Care for High Risk Patients: A Triple Aim Opportunity

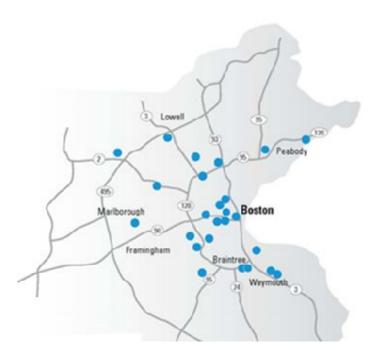
ACO Summit June 10, 2016 Track A

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About Atrius Health



Quality scores ranked #1 in New England and #3 nationally for Medicare ACOs for 2014

Providing care for 675,000 adult and pediatric patients in eastern Massachusetts

The Northeast's non-profit leader in delivering high-quality, patient-centered coordinated care.

Financially stable with \$1.8B annual revenue

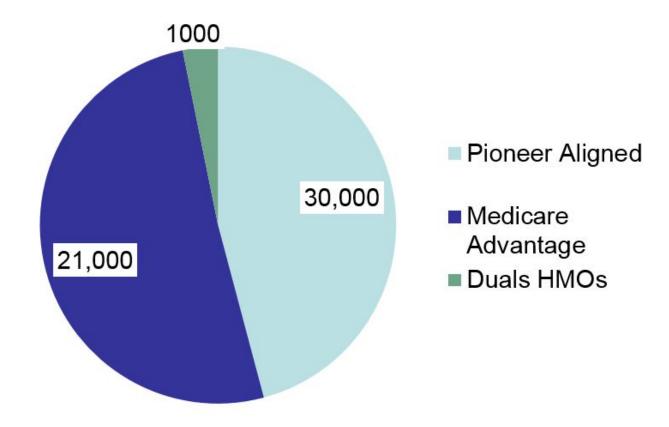
750 physicians across 32 clinical sites in over 35 specialties

Multi-specialty medical groups: Dedham Medical Associates, Granite Medical Group, Harvard Vanguard Medical Associates

VNA Care Network Foundation: Home health, palliative care and hospice, private duty nursing

Population of Focus: Medicare Eligibles

Approximately 52,000 Medicare beneficiaries in value-based payment contracts.



High Risk Patient Roster Review

Confirm diagnoses Social assessment **Review medications** Care needs Address quality assessment measures **PCP-Led Team Advance directives** Care plan Palliative care documentation & discussion orders

Managing the SNF "Neighborhood"

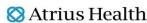
Developed expectations and tools to manage SNF stay

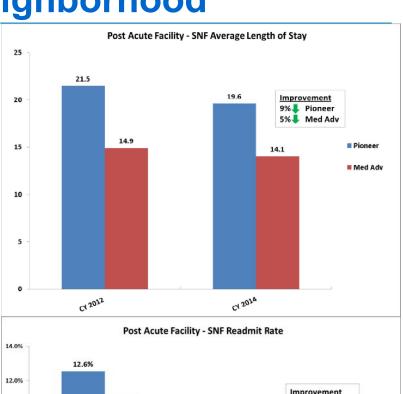
- Facility-level expectations
- Provider-level expectations
- Discharge workflow
- FHR documentation
- Monitoring & reporting
- Use of preferred discharge providers

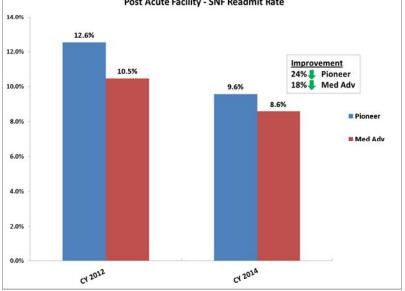
↓2.0 LOS = \$2M



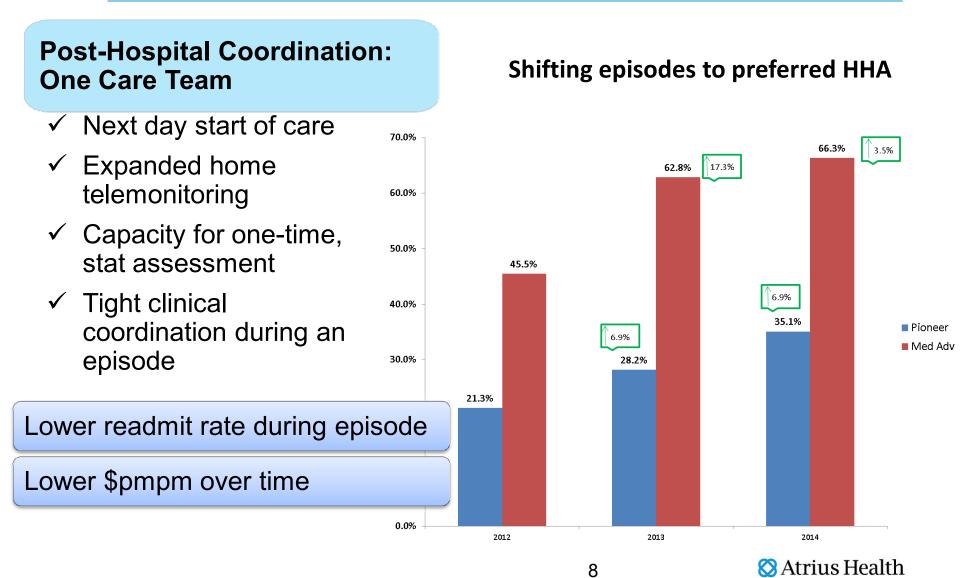
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Collaboration with Home Health Partner



Integrating Local Elder Services (ASAPs)

Phase 3

ASAP provided **Social Worker** embedded and integrated into care team

Phase 2

communication between practice Phase 1

Social Worker and ASAP to "close the loop" on services provided

Enhanced care coordination and

Direct communication between practice and ASAP via secure e-mail

PROGRESSION OF SERVICE DELIVERY

OUR IMPACT

Cost

- Early data shows directionally lower costs and reduced utilization of unnecessary care (hospital admissions, ED visits, and SNF days)
- Care plans indicate provider awareness of ASAP services

Quality and Patient Experience of Care

- Enhanced support for caregivers and family
- Positive patient feedback and enhanced access to ASAPs
- Potential for improved health outcomes through programs and services that assist patients in managing their health

Duals Integrated Care Model

Health Plan

Atrius Health

Coordination of Medicaid Services

- Home health aide services
- Integrated social/behavioral health services including community providers
- Dental
- Transportation

Dedicated Resources:

- Social Worker and/or Community Health Worker
- In Home Assessment
- Intensive care for complex patients
- Behavioral Health

Assessment and Care Plan Development

Ongoing Care Management:

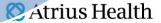
Patient-focused collaboration Care Team Communication Population Management

Single Point of Contact:

Facilitate Clinical
Communication and
Coordination

Direct Patient Care for Medicare Billable Services

Primary Care Medical Home



Independent "Near Market" Evaluation, May 2015

The **JAMA** Network

From: Association of Pioneer Accountable Care Organizations vs Traditional Medicare Fee for Service With Spending, Utilization, and Patient Experience

JAMA. 2015;313(21):2152-2161. doi:10.1001/jama.2015.4930

- Atrius Health saved \$36M compared to near market; \$67 pmpm in 2013.
- Atrius Health one of the ten Pioneers with savings in both years, and one of three accounting for 70% of 2013 savings.
- Key drivers: reduced IP admits & readmits
- Savings in OP facility, SNF, and HH
- More utilization of Hospice

Engagement Across the Continuum

- "One Model of Care" provides a burning platform for providers
- Groups that implemented High Risk Roster Review early and often saw bigger impacts on preventable utilization
- Effective care management is embedded into the primary care medical home
- Addressing palliative and end-of-life care is not only necessary, but part of patient-centered, respectful care
- Our ability to engage with other parts of the delivery system is key
- Where we focus, we get results