Integrating Care: Partnerships between Community-Based Organizations and Accountable Care Organizations

September 28, 2012

Agenda

- Housekeeping/Introductions
- Overview of Accountable Care Organizations (ACOs)
- Spotlight on a partnership between a Pioneer ACO and community-based organizations
- Questions/Comments

Presenters

- Daniel Farmer, Center for Medicare and Medicaid Innovation, Centers for Medicare and Medicaid Services
- Emily DuHamel Brower, Executive Director, Accountable Care Programs, Atrius Health
- Amy MacNulty, Project Director, Community Care Linkages, Mass Home Care

Accountable Care Organizations

What is an ACO?

- A legal entity recognized and authorized under state law
- Groups of health care providers and suppliers who come together voluntarily to give coordinated high quality care to their Medicare patients

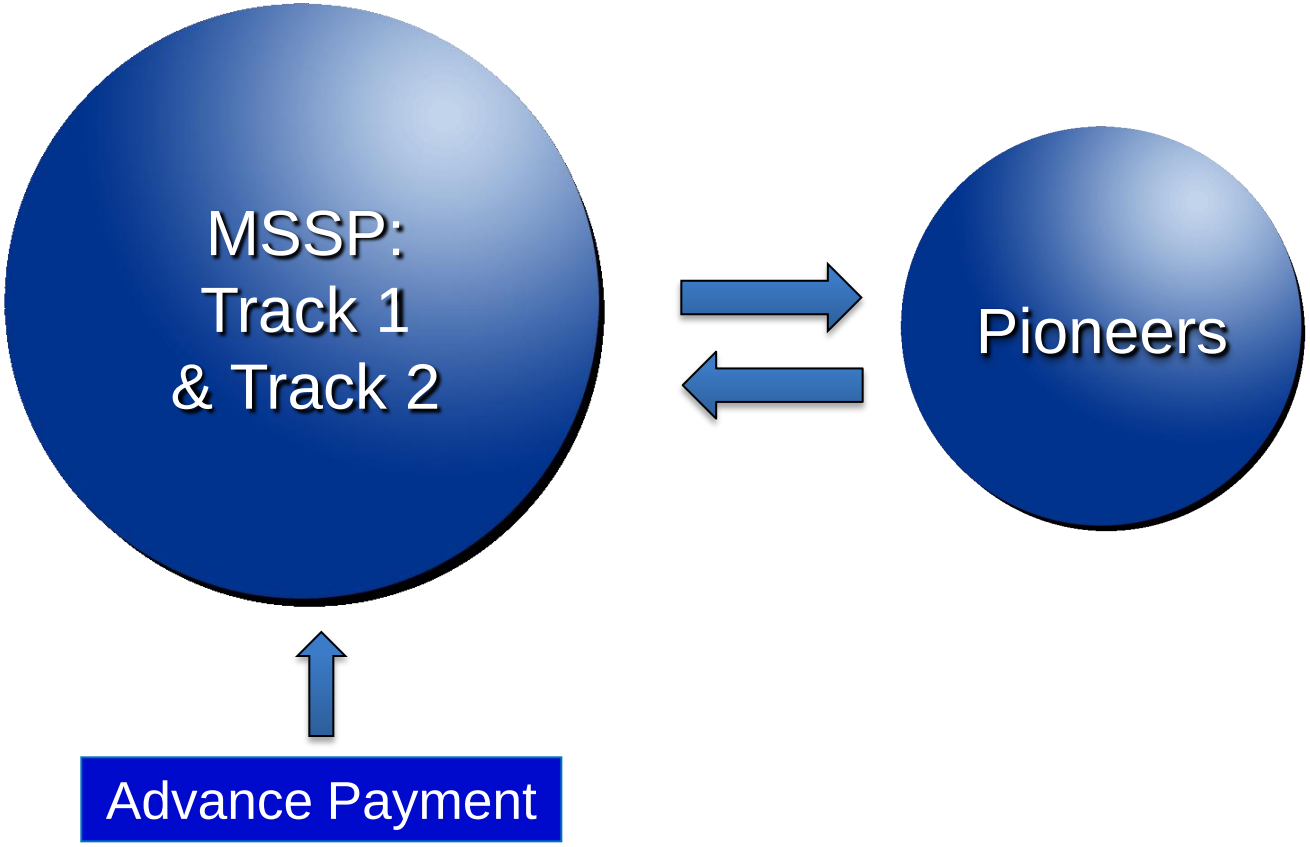
ACO Vision

- An ACO promotes seamless coordinated care
  - Puts the beneficiary and family at the center
  - Remembers patients over time and place
  - Attends carefully to care transitions
  - Manages resources carefully and respectfully
  - Proactively manages the beneficiary's care
  - Evaluates data to improve care and patient outcomes
  - Innovates around better health, better care and lower growth in costs through improvement
  - Invests in team-based care and workforce

Accountable Care Organizations

- Medicare Shared Savings Program, or MSSP (Center for Medicare)
- Pioneer ACO Model
- Advance Payment Model
- Physician Group Practice Transition Demonstration

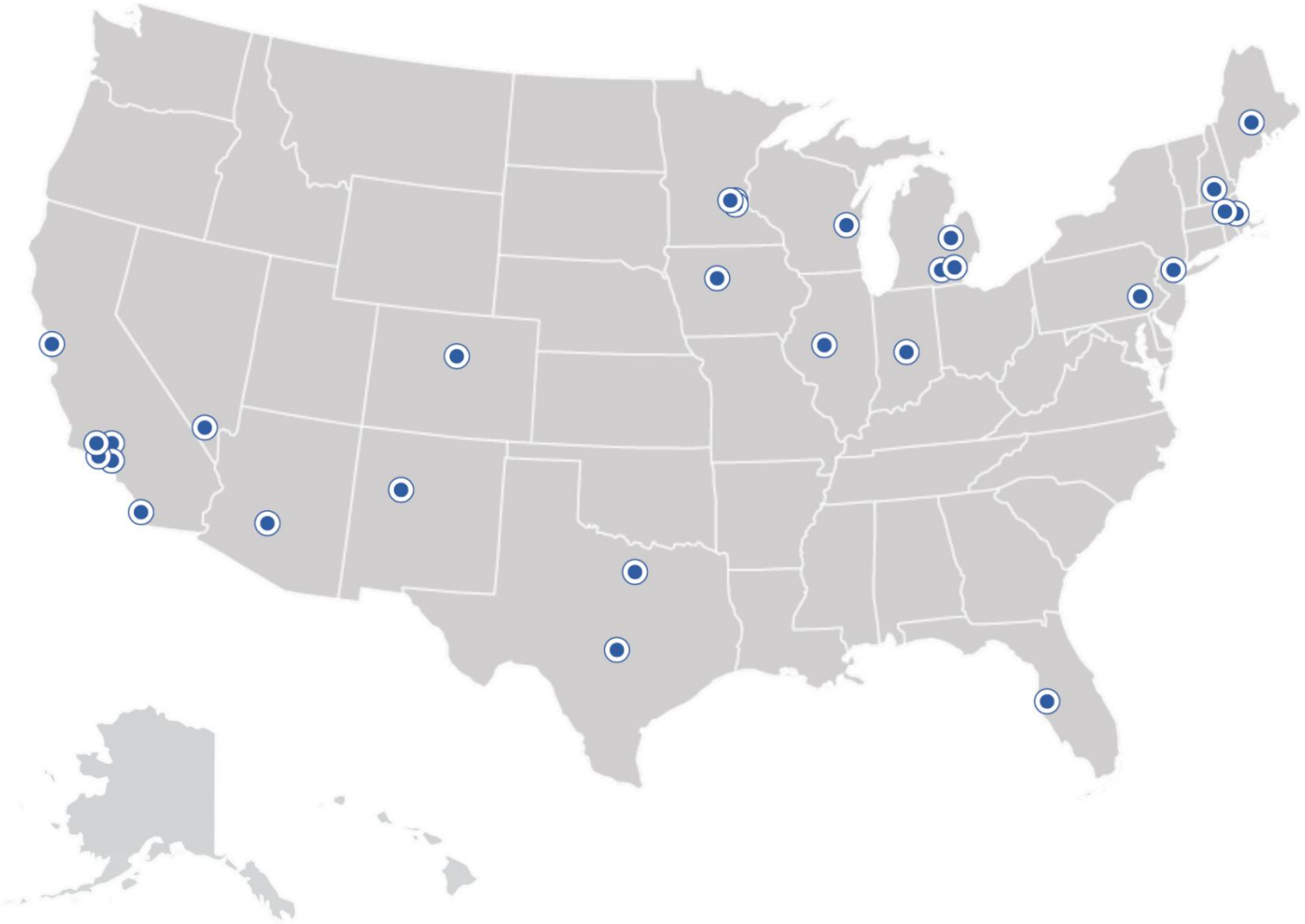
Accountable Care Organizations



Accountable Care Organizations

- **153 ACOs**
  - 115 Medicare Shared Savings Program ACOs
    - 20 also participating in the Advance Payment Model
  - 32 Pioneer ACOs
  - 6 Physician Group Practices
- **Over 2.4 million beneficiaries** receiving care from ACO providers

The Pioneer ACO Model



The Pioneer ACO Model

- Designed for organizations with experience
  - offering coordinated, patient-centered care
  - operating in ACO-like arrangements
- Years 1 and 2: Pioneer Model tests a shared savings and shared losses payment arrangement
- Year 3: Pioneer ACOs that have shown savings over the first two years will be eligible to move to a population-based payment model
- 32 Pioneer ACOs

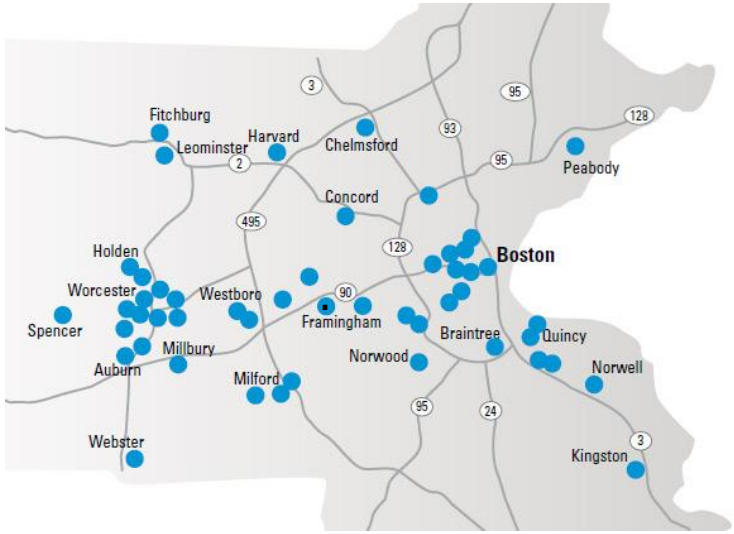
Atrius Health: ACO and the Area Agencies on Aging (AAAs) in Massachusetts

What We'll Cover

- Atrius Health background
- Our ACO strategy for home-based care
- MA AAA (ASAP – Aging Services Access Point) strategy ⇨ alignment!
- Atrius Health-ASAP pilots in progress
- Plans for measurement and spread
- Questions

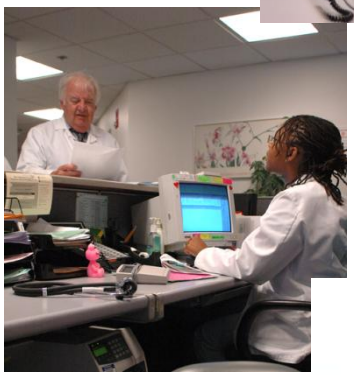
Atrius Health

- Non-profit alliance of six leading independent medical groups
  - Granite Medical
  - Dedham Medical Associates
  - Harvard Vanguard Medical Associates
  - Reliant Medical Group
  - Southboro Medical Group
  - South Shore Medical Center
- Providing care for ~ 1,000,000 adult and pediatric patients with 1000 physicians, 1450 other healthcare professionals across 35 specialties



Atrius Health

- 100% on an electronic medical record combined with corporate data warehouse, used for managing quality and cost.
- Long history with global payments: greater than 50% of patients under global risk across Commercial, Medicare and Medicaid
- Widespread use of rosters in population management
- Track record of quality measurement and reporting
- Over 30 National Committee for Quality Assurance (NCQA) certified Level 3 Patient-Centered Medical Homes



Why Pioneer? "Reason for Action"

- Participating in the Pioneer ACO will help Atrius Health **achieve high-quality, high-value care for all Medicare-eligible patients across the care continuum.**
- Successful implementation for Medicare-eligibles will **improve performance for commercial risk patients with similar clinical needs.**
- Access to full claims data set for Pioneer population offers true **opportunity to be accountable for quality and cost across the continuum.**
- Contracting for Medicare Fee for Service patients under a global budget through Pioneer ACO **maintains our position as a market leader in payment reform, moving towards 100% global payment.**

The Time Has Come

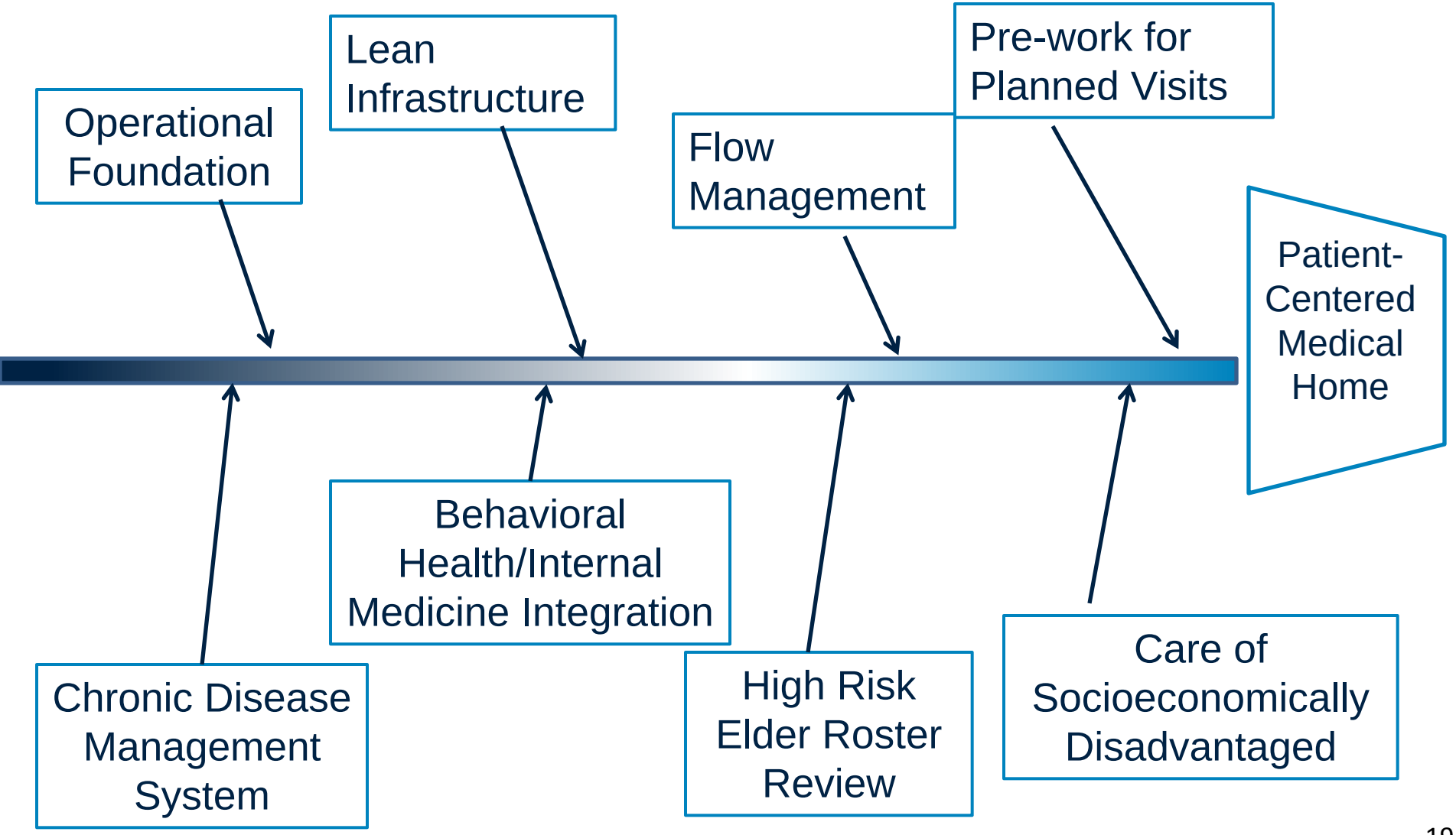
"The existing deficiencies in health care cannot be corrected simply by supplying more personnel, more facilities and more money. These problems can only be solved by organizing the personnel, facilities and financing into a conceptual framework and operating system that will provide optimally for the health needs of the population."

Dr. Robert Ebert
Founder, Harvard Community Health Plan
1969

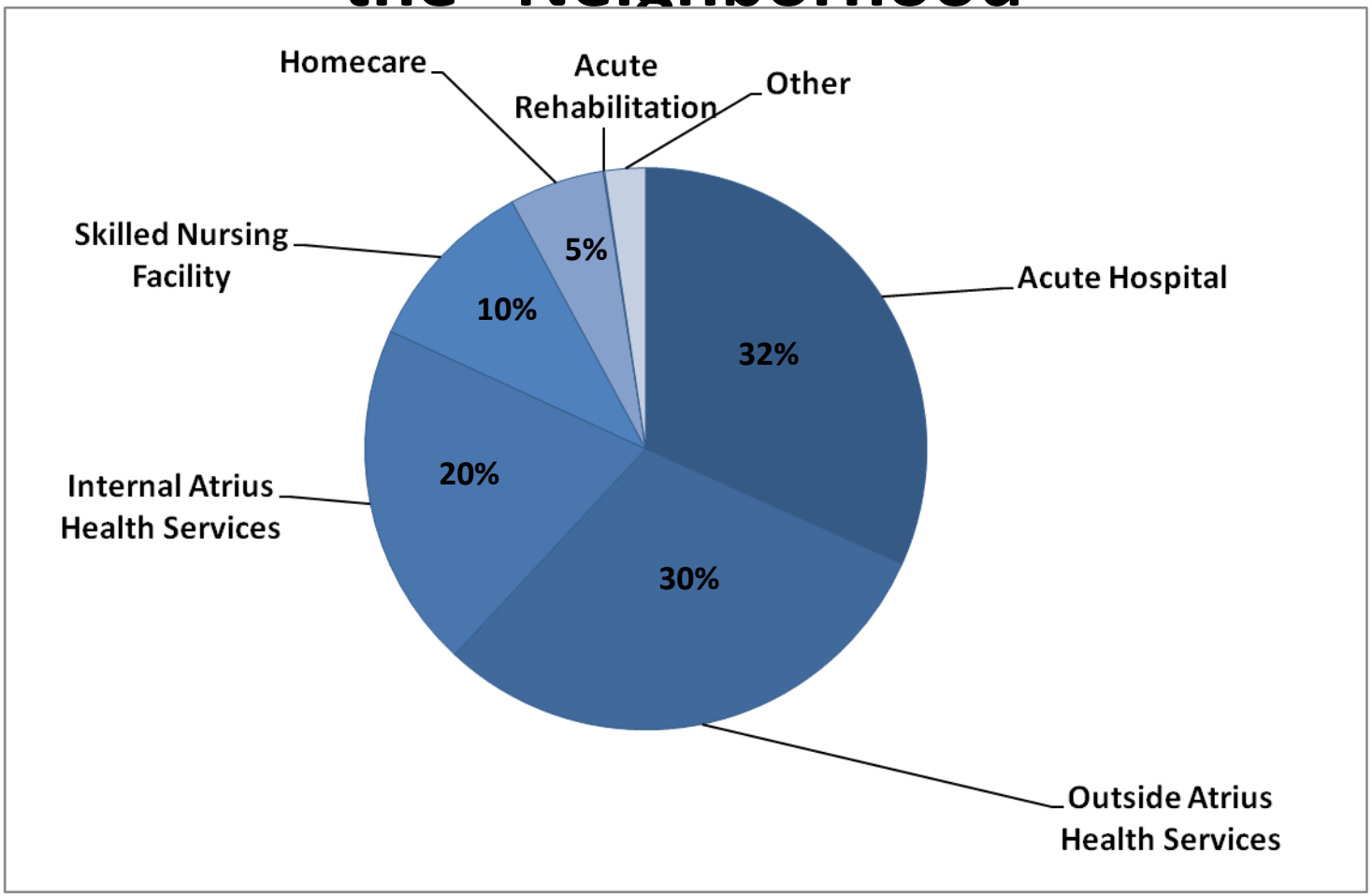
ACO Home-Based Strategy

- To successfully deliver ACO future state, **Atrius Health must engage and align post-acute facilities and providers at a strategic level to manage to the triple aim ACO future state.**
- **We are accountable for managing care, cost and quality of Medicare services in the home setting.** The costs are substantial across dozens of post-acute providers. Pioneer patients have choice and are widely distributed. There is no common standard work/model of care for home-based care across Atrius Health; there are no expectations for home-based providers nor routine measurements to assess their performance.
- **Transitions of care are chaotic and stressful for patients**. Poor transitions result in unnecessary readmissions and other wasteful costs, harm, and errors.
- **We believe that ASAPs/Elder Services, while not currently delivering Medicare benefits, can be an important resource for home-based care and community connections that will support Medicare beneficiaries.**

Improving the Patient-Centered Medical Home



Achieving Reduced Cost requires work in the "Neighborhood"



Atrius Health: Medicare Advantage Expenses

Community Care Linkages

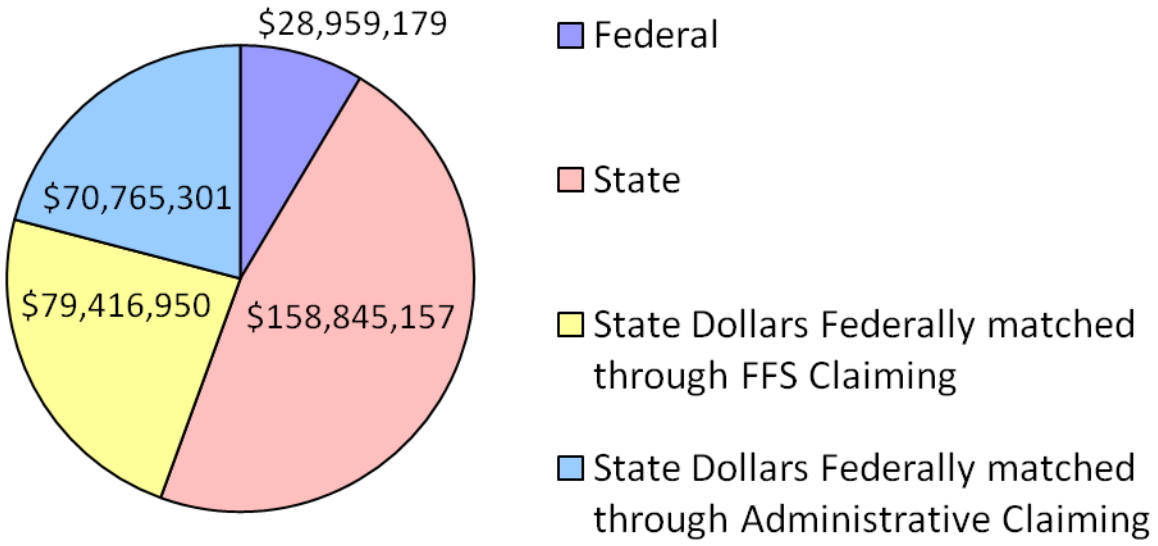
- Community Care Linkages is a strategic initiative to effectively integrate services of the Massachusetts *Aging Services Access Points (ASAPs)* into the evolving healthcare delivery system.
  - 27 Not-for-Profit Organizations
  - A 35 year old statewide network linking community resources to individuals and their families
  - Managing 60,000+ covered lives annually in home care programs (~$340m of services across MA)
  - Bring value to evolving community based health care systems.
    - Amy MacNulty, Project Director, Community Care Linkages
    - http:www.communitycarelinkages.org;
    - http://ww.masshomecare.org

Community Care *Linkages* SM
A Division of Mass Home Care

FY11 ASAP Spending ~$340m

2011 People Served Statewide	
55,800	Clinical Assessment & Evaluation
66,200	Home Care/Respite Care, Enhanced Community Options & care management (CM), Community Choices & CM
18,282	Protective Services reports

Total Program Dollars Administered by ASAPs in MA



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

Achieve triple aim objectives by linking primary care practices to community care management services

- 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

Center for Medicare & Medicaid INNOVATION

Getting to:

Community Integrated Health Care System 3.0

- High quality acute care
- Accountable care systems
- Shared financial risk
- Case management and preventive care systems
- Population-based quality and cost performance
- Population-based health outcomes
- Care system integration with community health resources

Community-based Care Transitions Program (CCTP)

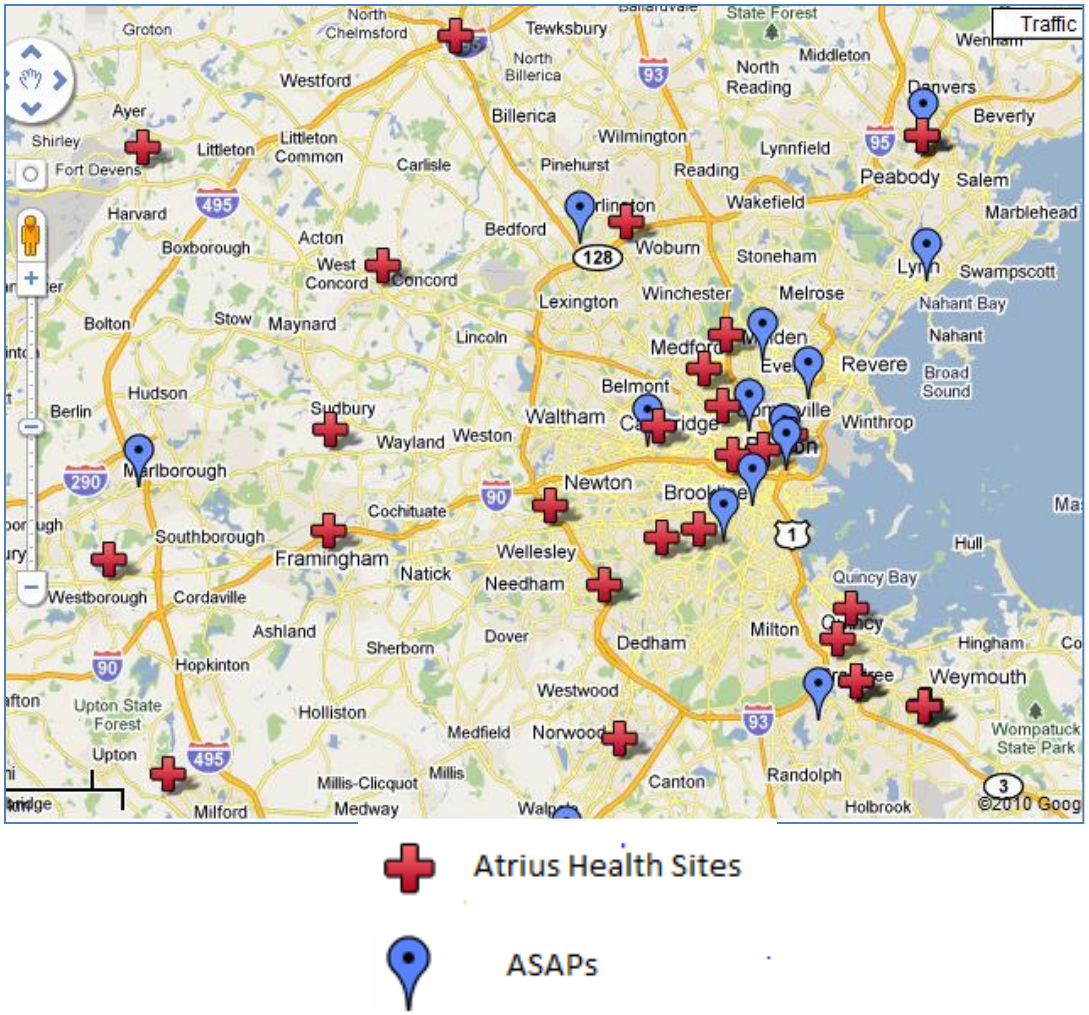
47 partners announced in three rounds, 4 in Massachusetts

1. **Elder Services of Berkshire County**
   - Berkshire Medical Center and the Berkshire Visiting Nurse Association
2. **Elder Services of Worcester & BayPath Elder Services**
   - MetroWest Medical Center; St. Vincent Hospital; UMass Memorial Medical Center; Wing Memorial Hospital; Marlborough Hospital; Clinton Hospital, and HealthAlliance Hospital
3. **Somerville-Cambridge Elder Services & Mystic Valley Elder Services**
   - Cambridge Health Alliance and Hallmark Health System
4. **Merrimack Valley of Massachusetts and Southern New Hampshire Elder Services**
   - Anna Jacques Hospital, Saints Medical Center, Holy Family Hospital, Lawrence General Hospital, and Merrimack Valley Hospital

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



1. Chelmsford & Elder Services of Merrimack Valley
2. Peabody & North Shore Elder Services
3. Southboro & Baypath
4. West Roxbury & Ethos
5. Watertown/Wellesley & Springwell

Practice-based Pilot #1

- Referral to Care Coordinator via fax or phone.
- Care Coordinator will go visit patient where the patient is: Extended Care Facility (ECF), Hospital, Rehab or home.
- Care Coordinator will do overall assessment of patient along with specific requests.
- Care Coordinator will phone and fax (eventually email) follow up report to appropriate person.

Standard Work Process

Referral from practice's Medical Social Worker (MSW)

MSW screens referral and documents information in Med Chart (EPIC)

If there is no need to refer to the ASAP, the referral stays with MSW @ Practice.

If there is a need for ASAP assistance, written referral faxed to ASAP Med Care Coordination Specialist (MCCS)

MCCS does Assessment and Care Plan & emails both to MSW

Throughout entire process MSW documents & transfers info. to EPIC @ cc's encounters to doctor, original referral source & other appropriate parties

MSW prepares agenda & identifies patients to be reviewed @ bi-weekly multi-disciplinary meetings. Items include discussion of follow-up w/activities identified on Care Plan

Team determines need for ongoing intervention

Care Plan Goals were met

Continue to **work** on Care Plan Goals - reviewing at team meetings as needed

Practice-based Pilot #2

- Practice referral to ASAP with brief description of patient/needs
- Referral form completed and faxed along with the problem list, medication list and the latest office visit
- ASAP contacts the patient and arrange an intake interview, updating practice on barriers and services recommended
- ASAP provides services, closes the loop with practice via phone call
- Practice documents care coordination note and routes to Primary Care Physician pool. Epic flag notes patient receiving care from ASAP.

Population-Based Intervention: Falls Risk Assessment (FRA)

- Identify population appropriate for home-based FRA
- Develop standard work for non-medical ASAP intervention (population based, rather than practice or ASAP dependent)
- Develop data capture in EPIC to meet Pioneer quality measure

Evaluation and Spread

Process Measures

- Referrals to ASAP
- Services requested/provided by ASAP
- ASAP services in care plan

Utilization/Cost Measures

- Patient utilization
  - Emergency Department (ED) visits
  - Hospital/Rehospitalization

Quality Measures

- FRA and intervention
- Patient Experience

Questions?

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Resources: *ACOs*

- http://www.cms.gov/aco (CMS resource on ACOs)
  - http://innovations.cms.gov/initiatives/ACO/Pioneer/ (CMS resource on the Pioneer ACO model)

- http://www.medicare.gov/acos.html (CMS resource on ACOs for Medicare beneficiaries)

Resources: *Affordable Care Act*

- http://www.aoa.gov/Aging_Statistics/Health_care_reform.aspx (ACL's Health Reform web page – where webinar recordings, transcripts and slides are stored)
- http://www.healthcare.gov/news/factsheets/2010/11/affordable-care-act-americans-disabilities.html (Fact sheet on the Affordable Care Act for Americans with Disabilities)
- http://www.healthcare.gov (Department of Health and Human Services' health care reform web site)
- http://www.thomas.gov/ (Affordable Care Act text and related information)
- http://www.healthcare.gov/blog/2012/04/disability041812.html (Disability, Disparities and the Health Care Law)

Next Training

- Topic *(tentative):* Health homes
  - Late October; watch your email in early-mid month for registration information

Questions/Comments/Stories/ Suggestions for Future Webinar Topics?

Send them to:

AffordableCareAct@aoa.hhs.gov