ACO Approaches to Addressing Health Equity

10.01.21

Institute for Accountable Care and NAACOS

Overview of Presenters

- Debbie Welle-Powell, Essentia Health – in person
- Tracey Wilkie, Umass Memorial ACO – virtual
- Patt Richesin, Kootenai Accountable Care - virtual

Setting the Stage for Equity

Source	White	Black	Asian	LatinX	Native American	Other/ UK
HHS 65+ (2018)	77%	9%	5%	8%	0.1%	0.8%
Medicare Advantage (2019)	67.2%	12.7%	3.9%	13.8%	0.2%	2.2%
FFS Overall (2019)	77.1%	9.2%	3.2%	7.0%	0.6%	2.9%
MSSP ACO (2018)	85.8%	8.3%	1.4%	1.3%	0.2%	3.1%

*Note, the FFS estimates include all beneficiaries in the program including ACO beneficiaries.

[9]https://acl.gov/sites/default/files/Aging%20and%20Disability%20in%20America/2019ProfileOlderAmericans508.pdf

[10,11] https://us.milliman.com/-/media/milliman/pdfs/2020-articles/articles/10-15-20-comparing-the-demographics-of-enrollees-v1.ashx

[12] MSSP Public Use file

Success within MSSP

MSSP ACO Beneficiary Diversity	Total ACOs	Mean Benes	Savings Rate	Earned Savings Per Bene	Percent ESRD	Percent Disabled	Percent Aged Dual	Percent Aged Nondual
Low	355	21,699	1.96%	$128	1%	11%	6%	83%
Medium	148	19,627	2.80%	$175	1%	12%	10%	77%
High	38	10,312	4.33%	$223	2%	18%	23%	57%

Low is defined at 0-17 percent non-White;
Medium is defined a 17-37 percent non-White;
High is 37 percent none-White or higher.

We are called to make a healthy difference in people's lives.

NAACOS: Fall 2021 Conference
Health Equity

Debbie Welle-Powell
Chief Population Health Officer

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At a glance: Essentia Health

- Nonprofit, integrated health care system headquartered in Duluth, MN
- 14,700 employees
- 15 hospitals, 75 clinics
- Serving 560,000+ unique patients in Minnesota, Wisconsin, and North Dakota
- NCQA Level 3 ACO
- 180,000 at risk Lives: Commercial, Medicare – Enhanced Track MSSP, Medicaid
- Approximately 43% of FFS Revenue flows through Total Costs of Care Contracts

Essentia Health
Hospital & Clinic Locations

LEGEND
Essentia Health Market
Essentia Health Hospital
Essentia Health Clinic

North Dakota
Minnesota
Wisconsin
Michigan
Fargo
Ada
Fosston
St. Mary's-Detroit Lakes
Deer River
Virginia
Northern Pines
EH-Duluth
St. Mary's Medical Center
St. Joseph's
Sandstone
St. Mary's Hospital-Superior
Holy Trinity Hospital
International Falls Clinic
Ely Clinic
Babbitt Clinic
Hibbing Clinic
Chisholm Clinic
Grand Rapids Clinic
Walker Clinic
Bagley Clinic
Jamestown Clinic
Valley City Clinic
Casselton Clinic
West Fargo Clinic
West Acres Clinic
32nd Avenue Clinic
Lisbon Clinic
Hankinson Clinic
Graceville Clinic
Spooner Clinic
Hayward Clinic
Ashland Clinic
Proctor Clinic
West Duluth Clinic
Hermantown Clinic
Lakewalk Clinic
Lakeside Clinic
Remer Clinic

Last Updated: January 2019
Created by:
Market Research Department

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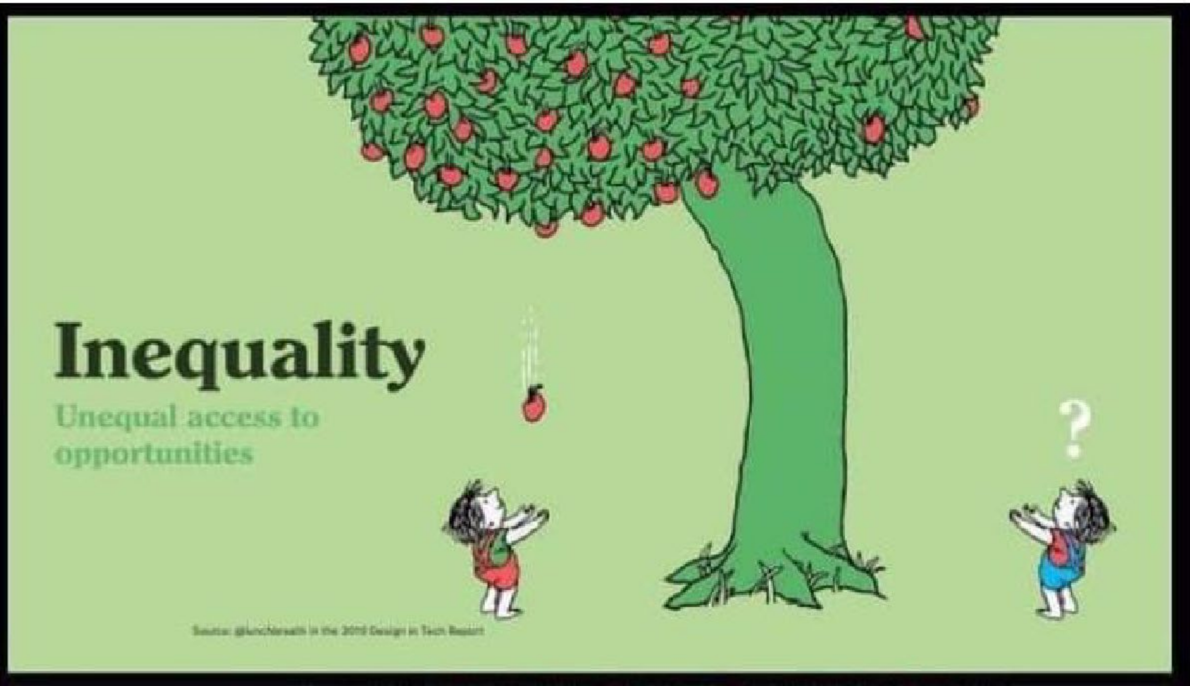
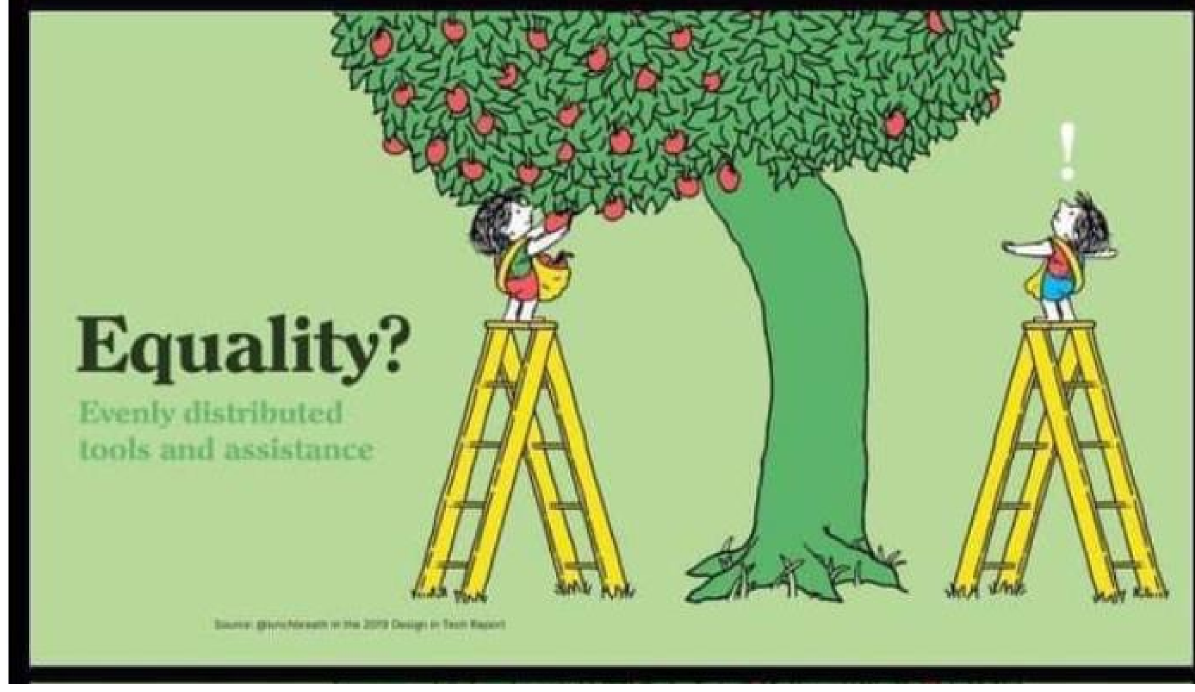
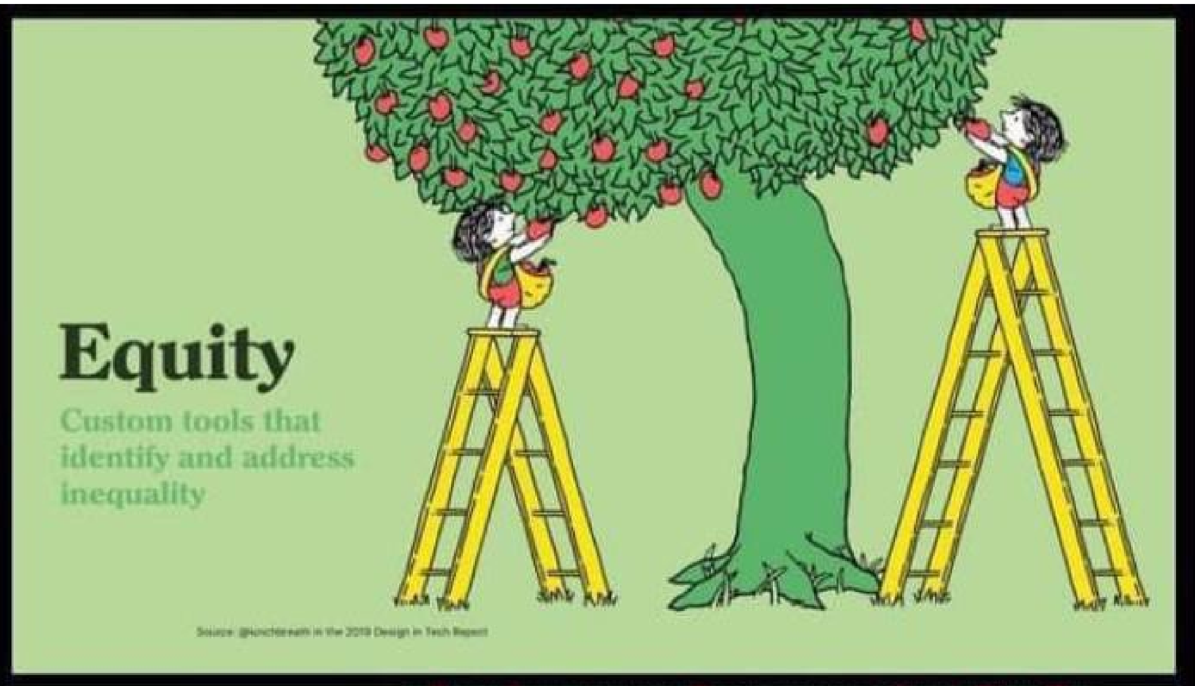
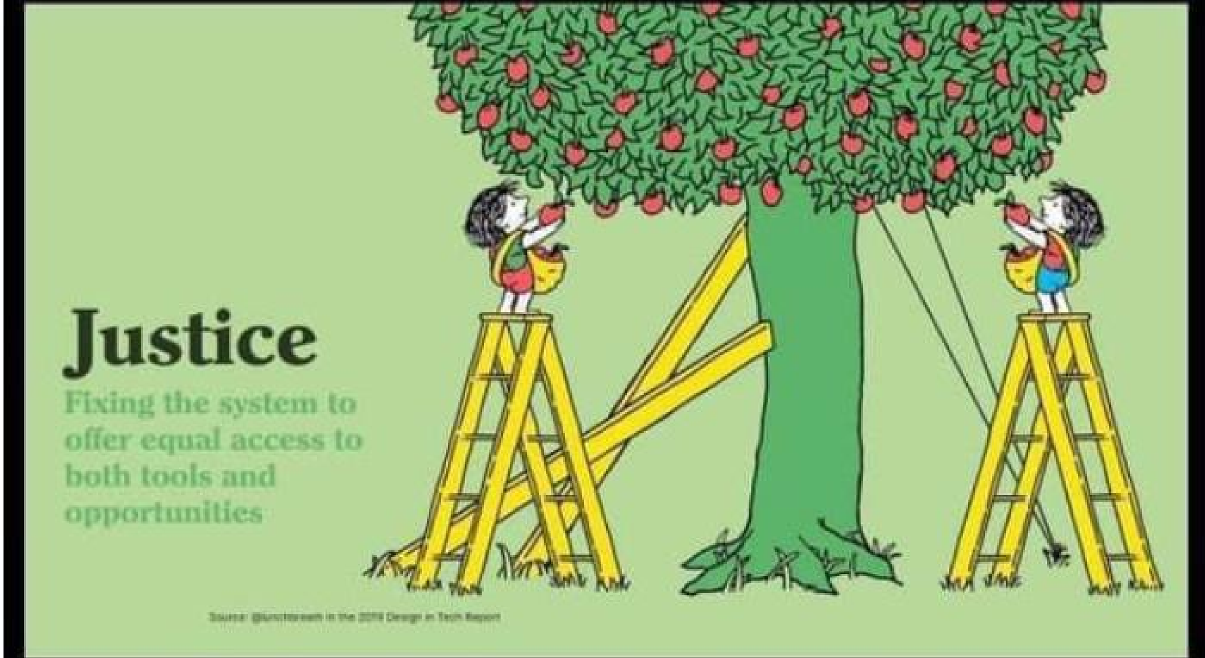

Inequality
Unequal access to
opportunities
?


Equality?
Evenly distributed
tools and assistance
!


Equity
Custom tools that
identify and address
inequality


Justice
Fixing the system to
offer equal access to
both tools and
opportunities

How we are prioritizing Health Equity

1. Programming
   - Screening SDoH and Social Needs
2. Community Partnerships
   - Resourceful
3. Technology and Tools
   - EPIC
   - Adopted Tool for Equity Accountability
4. Funding
   - Community Giving
   - Community Health Needs Assessment
   - Community Contributions
5. Participation
   - Vizient's Accelerator Program

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Why collect SDoH data?

- Health related social needs are a key driver in patient healthcare outcomes
- Improving social history information and integrating formal screenings for social needs in clinical practice
  - Better define and document increased complexity of patients
  - Better target clinical care
- Interventions can be effective at promoting health equity at individual patient level, and at broader community and structural level
  - Community partnerships to drive care transformation
  - Advocate for change with community

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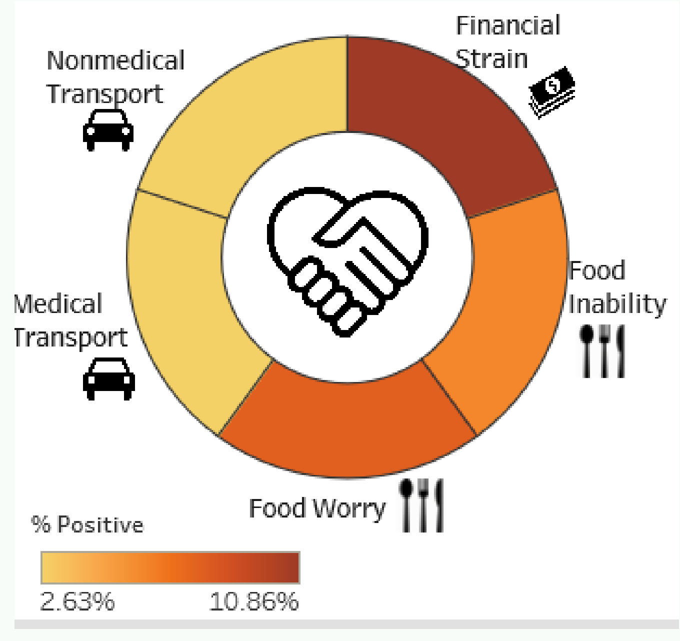
Background

- Social needs screening pilot expanded to all primary care and pediatric clinics April 2020
- 2,000+ patients referred to a community resource for their social need
- Developed relationships and referred patients to 80+ community based organizations
- Started partnership with Aunt Bertha in February 2021



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Levels of Impact

Individual

Addressing immediate, non-medical needs of a patient (example – connecting to food, housing, transportation resources)

Organizational

Develop partnerships to tackle needs beyond the medical setting. Improve communication and coordination between organizations (example – Aunt Bertha/Resourceful)

Community

Impact community conditions that affect health outcomes and risks. Understanding broader context that shapes health in community (example – community contributions, community benefit, CHNA)

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SDoH – Demographics – Interactive Dashboard

Social Determinants Of Health | Demographics

Choose a Question
Food Worry

Food Worry
8,965 Patients Responded Positively 32,495 Times

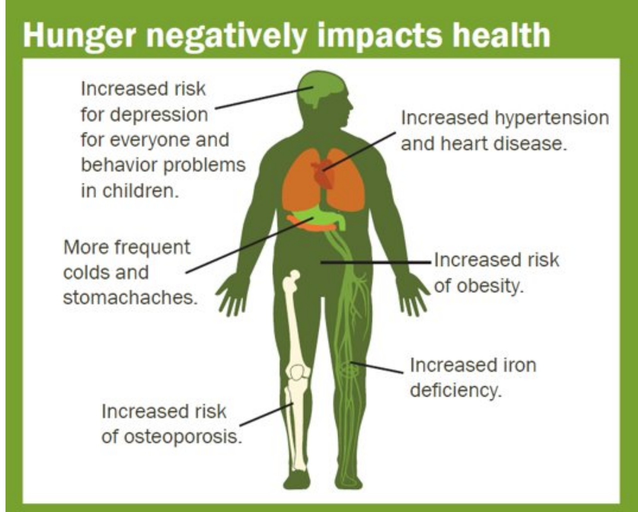
Percent Positive Responses by County *(With at least 10 responses)*

Zip Code Or County: County

Winnipeg
North Dakota
South Dakota
Wisconsin
Madison
Iowa
Chicago
© 2021 Mapbox © OpenStreetMap

Average Age (left), Percent Positive Responses (middle), Average Positives per Patient (right) by Race

Race	Average Age	% Positive	Average Positives per Patient
American Indian/Alaska Native	38	22.0%	3.93
Asian	34	10.0%	3.73
Black or African American	31	17.3%	2.99
Caucasian or White	42	7.2%	3.66
Native Hawaiian/Other Pacific Islander	35	13.1%	2.94
Unknown / Refused	25	9.5%	3.01



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SDoH – Ethnicity & Primary Language

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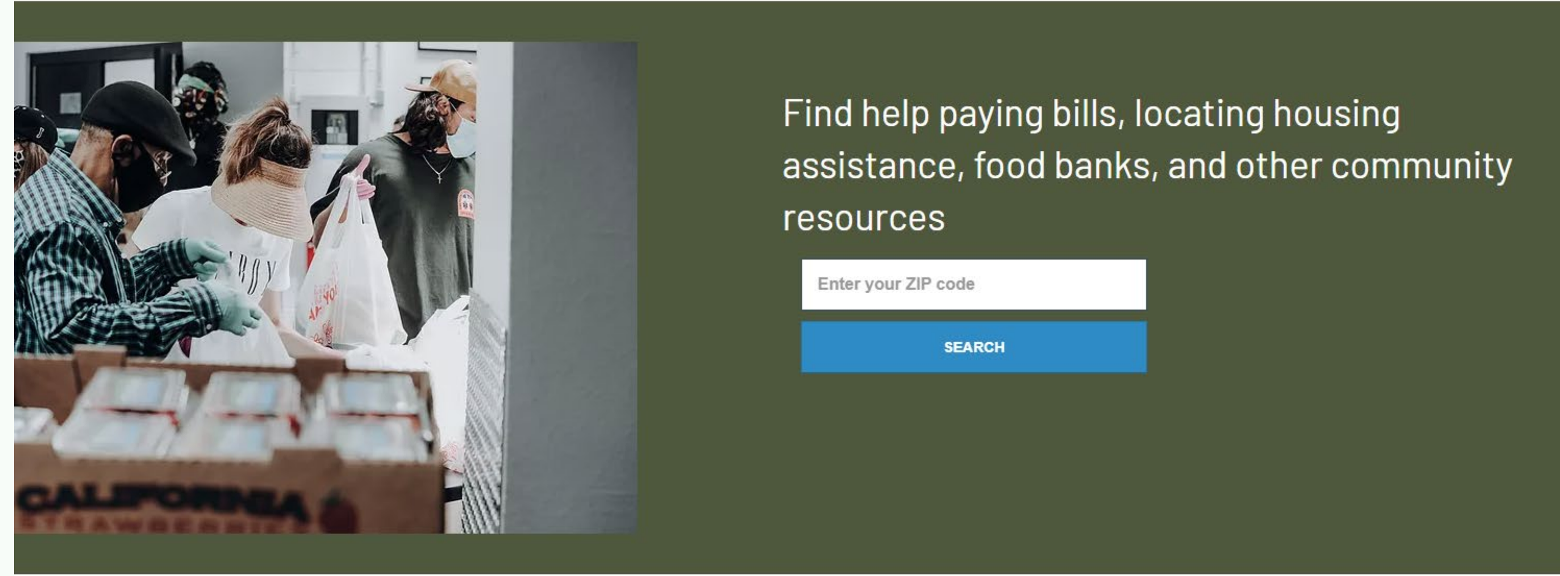
Introducing Resourceful

Resourceful - Find social services near you

Resourceful is a free community resource guide to help you find free and reduced cost services in your area



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Social Needs vs. Social Determinants of Health

SOCIAL NEEDS:
The immediate, non-medical needs of an individual. Efforts to address social needs provide invaluable assistance to individuals—for example, providing food, housing and transportation to a person or family—but do not address the underlying economic or social conditions that lead to social needs.

SOCIAL DETERMINANTS OF HEALTH:
The conditions in the environments where people are born, grow, live, work, and age that affect health outcomes and risks, and the broader systems that shape those conditions, including social, political, and economic programs and policies. Efforts to address SDOH prioritize the underlying social and economic conditions in which people live, rather than the immediate needs of any one individual.

- Systems change needed to address root causes of social needs to achieve health equity
- Collecting data to understand drivers, root cause, identify resource gaps
- Building community partnerships

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Influencing Community Conditions

- Systems change needed to address root causes of social needs to achieve health equity
- Data helps understand community needs, root causes, identify resource gaps
- Supporting Community Based Organization Capacity
- Donated $1.3 million to community-based organization in 2020

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We are called to make a healthy difference in people's lives.

Community Partnerships

Essentia Health

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Community Health Needs Assessment

- Guiding Principles:
  - Build trust through collaboration with community members
  - Prioritize strategies that advance health equity, address structural barriers, or reduce/eliminate disparities

- Adopted a Tool for Equity Accountability to co-design health improvement strategies *with* community

- Participating in :
  - Duluth NAACP Health and Environmental Equity Committee
  - SURJ (Showing Up for Racial Justice) Northland
  - MState Commission for Civil Rights and Social Justice

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Partnerships to boost vaccine confidence

Located along I-35

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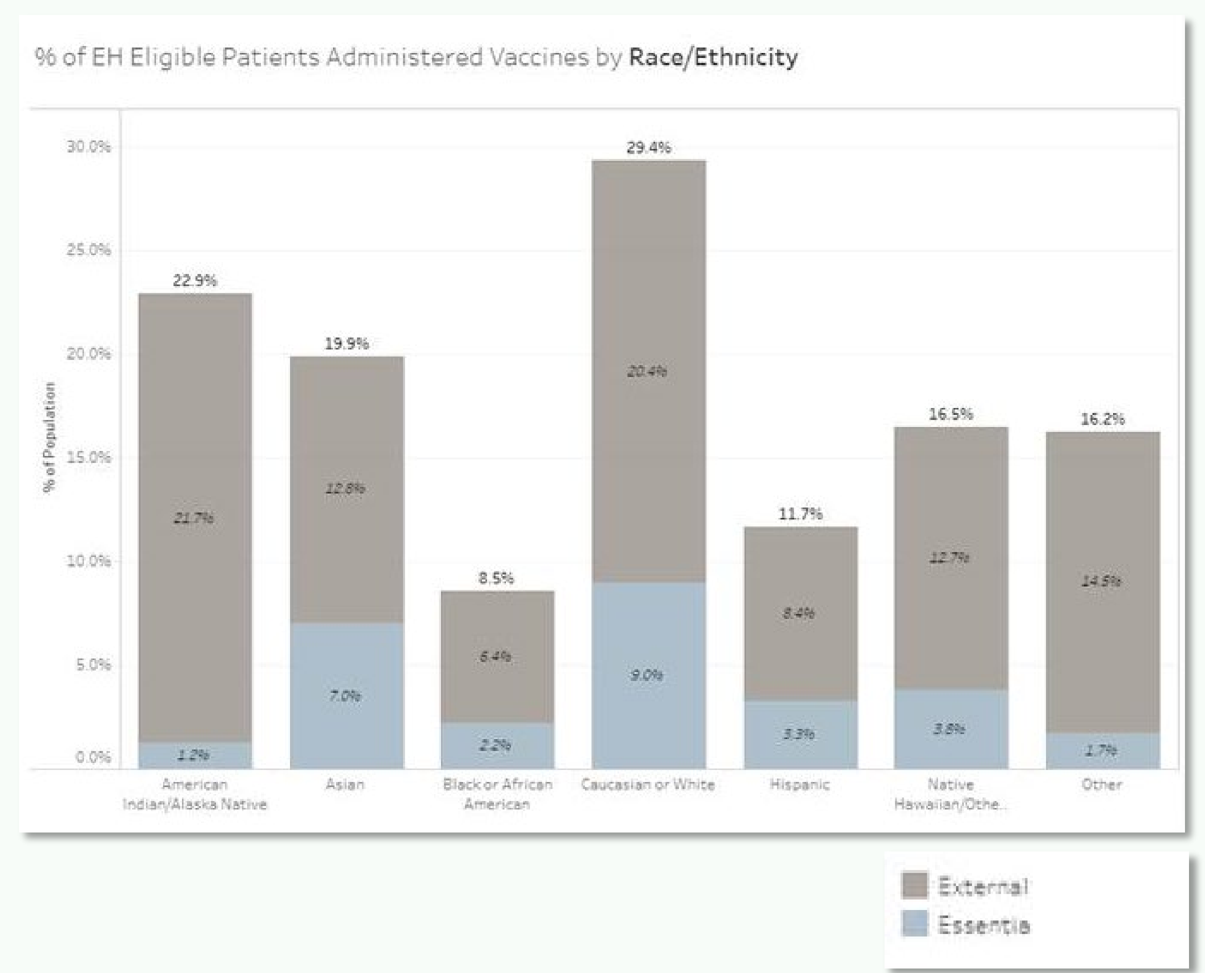
Monitoring our success

Working with our analytics team and available data sources to track our efforts to improve vaccination rates in Communities of Focus



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Vizient's ISP Equity Accelerator Tool

Vizient Accelerator Program

- Six-week participation: Health Equity Strategy Alignment Tool Framework
- Organizational readiness for health equity
- Peer group and experts
- Analytics-based framework: review organization performance and community metrics to assess the relationship between clinical, operational and quality performance and community needs
  - Zip code analysis – 150 zip codes
  - Access, admissions, inpatient, adherence to care, readmissions
  - Vulnerability index

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Next Steps

- Integrating Resourceful into our Electronic Medical Record and creating closed loop referrals
- Designing a Community Based Participatory Research plan to evaluate outcomes and impact
- Opportunities to learn over time

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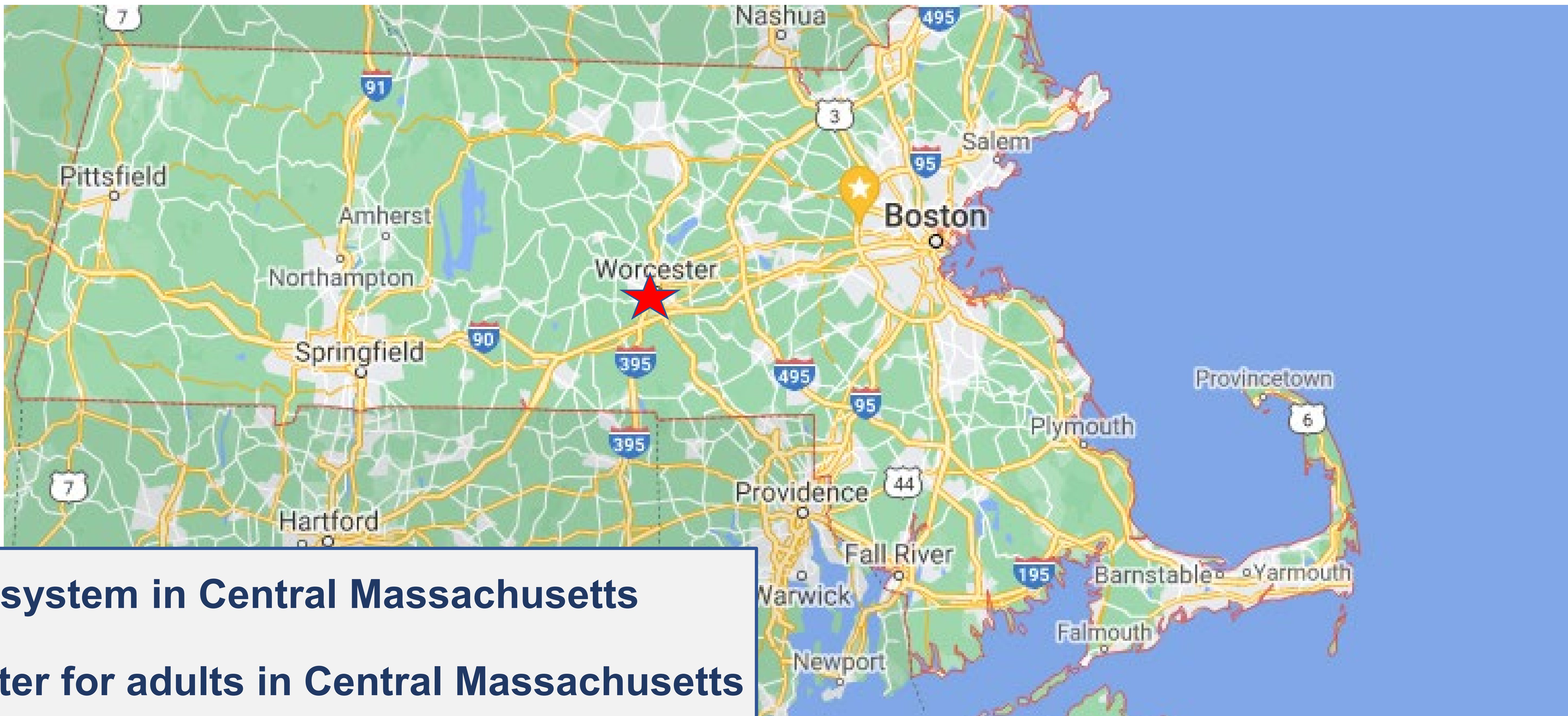
HEALTH EQUITY
WELL CHILD VISIT IMPROVEMENT

10/1/2021

Tracey Wilkie
Senior Director, Population Health Analytics

Rulan Lyu
Senior Data Scientist, Population Health Analytics

UMASS MEMORIAL HEALTH



- **Largest health care system in Central Massachusetts**
- **Level 1 Trauma Center for adults in Central Massachusetts**
- **Clinical partner of the UMass Chan Medical School**
- **5 Hospitals, 2,000 Physicians**
- **MSSP Track 1 ACO since 2015 with 45,000 beneficiaries**
- **Managed Care Network- 90,000 members**
- **Primary Care patients (all payer):**
  222,000 Adult 44,000 Pediatric

COVID-19 brought Health Equity to the forefront…..

COVID-19 Positive Patients:

Race and Ethnicity – Comparison by City

SELECTED CITY: WORCESTER

Race - All	Breakdown of Race by City (%)	Breakdown of COVID+ by R/E In Selected City (%)	Total # of COVID+
White	69%	49%	6,218
Other	10%	27%	3,494
Black or African American	13%	18%	2,270
Asian	8%	5%	685
American Indian or Alaska Native	0%	0%	45
Native Hawaiian or Other Pacific ..	0%	0%	16
Unknown		100%	1,307
Grand Total	100%	100%	14,035

Ethnicity - All	Breakdown of Ethnicity in City (%)	Breakdown of COVID+ by R/E In Selected City (%)	Total # of COVID+
Hispanic or Latino	21%	37%	4,571
Not Hispanic or Latino	79%	63%	7,836
REFUSED		0%	4
Unknown		100%	1,624
Grand Total	100%	100%	14,035

COVID+ Source
MAVEN All

City
WORCESTER

Selected Date Range:
3/11/2020 to 12/30/2020

** Calculated based on COVID+ patients with recorded Race or Ethnicity.

Data Source: MAVEN COVID+ Data (Worcester and 6 surrounding towns) as of 12/30/2020

Developed by the Office of Clinical Integration

Improving the Well Child Visit Quality Measure Performance rate for Hispanic and Black/African American pediatric patients was selected as our Health Equity True North Metric for FY21.

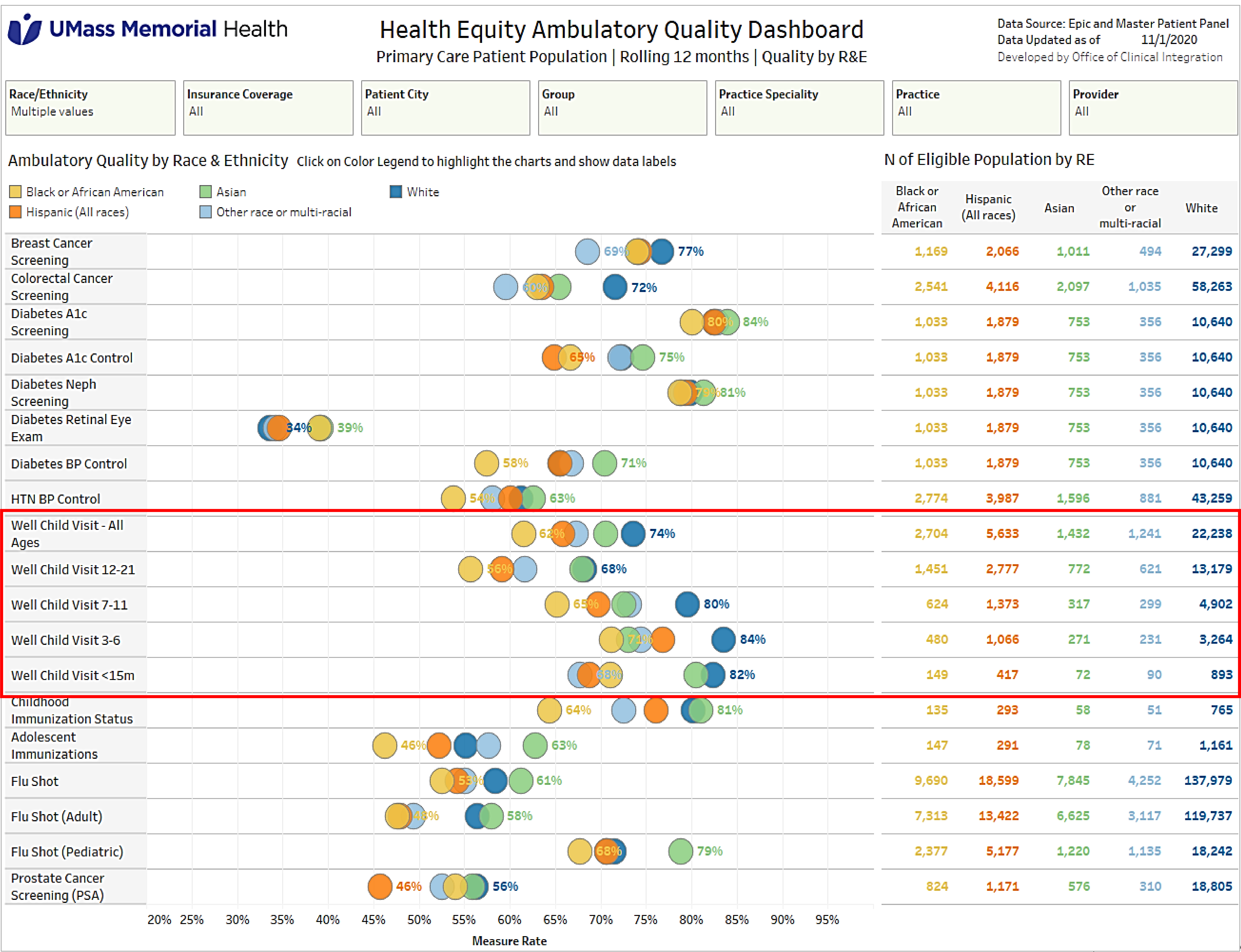
Our guiding principles:

- **Choose a measure for which we have data**
- **Choose a measure for which we know there is a disparity**
- **Choose a measure that we believe we can make meaningful improvement over the next year**
- **Choose a measure that applied to multiple departments throughout the healthcare system**

Additional considerations and the business case:

- **Well child visit HEDIS measures are in our commercial risk contracts (success with the quality measures = $$$)**
- **Population Health team already entrenched in this quality work**
- **We serve a large Medicaid pediatric population (14,000)**
- **Our Pediatricians and Family Medicine providers greatly supported this (53 primary care practices involved)**
- **Preventative care for our pediatric patients will mitigate some of the long term problems these children will have down the road.**

Ambulatory Quality HEDIS measures by Race and Ethnicity



Measure	Black or African American	Hispanic (All races)	Asian	Other race or multi-racial	White
Breast Cancer Screening	1,169	2,066	1,011	494	27,299
Colorectal Cancer Screening	2,541	4,116	2,097	1,035	58,263
Diabetes A1c Screening	1,033	1,879	753	356	10,640
Diabetes A1c Control	1,033	1,879	753	356	10,640
Diabetes Neph Screening	1,033	1,879	753	356	10,640
Diabetes Retinal Eye Exam	1,033	1,879	753	356	10,640
Diabetes BP Control	1,033	1,879	753	356	10,640
HTN BP Control	2,774	3,987	1,596	881	43,259
Well Child Visit - All Ages	2,704	5,633	1,432	1,241	22,238
Well Child Visit 12-21	1,451	2,777	772	621	13,179
Well Child Visit 7-11	624	1,373	317	299	4,902
Well Child Visit 3-6	480	1,066	271	231	3,264
Well Child Visit <15m	149	417	72	90	893
Childhood Immunization Status	135	293	58	51	765
Adolescent Immunizations	147	291	78	71	1,161
Flu Shot	9,690	18,599	7,845	4,252	137,979
Flu Shot (Adult)	7,313	13,422	6,625	3,117	119,737
Flu Shot (Pediatric)	2,377	5,177	1,220	1,135	18,242
Prostate Cancer Screening (PSA)	824	1,171	576	310	18,805

Between Group Variance (BGV) measurement proved clear disparity in Well Child Visit measure performance

September 2020

Low Disparity

High Disparity

Goal: Improve the overall Well Child visit performance rates for Hispanic and Black/African American patients

Well Child Visit- Overall Performance Rate			
	Baseline Performance Rate	TARGET 5% Improvement in Performance Rate	REACH 10% Improvement in Performance Rate
Hispanic	64%	69%	74%
Black/African American	59%	64%	69%
White	71%		

Data Source: EPIC; baseline data extracted end of September 2020
All Payers included; Patients eligible if current patient of a system primary care practice

- An additional 153 Black/African American and 303 Hispanic pediatric patients needed to reach 5% performance improvement.

Strategies Employed:

- **Communication to Primary Care** (PCPs, Quality Champions)
  - Description of the project, goals, Well Child Visit measure tip sheet
  - Practice Improvement Facilitators (PIF) meetings with practices- get on the agenda
  - Discuss ways to leverage acute appointments and complete well child visits at the same time; use telehealth with follow up in office for immunizations and other in person pieces

- **Reporting**
  - Expansion of reports in EPIC to include race, ethnicity, language
  - Registry reports to easily identify patients needing appointment
  - Use scheduling data to monitor completed visits, cancellations, and no shows
  - Transparent reporting among practices

- **Tools and Resources**
  - Well Child visit tip sheet: measure description, concepts, interventions, unique characteristics/approaches for age stratifications, barriers & resources to help with measure success
  - Develop workflow to help providers leverage the PT-1 form for Medicaid patients needing transportation

- **Appointment Scheduling** using Population Health outreach; follow up on cancellations

- **Talk to our patient families-** Ex. What are their barriers? Do they understand the importance of the well child visit?

Look at scheduling data- Completed Visits, Cancels, No Shows Example from March:

531 completed and 526 scheduled well visits for Hispanic and Black African American patients as of March 17

The key to success is to make sure these visits are COMPLETED

Appointment Status

Canceled | No Show | Scheduled | Arrived | Completed

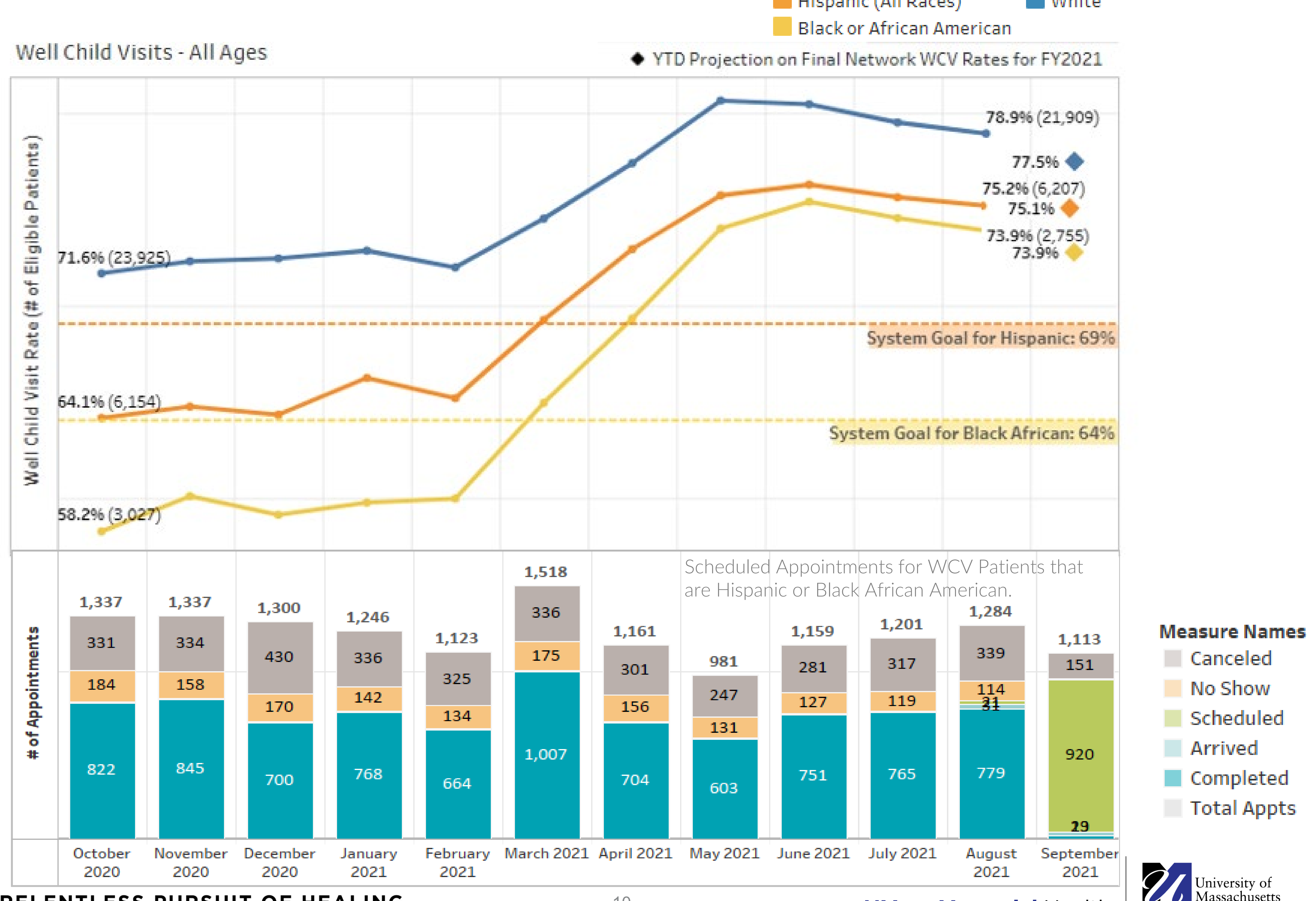
2019 | 2020 | 2021

FY2020 | FY2021

March

UMass Memorial Health

Results through August 2021:
Despite a leveling off recently, reach goal achieved for both groups



	October 2020	November 2020	December 2020	January 2021	February 2021	March 2021	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021
Total Appts	1,337	1,337	1,300	1,246	1,123	1,518	1,161	981	1,159	1,201	1,284	1,113
Canceled	331	334	430	336	325	336	301	247	281	317	339	151
No Show	184	158	170	142	134	175	156	131	127	119	114	
Scheduled											21	920
Arrived											31	19
Completed	822	845	700	768	664	1,007	704	603	751	765	779	23

BGV has been greatly reduced.

Hispanic (All Races) | White | Black or African American

Difference from Overall Rate | Overall Disparity Composite Value

Month	White	Black or African American	Hispanic (All Races)	Overall Disparity Composite Value
September 2020	2%	-10%	-4%	0.002792
October 2020	3%	-11%	-5%	0.003135
November 2020	3%	-10%	-5%	0.002788
December 2020	3%	-11%	-5%	0.003286
January 2021	2%	-11%	-4%	0.002886
February 2021	2%	-10%	-4%	0.002774
March 2021	2%	-8%	-3%	0.002287
April 2021	2%	-6%	-3%	0.002016
May 2021	2%	-5%	-3%	0.001789
June 2021	1%	-4%	-3%	0.001407
July 2021	1%	-4%	-3%	0.001426
August 2021	1%	-4%	-3%	0.001554

Disparity Narrowing
Disparity Widening
Same Disparity

Performance results by specific well child visit measure

Well Child <15m
86% (1,655)
75% (285)
72% (785)
83% (848)
72% (152)
68% (416)

Well Child 3-6
78% (3,479)
71% (1,134)
62% (538)
88% (3,143)
85% (1,197)
78% (490)

Well Child 7-11
77% (5,086)
67% (1,434)
61% (674)
85% (4,678)
83% (629)
82% (1,517)

Well Child 12-21
66% (13,705)
58% (2,801)
53% (1,530)
74% (13,240)
69% (3,0[illegible])

October 2020 | November 2020 | December 2020 | January 2021 | February 2021 | March 2021 | April 2021 | May 2021 | June 2021 | July 2021 | August 2021

Disparity Composite Value - Heat Map (BGV: Between-Group Variance)

	Black or African American	Hispanic (All Races)	White	**Disparity Composite Value**
BGV_Well Child Visit <15m	0.000242	0.002557	0.001765	0.004564
BGV_Well Child Visit 3-6	0.000754	0.000036	0.000212	0.001001
BGV_Well Child Visit 7-11	0.000020	0.000094	0.000052	0.000166
BGV_Well Child Visit 12-21	0.000128	0.000284	0.000142	0.000554

0.000020 — 0.004564
Low Disparity — High Disparity

- Babies were “aging out” of measure before 6 visits due to Covid-19 but mostly all caught up
- Most success in the 7-11 group
- Half of the eligible patients in the 12-21 range; we will split into 12-17, 18-21 going forward

Patient Family Interviews- What did we learn?

What did we learn?

- Patient families understand the importance of the well child visits
- Patient families like their physicians and the UMMH healthcare system
- Mixed feedback on office staff, appointment reminders, wait times
- Participants' reactions to COVID-19 and the impact the pandemic has had on attending appointments varied.
- Common themes emerged around the barriers and challenges

Note: 30 patient families whose children have not had recent well child visits- Half English speaking, half Spanish speaking

Barriers and Challenges based on Patients' Responses

Patient's response:
"…I do not have money for parking. In fact, sometimes I am faced with a choice- attend the visit and pay for parking or put food on the table that evening for my family and do not have my child see the doctor. "

Patient's Response:
"Before, it was a little crazy. I'm not going to lie. I did not use an interpreter for the first three visits because I felt I could understand English but could not speak it. Now, I use an interpreter even though my English is better…"

Next steps

Continued work on Well Child visits using the information we learned from the patient interviews

> **Parking vouchers, Transportation, Older pediatric patient appointments**

Select an adult measure- several under consideration

Inclusion of other race/ethnic groups (Asians, multi-racial) in interventions

Start to use the employee data to look for disparities in staffing

THANK YOU!

KootenaiCareNetwork

ACO Approaches to Addressing Health Equity in Rural/Frontier State

Patt Richesin

President

Kootenai Accountable Care

NAACOS, October 2021

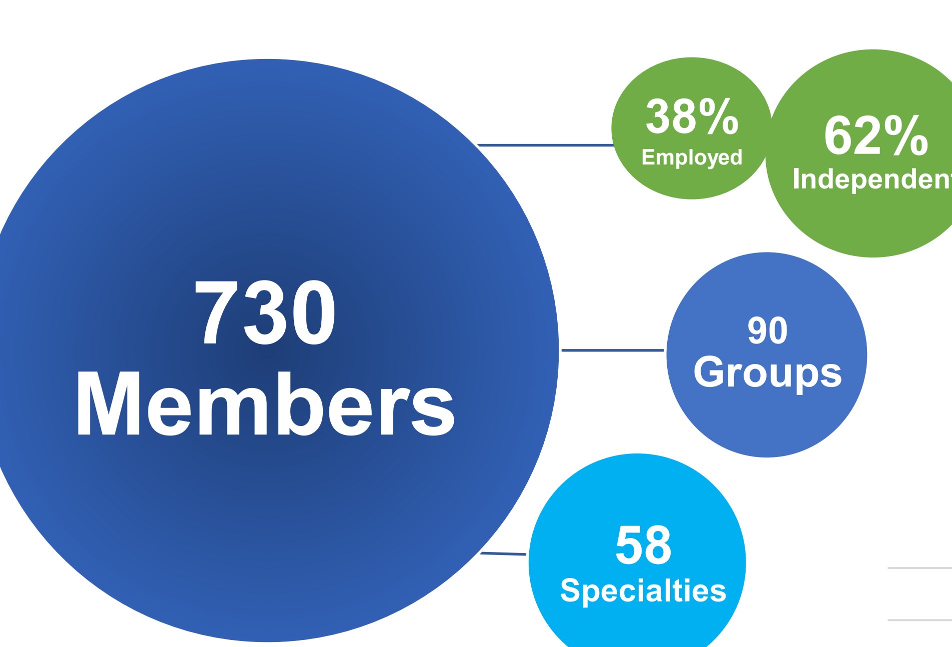
KootenaiCareNetwork

Kootenai Accountable Care

Based in Coeur d’Alene, Idaho:

- Kootenai Accountable Care represents the Medicare Shared Savings ACO supported by Kootenai Care Network
- Kootenai Accountable Care launched performance year 2018
- Kootenai Care Network launched Medicaid Value Care Organization 2021
- Together we are: Kootenai Care Network, Kootenai Accountable Care, and Kootenai Value Care

Kootenai Care Network by the Numbers

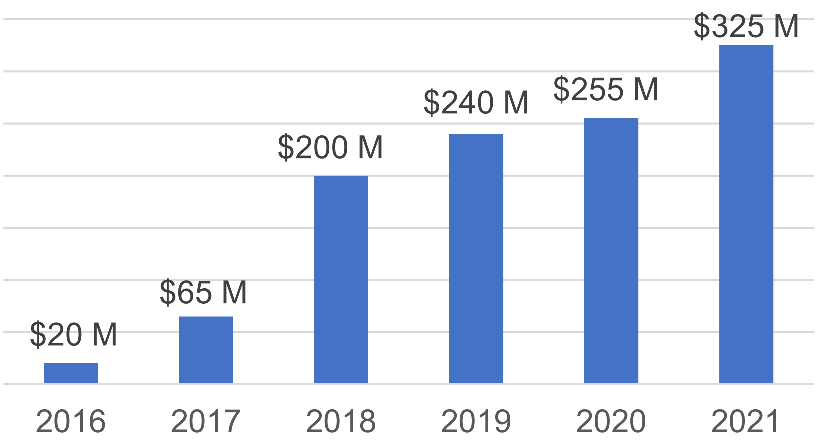


8 Hospitals

7 Health Plan Contracts

Kootenai Health Employee Health Plan
Blue Cross of Idaho QHP
Blue Cross of Idaho Commercial
Blue Cross of Idaho Medicare Advantage
PacificSource Medicare Advantage
Medicare Shared Savings Program ACO
Medicaid Value Care Program VCO

Contracted Medical Spend

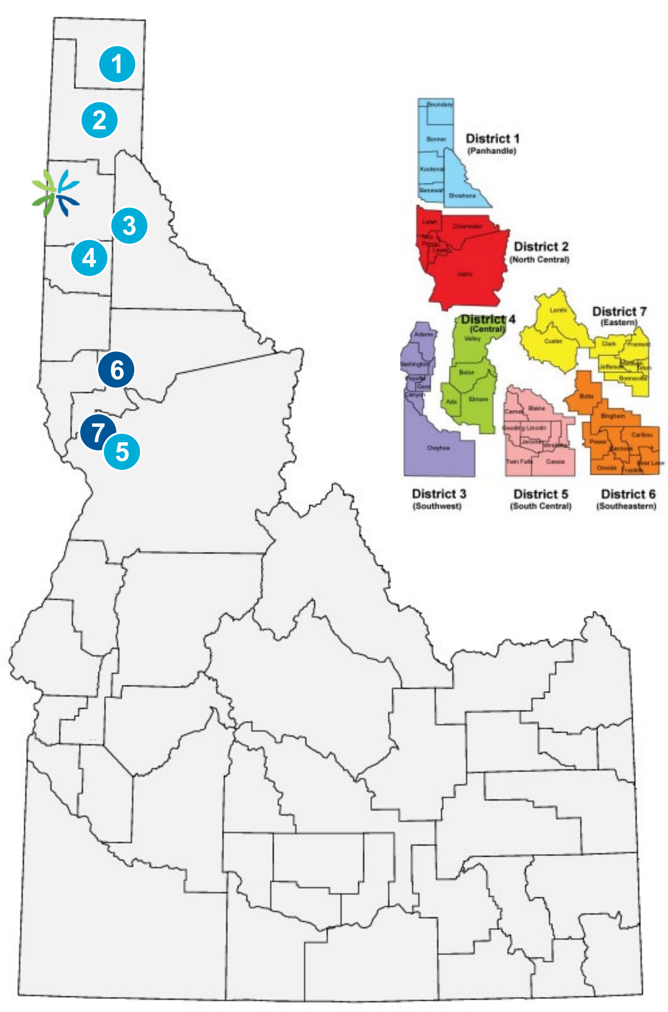


Lightbeam Population Health Analytics

590,000+ Patient Files
65 Interfaces
26 EMRs
7 Health Plan Claim Feeds

KootenaiCareNetwork

Connecting Care Across the Continuum



Kootenai Health*

CAHs in KCN/KAC/KVC:

1. Boundary Community Hospital*
2. Bonner General Hospital
3. Shoshone Medical Center*
4. Benewah Community Hospital
5. Syringa General Hospital*

*Hospitals in KCN/KAC/KVC

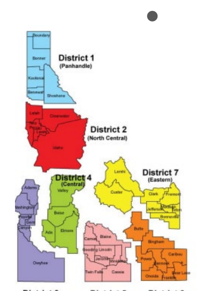
Current KH-Owned CAHs:

6. Clearwater Valley Hospital and Clinics*
7. St. Mary's Hospitals and Clinics*

Business Case for Health Equity
Top Community Health Issues

Snapshot: Statewide Public Health Districts

ACO Spans Panhandle Health, District #1



- Within Panhandle Health District
  - 2 counties ranked the least healthy for health factors and health outcomes

    - Years of potential life lost before age 75 per 100,000 = 9.2 and 10.2
    - Children in poverty = 23% and 26% (double national average)
  - Kootenai County expanding while gap in health equity widening at faster pace
- Top Priorities
  - Access to care
  - Mental Health/Suicide Prevention
  - Substance Abuse (including opioid) Prevention
  - Bridging the health care divide: urban/rural/frontier

Idaho ranks 49th in prevalence of mental illness and access to care

https://www.countyhealthrankings.org/app/idaho/2021/rankings

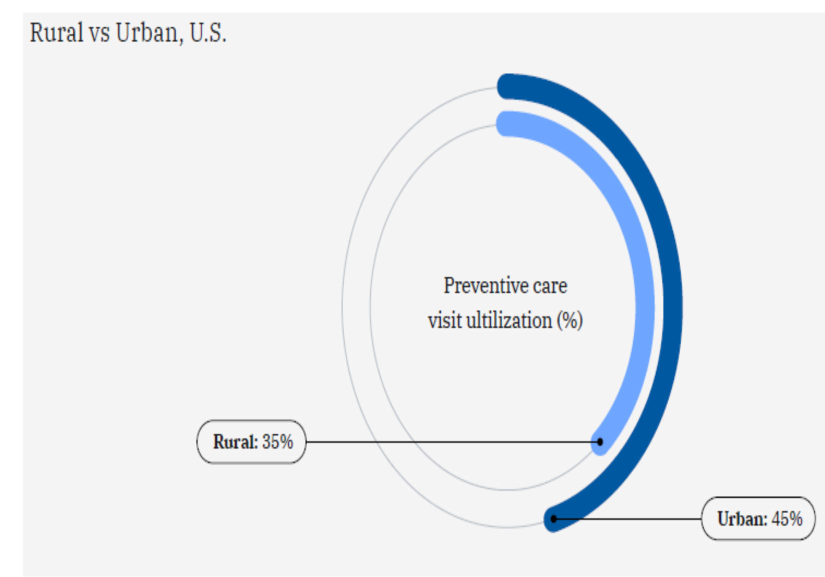
https://mhanational.org/issues/ranking-states

Idaho: 8th Lowest Number of PCP for Population

Rural Communities: Low Preventative Care Utilization

Figure 5. Primary Care Physicians per 100,000 Population by State, 2019

Source: American Medical Association (AMA) Physician Masterfile, 2019; United States Census Bureau, 2019 population estimates[44]



2019 U.S. Census Bureau Fast Stats:

National Poverty Rate;	11.4%
Idaho Poverty Rate:	11.2%
Kootenai County Poverty Rate:	14.8%

KootenaiCareNetwork

Our Region Attracts Many: The Gaps Are Widening

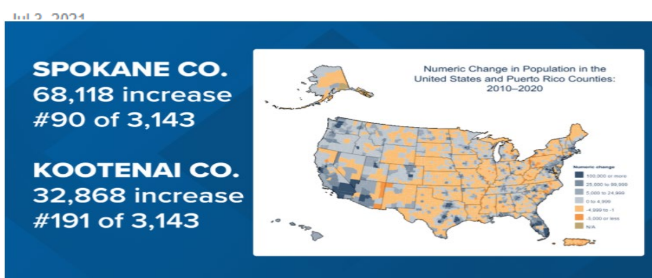
According to the US Census Bureau, Kootenai County population increased 23.7% since 2010

AP News

Spokane-Coeur d'Alene housing market booming, prices rising

In May, the Wall Street Journal/realtor.com Emerging Housing Markets Index ranked Coeur d'Alene, Idaho, part of this combined metropolitan...

Jul 2, 2021



Credit: Census Bureau data
Map of US counties showing numerical population growth between the 2010 and 2020 censuses.

The Spokesman-Review

Realtor.com ranks Coeur d'Alene, Spokane among nation's 10 hottest housing markets

Real estate website Realtor.com recently named Coeur d'Alene as the eighth-hottest housing market in the nation for February,...

Apr 19, 2021

Idaho median income has increased 27% over the last 10 years, while median home price has increased 145%

KREM

Skyrocketing housing prices push some Coeur d'Alene locals out of hometown

According to Realtor.com, the median house price in Coeur d'Alene is $495,000. Using its loan calculator, if a person makes the average down...

May 13, 2021

40% of Idahoans are not financially stable

KTVB

Idaho and 19 other states' minimum wages have stayed at $7.25 since 2009

In 2009, the federal minimum wage was set at $7.25 and has not since been changed on a federal level. Idaho and 19 other states have also left...

May 10, 2021

88% of Idaho's land area is in counties classified as rural, home to 28% of the state's population. This makes Idaho both low density and a highly rural state

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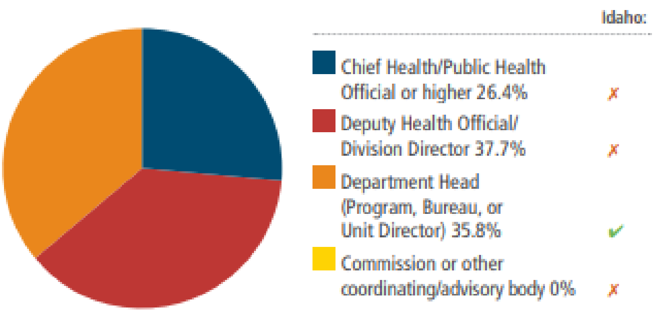
What Are The Limiting Factors?

Idaho Health Equity Snapshot

National Percentage of States with Contact Person for MH/HD/HE Reporting to Leadership Positions or Bodies (n=53)



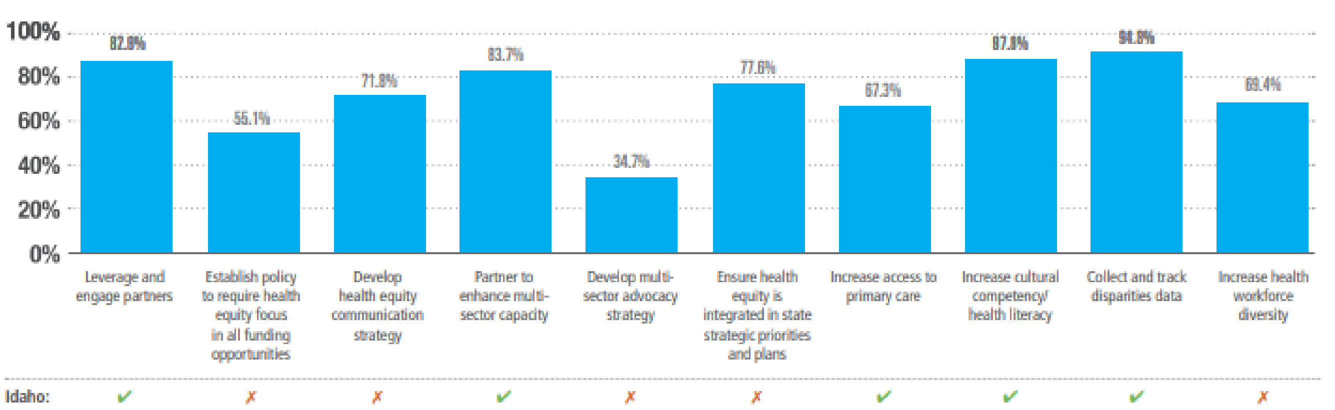
Funding for Health Equity

Funding received in FY 2013 from all sources of funding	Idaho (in thousands $)	National Funding in thousands (minimum – maximum; n=47)
Federal Funds	0	0 – 146,203
State General Funds	0	0 – 40,000
Other Sources	0	0 – 55,517

Strategic Planning for Health Equity

Idaho has an organizational strategic plan that addresses health equity and/or a health equity-specific strategic plan.

National Percentage of States with Strategies for Addressing MH/HD/HE in Strategic Plans (n=49)

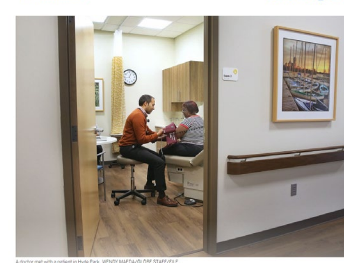


https://www.astho.org/Programs/Health-Equity/Minority-Health-Survey-2014/State-Snapshots/Idaho/

MH/HD/HE – minority health, health disparities, and health equity

Limitations

- Lack of funding
  - Programs dependent on current resources
  - Grant funding may be available but complexity for ACOs to access and deploy
  - Inadequate staffing resources lead to focus on traditional ACO outcomes
- Lack of data and measurement
  - Blue Cross of Massachusetts program for diversity gap closure
    - Paying provider to close gaps
    - But challenged since not collecting sufficient information to identify population
    - Launching program to address gaps in data for population, clinical outcomes, and situational remedies
- Unique challenges for rural residents
  - Vulnerability of critical access hospitals and their resources
  - Internet connectivity for telehealth
  - PCP shortage
  - Lack of Urgent Care facilities, leading to ED utilization for routine care
  - Social isolation
    - Zip codes and population density
    - Influence of rural and frontier culture of independence
    - Younger family members no longer aging in place
  - Food insecurity
  - Housing insecurity
  - Changes in labor market and job offerings
  - Income disparity
- Growing communities experiencing similar challenges



Blue Cross will reward doctors who close gaps in care for people of color

By Priyanka Dayal McCluskey Globe Staff, Updated September 23, 2021, 8:55 a.m.

A doctor met with a patient in Hyde Park. WENDY MAEDA/GLOBE STAFF/FILE

In a new initiative to tackle health inequities, Blue Cross Blue Shield of Massachusetts will begin paying doctors more money if they close longstanding and pernicious gaps in care for people of color.

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What Is Our ACO Doing To Improve Health Equity?

We Have Only Scratched the Surface

- Recently entered into Medicaid Value Based Care Contract with value care organizations statewide
- Most Medicare ACOs have been able to build programs based on lessons learned and opportunities from Medicaid value based efforts
- Need for merging our efforts across the uninsured, commercially insured, federal insurance and assistance programs
- But we have started….

North Idaho Connections Database

- The regional health system in our ACO, Kootenai Health –
  - Stood up database with over 1,500 community resources
  - Partnered with community based organizations, EMS, and local schools to distribute materials to those in need
  - Piloting program to create closed-loop referrals for Personal Care Services
- Issues with many community resource systems
  - Providers challenged in completed closed loop
  - Referrals are placed and follow ups can still be limited
  - Provider maintenance systems require robust resources
  - Cost can be prohibitive

Chronic Care Management and Modified Hospital in the Home

- Snapshot:
  - Embedded care managers managing traditionally enrolled chronically ill patients
    - July 2021 – 208 hours 1:1 patient contact
  - Other care managers in individual practices performing at similar levels
- Modified hospital in the home:
  - Leveraging the model, due to Idaho Crisis Standards of Care, Kootenai Health Emergency Department collaborated with KCN and CCMs have been assigned to follow-up daily with patients who are discharged from the ED on Oxygen or have received Regeneron treatment
    - Period 8/16-9/24
    - 109 patients
    - 48 discharged on oxygen
    - 61% discharged on Regen-Cov
    - 23 patients ultimately admitted
    - Able to keep 80% from returning to ED or being admitted
- Similar programs in place in critical access hospitals within the network

Palliative and Post-Acute Care Initiatives

North Idaho Palliative Care Coalition (NIPCC)

- Established in January 2018 to build standardized approach to palliative care in 5 rural northern Idaho counties
- Three areas of focus:
  - Education to providers and patients about the role of palliative care in the continuum of care
  - Standardization of advance directives and workflow for transitions of care
  - Creative staffing models to support end-of-life discussions
- Areas of growth identified:
  - Utilization of telehealth capabilities and leveraging technology to offset geographic limitations in rural areas

North Idaho Hospital Alliance

- Collaboration among Kootenai Health and area Critical Access Hospitals
- Coordinated transfer efforts to ensure patients from rural areas are able to transition back to their community

Learning from the Success of Others

- Would like to see specific efforts to address health equity within and across ACOs
- Limited resources to map across populations to manage health equity
- Work across providers generally designed to be payer agnostic
- Reliance on other resources such as rural health centers, federally qualified health centers, and community agencies
- Lessons to be learned through current Medicaid VCO efforts

Thank you!

Questions?

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