Medicare ACO as a Platform for Population Health

Mass Health Data Consortium
September 30, 2015

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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)
Accountable Care = Population Management

- What is the target population?
  - How is the cohort defined?
  - How is accountability defined?
- What population outcomes do we want & how are they measured?
  - What conceptual framework links potential care processes to target outcomes?
  - What are the overall key indicators? What are interim process/operational indicators?
- How do we support the key processes required to achieve outcomes?
  - Which of these processes are most effective, efficient, and patient centered?
  - What infrastructure is required to ensure reliable frontline process execution?
Atrius Health

The Northeast’s largest nonprofit independent multi-specialty medical group. A national leader in delivering high-quality, patient-centered coordinated care.

Dedham Medical Associates
Granite Medical Group
Harvard Vanguard Medical Associates
VNA Care Network

Providing care for ~ 675,000 adult and pediatric patients with 750 physicians across more than 35 specialties
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
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

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ACO = Medicare Population Health Strategy

Approximately 52,000 Medicare Beneficiaries in
• Outcomes-Based Contracts with
• Triple-Aim Accountability

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**Outputs:** Population Health Initiatives

**Inputs:** Quality Measurement and Improvement, Data Analytics, Medical Management, Clinical Champions, Internal Best Practices, External Peer Accomplishments
Medicare Population Health Approach

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

» Local Implementation – Practices at different starting points.
» Central support to reach goals, manage CMS relationship and obligations.
Focus One: High Risk Patients, High Cost Events

- Advance Care Planning
- High Risk Roster Review
- Care Transitions
- Post Acute Episode Mgmt
- CKD Management
- Community Support and Duals plans

Advanced Illness Management - Top 2%
High Risk Poly-Chronic - Another 3%
Chronic Care, Rising Risk - Next 15%
Risk Prevention and Reduction - Remaining 80%
Focus Two: Health Risk Prevention

- Falls Risk/Fractures
- Depression Screening
- Med Reconciliation
Keep Working the Medicare Population Pyramid

2015 Focus:

- New Custodial Nursing Home program
- Expanded Palliative Care/Hospice
- Redesigned Care Transitions
- COPD/CHF standards
- Expanded home tele-monitoring
- New ACO Quality Measures
Population Management:

IDENTIFICATION AND MANAGEMENT OF HIGH RISK PATIENTS
Using both claims and Electronic Health Records databases, the tool allows to identify members at risk of hospitalization, poor health outcomes, high costs.

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<thead>
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<th>Factor</th>
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<td>DxCG Likelihood of Hospitalization Score</td>
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<td>(Model 71)</td>
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<td>Hospital Admissions or ED Visits</td>
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<td>Behavioral Health (Psychiatric, Substance</td>
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<td>Abuse, Dementia)</td>
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<td>Maximum Score</td>
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Proportions of High Cost (Atrius Health ACO) Patients & attributable to them Costs (Aug 2012)

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High Risk Patient Roster Review

Confirm diagnoses
Review medications
Address quality measures

Social assessment
Care needs assessment

Advance directives
Palliative care discussion

Care plan documentation & orders

PCP-Led Team
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
- Population Manager
- Care Manager
- Geriatric Champion or Palliative Care Specialist
- Social Worker
- VNA representative
- Clinical Pharmacist
Proof of Concept: Medical Group Pilot

- 5 hours medical management time/FTE/week
- Care Manager on site
- Roster Reviews
- Also expanded population managers role
- Bonus payments for exceptional performance
  - Quality
  - Utilization
  - Access

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Advance Care Planning Initiatives

Description:
- Developed advance care planning (ACP) curriculum with CME/CEU credits.
- Established site-based ACP champions to train and provide ongoing ACP support locally.
- Developed new tools in Epic to track and document advance care planning.

Expected Outcomes:
- Improve PCP knowledge and comfort with ACP.
- Increase end of life conversations and collection of patient’s care wishes, advance directives and proxy information.
- Minimize use of aggressive curative care when not aligned with patient’s care wishes.
Advance Care Planning: Results

Number of Advanced Care Planning Document Scanned in Epic

Number of Documents


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### CKD: Clinical Guidelines

#### Atrius Health CKD Guidelines for Primary Care

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<tr>
<th>Stage (eGFR)</th>
<th>Albuminuria? (≥30mg/g)</th>
<th>Serum eGFR and Urine Microalbumin</th>
<th>Hgb, 25-OH Vit D, Phos, PTH, Lipids, Ca Electrolytes</th>
<th>Initial Renal Ultrasound</th>
<th>Nephrology Consult</th>
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<td>Stage 3a (45-59)</td>
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* Might require more frequent monitoring if abnormal and/or if undergoing changing treatment strategies


Approved by the Atrius Health Accountable Care Organization's Geriatric Care Model CKD Workgroup, which includes the Harvard Vanguard Chief of Nephrology; February 2013

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## CKD Dashboard/Roster

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<th>EPIC CKD Diag in 12m</th>
<th>On Problem List</th>
<th>Last BP &lt;140/80</th>
<th>Last LDL&lt;100</th>
<th>Diab + Last A1C&lt;7</th>
<th>Stage 3b or 4 w/ Neph Referral</th>
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<th>Calcium</th>
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### Primary Care Dashboard: Merge of EPIC and Claims Data
- Lab Result Based Total CKD Population
- Laboratory Screening (Ca, Phos, CBC, UA, Vit D, PTH)
- Clinical Outcomes (BP, LDL, HgA1c)
- Referral to Nephrologist Specialist
- Visit to Nephrologist
CKD: Impact

Patients w/EGFR<60

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Population Management:
CLOSE MANAGEMENT OF HIGH COST EVENTS
Variation in 2010 Medicare Average Length of Stay for Skilled Nursing Facilities

Difference Between Top & Bottom Quartile
10 Days = $4,000

Source: Adapted from Office of HHS Inspector General December 2010.
Variation in 2009 Risk Adjusted Readmission Rates from Skilled Nursing Facilities


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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

Good metrics*

History of positive relationship

Geographic needs

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

- Facility-level expectations
- Provider-level expectations
- Discharge workflow
- EHR documentation
- Monitoring & reporting
- Use of preferred discharge providers

\[\downarrow 2.0 \text{ LOS} = $2M\]
\[\downarrow 2\% \text{ Readmit Rate} = $.5M\]
Still Lots of Opportunity
Population Management:

HEALTH RISK PREVENTION
Patient Care Checklist

For each....

- Review current state, best practices
- Choose an assessment tool, develop workflows
- Develop EMR tools and trackers
- Set target
- Measure and track performance
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

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Average Quality Score For Each Pioneer Performance Year 1 vs. Performance Year 2

2014: #1 in MA; #3 Nationally

*Left the Pioneer Program After Performance Year 1

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
# Keys to Success

## Leadership and Facilitation
- Create the data-based hypothesis
- Identify evidence-based best practice
- Develop standards & tools to close gaps
- Measure and track outcomes
  - Fidelity to Process

## Core Competencies
- Small team with operational credibility
- Diverse clinical expertise
- Share resources clustered together (no silos)
- Home for shared values
- Exploratory mindset
- Laser focus on triple aim
Getting To The ACO Tipping Point: What Else Might Be Needed?
Madeleine Phipps-Taylor
June 3, 2015

"Population health management, whether you call it an ACO or an IPA, is a business strategy, not an experiment or demonstration."

"…with more data becoming available faster, clinical behavior can change relatively rapidly. This phenomenon is quite apparent when physicians review their own performance…compared with their peers."
Population Health Strategy: Population Agnostic

- 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
Choosing Populations of Focus

- From the Practice Team – what we are struggling with, on the ground
- From Leadership – goals we are not reaching
- High cost services requiring shared resources
- Pervasive challenge benefiting from a common approach