How ACOs Are Addressing Health Equity: *Insights from Innovators*

The webinar will begin at 11:00 am ET.

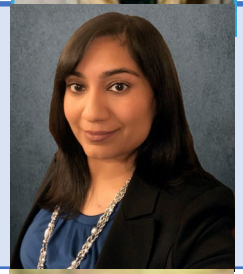
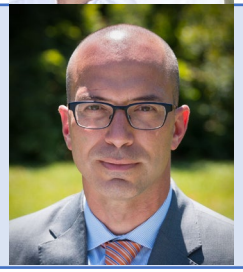
Agenda

1. Housekeeping
2. Policy issues
3. ACO presentations:
   - Advocate Aurora Health
   - Aledade
   - Mount Sinai Health System
3. Discussion questions and audience Q&A

Housekeeping

1. NAACOS will present policy issues related to addressing health equity
2. ACO speakers will present for around 40 minutes
3. Speakers will share feedback on discussion questions in panel format
4. Q&A will take the remainder of the time
   - You can submit written questions using the Questions tab on your dashboard to the right of your screen at any time during the webinar
5. Webinar is being recorded
   - Slides and recording will be available on the NAACOS website within 24 hours.

Speakers

	**Jennifer Gasperini** Director of Regulatory and Quality Affairs NAACOS
	**Alvia Siddiqi, MD** Vice President of Population Health Advocate Aurora Health
	**Kisha Davis, MD** Vice President of Health Equity Aledade
	**Robert Fields, MD, MHA** Executive Vice President and Chief Population Health Officer Mount Sinai Health System

Speaker Introductions

Alvia Siddiqi, MD
VP, Population Health
Advocate Aurora Health

Dr. Alvia Siddiqi serves as vice president of population health at Advocate Aurora Health, a large non-profit Integrated delivery network based in the Midwest region. She is an executive leader of Enterprise Population Health and the Advocate Physician Partners (APP) ACO, which includes nearly 1 million value-based risk lives. She oversees the regional population health medical directors team and is responsible for providing strategic guidance to integrated care management, government and value-based programs, quality improvement, patient safety & high reliability, and ACO governance.

Dr. Siddiqi is an appointed member of the system Health Equity Council, where she supports efforts to address health disparities and tackle social determinants of health. She serves as co-investigator of the NIH Minority Health and Disparities R01 grant to investigate leveraging health information technology to address racial and ethnic disparities in hypertension control (REDUCE-BP). Dr. Siddiqi also serves as an associate faculty member in the department of health policy and management at Johns Hopkins Bloomberg School of Public Health.

Dr. Siddiqi is a board-certified family medicine physician and fellow of the American Academy of Family Physicians (AAFP). She is past board chair and president of the Illinois Academy of Family Physicians. Dr. Siddiqi previously has served on the AAFP Commission on Quality and Practice and Subcommittee on Health Equity. She has provided guidance to several state and national committees, including the CMS Advisory Panel on Outreach and Education (APOE), CMS MACRA TEP Panel on Cost measures, NQF Medicaid Quality Scorecards, and NCQA Patient-Centered Specialty Practice (PCSP) Advisory Council.

Speaker Introductions

Kisha Davis, MD
VP, Health Equity
Aledade

Dr. Kisha Davis, family physician, is a passionate primary care provider and community health advocate. She is a vice president of health equity at Aledade, working to reduce health disparities in physician-led ACOs across multiple states. Prior to joining Aledade, she served as medical director at CHI Health Care, an integrative primary care center in Maryland.

Dr. Davis is a vice-chair of the Medicaid and CHIP Payment and Access Commission (MACPAC). She recently served as a project manager at CFAR working on the Family Medicine for America's Health project focusing on payment reform, practice transformation, and health equity. Just prior to joining CHI, she served as a White House fellow at the US Department of Agriculture. Dr. Davis completed an undergraduate degree from Duke University and her MD from the University of Connecticut. She completed her residency from the University of Maryland where she served as chief resident, and later earned a master's in public health from Johns Hopkins University.

Speaker Introductions

Robert Fields, MD, MHA
EVP & Chief Population Health Officer
Mount Sinai Health System

Dr. Robert Fields is a family medicine physician and serves as the EVP, chief population health officer at Mount Sinai Health System. In this role, Dr. Fields leads system strategy and operations for population health including managed care and value-based contracting as well as population health analytics.

Dr. Fields began his career as an independent primary care physician serving all ages with a particular concentration on underserved Latino patients in Western North Carolina. He held various leadership positions in North Carolina in the areas of quality and value-based care and came to Mount Sinai in March of 2018 as the SVP and CMO for population health. Dr. Fields oversaw the redesign of clinical operations for value including care management, provider engagement, quality programs, remote monitoring and condition management, social determinants, and other aspects of the system's population health strategy. He was promoted to chief population health officer in 2021.

Dr. Fields has previously served as the board chair of NAACOS and currently serves on the board of America's Physician Groups. He is also a member or chair for various national committees on quality and measure development for the National Quality Foundation and CMS. He earned his medical degree from the University Of Florida College Of Medicine, and completed a family medicine residency at the Mountain Area Health Education Center where he was chief resident. Dr. Fields earned his master of health administration from the University of North Carolina at Chapel Hill.

Policy

NAACOS has been engaging in a variety of work on health equity, including launching a webpage to house NAACOS resources and comments, helpful definitions, and relevant research and evidence for ACOs working to address health equity.

ACOs and Health Equity:
Linking Clinical Care and Social Services

September 2021

ACOs Lead Equity Efforts

During the pandemic, ACOs have seen firsthand how social determinants of health (SDOH)—the conditions where people live, learn, work and play—can drive racial and ethnic disparities. By any measure—COVID-19 cases, hospitalizations, and deaths—Black, Indigenous, and people of color (BIPOC) across America have fared worse, underscoring longstanding structural and systemic inequities facing marginalized communities.

As community-based and patient-centered organizations, ACOs—local physicians, hospitals and others working together to improve quality and keep costs down—have been leaders in adopting practices to improve care management, including identifying patients with health-related social needs like housing and food insecurity and linking them to community resources. Moving forward, ACOs, with their strong community roots, increasingly are looking for opportunities to address health inequities further upstream by moving beyond patient-level interventions to community-level SDOH initiatives aimed at food insecurity at a population level.

Moving from Health Care to Health

Compared to other developed nations, the United States spends much more on health care and much less on social services proportionately—for example, for every $1 in health care spending, other industrialized nations spend $2 on social services, while the U.S. spends about 60 cents, according to Alice Chen, M.D., M.P.H, medical director of Covered California and a presenter on health equity at a NAACOS conference earlier this year. And yet all that extra health care spending doesn't deliver better health, Chen said, adding, "It's become pretty widely accepted that if we do want to improve health, we need to look outside our walls."

Social Needs vs. Social Determinants

With their focus on population health and care management, ACOs are leading efforts to address how unmet social needs like food and housing insecurity impact health. "ACOs very much have led the way...have really focused on the issue of health-related social needs in a pretty organic way, because truly...as soon as you start talking to your patients, as soon as you start doing care management, population health, you start bumping up against issues like food insecurity, lack of transportation, financial stress, marginal housing," Chen said. At the same time, Chen urged ACO leaders and others to use precise terms and avoid conflating health-related social needs—food and housing insecurity, for instance—and SDOH, or the broader social context and environmental conditions, including racism, in which people live, learn, work and play (see Exhibit 1 and ***Defining Equity and Disparity*** on page 2 for more detail).

Exhibit 1. Social Determinants of Health

Source: Centers for Disease Control and Prevention

Race, Place, Poverty and Health

Both Chen and co-presenter Rick Gilfillan, M.D., former CEO of Trinity Health, pointed to structural racism and the generational fallout on wealth and health for members of marginalized communities, especially Black Americans. "Every city in America has an avenue you can follow to find people who live longer on one side versus the other," Gilfillan said. Using maps of San Francisco, Chen pointed to the legacy of "redlining," a practice in the mid-1900s that declared certain

The Role of ACOs in Addressing Health Equity

...rs and systematic discrimination have led to wide and longstanding gaps in health equity for ...communities.[i] Improving health equity is critical to delivering high quality care in a cost-...ner, as some research shows that social drivers of health contribute more significantly to ...s than medical care.[ii] These social factors cannot be addressed if they are not adequately ...d, and reported.[iii] Innovative payment and care delivery models that rely on data ...nity to better understand and highlight existing disparities and also to provide the ...r interventions based on individual needs. Total cost of care models such as ...nizations (ACOs) are incentivized to improve quality while controlling costs, and the ...t ACOs make in health information technology (HIT) and infrastructure to provide ...em uniquely poised to address health inequities.

...ACOs (NAACOS) is the largest association of ACOs and Direct Contracting ...ore than 12 million beneficiary lives through hundreds of Medicare Shared ...Generation ACO Model, Global and Professional Direct Contracting Model ...NAACOS is a member-led and member-owned nonprofit organization that ..., across the nation to improve the quality of Medicare delivery, ...and healthcare cost efficiency. NAACOS is committed to advancing ...ur members want to see an effective, coordinated, patient-centric ...ing all individuals healthy. Strengthening the ACO model and ...an important opportunity to reduce health inequities and ...r value.

...ities in federal healthcare programs hinge on increasing ...O models, which can be leveraged to advance health ...comes and lower healthcare costs.

...ded inequities in our healthcare system, revealing ...and treatment, quality of care, and health ...nizations like ACOs have been uniquely poised ...r due to their financial flexibilities and ...ities they serve.[iv] Even prior to the ...cial needs and reduce inequities among ...g patients' social needs is critical to ...on the broader concept of an ...althy and improve the value of

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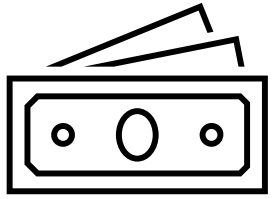
Policy

NAACOS has published two position papers with recommendations to better position ACOs to address health inequities, and to address equity within quality measurement for ACOs. Some key recommendations:

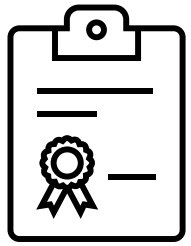


Funding

- Upfront financial investment
- Forgivable loans
- Adjusted financial benchmarks

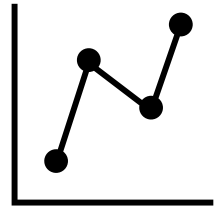
Supplemental Benefits

Allow ACOs to bill Medicare for services that improve health equity, and meet social needs as part of a "chronic social determinant management" service



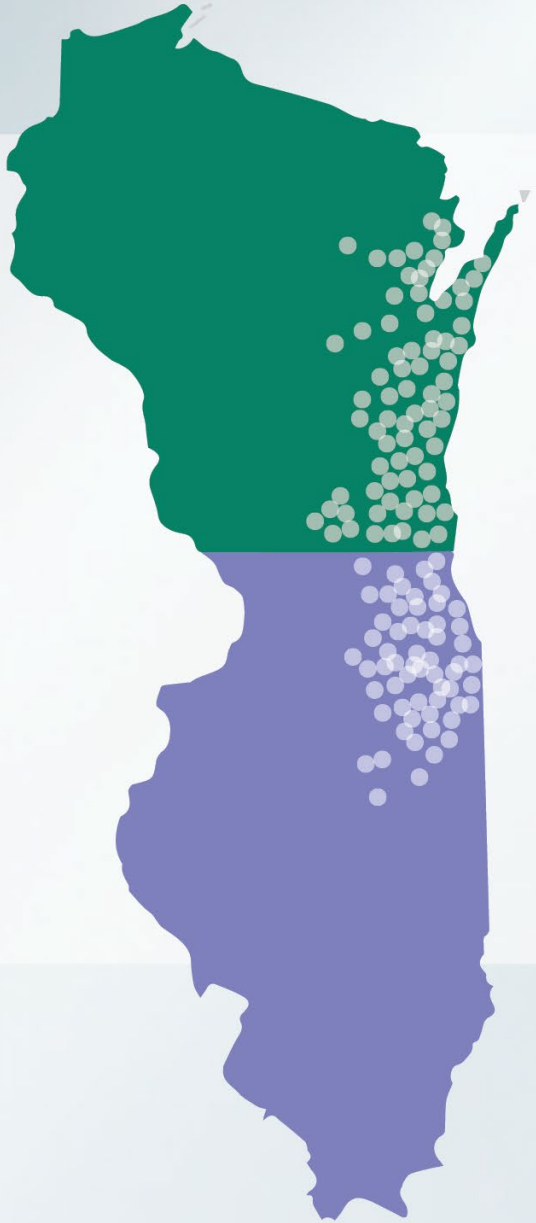
Quality

- Ensure quality requirements are thoughtfully designed and implemented
- More specific quality recommendations for improving health equity



Data

Provide ACOs with timely and actionable data needed for care coordination



Advancing Health Equity

Dr. Alvia Siddiqi, VP Population Health

Linked In: https://www.linkedin.com/in/alvia-siddiqi-md-faafp-a747a41/

2/15/2022

AdvocateAuroraHealth

Advocate Health Care Aurora Health Care®

Agenda

- Advocate Aurora Health and Enterprise Population Health overview
- Laying the foundation to Advance Health Equity (HE)
  - Health Equity Council (HEC) Governance
  - Health Equity Assessment & Clinical Prioritization
  - HEC Hypertension Analysis
  - HEC Hypertension Road Map
- CMS Disparities Impact Framework and SMART Action Plan

BY THE NUMBERS

28 HOSPITALS

500+ SITES OF CARE

Top 12

NOT-FOR-PROFIT HEALTH SYSTEM

Top 10

IN QUALITY AMONG NATIONAL HEALTH SYSTEMS

70,000+

TEAM MEMBERS

22,000+ NURSES

10,000+ PHYSICIANS

10,000+

VOLUNTEERS

3M UNIQUE PATIENTS

1.3M VALUE-BASED LIVES

53

INTEGRATED HEALTH & SAFETY MEASURES TRACKED

NEARLY

$2.2B

COMMUNITY BENEFITS IN 2019

1M+

LIVEWELL APP DOWNLOADS

AdvocateAuroraHealth

Enterprise Population Health

1.3 million value-based lives across 400 miles in IL & WI

Illinois: ~1 million value-based lives

- Team Member: **35,000 lives | $0.1B total spend**
- Commercial HMO: **221,000 lives | $0.7B total spend**
- Managed Medicaid: **87,000 lives | $0.1B total spend**
- Medicare Advantage: **37,000 lives| $0.3B total spend**
- Medicare Shared Savings Program: **124,000 lives | $1.5B total spend**
- Commercial Shared Savings: **445,000 lives | $1.6B total spend**

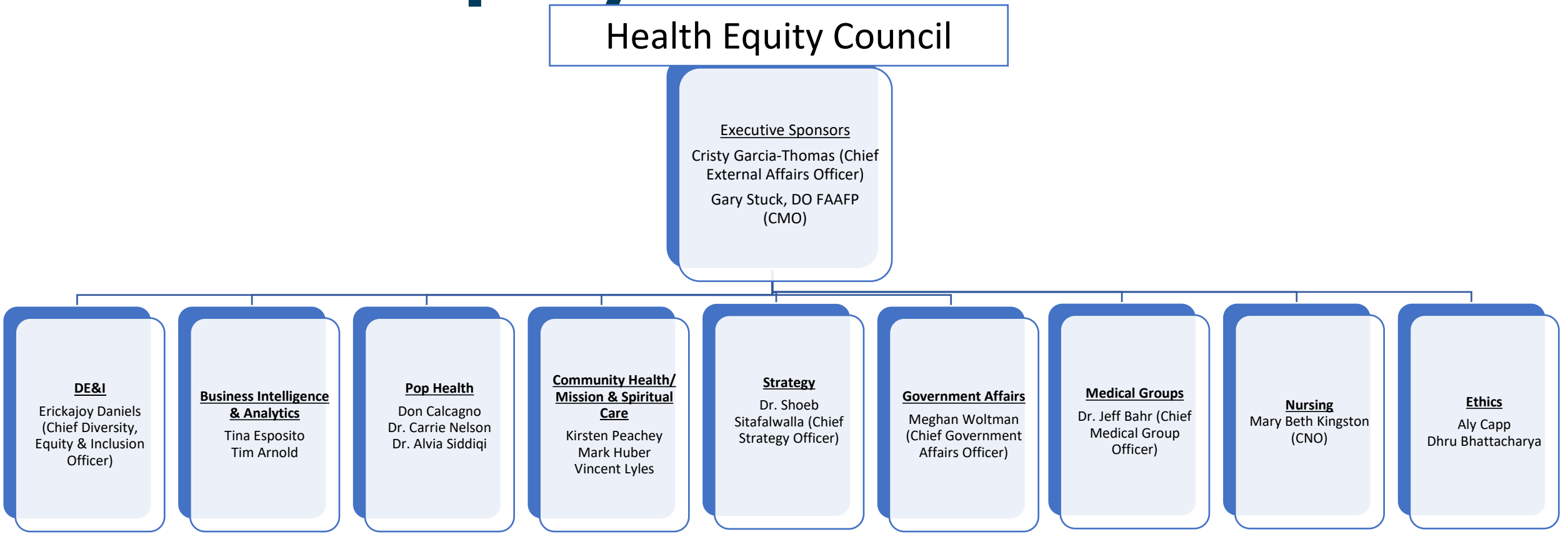
Wisconsin: ~300,000 value-based lives

- Team Member: **52,000 lives | $0.1B total spend**
- Commercial Shared Savings: **132,000 lives | $0.9B total spend**
- Medicare Advantage: **61,000 lives | $0.5B total spend**
- Medicare Shared Savings Program: **81,000 lives | $0.8B total spend**

Laying the Foundation to Advance Health Equity

AdvocateAuroraHealth

Health Equity Council Governance

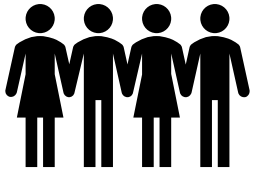


TARGET & SCOPE: Two Parallel Efforts

AAH strives to be an industry leader in Health Equity

Improve Health Equity in our **SYSTEM**

- Focused on improving internal AAH measures
- Close alignment with existing operations
- Needs clinical and operational expertise
- Should effect change in 1-5 years



Improve Health Equity in our **COMMUNITIES**

- Focused on improving external community-based measures
- Requires trust-building and partnership with external organizations and communities
- Needs community organization and social change expertise
- Should effect change in 5-50 years

HE Assessment and Clinical Prioritization

AdvocateAuroraHealth

Population Health Ambulatory Workgroup Measures

Goal: Create a **common set of ambulatory performance measures** for inclusion in the 2020 Safety & Health Outcomes Score
Status: Bolded measures have been approved by the respective workgroup.

WORKGROUP MEASURES

CARDIO

- *Hypertension - Controlling High Blood Pressure <140/90*
- *IVD/CAD: Statin Therapy - All Groups*
- *Cardiac Rehab Referral*
- *ICD Discharge Medication Composite (ACE/ARB and Beta Blockers)*

ONCOLOGY

- **Chemotherapy intent (curative vs. non-curative) documented before or within two weeks after administration** ***QOPI Core #10***
- **Staging documented within one month of first office visit** ***QOPI Core #2***
- **% of IP admissions and ED visits of ALL Payors within 30 days receiving OP chemotherapy**

PEDIATRIC

- **Childhood Immunization: HEDIS Combo 7**
- **Childhood Influenza Immunization**
- **Immunizations for Adolescents: HEDIS Combo 1**
- **HPV Vaccination**
- **Influenza Vaccination Full Season**
- **Well-Child Visits in the First 15 Months of Life**

PRIMARY CARE

- **Breast Cancer Screening**
- **Cervical Cancer Screening**
- **Colorectal Cancer Screening**
- **Hypertension - Controlling High Blood Pressure <140/90**
- **Diabetes A1c <8**

WOMEN'S HEALTH

- **Breast Cancer Screening**
- **Cervical Cancer Screening**
- *Chlamydia Screening in Women*
- *Pregnancy Tdap Vaccination*
- *Pregnancy Influenza Vaccination*
- *Postpartum visit rate*
- *NTSV Caesarean Birth Rate*

Guiding Principles for Measure Selection

1) Alignment with system improvement efforts and Health Equity Council (HEC) goals and priorities
2) Endorsement from business owners i.e., Service Line(s) where applicable
3) Process/Outcome impact will further our DE&I and Health Equity system efforts
4) National, state, or payer requirement and/or incentives
5) Measures with known disparities “health-equity centric”

HEC Hypertension Analysis

AdvocateAuroraHealth

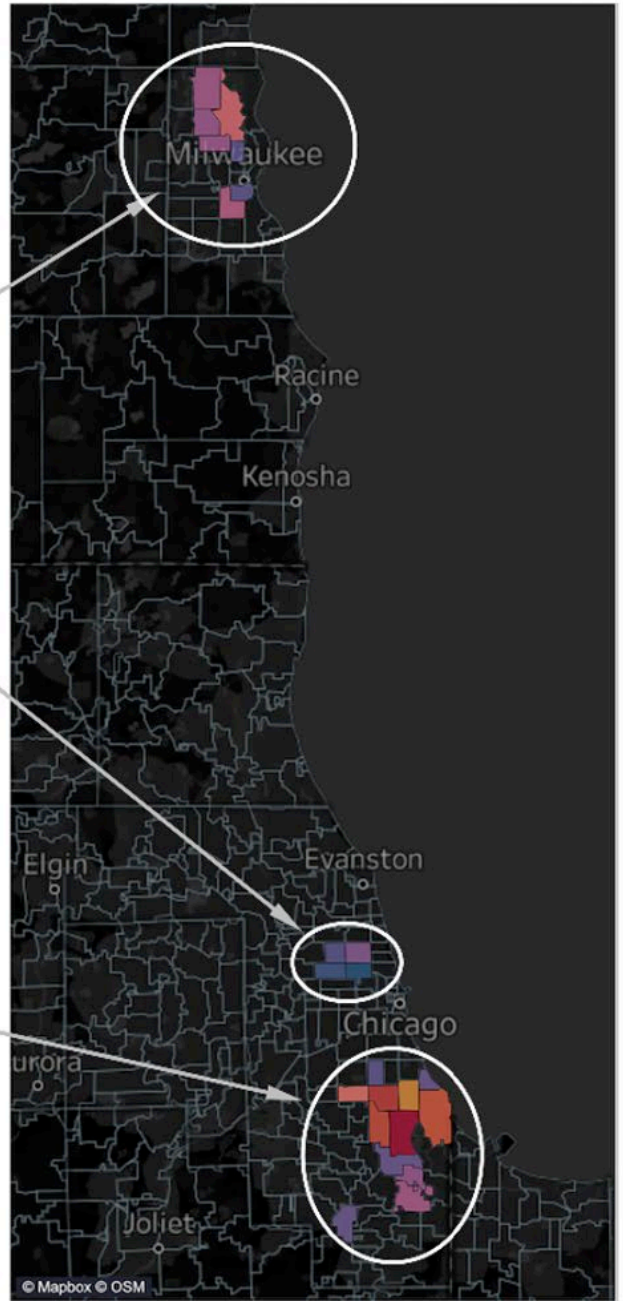
Target Zip Codes

	TOTAL	Target Zip Codes	% in Target Zip Codes
Black Hypertensive	104,022	48,445	46.6%
Black Uncontrolled BP	28,004	13,582	**48.5%**
Hispanic Hypertensive	46,092	10,635	23.1%
Hispanic Uncontrolled BP	9,737	2,376	**24.4%**

**includes all zip codes with >400 patients within Black sub-population OR >220 patients within the Hispanic sub-population with uncontrolled hypertension*

Uncontrolled HTN (pt. count)

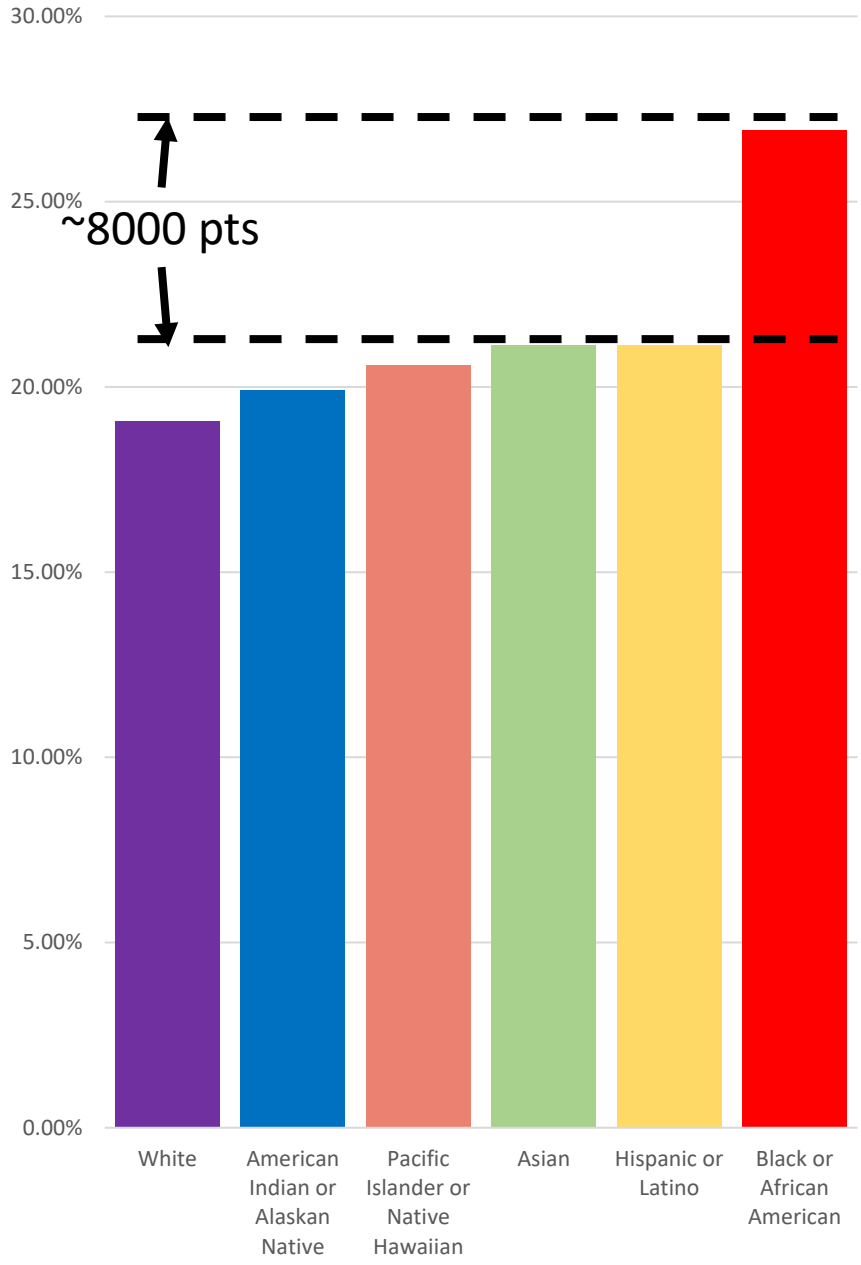
PSA	Zip Code	Black or African American	Hispanic or Latino	Total
Greater Milwaukee	53204	94	226	320
	53206	435	5	440
	53209	636	15	651
	53215	88	305	393
	53216	558	15	573
	53218	530	14	544
	53223	417	8	425
	Total	**2,758**	**588**	**3,346**
Central Chicagoland	60618	32	387	419
	60639	111	310	421
	60641	28	272	300
	60647	24	284	308
	Total	**195**	**1,253**	**1,448**
South Chicagoland	60419	598	4	602
	60473	631	12	643
	60478	449	7	456
	60617	1,050	323	1,373
	60619	1,147	4	1,151
	60620	1,565	8	1,573
	60628	1,795	23	1,818
	60636	435	6	441
	60643	1,345	19	1,364
	60649	476	2	478
	60652	678	122	800
	60827	460	5	465
	Total	**10,629**	**535**	**11,164**
Grand Total		**13,582**	**2,376**	**15,958**



Closing the Gap for the Black or African American Sub-Population

Race	Uncontrolled %	Uncontrolled Count
White	19.08%	78,215
American Indian or Alaskan Native	19.90%	406
Pacific Islander or Native Hawaiian	20.58%	148
Asian	21.12%	5,017
Hispanic or Latino	21.12%	9,737
Black or African American	26.92%	28,007

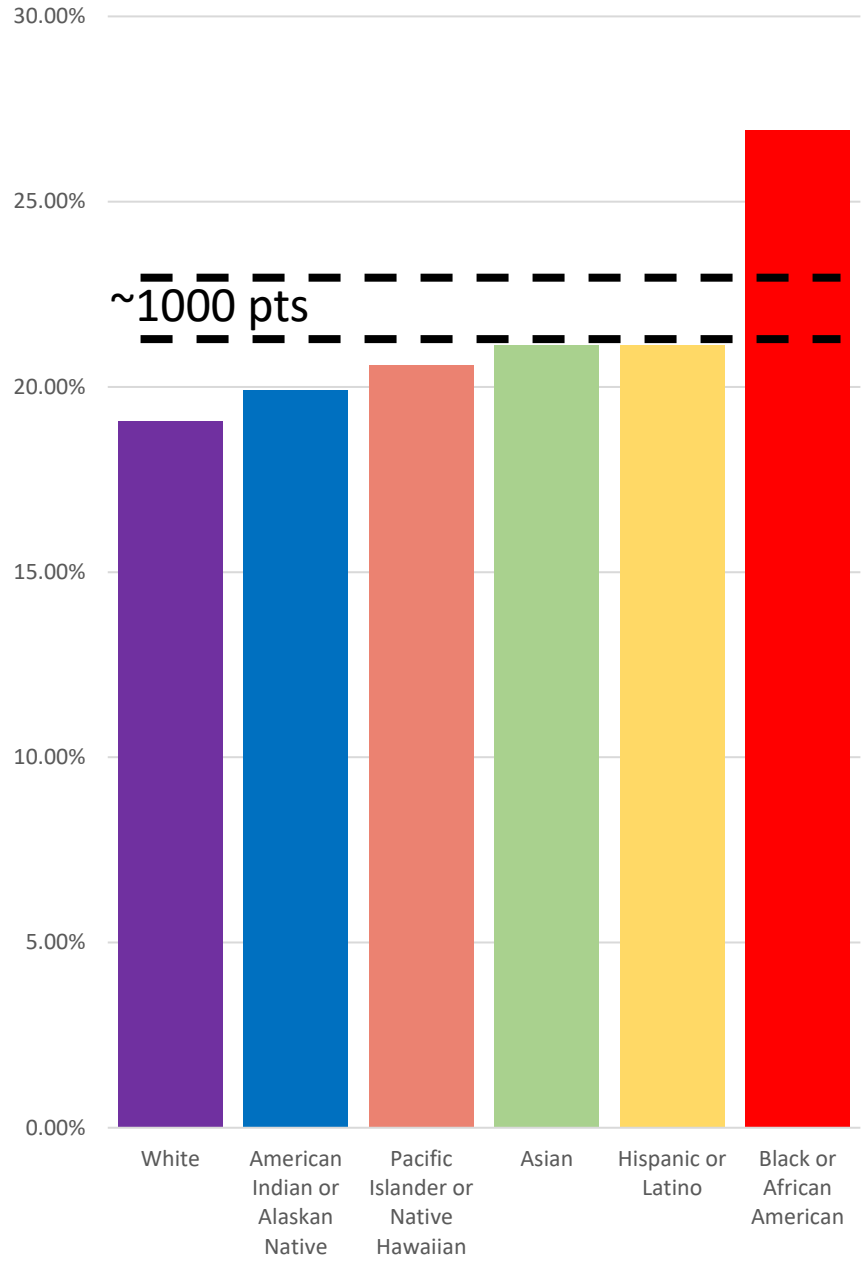
Objective	Target Date	Target %	Approx. # of patients
Close gap by 10%	12/31/22	26.14%	800
Close gap by 20%	12/31/23	25.35%	1600



Closing the Gap for the Hispanic or Latino Sub-Population

Race	Uncontrolled %	Uncontrolled Count
White	19.08%	78,215
American Indian or Alaskan Native	19.90%	406
Pacific Islander or Native Hawaiian	20.58%	148
Asian	21.12%	5,017
Hispanic or Latino	21.12%	9,737
Black or African American	26.92%	28,007

Objective	Target Date	Target %	Approx. # of patients
Close gap by 10%	12/31/22	20.92%	100
Close gap by 20%	12/31/23	20.71%	200



HEC Hypertension Road Map

AdvocateAuroraHealth

Stakeholder Groups

Data/HIT

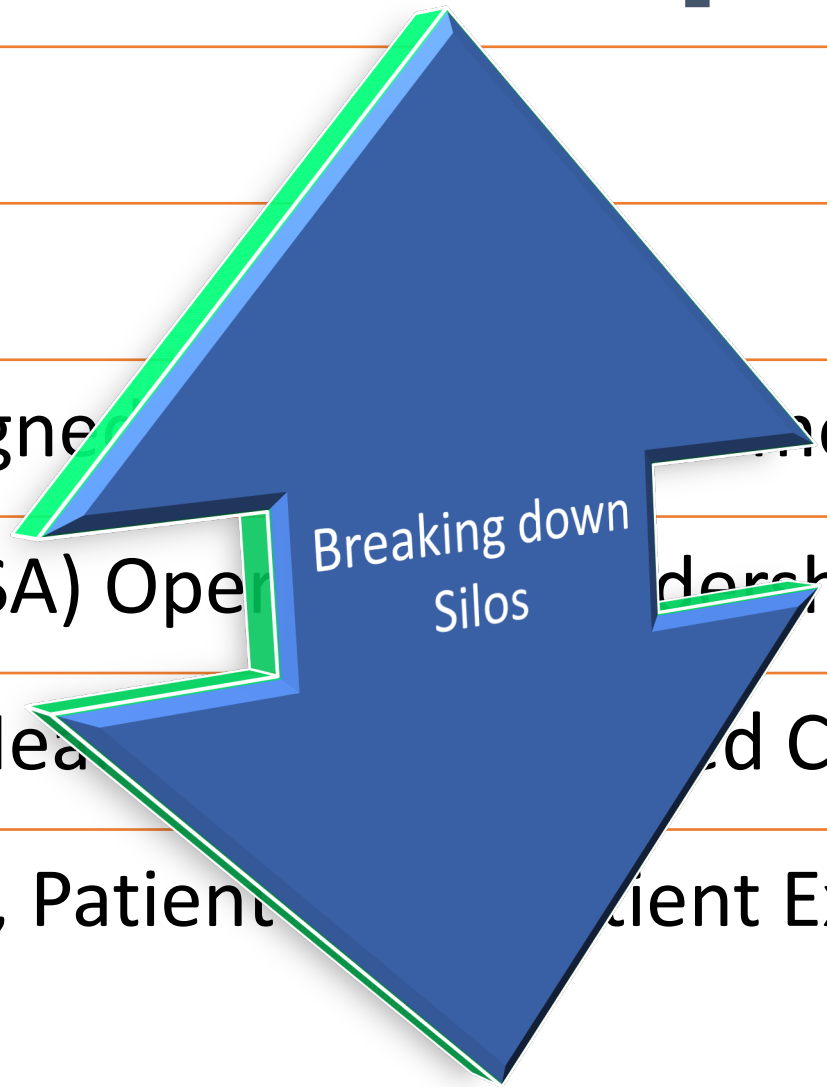
Community Health

Medical Group/APP Aligne… …e Health

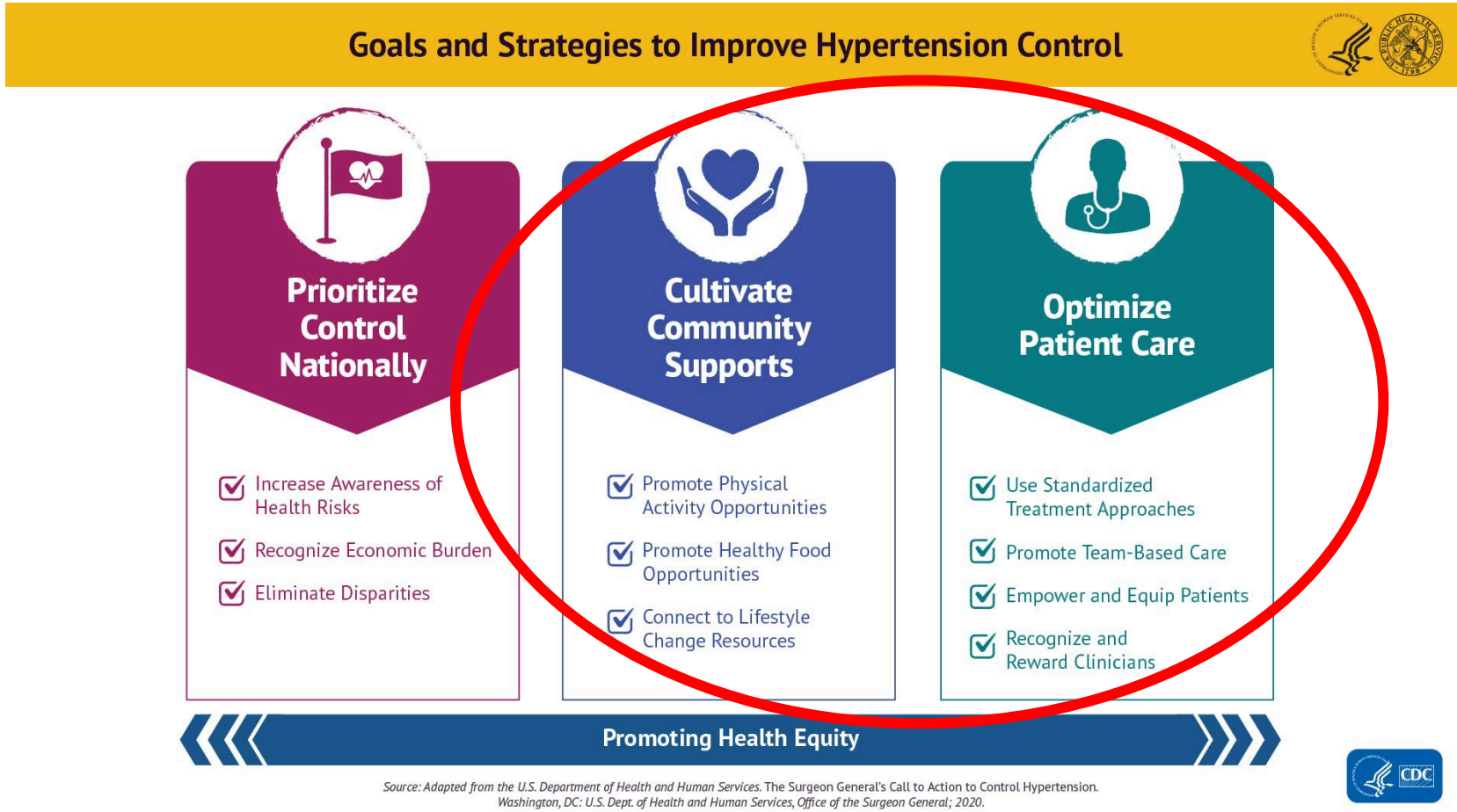
Patient Service Area (PSA) Ope… …dership

Enterprise Population Hea… …d Care Management

Ad-hoc: Research, PAM, Patient… …ient Experience, HR



HHS Surgeon General Call to Action – Control Hypertension

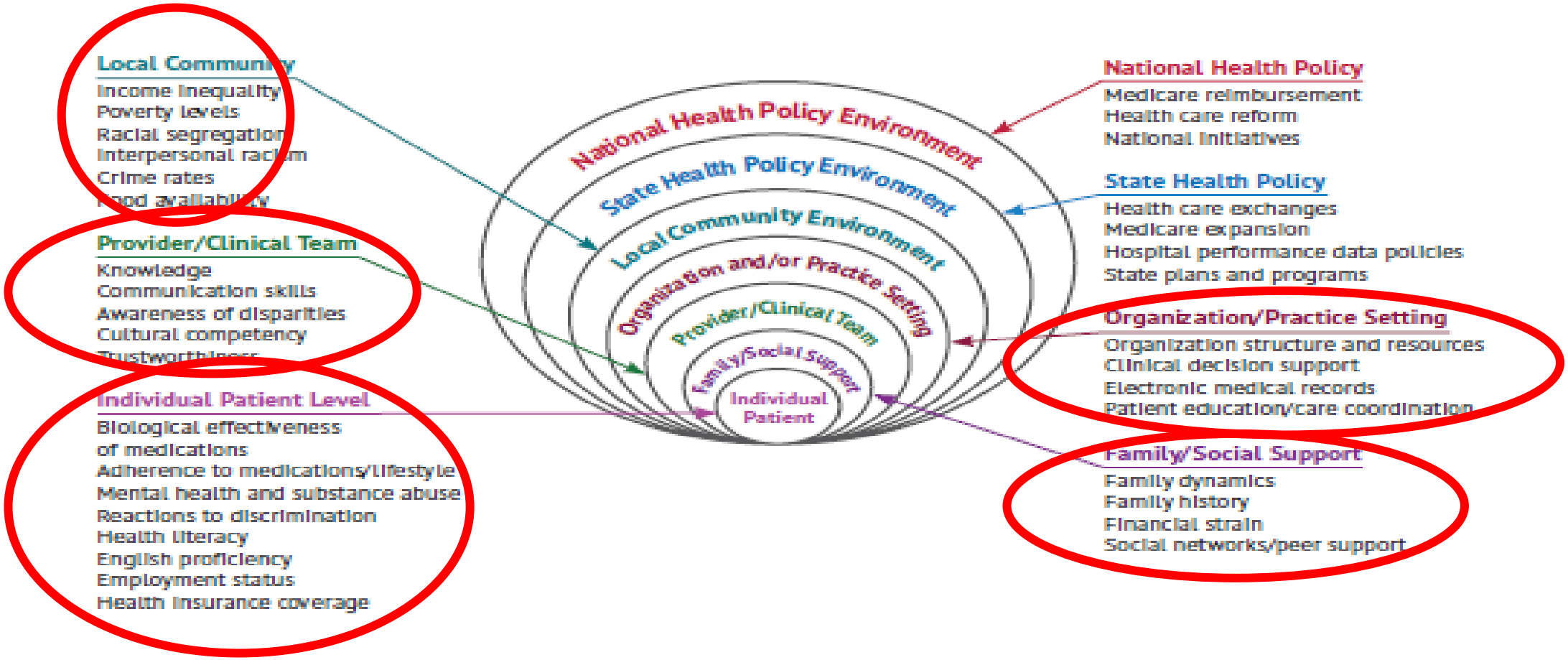


- Nearly half of US Adults have HTN
- 1 in 4 have controlled HTN BP<130/80
- Major preventable risk factor for Heart disease (1💙) and Stroke (5th) leading cau🧠f death in the US.

Source: https://www.hhs.gov/about/news/2020/10/07/surgeon-general-releases-call-to-action-on-hypertension-control.html

Factors for Consideration

Figure 4. Multilevel Influences on Disparities in Hypertension Prevention and Control



Source: Mueller M, Purnell TS, Mensah GA, Cooper LA. Reducing racial and ethnic disparities in hypertension prevention and control: what will it take to translate research into practice and policy? *Am J Hypertens.* 2015;28(6):699–704.

Link: https://www.hhs.gov/about/news/2020/10/07/surgeon-general-releases-call-to-action-on-hypertension-control.html

CMS Disparities Impact Framework & SMART Action Plan

AdvocateAuroraHealth

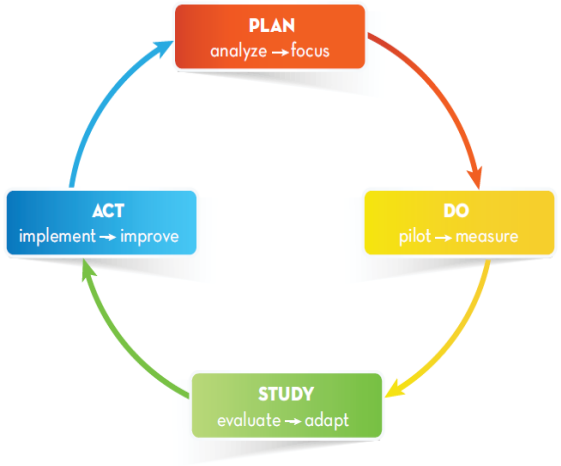
SMART Action Plan

Building an Organizational Response to Health Disparities

DISPARITIES IMPACT STATEMENT

Learn how to **identify, prioritize, and take action** on health disparities by championing the Disparities Impact Statement in your organization. Participants receive personalized technical assistance focused on strengthening your quality improvement program through a series of consultations from subject matter experts. To learn more, contact HealthEquityTA@cms.hhs.gov.

Health disparities are differences in health outcomes closely linked with social, economic, and environmental disadvantage – are often driven by the social conditions in which individuals live, learn, work, and play. Characteristics including race, ethnicity, disability, sexual orientation or gender identity, socio-economic status, geographic location, and other factors historically linked to exclusion or discrimination are known to influence the health of individuals, families, and communities.



CMS

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ACTION PLAN (PRINT ONE FOR EACH SMART AIM)

Health Equity Champion (Disparities Impact Statement Lead):	Organization:	Date:
Program, Model, or Demonstration(s):	Projected Timeline (e.g., 6 months to plan, begin implementation on XX/XX):	

SMART Aim	Primary Drivers	Secondary Drivers	Key Individuals & Organizations	Metrics	Measurable Outcomes/ Impact
What are you trying to improve for the populaton you identified?	What is needed to achieve your aim? You may have more drivers. Print a second page to add rows.	List interventions that will help you achieve the primary drivers.	Key staff, partners, stakeholders, or members of the community accountable for the secondary drivers.	What will you monitor? What data will you use to track progress toward your aim and how often?	Should align with aim.

Driver Team 1 (Remote Monitoring)

Driver Team 2 (SDOH)

Driver Team 3 (Community Health)

Driver Team 4/5 (Patient Education/Voice)

Driver Team 6 (REDUCE-BP EPIC HTN Disparity Dashboard)

Driver Team 7 (Care Management POD)

Driver Team 8 (Primary Care - RN Intervention & Visit Model)

Source - https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Disparities-Impact-Statement-508-rev102018.pdf

This is just the beginning!

- HEC HTN SMART Action Plan launches Q1 2022
- South Side Healthy Community Organization (SSHCO) recently awarded state funding to support healthy community model
  13 Coalition Partners including Advocate Trinity Hospital, University of Chicago Medicine, safety net hospitals, and FQHCs
    - State Medicaid Agency HFS IL imposed measures include Hypertension BP Control, Access to Preventive Care, and Follow-up for MI/SUD along with emphasis on Maternity and Infant health
- 2022 DE&I Dashboard includes new Health Equity measures: Uncontrolled Hypertension and Promoting Vaginal Birth measures

Charting a Path to Equity

Kisha Davis, MD, MPH
VP of Health Equity
Aledade

Aledade is building a movement of independent physicians by aligning financial models with patient outcomes.

Founded in 2014, **Aledade champions value-based care in primary care practices** through easy-to-use technology, in-person implementation support, and aligned incentives

Fast Facts about Aledade

$17+ billion under management

1,000+ independent practices

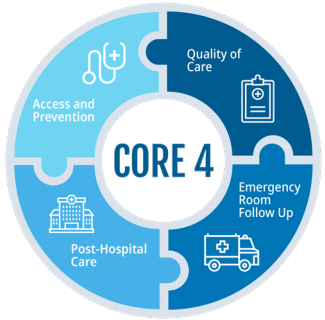
7,300+ clinicians

1.7+ million attributed patients

Core 4 Quality Improvement Strategies

Access and Prevention

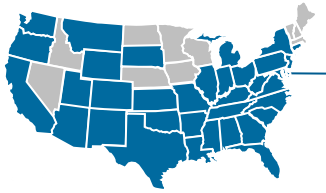
Post-Hospital Care



Closing Quality Gaps

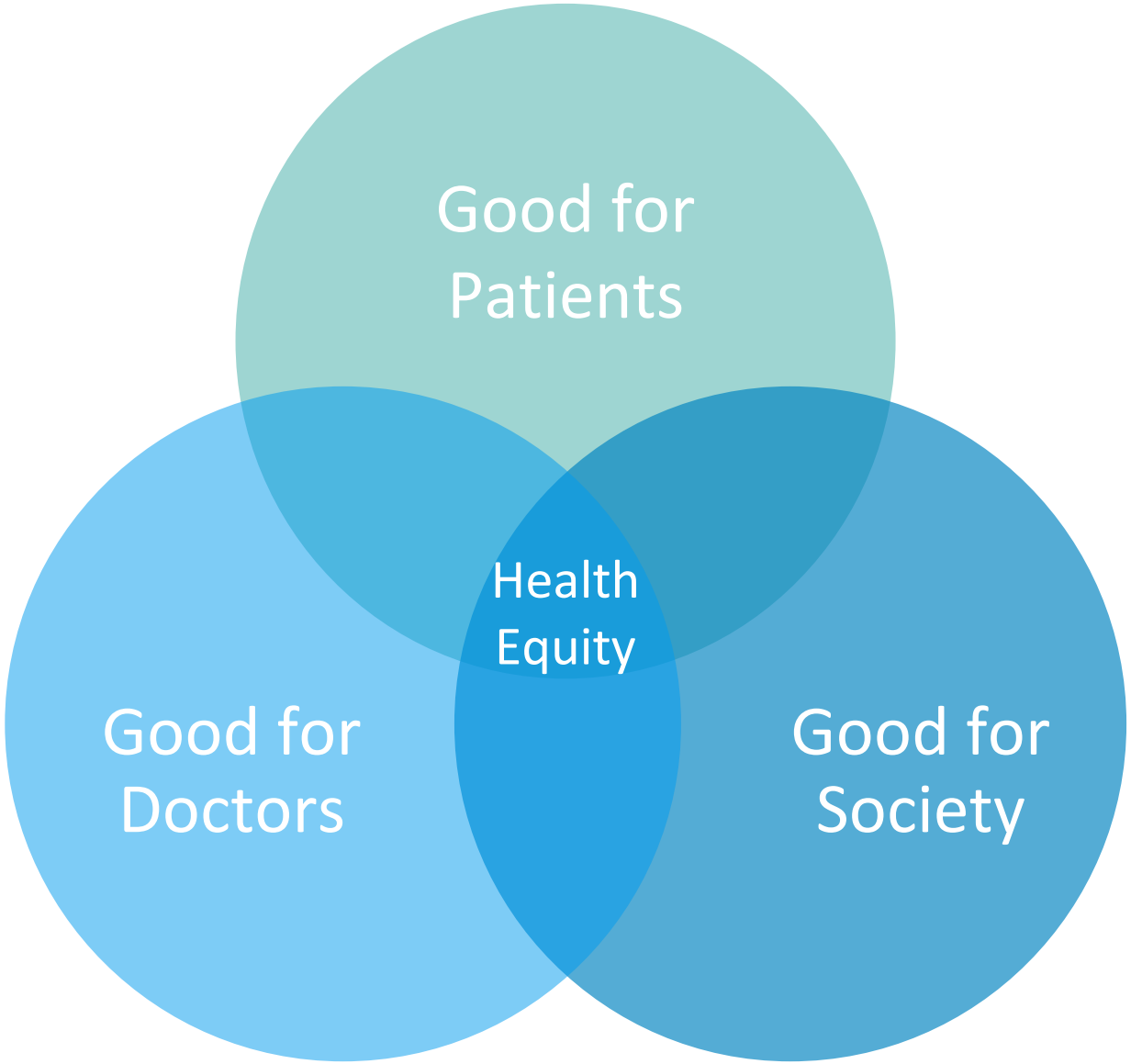
Emergency Room Follow Up

National Footprint



Our fast-growing network includes 35 MSSP ACOs and 55 other value-based care partnerships, spans 37 states, and encompasses both urban centers and hard-to-reach rural areas

Health Equity is



Health Equity, an Aledade organizational key objective in 2021 & 2022

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

Continuously improve the quality and equity of care delivered to the nearly 2 million patients in Aledade's network

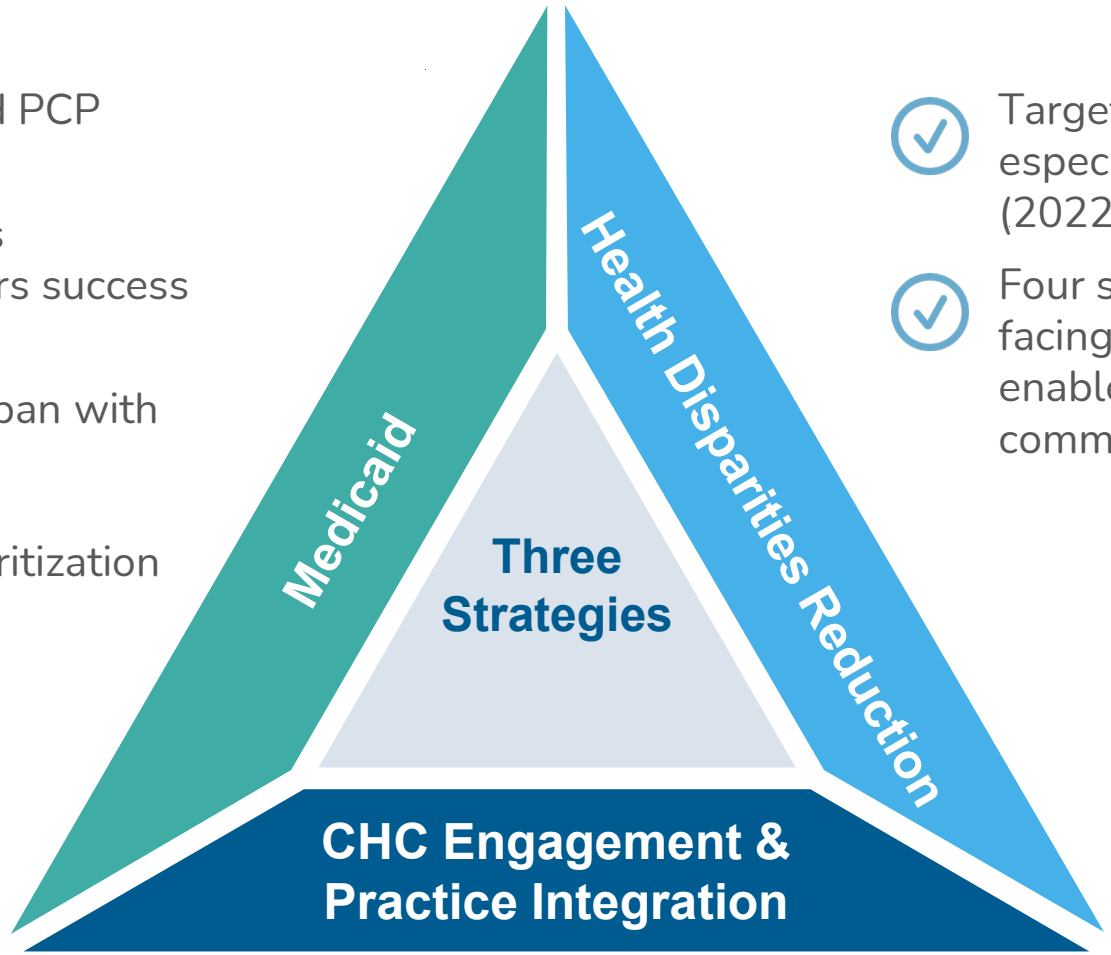
Destination Postcard for Health Equity at Aledade

Aledade patients exceed targets AND have little to no racial disparity on chronic disease and prevention metrics.

Aledade ACOs thrive in minority and vulnerable communities and the patients and doctors served are better off because of our partnership with them.

Aledade's Center for Health Equity adheres to three key strategies

- 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 and prioritization (esp. with BH & SDoH)

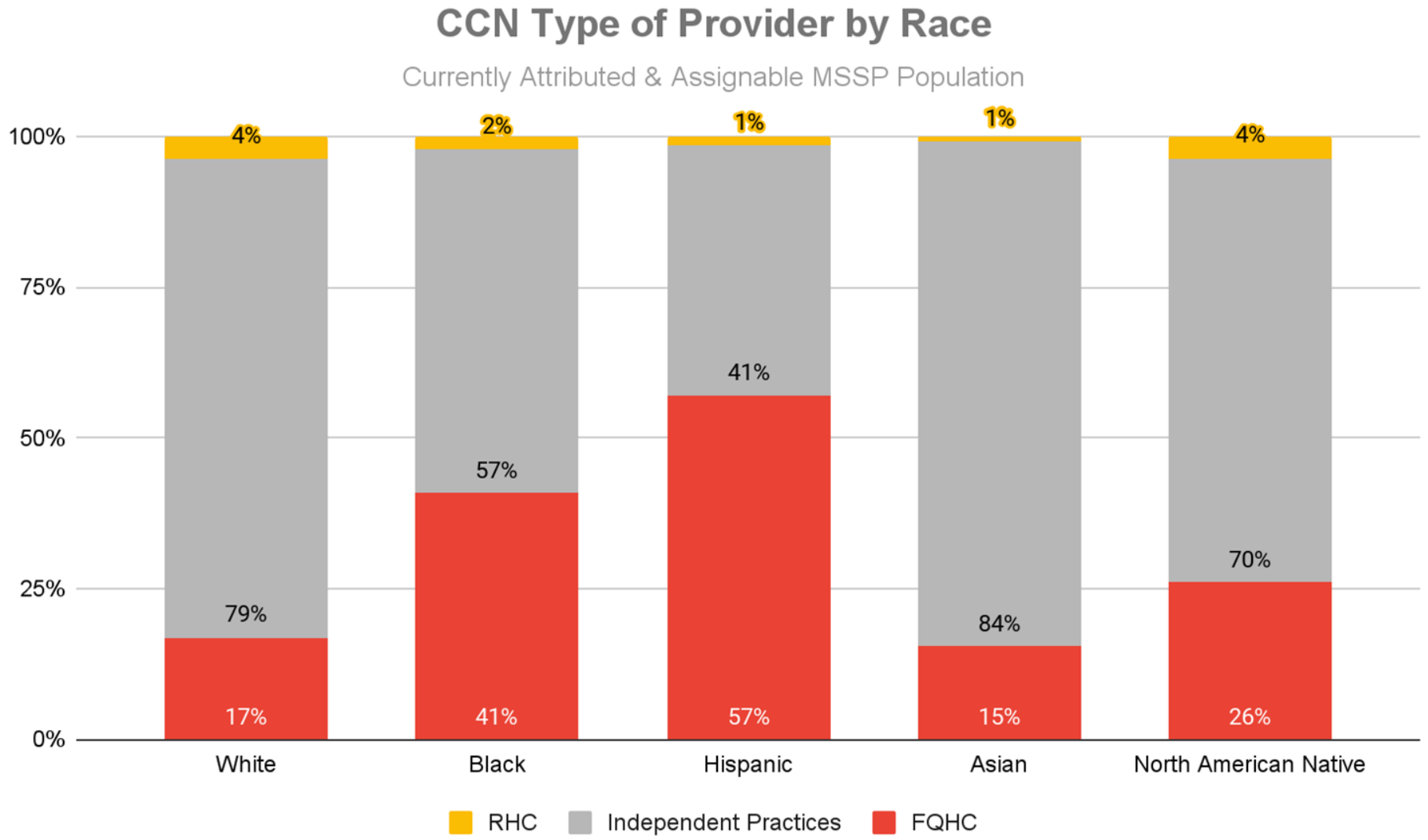


- Target HTN control and disparity, especially among Black patients (2022)
- Four segments of action: patient-facing, provider-facing, tech enabled interventions, and community & caregiver supports

- Flagship multi-state CHC-only ACO in 2021
- Bolster capacities of PCP practices caring for predominantly minority or vulnerable communities

Community Health Centers

Aledade's Black and Hispanic patients are more likely to be served by FQHCs



Insight:

- Aledade shows a strong commitment to caring for vulnerable populations, 24% of LUM comes from federally subsidized Community Health Centers (CHCs)
- Almost half of Aledade's Black and Hispanic patients are cared for in FQHCs

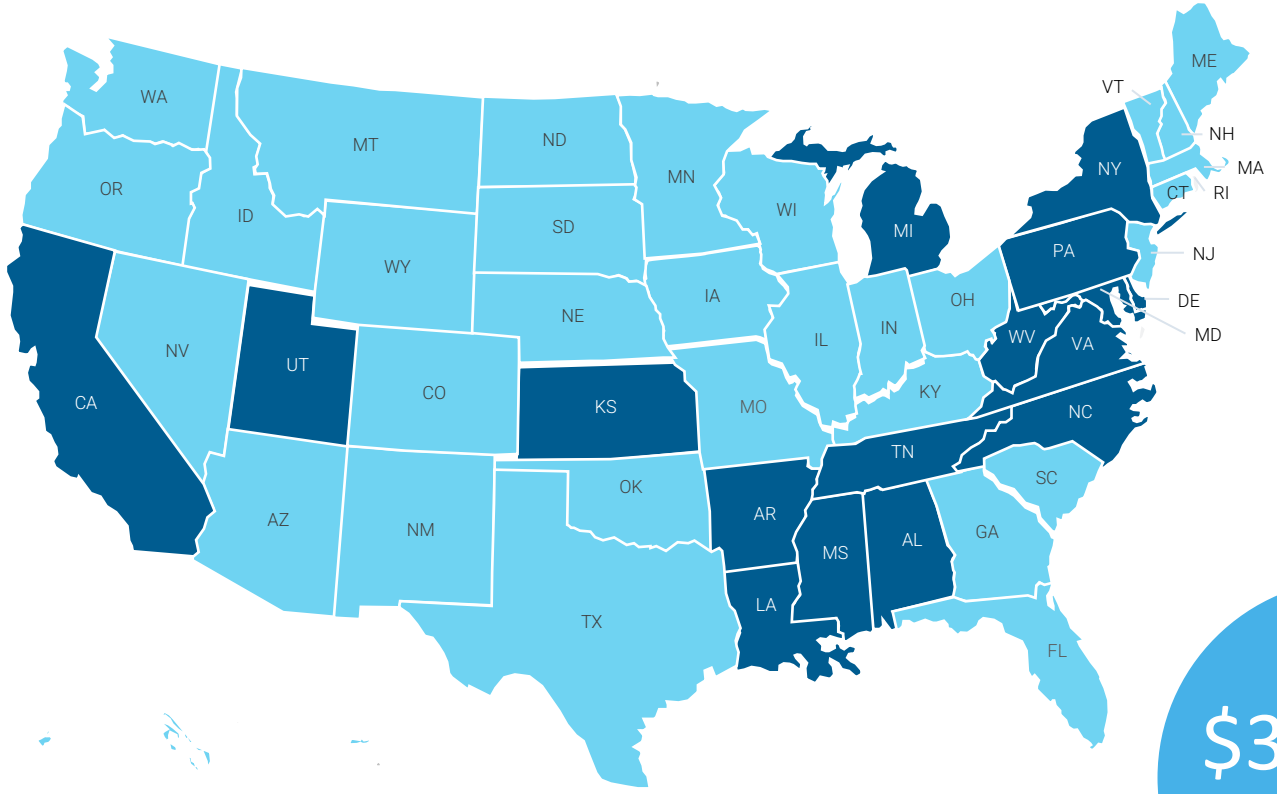
Aledade's CHC Network Spans 17 States and 5 PCAs

Partnering With the Best

An investment in CHCs is an investment in vulnerable communities.

In 2022 we will focus on building strong service and tech-enabled processes to support CHCs in VBC.

We help them get credit for what they already do well- **provide high quality, cost effective care care for marginalized patients**



$64.27M
Total Medicare savings in 2020 across 6 CHC ACOs

$30.41M
Total Medicare shared savings in 2020 across 6 CHC ACOs

- **142 CHCs** in **17 states**; 44 contracts and 11 payers
- Current **PCA relationships:** MS, LA, TN, AR and AL
- **6 CHC-only, state-specific Medicare ACOs, plus 1 national CHC ACO (**MS, KS, WV, NY, LA, AR, CA) and a combined ACO of TN and NC practices

Medicaid

Snapshot of Medicaid PY 2020 performance

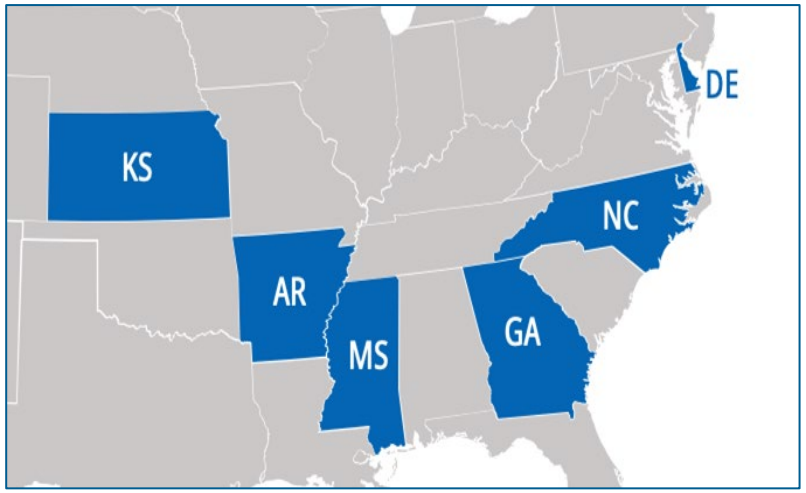
PY 2020: Performance Overview

104K Total Lives Under Management

Lowered total cost of care for Medicaid patients by **4-10%**

Increased cervical cancer screening rates 4%

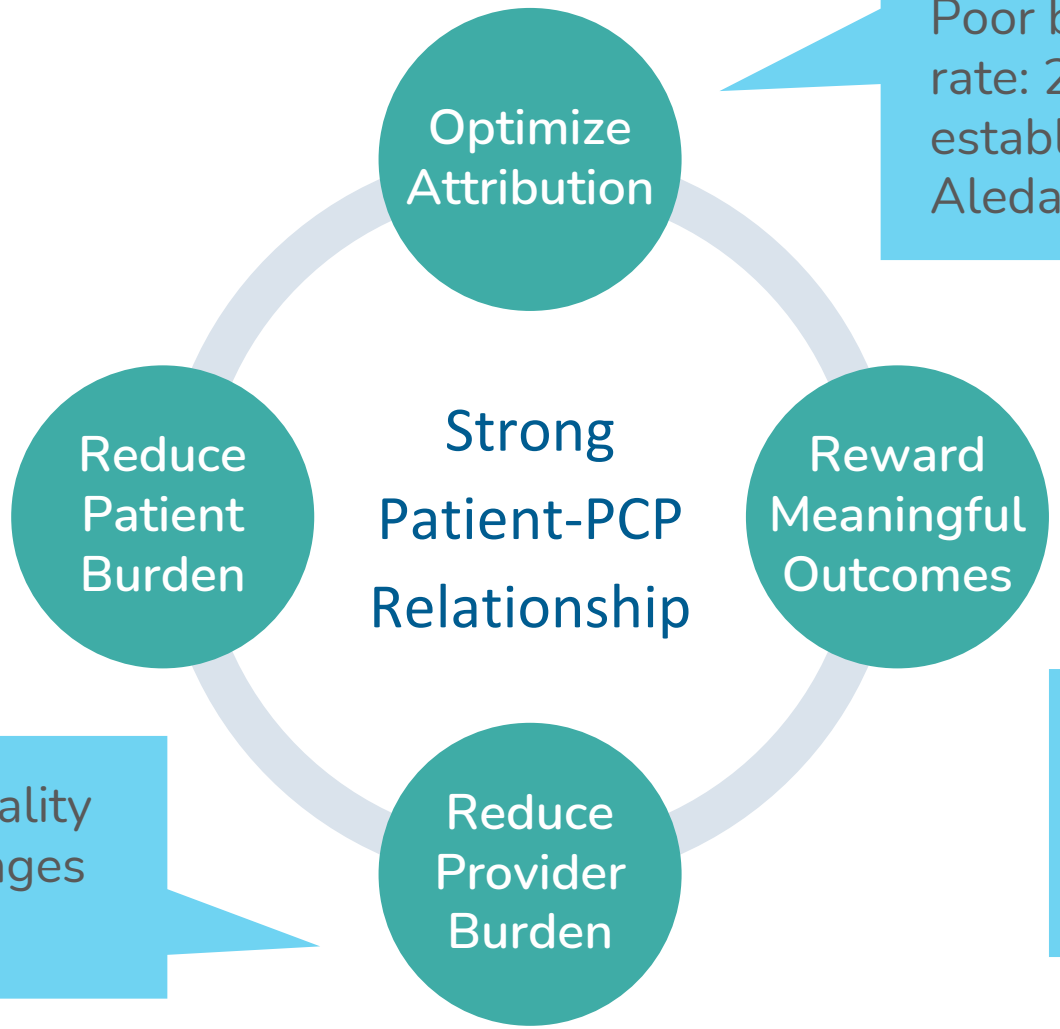
Increased PCP visit rate from **49%** in 2019 to **87%** in 2020



Drivers of Performance

- Conducted mobile medical unit events located within rural geographic “hotspots”
- 20 full-time staff to conduct text and call outreach to disengaged patients
- Increase performance through broad integration of patient data into Aledade app

Success in Medicaid requires establishing & maintaining strong patient-PCP relationship



Poor baseline PCP engagement rate: 22-69% of attributed pop. established care with their Aledade PCP in 2021

Lack of early connection to PCPs & cost sharing disincentives

Inconsistent quality target; failure to account for Medicaid churn in quality measurement.

Proliferation of quality measures; Challenges with prior auth.

Health Disparities

Aledade serves more beneficiaries in lower income areas

Aledade partners with practices that disproportionately serve patients in areas with a lower median income compared to both Traditional Medicare and the Medicare Shared Savings Program

Median County Household Income (2020)	**Traditional Medicare** (36.9M)	**Lives attributed to all MSSP ACOs** (10.1M)	**Lives attributed to Aledade** (406k)
Less than $46,309	8.3%	7.9%	**21.6%**
$46,310 to $54,505	15.6%	16.0%	**25.9%**
$53,506 to $62,327	23.3%	23.4%	18.5%
Up to $151,806	52.7%	52.6%	34.0%

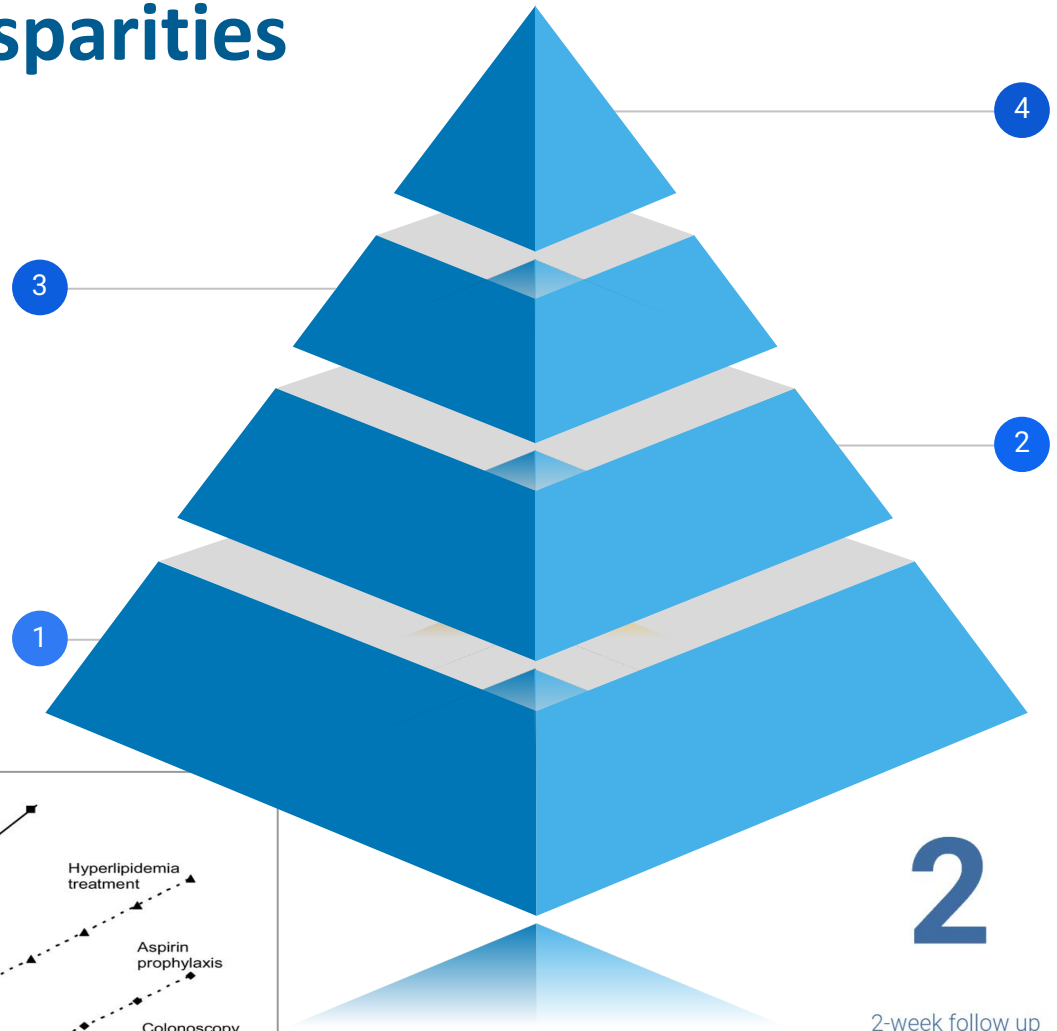
Tackling HTN Disparities

Practice Coaching

Target practices for intervention with the largest opportunity to effect change in the HTN disparity. Clinical Performance Specialists partner with practices on HTN goals.

Metrics & Dashboarding

Identification of patients based on severe/moderate BP. Stratification by race. Dependent on data integrity from practices and payers.



Patient Coaching

Self monitored blood pressure program. Exploring nutrition interventions, SDOH screening, medication adherence & optimization, and community health workers.

Awareness Campaign

Elevating hypertension as a primary care goal. Better control is good for everyone and especially good for Black patients.

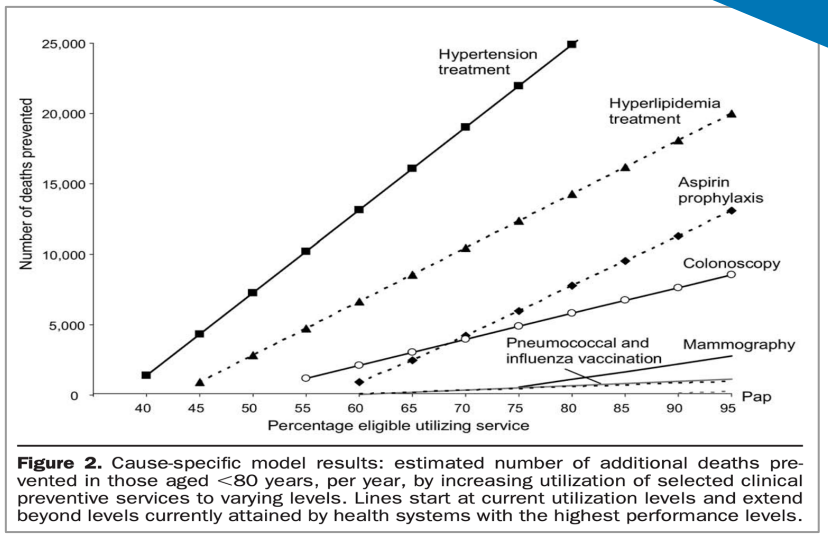


Figure 2. Cause-specific model results: estimated number of additional deaths prevented in those aged <80 years, per year, by increasing utilization of selected clinical preventive services to varying levels. Lines start at current utilization levels and extend beyond levels currently attained by health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

2 / **4** / **7**

2-week follow up appointments for severely elevated BP (BPSEV in the App)

And 4-week follow up appointments for moderately elevated BP (BPMOD in the App)

4 everyone to be engaged in hypertension work!

Clinical **and** administrative practice staff play a role!

7-day post-office visit follow-up calls

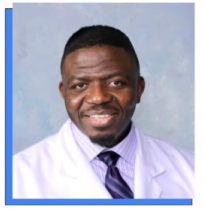
Creating a Pipeline for Diversity in Practices

Diverse Practice Recruitment

Pod of practices in AR serving majority minority patient population.

Willis Clinic PLLC
Dr. Sherita Willis
Osceola, AR

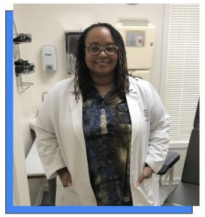
Dr. Benny Green
Little Rock, AR



Dr. Olabode Olumofin
Pine Bluff, AR

Jimmerson Family Healthcare
Dr. Robert Jimmerson
Little Rock, AR

Nayles Medical Center
Dr. Lee Nayles
Little Rock, AR



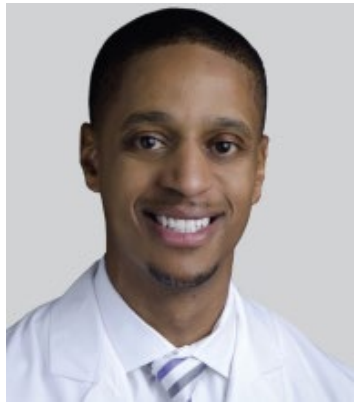
Alliance Senior Health
Dr. Koyia Figures
West Memphis, AR

Resident Recruitment

Recruiting 2nd year residents to commit to a VBC Aledade practice with stipend and signing bonus.

New Turn-Key Practices

Start-up cost investments to help launch new practices.

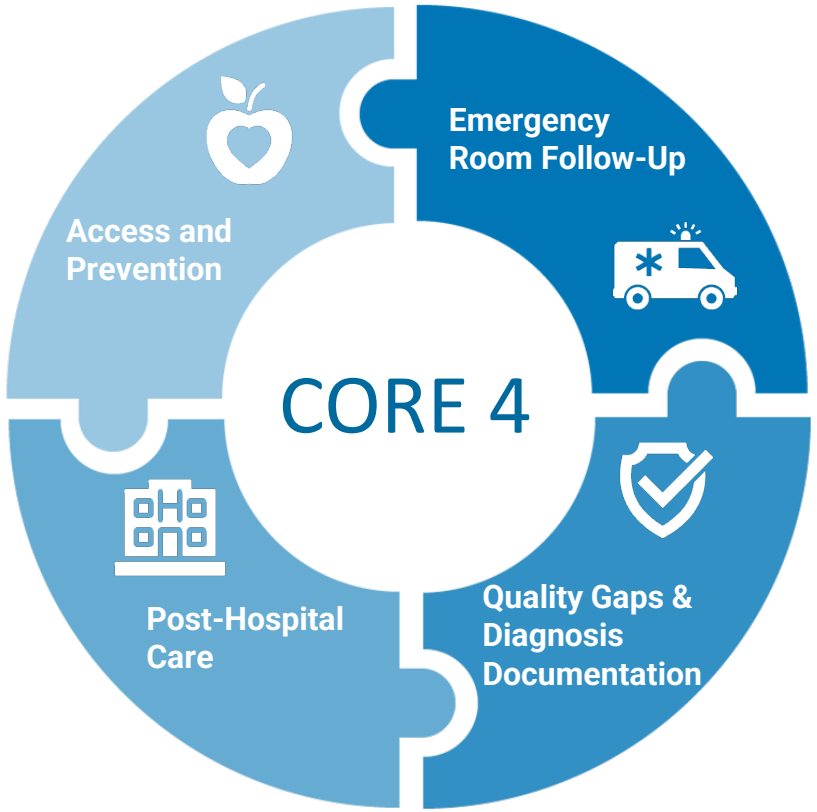


Dr. Umar Bowers
Dawson Med Primary & Urgent Care

Our ACOs Generate Savings by Focusing on Key Quality Initiatives

If 40% of your patients are considered high priority to receive an Annual Wellness Visit (AWV), by identifying and treating these patients, it could result in a downstream savings opportunity of $1,000 per patient.

Managing transitions of care is a major focus: “1 hospital readmission is avoided for every 7 Transitional Care Management (TCM) visits coded.” This results in a downstream savings opportunity of $10,000 per readmission.



It takes 12 Emergency Department (ED) follow-up calls to avoid 1 future ED visit, resulting in a downstream savings opportunity averaging $2,713 per visit.

Aledade clinicians who use the *Daily Huddle i*n the App are 2 to 3 times more likely to document accurate diagnosis suggestion opportunities during the patient's visit.

On the Horizon

- Applying a health equity lens to everything that we do
- Diving deeper with individual ACOs and markets on health equity strategy that meets their local needs
- Building out a quality care strategy that encompasses equity
- Meeting the challenges of data integrity
- Continued focus on reducing hypertension disparity
- Building out resources SDOH screening and referrals

NAACOs Webinar

Driving Towards Equity in VBC

Rob Fields, MD MHA
EVP, Chief Population Health Officer
Mount Sinai Health System

Mount Sinai

Mount Sinai Health Partners: Clinically Integrated Network

~ 3,100 full-time faculty physicians

~ 1,300 committed voluntary physicians

8 hospitals spanning Manhattan, Brooklyn, Queens, and Long Island

55 urgent care sites covering Manhattan, Brooklyn, Queens, and Long Island

Geographic access and coverage across the 5 boroughs, Long Island, and beyond

Integration with ASCs & FQHCs across New York City

Over 400 community locations

45 skilled nursing facilities that collaborate with our network

Committed to a vision of transforming healthcare in New York towards value-based care and population health

The Data Problem…

base case…

38% of our attributed lives had "blank" race/ethnicity fields in Epic
(employed sites)

Education and Training

Measurement and Re-measurement

Supplement with External Data (for reporting only)

current…

95% of our attributed lives have reportable data for Race and ethnicity

If the moral argument had been enough, we would have been doing it already.

Equity As Strategy

52% of our attributed lives across all contracts identify with a racial or ethnic minority

(with 38% unknown; most of the unknowns were in our full risk Medicaid population)

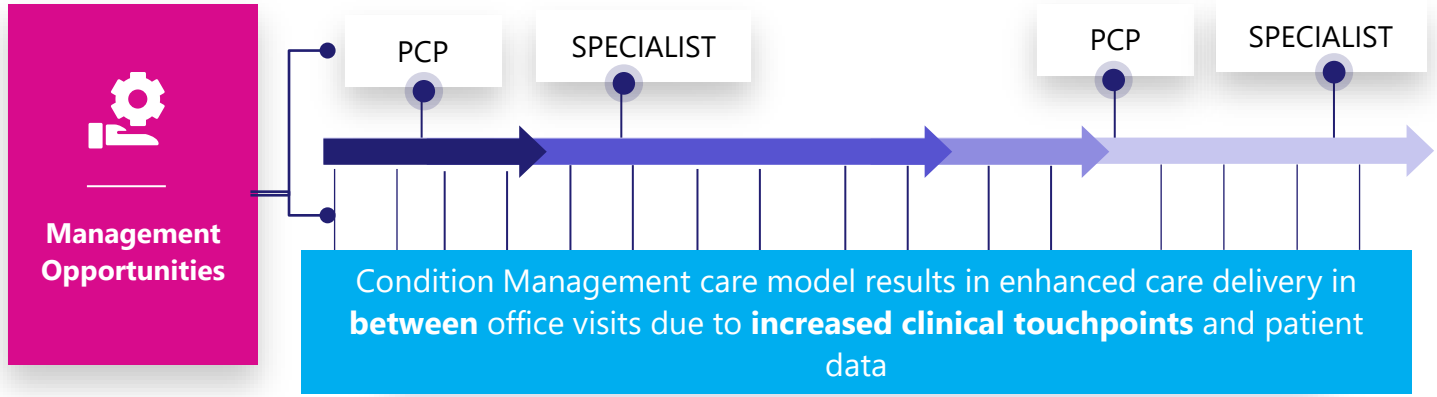
There is not path to value-based success without achieving equitable outcomes.

Condition Management Program

Traditional Care Model

Episodic care model often leads to incremental adjustments towards achievement of clinical outcomes due to less patient data and **few clinical touchpoints**

Condition Management Care Model



Condition Management care model results in enhanced care delivery in **between** office visits due to **increased clinical touchpoints** and patient data

Condition Management Program

Mission

The Condition Management program focuses on patient-centered clinical services using innovative technologies that improves access to care, positively impacts health determinants, and improves overall clinical outcomes.

Through services such as remote patient monitoring, therapeutic optimization and clinical coaching, we strive to help patients monitor, manage, and maintain their conditions.

- Currently serving over **700 patients** for hypertension, heart failure or COVID management. In 2022, will expand to diabetes, pulmonology and maternity.
- **Dedicated care team** consisting of a clinical pharmacist, dietician and patient coordinator
- Devices are **easy to use** – no additional Wifi or technology required from patients
- Strong focus on health equity and **reducing health disparities**

Remote Patient Monitoring — Hypertension and Heart Failure

The Condition Management Program provides pharmacy co-management services across the health system through a virtual department. A core component of the program is **remote patient monitoring**. Clinical pharmacists **enroll, monitor and manage patients** with their collaborating providers. The program, has over 700 patients enrolled across 17 practices.

- Bluetooth-enabled devices and cellular data hub
- How it works:
  - Patient plugs in the data hub, keeps the devices within 20 feet
  - Readings transferred from the device to the hub, analyzed in vendor's cloud, and uploaded to EPIC EMR
  - Notifications generated for out-of-range values based on pre-determined thresholds, which can be adjusted at any time by the referring provider

RPM as a Tool For Driving Equitable Outcomes

Consider the effect of the digital divide

"Low tech" design with data hub improves access to RPM

Use of registries for enrollment targets

Do not just depend on physician referral and those that come in for an appointment

Measure outcomes by race and ethnicity

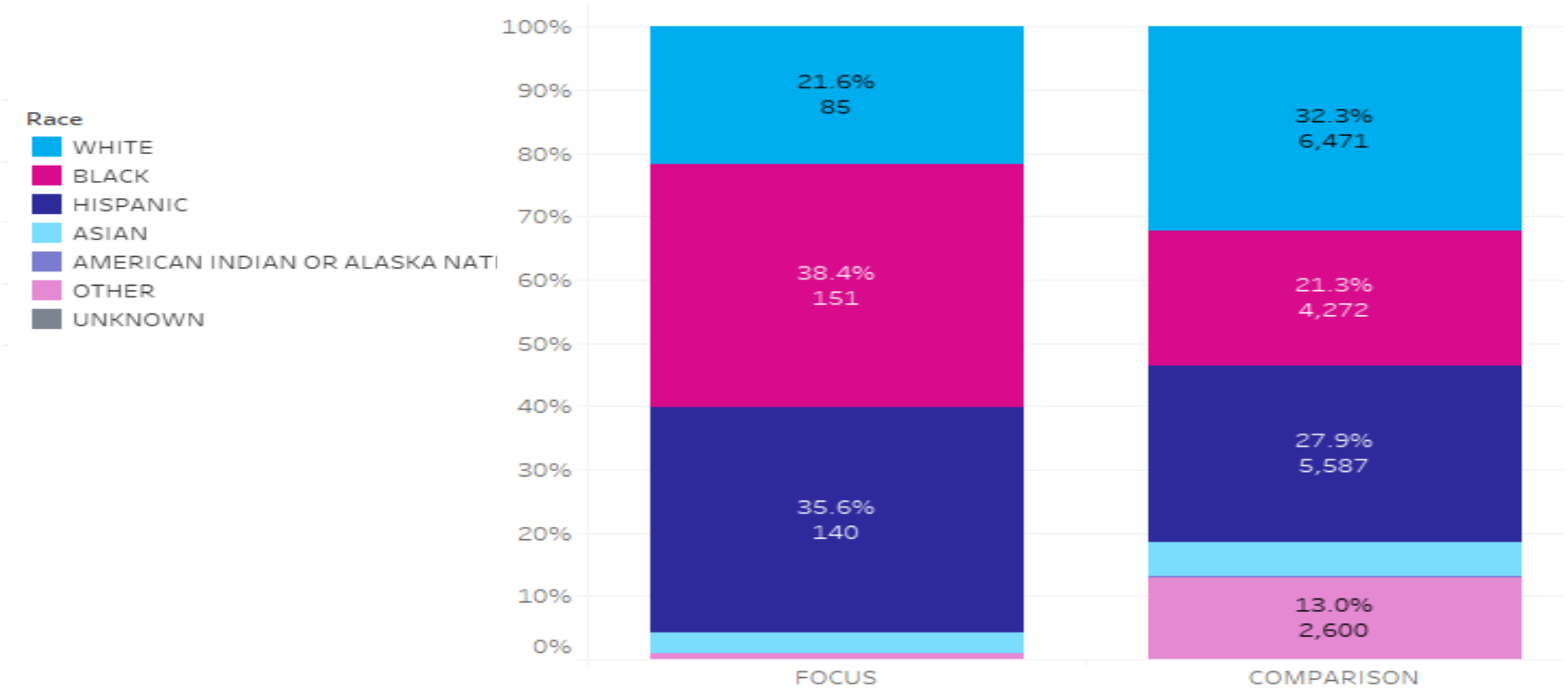
Not just clinical outcomes but also process measures such as enrollment and retention data

Continuous Improvement Model

PDSA with equity as one of the goals

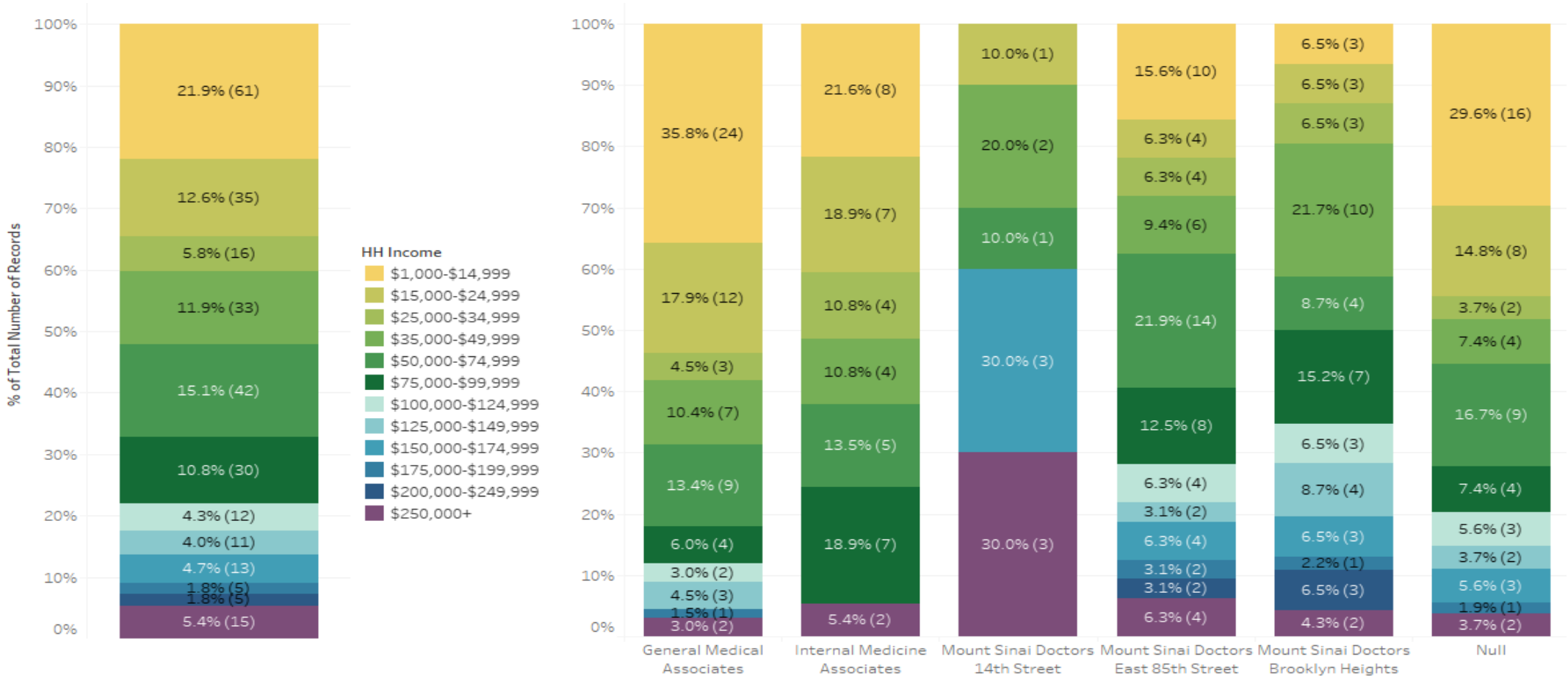
Race

More than half of the RPM patients are black and Hispanic.



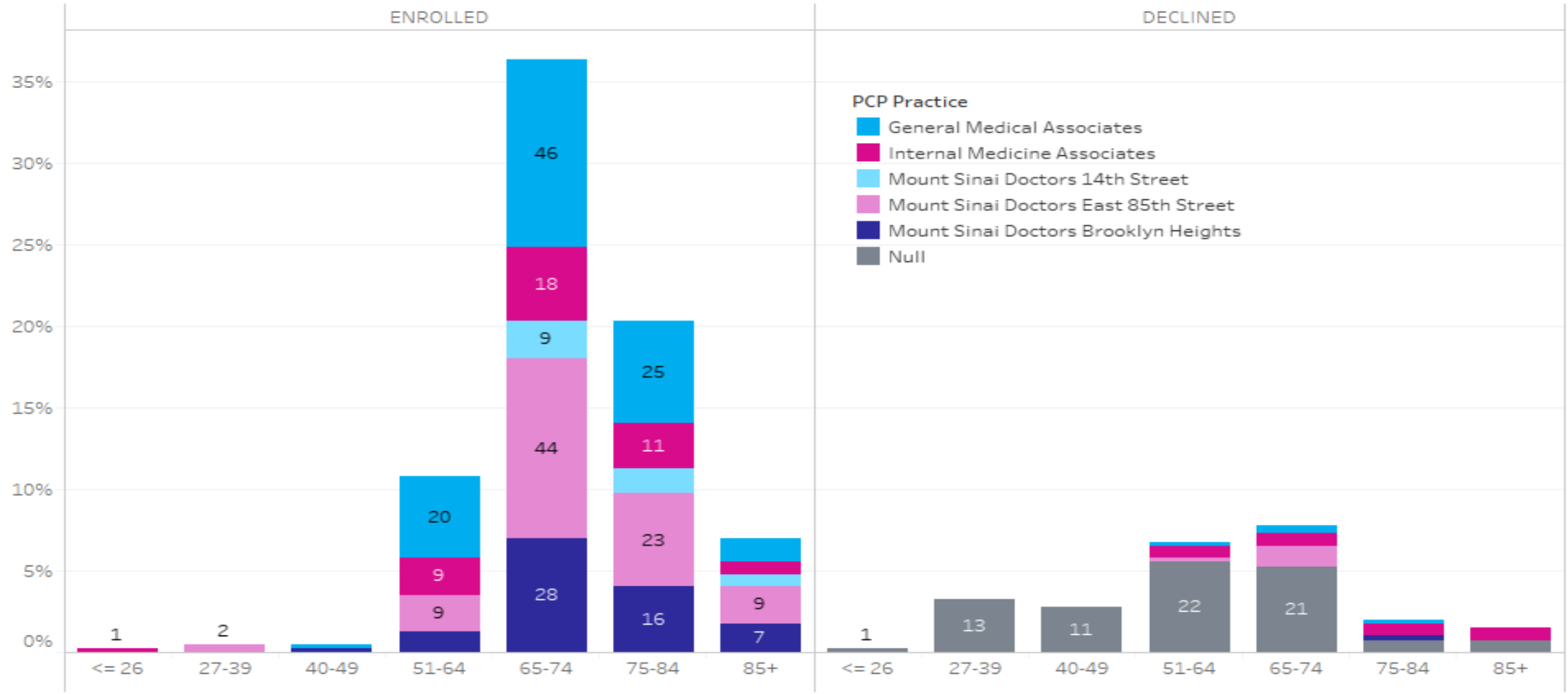
Income

More than half of the RPM patients have a household income <$50K per year.



Age

More than half of the RPM patients are >65.



Looking Ahead…

In 2022, we will focus heavily on our high-risk maternity population to continue to drive clinical outcomes and reduce health disparities.

- In NYC, Black women are **8-12x** more likely than white women to die complications during pregnancy and childbirth, including preeclampsia

- Nationally, it has been shown that 60% of maternal deaths can be avoided. **Continuous pregnancy support**, **symptom education and screening**, and **timely interventions** for high risk conditions have been shown to prevent complications and reduce maternal deaths

- **Condition Management** team has been awarded an FCC Telehealth grant to build a high-risk maternity program in 2022 and will start enrolling January' 22

Appendix

Early Engagement Data

Hypertension Management through Remote Patient Monitoring Program — Patient engagement and access to care improved

- **Sustained usage of devices** - 75% of patients are using their blood pressure machine daily for at least half of the month
- **Successful care coordination** - 75% of patients are engaging with their Condition Management health care team for at least 20 minutes per month
- **Minimal program disenrollment** - the program has a low disenrollment rate of 2% per month

- **Outpaced demand for enrollment** - on average, the program has enrolled 25% above the projected monthly enrollment target for 2021

Patient Journey

Patient Referral

Physician places a 'Referral to Condition Management' in Epic

After physician referral, the patient is aligned with a **patient coordinator, dietician** and **clinical pharmacist** who completes enrollment and consent

01

Program Enrollment Phase

Within 2 weeks, patients receive and are setup with their devices, their care team, receive training and scheduled for their first clinical visit with the clinical pharmacist

02

Clinical Management Phase

The Condition Management team facilitates care path changes with patients through collaboration with **referring physicians.**

Care team will also be notified on out-of-range notifications

03

Clinical Maintenance Phase

Once patients have reached individual clinical goals, patients **remains enrolled** with communication conducted by the care team on a **monthly basis**

04

Enrollment Criteria and Cost

HTN Enrollment Criteria

Patients with chronically uncontrolled hypertension (last 3 office visits >140/90)

Cost Sharing for Services

Traditional Medicare: 80/20 coinsurance split

Medicare + Secondary: 20% coinsurance is typically offset by secondary

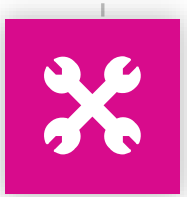
Healthfirst Medicaid, UMR service is also covered

Physician Journey

- Physicians identifies patient as potential candidate
- Introduce briefly to patient, send ‘Referral to Condition Management – Remote Patient Monitoring ’ in Epic

- Patient outreach and enrollment visit completed within one week. If RPM not covered, or patient declines, physician informed
- If patient enrolls, pharmacist will route note to physicians, and request to sign device order, co-sign and attest note

- Device sent to patients home
- Patient receives call from vendor +/- patient navigator to ensure proper set-up



Management/Maintenance Phase:

- Bi-weekly- monthly visits with pharmacist +/- dietician
- Out-of range notification responses from pharmacist
- Each billable encounter will require co-signature from physician
- Patient will have at least one billable encounter per month
- Clinical pharmacist will route all management visit notes to physician

Case Studies

Discovery and resolution of medication errors	• An out of range alert notification for BP <90/50 was received for a 69F patient followed by cardiology and primary care provider • Pharmacist conducted a chart review - patient recently discharged from the hospital and was prescribed both valsartan 320mg and losartan 100mg every 12 hours. Patient reported taking both agents • Through collaboration with PCP and cardiology, the patient was advised to discontinue losartan and continue valsartan • She was scheduled for timely follow up to evaluate her BMP after duplicating ARB therapy
Discovery of an undiagnosed medical condition	• Team received an out of range notification for a hypotensive patient who is typically hypertensive • Pharmacist informed the provider, who brought the patient in for work-up and labs sooner than next scheduled visit • Work-up revealed that patient had anemia, provider referred patient to renal and hematology • Provider states that without the Condition Management program, he would not have been able to identify as quickly

Discussion

Audience Q&A

Thank you!