Rethinking Post-Acute Care Under ACOs and Bundled Payments

Mary Ann O'Connor, President & CEO
VNA Care Network Foundation and Affiliates
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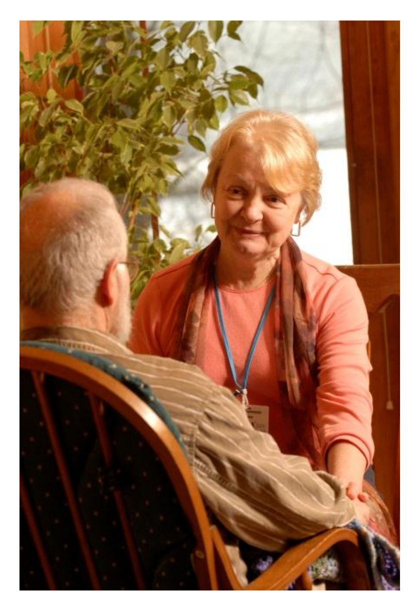
Atrius Health

Seven leading community-based groups have joined together as Atrius Health, a non-profit alliance, to transform the delivery of health care in eastern and central Massachusetts. Building on our long and proud history of high quality care

- Granite Medical
- Dedham Medical Associates
- Harvard Vanguard Medical Associates
- Reliant Medical Group
- Southboro Medical Group
- South Shore Medical Center
- VNA Care Network & Hospice Foundation

Atrius Health medical groups serve more than 1 million adult and pediatric patients in over 3.5 million visits annually to 50 practice locations. Our medical groups include more than 1,000 physicians and 2,100 other medical professionals, with a combined total of almost 8,200 employees

Integration of Best Practice with PC Practice



Best Practice → Improved Outcomes

Community Support ID
Health Literacy
Risk Stratification
Patient Engagement

Front Loading (60% within 3 wks)
Medical Reconciliation/Review
(within 48hrs/documented in EMR)
Personal Health Record

MD Follow up
Appointment
(5 – 7 days)

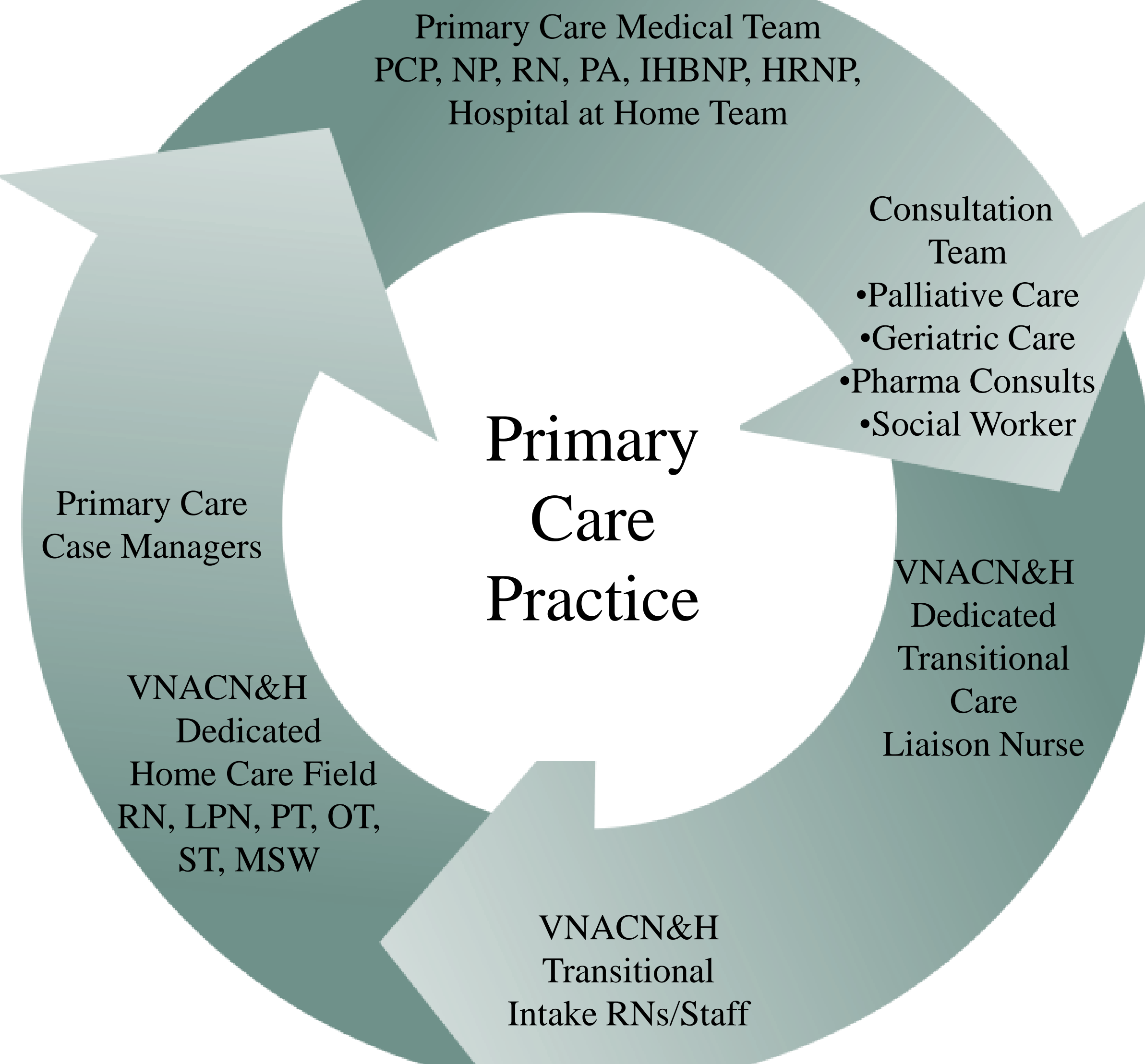
Exacerbation of
Condition
Telehealth

Falls Risk Assessment/
Intervention–Sure Steps

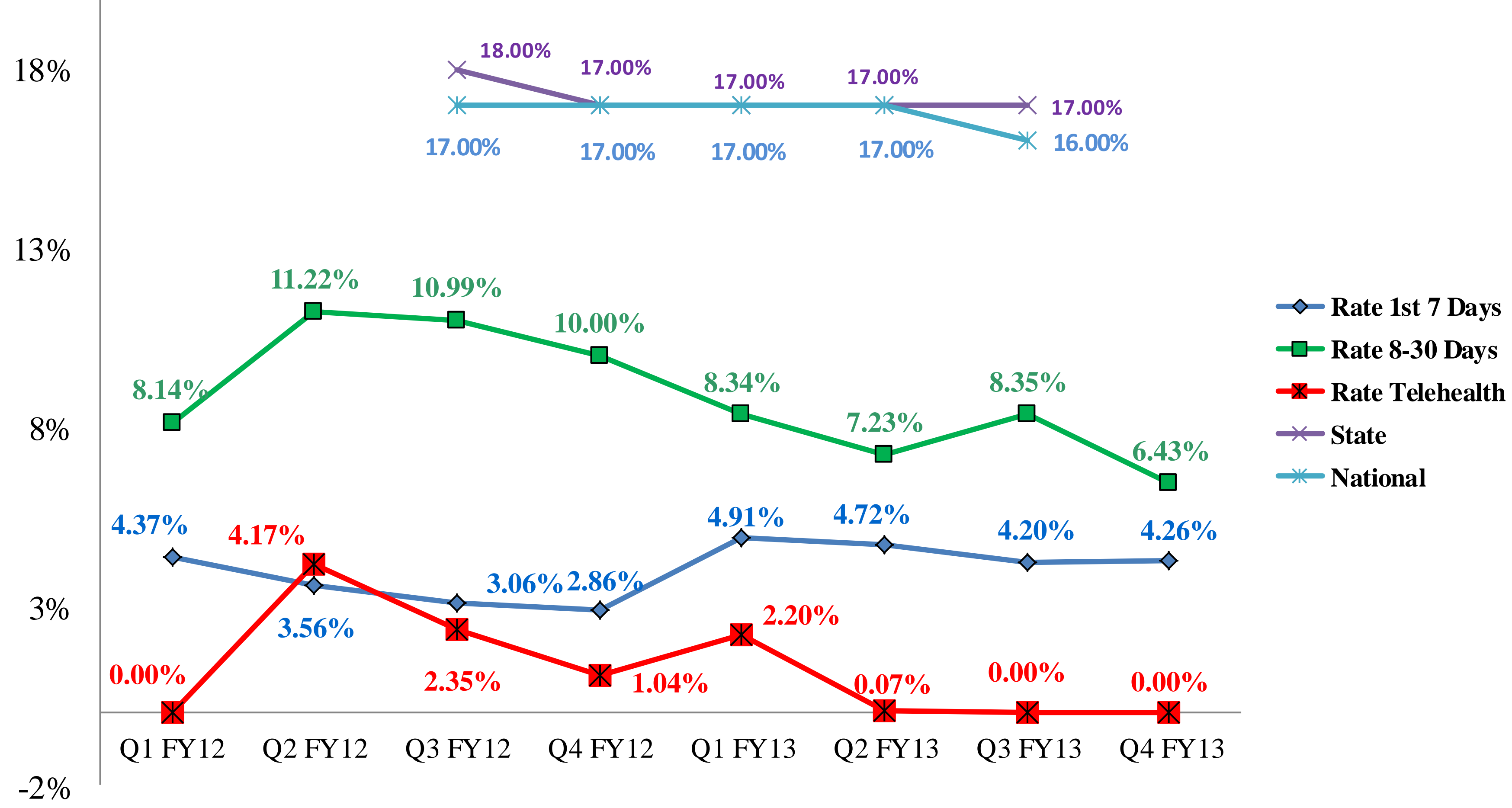
Immunization
Advance Care
Planning

Behavioral Health
Telephonic
Follow up

INTEGRATION MODEL



VNA Care Network & Hospice – Atrius Metrics Rehospitalization Rate



***Note**:

- Rehospitalizations are calculated by dividing # patients admitted to Hospital by total Medicare patients served whether or not they originally came from a hospital
- Rehospitalizations do not include hospice patients

- VNA Care Network rehospitalization rate was 29% in December 2011
- State & National Average unavailable for Q4 FY13
- Rate for Telehealth is measuring admissions for the first 30 days

“Most Promising Innovations”

- Best Practice Redesign
- Advanced Urgent Care
- Advanced Telehealth
- Clinically Home– acute care admissions in the home setting
- ED Diversion Program
- Behavioral Health Program

Our Care Model

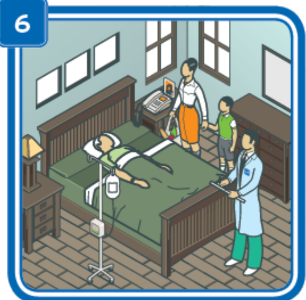
Patient Arrives at ED.

Patient Identified as Clinically Home Candidate.

Clinically Home MD Assessment.

Clinically Home MD Admits Patient. Patient Meets With Clinically Home Greeter.

Welcome Home.



Setup Home Hospital Unit.

Clinically Home NP Visit.

Provide Additional Care as Needed.

PCP Office Visit.

Recuperative Period.

Transfer Patient and Medical Records Back to PCP.

Your Home. **Our Hospital.**

LEGEND

Phase I: Diagnostic Period
Phase II: Treatment Period
Phase III: Recuperative Period

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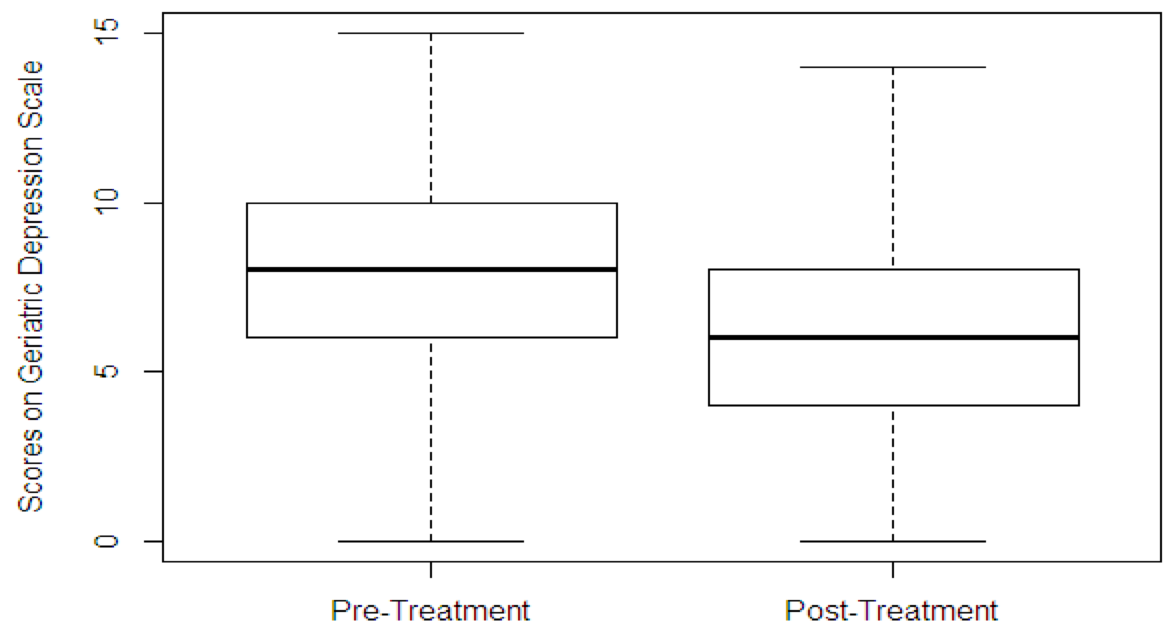
Behavioral Health Program Structure

- Team composition: Psychiatrists, Psychiatric Nurse Practitioners, Psychiatric CNS and Psychiatric Home Care Nurses
- Care planning components are driven by the comprehensive assessment including OASIS C items and specific behavior assessment items
- Predictive model algorithm for screening under care and EBP tools for evaluation
- PHQ 2, PHQ9, Hamilton Anxiety, SAD Persons (suicide risk), GDS, and Mini Cog and FAST for dementia; MANIA scale for Bi-Polar disorders and BPRS for Schizophrenia.
- Evidence based clinical protocols & visit guidelines are utilized from best practice in psychiatric care management guidelines for homebound individuals :
    - Use of combination therapy including treatment, psychopharmacology consults, and CBT (Cognitive Behavioral Therapy) counseling.

2012 Results

The mean level of depressive symptoms at start of care was 7.88 (s = 3.21) points on the 15 point GDS scale and at post treatment the mean was 6.28 (s = 3.35), which was a statistically significant improvement

Box-Plot of Pre-and Post-Treatment Scores on the Geriatric Depression Scale



Emergency Room Partnership

GOALS

- To create a clinical partnership that will:
  - Decrease LOS
  - Decrease preventable readmissions
  - Avoid social admissions
  - Reduce short stay (24-48 hour) hospitalizations

Successful Emergency Room Partnerships: Essential Program Components

- Clear identification of project leadership
- Dedicated home care resource for pilot
- Evidence based screening tool to identify aftercare needs
- Build awareness of home care capabilities
  - “Think Homecare” campaign
- Direct admissions from ED to home
- Identify home care needs for patients admitted from ED
  - Early identification to reduce LOS
- Data sharing
- Practice improvement opportunities to devise new approaches

Questions?

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