Atrius Health and AAAs: Partners in Accountable Care:

ACL Learning Collaborative

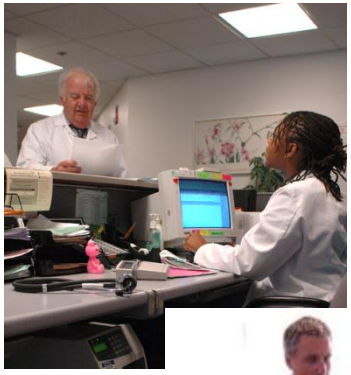
July 16, 2013

Today's Discussion

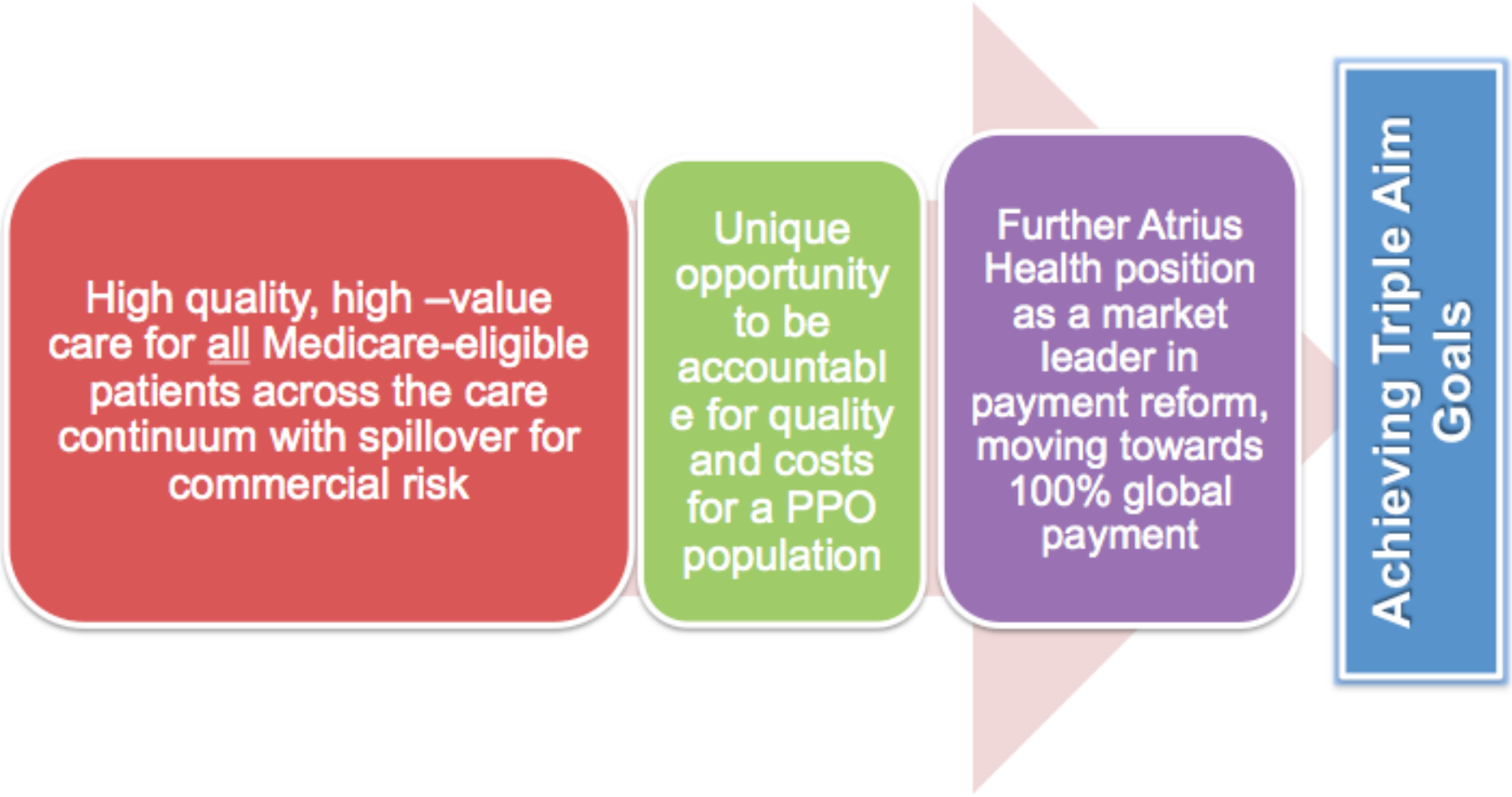
- Atrius Health: Who We Are
- Atrius Health's Pioneer ACO Strategy
- Atrius Health - ASAP Partnership
- Lessons Learned and Next Steps

Atrius Health Core Competencies

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



Why Participate in Pioneer ACO? "Reason for Action"



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
- Medicare FFS beneficiaries aligned with ACO based on their historical claims data
- Global budget and performance measured against national benchmark
- Upside and downside risk sharing with CMS
- Incentives rewards to achieve high quality performance measurements
- Accountable to Pioneer ACO obligations

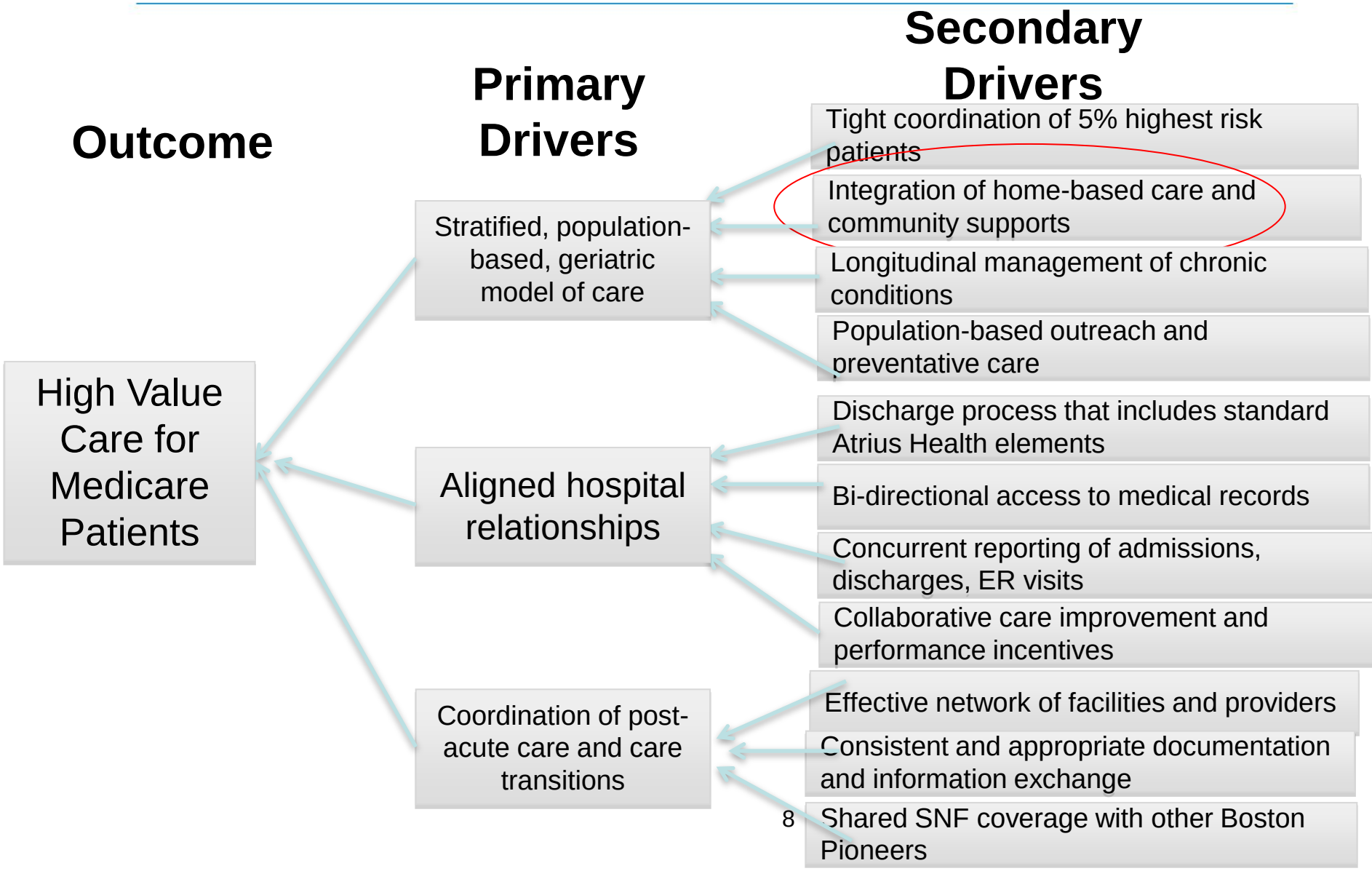
Quality Measures: Key Features

33 Quality Measures:

many new, or with new features

- **Patient/Caregiver Experience, measured by CG-CAHPS**
- **Meaningful Use (double weighted)**
- **Care Coordination/Patient Safety, measured by claims data**
  - Ambulatory Sensitive Condition Admissions
  - Readmissions
- **At Risk Population/Preventive Health, measured with EMR data**
  - Diabetes
  - IVD
  - CAD
  - Heart Failure
  - Hypertension
  - Immunizations

Atrius Approach to Pioneer

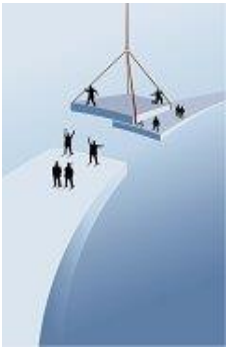


Addressing the Gaps in Home-Based Care

Accountable for managing care, cost and quality of Medicare services in the home setting.

- Costs are substantial across dozens of post-acute providers.
- Patients have choice and are geographically distributed.
- Poor transitions result in unnecessary readmissions and other wasteful costs, harm, and errors.
- No standard model of home-based care across Atrius Health, no standard measurement

ASAPs, while not currently Medicare providers, can be an important resource in closing these gaps.



ASAP Strategy: *Link Primary Care to Community Home Care Services*

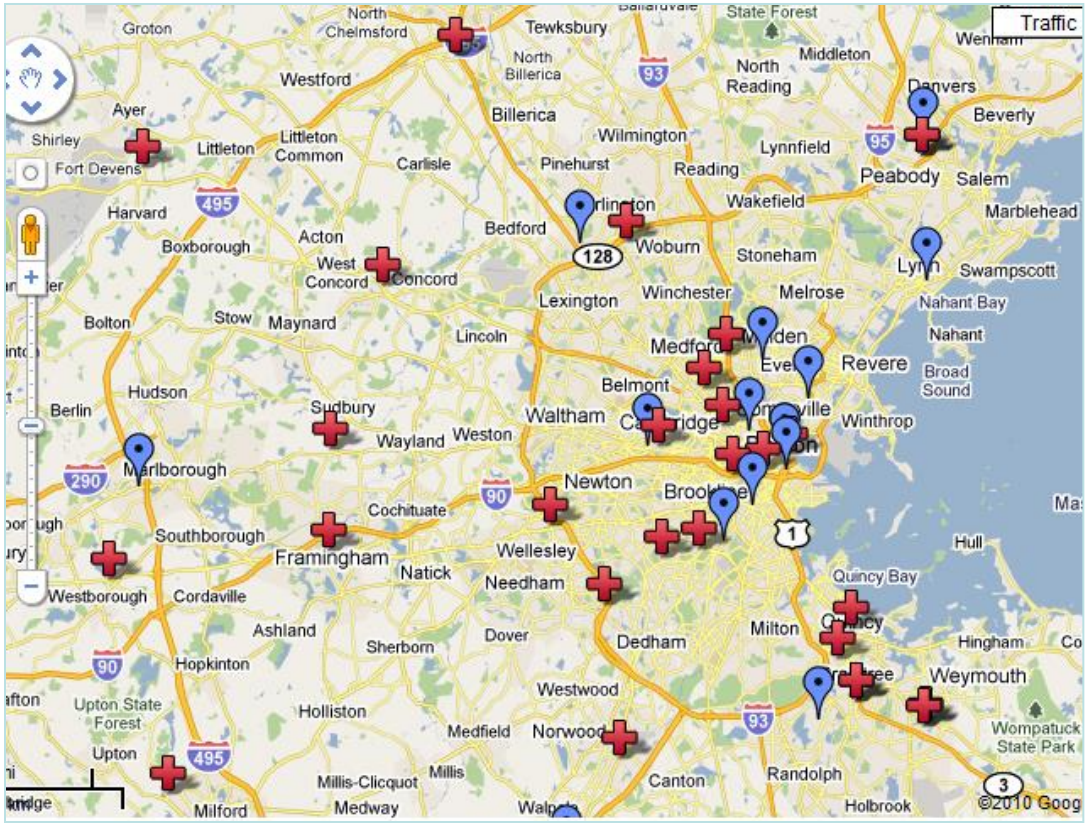
Achieve triple aim objectives by linking primary care practices to community resources

- Reduce costs through **prevention** and/or **reduction of unnecessary utilization** of health care services
- Improve health outcomes through **better care coordination** and **patient education**
- Improve patient experience and satisfaction by **aligning with goal of remaining functionally active at home**

Atrius Health – ASAP Collaboration

- Expansion of the **"Care Team" to include the patient's home** and community-based networks
- Requires: effective communication for timely and efficient referrals, hand offs, and "**closing the loop**"
- Results in: **patient centered care plans with realistic goals and resources for implementation**
- **Collaboration through:**
  - ✓ Practice-based Pilots
  - ✓ Population-based Interventions

Atrius Health/ASAPs Practice-Based Pilots



Atrius Health Sites

ASAPs

1. HVMA Chelmsford & Elder Services of Merrimack Valley
2. Southboro & BayPath
3. HVMA West Roxbury & Ethos
4. HVMA Wellesley/Watertown & Springwell

Currently expanding to new sites

OUR PARTNERSHIPS

- **Practice-based pilots and population-based interventions** of varied intensity
- Creation of **patient centered care plans with resources** for implementation
- Development of **standard work processes for optimal care coordination**

Harvard Vanguard Medical Associates-Wellesley and Watertown with

springwell

Harvard Vanguard Medical Associates-Chelmsford with

Elder Services of the Merrimack Valley, Inc.
Choices for a life-long journey

Southboro Medical Group with

BayPath
BayPath Elder Services, Inc.

Enhanced care coordination to "close the loop" on services provided

On-site ASAP Social Worker integrated into the practices

Direct communication between practices and ASAPs with secure e-mail

PROGRESSION OF SERVICE DELIVERY

Opportunities & Challenges

- Opportunities
  - Build sustainable relationships beyond individuals
  - Continuous learning together => innovation
  - Demonstrate Value => Clinical and Financial Commitment
- Challenges
  - Slow Start Up
    - Hard to scale
    - Building as we go
  - Data timing
    - Utilization & costs
    - Quality measures
  - Integration into primary care protocols
    - Work flow changes
    - Education

Atrius Health

Value Proposition for Southboro Medical

ASAP as Authentic Member of Care Team

- Quicker and "more economically feasible" to buy
- Better access to ASAP services through embedded staff in practice (vs. standard I&R)
- Improved care management that reduced duplication of handoffs
- More patients access ASAP network services through relationship
- Opportunity to focus on prevention, develop innovative model for best practice
- Align with ACO measures
- Reduces burden on MD practices

"wish she was here 5 days per week"

"Our staff can focus more on care management and less on the details or making arrangements"

Lessons Learned

ASAP Collaboration

- Build relationship with one point of contact and spread
- Allow time for MD practice staff to experience value of ASAP, one patient at a time
- Participation in case “roster” review is powerful

Internal Atrius Health

- MD engagement drives change
- Care Managers are key to everything
- New opportunity to spread pilots across Atrius Health

External

- Potential conflicts AND/OR opportunities with other initiatives
  - CCTP, MSSP ACOs, Bundled Payment Pilot

What's Next?

- For Pioneer and ASAP work
  - Spread the good work
  - Track the results

- For Atrius, More "O"s….
  - SCO – Existing MA duals plan, 65+
  - ICO – New MA plans, < 65

Questions?

Emily Brower
Executive Director, Accountable Care Programs
Atrius Health
Emily_Brower@AtriusHealth.org

Amy S. MacNulty
Project Director
Community Care *Linkages*
amy@macnultyconsulting.com