Building a Strong Foundation:

How Health Centers can embrace value-based care to improve patient outcomes, drive health equity, and strengthen community.

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On Belay
Health Solutions

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No financial relationships to disclose

Dartmouth Medical School

25 years in Federally-Qualified Health Centers

- **Jesuit Volunteer:** 1981-1982, Teche Action Clinic, Franklin LA
- **Medical Director:** 1989-1992, Blackstone Valley Community Health Care, Central Falls RI
- **Founding Residency Program Director**: 1992-2009 Greater Lawrence Family Health Center
- **Chief Medical Officer:** 2011-2015, Lynn Community Health Center

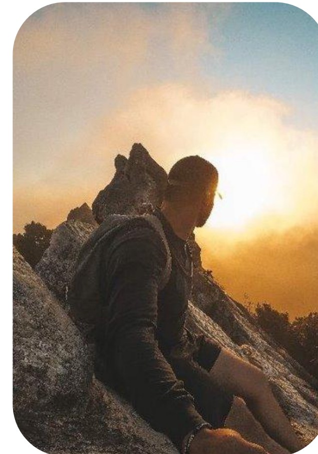
2009 - 2011 – **Vice President for Family Medicine:** Caritas Christi Health Care

2015 to present – **Founded Kronos Health:** a Lawrence, Mass.-based practice delivering patient-centered, value-based care in a dramatically higher touch, higher impact primary care model

2020 to present – **Co-Founder and President, On Belay Health Solutions**

Goals of our session today

1. Understand how innovative care models supports health equity
2. Learn how value-based care can help your organization
3. Explore best practices and keys to success in moving away from fee-for-service
4. Gain practical knowledge and actionable steps towards building a strong foundation



Health disparities account for $93 billion in excess medical costs and $42 billion in lost productivity due to premature deaths.[1]

1. Nambi Ndugga et al., "Disparities in Health and Health Care: 5 Key Questions and Answers," Kaiser Family Foundation, last accessed November 1, 2022, https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/.

Health centers have a long-standing commitment to health equity

Providing accessible, affordable and high-quality health care for all while serving as economic engines in underserved communities

Under traditional fee-for-service (FFS), payment is based on volume rather than quality which stifles innovation and limits ways providers can care for their patients

Health centers often **lack data and data management systems** to monitor where patients get their care resulting in poor care coordination

FQHCs are **not paid to address the health-related social needs** of patients, such as housing insecurity, despite their substantial impact on outcomes and costs

Pervasive financial instability due to reliance on grants and unstable revenue streams

Achieving health equity requires systematically addressing disparities in healthcare

To do so, health centers need:

1. Effective equity measures and accurate sociodemographic data
2. Stratification of quality measures and outcomes by sub-groups
3. Ability to move upstream to address social drivers of health
4. Financial incentives based on outcomes and cost of care

BENEFIT	VALUE
Fixed population-based payments and quality-based financial incentives Risk adjusted, predictable PMPM Reward for improving outcomes, care delivery, and cost	**Invest in new staff and technology; ensure financial stability**
Accountability for engaging patients Incentives for proactive rather than reactive care	**Effective preventative care and chronic care management**
Extend care beyond the clinic Visibility into patient activity outside the four walls Care for patients in the home or in community settings Patients get access to critical community resources	**Team stays engaged with patient and intervenes at the right time Builds trusted relationships that support whole-person care for all**
Expand care team Beyond physician, NP, or PA, visits can be with nurses, therapists, social workers, community health workers, and group visits	**Increase access to care and HC's ability to provide integrated behavioral health and address social determinants of health**
Access to population-health data Drive effective equity measures through accurate and timely collection of key sociodemographic data	**Stratify quality measures and outcomes by subgroups to effectively address inequities**

Value-based care positions health centers to drive meaningful change by realigning incentives around outcomes and facilitating integration of resources, infrastructure and programs that remove barriers

According to CMS, all Medicare fee-for-service beneficiaries will be a in care relationship with accountability for quality and total cost of care by 2030

ACO Realizing Equity, Access, and Community Care (REACH) Model

Goal: Improve quality of care and outcomes for all Medicare beneficiaries by to reducing disparities in health such that those with the greatest needs and least resources receive the care they need

New policies to promote health equity started in 2023:

1. Health Equity Plan Requirement
2. Health Equity Benchmark Adjustment
3. Health Equity Data Collection Requirement
4. Nurse Practitioner Services Benefit Enhancement
5. Health Equity Questions in Application and Scoring for Health Equity Experience

Making Care Primary (MCP) Model

Goal: The MCP care delivery approach is based on care management to reduce cost of care, care integration with specialists and behavioral health, and community connection to address health related social needs (HRSNs)

MCP includes several model components to improve health equity:

1. Some payments will be adjusted by clinical indicators and social risk
2. Participants will be required to develop a strategic plan for identifying and reducing disparities
3. Participants will be required to implement HRSN screening and referrals
4. CMS will measure percentage of patients screeds for HRSNs
5. CMS will collect data on certain demographic information and HRSNs to evaluate health disparities in MCP communities

Getting Started

KEY TRANSITIONS	FEE-FOR-SERVICE	VALUE-BASED CARE
Approach to care	Treatment of disease	Wellness, prevention
Source of revenue	Fee-for-service Volume driven	Capitation, shared savings Outcomes driven
Population health	Reactive care at point of visit	Proactive care through risk and patient stratification
Utilization optimization	Maximizing visits per hour	Team based approach to improve care and eliminate waste
Patient engagement	In clinic	In clinic, in home, in community

Keys to success in Value-Based Care

- Proactive patient-centered care
- Reducing administrative burden
- Access to data and insights
- Risk stratification and management
- Expanded access to care
- Care coordination and collaboration
- Care management
- Measuring quality, performance, and satisfaction

You can’t do it alone

Accountable Care Organization (ACO) is a group of doctors, hospitals, and other health care providers who come together voluntarily to deliver coordinated, high-quality care to their Medicare patients

By joining an ACO, health centers benefit from:

1. Access to value-based contracts
2. Risk-mitigation
3. Outcomes based financial incentives
4. Guidance and mentorship from experts that stay up-to-date on rules and regulations
5. Population health data and management
6. Care management
7. Infrastructure and resources
8. Like-minded peer community

Impact Stories

PARTNERSHIP OVERVIEW

Joined On Belay in 2022

On Belay quickly onboarded practice and supported with:

- Access to **meaningful contract**
- **VBC education** with SMEs for mentorship
- **Risk adjustment** best practices and operationalizing knowledge across team
- **Care management** support for existing team to share information, best practices, and community resources
- **Population health** data and management

Best Practices

- **Early and ongoing multi-disciplinary stakeholders' engagement** spanning physician champion to IT to office manager
- **Open, thoughtful dialogue and planning for transition**
- Identified key implementation opportunities
  - **Proactive annual wellness visits**
  - **ER utilization**
  - **Transitional care**
  - **Risk adjustment**
- **Leverage data for decision making**
  - Visibility into what patients doing outside of clinic
  - Ability to improve outcomes by changing care delivery
  - With ADT feeds can take more ownership of their patients
- Good stewards of community resources

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Thomas faced complex barrier to care

Complex medical history
Low education level
ESL
20 ED visits since 2020
Challenging living situation
Lack of **transportation**
Lack of access to behavioral health support
High medical spend in 2022

How we helped

INTERVENTIONS

- **Individualized support** from OBHS RNCM and LSW
- **Home situation** and care plan assessment
- Revised service plan with **consistent nursing support**
- **Communication on all appointment details** via text to patient and caretaker
- **Initiated DMH, therapy**, and adult day program referrals
- **Regular check-ins** with OBHS care team

OUTCOMES

- **Obtained custom abdominal binder** to greatly improve patient's comfort
- **Consistently attends medical appointments** and weekly appointments with active DMH team and therapist
- **Thriving in the Quality Life Adult Program** he attends 5x/week
- **Developed trusting relationship** with OBHS team, knows to notify instead of ED
- **Offered housing support** in hometown to live independently
- **2 ED visits in 2023 down from ~7/year**

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