Medical Home as a Platform for Population Health

Population Health Colloquium
March 8, 2016

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Population Health Management: Different Perspectives

• Improve the health, experience, and cost of care for a targeted population, over time (Outcomes)

• The iterative process of strategically and proactively managing clinical and financial opportunities and resources to improve health outcomes while also reducing costs (Process)
Population Health Management: Process

- Data-identify gaps in a care/outcomes for a clinical population (payer blind)
- Engage clinical and operational leaders in understanding reason for gaps
- Identify evidence-based best practice
- Design future state care delivery based on evidence (the “Atrius Health way”)
- Develop standards & tools to implement
- Measure and monitor execution to get results
About Atrius Health

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

Quality scores ranked #1 in New England and #3 nationally for Medicare ACOs for 2014
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
Our Population Health Approach

- Close medical management at end of life
- Tight coordination of 5% highest risk
- Management of chronic conditions
- Preventive care and Risk Reduction
Accountability Across the Medical Neighborhood: High Risk Patients & High Cost Events

Ongoing:
- High Risk Roster Review
- Hospital Partnerships
- Post Acute Episode Mgmt
- Integrated Community Supports
- Partnering with Duals plans

Redesign Work for 2016:
- Care Transitions
- Palliative Care/Hospice

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High Risk Patient Roster Review

Confirm diagnoses
Review medications
Address quality measures

Social assessment
Care needs assessment

Advance directives
Palliative care discussion

PCP-Led Team

Care plan documentation & orders
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
Hospital Strategy

• Defined hospital network to optimize hospital care for Atrius Health patients as part of our comprehensive system of care.

• Key Features:
  – Care delivered in the patients’ communities, follow up coordinated with Atrius Health
  – Scorecard drives improvement in quality, patient experience
  – Collaborative payment methodologies to enable us to jointly reduce cost of care
  – Collaboration and continuous improvement are built into the relationship
Post Acute Strategy: Development of Preferred SNFs Network

Created preferred SNF network to enhance the delivery and coordination of care.

- Meet service standards
- Atrius Health team on-site
- SNF willingness to collaborate
- Good metrics*
- History of positive relationship
- Geographic needs

*Good Metrics: Medicare Compare; State survey; Readmission during SNF stay; LOS
Post Acute Strategy: Managing SNF Events

- 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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Post-Acute Strategy: Collaboration with VNA Care Network (HHA)

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
- Leverage Palliative and Hospice services

% HHA referrals to preferred VNA
Integrating Community Supports: Local Elder Services (ASAPs)

Phase 1
Direct communication between practice and ASAP via secure e-mail

Phase 2
Enhanced care coordination and communication between practice Social Worker and ASAP to “close the loop” on services provided

Phase 3
ASAP provided Social Worker embedded and integrated into care team

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

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Direct Patient Care for Medicare Billable Services

Primary Care Medical Home

Assessment and Care Plan Development
Ongoing Care Management:
Patient-focused collaboration Care Team Communication
Single Point of Contact:
Facilitate Clinical Communication and Coordination

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

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Partnerships Drive Savings - Particularly in the Medicare Population

- Favorable inpatient hospital trend
- Savings in SNF costs per episode, and significant reductions in need for IRF, LTACH stays with direct-to-SNF admits
- Home Health supports overall saving
- Palliative and Hospice Care services are a triple-aim home run
Discussion