New Models of Care and Approaches to Payment

Richard Lopez, MD

Chief Medical Officer

Richard_Lopez@AtriusHealth.org

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Atrius Health

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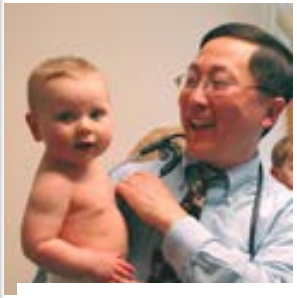
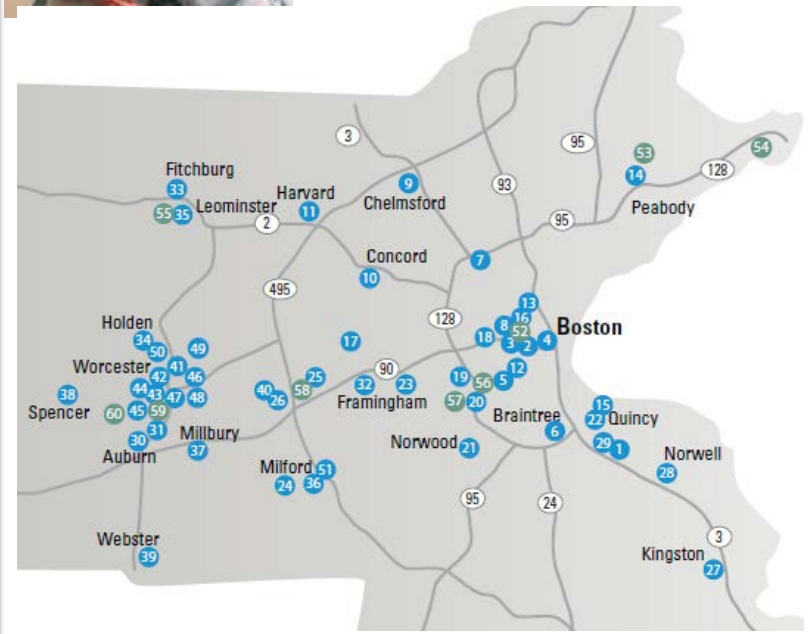
Non-profit alliance of six leading independent medical groups in Eastern Massachusetts and home health agency and hospice

- 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





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Atrius Health Core Competencies

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

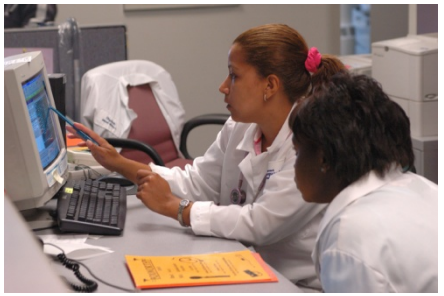
Widespread **Population Management** tools including disease-based & risk-based rosters

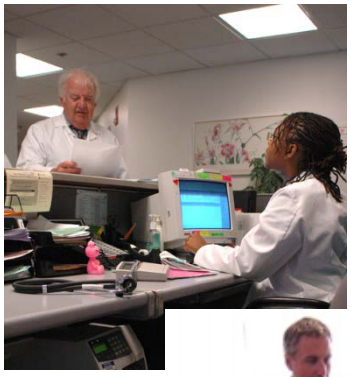
Long history with & majority of revenue under **Global Payment** across commercial & public payers

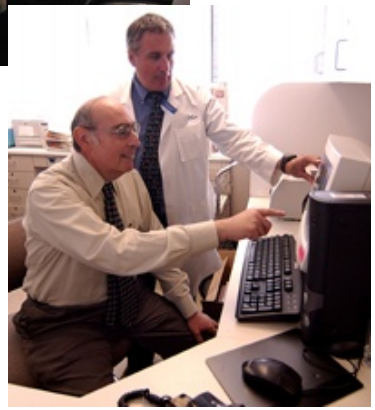
Sophisticated development & reporting of **Quality and Performance Measures**

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)







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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

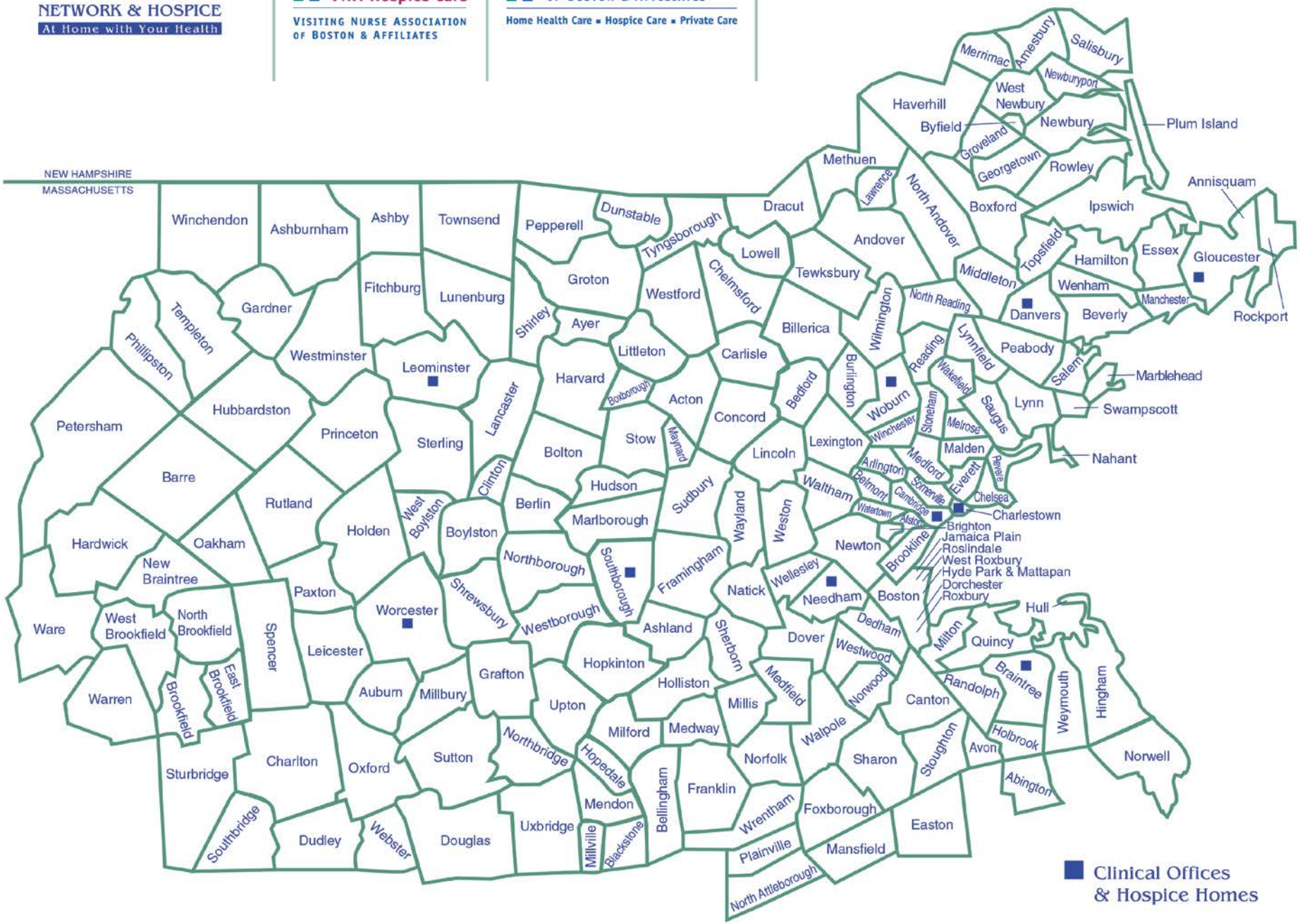
Co-owner of Home Staff a private duty agency serving much of the service area with nursing assistance, personal care, cleaning, household management, and errand services

VNACare
NETWORK & HOSPICE
At Home with Your Health

VNA Hospice Care
VISITING NURSE ASSOCIATION OF BOSTON & AFFILIATES

VISITING NURSE ASSOCIATION OF BOSTON & AFFILIATES
Home Health Care ▪ Hospice Care ▪ Private Care

Working together to redefine health care at home



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

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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

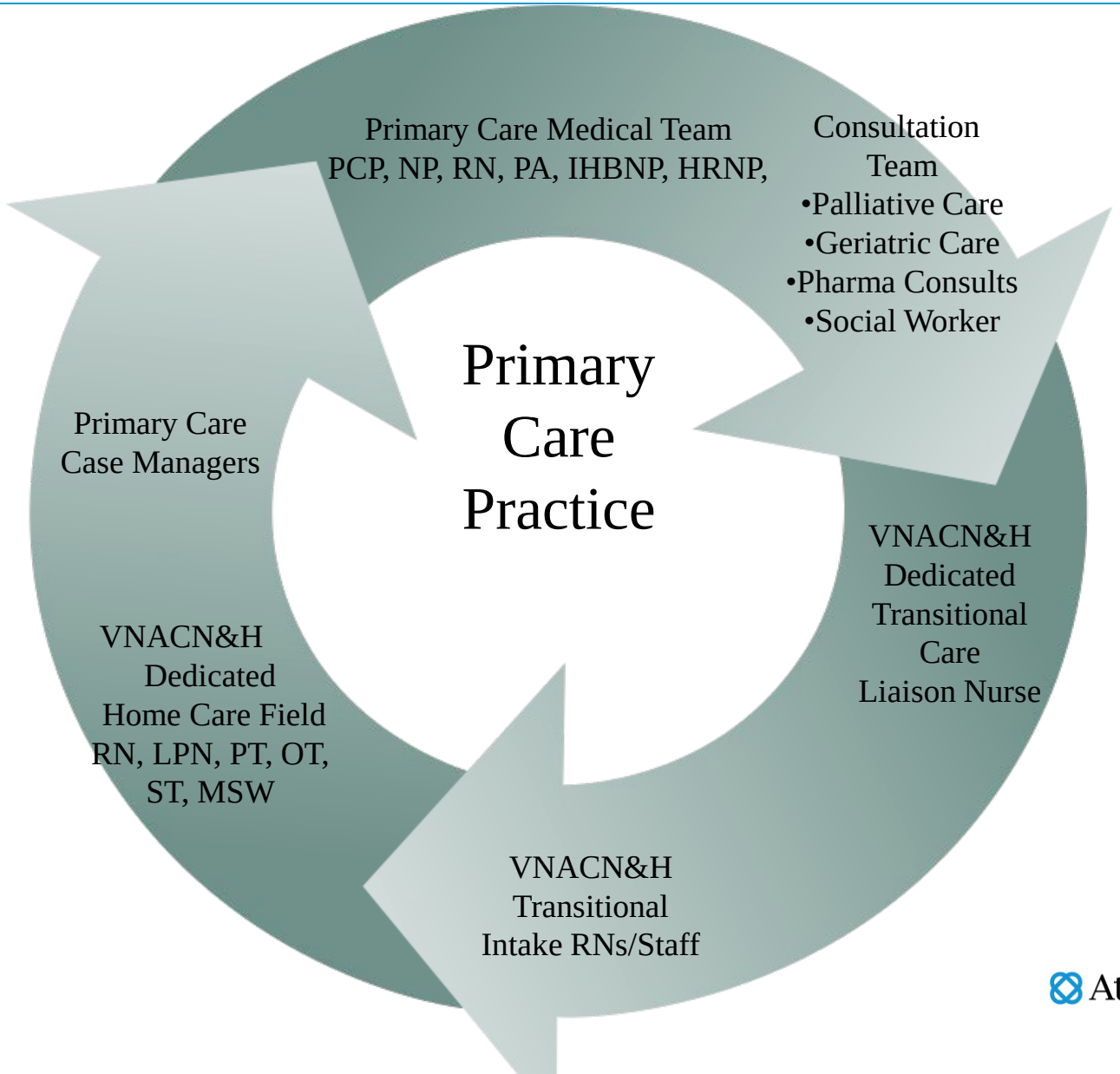
Team Work: Atrius Health Initiatives with VNA Care Network and Hospice

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



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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

Adopted common standards for High Risk Patient Roster Reviews	**Review and confirm accuracy of diagnosis**
	Review appropriateness of medications
	Perform a care needs assessment
	Create a clinical summary of the patient
	Perform a social assessment
	Review applicable diseases related quality measures
	Confirm existence and need for advance directives
	Update the patient's care plan and document next steps

Early adopters saw greater reductions in total medical expense – mostly from reduced hospital and SNF admits

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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

Criteria

- Missing Piece of the Puzzle
- Home Safety Concerns
- Unclear if patient meets "certification"
- Visit based on need, not coverage

Goal

- Care management, not medical management
- Clear expectations around the content of visit and follow up
  - Templated Visit
  - Standard Work
- Communication in Epic that informs the care plan
- Reasonable reimbursement

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

VNACN Measures: 2013 Results	PIONEER ACO					Med Adv
1. Cost & Utilization	**2011**	**Q1 2012**	**GOAL**	**NOV YTD 2013**		**NOV YTD 2013**
ED Visit per 1000 during Home Health episode	98.5	81.9	73.7	N.A. - data issue		87.40
Readmit rate during Home Health episode	11.3%	11.0%	<10%	9.4%		9.7%
VNACN Episodes as % of Total Home Health Episodes	7.4%	11.3%	25.0%	25.7%		53.1%
2. Quality	**2011**	**Q1 2012**	**GOAL**	**NOV YTD 2013**		**NOV YTD 2013**
% of patients admitted to VNACN who have falls risk assessment scanned in EPIC within the episode.	unk	unk	TBD	85.2%		50.5%
% of patients admitted to VNACN who have ACP form (MOLST, Adv Dir, or HCP) scanned in EPIC within the	unk	unk	TBD	17.6%		23.1%
% of patients admitted to VNACN who have depression screen and plan scanned in EPIC within the episode	unk	unk	TBD	84.8%		50.9%
3. Patient Experience	**2011**		**GOAL**	**Average 2013**		**Best Q 2013**
% of patients who gave VNA CN a rating of 9 or 10 (Home Care Compare). [5]	87%		90%	84%		85%
% of patients who reported that VNA CN team discussed medicines, pain, and home safety (Home Care Compare) [5]	85%		90%	90%		93%

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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?

Richard Lopez, MD
Chief Medical Officer
Atrius Health
richard_lopez@atriushealth.org