Medical Home as a Platform for Population Health

Population Health Colloquium
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Emily Brower
Vice President, Population Health
Atrius Health
Emily_Brower@atriushealth.org

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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

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

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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

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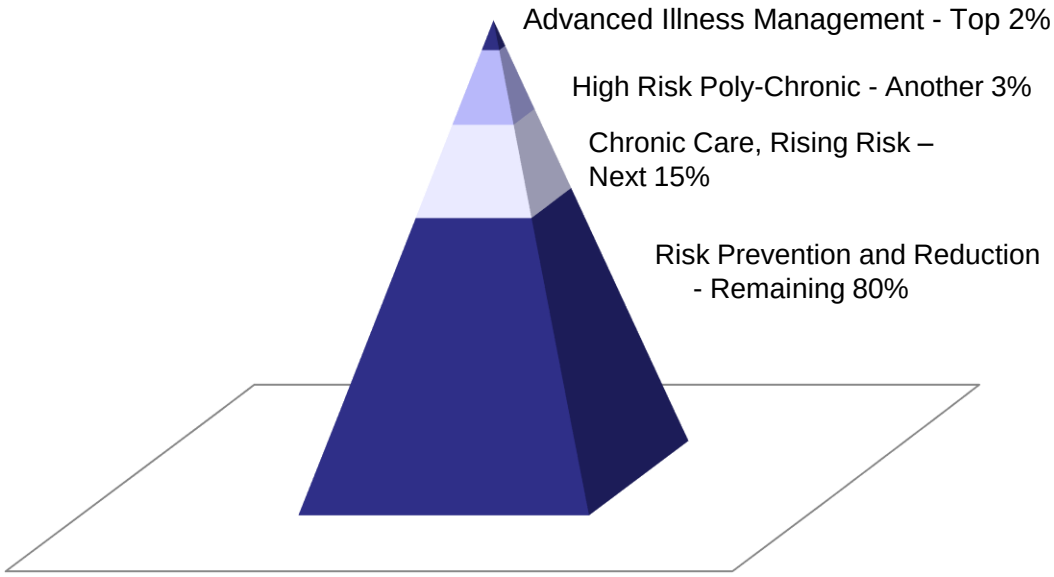
Our Population Health Approach

- Close medical management at end of life
- Tight coordination of 5% highest risk
- Management of chronic conditions
- Preventive care and Risk Reduction



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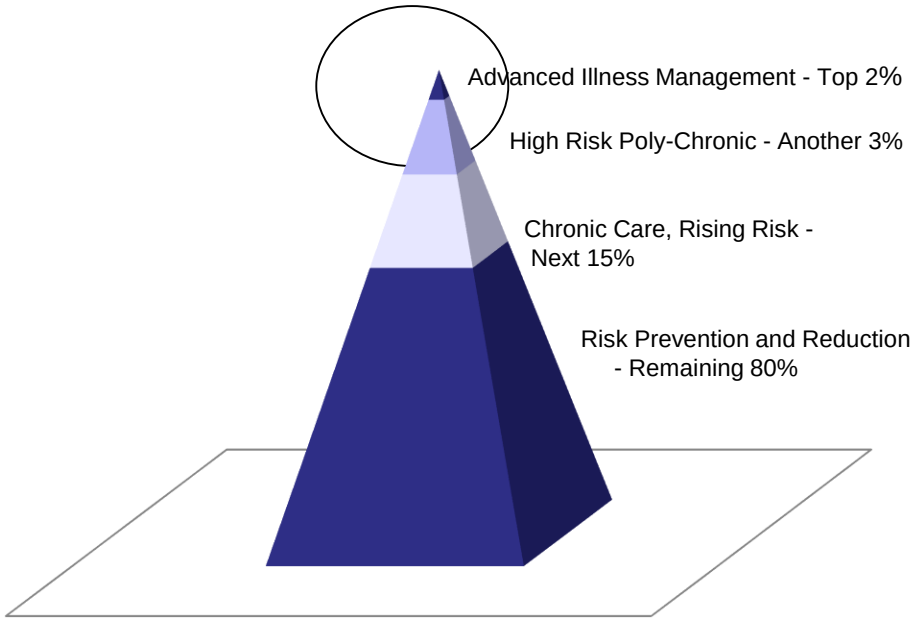
Accountability Across the Medical Neighborhood: High Risk Patients & High Cost Events



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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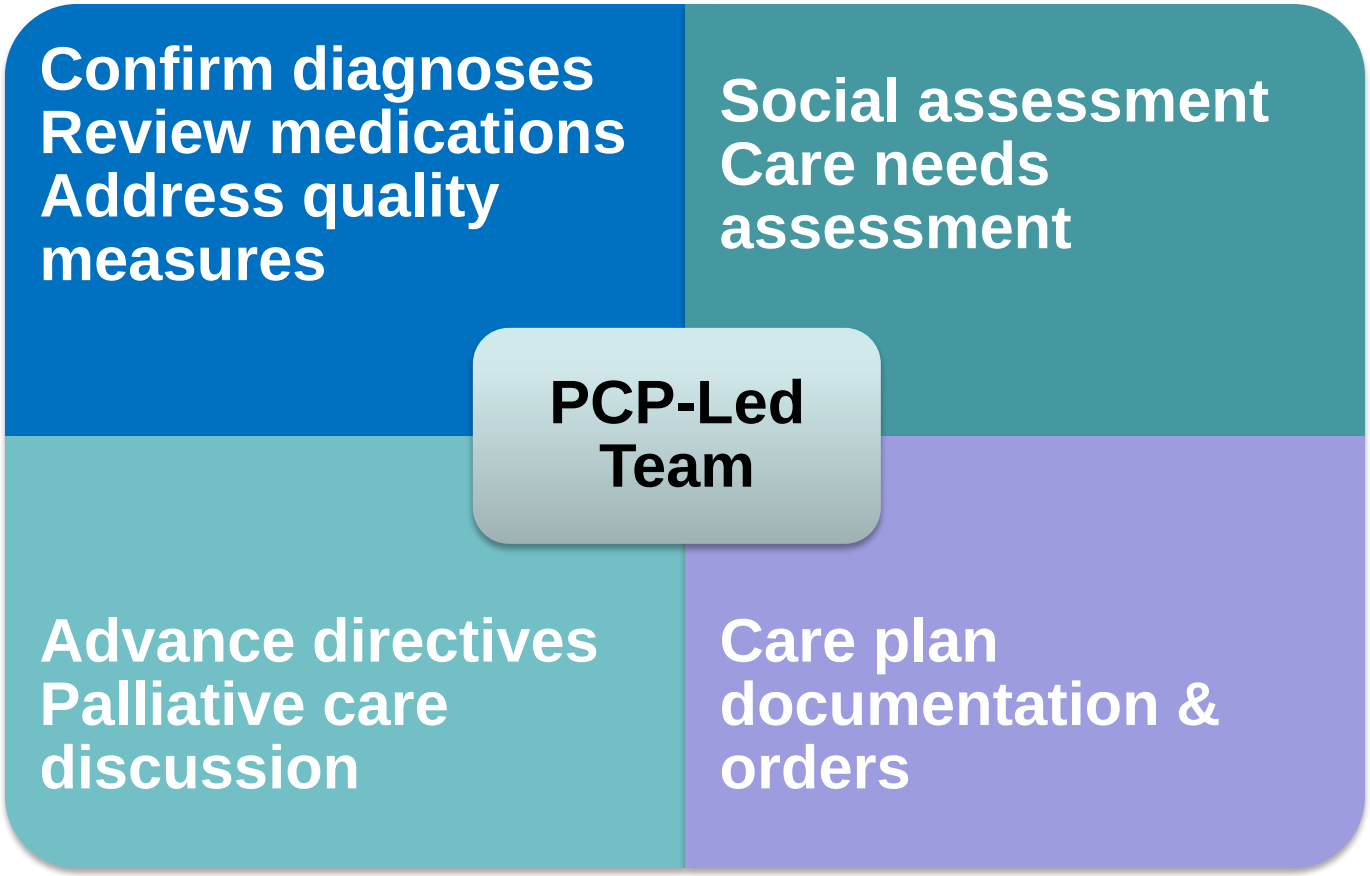
High Risk Patient Roster Review



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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

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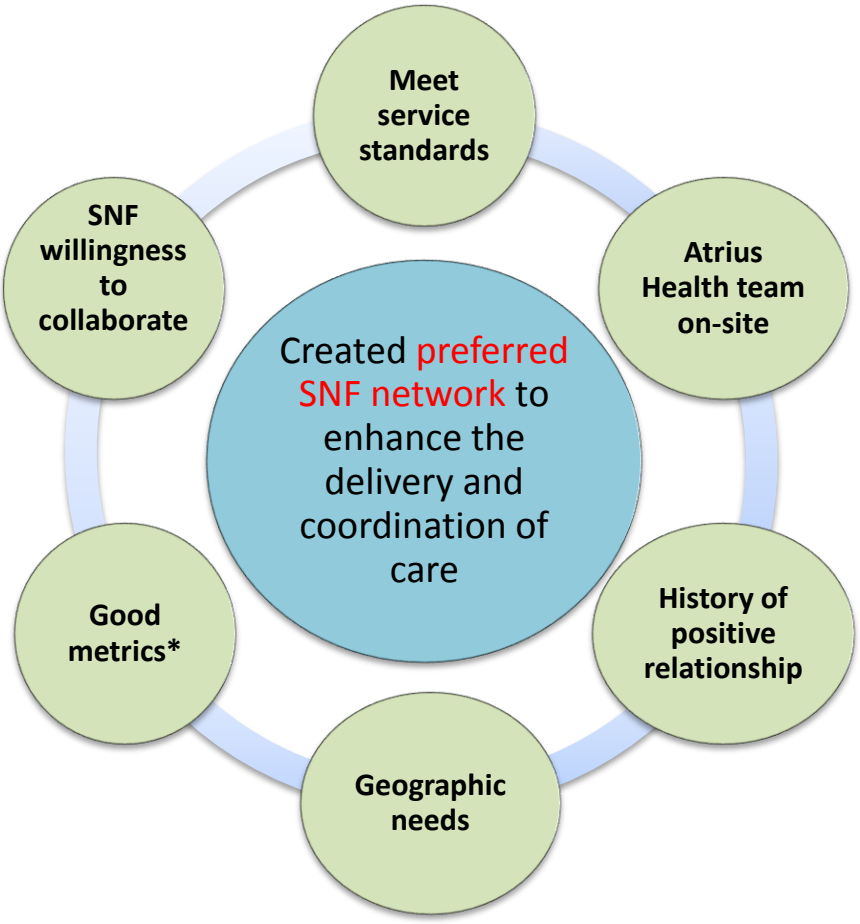
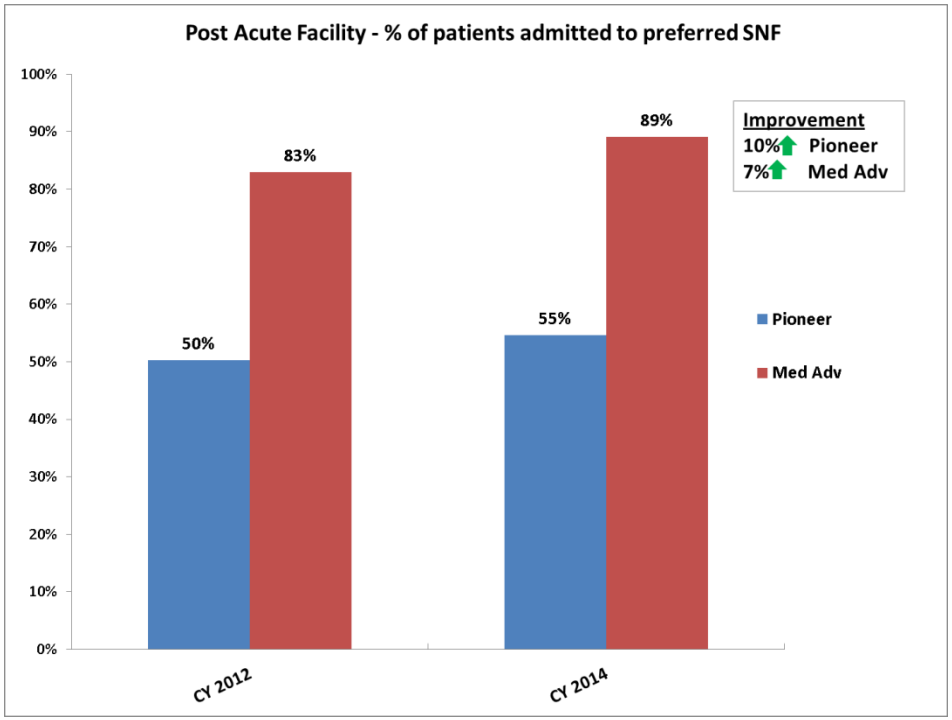
Hospital Strategy

- 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





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

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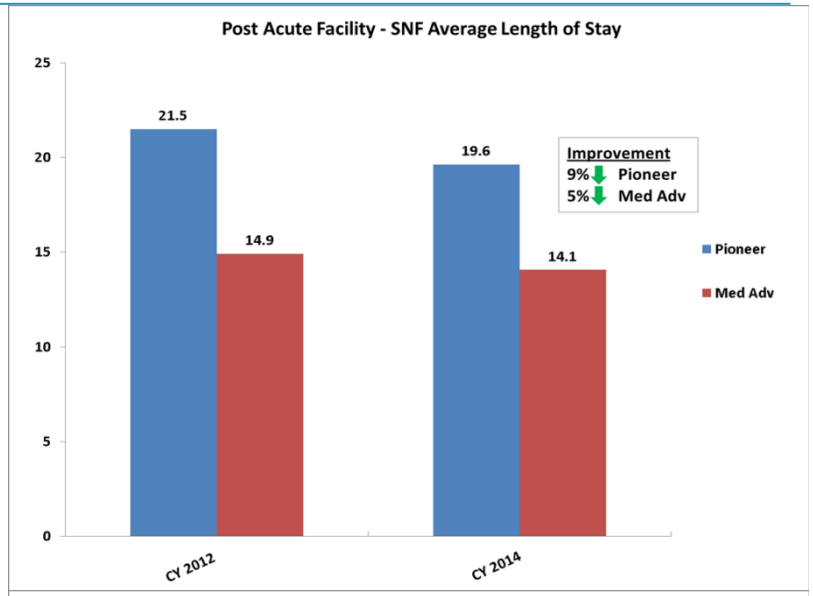
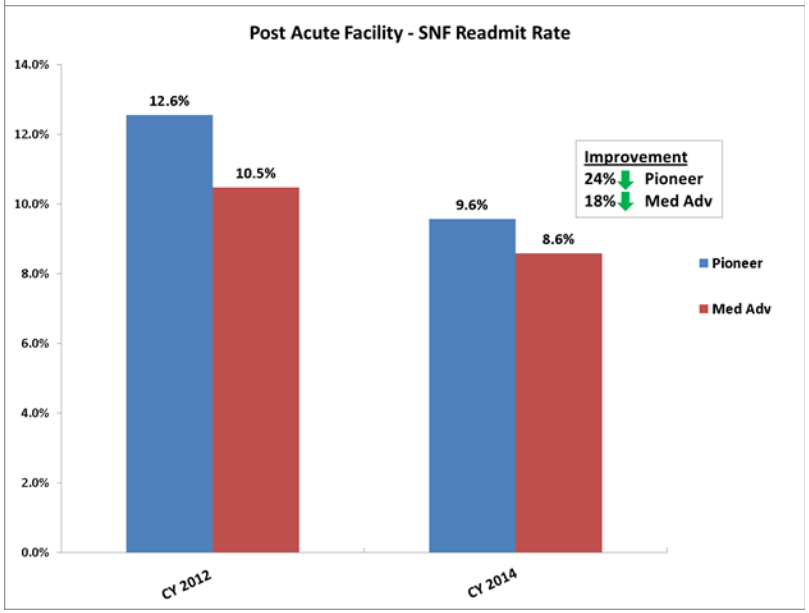
Post Acute Strategy: Managing SNF Events

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





↓2.0 LOS = $2M

↓2% Readmit Rate = $.5M

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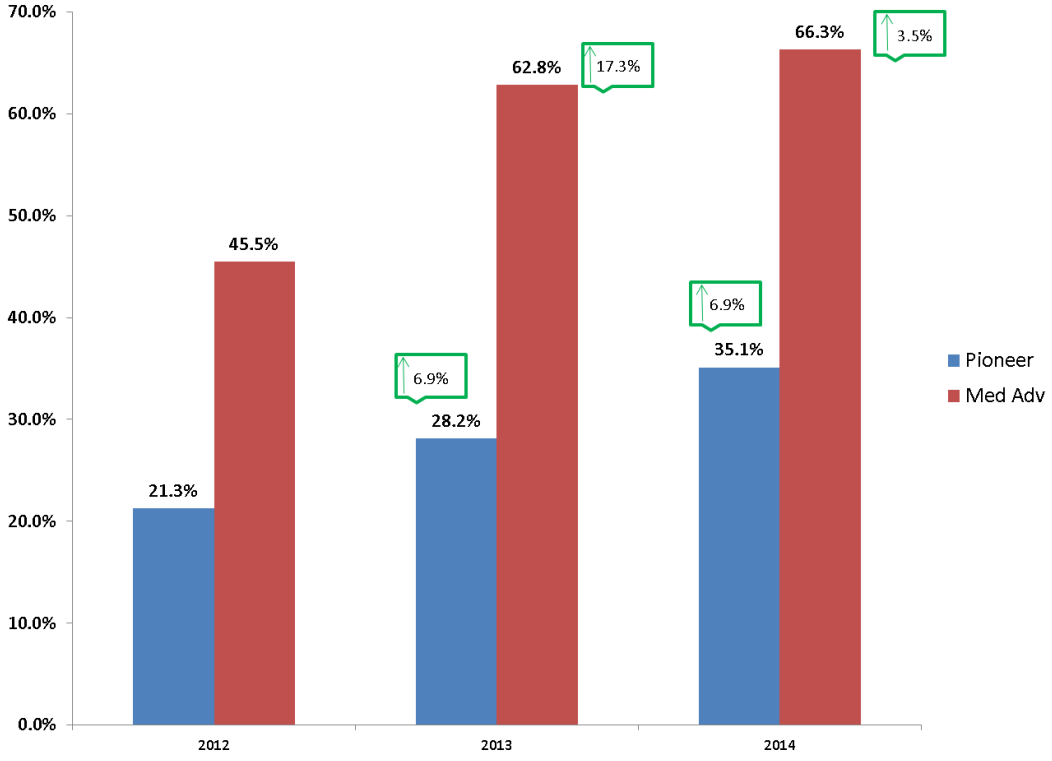
Post-Acute Strategy: Collaboration with VNA Care Network (HHA)

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



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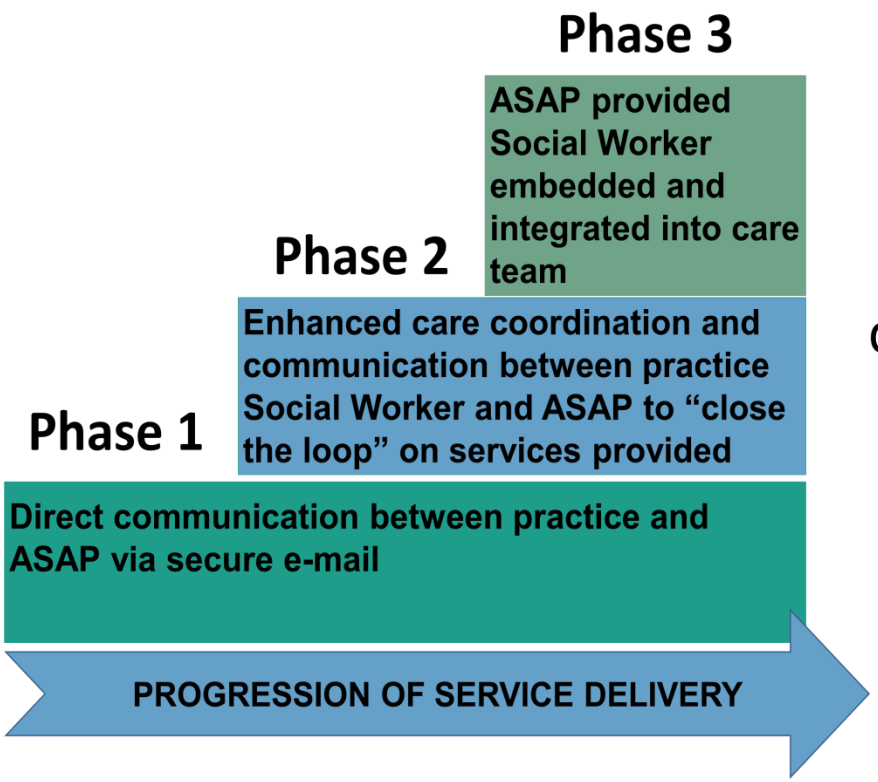
Integrating Community Supports: Local Elder Services (ASAPs)



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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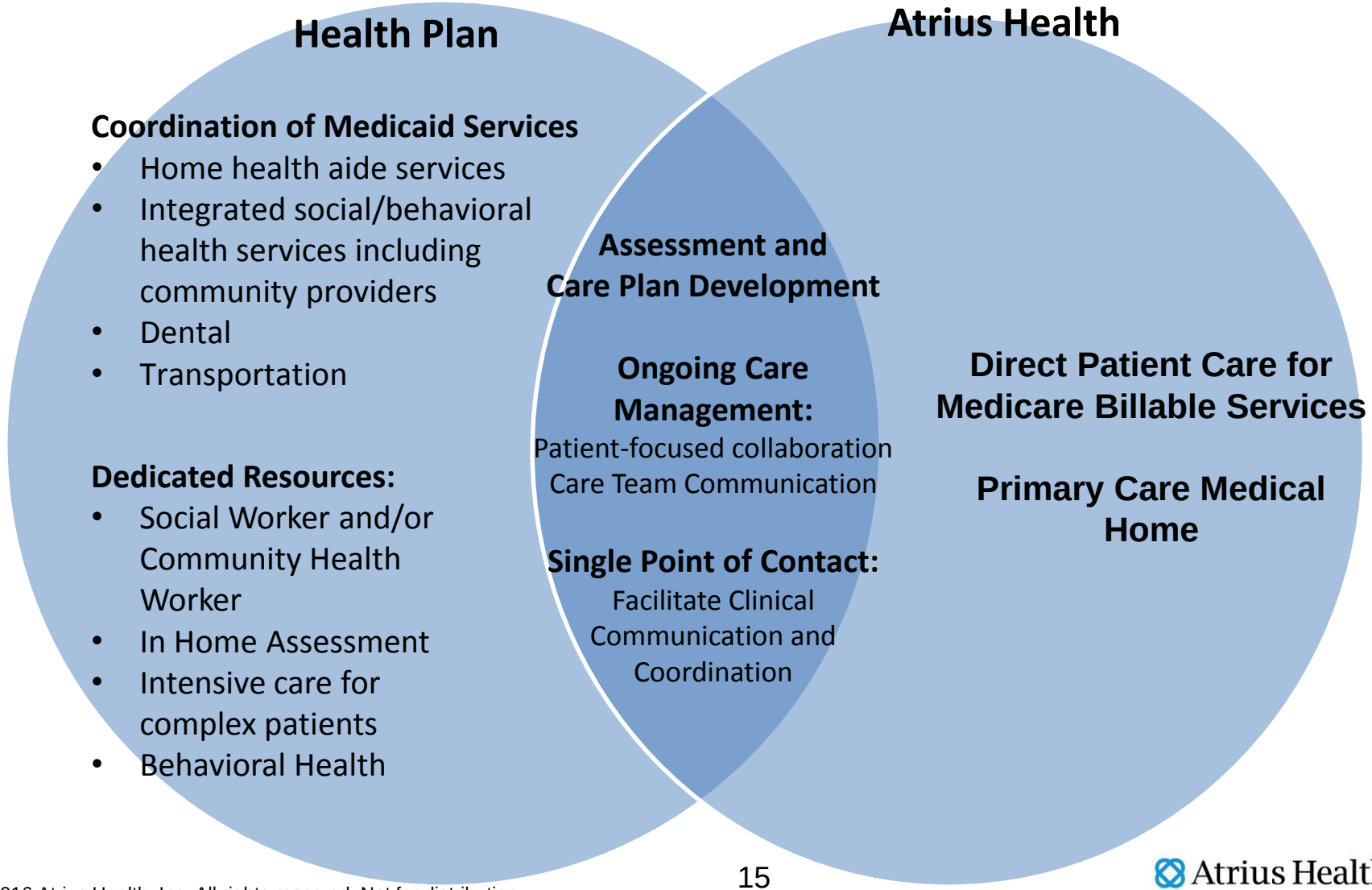
Integrating Community Supports: Dual-Eligible Payer Partnerships



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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