How Value Based Care Advances Health Equity

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NHAFP Annual Meeting

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Learning Objectives

1. Understand the role of value-based care in the continuum of primary care
2. Identify how value-based models complement evolving primary care practices as we move towards population health
3. Understand how value-based care addresses health equity
4. Identify at least three qualities of a positive strategic partnerships in ACO contracting that can support sustainable practice models to improve care for target populations.

The inevitable shift to value-based care, if managed correctly, will create many opportunities for your community health center.

What is an ACO?

An **ACO**, or Accountable Care Organization, is a team of providers and support staff who work together to improve quality and earn value-based incentives through contracts with Medicare or commercial insurance companies

What is an CHC ACO strategic partner?

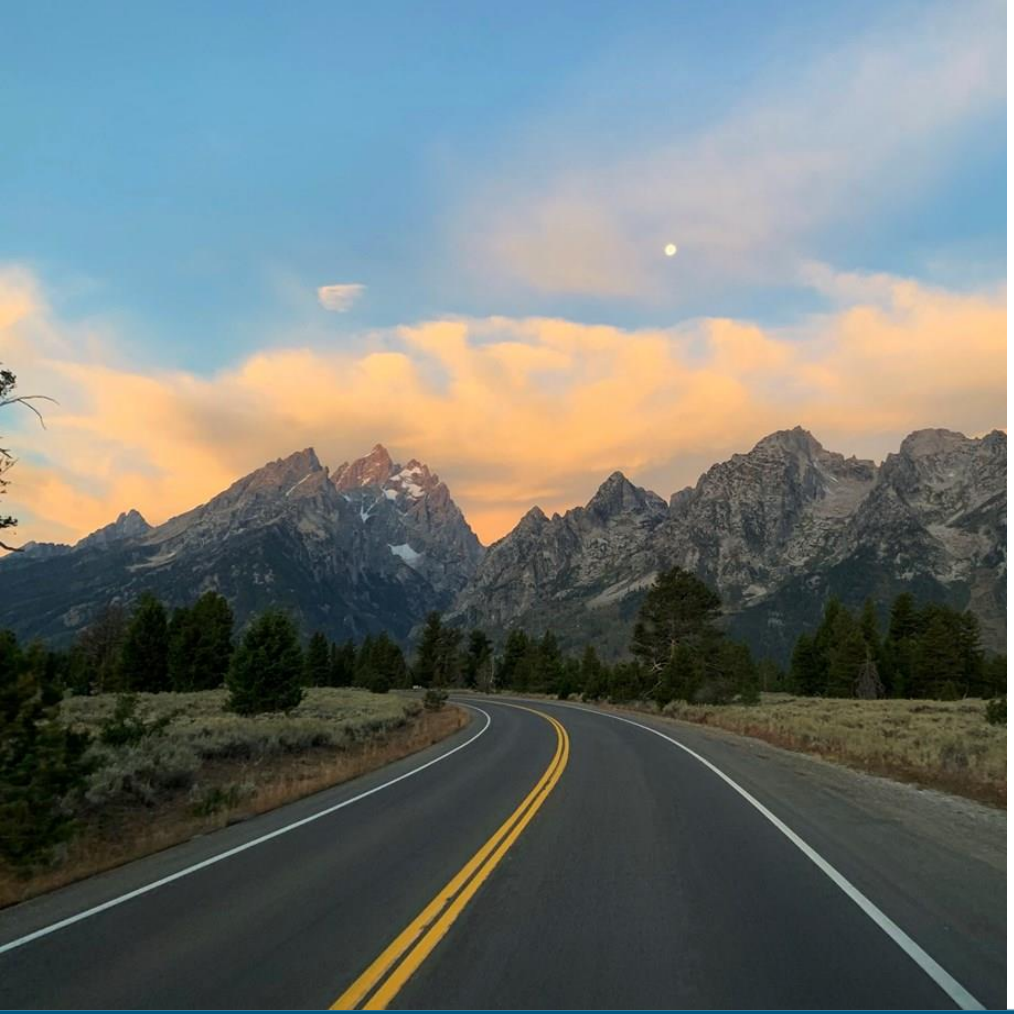
A strategic partner for a CHC helps community health centers navigate the world of value-based care while supporting them in physician-led ACOs.

Fee for Service

- Quantity of services
- Individual patient
- Utilization

Value-Based Care

- Patient centered care
- Quality of services
- Access and prevention
- Balancing patient utilization
- Reducing readmissions
- Total cost of care



Everyone's journey to value-based care is different:

- Some practices have already explored capitated revenues
- Some have had previous engagements with ACOs
- Some are still learning about ACOs

Wherever you are on the journey, value-based care meets you there. The common goal is greater value and a strong partnership.

CATEGORY 1

FEE FOR SERVICE – NO LINK TO QUALITY & VALUE

CATEGORY 2

FEE FOR SERVICE – LINK TO QUALITY & VALUE

A

Foundational Payments for Infrastructure & Operations

(e.g., care coordination fees and payments for HIT investments)

B

Pay for Reporting

(e.g., bonuses for reporting data or penalties for not reporting data)

C

Pay-for-Performance

(e.g., bonuses for quality performance)

CATEGORY 3

APMS BUILT ON FEE -FOR-SERVICE ARCHITECTURE

A

APMs with Shared Savings

(e.g., shared savings with upside risk only)

B

APMs with Shared Savings and Downside Risk

(e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)

3N

Risk Based Payments NOT Linked to Quality

CATEGORY 4

POPULATION – BASED PAYMENT

A

Condition-Specific Population-Based Payment

(e.g., per member per month payments, payments for specialty services, such as oncology or mental health)

B

Comprehensive Population-Based Payment

(e.g., global budgets or full/percent of premium payments)

C

Integrated Finance & Delivery System

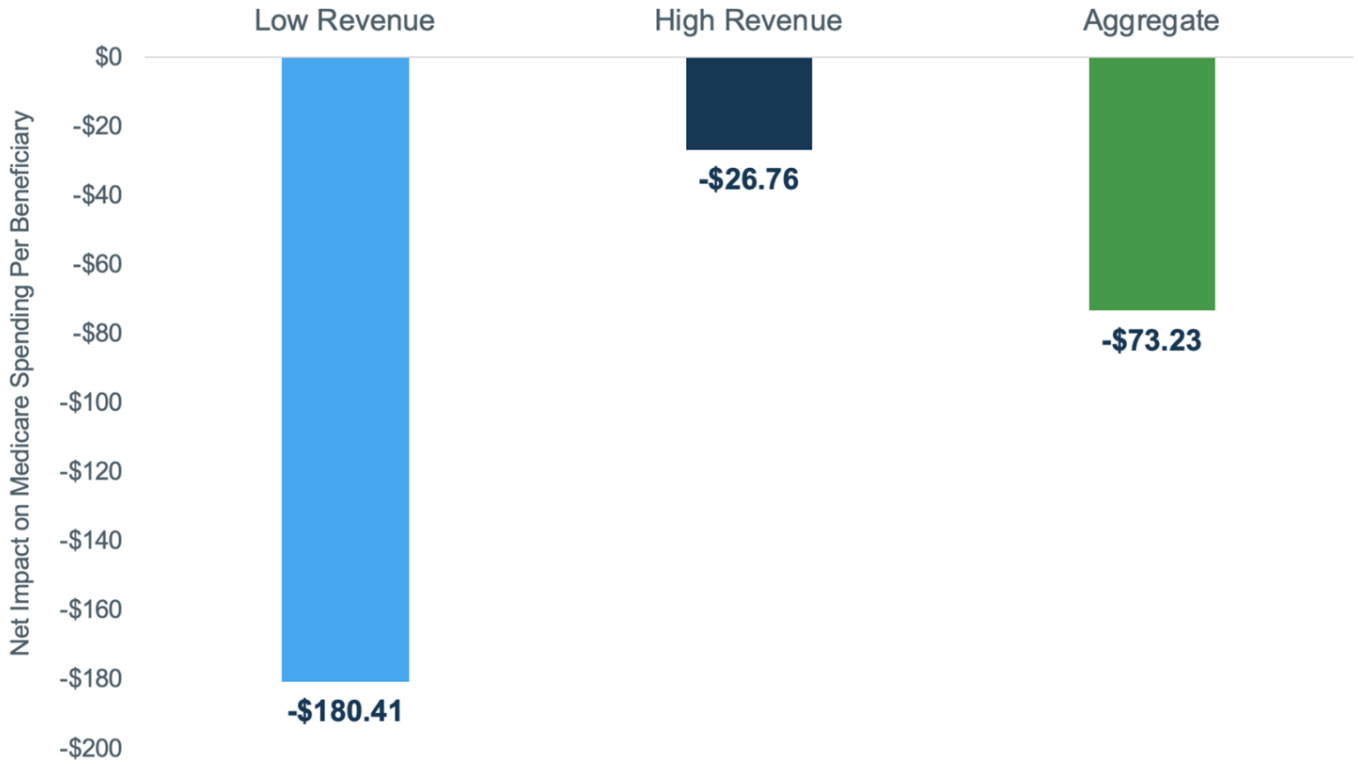
(e.g., global budgets or full/percent of premium payments in integrated systems)

4N

Capitated Payments NOT Linked to Quality

Source:https://hcp-lan.org/workproducts/apm-figure-1-final.pdf

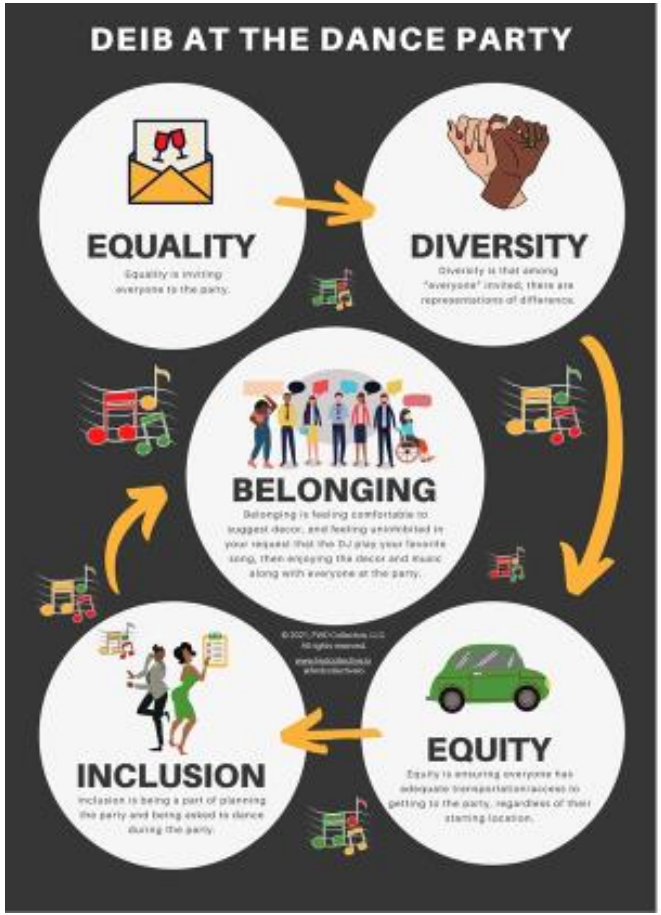
Physician-led ACOs dramatically outperform hospital-led ACOs.



Alignment of Primary Care Mission and Value-Based Care

Population Health is a term used to talk about the **health status of groups** of people in your community. Population Health tools **tracks people over time, grouped** (for example) by disease, care costs, and how happy they are with their care. **High-risk patients** are those most likely to be hospitalized, use the emergency room, and need high-cost care to manage chronic conditions, for example.

Attribution is the process of **assigning patients** to providers in an ACO. It **identifies the primary care provider** that Medicare views as the most responsible for the patient's care, patient satisfaction, cost of care and health outcomes.



Equality: Everyone gets the same thing

Diversity: Different communities/identities represented

Equity: Everyone gets what they need to have a fulfilling experience

Inclusion: All represented can act on their influence and power to make changes

Belonging: Feeling safe and welcome to express oneself and partake in community

Optimize Infrastructure

Value-based care models, on a systemic level provides additional consistent revenue streams that can be used to optimize health center infrastructure that contribute to burnout

Source: http://hiteqcenter.org/Resources/Health-IT-QI-Workforce-Development/Professional-Development/assessing-provider-satisfaction

HEALTH CENTER

INFRASTRUCTURE

IMPROVEMENT STRATEGY
Effectively and routinely measure and communicate information about the quality, value, and outcomes of the health care experience and use this information to drive improved performance.

HEALTH INFORMATION TECHNOLOGY
Leverage health information technology to track, improve, and manage health outcomes and costs.

POLICY
Pursue decisions, plans, and actions that help secure support and resources for health centers and expand access for under-served populations.

PAYMENT
Utilize value-based and sustainable payment methods and models to facilitate care transformation.

COST
Effectively address the direct and indirect expense of delivering comprehensive primary care to health center patients while considering the total cost of care for attributed patients.

CARE DELIVERY

POPULATION HEALTH MANAGEMENT
Use a systematic process for utilizing data on patient populations to target interventions for better health outcomes, with a better care experience, at a lower cost.

PATIENT-CENTERED MEDICAL HOME
Employ a model of care that transforms the delivery of primary care into a comprehensive, patient-centered system focused on high quality, accessible, and coordinated care.

EVIDENCE-BASED CARE
Make patient care decisions using a process that integrates clinical expertise and best-practice research with patient values and self-care motivators.

CARE COORDINATION AND CARE MANAGEMENT
Facilitate the delivery and coordination of care and manage high-risk and other subgroups of patients with more targeted services, when and how they need it.

SOCIAL DETERMINANTS OF HEALTH
Address the social and environmental circumstances that influence patients' health and the care they receive.

PEOPLE

PATIENTS
Intentionally and actively incorporate the patient perspective into governance, care system design, and individual care.

CARE TEAMS
Utilize groups of staff with different skills to work together to deliver and improve care, offering a wider range of services more efficiently than a provider alone.

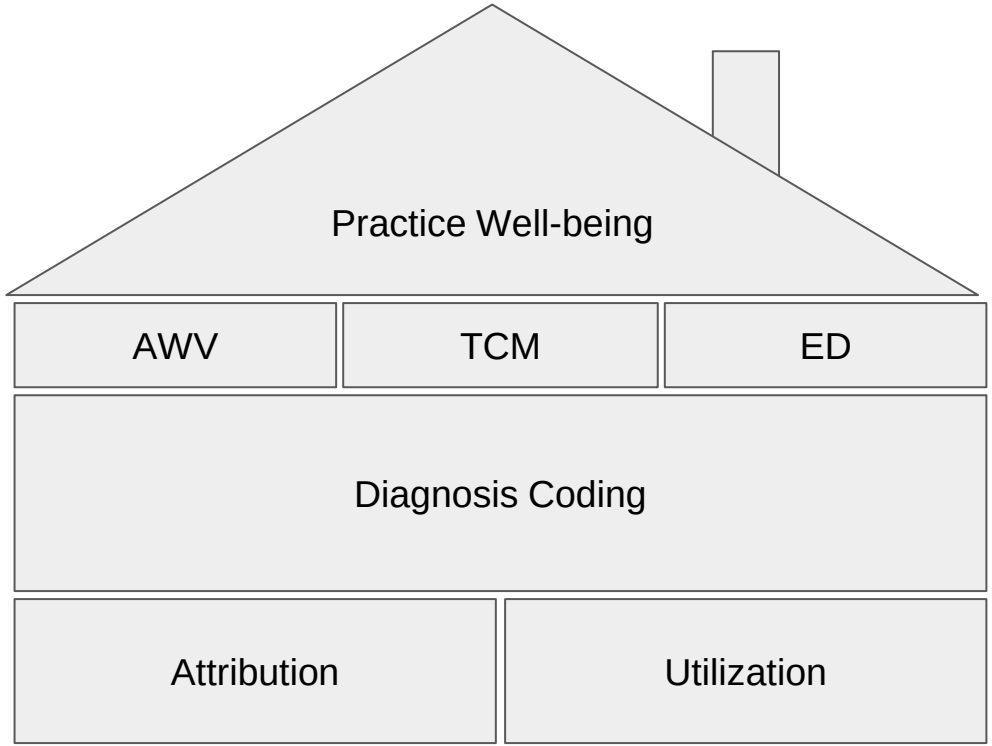
LEADERSHIP
Apply position, authority, and knowledge of leaders and governing bodies (boards) to support and advance the center's people, care delivery processes, and infrastructure to reach transformational goals.

WORKFORCE
Leverage a trained and fully engaged staff to successfully address the health center's mission and goals, with optimal joy in work.

PARTNERSHIPS
Collaborate and partner with external stakeholders to pursue the Quadruple Aim.

https://www.nachc.org/wp-content/uploads/2019/08/Value-Framework-Factsheet-Aug-2019.pdf

The House of Value-Based Care



General ACO Definition

According to CMS, ACOs are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to their Medicare patients.

The goal of **coordinated care is to ensure that patients get the right care at the right time,** while avoiding unnecessary duplication of services and preventing medical errors.

When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, the ACO will share in the savings it achieves for the Medicare program

Hospital/Health System Led ACOs vs. Physician Led

Hospitals and health system sponsored and led the operations and strategy of the majority of new accountable care organizations (ACOs) from 2010 to 2015. They influenced priorities and strategies of the policies designed to drive ACO adoption. Hospitals/health systems have opposite incentives compared to those of value-based care.

VBC goals of high quality, lower cost, patient-centered care focus on keeping patients healthy. Hospitals do not thrive financially on healthy patients.

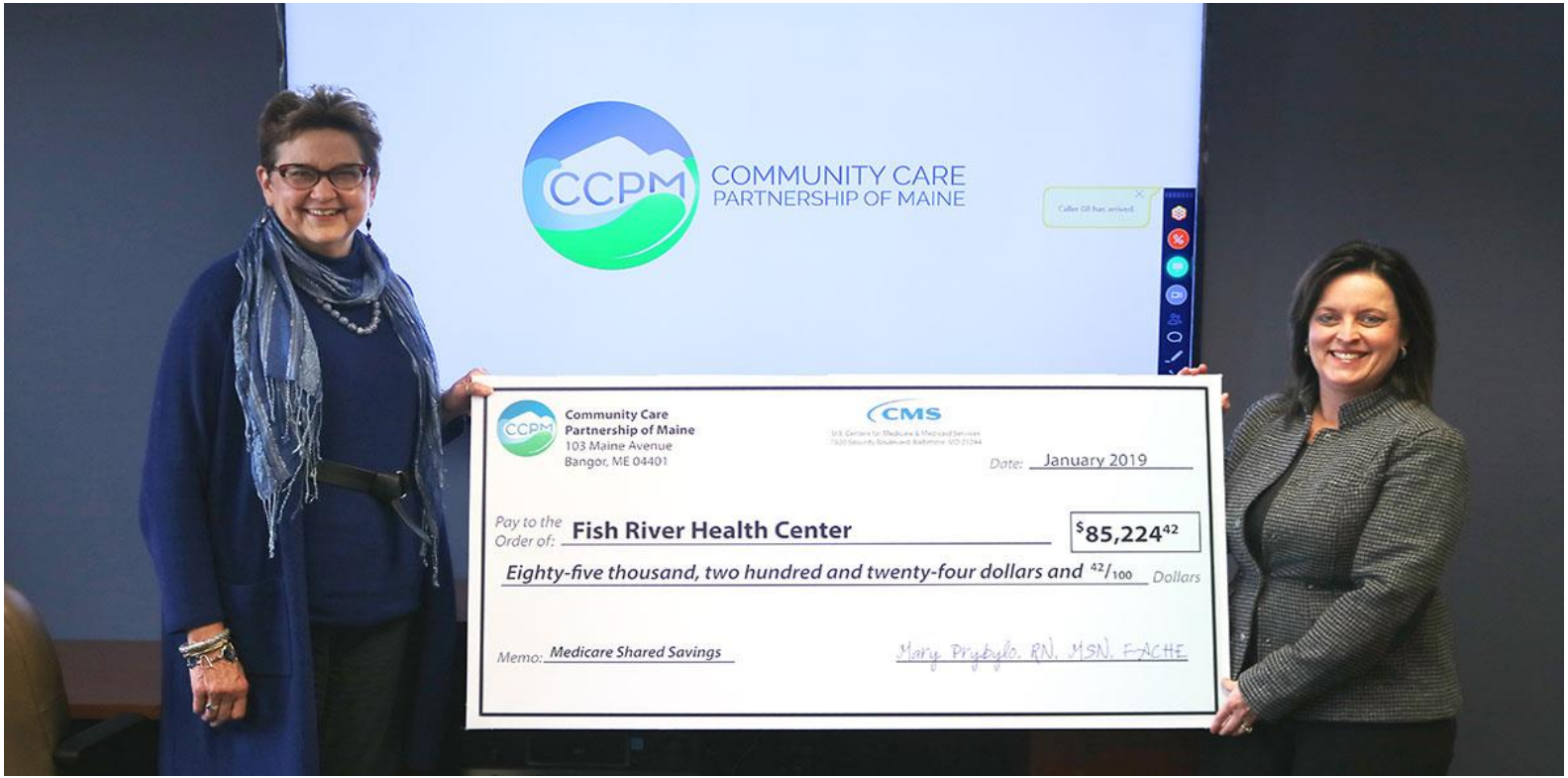
VBC incentives align with those of primary care providers and CHCs, physician led ACOs have shown to be more successful in creating shared savings than their hospital led ACO counterparts.

Source: https://doi.org/10.37765/ajmc.2020.43154

MSSP ACOs in Northern New England

ACO Name	State(s)	Physician Led?
Lahey Clinical Performance ACO	MA, NH	No
Beth Israel Deaconess Care Organization	MA, NH	No
Mass General Brigham ACO, LLC	MA, NH	No
Circle Health Alliance, LLC	MA, NH	No
Berkshire ACO	MA, NY	(Caravan Health ACO dba Berkshire ACO)
Southcoast Accountable Care Organization, LLC	MA, RI	Yes
Central Maine ACO	ME	No
Community Care Partnership of Maine, LLC	ME	Yes
Beacon Rural Health, LLC	ME	No
MaineHealth Accountable Care Organization	ME, NH	No
NH-Cares ACO LLC	NH	No
SolutionHealth ACO LLC	NH, MA	Yes
NH Value Care ACO, LLC	NH, VT	No

Example Strategic Partnership In ACO-Based Models



TEAM

Important strategic partner qualities that assist CHCs in moving to value-based care

Clinical intelligence data driven by payor claims.

Partner specifically with **Primary Care Teams**

Why a central convener/ champion?

Focus only on **independent practices and community health centers**

Align economic incentives to your practice

The complex needs of primary care

Lack of referral information	ADT feeds for inpatient, TOC & ED visits
Gaps between payers	Multi-payer value-based contracts **(including Medicaid)**
Lagging or incomplete data	Actionable, user-friendly insights
Complex quality reporting requirements for grants	Resources and support that align grant goals with value-based care objectives
Ensuring comprehensive care for high-risk patients	Chronic Care Management support, tools, and Complex Care Rounds

A strategic partner provides the **comprehensive support** CHCs need to be successful in value-based care.

Industry Expertise

✓ Quality Reporting Automation

✓ Leveraged Nationwide Payer Relationships

✓ Structured Shared Savings Roadmap

✓ CME/CEU Credit Opportunities

✓ Advise on Policy Updates/New Programs in Value-Based Care

Hands-On Support

✓Local Aledade Team Support/Monthly Clinicals Check Ins

✓Custom Clinical Integration

✓Care Coordination with Custom EHR Workflows and Templates

✓Staff Training on Value Based Care Programs

✓Billing and Coding Guidance

Data and Analytics

✓Proprietary Population Health Tool

✓Integrated data from Payer Claims, National Lab/Pharmacy Claims, and Scheduling Data

✓ADT Feed/Discharge Tracking and Follow Up

✓Specialist Utilization Details

✓Diagnosis Coding Suggestions with Visibility into Total Cost of Care

Goal: To achieve better care, superior savings, and improved clinician satisfaction

Integrated data from across the care continuum

+

Comprehensive patient data & actionable insights

=

Optimizing care delivery and improving results

How can value-based care help address health disparities?

Health Disparities: differences that are closely linked with social, economic, and/or environmental disadvantage (*Health People 2020)*

Health inequities are systematic differences in the health status of different population groups that unjust and preventable. (*World Health Organization*)

What are some ways that your organizations work toward of reducing health disparities?

What would an ideal support team look like?

- Integration team
- PTS
- Clinical calls/pods
- Board meetings
- Practice Manager Rounds
- Monthly Rounds
- Podcast
- Practice Manager Retreats

Value- based care strategically addresses the fundamental commitment of primary to address health equity.

“Better serve those who care for the most disadvantaged and reduce racial disparities in poorly controlled HTN by 50%”

Reducing health disparities: BP control

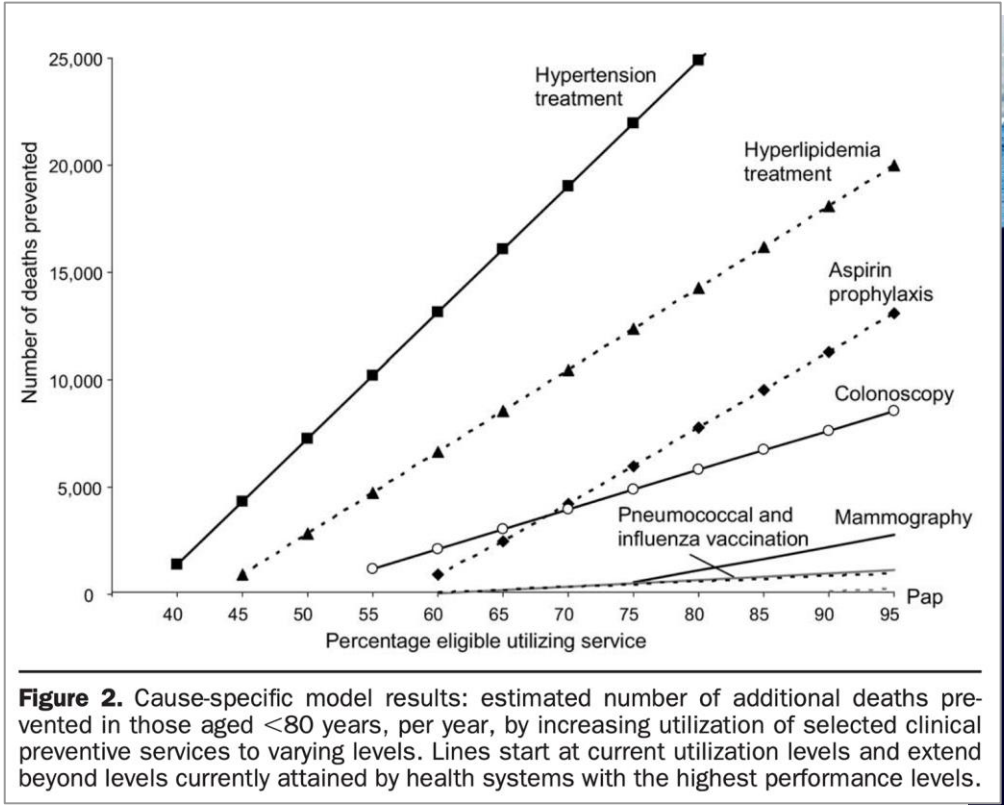
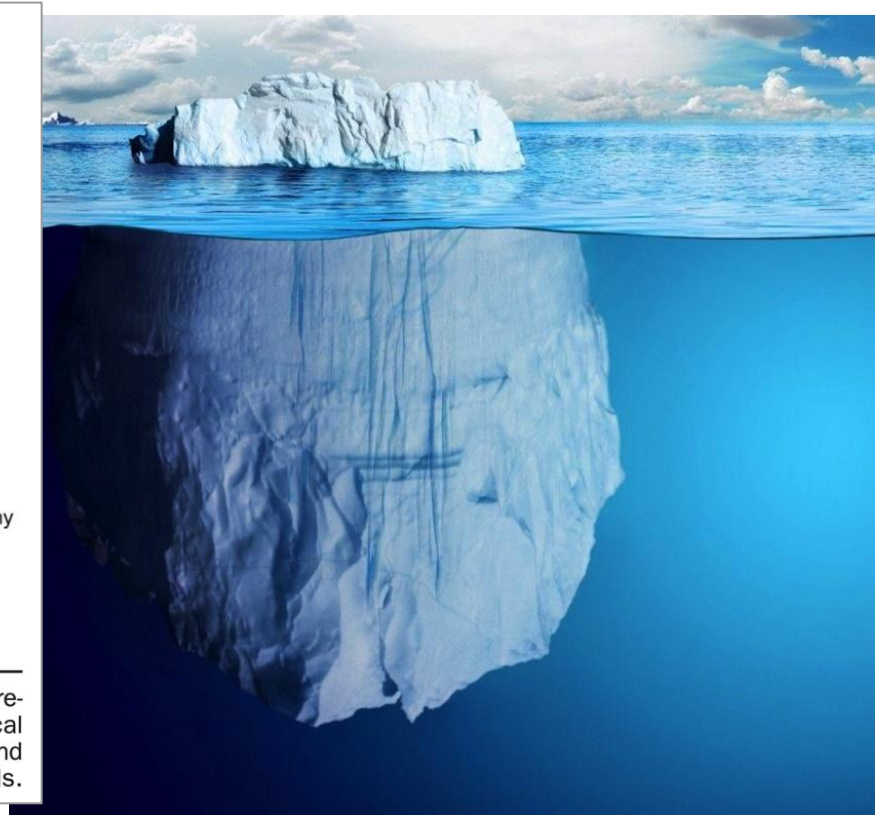


Figure 2. Cause-specific model results: estimated number of additional deaths prevented in those aged <80 years, per year, by increasing utilization of selected clinical preventive services to varying levels. Lines start at current utilization levels and extend beyond levels currently attained by health systems with the highest performance levels.



Amer J Prev Med, 2010: 366(6), 600-609, Farley et al

What is the value of focusing on BP?

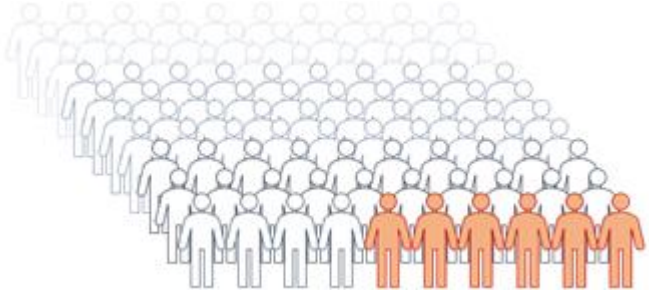
Patients with severe BP readings have poorer outcomes than those without:

1.6 times more likely to have an inpatient stay

1.8 times as likely to have an ED visit

$2,770 higher average total cost of care

We have the potential for tremendous impact:



In January 2021, 6% (20,063) of Aledade MSSP patients had severe BP

Moving 1 in 6 patients from severe to normal BP (about 3000 patients)...

... could result in an estimated:

132 saved heart attacks

93 saved strokes

$2,766,723 in inpatient stays

Example of 3 key health equity strategies

1	Medicaid	• Ensure all with a trusted PCP relationship • Success directly impacts communities and bolsters success • Drive health outcomes throughout the full lifespan with intense focus on access/prevention, care transitions, risk & prioritization (esp. with BH & SDoH)
2	Health Disparities Reduction	• Target HTN control and disparity, especially among Black patients Four segments of action: patient-facing, provider-facing, tech enabled interventions, and community & caregiver supports
3	CHC Engagement & Practice Integration	• Multi-state CHC-only ACO • Bolster capacities of PCP practices caring for predominantly minority or vulnerable communities

THANK YOU!!

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