Accountable Care is Transformative: Atrius Health and the ACO Journey

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Objectives

• Recognize factors that contribute to success as an ACO before and during organizational transformation
• Explore how diverse strategies can align to boost success across multiple service lines leading to greater improvements in quality and savings in an accountable care model.
• Understand how payment incentives can contribute to population health
• Role of Preventive Medicine in an ACO
Accountable Care Organizations - ACOs

• Groups of doctors, hospitals, and other health care providers coming together to coordinate care
• High quality care provided in the right place, at the right time
• Avoid duplication and waste, improve safety
Another way to think about ACOs

ACO  PCMH
Why Participate in Pioneer ACO? “Reason for Action”

High quality, high-value care for all Medicare-eligible patients across the care continuum with spillover for commercial risk

Unique opportunity to be accountable for quality and costs for a PPO population

Further Atrius Health position as a market leader in payment reform, moving towards 100% global payment

Achieving Triple Aim Goals
Key ACO Initiatives

Geriatric Care Model
- Patient Risk Stratification
- High Risk Roster Reviews
- Advance Care Planning
- Chronic Disease Management
- Home-based Primary Care

Care Management Strategy
- Leverage home health partner (VNACN)
- Integrate Local Elder Services Agencies
- Launch programs for Dual-eligibles
- Support Preferred Hospital strategy

Post-Acute Strategy
- Preferred SNF Network
- SNF Service Standards/provider expectations
- SNF Provider Expectations
- Preferred ambulance strategy

Data Analytics & Reporting
- Support Workgroup Initiatives
- Monitor Results

Electronic Health Record and Health Information Exchange
- Tools to Support ACO Initiatives & Workflows

Quality & Safety
- ACO Quality Metric Reporting and Improvement
Geriatric Care Model: Geriatric Checklist

For each....

- Review current state, best practices
- Design Intervention or choose an assessment tool, develop workflows
- Develop EMR tools and trackers
- Set target, measure and track performance

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Care Management Strategy: Collaboration with VNA Care Network

Developed Standard Work for referrals to and communication within VNACNH during episode.

Care plan transmitted to EPIC within 48 hours of admission, including:

- Follow up appointment with PCP within 7 days of hospital discharge
- Collection of ACO quality metrics
  * Fall risk assessment
  * Medication review
  * Depression screen (PHQ2)
  * ACP Documentation (in development)
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
- History of positive relationship
- Geographic needs
- Good metrics*

*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

\[ \downarrow 2.0 \text{ LOS} = $2M \]
\[ \downarrow 2\% \text{ Readmit Rate} = $.5M \]
The root of the problem in health care is that the business models of almost all US health care organizations depend on keeping these aims separate. Society on the other hand needs these three aims optimized...simultaneously. - Tom Nolan, PhD., IHI
Pioneer Financial Performance

Year over Year Improvement

2012 (PY1) = 1% loss, in the noise
- Atrius Health expenditure $10,700 vs.
- Massachusetts Pioneer Expenditure $12,000+

2013 (PY2) = 1% savings, in the noise
- $3M saved for Medicare

2014 (PY3) = 1.4% savings, above the noise
- $4.5M saved for Medicare
- $2.8M share to Atrius Health 2014 groups
#1 ACO in New England; #2 Pioneer Nationally

2014: Still highest Quality, Lowest Cost Pioneer in Massachusetts

Pioneer ACOs saved $384M over two years
  - Atrius Health saved $36M compared to near market

Ten of 32 Original Pioneers had statistically significant savings in both years
  - Atrius Health was one of the ten
  - Atrius Health noted as one of three Pioneers accounting for 70% of savings in 2013
What’s next?

• Increasing focus on transitions of care
• Bringing more care into the home
• Advancing our integration with VNA
• Expansion of Palliative Care
ACO Evolution to Population Health

• Evolve the processes we have developed for the Medicare Population (ACO) to improve care, reduce cost for any patient population.

• Leverage the integrated Atrius Health structure for greater impact: Removing organizational silos, realign similar services based on best practices, create uniform standards of care, reduce geographical gaps in patient coverage.

• Serve as the organizational vessel for Shared Clinical Services in an integrated Atrius Health.

• Provide affordable, highest quality care that meets our patients needs, delights them with our service, and creates an excellent work environment.
Role of the Preventive Medicine Clinician

- Wider understanding of drivers of change
  - Communities
  - Determinants of health
- Connecting population care to clinical care
  - Population health is a new skill for most clinicians
- Skill in measurement tools, process tools invaluable for your organization
Discussion and Questions