

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Key Atrius Health Initiatives with VNA Care Network and Hospice – Program Design

- Advanced Care Planning
- One Time Home Assessments
- Joint Replacement Program
- Telehealth
- Integration with Primary Care at Home
- ED Diversion Program
Geriatric Care Model: Advance Care Planning

Description:
- Developed advance care planning (ACP) curriculum with CME/CEU credits.
- Established site-based ACP champions to train and provide ongoing ACP support locally.
- Developed new tools in Epic to track and document advance care planning.

Expected Outcomes:
- Improve PCP knowledge and comfort with ACP.
- Increase end of life conversations and collection of patient’s care wishes, advance directives and proxy information.
- Minimize use of aggressive curative care when not aligned with patient’s care wishes.

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Advance Care Planning: Role for VNACN

- Provider training on Palliative Care and Hospice
- Home-based NP Palliative Care consults with referral from PCP, follow up back to PCP/team.
- Hospice enrollment – earlier identification and referral through participation in high risk roster review, liaison role for the care team.
# Care Management “Proxy” visit - One Time Home Assessment

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Missing Piece of the Puzzle</td>
<td>• Care management, not medical management</td>
</tr>
<tr>
<td>• Home Safety Concerns</td>
<td>• Clear expectations around the content of visit and follow up</td>
</tr>
<tr>
<td>• Unclear if patient meets “certification”</td>
<td>– Templated Visit</td>
</tr>
<tr>
<td>• Visit based on need, not coverage</td>
<td>– Standard Work</td>
</tr>
<tr>
<td></td>
<td>• Communication in Epic that informs the care plan</td>
</tr>
<tr>
<td></td>
<td>• Reasonable reimbursement</td>
</tr>
</tbody>
</table>
Post Acute Care – Moving patients home for Total Joint Rehab

• 800 total hips and knees annually, Pioneer + MA
• 69% go to SNF or IRF
• Home about $3500 savings over SNF, with same or better outcomes
• $500K savings if we move 30% from SNF to Home
  – Patients with fewer co-morbid conditions
  – Patients with home support
Moving Patients Home for Total Joint Rehab: Requirements being rolled out

- Standard process that identifies patients most appropriate for home-based rehab (prior to surgery)
- A home visit that acquaints those patients with home rehab to give them confidence and prepare them prior to surgery, set expectations
- Smooth pathway in Epic for referral and communication
- Reasonable reimbursement
Newest Initiatives in Development

• Expanding home telehealth beyond the Medicare Episode
  – Non-certified Pioneer patients
  – Certified Pioneer patients who have not met self-management goals
  – Medicare Advantage patients
  – Moving beyond CHF

• Expanding Home Based Primary Care
  – Streamlining communication and scheduling to work as a care team, reduce patient confusion

• Increasing ED discharges home with VNACN to avoid Hospital Admission
## ED Discharge Home with Services

### Scope/Target:
- Avoidable (PQI) admits
- One-day admits
- OBS stays
- Two Pilot hospitals
- VNACN first call

### Requirements
- ED partnership
- Straightforward criteria
- Dedicated CM for approval and coordination
- Complete clinical and referral info including EPIC access in ED
- Warm clinical handoff
- Easy!
Key Atrius Health Initiatives with VNA Care Network and Hospice - Metrics

1. Cost & Utilization
   - ED Visit per 1,000 episodes during Home Care episode
   - Readmit rate during Home Care episode
   - Cost per Case

2. Quality
   - % of Patients admitted to Home Care who have falls risk assessment documented in EPIC
   - % of Patients admitted to Home Care who have ACP form (MOLST, Adv Dir or HCP) documented in EPIC
   - % of Patients admitted to Home Care who have depression screen & plan documented in EPIC
   - % of Patients admitted to Home Care who have med review CM or telephone encounter in EPIC, cc routing to PCP
   - % of Patients admitted to Home Care who have follow up appointment with PCP within 7 days of hospital discharge

3. Patient Experience
   - % of Patients who gave Home Care Agency a rating of 9 or 10 (Home Care Compare)
   - % of Patients who reported that Home Care team discussed medicines, pain & home safety (Home Care Compare)
## Key Atrius Health Initiatives with VNA Care Network and Hospice - Metrics

### Post Acute Home

**Jan2013 thru Sep2013 YTD**

*(Claims paid through Dec2013)*

<table>
<thead>
<tr>
<th></th>
<th>INITIAL STATE</th>
<th>FUTURE STATE 2013</th>
<th>ACTUALS 2013</th>
<th>YTD 2013</th>
<th>PIONEER VARIANCE</th>
<th>TMP VARIANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Cost &amp; Utilization</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ED Visit per 1000 during Home Health episode</td>
<td>62.7</td>
<td>81.9</td>
<td>73.7</td>
<td>76.4</td>
<td>72.6</td>
<td>74.5</td>
</tr>
<tr>
<td>ED Visit per 1000 during VNACN episode</td>
<td>62.7</td>
<td>81.9</td>
<td>73.7</td>
<td>90.9</td>
<td>77.7</td>
<td>81.3</td>
</tr>
<tr>
<td>Readmit rate during Home Health episode</td>
<td>9.8%</td>
<td>11.0%</td>
<td>&lt;10%</td>
<td>12.6%</td>
<td>8.4%</td>
<td>13.2%</td>
</tr>
<tr>
<td>Readmit rate during VNACN episode</td>
<td>9.8%</td>
<td>11.0%</td>
<td>&lt;10%</td>
<td>14.3%</td>
<td>2.6%</td>
<td>15.5%</td>
</tr>
<tr>
<td>VNACN Episodes as % of Total Home Health Episodes</td>
<td>30.8%</td>
<td>11.3%</td>
<td>25.0%</td>
<td>22.2%</td>
<td>18.5%</td>
<td>22.0%</td>
</tr>
</tbody>
</table>

### PAH 2. Quality (excludes RMG)

<table>
<thead>
<tr>
<th></th>
<th>Goal</th>
<th>Pioneer</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of patients admitted to VNACN who have falls risk assessment scanned in EPIC within the episode</td>
<td>unk</td>
<td>unk</td>
</tr>
<tr>
<td>% of patients admitted to VNACN who have ACP form (MOLST, Adv Dir, or HCP) scanned in EPIC within the episode</td>
<td>unk</td>
<td>unk</td>
</tr>
<tr>
<td>% of patients admitted to VNACN who have depression screen and plan scanned in EPIC within the episode</td>
<td>unk</td>
<td>unk</td>
</tr>
<tr>
<td>% of patients admitted to VNACN with a post discharge visit within 7 days.</td>
<td>unk</td>
<td>unk</td>
</tr>
</tbody>
</table>

### PAH 3. Patient Experience

**2012**

<table>
<thead>
<tr>
<th></th>
<th>Goal</th>
<th>Reported Quarterly</th>
<th>Q1 2013</th>
<th>Q2 2013</th>
<th>Q3 2013</th>
<th>Q4 2013</th>
<th>Average 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of patients who gave VNA CN a rating of 9 or 10 (Home Care Compare).</td>
<td>87%</td>
<td>90%</td>
<td>79%</td>
<td>87%</td>
<td>91%</td>
<td>0%</td>
<td>86%</td>
</tr>
<tr>
<td>% of patients who reported that VNA CN team discussed medicines, pain, and home safety (Home Care Compare)</td>
<td>83%</td>
<td>90%</td>
<td>82%</td>
<td>80%</td>
<td>86%</td>
<td>0%</td>
<td>83%</td>
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</table>
VNA Care Network & Hospice – Atrius Metrics

# of Admissions

<table>
<thead>
<tr>
<th>Quarter</th>
<th>FY</th>
<th>Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 FY12</td>
<td></td>
<td>1,837</td>
</tr>
<tr>
<td>Q2 FY12</td>
<td></td>
<td>2,077</td>
</tr>
<tr>
<td>Q3 FY12</td>
<td></td>
<td>2,369</td>
</tr>
<tr>
<td>Q4 FY12</td>
<td></td>
<td>2,515</td>
</tr>
<tr>
<td>Q1 FY13</td>
<td></td>
<td>2,384</td>
</tr>
</tbody>
</table>
VNA Care Network & Hospice – Atrius Metrics
Hospice LOS Days

Q1 FY12: 37.04
Q2 FY12: 49.23
Q3 FY12: 45.01
Q4 FY12: 44.05
Q1 FY13: 58.88

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VNA Care Network & Hospice - Atrius Rehospitalization Rate

*Note:
- Rehospitalizations are calculated by dividing # patients admitted to Hospital by total Medicare patients served whether or not they originally came from a hospital
- Rehospitalizations do not include hospice patients
- VNA Care Network rehospitalization rate was 29% in December 2011
First Year Pioneer Results: Financial

Performance Against Pioneer Benchmark
(12 months ending March 2013)

Typical Massachusetts Pioneer $12,000+
Atrius Health Benchmark $10,665
Atrius Health Actual Expenditure $10,700
Atrius Health % loss = .98% (“within noise”)

NO SHARED SAVINGS OR LOSS

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First Year Pioneer Results: 2012 ACO Quality Metrics

www.medicare.gov/physiciancompare/aco/search.html

Atrius Health compared to Pioneer ACO Range

- **A1c** = % of diabetic patient population with blood sugar (hgba1c) control < 8
- **BP** = % of hypertensive patient population with blood pressure control <140/90
- **Tobacco** = % of diabetic patient population who do not currently smoke
- **Aspirin** = % of diabetics with ischemic vascular disease (IVD) who are currently taking aspirin
- **ACE/ARB** = % of patients with coronary artery disease (CAD) who are also diabetics OR have left ventricular systolic dysfunction (LVSD) and are on an angiotensin converting enzyme (ACE) inhibitor or an angiotensin receptor blocker (ARB)
Hot off the Presses: ACO public reporting for 2012

<table>
<thead>
<tr>
<th>Measures</th>
<th>Atrius</th>
<th>BIDCO</th>
<th>MACIPA</th>
<th>Partners</th>
<th>Steward</th>
</tr>
</thead>
<tbody>
<tr>
<td>DM: HgbA1c &lt; 8 percent</td>
<td>80%</td>
<td>70%</td>
<td>65%</td>
<td>79%</td>
<td>25%</td>
</tr>
<tr>
<td>HTN: BP &lt; 140/90 Control</td>
<td>84%</td>
<td>67%</td>
<td>61%</td>
<td>74%</td>
<td>39%</td>
</tr>
<tr>
<td>Tobacco Non Use</td>
<td>89%</td>
<td>79%</td>
<td>59%</td>
<td>82%</td>
<td>39%</td>
</tr>
<tr>
<td>Aspirin Use</td>
<td>83%</td>
<td>86%</td>
<td>79%</td>
<td>94%</td>
<td>30%</td>
</tr>
<tr>
<td>ACE/ARB Tx in CAD + DM and/or LVSD</td>
<td>86%</td>
<td>75%</td>
<td>79%</td>
<td>80%</td>
<td>59%</td>
</tr>
</tbody>
</table>
Questions?

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