New Models of Care and Approaches to Payment

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Atrius Health

Non-profit alliance of six leading independent medical groups in Eastern Massachusetts and home health agency and hospice

- Granite Medical
- Dedham Medical Associates
- Harvard Vanguard Medical Associates
- Reliant Medical Group
- Southboro Medical Group
- South Shore Medical Center
- VNA Care Network & Hospice, including VNA of Boston

Providing care for ~ 1,000,000 adult and pediatric patients with 1000 physicians, 2100 other healthcare professionals across 35 specialties
Atrius Health Core Competencies

**Corporate Data Warehouse** integrates single platform, electronic health record data with multi-payer claims data to manage quality & cost

Widespread **Population Management** tools including disease-based & risk-based rosters

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

Sophisticated development & reporting of **Quality and Performance Measures**

**Patient-Centered Medical Home** foundation, achieving level 3 NCQA at all 37 adult primary care practices

Newest Addition to Atrius Health: home health care, private duty nursing & hospice care through VNA Care Network & Hospice (VNACNH)
VNA Care Network & Hospice: Experienced

120 years of experience caring for residents in more than 200 Eastern and Central Massachusetts communities

First Medicare-certified home health agency in the Commonwealth of Massachusetts

Pioneer in end-of-life care as first Medicare-certified hospice in Massachusetts with first hospice residence in the state

Co-owner of Home Staff a private duty agency serving much of the service area with nursing assistance, personal care, cleaning, household management, and errand services
Atrius Health and VNA Care Network & Hospice: Key Partner in Accountable Care

Long-standing, trusted referral relationship within the Atrius Health system of care

Aligned coverage area, single point of contact

High Quality

- Evidence based practice & programs
- High Home Health Compare scores
- High patient satisfaction
- Consistency across providers
Key Atrius Health Initiatives with VNA Care Network and Hospice

Four Major Areas of Focus:

1. Communication
   - Seamless
   - Electronic
   - Expedite Work Flow

2. Team Work
   - From nameless faces to face and names
   - Integrated

3. Program Design
   - Meet true care needs regardless of payment

4. Metrics
   - Accountability
Communication: Key Atrius Health Initiatives with VNA Care Network and Hospice

Current

– Daily electronic exchange of ACO reports which consists of:
  • Falls Risk Assessment
  • Medication Review
  • Depression Screening

Automatically distributed to Atrius Health Information Management Department for entry into the EMR

– Weekly Active patient clinical data sent which consists of:
  • Progress towards goals
  • Response to Teaching
  • Discharge Planning
  • Hospice Team meeting notes

Extracted & e-mailed to case managers at each site
Communication: Key Atrius Health Initiatives with VNA Care Network and Hospice

- Current
  - Encrypted email connection to all medical groups
  - Referrals made electronically and intake retrieves patient information directly from eRecord Link Epic access
  - EMR read-only access established for Clinical Managers, Coordinators and Hospice MD’s for care coordination; able to extract clinical information for RN assigned to a case
Communication: Key Atrius Health Initiatives with VNA Care Network and Hospice

• Future
  ▪ Investigating EPIC Home Care software for future full integration
  ▪ Prototyping electronic Face to Face document in EPIC with transmission via eRecordlink
  ▪ Developing automation of Plan of Treatment Orders creation (485’s) through MD Portal
Team Work: Atrius Health Initiatives with VNA Care Network and Hospice

Team Work begins at the top:

The charter of the Atrius Health, VNACN & H Clinical Collaboration Steering Committee (“CCSC”) is to oversee all clinical integration and referral transition work:

- CCSC will define policies and procedures which will be used to implement the relevant care coordination and collaboration programs.
- CCSC will define the process for CCSC review of cases and the process for making recommendations.
- CCSC will recommend new program design and innovative activity and function as the oversight body for all development.
- CCSC will propose alternative funding requirements to support programs as necessary, i.e. under or unfunded services.
Team Work: Atrius Health Initiatives with VNA Care Network and Hospice

Primary Care Practice

Primary Care Medical Team
PCP, NP, RN, PA, IHBNP, HRNP,

Consultation Team
- Palliative Care
- Geriatric Care
- Pharma Consults
- Social Worker

VNACN&H Dedicated Transitional Care Liaison Nurse

VNACN&H Transitional Intake RNs/Staff

Primary Care Case Managers

VNACN&H Dedicated Home Care Field
RN, LPN, PT, OT, ST, MSW

Atrius Health
Team Work: Atrius Health Initiatives with VNA Care Network and Hospice

Transformation from vendor relationship to a partnership as part of Atrius Health:

- ED VNA coverage at identified hospitals
- High Risk Geriatric Roster review participation at some sites
- Home Health Liaison Navigator services provided to Nurse Case Managers at each practice site
- Liaisons assigned to Network ECFs and hospitals
### Team Work: Multidisciplinary Geriatric Roster Reviews

<table>
<thead>
<tr>
<th>Adopted common standards for High Risk Patient Roster Reviews</th>
<th>Review and confirm accuracy of diagnosis</th>
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<tbody>
<tr>
<td></td>
<td>Review appropriateness of medications</td>
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<td></td>
<td>Perform a care needs assessment</td>
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<td></td>
<td>Create a clinical summary of the patient</td>
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<td></td>
<td>Perform a social assessment</td>
</tr>
<tr>
<td></td>
<td>Review applicable diseases related quality measures</td>
</tr>
<tr>
<td></td>
<td>Confirm existence and need for advance directives</td>
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<td></td>
<td>Update the patient’s care plan and document next steps</td>
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Early adopters saw greater reductions in total medical expense – mostly from reduced hospital and SNF admits.
Program Design: Key Atrius Health Initiatives with VNA Care Network and Hospice

- Advanced Care Planning
- One Time Home Assessments
- Joint Replacement Program
- Telehealth
- Integration with Primary Care at Home
- ED Diversion Program
Program Design: Advance Care Planning Role for VNACN

- Provider training on Palliative Care and Hospice
- Home-based NP Palliative Care consults with referral from PCP, follow up back to PCP/team.
- Hospice enrollment – earlier identification and referral through participation in high risk roster review, liaison role for the care team.
# Program Design: Care Management “Proxy” visit-One Time Home Assessment

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Goal</th>
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<tbody>
<tr>
<td>• Missing Piece of the Puzzle</td>
<td>• Care management, not medical management</td>
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<tr>
<td>• Home Safety Concerns</td>
<td>• Clear expectations around the content of visit and follow up</td>
</tr>
<tr>
<td>• Unclear if patient meets “certification”</td>
<td>– Templated Visit</td>
</tr>
<tr>
<td>• Visit based on need, not coverage</td>
<td>– Standard Work</td>
</tr>
<tr>
<td></td>
<td>• Communication in Epic that informs the care plan</td>
</tr>
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<td></td>
<td>• Reasonable reimbursement</td>
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Program Design: Post Acute Care –
Moving patients home for Total Joint Rehab

- 800 total hips and knees annually, Pioneer + MA
- 69% go to SNF or IRF
- Home about $3500 savings over SNF, with same or better outcomes
- $500K savings if we move 30% from SNF to Home
  - Patients with fewer co-morbid conditions
  - Patients with home support
Program Design: Moving Patients Home for Total Joint Rehabilitation: Requirements

- Standard process that identifies patients most appropriate for home-based rehab (prior to surgery)
- A home visit that acquaints those patients with home rehab to give them confidence and prepare them prior to surgery, set expectations
- Smooth pathway in Epic for referral and communication
- Reasonable reimbursement
- Status: implementation well underway
## Program Design: ED Discharge Home with Services

### Scope/Target:
- Avoidable (PQI) admits
- One-day admits
- OBS stays
- Two Pilot hospitals (now expanded more broadly)
- VNACN first call

### Requirements
- ED partnership
- Straightforward criteria
- Dedicated CM for approval and coordination
- Complete clinical and referral info including EPIC access in ED
- Warm clinical handoff
- Easy!
Program Design: Newest Initiatives in Development

• Expanding home telehealth (mostly for CHF) beyond the Medicare Episode
  – Non-certified Pioneer patients
  – Certified Pioneer patients who have not met self-management goals
  – Medicare Advantage patients

• Moving beyond CHF to do physician/VNA e-visits with video and diagnostic technology

• Expanding Home Based Primary Care
  – Streamlining communication and scheduling to work as a care team, reduce patient confusion
Metrics: Key Atrius Health Initiatives with VNA Care Network and Hospice

**Cost & Utilization – Atrius Health patients with VNACN episode**
- ED Visit per 1,000 episodes during VNACN episode
- Readmit rate during VNACN episode
- % of all HHA admits going to VNACN

**Quality – Atrius Health patients with VNACN episode**
- % of patients with falls risk assessment documented in EPIC
- % of patients with ACP form (MOLST, Adv Dir or HCP) documented in EPIC
- % of patients with depression screen documented in EPIC

**Patient Experience – All VNACN Medicare patients served**
- % of patients who gave Home Care Agency a rating of 9 or 10 (Home Care Compare)
- % of patients who reported that Home Care team discussed medicines, pain & home safety (Home Care Compare)
## Metrics: Key Atrius Health Initiatives with VNA Care Network and Hospice

<table>
<thead>
<tr>
<th>VNACN Measures: 2013 Results</th>
<th>PIONEER ACO</th>
<th>Med Adv</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>2011</td>
<td>Q1 2012</td>
</tr>
<tr>
<td><strong>1. Cost &amp; Utilization</strong></td>
<td></td>
<td></td>
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<tr>
<td>ED Visit per 1000 during Home Health episode</td>
<td>98.5</td>
<td>81.9</td>
</tr>
<tr>
<td>Readmit rate during Home Health episode</td>
<td>11.3%</td>
<td>11.0%</td>
</tr>
<tr>
<td>VNACN Episodes as % of Total Home Health Episodes</td>
<td>7.4%</td>
<td>11.3%</td>
</tr>
<tr>
<td><strong>2. Quality</strong></td>
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<tr>
<td>% of patients admitted to VNACN who have falls risk assessment scanned in EPIC within the episode</td>
<td>unk</td>
<td>unk</td>
</tr>
<tr>
<td>% of patients admitted to VNACN who have ACP form (MOLST, Adv Dir, or HCP) scanned in EPIC within the episode</td>
<td>unk</td>
<td>unk</td>
</tr>
<tr>
<td>% of patients admitted to VNACN who have depression screen and plan scanned in EPIC within the episode</td>
<td>unk</td>
<td>unk</td>
</tr>
<tr>
<td><strong>3. Patient Experience</strong></td>
<td></td>
<td></td>
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<tr>
<td>% of patients who gave VNA CN a rating of 9 or 10 (Home Care Compare).</td>
<td>87%</td>
<td>90%</td>
</tr>
<tr>
<td>% of patients who reported that VNA CN team discussed medicines, pain, and home safety (Home Care Compare)</td>
<td>85%</td>
<td>90%</td>
</tr>
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Future Directions and Challenges

Future Directions

- Expansion of integrated services beyond current payment models:
  - Episodes of care with bundle payments
  - Telehealth including integration with physician involvement
  - Primary care at home
  - Expansion of clinical pharmacy into the home
  - Hospital at home
- Full electronic integration of home related services with EMR
- Closer integration with ASAP’s
Future Directions and Challenges

Challenges

- Coordination of and communication between alternate universes
- Reduce restrictive Medicare payment and administrative regulations for ACO’s in Medicare risk arrangements
Questions?

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