Leveraging Value-Based Contracts to Advance Health Equity

Joe Mando
Community Care Cooperative

COMMUNITY CARE COOPERATIVE

Who We Are

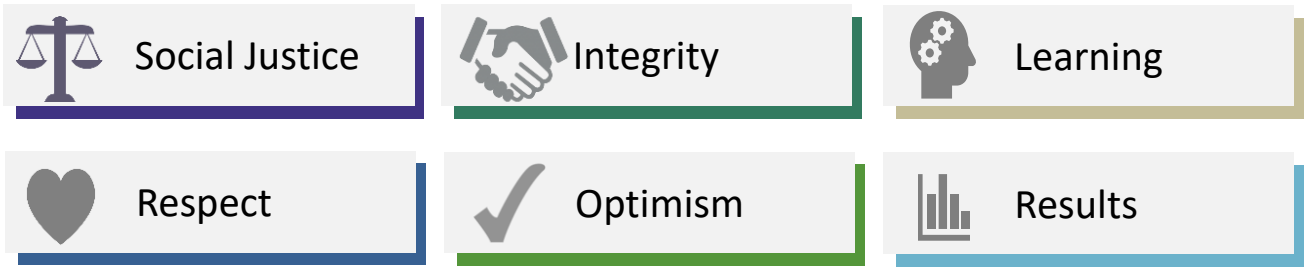
- Welcome to Community Care Cooperative (C3), Community Technology Cooperative (CTC), and Community Pharmacy Cooperative (CPC)
- The next few slides explain who we are, our origins as an Accountable Care Organization (ACO), and how our work has expanded since 2016 to include other services that benefit Federally Qualified Health Centers (FQHCs) and the patients and communities they serve

GREAT HEALTH IS OUR PRIMARY PURPOSE

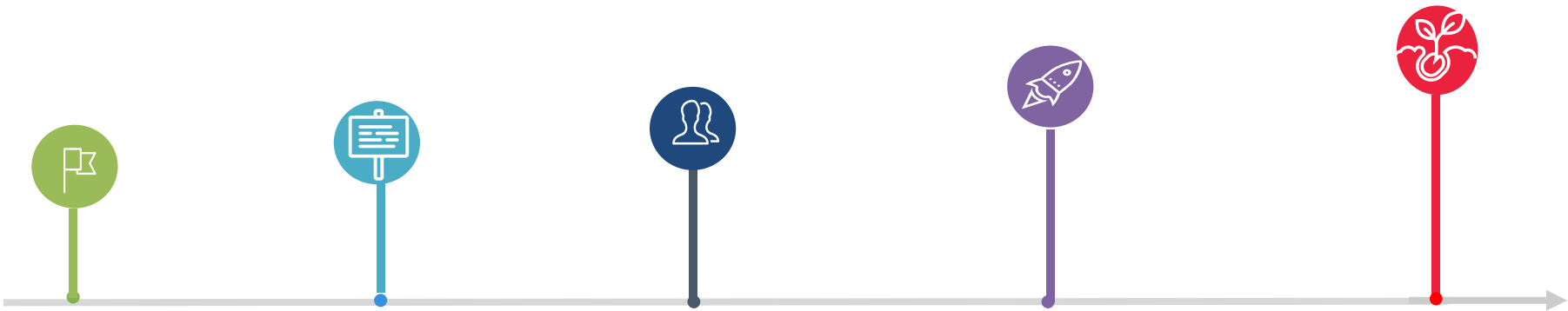
Community Care Cooperative (C3) was created by health centers, for health centers. ***Our mission is to leverage the collective strengths of Federally Qualified Health Centers (FQHCs) to improve the health and wellness of the people we serve****. In doing so, we unite FQHCs at scale to strengthen primary care, improve financial performance, and advance racial justice*

Current Vision, Mission and Strategy

- Vision
  - Transforming the health of underserved communities
- Mission
  - To leverage the collective strengths of federally qualified health centers to improve the health and wellness of the people we serve
- Strategy
  - We unite federally qualified health centers at scale to strengthen primary care, improve financial performance, and advance racial justice
- Core values



Our Story



Early 2016

Nine health center leaders created Community Care Cooperative to play a leading role in a redesigned Medicaid program in MA

2018

We launched our MassHealth (MH) ACO with 15 FQHCs and 110,000 Medicaid members

2019-2020

In 2019, we grew to 17 FQHCs serving 125,000 Medicaid members making us the largest MH ACO in Massachusetts

2021-2022

We grew to 19 FQHCs/Provider Practice serving 170,000 members in 3 risk contracts (MH ACO, BCBS AQC, ACO REACH)

We launched 2 subsidiaries: Community Pharmacy Cooperative (CPC) and Community Technology Cooperative (CTC)

2023-2024

In 2023, we grew to 23 FQHCs/Provider Practice in the MH ACO and 1 Louisiana FQHC in our REACH contract

For 2024, we welcome 17 new FQHCs from CA, NC, CT, and DC to participate in our Medicare Shared Savings Contract!

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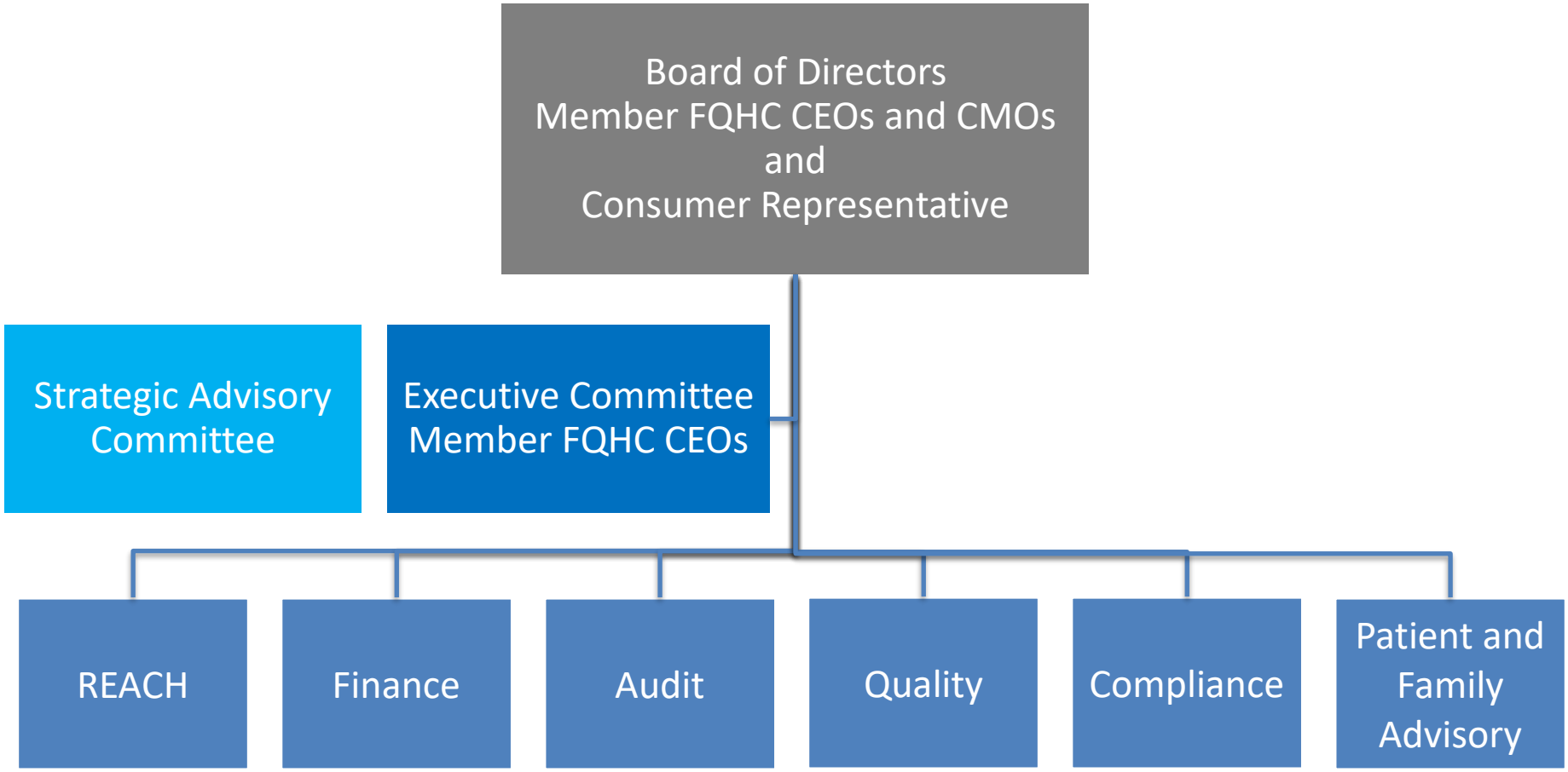
We Are Governed by Our Members



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Investment Committee not shown; that Committee is composed of select health center CEOs, CFOs, and CMOs and one CEO Emeritus with Investment expertise

Our Statewide Footprint

- We are **the largest** Mass. Medicaid ACO
- We are **the only** FQHC-governed ACO taking significant two-sided risk in the U.S.

Health Equity Is Justice

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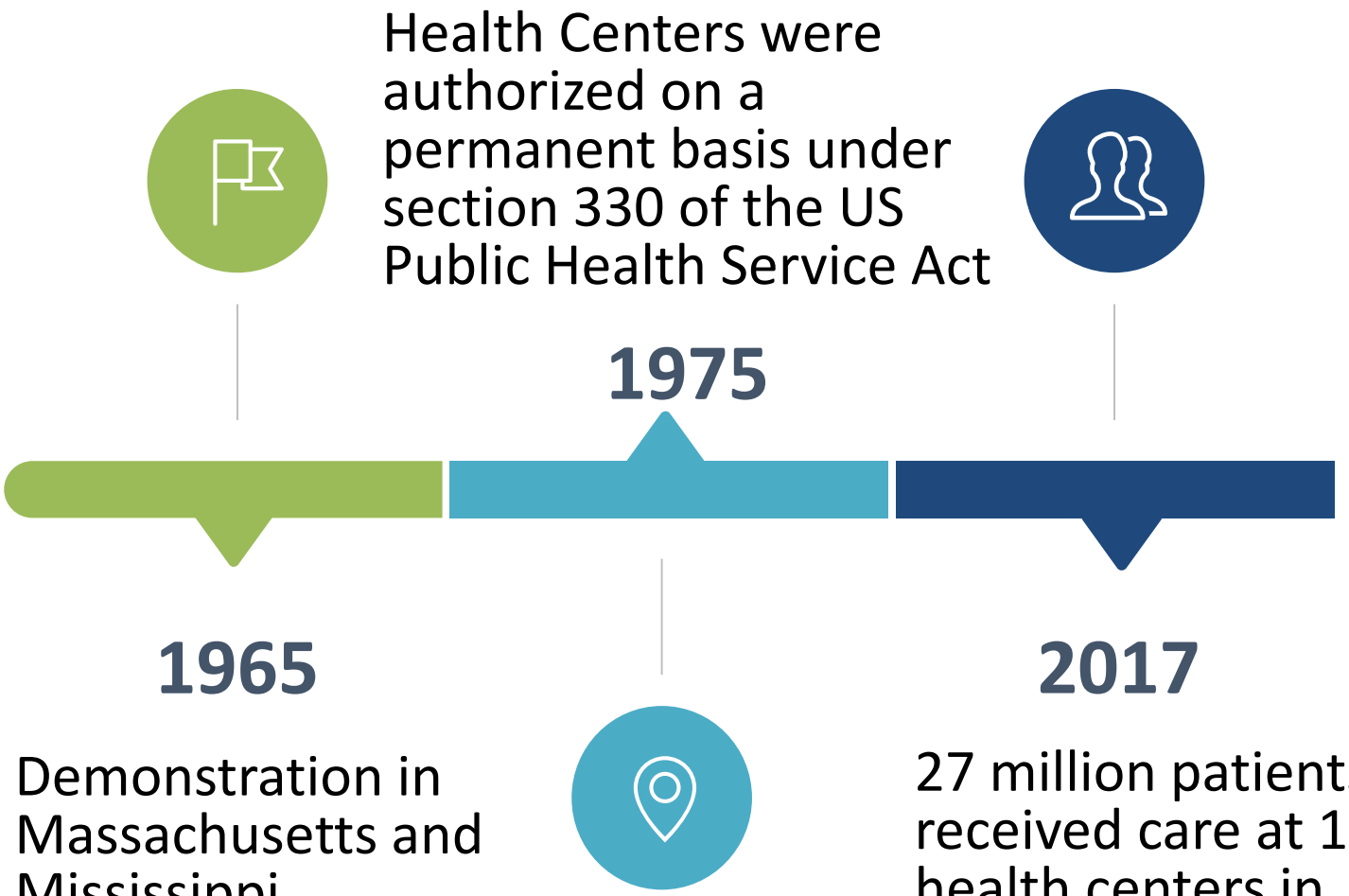
At a Glance: History of Health Centers



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Today...

Health Centers Provide Care to

1 in 12

People in the US, including

1 in 3 people living in poverty

1 in 5 people in rural areas

1 in 6 Medicaid beneficiaries

1 in 8 people of a racial/ethnic minority

1 in 9 children

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Source: NACHC Community Health Center Chartbook, January 2019

Racial Justice at C3

- Our mission embodies our dedication to racial justice
- Following the death of George Floyd, we initiated proactive efforts to pursue racial justice
  - Our Board of Directors issued a resolution declaring racism as a public health crisis
  - We established the Diversity, Equity, and Racial Justice (DERJ) committee, tasked with leading our internal racial justice initiatives

DERJ 3-Year Strategic Plan

HUMAN RESOURCES

Reorient Human Resources policies and practices to provide for and assure proportional representation of the population C3 services.

INCLUSION

Dismantle all forms of racism against blacks and people of color within C3.

RACIAL JUSTICE

Racial Justice: Support the racial justice movement within the communities we serve and in the industry.

HEALTH EQUITY

Close health disparity gaps to a variance of less than 5% for each measure.

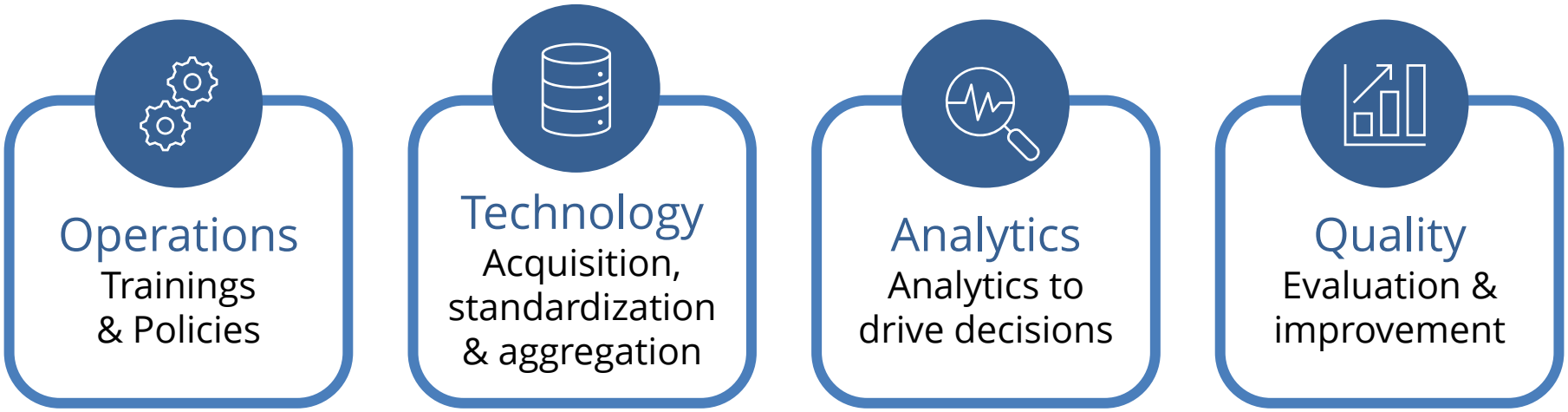
Health Equity Goals Adopted in Strategic Plan

- In 2020, we integrated health equity goals into our balanced scorecard (organizational strategic plan)
  - We initiated an ambitious effort that raised our race, ethnicity, and language (REL) data collection from 75% to 87% within three years
  - We began to stratify data by REL to identify inequities
    - Immunizations: We discovered a 20 percentage-point difference between our white and black members, which we have since reduced to approximately 7%

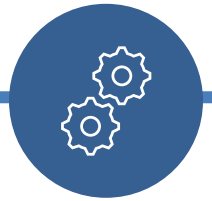
Health Equity Program

- In 2022, we established a Health Equity Program
- In the same year, we responded to a MassHealth Request for Information (RFI) regarding potential health equity requirements in the next MassHealth Section 1115 Demonstration
  - We advocated for a program to incentivize:
    - Data collection
      - » Expanded slate, including Sexual Orientation and Gender Identity (SOGI) and disability
    - Requirements for Cultural and Linguistic Appropriate Services (CLAS)
- Later in the year, we responded to the Request for Responses (RFR), which inspired our Health Equity Strategic Plan
- We also responded to a CMS ACO REACH RFP and a Blue Cross Blue Shield Massachusetts RFP

Health Equity Strategy Statement



- Align operations, technology, analytics, and quality improvement functions to support health equity within Federally Qualified Health Centers (FQHCs). By providing training and technical assistance, we will leverage our collective strength in improving the health and wellbeing of underrepresented members.



Operations

Trainings
& Policies

Strengthen Workforce Cultural Competence

- FQHC providers and staff will complete an anti-racism or related training
- Front-desk staff at FQHCs will complete a training in RELD/SOGI data-collection
- FQHCs will improve REL/D/SOGI data collection

Strengthen network infrastructure for delivering culturally-competent care

- Maintain compliance with NCQA accreditation as well as all contract provisions for providing care that is accessible to members with disabilities and is culturally and linguistically appropriate

REL/D: Race, Ethnicity, Language, Disability
SOGI: Sexual Orientation & Gender Identity
NCQA: National Committee for Quality Assurance

Technology

Acquisition, standardization, & aggregation

Improve Electronic Health Record (HER) Data-Capture Capabilities

- EHRs will have the capability to record disability and sexual orientation & gender identity data in addition to race, ethnicity, language, and HRSN data

Enhance Mapping of EHR data to Arcadia, our Central Enterprise Data Warehouse

- All FQHC EHRs will be mappable to Arcadia
- Data will rollup to MassHealth data definitions

REL: Race, Ethnicity, Language
SOGI: Sexual Orientation & Gender Identity
NCQA: National Committee for Quality Assurance

Analytics

Analytics to drive decisions

Stratify Data by Social-Risk Factors

- FQHC data will be strategized by RELD/SOGI and Health-related Social Needs

Population Health Needs Assessment (PHNA)

- Conduct PHNA every three years

REL: Race, Ethnicity, Language
SOGI: Sexual Orientation & Gender Identity
NCQA: National Committee for Quality Assurance

Quality

Evaluation & improvement

Health Equity Improvement

- Close disparity gaps in outcomes across demographic groups:
  - Hypertension
  - Diabetes

REL: Race, Ethnicity, Language
SOGI: Sexual Orientation & Gender Identity
NCQA: National Committee for Quality Assurance

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Leveraging the Power of Data to Drive Health Equity Improvement

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Disaggregation of Data

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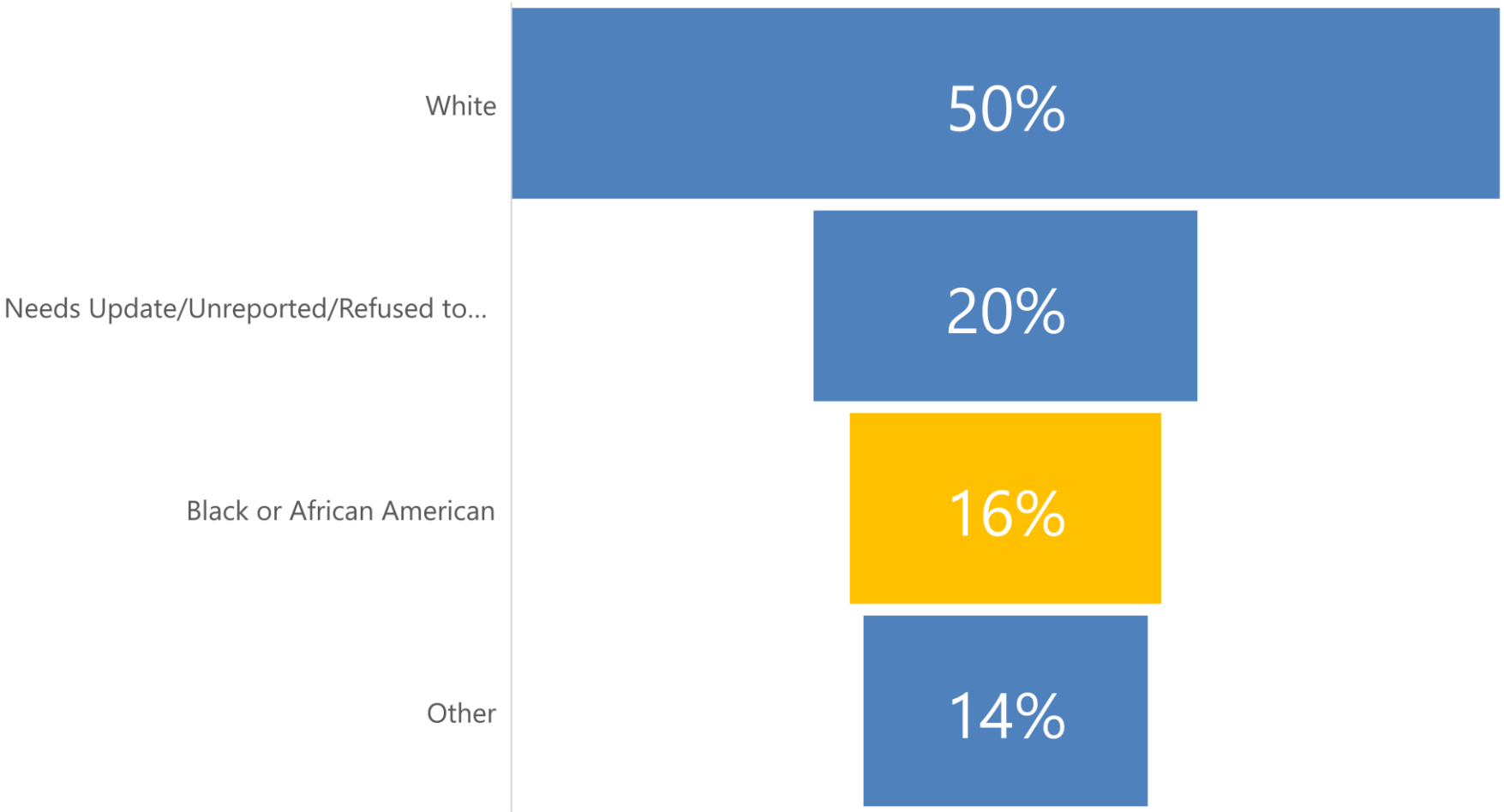
Members With Controlled BP: Distribution by Race



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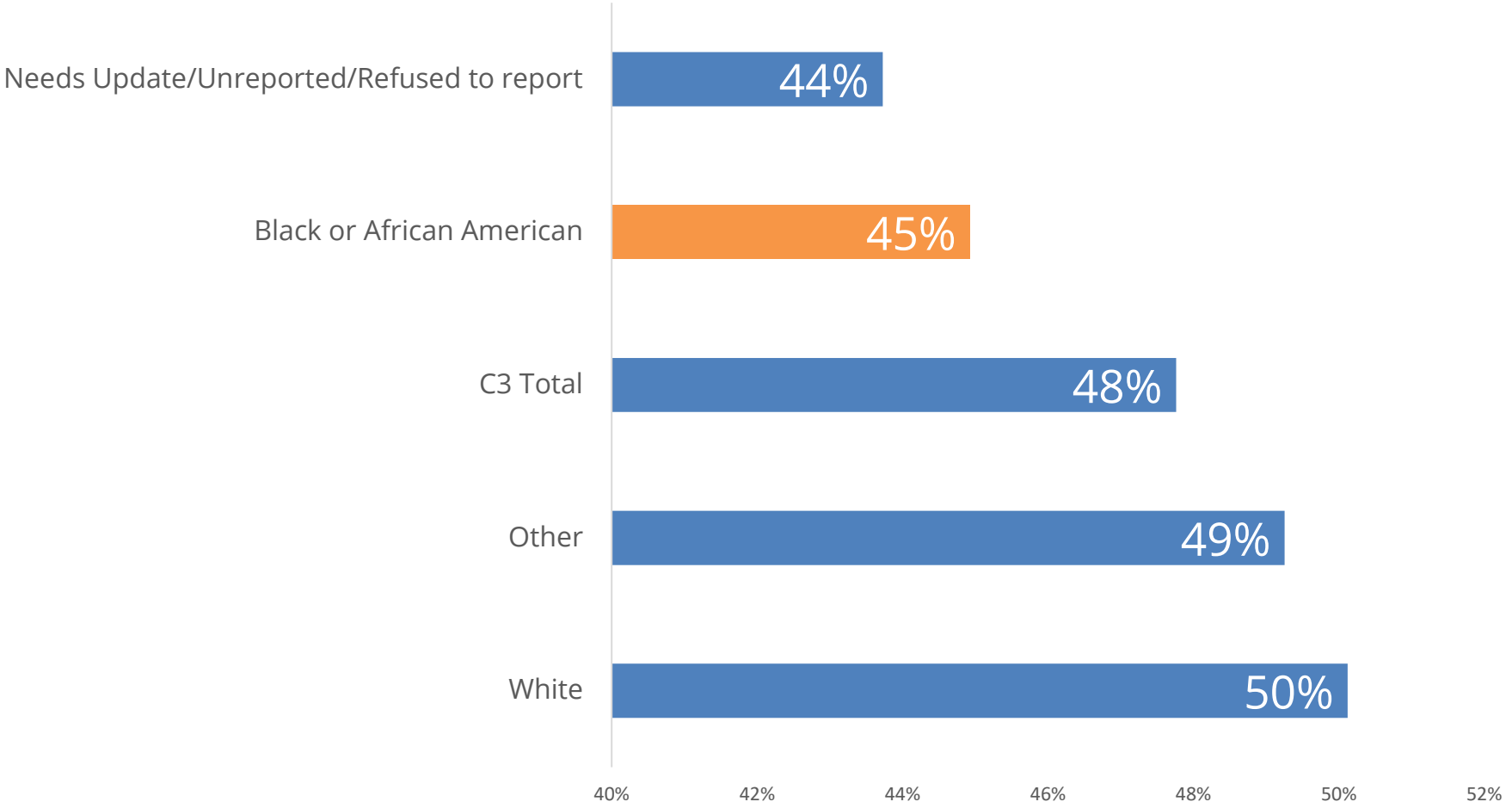
Proportion of Members With Controlled BP within Each Race



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Case Study 1: Childhood Immunizations Within Health Center & Between Health Center Inequities

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Distribution of 62.2k white members by health center

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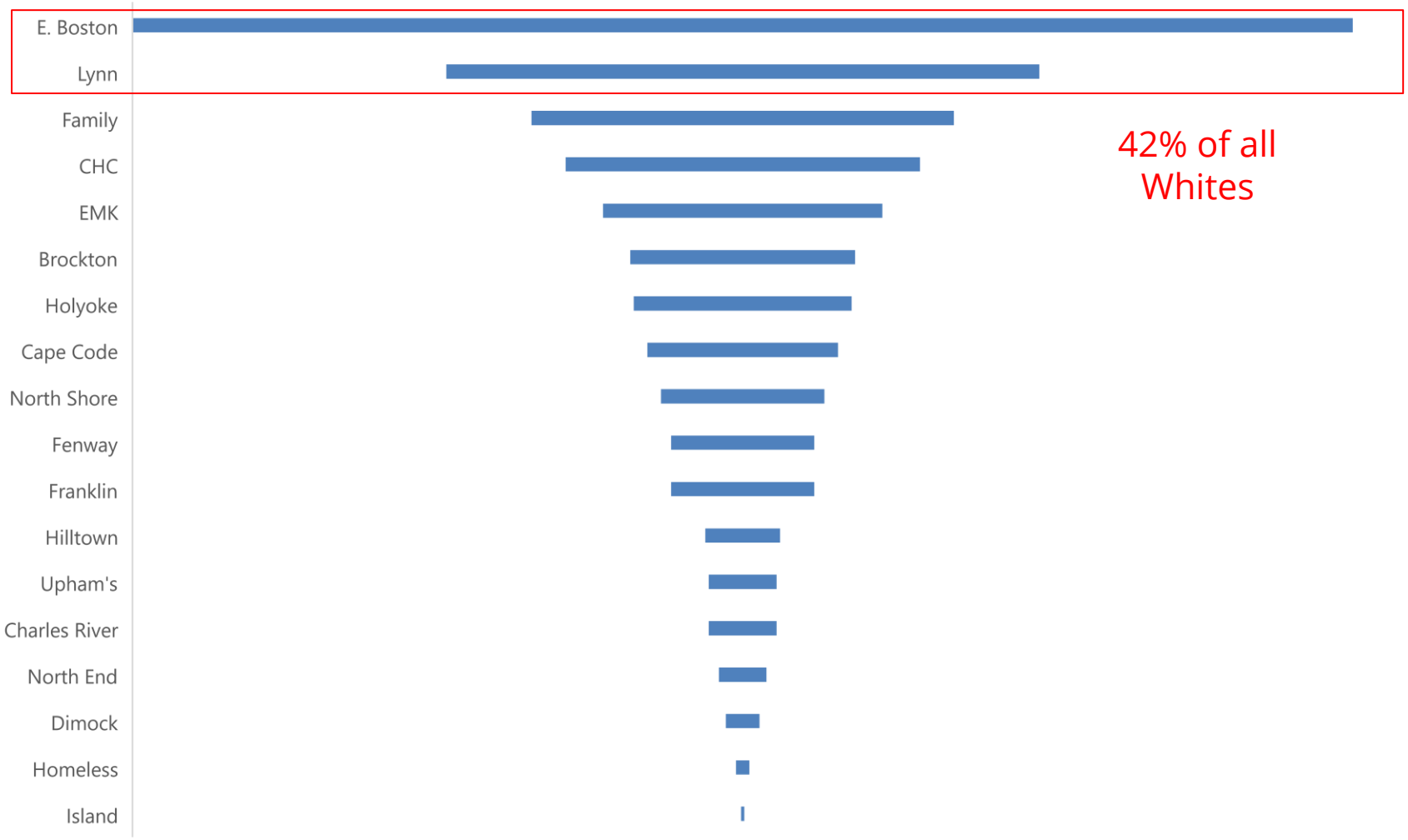
Distribution of 62.2k white members by health center



42% of all Whites

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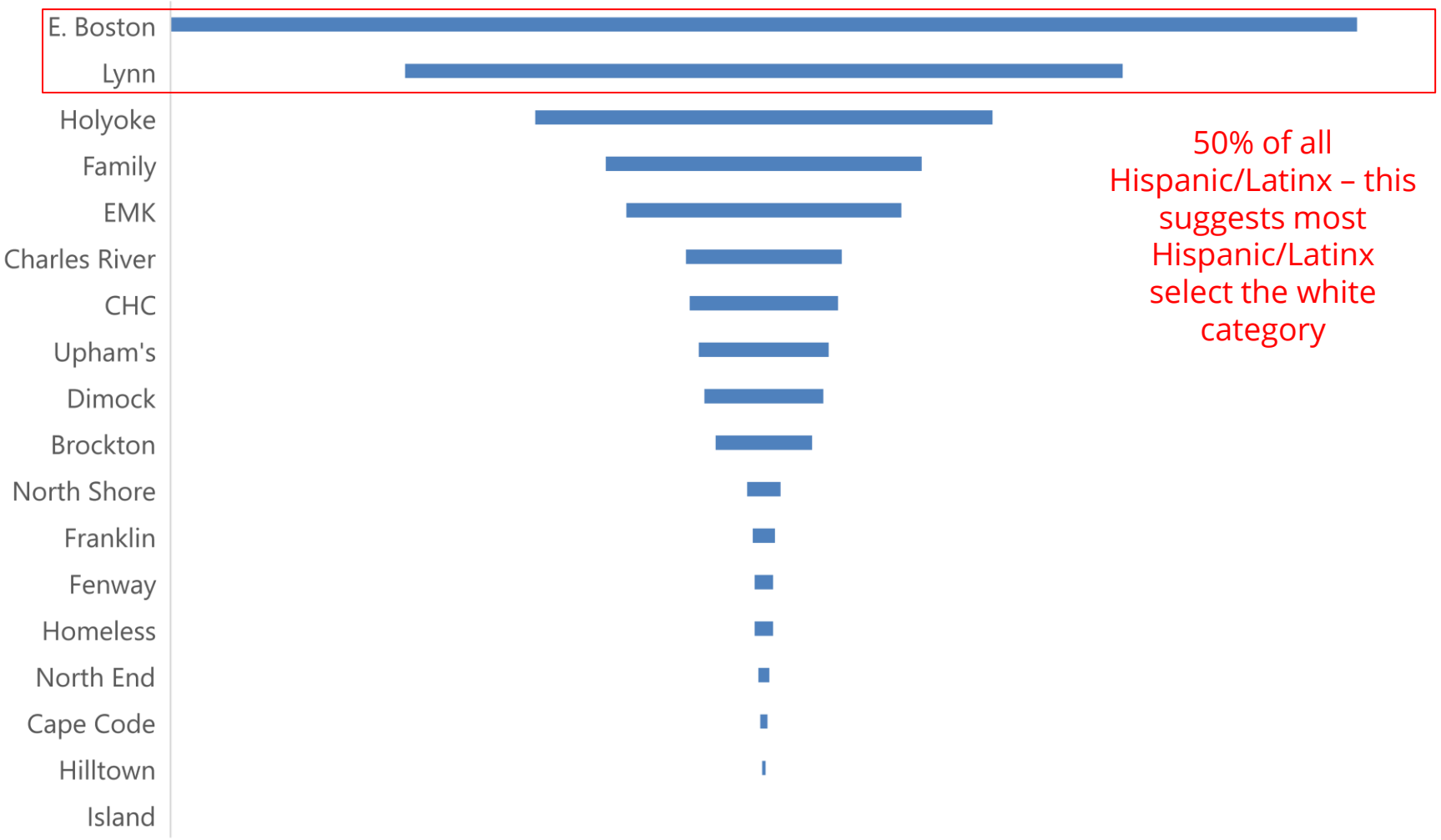
Distribution of 47.7k Hispanic/Latino members by health center



50% of all Hispanic/Latinx – this suggests most Hispanic/Latinx select the white category

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Distribution of 20k Black members by health center

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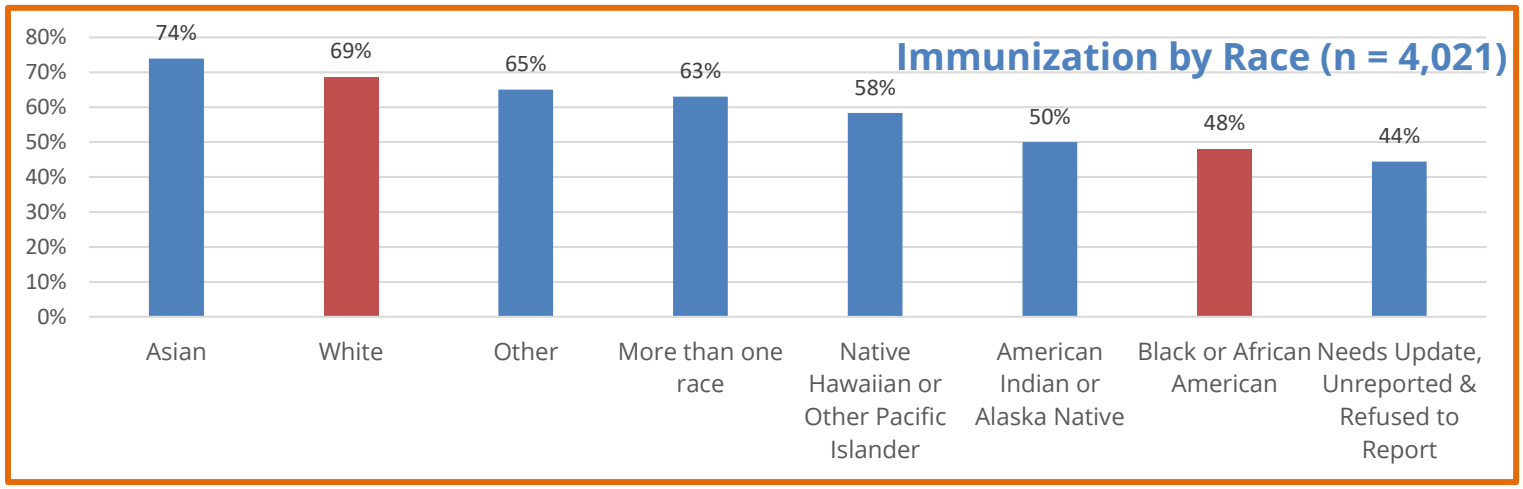
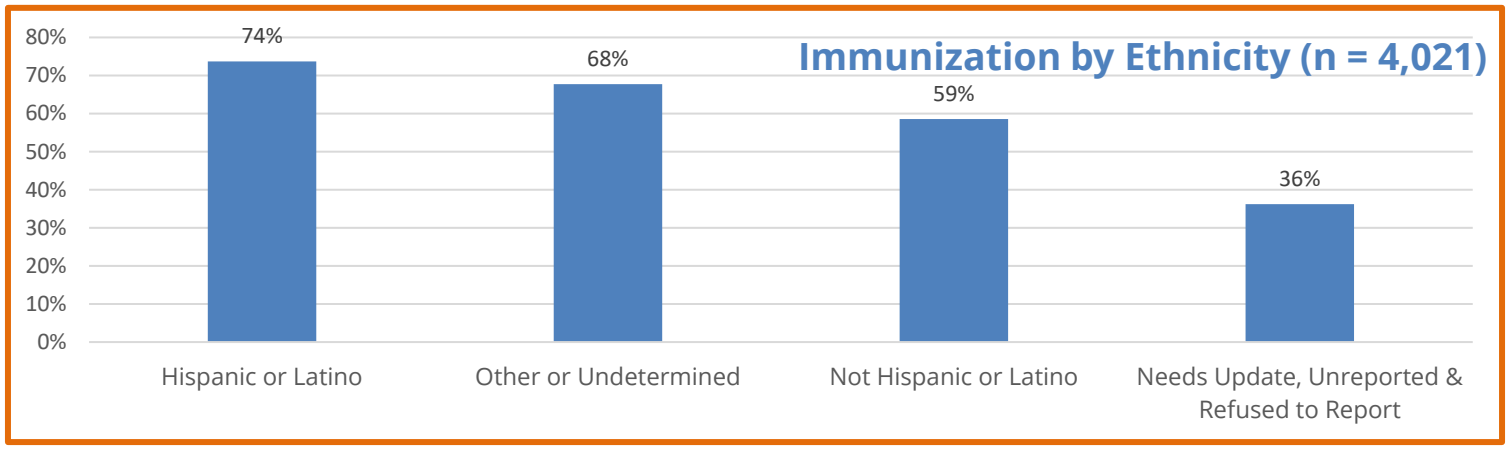


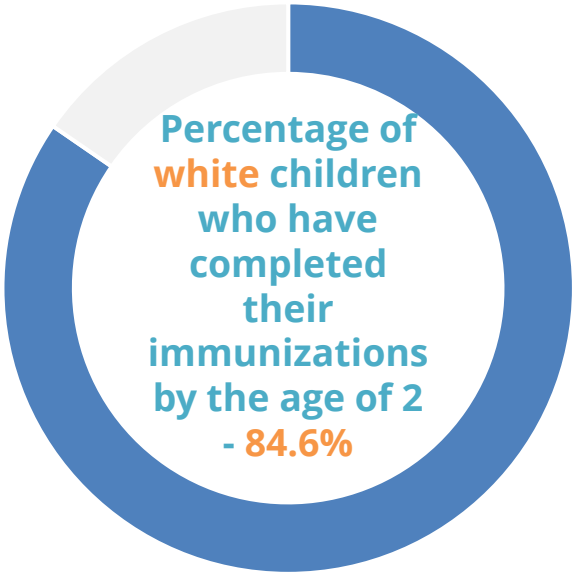
Of the 4021 children aged 1-3 years old, Asians and Whites have the highest percentage of children who completed their immunizations by the age of 2 (74% & 69% respectively). Blacks have the second lowest, at 48%

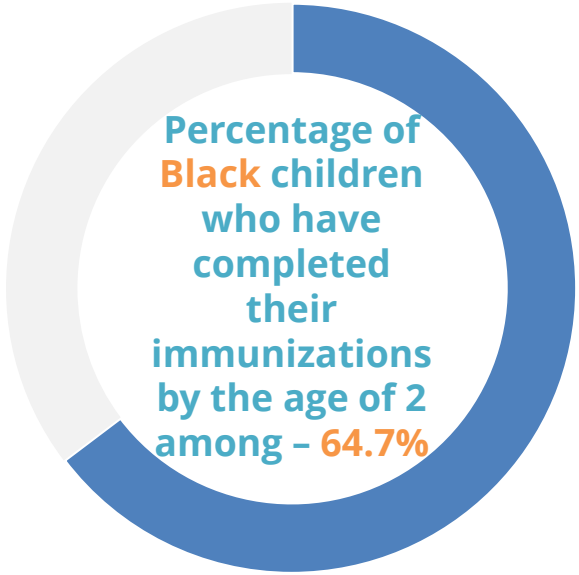


Among 1,758 Hispanic/Latinx children aged 1-3 years old, 74% have completed their immunizations by the age of 2 compared to 59% of 802 non-Hispanic children.

Within Health Center Inequities

Health disparities can be seen within health centers and between health centers. Below, the data indicates that within the same health center, the immunization rate for black children is less than that of white children.

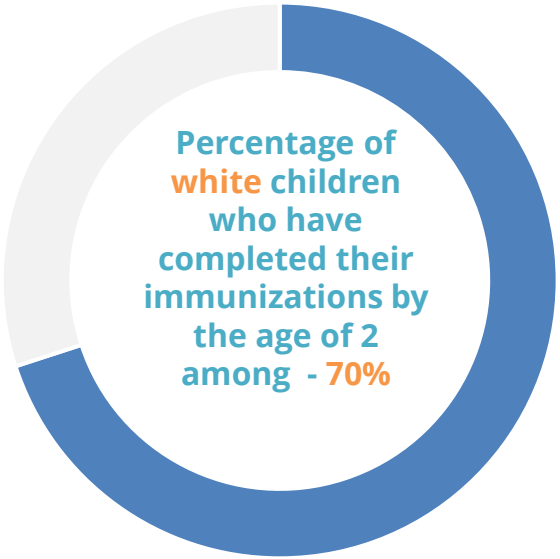


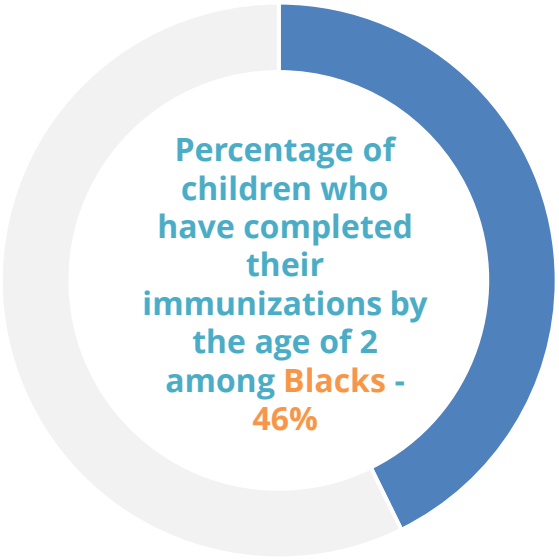


White category includes Hispanic/Latinx who identified themselves as "White"

Within Health Center Inequity

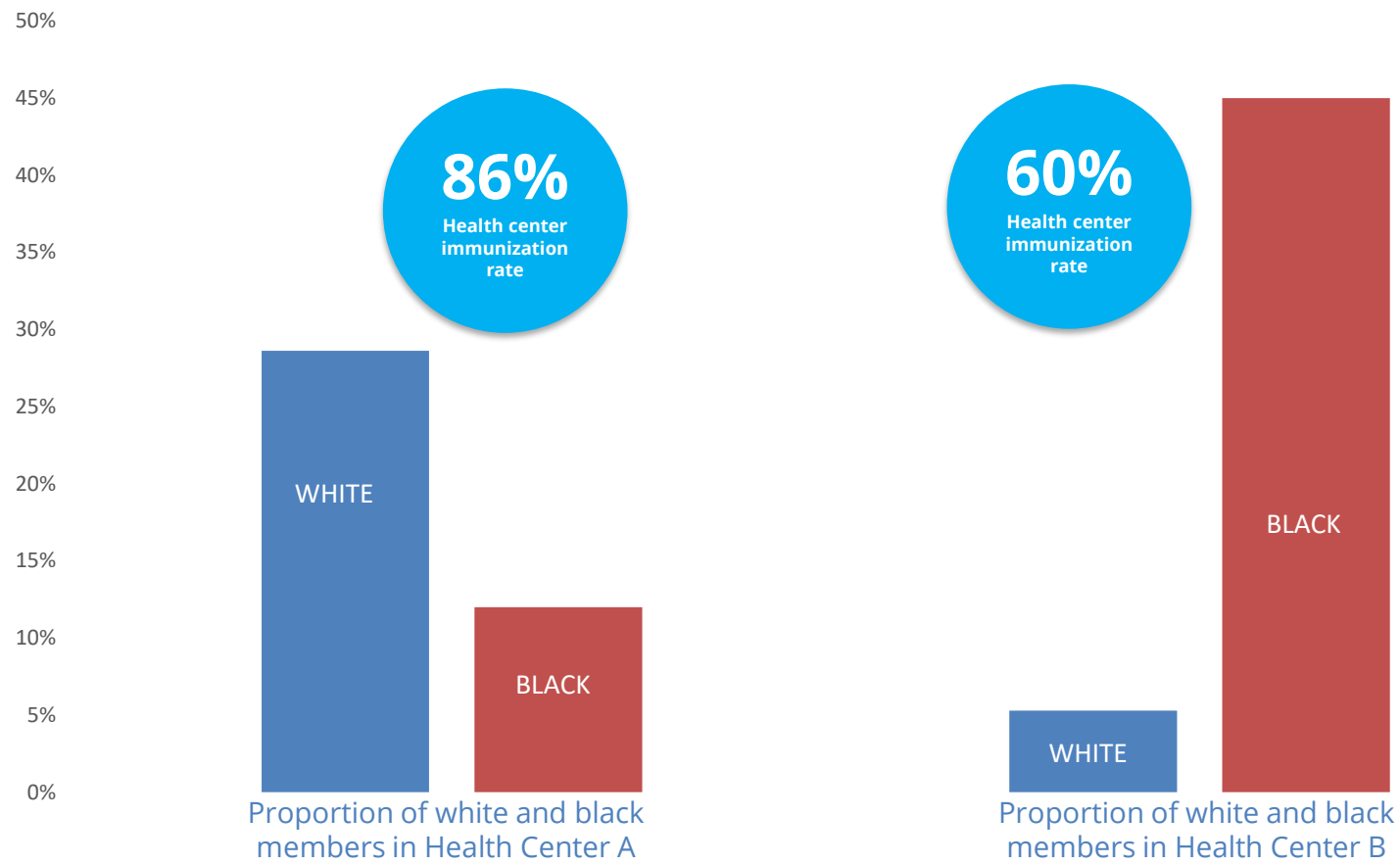
The same can be seen in another health center, where the data indicates that within the same health center, the immunization rate for black children is less than that of white children.





White category includes Hispanic/Latinx who identified themselves as “White”

Between Health Center Inequity



Above, the data indicates that a health center with predominantly white members has a higher childhood immunization rate than a health center with predominantly black members

White category includes Hispanic/Latinx who identified themselves as "White"

Case Study 2: CMS ACO REACH Health Equity Plan: Addressing Inequities Without Reference to "Race or Ethnicity"

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Health Equity at Risk: Students for Fair Admissions v. President and Fellows of Harvard College

I could not wait until our next DERJ meeting to express my strong concern and outrage at the ruling of the Supreme Court of the United States (SCOTUS) in the Harvard affirmative action case. This ruling troubles me for two reasons. First, it is disheartening to see that the very same law that was originally designed to protect racial and ethnic minorities is now being used to dismantle decades of progress made in the pursuit of racial justice. The ruling raises questions about the potential regression in achieving equity and equal opportunities for historically marginalized communities. Second, this ruling highlights the unsettling possibility that we are only one lawsuit away from health equity being declared illegal.

The case brought forward by Students for Fair Admissions, Inc. (SFFA) challenged Harvard University's admissions programs, arguing that the consideration of race in admissions violated Title VI of the Civil Rights Act of 1964 and the Equal Protection Clause of the U.S. Constitution's 14th Amendment. These constitutional provisions were enacted as part of the civil rights movement, with the intent to address racial discrimination and promote equal treatment under the law. Title VI of the Civil Rights Act of 1964 prohibits racial discrimination and states that no person in the United States should be excluded from participation in or denied benefits of any federally assisted program based on race, color, or national origin. The Equal Protection Clause of the 14th Amendment ensures equal protection of the laws and has been instrumental in granting civil rights to disadvantaged populations in landmark cases such as Brown v. Board of Education (racial discrimination), Roe v. Wade (reproductive rights), and Reed v. Reed (gender discrimination). The idea that these constitutional provisions can now be used to deny people of color the basic imperative for a “fair playing field” is in my view a grotesque application of the law, which I regard with contempt.

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Most-common Diagnoses

ICD10 Code	ICD10 Description	Member Count	% of Medicare Pop	% with BH Comorbid
I10	Essential (primary) hypertension	8993	67%	61%
E78.5	Hyperlipidemia, unspecified	6326	47%	63%
E78.00	Pure hypercholesterolemia, unspecified	4173	31%	62%
E78.2	Mixed hyperlipidemia	3599	27%	62%
K21.9	Gastro-esophageal reflux disease without esophagitis	3556	27%	73%
H25.13	Age-related nuclear cataract, bilateral	3482	26%	57%
E55.9	Vitamin D deficiency, unspecified	3307	25%	66%
G89.29	Other chronic pain	3263	24%	74%
Z87.891	Personal history of nicotine dependence	3249	24%	73%
E11.9	Type 2 diabetes mellitus without complications	3117	23%	64%
F41.9	Anxiety disorder, unspecified	3103	23%	100%
L82.1	Other seborrheic keratosis	2981	22%	54%
U07.1	COVID-19 acute respiratory disease	2889	22%	66%
R06.02	Shortness of breath	2884	22%	77%

- Our ACO REACH claims data shows that of the 8,993 diagnoses that occurred since 2020, 67% were associated with hypertension and 61% were associated with a BH comorbidity

Priority FQHCs for Hypertension

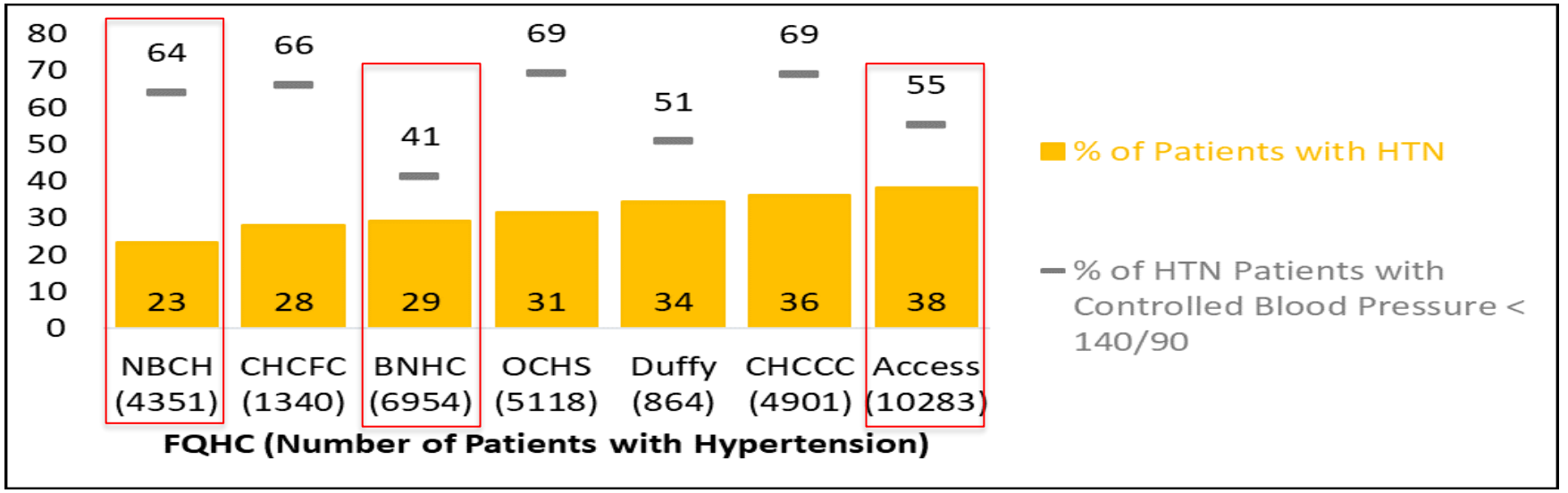

Chart 3: Percentage of ACO REACH members with hypertension (HTN) by FQHC and percentage of total population with controlled blood pressure

- Given that AHL has the largest population and relatively low outcomes for hypertension control, we prioritized it together with BNHC and NBCH for interventions

Demographic Breakdown of REACH Population

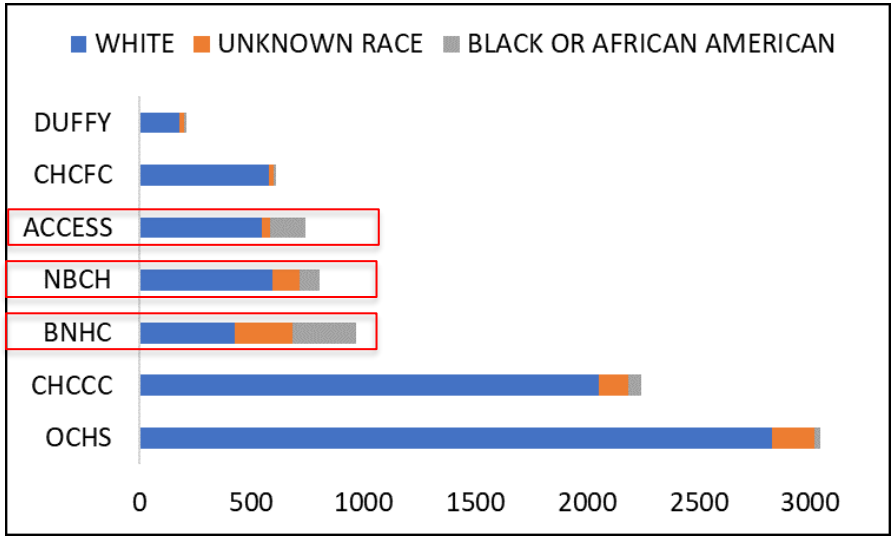

Chart 1: Racial Distribution of our ACO REACH members

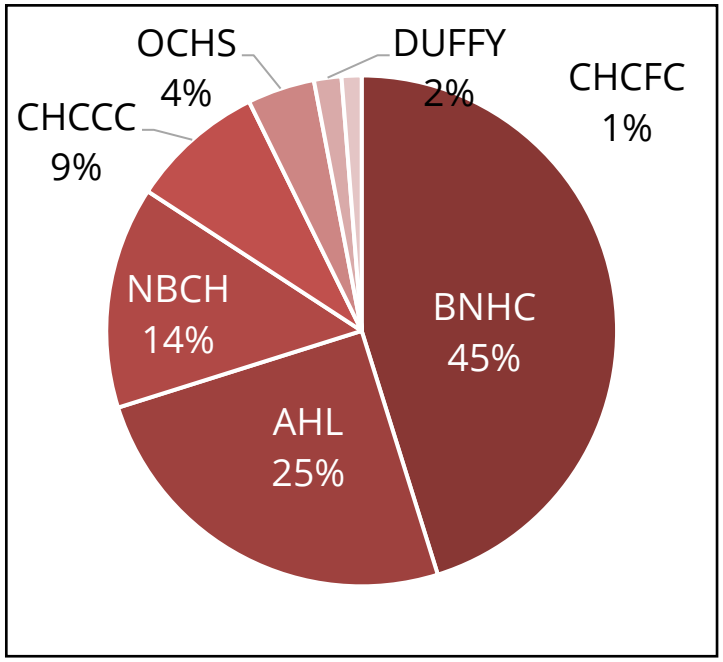

Chart 2: Distribution of Black ACO REACH members by FQHC

- We conducted an analysis of our ACO REACH population which showed that
  - 83% of members identify as White,
  - 7% of members identify as Black,
  - And 2% of members identify as Hispanic
- Of our REACH health centers, Brockton Neighborhood Health Center, Access Health, and New Bedford Community Health had the most racial diversity

Case Study 3: Blue Cross Blue Shield of Massachusetts Hypertension & Diabetes Precision Targeting & QI

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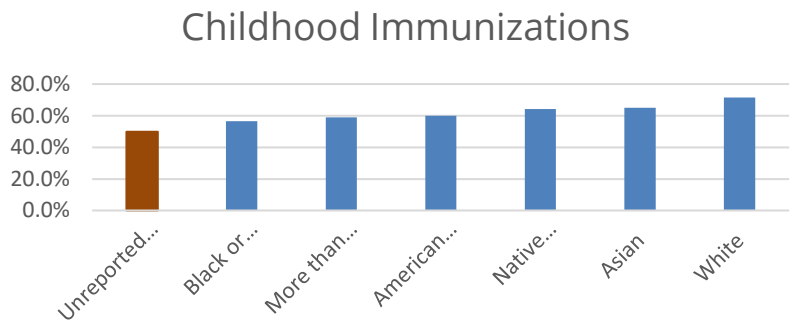
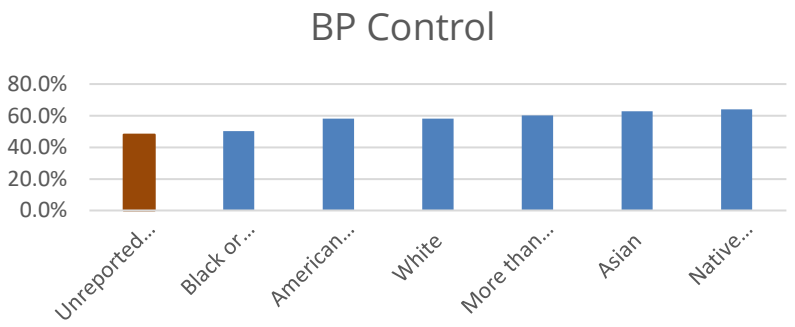
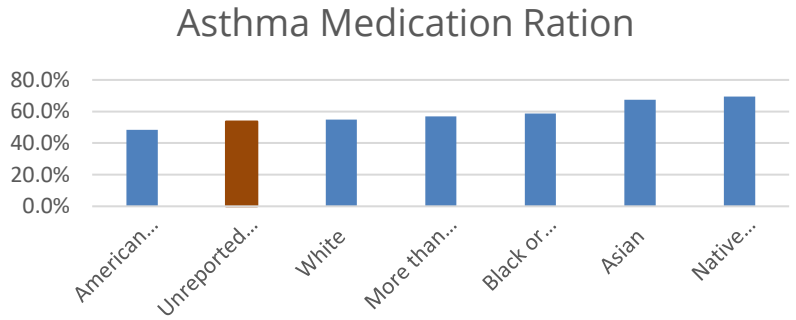
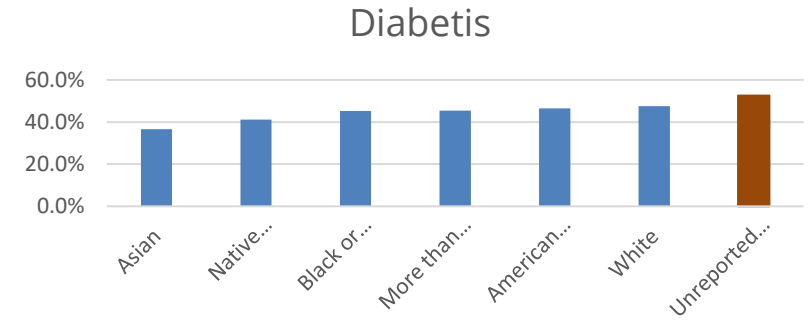
Members Without Race Data Had Poor Outcomes on 11 of the 16 Quality Measures We Were Monitoring in 2022









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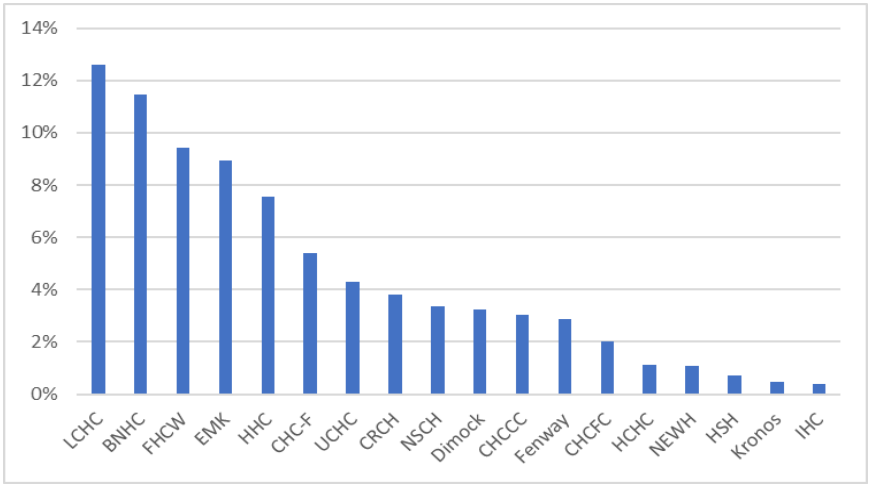
Where Are Members Without Race Data Located?

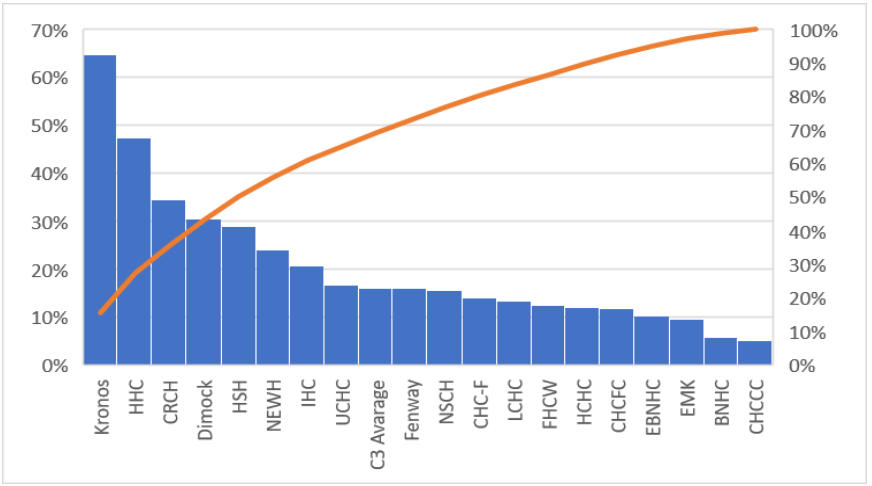
Pareto Opportunities:

HHC has the 5th highest proportion of C3 members and the 2nd highest proportion of members without a valid REL response (or highest volume)

Proportion of C3 Members by FQHCs



Proportion of C3 Members without race response by FQHCs



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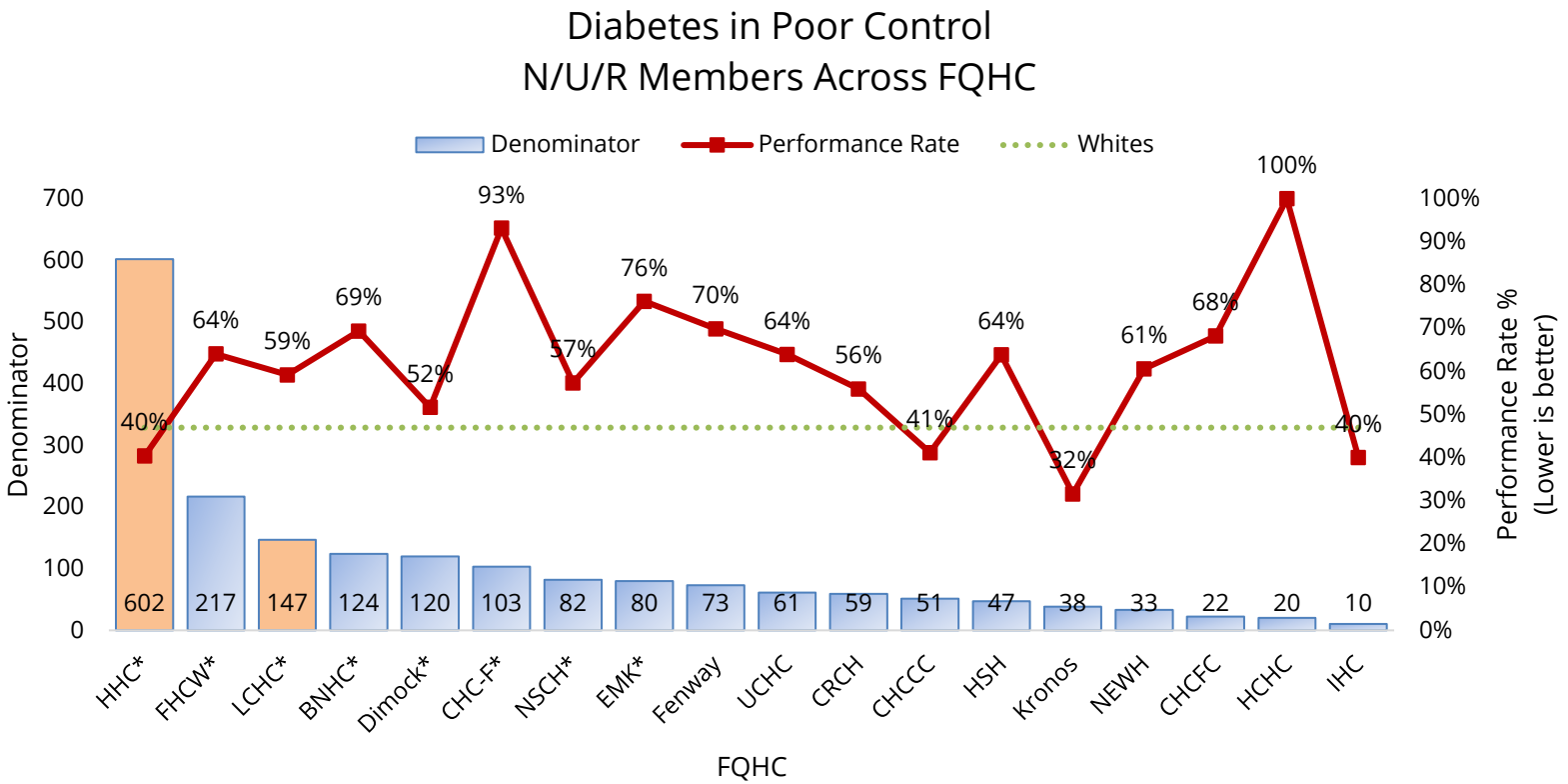
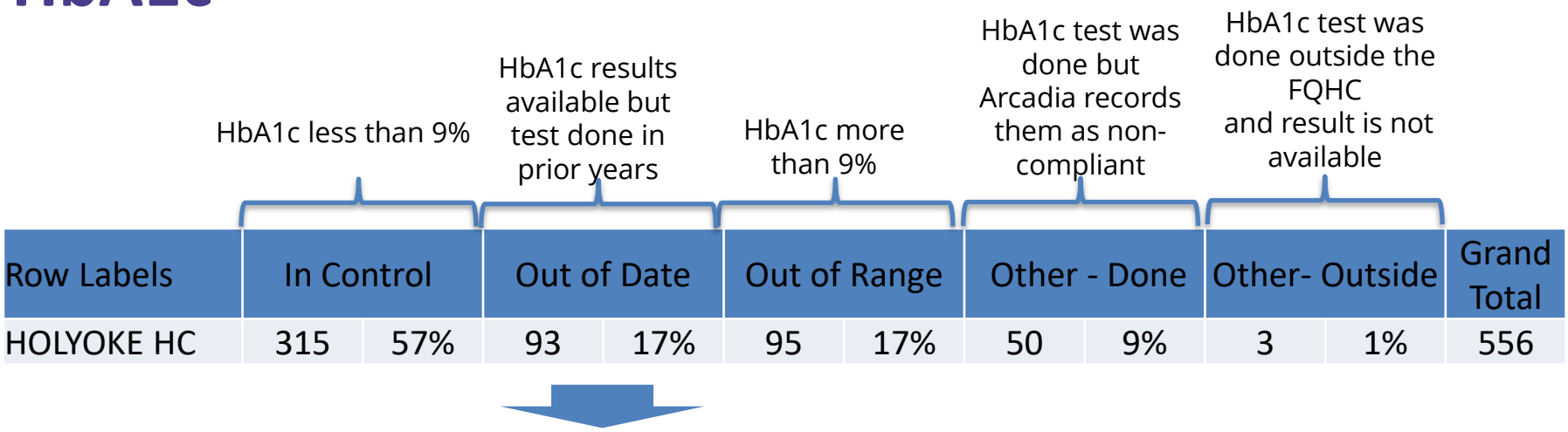
Pareto Opportunities



(* FQHCs makes up 80% of Members whose Race is identified as Needs Update, Unknown, or Refused)

As of October 2022, HHC had the highest volume of C3 members without a valid race response who have diabetes (602). Although the FQHC had a low percentage of members who have uncontrolled diabetes (HbA1c >9%), the number of members with uncontrolled diabetes (240) was higher than the member-population of the FQHC with the second highest volume

Understanding Population With Uncontrolled HbA1c



Row Labels	In Control		Out of Date		Out of Range		Other - Done		Other- Outside		Grand Total
HOLYOKE HC	315	57%	93	17%	95	17%	50	9%	3	1%	556

Holyoke HC = 93 members

No test result	29
HbA1c = 10-15%	16
HbA1c = 9-10%	8
HbA1c = 4-9%	40

HHC Diabetes Control Rate (<HbA1c 9%)

64% (36%)

The biggest opportunity for improvement lies with members who did not get a HbA1c test over the last 2 years. Of the 93 members at HHC, 40 had controlled diabetes at their last check. If they remained their controlled status, engaging them back into care would reduce the percentage of members with uncontrolled diabetes from 43% (as of March 2023) to 34%

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Understanding Population With Uncontrolled HbA1c

HbA1c less than 9%

HbA1c results available but test done in prior years

HbA1c more than 9%

HbA1c test was done but Arcadia records them as non-compliant

HbA1c test was done outside the FQHC and result is not available

Row Labels	In Control		Out of Date		Out of Range		Other - Done		Other- Outside		Grand Total
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Holyoke HC Diabetes Control Rate (<HbA1c 9%)

66% (34%)

If members who do not have a test result went in for a test, and assuming half have controlled diabetes, the inverse measure rate would reduce to 34%

Understanding Population With Uncontrolled HbA1c

	HbA1c less than 9%		HbA1c results available but test done in prior years		HbA1c more than 9%		HbA1c test was done but Arcadia records them as non-compliant		HbA1c test was done outside the FQHC and result is not available		
Row Labels	In Control		Out of Date		Out of Range		Other - Done		Other- Outside		Grand Total
HOLYOKE HC	315	57%	93	17%	95	17%	50	9%	3	1%	556

Holyoke HC = 93 members

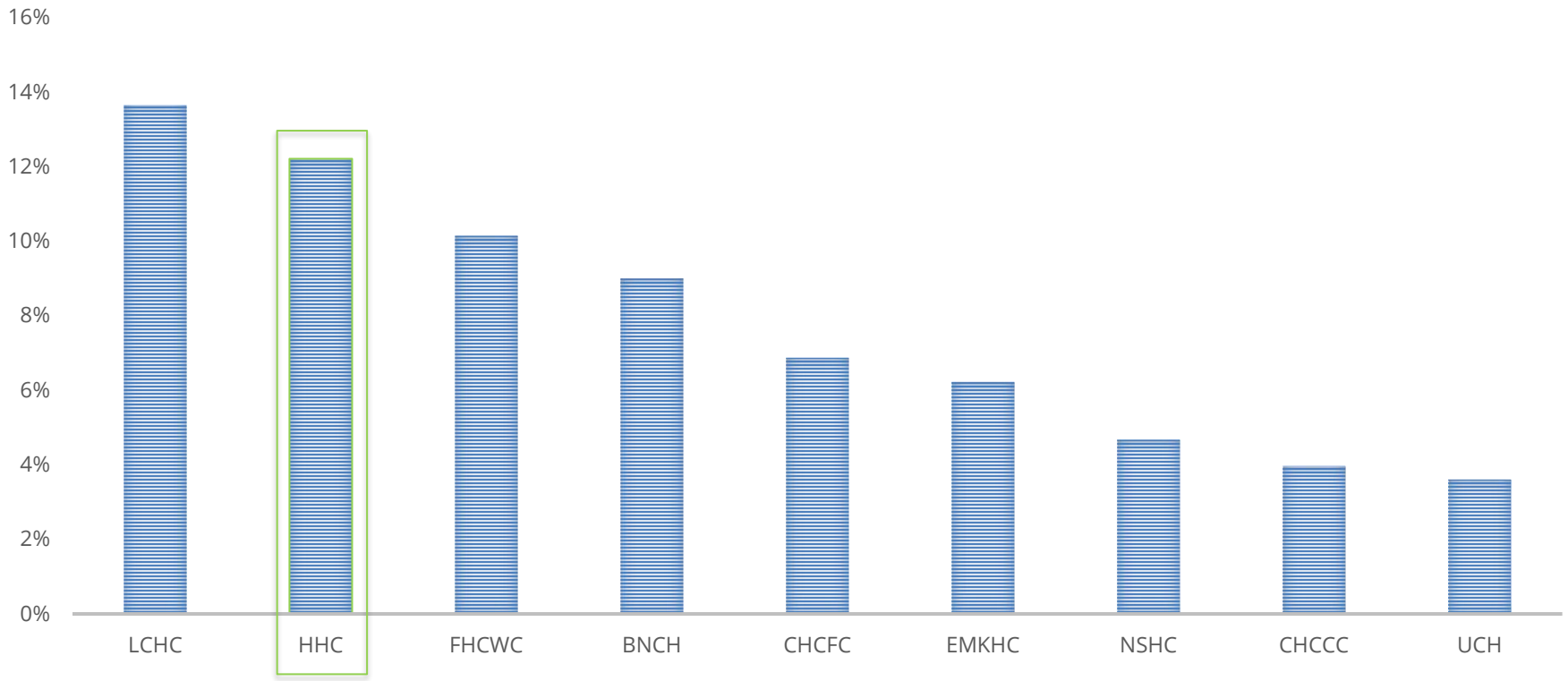
No test result	29
HbA1c = 10-15%	16
HbA1c = 9-10%	8
HbA1c = 4-9%	40

HbA1c 10.1-11% = 7 members
HbA1c 11.1-15% = 9 members

HbA1c 9-9.5% = 4 members
HbA1c 9.6 -10% = 4 members

Our HE improvement efforts will target all members. If all members were able to reduce their HbA1c values by 1%, up to 8 members at HHC have the potential to achieve controlled diabetes status and join the population of members with controlled diabetes

Hospital Admissions for Diabetes



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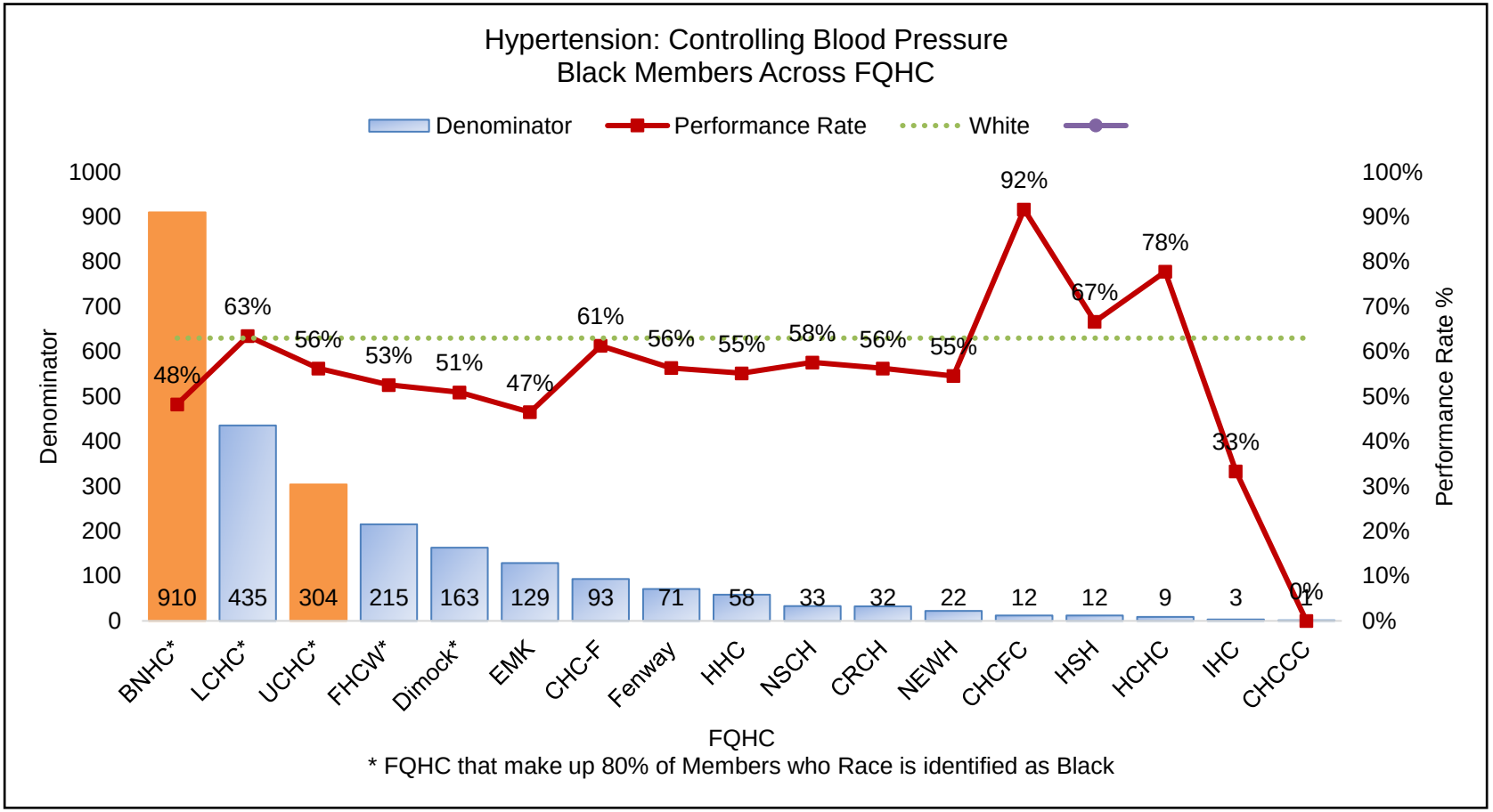
Hypertension Pareto Analysis



Upham's Community Care's Members with Hypertension (n=536)

Race/Ethnicity	Members with Hypertension	Controlled Hypertension	Rate
NH/PI	7	7	100%
White & Non-Hispanic	**28**	**26**	**93%**
Asian	11	10	91%
White and Hispanic	**73**	**51**	**70%**
All White	101	67	66%
All Hispanic or Latino	176	115	65%
Black and Hispanic	**72**	**42**	**58%**
All Black or African American	334	190	57%
Black & Non-Hispanic	**262**	**148**	**56%**
No Race Data	82	31	38%
American Indian or Alaska Native	1		0%

Opportunities for Improvement

- Of the total 334 Black members with uncontrolled high blood pressure, there are **14 members who have controlled systolic blood pressure** but slightly elevated diastolic blood pressure ranging from 90-100 mmHg.
- Additionally, there are **39 members who have controlled diastolic blood pressure** but slightly elevated systolic blood pressure ranging from 140-150 mmHg.
- These 53 members present the highest potential for improvement in increasing the proportion of members with controlled hypertension.
- If all the 53 members were provided with the necessary support to bring their blood pressure under control, the rate of Black members with controlled hypertension would **increase from the current rate of 57% to 73%.**
- This improvement would significantly contribute to reducing the racial disparities in hypertension outcomes and increase the overall rate of members with controlled hypertension from the current **56% to 67%.**

AIM Statement

- By May 2024, we will increase the rate of all members with controlled hypertension 56% to 63%.
- By May 2024, we will increase the rate of Black members with controlled hypertension 57% to 63%.
- By May 2024, we will support 80% of all Black members with uncontrolled hypertension to reduce their systolic or diastolic blood pressure by at least 2mmHg.

Theory of Change

AIM	Sub-AIM	Activities
By May 2024, we will increase the rate of all members with controlled hypertension 56% to 63%.	By May 2024, we will increase the rate of Black members with controlled hypertension 57% to 63%.	**Active outreach:** Our Hyper Squad will conduct chart reviews to determine the best method of outreach. Our C3 Coordinator will be the primary outreach person and she will create patient lists (In Ochin) for everyone she reaches. She will track appointments and pilot reminder calls the business day before the appointment. We will be able to track and improvement in medical adherence
		Clinical Care: For patients who are interested, we will be conducting monthly education groups supported by our Senior Nutritionist and our CM RN. For HTN patients who need additional support we will enroll them into Care Management. with the possibility of transitioning into BHCP when appropriate
	By May 2024, we will support 80% of all Black members with uncontrolled hypertension to reduce their systolic or diastolic blood pressure by at least 2mmHg.	**Disease self-management management education:** We will conduct monthly education groups supported by our Senior Nutritionist and our Care Management RN. This will run for at least six months. We have also adapted a self-efficacy tool from Stanford and will complete these on the first day of the nutrition group and the last session
		Wellness:. When our C3 Coordinator does outreach, when possible, she will conduct an SDOH on the phone and follow up the positive screenings. We will also be offering free memberships at the YMCA while patients are participating in the educational groups

Measurement Plan

Measure	Measure Type	Measure Definition	Measure Source/Data Collection Plan
Hypertension cohort recruitment	Process	Percent of members recruited into the improvement project cohort out of all members who identify as “Black or African-American” who have uncontrolled hypertension at UCHC	Electronic Health Record data
Care delivery	Process	Percent of members in the improvement project cohort who receive the full intervention package	Electronic Health Record data
Hypertension improvement	Outcome	Percent of members in the improvement project cohort who reduce BP	Electronic Health Record data
Hypertension control	Outcome	Percent of members in the improvement project cohort who achieve BP control	Electronic Health Record data
Social Risk Factor data collection	Process	Percent of members in the improvement project cohort who provide valid self-reported SRF data	Electronic Health Record data
Comparison	Outcome	Percent of members recruited into the wellness project cohort out of all members who have uncontrolled hypertension	Electronic Health Record data

Current Status

- Recruitment of members in the improvement cohort is ongoing
- Our Analytics team is using historical data to constract a run chart
- A partnership with the YMCA has been established

Learning Action Collaborative

Health Center	Target	Intervention Focus
Caring Health Center	By May 2024, we will increase the percentage of C3 members whose blood pressure was adequately controlled from the current 58% to 61% By May 2024, we will reduce the percentage of C3 members whose blood sugar was poorly controlled (from the current 47% to 45%	**Care Coordination:** Test care coordination, REL-D & SOGI data collection in engaging members in disease management.
Brockton Neighborhood Health Center	By May 2024, we will support 80% of project enrolled patients to reduce their systolic or diastolic blood pressure by at least 2mmHg.	**Telehealth:** Leverage Telehealth Navigators to outreach and engage patients using phone calls and in person outreach
Holyoke Health Center	By May 2024, we will reduce the rate of all members with uncontrolled diabetes from 37% to 32%.	**RN education:** Testing approach of training RNs to provide monitoring, and medication management, and CGM implementation in collaboration with CDTM pharmacists
Upham's Corner Health Center	By May 2024, we will increase the rate of Black members with controlled hypertension 57% to 63%.	**Group Education:** monthly education groups supported by our Senior Nutritionist and our Care Management RN.
Family Health Center of Worcester	By May 2024, we will increase the rate of Black members with controlled hypertension 51% to 68%.	**UMass Intervention:** Test an evidence-based program of education, motivational interviewing, and outreach initially created by UMass
Hilltown Community Health Center	Tablets + hypertension/diabetes	TBD
Lynn Community Health Center	Diabetes	TBD
Island Health Care	Hypertension	TBD

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Questions…