

From Medical Home to Medical Neighborhood to ACO and Beyond

Medical Home Summit
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About Atrius Health



***Quality scores ranked #1
in New England and #3
nationally for Medicare
Pioneer 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

Atrius Health Core Competencies

Corporate Data Warehouse integrates single platform, electronic health record data with multi-payer claims data

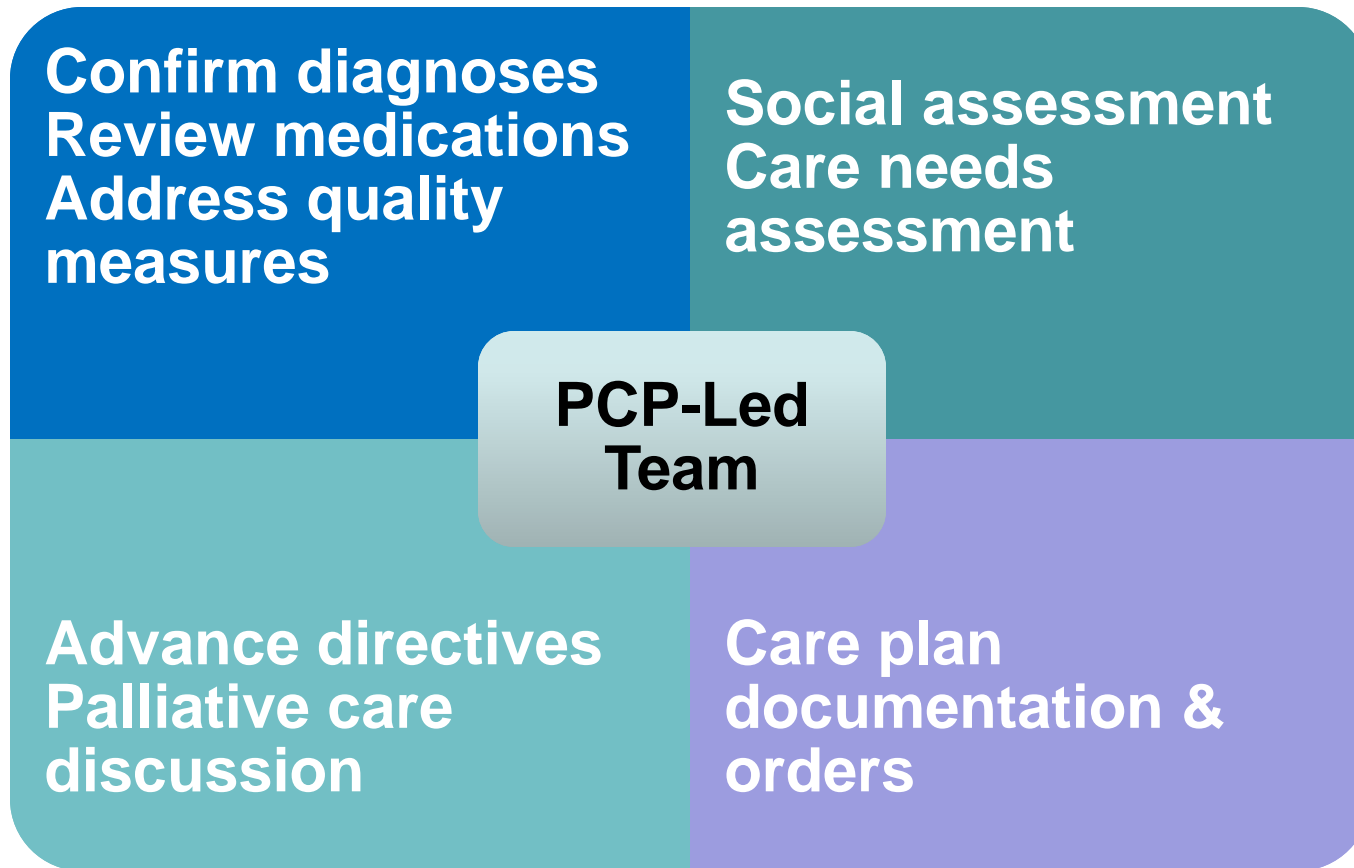
Widespread Extensive **Population Health Management** including disease-based and risk-based rosters, population managers

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

Sophisticated development and reporting of **Quality and Performance Measures** leading to high achievement

Patient-Centered Medical Home foundation, achieving level 3 NCQA across all primary care practices

High Risk Patient Roster Review



High Risk Roster Participants

“Each site may choose to have any number or combination of participants so long as the goals of high risk roster reviews are being met.”

Typical participants include:

- PCP
- Primary Nurse or Medical Assistant
- Care Manager
- Geriatric Champion or Palliative Care Specialist
- Social Worker
- VNA representative
- Clinical Pharmacist



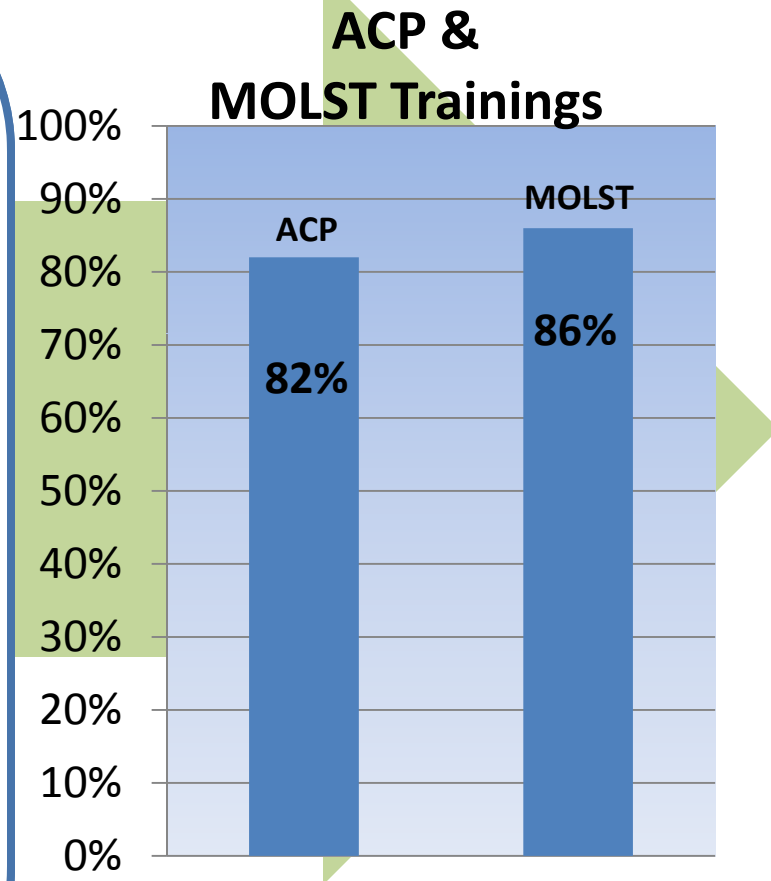
Advance Care Planning Initiatives

Description:

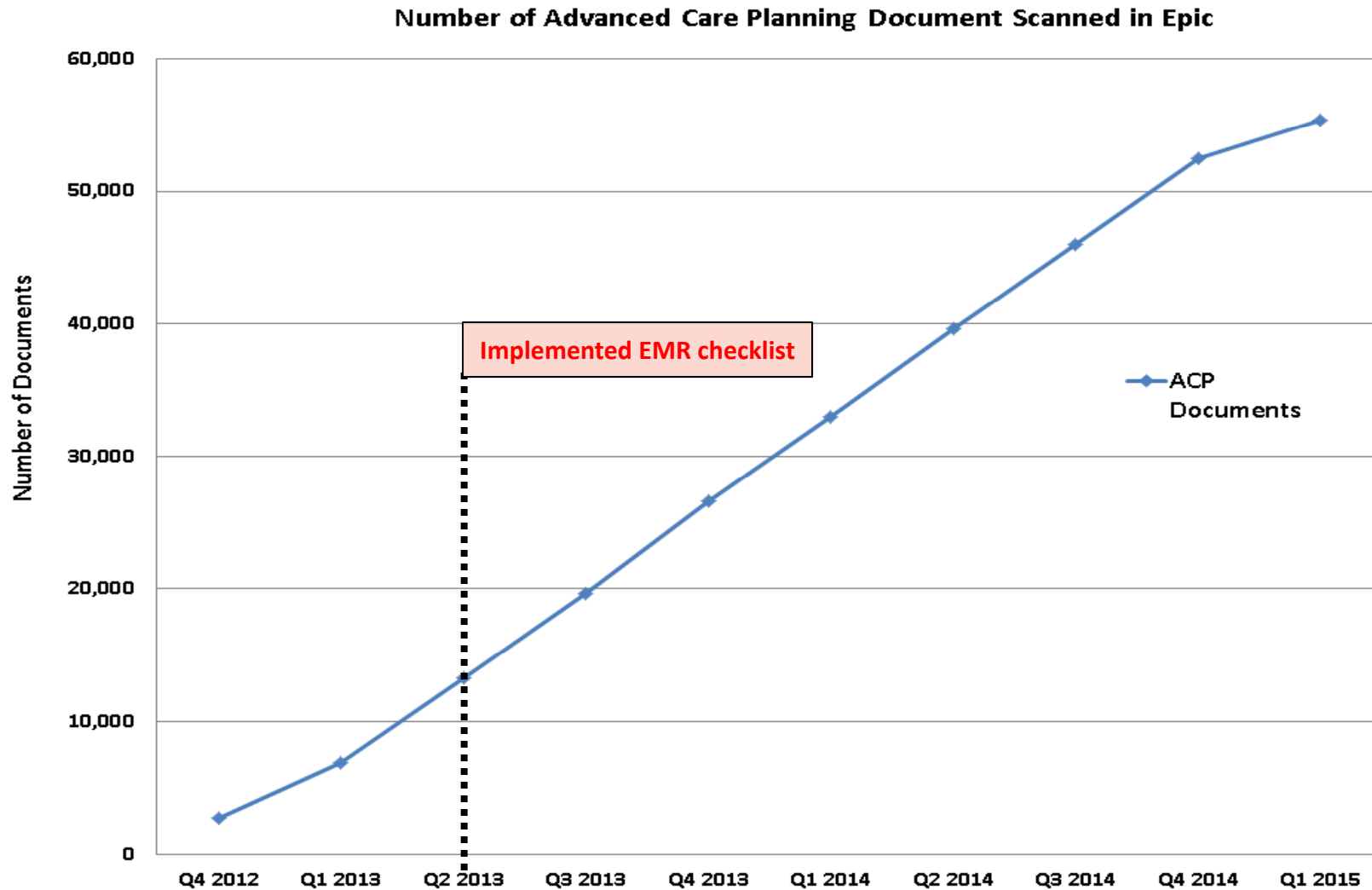
- Developed advance care planning (ACP) curriculum with CME/CEU credits.
- Established site-based ACP champions to train and provide ongoing ACP support locally
- Developed new tools in Epic to track and document advance care planning across settings

Expected Outcomes:

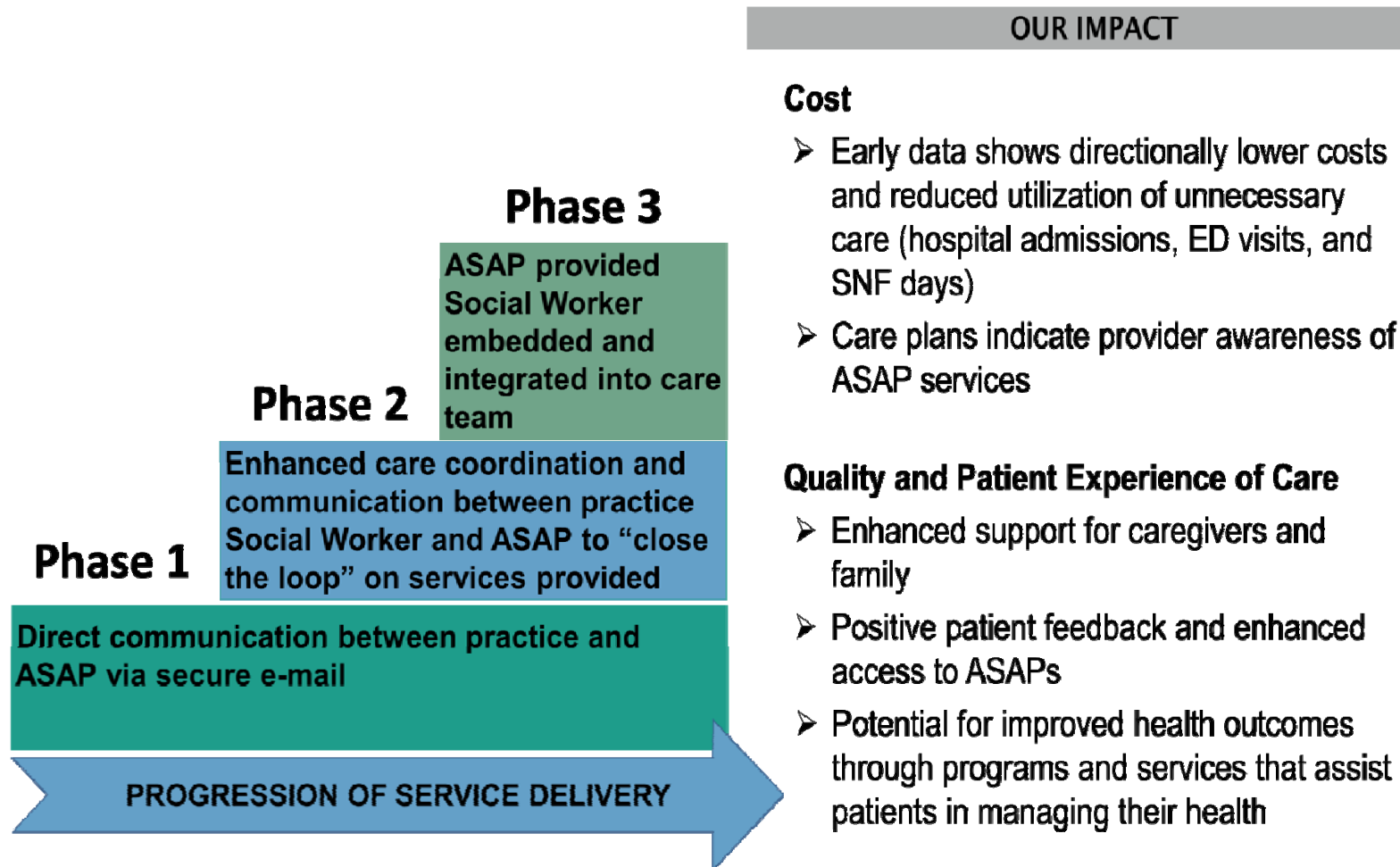
- Increase end of life conversations and collection of patient's care wishes, advance directives and proxy information
- Minimize use of aggressive curative care when not aligned with patient's care wishes



Advance Care Planning: Results



Integrating Local Elder Services (ASAPs)

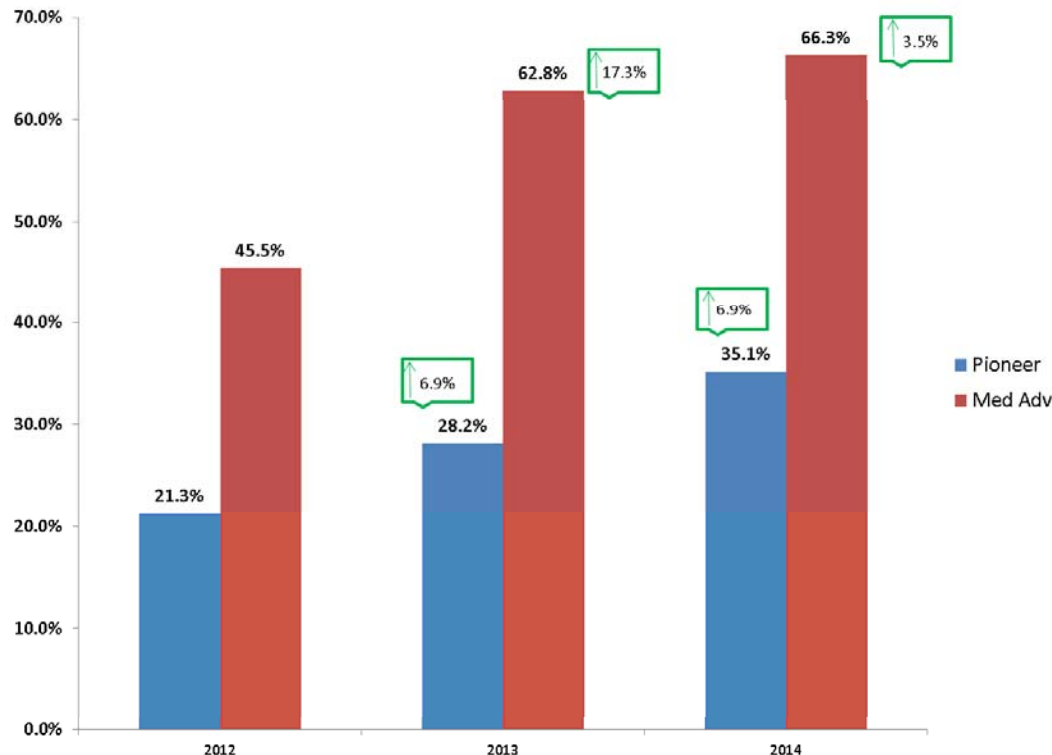


Collaboration with Home Health VNA Care

Post-Hospital Coordination: One Care Team

- ✓ Next day start of care
- ✓ Common assessments
- ✓ Expanded home telemonitoring
- ✓ Capacity for one-time assessments, stat visits
- ✓ Tight coordination of home care and in office services during an episode

% HHA referrals to preferred VNA



Managing the SNF “Neighborhood”

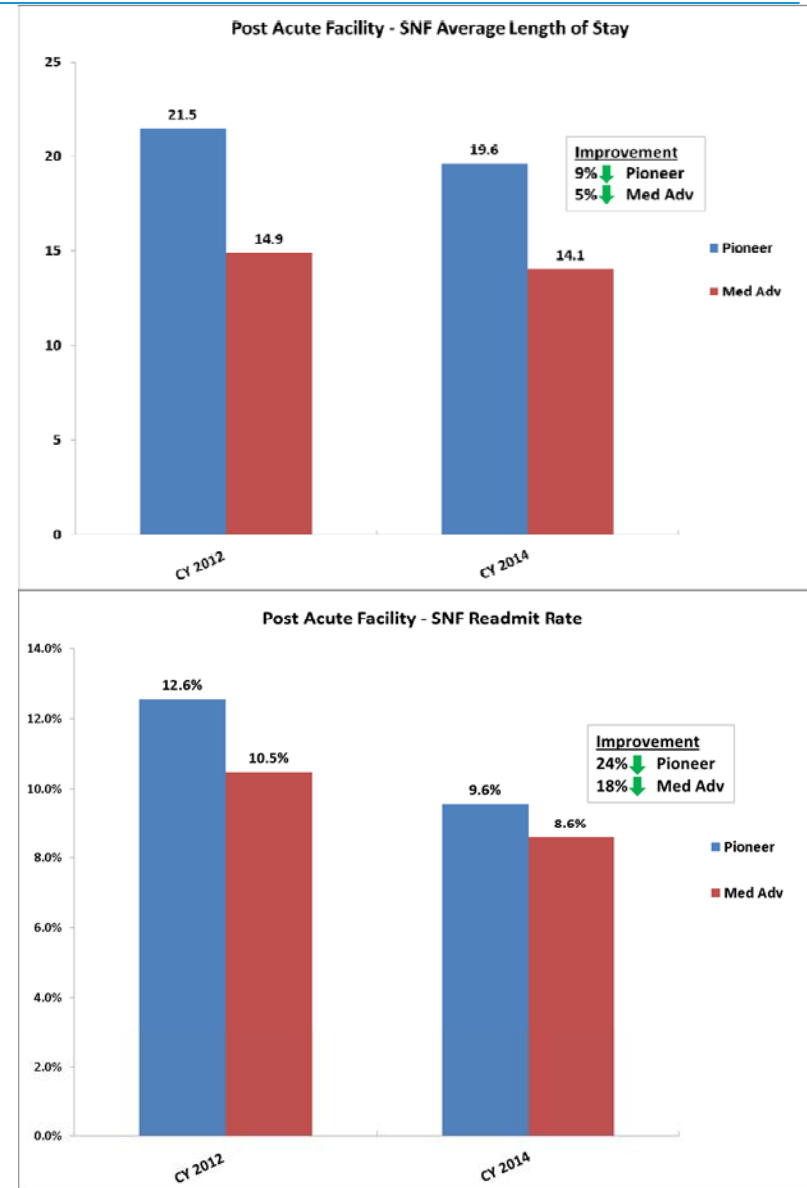
Developed expectations and tools to manage SNF stay

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

↓ 2.0 LOS = \$2M

↓ 2% Readmit Rate = \$.5M

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Independent “Near Market” Evaluation, May 2015



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

- Pioneer ACOs saved \$384M over two years
 - Atrius Health saved \$36M compared to near market
- Ten of 32 Original Pioneers had statistically significant savings in both years
 - Atrius Health was one of the ten
 - Atrius Health noted as one of three Pioneers accounting for 70% of savings in 2013

Discussion

