Partnership to Align Social Care

A National Learning & Action Network

FREEDMEN'S HEALTH
HEALTH IS FREEDOM

ACL
Administration for Community Living

Project ECHO®

Health Equity Learning Collaborative and CCH National Learning Community Joint ECHO Session 1

January 4, 2024 | 2:00-3:30 p.m. ET

A Few Reminders

- Please introduce yourself and your organization in the chat
- Recording and slides will be shared following this session with all participants of the CCH NLC and the HELC
- Please keep yourself muted until open discussion and Q&A
- A live transcript of the meeting is available. To turn on closed captioning, click on the upward arrow next to Live Transcript and select “Captions.” The Captions option may also be available under the icon labeled “More.”

Agenda

- Freedmen's Health Consulting Experience with Accountable Care Organizations (ACOs)
- Introduction to the ECHO Learning Framework
- ACO Background
- Anonymized Case Study and Discussion
- Reminders

Freedmen's Health Value-Based Payment Experience

- **2012**: Setup and managed a statewide physician-led ACO that included FQHCs and solo-providers.
- **2014**: Created the first hospital-led ACO in the State of Maryland
- **2018**: Maryland State Department of Health Consultant to support Value-Based Payment Implementation of disease prevention programs
- **2020**: Created a Physician Led, Multi-State Direct Contracting Entity
- **2021**: Lead Consultant to facilitate the conversion of multi-state Direct Contracting Entity to two separate ACO REACH organizations.

ECHO Learning Framework

- Overview of the ECHO Learning Framework can be found at:
  - https://hsc.unm.edu/echo/what-we-do/about-the-echo-model.html
- Hallmark tenet of the ECHO Learning Framework
  - **"All Teach, All Learn"**
- Participants engage in a virtual community with their peers where they share support, guidance, and feedback
- Goal: Collective understanding of best practices to address complex issues derived from interactive discussions in a virtual group setting

Disclaimer

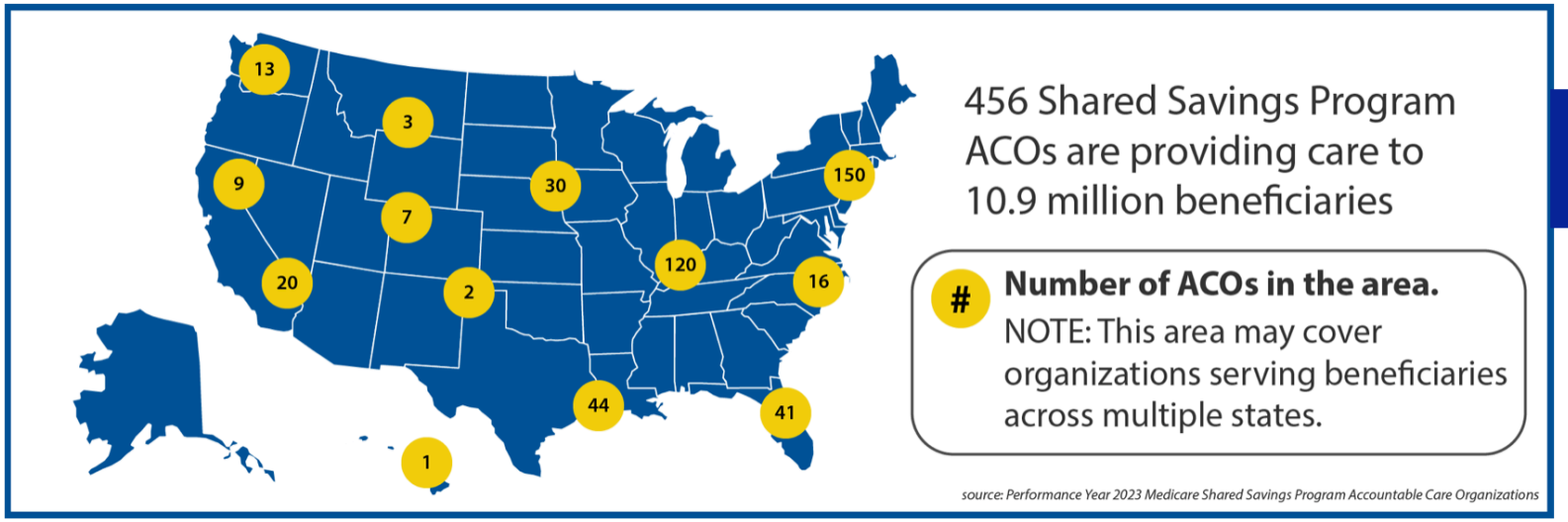
"Project ECHO® collects registration, participation, questions/answers, chat comments, and poll responses for some ECHO programs. Your individual data will be kept confidential. These data may be used for reports, maps, communications, surveys, quality assurance, evaluation, research, and to inform new initiatives."

Accountable Care Organizations

Accountable Care Organizations

- Groups of providers and suppliers participating in one-sided or two-sided risk models with CMMI for total cost of care for Medicare Fee for Service beneficiaries.

National Participation



To learn more about the number and geographic location of Shared Savings Program ACOs, reference Program Data.

CMMI Proposed Solution for Advancing Health Equity

Develop new models and modify existing models to address health equity and social determinants of health

Increase the number of beneficiaries from underserved communities who receive care through value-based payment models by increasing the participation of Medicare and Medicaid providers who serve them

Evaluate models specifically for their impact on health equity and share data and "lessons learned" to inform future work

Strengthen data collection and intersectional analyses for populations defined by demographic factors such as race, ethnicity, language, geography, disability, and sexual orientation/gender identity to identify gaps in care and develop interventions to address them

Analyzing ACO Data

- ACO Patient Population
  - All persons in a ACO are enrolled in Original Medicare
- ACO Objectives
  - Improve clinical quality
  - Reduce total cost of care
- Link to finding ACOs in your State and ACO Quality Data:
  - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/program-data

Priority Populations for Each Intervention

Community Health Integration	Principal Illness Navigation	PIN-PS
Health-Related Social Need that directly impedes the ability to treat or diagnose a health condition.	A major health issue that is intended to last at least 3 months in duration. The person would benefit from having an assigned person to work with the beneficiary and caregivers to provide navigation supports to help achieve optimal health outcomes. Health-related social need can be present but is not required to receive this benefit.	Limited to the behavioral health population. Case management services is not part of the core services.

Referral Process Options

- EMR Data to perform patient stratification
- Roster referrals based on disease state or other factors
- Patient lists
- Individual patient assessments
- Case management referrals
- Physician referrals
- Hospital discharge planner referrals
- Other sources…

Pros and Cons

Roster/List Referrals

- Pros
  - The ability to identify large numbers of patients that are potentially eligible for the service.
  - Promise of scale
  - Increased efficiency in referral management
- Cons
  - Requires a secure method of exchanging the data.
  - Requires outreach and engagement to the persons on the list.
  - Additional labor required to engage individual persons to deliver service.

Individual Referrals

- Pros
  - Individual needs are identified at the time of the referral.
  - Data shows that a direct referral generally leads to increased adherence to the referral.
  - "My doctor ordered this service for me"
- Cons
  - Less efficient
  - Requires continual reminders to referrals sources to maintain referral volume.
  - Takes time to build the patient volume.

Impact on Quality Measures

CMS Research on the impact of socioeconomic factors

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Examining the Potential Effects of Socioeconomic Factors on Star Ratings*

Center for Medicare

September 8, 2015

Goal of Research

Provide the scientific evidence as to whether MA or Part D sponsors that enroll a disproportionate number of vulnerable beneficiaries are systematically disadvantaged by the Star Ratings.

Parallel analyses are being conducted to determine if modifications are needed for the payment risk adjustment models.

Likelihood of Receiving Recommended Care or Outcomes

HEDIS Measure (MA Contracts)	LIS/DE Adjustment Odds Ratio	Disability Adjustment Odds Ratio
Adult BMI Assessment	1.11***	0.93***
Rheumatoid Arthritis Management	0.85***	1.17***
Breast Cancer Screening	0.69***	0.72***
Controlling High Blood Pressure	0.99	1.02
Diabetes Care – Blood Sugar Controlled	0.68***	0.63***
Diabetes Care – Eye Exam	0.93***	0.68***
Diabetes Care – Kidney Disease Monitoring	0.93***	0.69***
Colorectal Cancer Screening	0.87***	0.47***
Osteoporosis Management in Women who had a Fracture	0.71***	0.56***
Plan All-Cause Readmissions#	0.87***	N/A&
Annual Flu Vaccine	0.85***	0.72***

NOTE: Separate analyses conducted for LIS/DE and Disability adjustment. Models control for between-contract differences.
Measure is reverse-coded to make interpretation of Odds Ratio the same as other measures.
* Significant at p<0.05 ** Significant at p<0.01 *** Significant at p<0.001
Blue Odds Ratio greater than 1.0 indicates a significant positive effect of being LIS/DE or Disabled.

Likelihood of Receiving Recommended Care or Outcomes

HOS and PDE Measure (MA Contracts)	LIS/DE Adjustment Odds Ratio	Disability Adjustment Odds Ratio
Monitoring Physical Activity	0.98	1.34***
Reducing the Risk of Falling	1.67***	1.32***
Medication Adherence for Diabetes Medications^	0.94***	0.75***
Medication Adherence for Hypertension^	0.86***	0.72***
Medication Adherence for Cholesterol^	0.94***	0.79***

NOTE: Separate analyses conducted for LIS/DE and Disability adjustment. Models control for between-contract differences.
* Significant at p<0.05 ** Significant at p<0.01 *** Significant at p<0.001
Blue Odds Ratio greater than 1.0 indicates a significant positive effect of being LIS/DE or Disabled.
Orange Odds Ratio less than 1.0 indicates a significant negative effect of being LIS/DE or Disabled.
Black Odds Ratio indicates no significant effect.
^The sample sizes for PDE were very large, so very small differences become statistically significant

Summary of Associations Between Performance and LIS/DE or Disability

Type of Association	LIS/DE	Disability
Positive	2	3
No effect (not significant)	2	1
Negative	12	11
Total Number of Measures	16	15*

** Readmissions is excluded as it is already adjusted for several factors that could determine Disability status.*

CMS Medicare-Medicaid Coordination Office Data

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE-MEDICAID COORDINATION OFFICE
Centers for Medicare & Medicaid Services

FACT SHEET – MARCH 2020

People Dually Eligible for Medicare and Medicaid

In 2018, there were 12.2 million individuals simultaneously enrolled in Medicare and Medicaid.[1] These dually eligible individuals experience high rates of chronic illness, with many having long-term care needs and social risk factors. Forty-one percent of dually eligible individuals have at least one mental health diagnosis, 49 percent receive long-term care services and supports (LTSS), and 60 percent have multiple chronic conditions.[2,3] Eighteen percent of dually eligible individuals report that they have "poor" health status, compared to six percent of other Medicare beneficiaries.[4]

Dually eligible individuals must navigate two separate programs:

- Medicare for the coverage of most preventive, primary, and acute health care services and prescription drugs, and
- Medicaid for the coverage of LTSS, certain behavioral health services, and Medicare premiums and cost-sharing.

- 41% have at least one mental health diagnosis
- 49% receive long-term services and supports
- 60% have multiple chronic conditions

Case Study Discussion

Local ACO

- A Medicare Shared Savings ACO (Local ACO) has participated in the MSSP program as a one-sided risk model.
- Beginning in CY2024, the MSSP must move to a two-sided risk model.
- For the first four years of participation, the MSSP ACO has not generated any shared savings.
- The ACO is a high-revenue ACO with two participating hospitals in the ACO provider list.
- ACO leadership want to work with CBOs to address needs of the population.

Key ACO Data Elements

ACO Demographics

- Total Medicare Beneficiaries: 7,324
- ESRD 160
- Non Duals 5,953
- Duals 1,211

Age distribution

- 0 – 64: 925
- 65 – 74: 4,562
- 75 – 84: 1,334
- 85+ - 503

- Percent Dual – 18.7%

ACO Quality Measures

- 30-Day Readmission Rate 16.2%
- All Unplanned admissions for patients with multiple chronic conditions: 41.23
- Screening for Depression: 91.02
- Remission for depression within 12 months: 0.0%
- Diabetes poor control: 15.24 (A1c >9.0%)
- Controlling High Blood Pressure 64.32

*Question: What populations in the ACO could be targeted for HRSN screening/interventions?

ACO Executive

FREEDMEN'S CONSULTING
HEALTH IS FREEDOM

- Data analysis shows the following ACO patient diagnosis groups have high costs and poor health outcomes:
  - Diabetes with complications
  - Heart Failure
  - Falls
  - Dementia
  - Behavioral Health/SUD
  - Dual Eligible
- The top HRSNs are medication access, food insecurity, & transportation. How could these needs impact the management of the conditions listed?
- What methods could the ACO Executive deploy to evaluate the impact of working with a CBO?

ACO Medical Director

FREEDMEN'S CONSULTING
HEALTH IS FREEDOM

- Medical Director attended a Value-Based Care Webinar on partnering with CBOs.
- Medical Director wants to launch this model for the ACO.

- Should the ACO start system wide or initiate a pilot?
- How will the medical director identify the participating practices?
- How will the CBO integrate with the practices?
- How would they interact with the ACO participating hospitals?

ACO IT Director

FREEDMEN'S CONSULTING
HEALTH IS FREEDOM

- ACO Executive and ACO Medical Director request that data on ACO patients be shared with a CCH.
- The CCH will need access to EMR data to document HRSN interventions.

- What are the options for the ACO to share data with the CCH in a compliant manner?
- How will the CCH share outcome data for closed-loop referrals?
- The CBOs are resistant to using Unite Us, but Unite Us is integrated with the hospital EMR for referrals. What can be done to address this issue?

ACO Provider

FREEDMEN'S CONSULTING
HEALTH IS FREEDOM

- I am interested in working with a CBO to address the needs of my patients.
- Initiating the Process:
  - How do we make referrals?
  - Where will the data live?
  - How often will I receive feedback on referrals?
  - How is this work funded?
  - Some patients refuse the copay for CCM, how do we handle this?

CBO

- I will begin receiving referrals for screening and addressing HRSNs?
- Who completes the SDOH assessment?
- A consent is required. Can the CBO obtain consent?
- What are the methods of obtaining consent?
- How are copays handled?
- What is the patient does not accept the service?
- What if the patient tells me that they do not want to pay the copay but they want assistance?

Reminders

CCH National Learning Community Reminders

- Upcoming Meetings
  - NLC Small Group Discussion – January 25, 2024, 2-3pm EST
- Review of Important Timelines
  - Community Care Hub Capacity Assessment due January 11, 2024 – *Link with organization log in information shared by Collaborative Consulting*
  - Action Plan due January 11, 2024 – email plan to CommunityCareHubs@acl.hhs.gov

Partnership to Align Social Care

A National Learning & Action Network

HELC Reminders & Requests

FREEDMEN'S HEALTH
HEALTH IS FREEDOM

- Make sure that the Partnership has contact information for all HELC participants and Community-Clinical Team Members as they are committed.
  - **Please complete this form by Friday, January 19**: https://forms.gle/7VfVEu1hzGqnMDBJ7
- Reach out to healthequity@partnership2asc.org if you have changes to Community-Clinical Team Members.
- Upcoming ECHO Learning Session Dates:
  - Thursday, January 18 @ 2-3:30 p.m. ET
  - Thursday, February 1 @ 2-3:30 p.m. ET

FREEDMEN'S CONSULTING
HEALTH IS FREEDOM

Project ECHO®

Thank you!

Tim McNeill, RN, MPH

811 L Street, SE;
Washington, DC 20003

202-344-5465

202-344-1234

tmcneill@freedmenshealth.com