Atrius Health Pioneer ACO: First Year Accomplishments, Results and Insights

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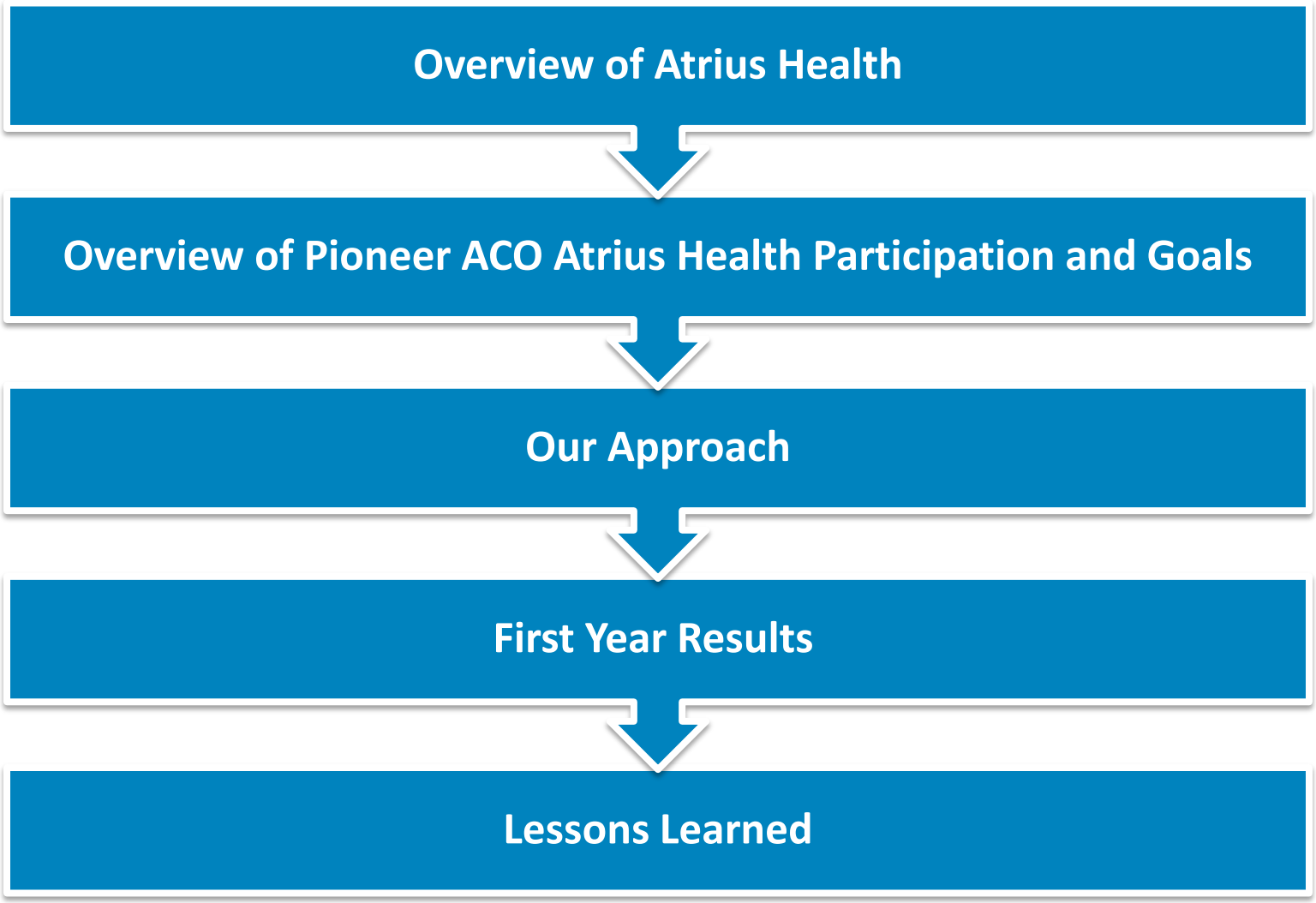

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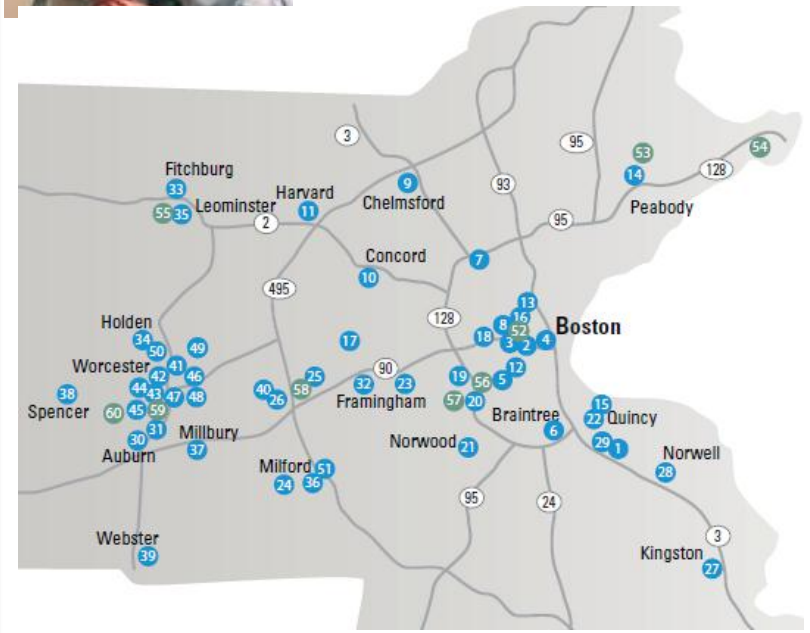
Non-profit alliance of six leading independent medical groups in Eastern and Central Massachusetts and home health agency and hospice

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

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



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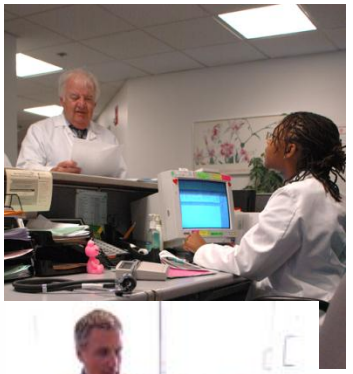
Atrius Health Core Competencies

- **Corporate Data Warehouse** integrates single platform, electronic health record data with multi-payer claims data
- Widespread **Population Management** tools including disease-based and risk-based rosters
- Long history with and majority of revenue under **Global Payment** across commercial and public payers
- Sophisticated development and reporting of **Quality and Performance Measures**
- **Patient-Centered Medical Home** foundation, achieving level 3 NCQA
- Newest Addition: **home health and hospice care**



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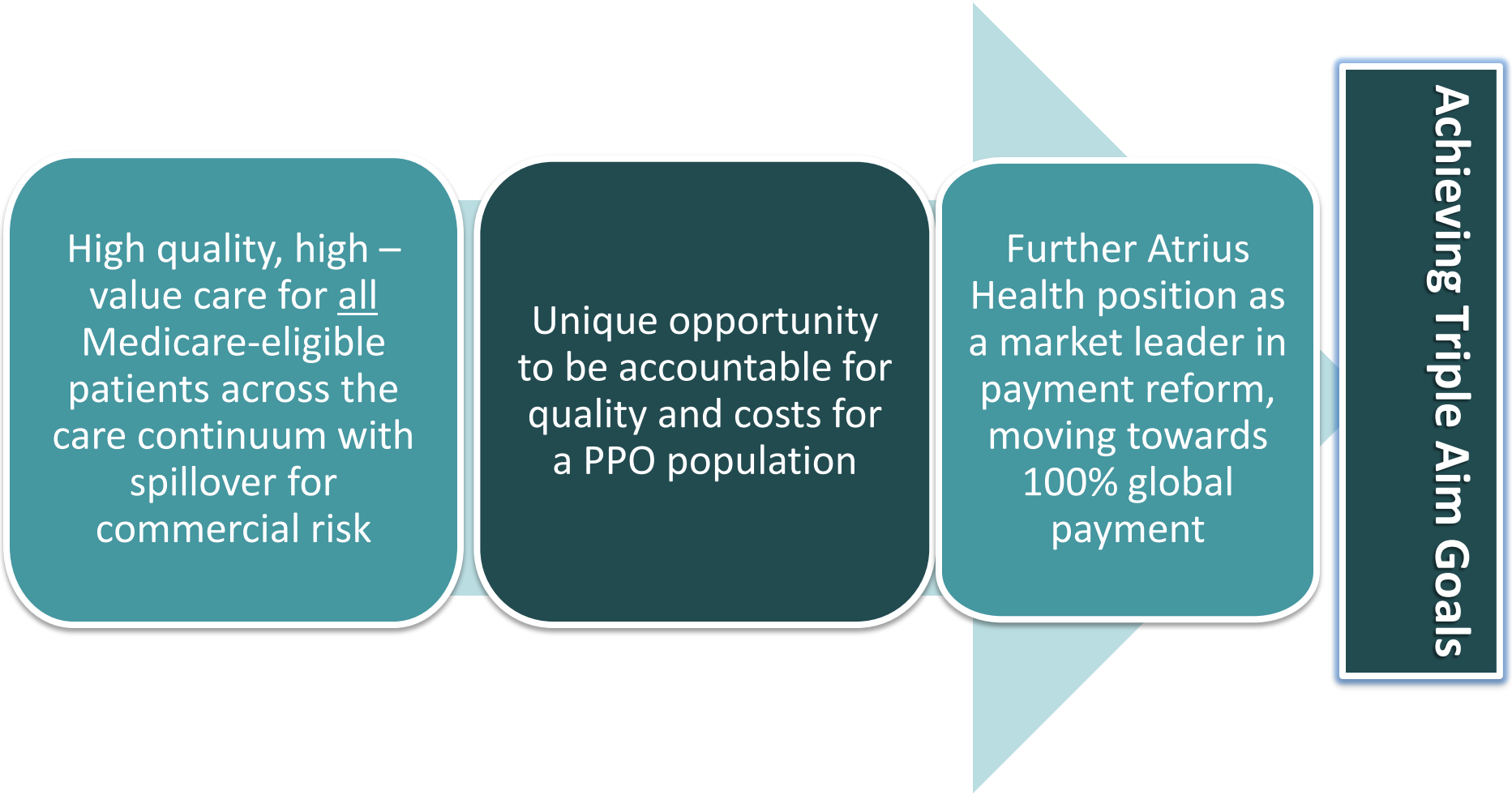
Why Participate in Pioneer ACO?
"Reason for Action"



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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

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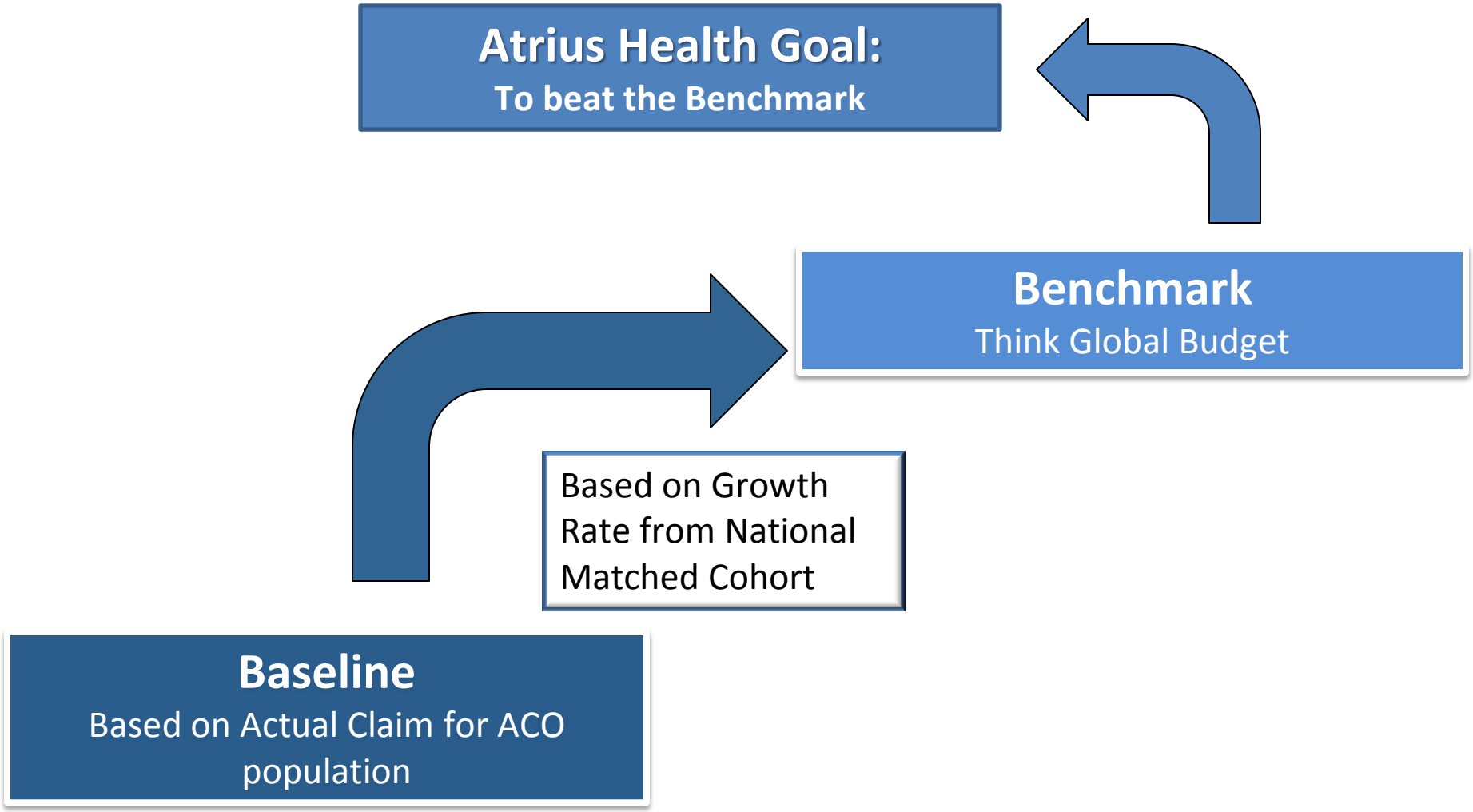
Financial Measures: Shared saving/loss



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Quality Measures: Key Features

33 Quality Measures:

- Many new, or with new features
- 2012-Reporting Only
- 2013 – Empirical benchmarks tbd

- **Patient/caregiver experience, measured by CG-CAHPS**
- **Care coordination/patient safety using claims data (eg. Readmission rates)**
- **At Risk Population, using EHR measures**
  - Diabetes
  - IVD
  - CAD
  - Heart Failure
  - Hypertension
- **Preventive Health**

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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
- Leverage home health/partner (VNACNH)
- 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

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Geriatric Care Model: Patient Risk Stratification Tool

Using both claims and Electronic Health Records databases, the tool allows to identify members at risk of hospitalization, poor health outcomes, high costs

The model consists of five key factors:

Likelihood of Hospitalization

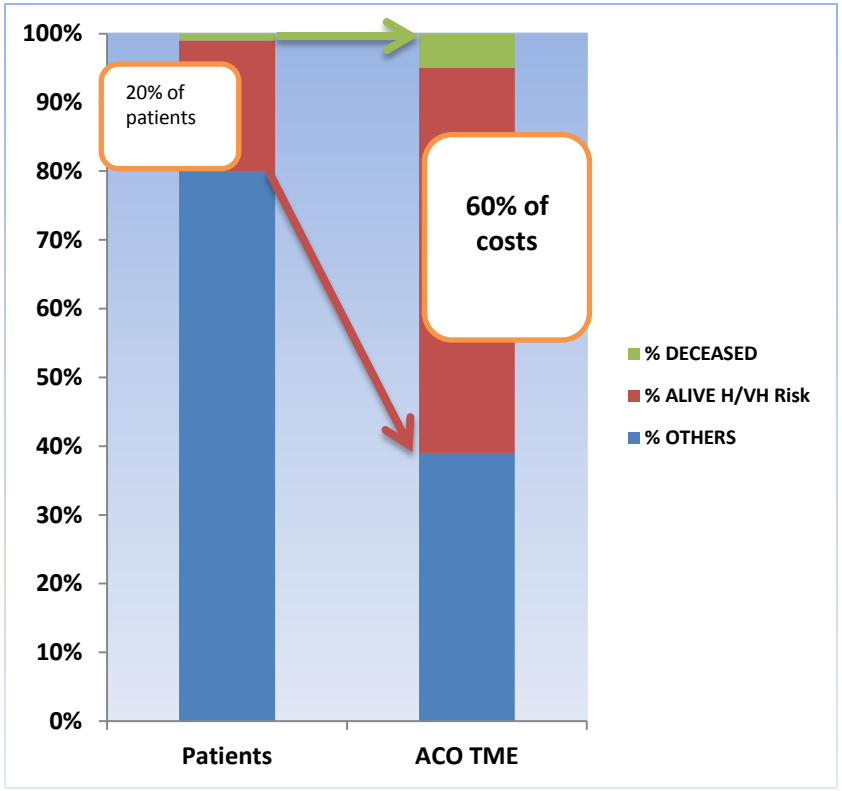
Hospital admissions or ED visits

Behavioral Health diagnosis

CHF or COPD

>= 15 medications

Proportions of High Cost (Atrius Health ACO) Patients & attributable to them Costs (YTD: Aug 2012)



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Geriatric Care Model: Multidisciplinary Roster Reviews

Adopted common standards for High Risk Patient Roster Reviews	**Review and confirm accuracy of diagnosis**
	Review appropriateness of medications
	Perform a care needs assessment
	Create a clinical summary of the patient
	Perform a social assessment
	Review applicable diseases related quality measures
	Confirm existence and need for advance directives
	Update the patient's care plan and document next steps

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

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Geriatric Care Model: Chronic Kidney Disease

Description

- Clinical guidelines
- Provider education & training
- Patient education and engagement
- Keeping services in-house when appropriate
- Expectations for outside nephrologists
- Epic tools
- Risk score modification

Expected Outcomes

- Improve diagnosis
- Slow progression of CKD
- Improve management of other chronic diseases

Result:

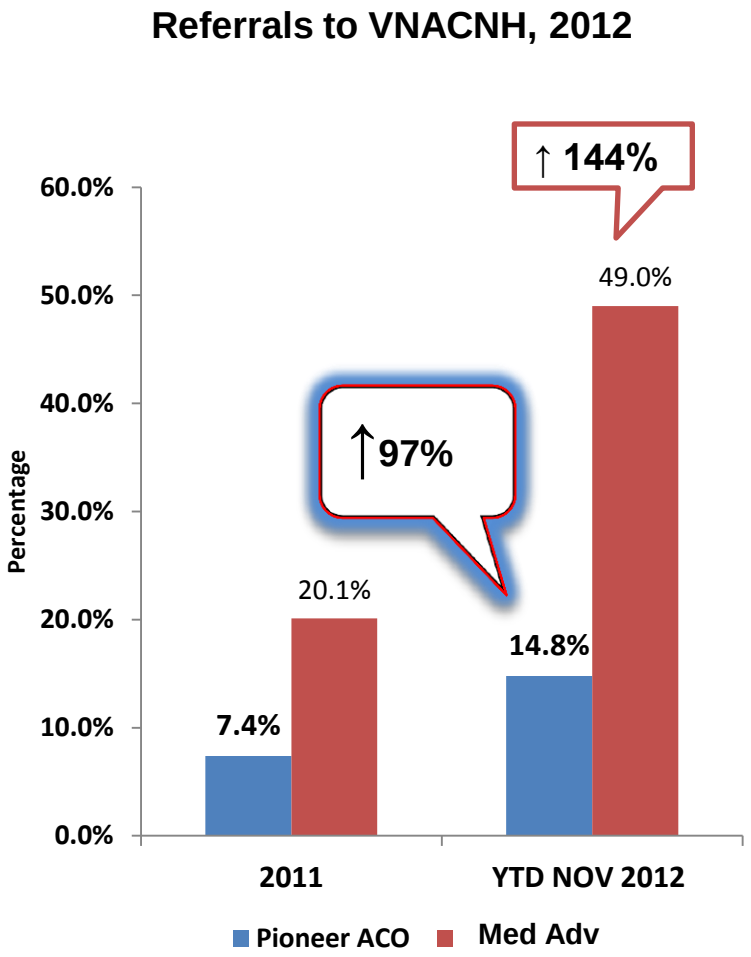
In first 5 months, 66% of patients with lab defined criteria were diagnosed with CKD triggering clinical interventions.

Care Management Strategy: Stronger Collaboration between primary care/VNA

Developed Standard Work for referrals to and communication with VNACNH during episode of care.

Care plan transmitted to EPIC within 48 hours of admission, including:

- Advance care planning forms
- Follow up appointment with PCP within 7 days of hospital discharge
- Collection of ACO quality metrics
  - * Fall risk assessment
  - * Medication review
  - * Depression screen (PHQ)



We see a decrease in Home Health $pmpm and a decrease in readmits during VNA episode

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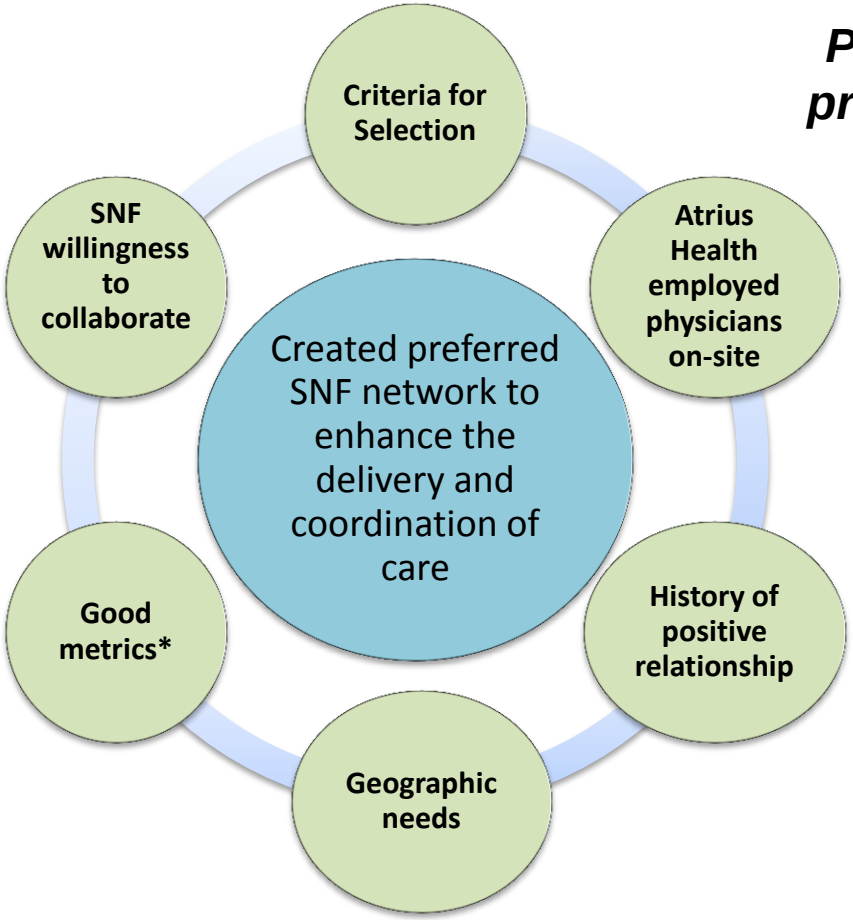
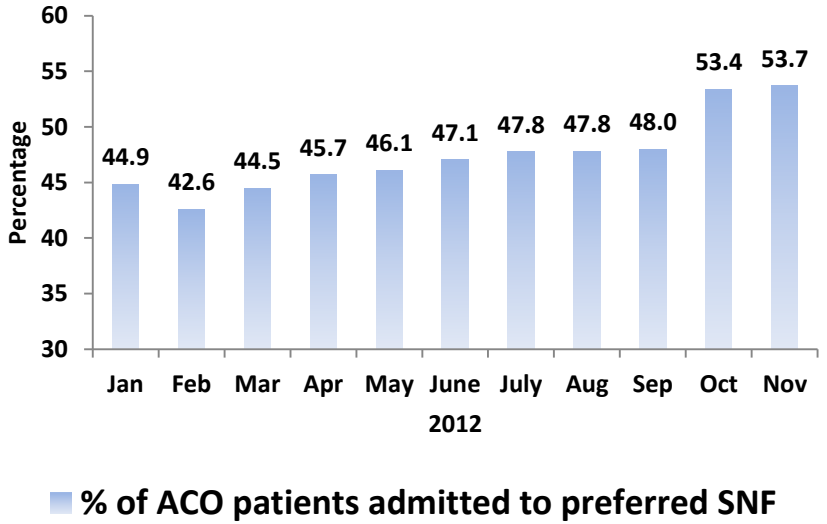
Post-Acute Strategy: Development of Preferred SNFs Network



Percentage of ACO patients admitted to preferred Skilled Nursing Facilities (2012)



*Good Metrics: Medicare Compare; State survey; Readmission during SNF stay

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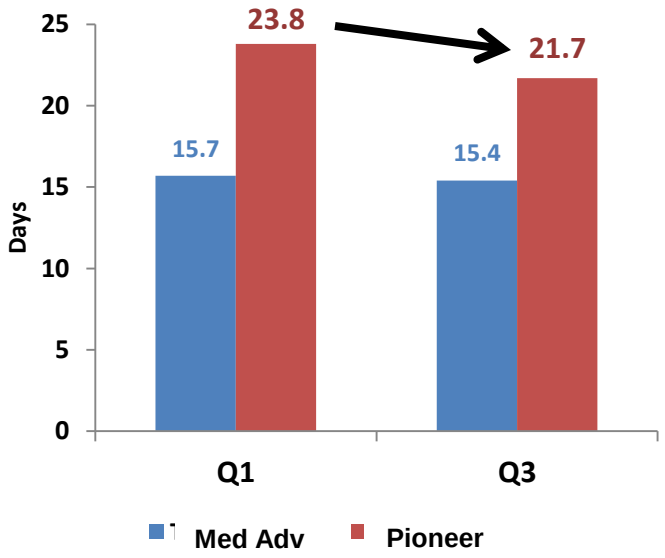
Post-Acute Facility Strategy: Hold SNFs to higher Service Standards

Developed expectations and tools to manage length of stay

- Facility-level expectations
- Provider-level expectations
- Discharge workflow
- EHR documentation
- Monitoring & reporting
- Use of preferred discharge providers

Average Length of Stay at Preferred SNFs (2012)



Reduced LOS is decreasing SNF costs which is decreasing total medical expense

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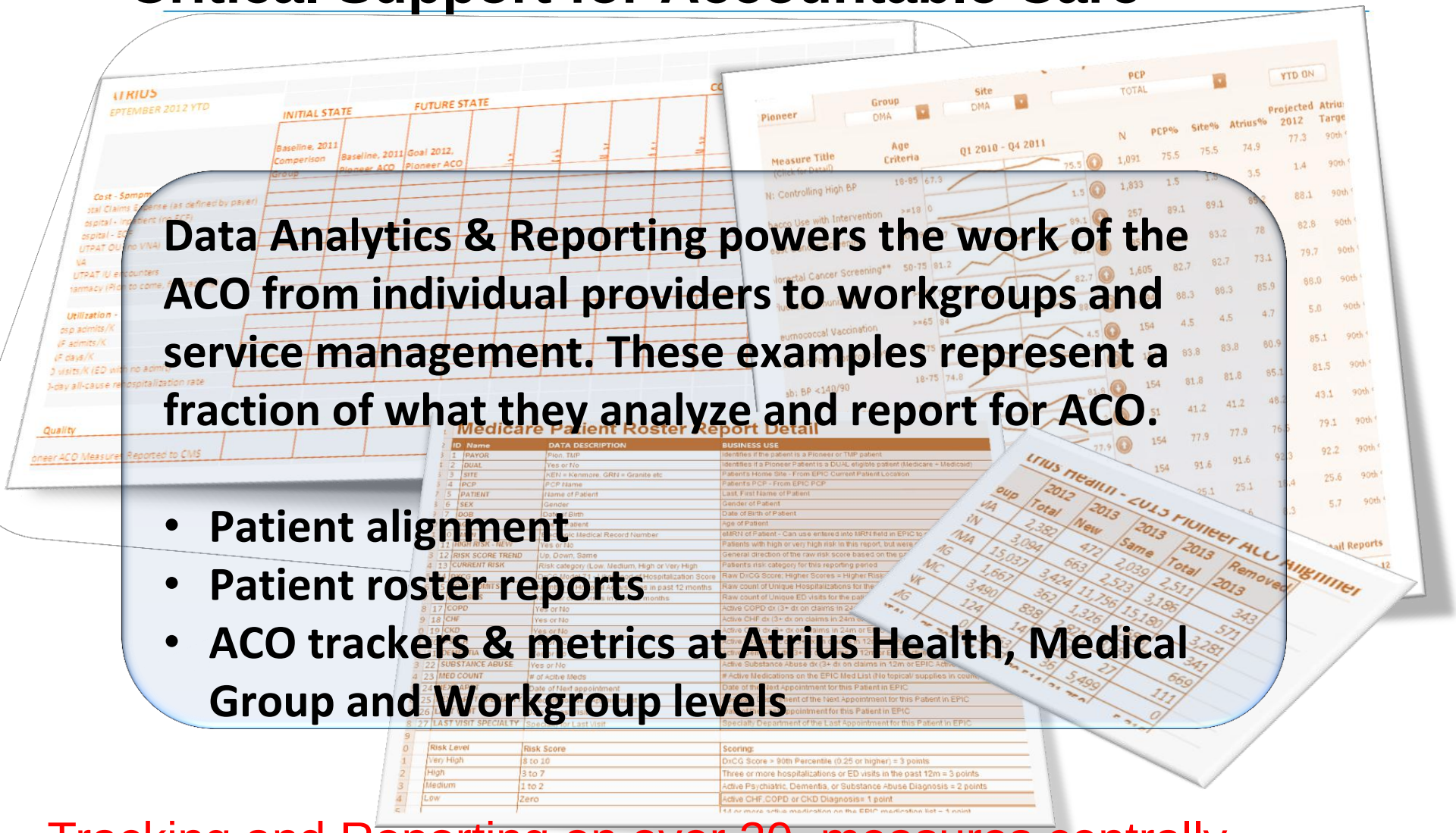
Data Analytics and Reporting: Critical Support for Accountable Care



Tracking and Reporting on over 30 measures centrally

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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 Performance: Loss <1% (“within noise”)

NO SHARED SAVINGS OR LOSS

Lessons Learned

Internal

- MD engagement key to driving change
- Wide adoption of Lean problem solving methodology created strong foundation for change
- “One Model, One Contract” provided burning platform
- Making long-lasting change takes time
- Our ability to partner effectively is key

External

- More unknowns = more risk
- Engagement of other Pioneers – big opportunity, but differing priorities
- CMS is a “Pioneer” also
- Pioneer model is bigger than CMS - many federal agencies have a stake
- Terms like “global payment” or “full risk” need to be fully defined.