Quality, Disparities + Culture: How Does Value-Based Care Narrow the Gap?

AGENDA

- Focusing on Social Determinants of Health Can improve outcomes in Value-based Payment Systems
- Success in a Value Based Care system can be achieved through new designs in care delivery
- The power of targeted data analysis to guide understanding of health and disease disparity

Focusing on Social Determinants of Health Can Improve Outcomes in Value-based Payment Systems

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Chief Medical Officer
Rainmakers Strategic Solutions

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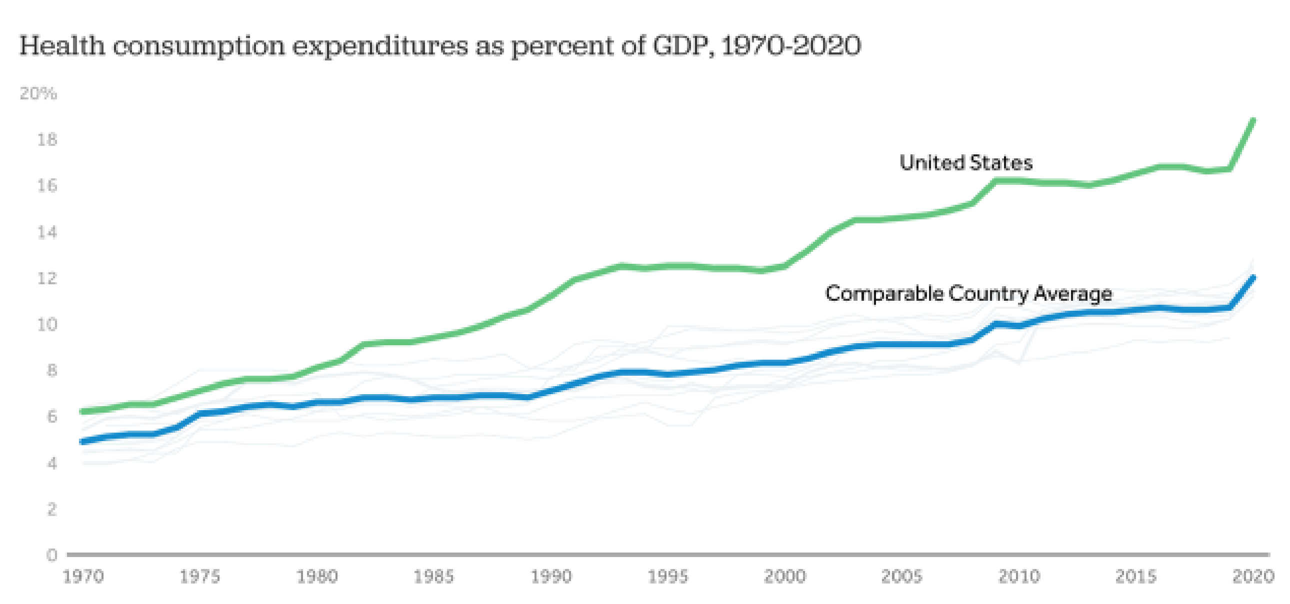
US Health Care Cost Rise is Unsustainable

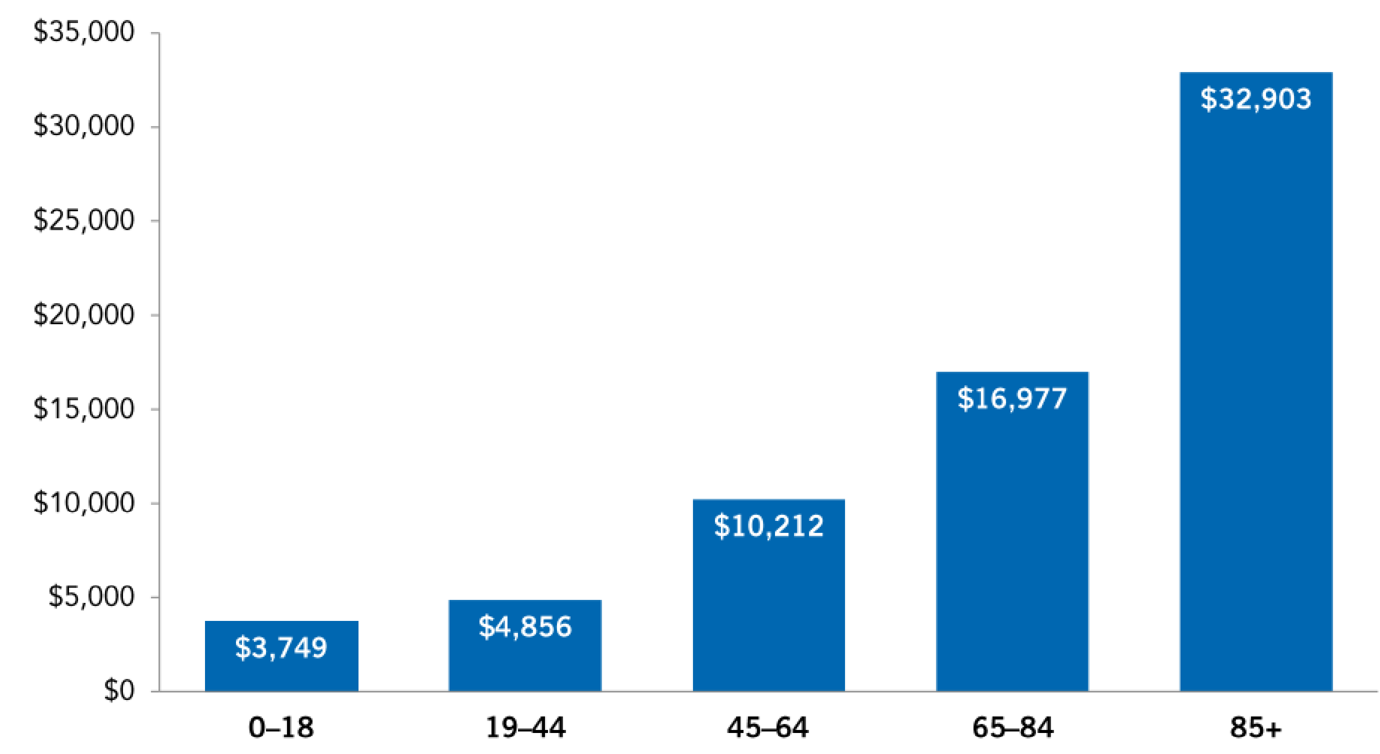


Notes: U.S. values obtained from National Health Expenditure data. Health consumption does not include investments in structures, equipment, or research. 2020 data not yet available for Australia, Belgium, Canada, Japan or Switzerland. Provisional 2020 data for Austria, Germany, Netherlands, Sweden and the United Kingdom. Provisional 2019 data for Canada. Data for Australia and Japan in 2019 and France in 2020 is estimated. France data before 1990 is not shown.

Source: KFF analysis of OECD and National Health Expenditure (NHE) data

Peterson-KFF
Health System Tracker

Highest Costs are in Older Adults



Selected Charts on the Long-Term Fiscal Challenges of the United States (pgpf.org)

Prevalence of Chronic Conditions in FFS 2018

Condition	Prevalence
Hypertension	57%
Hyperlipidemia	48%
Arthritis	33%
Diabetes	27%
Ischemic Heart Disease	27%
Chronic Kidney Disease	24%
Depression	18%
Heart Failure	14%
COPD	11%
Alzheimers Disease/Dementia	11%
Atrial Fibrillation	8%
Cancer	8%
Osteoporosis	7%
Asthma	5%
Stroke	4%
Drug Abuse/Substance Abuse	3%
Schizophrenia/Other Psychotic Disorders	3%
Alcohol Abuse	2%
Hepatitis (Chronic Viral B & C)	0.8%
HIV/AIDS	0.4%
Autism Spectrum Disorders	0.3%

Specific Chronic Conditions - Centers for Medicare & Medicaid Services Data (cms.gov)

Prevalence of Multiple Chronic Conditions

Figure 5: Prevalence of Multiple Chronic Conditions among Fee-for-Service Beneficiaries: 2018

Number of Chronic Conditions	Prevalence
0 to 1	31%
2 to 3	29%
4 to 5	22%
6+	18%

Specific Chronic Conditions - Centers for Medicare & Medicaid Services Data (cms.gov)

Cost of Multiple Chronic Conditions

Figure 9: Per Capita Medicare Spending among Medicare Fee-for-Service Beneficiaries: 2018

Number of Chronic Conditions	Per Capita Medicare Spending
0 to 1	$2,067
2 to 3	$6,009
4 to 5	$11,580
6+	$32,475

Specific Chronic Conditions - Centers for Medicare & Medicaid Services Data (cms.gov)

Medicare Spending by Number of Chronic Conditions

0 to 1 condition | 2 to 3 conditions | 4 to 5 conditions | 6+ conditions

	Percent of Beneficiaries	Percent of Total Medicare Spending
6+ conditions	18%	54%
4 to 5 conditions	22%	24%
2 to 3 conditions	29%	16%
0 to 1 condition	31%	6%

Chartbook and Charts | CMS

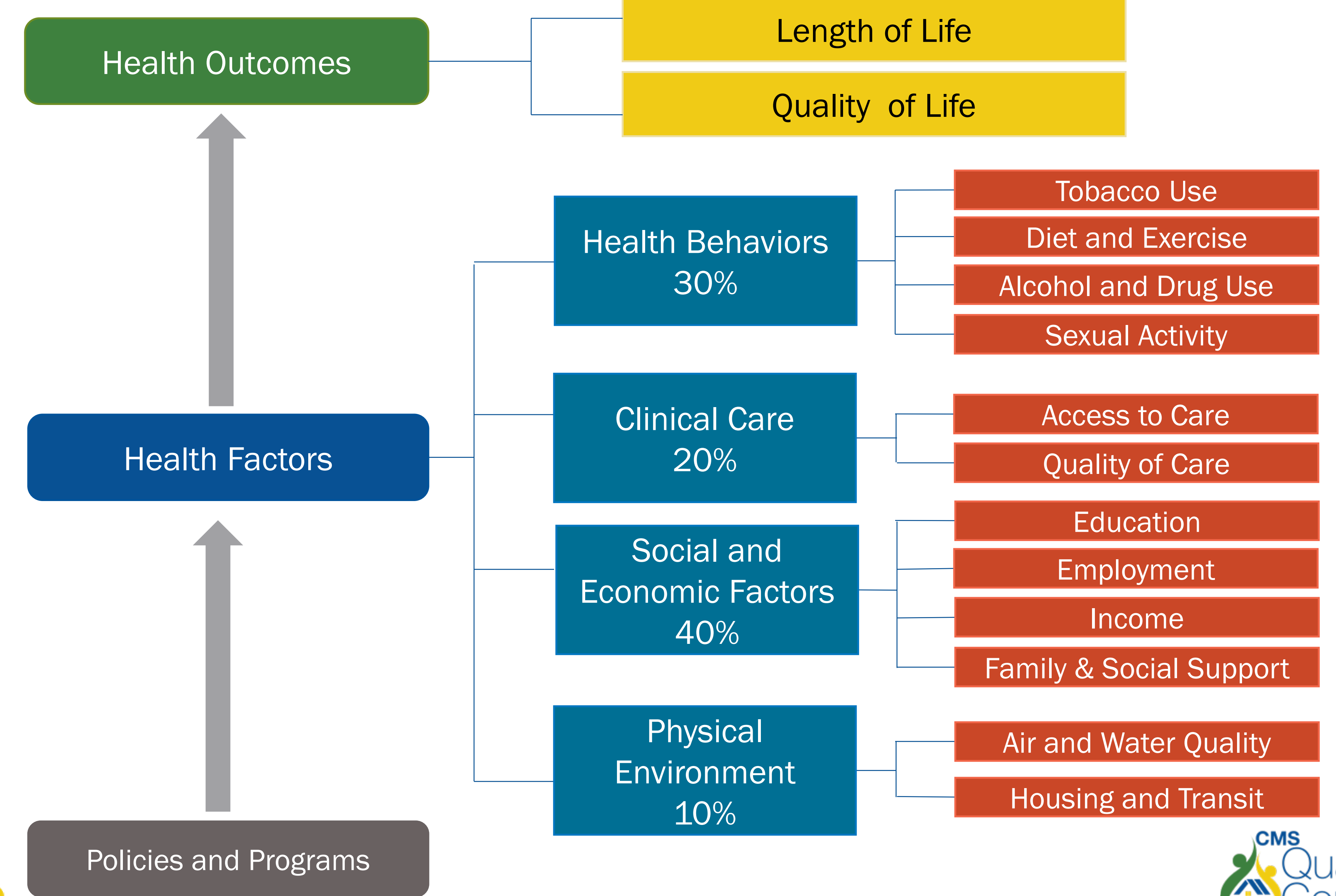
Co-occurring Medical Conditions Among Older Adults

Only condition | 1 to 2 other conditions | 3 to 4 other conditions | 5+ other conditions

Autism Spectrum Disorders
HIV/AIDS
Schizophrenia/Other Psychotic...
Arthritis
Cancer
Depression
Hepatitis (Chronic Viral B & C)
Osteoporosis
Hypertension
Hyperlipidemia
Alzheimer's Disease/Dementia
Alcohol Abuse
Drug Abuse/Substance Abuse
Asthma
Diabetes
Ischemic Heart Disease
COPD
Atrial Fibrillation
Chronic Kidney Disease
Stroke
Heart Failure

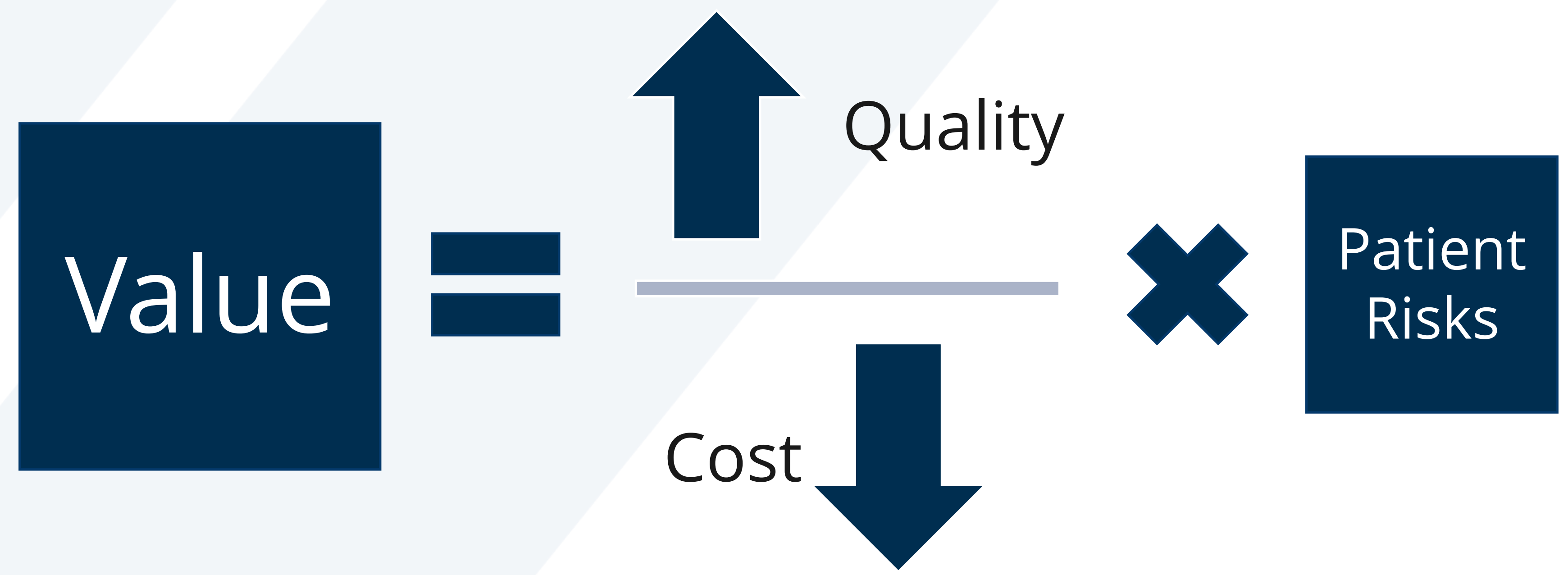
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

[Chartbook and Charts | CMS]



https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/

Factors that Influence the Value Equation in Healthcare



Healthcare Delivery Reform Requires Focus

Pay Providers

Deliver Care

Distribute Information

Health Care Payment Learning & Action Network

	Medicaid	Commercial	Medicare Advantage	Traditional Medicare
2024	25%	25%	55%	50%
2025	30%	30%	65%	60%
2030	50%	50%	100%	100%

About Us - Health Care Payment Learning & Action Network (hcp-lan.org)

Quality, Disparities + Equity: How Does Value-Based Care Narrow the Gap?

Ali Khan, MD, MPP, FACP

Oak Street Health

CMS Quality 2023 Conference

Building Resilient Communities: Having an Equitable Foundation for Quality Healthcare

OAK
STREET
HEALTH

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Building Resilient Communities:
Having an Equitable Foundation for Quality Healthcare

Problems with the U.S. healthcare system are well-documented:

Expensive [1,2]

$4.1 tn

US annual healthcare spend

+267%

US per-capita healthcare spend vs OECD average

Poor Outcomes [1]

-2 years

US life expectancy vs OECD average

+52%

US diabetes hospital admits vs OECD average

Negative Experience [3,4]

>40%

US Physician Burnout rate

-1.2

Average Net Promoter Score for primary care physicians

High costs and poor outcomes are concentrated in older adults, who tend to be the sickest patients. Today, 96% of Medicare spend relates to chronic disease[2]

1. Source: OECD
2. Source: Centers for Medicare and Medicaid Services (CMS.gov) 2020 data
3. Source: Medscape National Physician Burnout and Suicide Report
4. Source: The Advisory Board, 2019

Note: All OECD comparisons are from 2019 or earlier to remove any uneven impact of COVID-19

For certain communities, those challenges are even more stark:

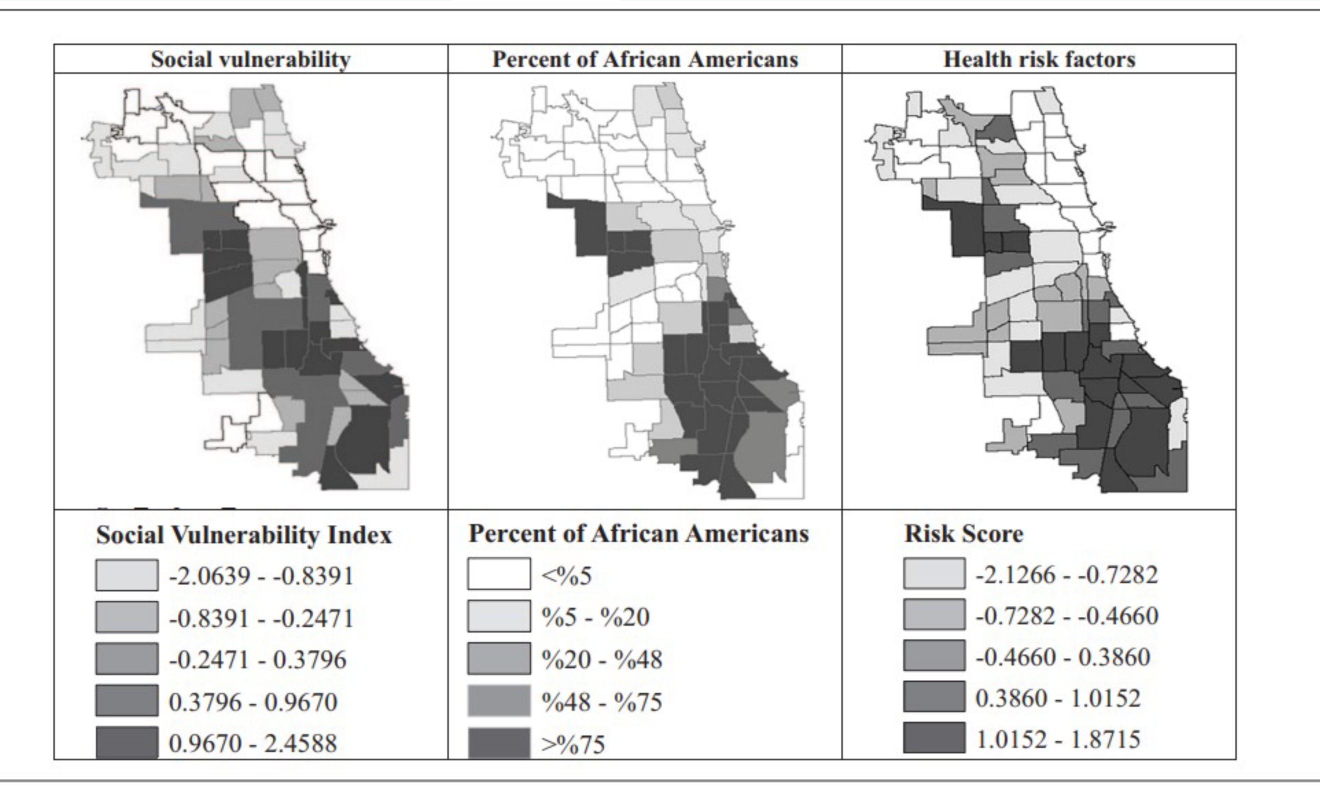


Figure 2. The spatial distributions of social vulnerability, health risk factors, and the percentage of African American residents in Chicago Community Areas.
Note. Social vulnerability index ranged from −2.0640 to 2.4859; Risk Score ranged from −2.1266 to 1.8715.

Communities with higher rates of poverty and unemployment, among other factors, suffer higher-risk health outcomes.[1]

13.4%

Proportion of Black Americans in US population[2]

40%

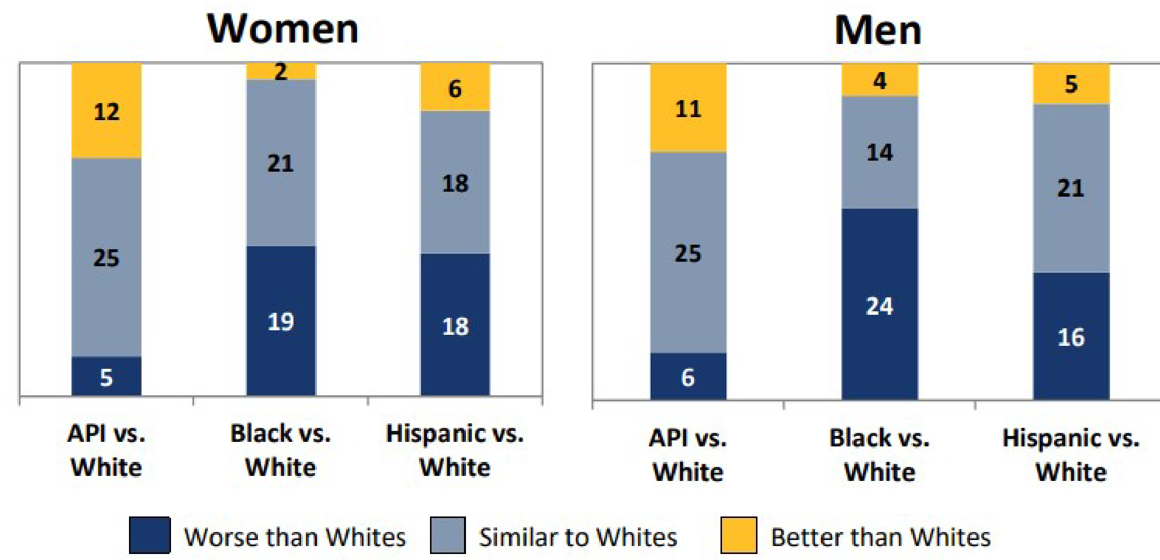
Proportion of Black Americans among COVID-19 hospitalizations

~3.1x

Rate of Black American hospitalizations for COVID-19, relative to population size

1. Source: Kim and Bostwick, "Social Vulnerability and Racial Inequality in COVID-19 Deaths in Chicago." Health Education and Behavior. 2020
2. Source: Centers for Disease Control and Prevention; Gaynor and Wilson, "Social Vulnerability and Equity: The Disproportionate Impact of COVID-19.".Public Administration Review. 2021.

When we examine the care we deliver, further equity gaps emerge:



While patient-reported rates of care delivery are often equivalent across racial categories, outcome measures tell a different story.[1]

~9-10% lower

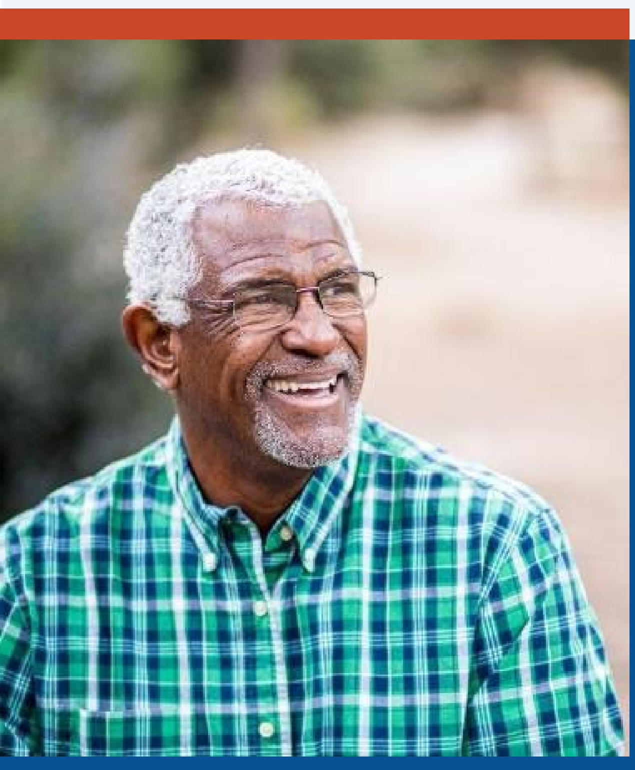
Likelihood that Black + Hispanic patients had adequately controlled high blood pressure, relative to Whites

~11-12% lower

Likelihood that Black + Hispanic patients had adequately treated depression episodes with continuous antidepressant use, relative to Whites

1. Source: Martino et al, "Racial, Ethnic and Gender Disparities in Health Care in Medicare Advantage." CMS Office of Minority Health/RAND. 2021.

Enter: Oak Street Health



We are…

A patient-centric network of primary care centers for Medicare-eligible patients

We leverage…

The Oak Street Health platform to provide comprehensive care for our patient population

We improve…

Experiences and outcomes for our patients

We reduce…

Hospitalizations by over 50% and retain the savings generated by our care model

169	Oak Street owned and operated centers
21	States currently covered
160k	At-risk patients receiving our care
$2.155b	Est. 2022 revenue , 62% annual revenue growth
~6,000	Team members, all aligned with our mission & vision, including ~500 primary care providers

Note: Centers and states as of 03/16/2022; remaining data as of 12/31/2021

Oak Street Health locations

Currently serving 175,000+ Medicare beneficiaries and growing.

- About 45% of Oak Street patients are dually eligible for Medicare and Medicaid

State	Locations	State	Locations
Alabama	2	New Mexico	4
Arizona	10	New York	10
Georgia	5	North Carolina	8
Illinois	27	Ohio	11
Indiana	8	Oklahoma	5
Kentucky	1	Pennsylvania	10
Louisiana	5	Rhode Island	4
Michigan	11	South Carolina	3
Mississippi	2	Tennessee	4
Missouri	4	Texas	17

Why: complex patients require a multi-dimensional care model – and time

68 average age

86% of patients have one or more chronic conditions

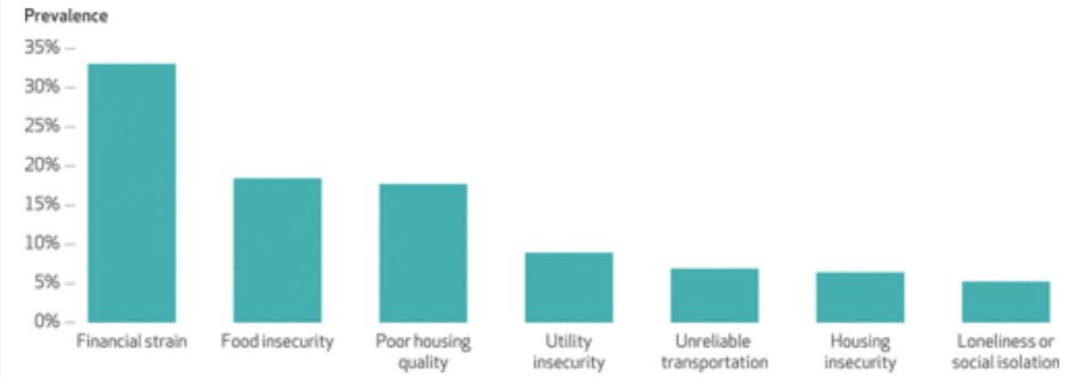
7+ average number of medications

>50% of patients identify as African American, Latino, or Indigenous

42% of patients are dually eligible for Medicare and Medicaid

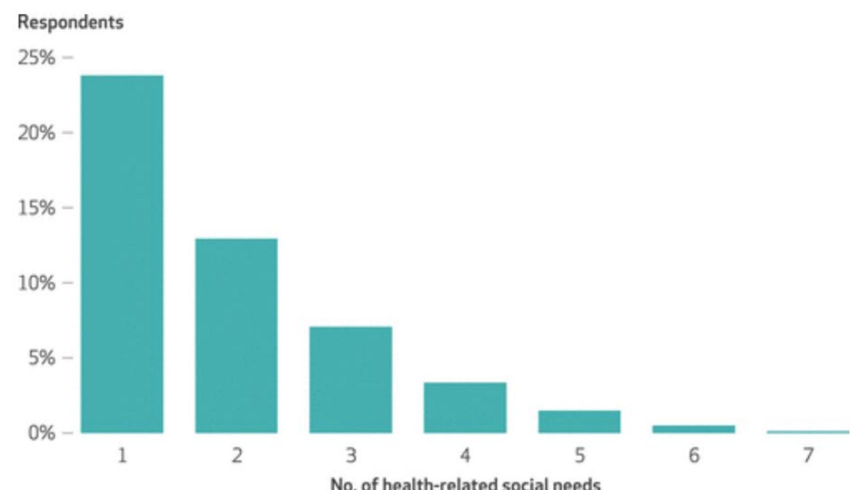
~50% of patients have a housing, food, or isolation risk factor

All too often, resource limitations stymie progress in health outcomes



HealthAffairs

SOURCE Authors' analysis of Humana survey data, 2019–20. NOTES Sample limited to respondents who answered all survey questions (n=51,201). Prevalence estimates are weighted for nonresponse and national age and sex distribution. Health-related social needs are not mutually exclusive, and respondents could be counted in more than one category.



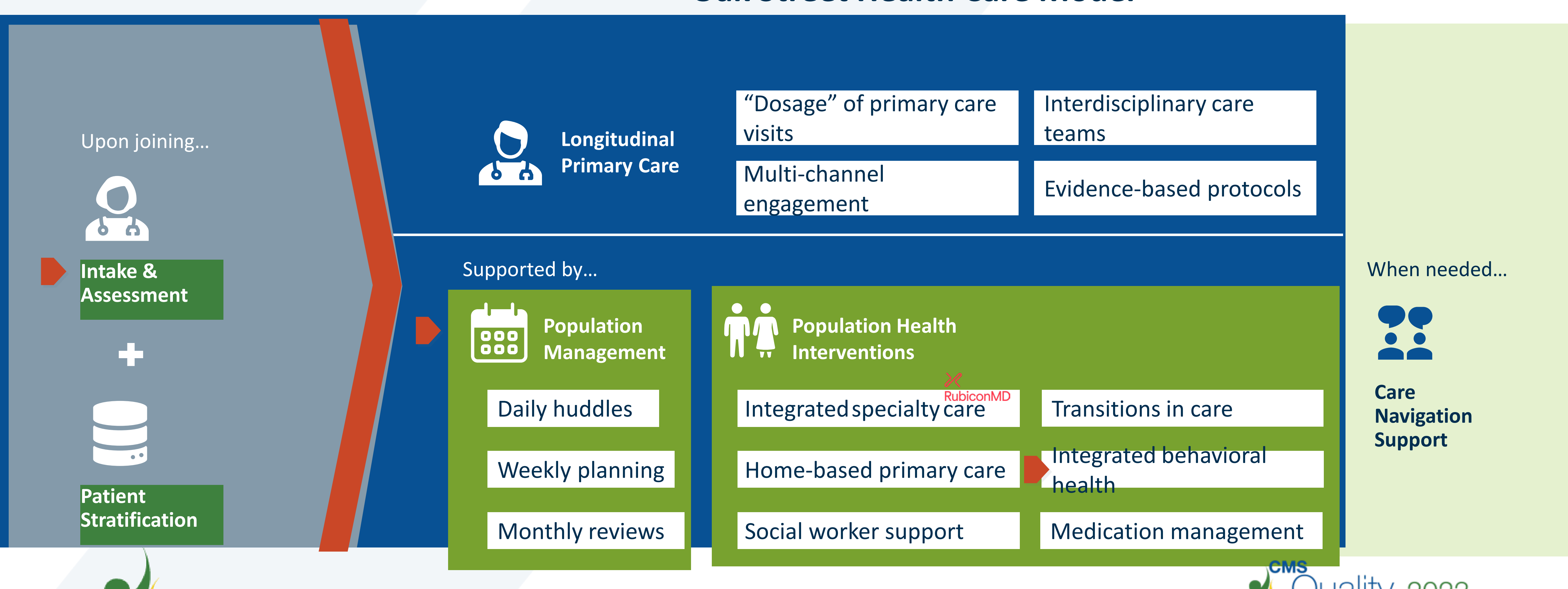
1. Source: Long et al. "Health-related social needs among older adults enrolled in Medicare Advantage." Health Affairs. 2022.

Value-based models invest upfront to keep patients happy, healthy, and out of the hospital

Challenges in Primary Care Settings	Fee For Service	Value Based Practices (Medicare, Medicaid)
Not enough time with patients	**2,000+** Avg doctor panel[1]	**~400-800** Patient panel
No patient specialization	Accepts all ages	Medicare-eligibles focused (most often); Medicaid-eligibles focused (less common – Cityblock, CareMore, Waymark)
No non-facing patient time	No time to plan for care outside the exam room	**>1/3** Provider/nursing time used to **communicate**, coordinate care, close care gaps + proactively plan
No support beyond primary care	Minimal focus on social determinants of health	Behavioral health, pharmacy, home-based support, well-being programs + social worker/community health worker assistance within **large care teams**
Limited technology integration	Limited EMR use focused on billing & record-keeping; no time to engage with population health overlays	**4 hrs/day** Average time that clinical staff use technology platforms optimized to provide an integrated clinical and care plan – *single source of truth for teams*

1. Source: Journal of General Internal Medicine

Value-based models leverage a deep understanding of patients, leading to coordinated and holistic support



To be discussed in further detail

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Care Model Deep-Dive: Integrated Behavioral Health
Taking care of our patients' population health needs

Mental Health in the US[1]

1 in 5
US adults who experienced a mental illness in 2020

>17 million
US adults who experienced delays or cancellations in mental health appointments

At Oak Street Health

All patients
screened for behavioral health at initial visit and annually

All centers
provide access to behavioral health care

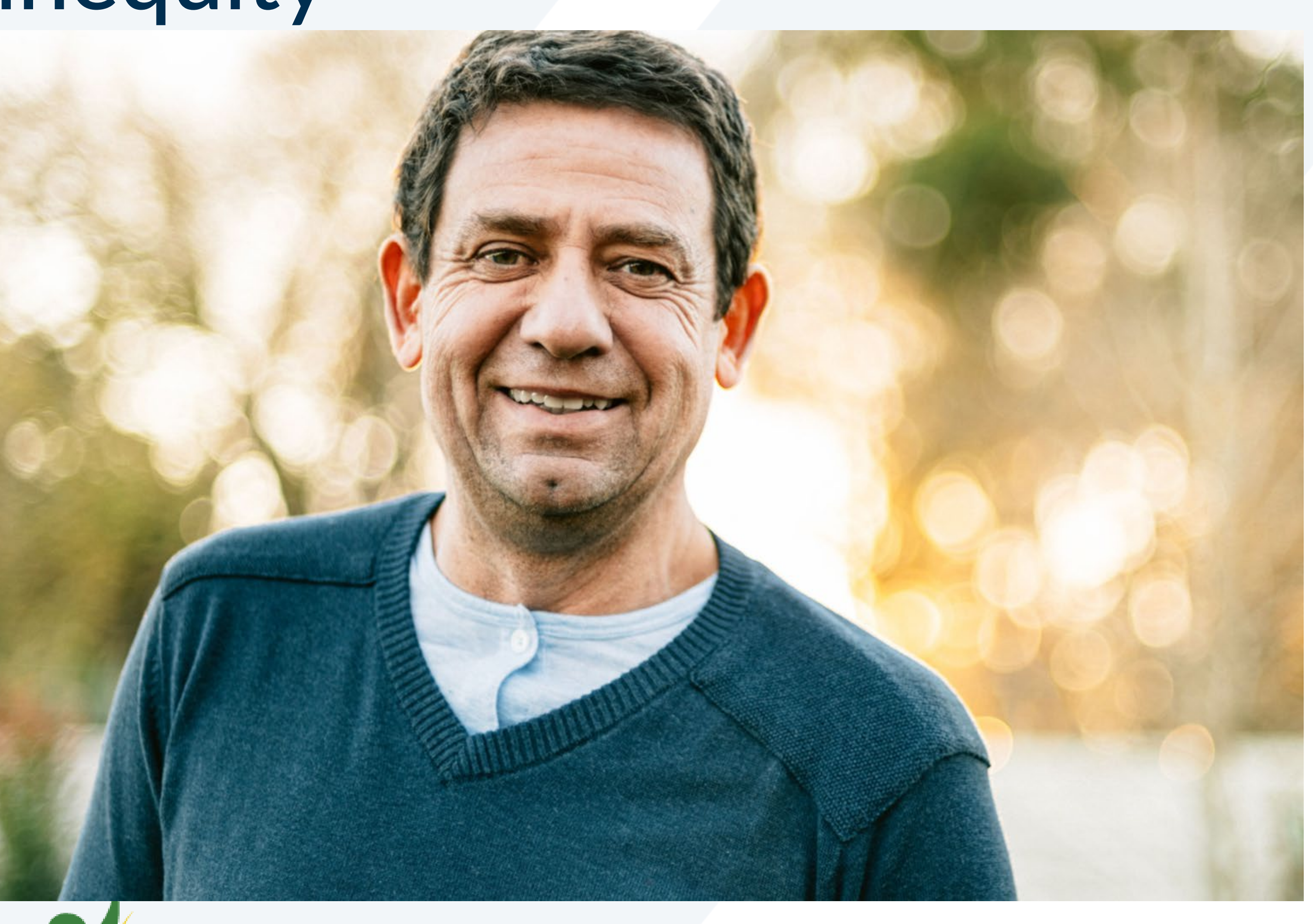
Collaborative care
Behavioral health is not stigmatized or siloed;
it is a part of whole-person care at OSH

73%
OSH patients seeing a significant reduction in depressive symptoms through Oak Street collaborative behavioral health care model[2]

vs 19% of patients in traditional behavioral health care model[3]

1. National Alliance on Mental Illness, 2020 data
2.Oak Street Health patient data following 6-month study, May 2021
3 JAMA 2002, "Collaborative Care Management of late-life depression in the primary care setting"; Primary Care: Clinics in Office Practice 2012

Value-based models yield better quality care delivery for patients – and, in doing so, close gaps in health inequity



5-Star HEDIS Level Performance[1]:

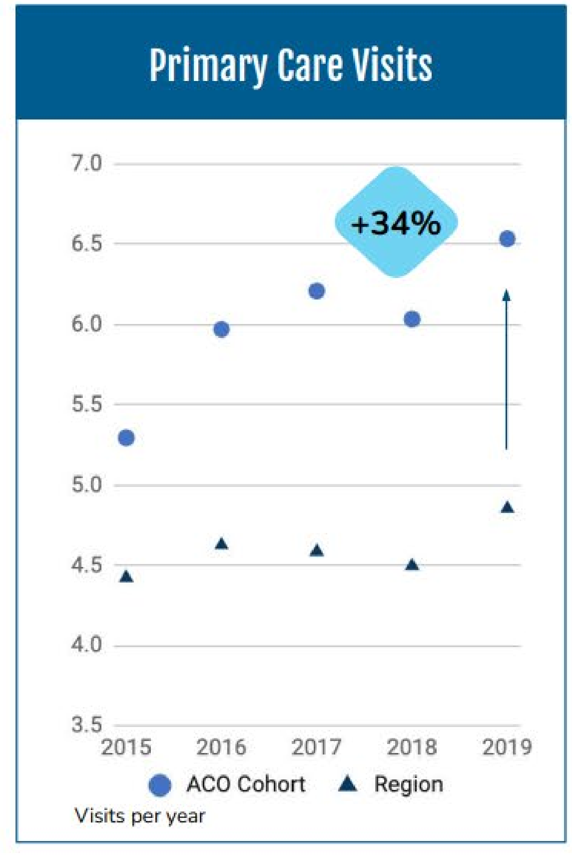
85%
Diabetic patients with well-controlled diabetes (Hemoglobin A1C of <9)
+6% above industry 5-star benchmark

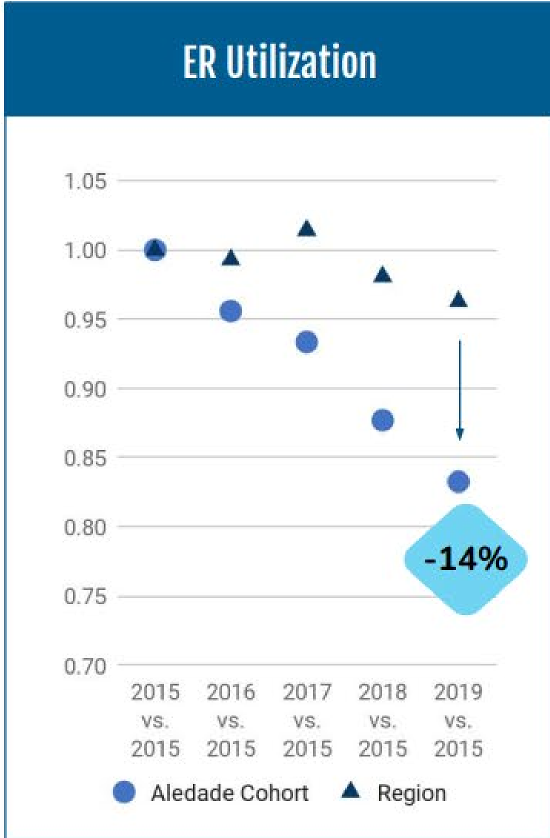
87%
Patients with a breast cancer screening
+12% above industry 5-star benchmark

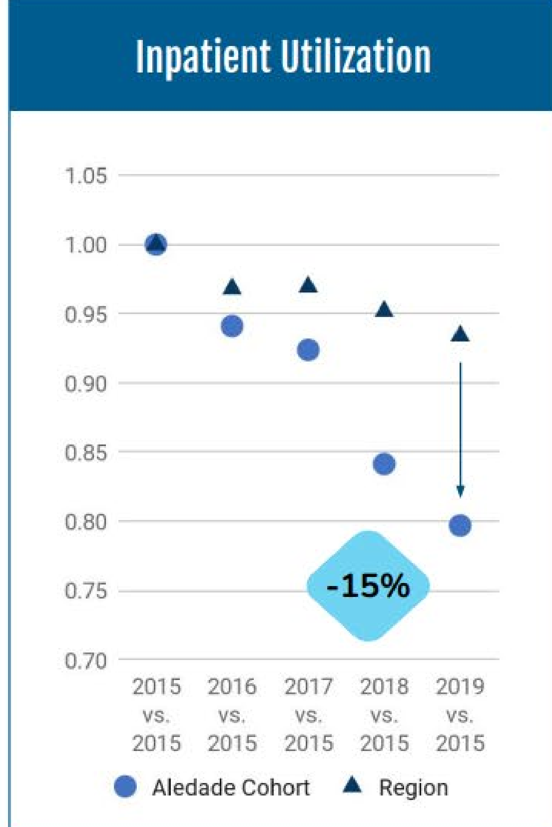
88%
Patients with colorectal cancer screening
+14% above industry 5-star benchmark

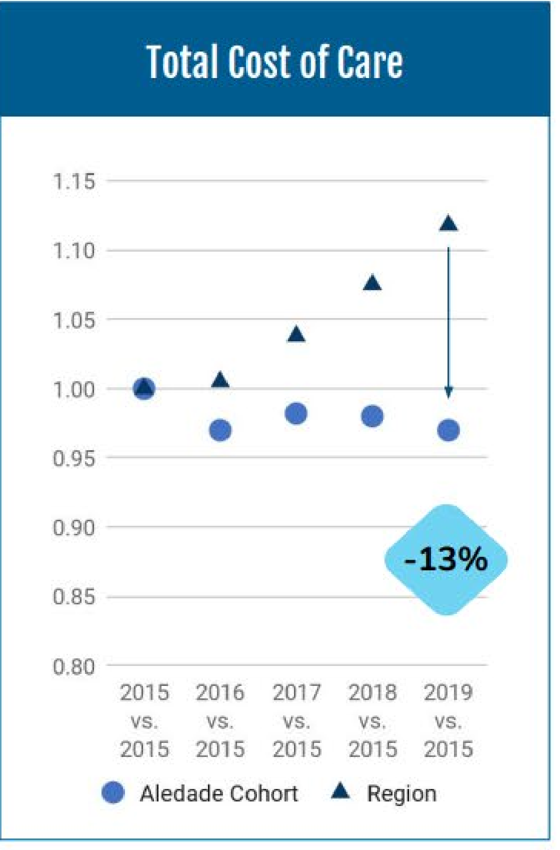
1. For patients that completed a 2021 wellness review visit

Value-based care allows for critical investment in primary care (1 of 2)









VBC models demonstrate improved quality and lower cost across plan types (HMO, PPO, Open Access, SNP, MMP) and programs (MA, MSSP, DC and Medicaid)

1. Source: Aledade analysis of the CMS Virtual Research Data Center, containing 100% of Medicare claims nationally. More primary care, fewer ER visits, and hospitalization means lower cost over time. Primary Care Visits ER Utilization Inpatient Utilization Total Cost of Care https://www.ajmc.com/view/more-than-beating-the-benchmark-5-medicare-acos-2015-2019

Value-based care allows for critical investment in primary care (2 of 2)

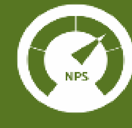
In 2018, hospitalizations were >60% of Medicare expenditures[1]…

…while Primary Care spend accounted for only ~3%

51% reduction in hospital admissions[2]

42% reduction in 30-day readmission rate[2]

51% reduction in ED visits vs. Medicare FFS benchmark[2]



NPS of 90[2]

VBC models invest in proactive primary care, spending more than 3x the average[3]. We remove reactive and more-expensive costs from the system

VBC models demonstrate improved quality and lower cost across plan types (HMO, PPO, Open Access, SNP, MMP) and programs (MA, MSSP, DC and Medicaid)

1. Source: CMS and Kaiser Family Foundation
2. Please see our S1, filed 2/8/2021, for information on how these statistics are calculated
3. Based on our 2021 spend (please see our 10K, filed 2/28/2022) vs industry average (sourced from Kaiser Family Foundation)

Despite progress in quality + equity, the value journey is adolescent

- **Incentive Design**: Future expansion of Medicare-led payment models to more deeply link payment reform, quality + equity in equal measure (MA STARs, ACO REACH)
- **Scalability**: Moving beyond ~1-10% of Medicare beneficiaries; application to high-risk commercial models, expansion of Medicaid services/scope
- **Clinical Excellence**: Ongoing evaluation of clinical outcomes + patient-reported outcome measures; collaborative benchmarking

Narrowing the Gap in Quality and Disparities with Intentional Program Design

- Severe Hypertension
- Comprehensive Advance Care Planning
- Advanced Kidney Disease

Samuel "Le" Church, MD, MPH, CPC-I, FAAFP

Aledade Local Medical Director

GAFP – President-elect

The Aledade Core 4

Access & Quality

The best quality metric is a true connection to primary care. The Aledade App enables a thorough assessment of risk factors and discussions on wellness education.

Risk Stratification

Risk Stratification enables physicians to align patients with the right clinical initiatives according to their clinical complexity.

Care Transitions

We have found it takes 7 high-priority Transitional Care visits to avoid one readmission. We have integrated hospital and claims data for recent ED and hospital patients, with easy-to-use post-discharge workflows.

Care Compass

Using data to help practices offer patients high-quality complementary care, like high value referral management and Comprehensive Advance Care Planning.

Aledade's Footprint in Settings with Greater Likelihood of Health Disparities

CA Legacy

AR All CHC ACO

LA All CHC ACO (HPSA + MUA)

MS CHC

FL ACO

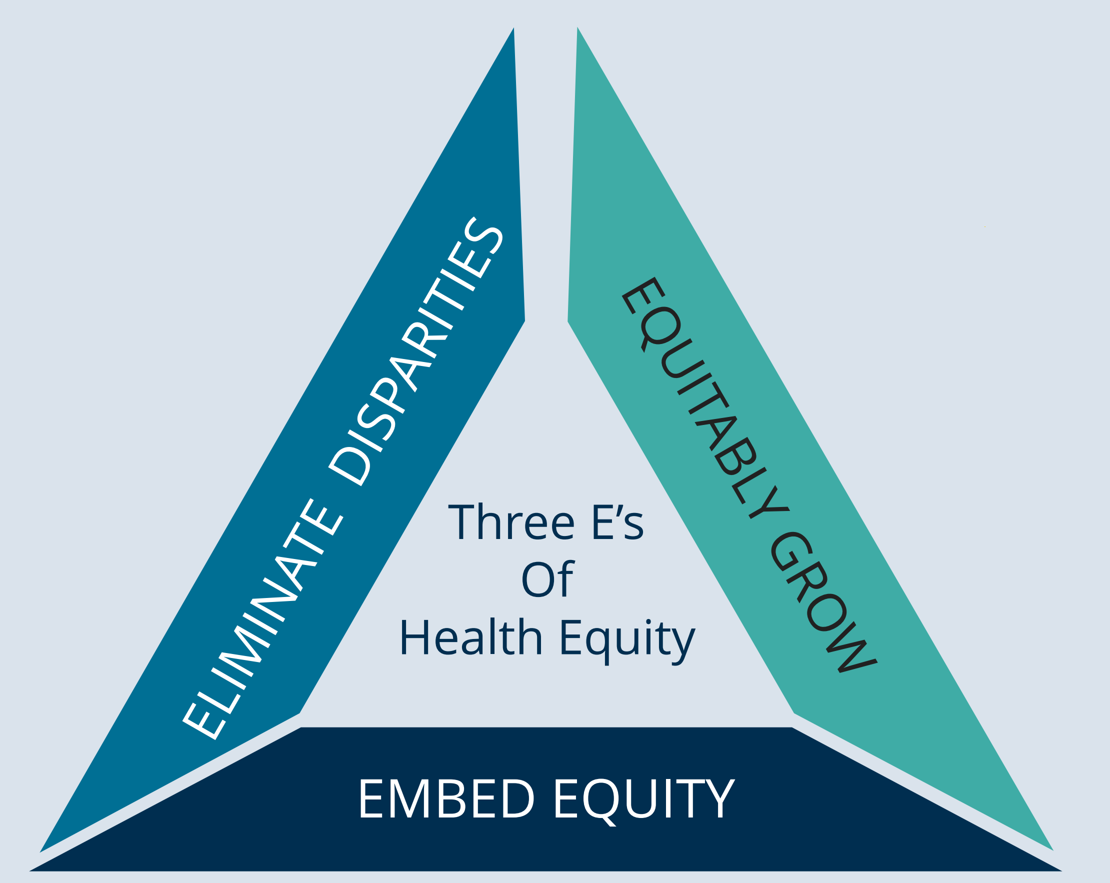
> 200 CHCs & RHCs across more than 20 states. About 40% of Aledade ACO-attributed Black and Hispanic beneficiaries are served by member CHCs

In AL, FL, and LA, > 91% Aledade ACO-attributed beneficiaries are served by a practice in a medically underserved area (MUA)

In CA and MS, > 40% of Aledade ACO-attributed beneficiaries are served by a member practice in a geographic health professional shortage area (HPSA)

Aledade Commitment to Health Equity is Company-Wide

What does Health Equity look like at Aledade?



Embed a culture of equity into **all that Aledade does**, from our systems and operations to policies and practice

"Health equity means that everyone has a fair and just opportunity to be as healthy as possible.

This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."

\- Robert Wood Johnson Foundation

Hypertension Control - Key Program Design Elements

Practice Support

- Aledade Medical Director and Practice Transformation Specialist support to assist practices in implementing evidence-based BP control workflows and protocols
- Data sharing via Practice Scorecards to highlight practice & clinician-level BP control rates stratified by race

Pharmacy Outreach

- Pharmacist and pharmacy tech direct-to-patient engagement on Medication Adherence

Resources for Disparity Reduction

- Clinical Outcomes Support team coaching of high opportunity practices through a hypertension quality improvement program (AMA Target BP)
- Self-Measured Blood Pressure program adoption by practices with high density Black patients
- DASH diet, medication considerations in Black patients, Pilots on CHW and self-management

Tech Enablement

- Hypertension worklist in the Aledade App to identify and prioritize outreach to patients with uncontrolled HTN

Hypertension Control Outcomes

Medicare population totals 938,161 with 89,990 (10%) Black patients

Overall BP control increased as did BP control in Black patients

The percentage of severe BP in Black patients and disparity between Black and White patients decreased, showing improvement throughout the year

Population	% Controlled All Patients	% Controlled Black Patients	% Severe BP Black Patients	% Disparity in Severe BP for Black Patients
All Medicare* (MA + MSSP)	69.2% → 73.0%	63.5% → 66.9%	8.5% → 7.2%	3.1% → 2.7%

Approximately 1200 black patients moved from uncontrolled to controlled in 2022 - which we estimate avoided 34 heart attacks and strokes*

*internal unpublished data as of December 2022

Comprehensive Advance Care Planning (CACP): Culturally Tailored CACP

Aledade provides culturally tailored CACP facilitations that address potential language and cultural barriers by:

Guiding individuals through documentation, adjusting for comprehension levels, and using plain language documentation available in 29 languages

+

Using bilingual facilitators and translation services to deliver personalized CACP conversations & education

+

Communicating clearly to ensure understanding of treatment options so individuals could make informed decisions

+

Addressing cultural beliefs and concerns by partnering with the individual to understand their unique perspectives

CACP Outcomes and Equitable Program Design ensures equitable engagement

CACP % of Patient Engagement Level by Practice Type

% Contacted that are Participating in CACP, by Primary Facility Type & Patient Race

	Practice Type Total	Minority	White
FQHC	15	16	14
RHC	20	27	18
Private Practice	16	20	15
Combined Totals for ALL practice types		20	15

- $4,088 annualized reduction per patient in EOL spend in MSSP among all participants**
- High patient and family satisfaction
- Minority patients proportionally represented in program eligibility (30% higher)
- Minority participation was ***higher*** than non-minority in all three clinic types

**Am. J. Accountable Care. 2022;10(2):4-6.*

What are the top predictive variables in the KCM Patient Identification Algorithm?

Highly predictive medical variables:

- Complicated diabetes
- Episodes of AKI
- Multiple procedures, surgeries/anesthesia
- CHF

Highly predictive non-medical SDOH variables:

- Non-white, African American
- Community safety/violence
- Housing costs/housing risk
- Frequent ER visits

SDOH makes up nearly one-third of the weight for each individual risk for crashing into dialysis

Predictive Variables by Weight in Descending Order

hcc_chronic_kidney_disease_severe_stage_4
provider_specialty_nephrology
age
hcc_chronic_kidney_disease_stage_5
hcc_diabetes_w_chronic_complications
hcc_chronic_kidney_disease_moderate_stage_3
hcc_acute_renal_failure
hcc_congestive_heart_failure
race_white
sex
provider_specialty_emergency_medicine
race_african_american
violent_crime_index
total_hcc_score
number_codes_procedure
n_unique_facilities
n_unique_providers
white_index
house_price_index
provider_specialty_anesthesiology

Kidney Care Management (KCM) Program Equitably Enrolls Minority Patients

Driven by intentionally designed patient identification algorithm and patient enrollment competency

Population	KCM program goal was to identify and enroll highest risk CKD patients, stages 4 and 5, into a RN led care management program	Black patients as percent of eligible population(s)
CKD 4-5 patients	The pilot project included over 2,000 Medicare beneficiaries with CKD 4 stages 4 and 5 across 128 clinics	15.9%
Top 50% risk CKD 4 - 5 patients	We used a patient identification algorithm including SDOH methods to include patients with highest risk for crashing into dialysis	19.8%
Enrolled patients	The patient outreach team enrolled black or African American patients at a rate higher than their eligibility	29.9%

[3] unpublished internal data as of November 2022

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Conclusions & Recommendations

Evidence-based programs need to be offered equitably to all beneficiaries

Intentional program design narrows the gap in quality and outcomes

Data collection, integration and aggregation is crucial for all efforts

Culturally sensitive outreach and patient care is effective