Optimizing Population Health and Enhancing Health Equity for Value Based Care Success

Kim Yu, MD, FAAFP, DABFM
PRIME National Strategy Consultant,
Center for Professionalism & Value in Health Care,
American Board of Family Medicine
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Disclosure

- Dr. Yu works as a consultant for the American Board of Family Medicine and has no conflicts of interest

Objectives

1

Discuss Population Health and Tools for Optimization in Primary Care

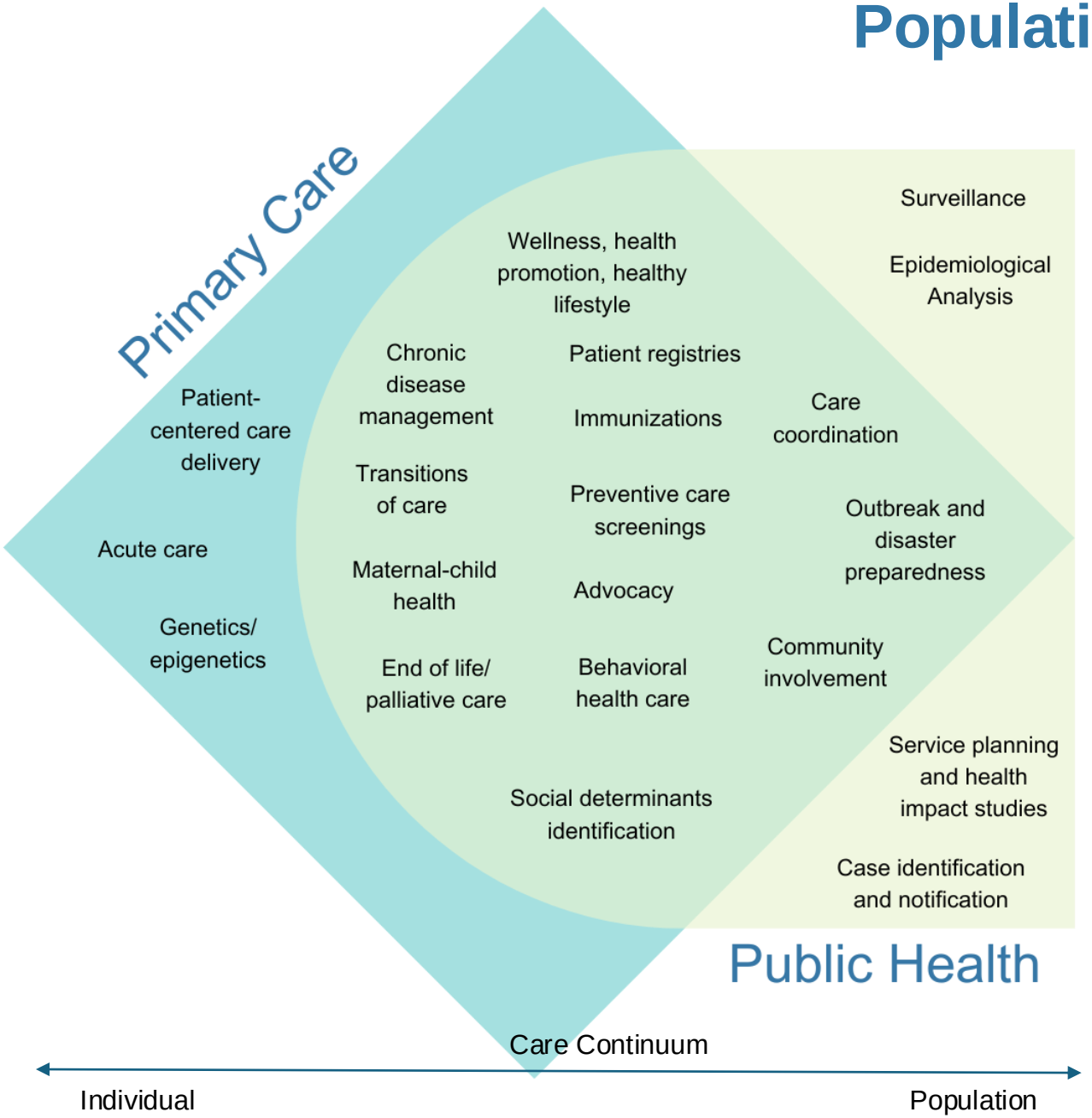
2

Address Barriers and Opportunities to Advance Health Equity

3

Learn Tips for Success in Value Based Care and what is required to achieve the Quintuple Aim

Population Health Basics



> **Population Health** is the health outcomes of a group of individuals, including the distribution of such outcomes within the group.

From Integration of Primary Care and Public Health (Position Paper) | AAFP

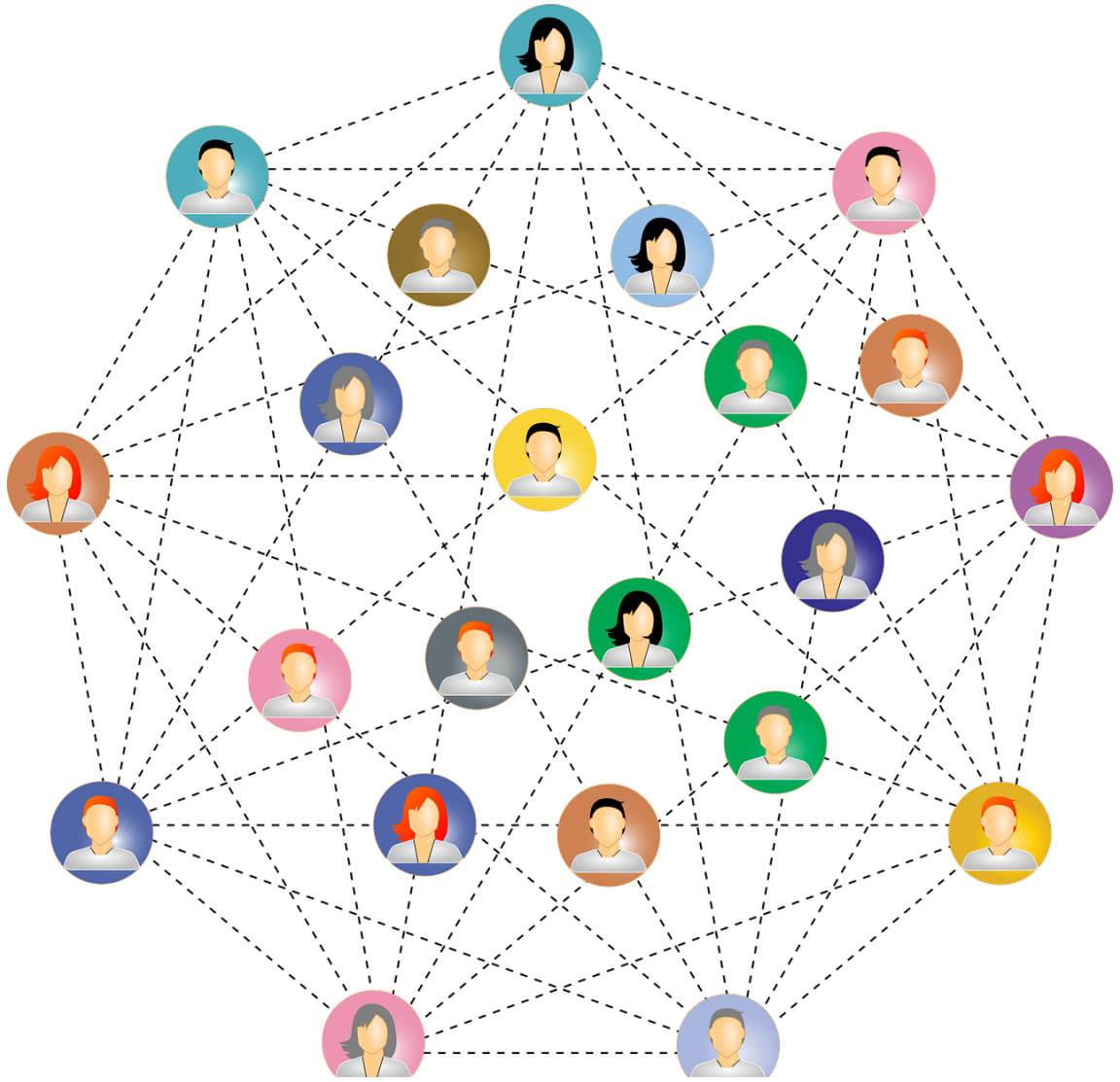
Population Health Tools and EHRs

Value-Based Care: Necessary Tools for Success

- Access to strong, comprehensive primary care
- Informed Clinicians and Practices who understand the why
- Data – updated, easily accessible
- Integrated Care with Care Coordination
- Health Equity Lens with strong commitment to population health
- A strong workforce
- Incentive structure that makes sense

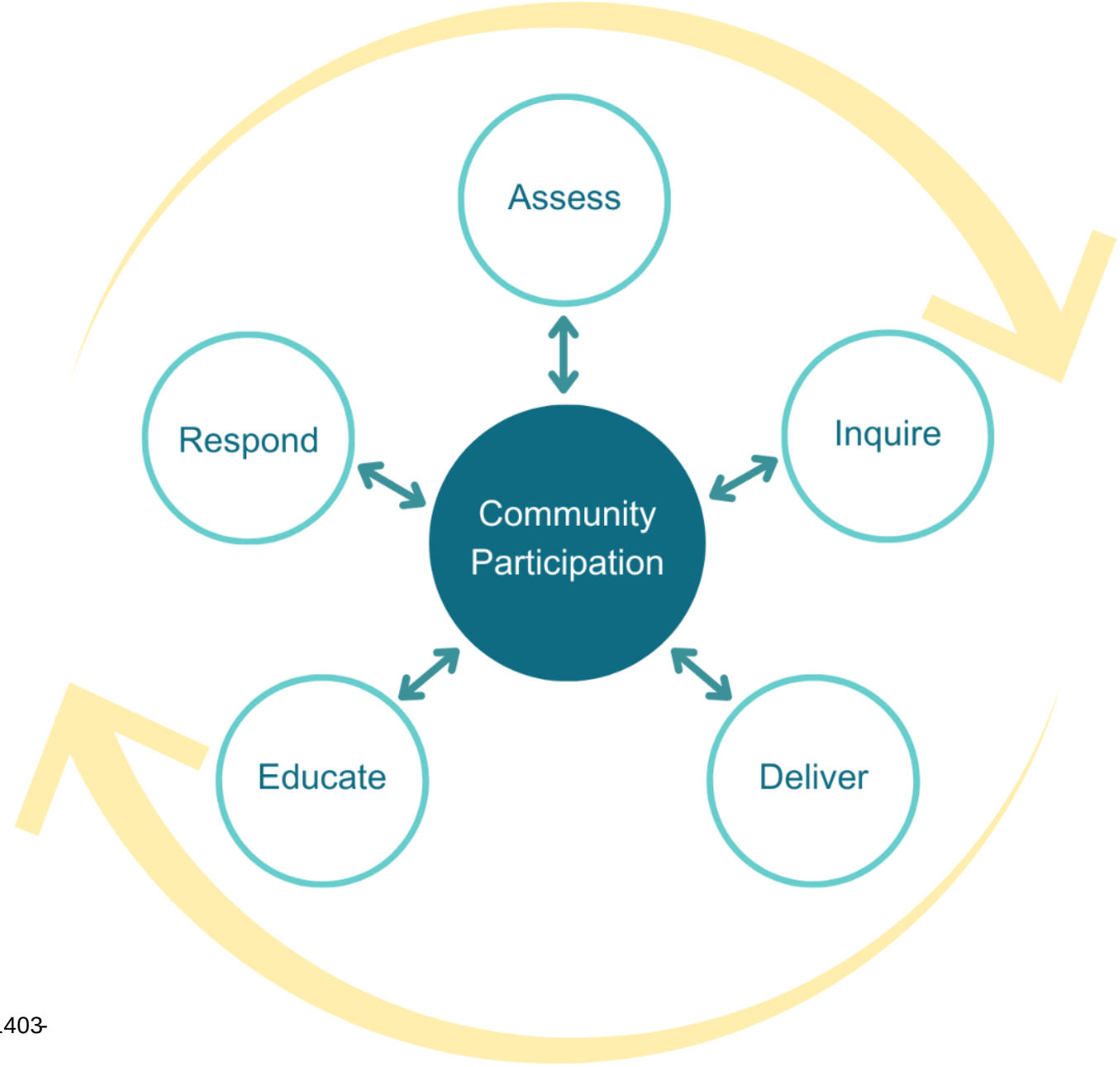
Populations at Risk of Vulnerability must be:

- Included
- Heard
- Engaged and
- Supported by an environment that promotes engagement between health care systems and people



The AIDER Model

The five steps: Assess, Inquire, Deliver, Educate and Respond form a continuous monitoring process which physicians and medical institutions can use for education and socially accountable practices.



Sandhu G, Garcha I, Sleeth J, Yeates K, Walker GR. AIDER: A model for social accountability in medical education and practice. Medical Teacher. 2013;35(8):e1403-e1408.

PEOPLE

- Who is positively and negatively affected by (this issue) and how?
- How do people perceive barriers?
- Who are the people in my community most likely to be vulnerable to the issue?
- What are the physical, spiritual, emotional and contextual effects related to the issue?

PLACE

- What kind of “positive” place are we creating?
- What kind of “negative” place are we creating?
- How are resources and investments distributed?
- How are you considering environmental impacts and environmental justice?

Issue/Decision

- How are we meaningfully including or excluding people (refugees, minority communities, disabled, non-English language proficient, rural, etc) who are affected?
- What clinic policies, processes and social relationships contribute to the exclusion of communities most affected by inequities?
- What empowering process can we initiate?

PROCESS

- What are barriers to doing equity and racial justice work for our clinic/health system/organization?
- What are the benefits and burdens that communities experience with this issue?
- Who is accountable

POWER

Adapted from Balajee, Sonali S., et al., (2012). Equity and Empowerment Lens (Racial Justice Focus), pg 28. www.multco.us/diversity-equity

ICD10 codes to use

Z55 Problems related to education and literacy

Z56 Problems related to employment and unemployment

Z57 Occupational exposure to risk factors

Z62 Problems related to upbringing

Z63 Other problems related to primary support group, including family circumstances

Z64 Problems related to certain psychosocial circumstances

Z65 Problems related to other psychosocial circumstances

Z59 Problems related to housing and economic circumstances

- Z59.0 Homelessness
- Z59.1 Inadequate housing
- Z59.2 Discord with neighbors, lodgers and landlord
- Z59.3 Problems related to living in residential institution
- Z59.4 Lack of adequate food and safe drinking water
- Z59.5 Extreme poverty
- Z59.6 Low income
- Z59.7 Insufficient social insurance and welfare support
- Z59.8 Other problems related to housing and economic circumstances
- Z59.9 Problem related to housing and economic circumstances, unspecified

Z60 Problems related to social environment

- Z60.0 Problems of adjustment to life-cycle transitions
- Z60.2 Problems related to living alone
- Z60.3 Acculturation difficulty
- Z60.4 Social exclusion and rejection
- Z60.5 Target of (perceived) adverse discrimination and persecution
- Z60.8 Other problems related to social environment
- Z60.9 Problem related to social environment, unspecified

Using Z Codes

Step 1: Collect SDOH data

Step 2: Document SDOH data

Step 3: Map SDOH data to Z codes

Step 4: Use SDOH Z code data

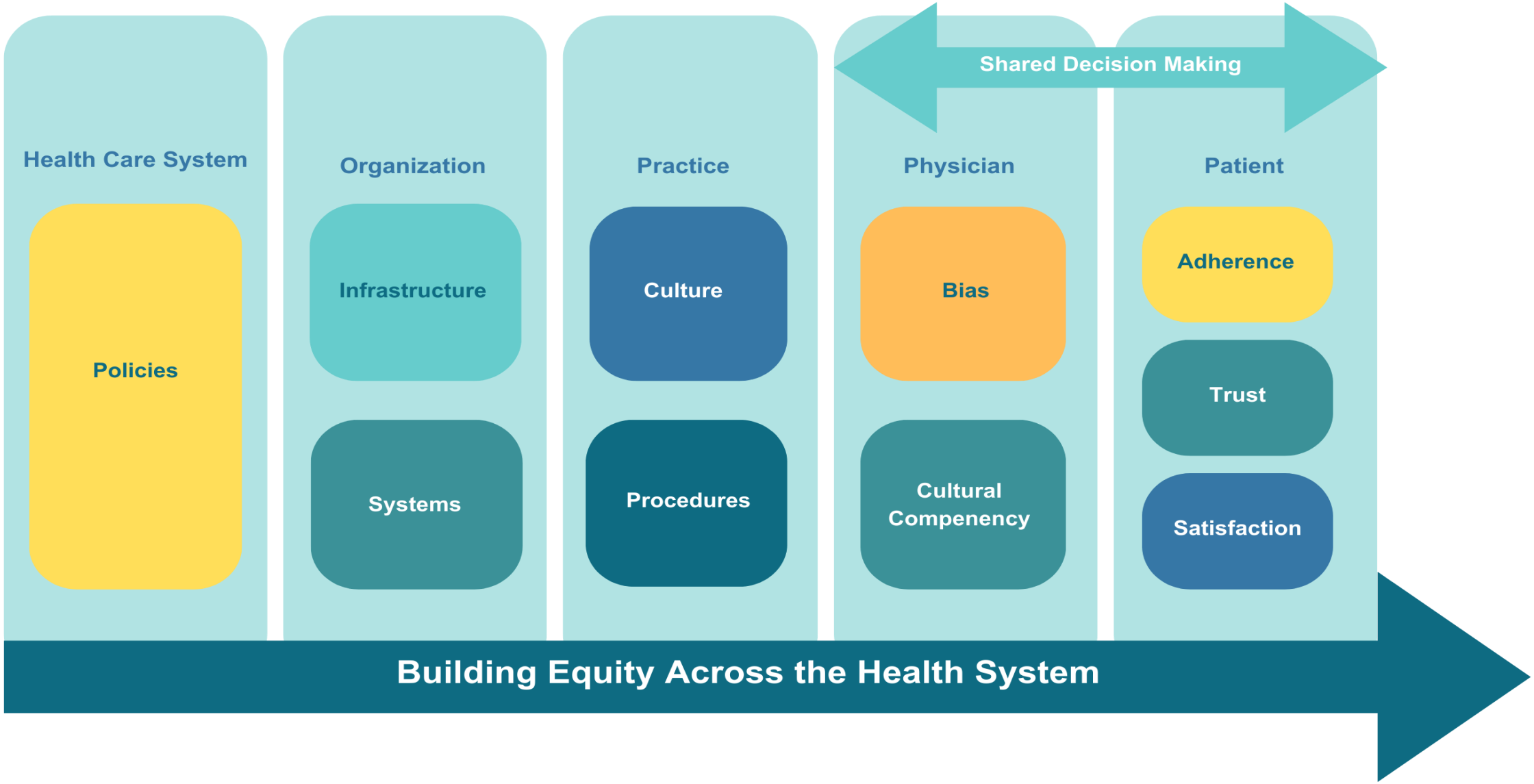
Step 5: Report SDOH Z code findings

Develop a plan to use SDOH Z code data to:

- Enhance patient care.
- Improve care coordination and referrals.
- Support quality measurement.
- Identify community/population needs.
- Support planning and implementation of social needs interventions.
- Monitor SDOH intervention effectiveness.

Among 33.7 million total Medicare FFS beneficiaries in 2017, approximately 1.4% had claims with Z codes, as reported by CMS in Jan 2020. Of the 467,136 Medicare FFS beneficiaries with Z code claims, 334,373 individuals (72%) had hypertension and 248,726 individuals (53%) had depression.

https://www.cms.gov/files/document/zcodes-infographic.pdf



The Bigger Picture

Ref: Center for Diversity and Health Equity, AAFP

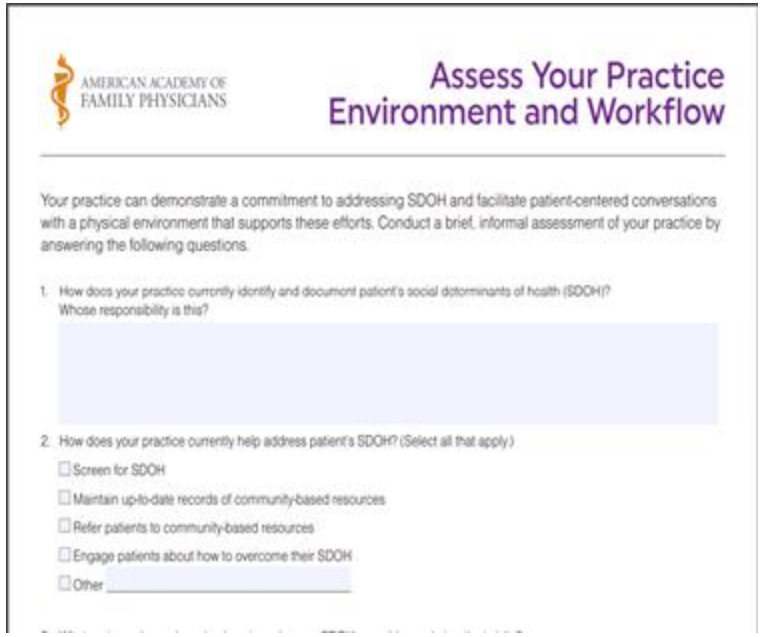
Things to consider as you build a plan to enhance your practice's health equity lens:

1. How does your practice currently identify and document patients social determinants of health?
2. What systems do you have in place to ensure that social determinants of health are addressed at patient visits?
3. Imagine that your practice is successful in doing everything possible to address patient's social determinants of health. What would that look like?
4. What are some challenges you and your practice team face in identifying and addressing SDOH?
5. What resources are available in your community to address your patient's SDOH?
6. Consider social accountability - who is accountable?

AAFP Practice Assessment

Define a Team Based Approach to Health Equity

- Practice Assessment
- Patient Flow Evaluation
- Implementation Plan



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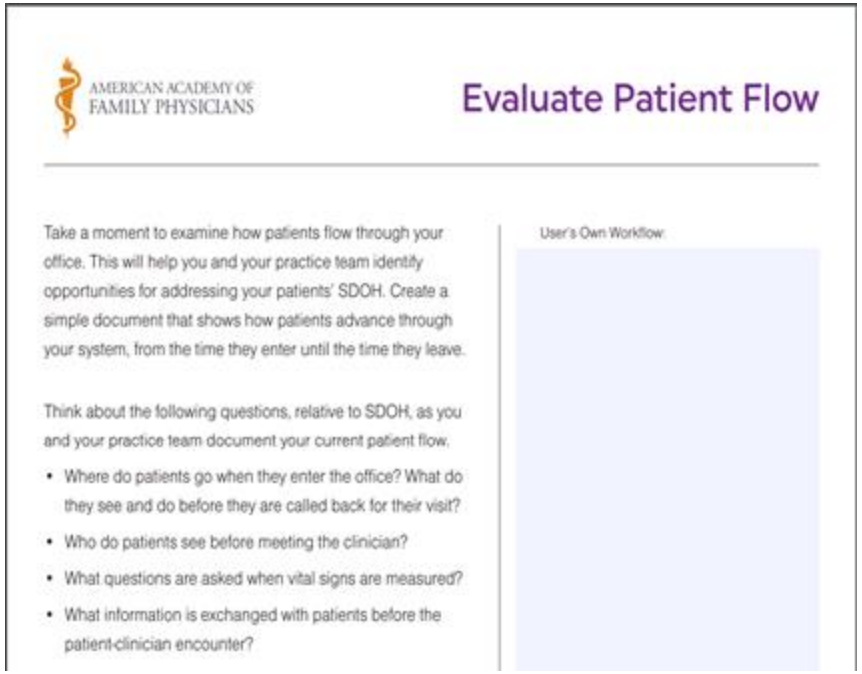
Assess Your Practice Environment and Workflow

Your practice can demonstrate a commitment to addressing SDOH and facilitate patient-centered conversations with a physical environment that supports these efforts. Conduct a brief, informal assessment of your practice by answering the following questions.

1. How does your practice currently identify and document patient's social determinants of health (SDOH)? Whose responsibility is this?

2. How does your practice currently help address patient's SDOH? (Select all that apply.)

- ☐ Screen for SDOH
- ☐ Maintain up-to-date records of community-based resources
- ☐ Refer patients to community-based resources
- ☐ Engage patients about how to overcome their SDOH
- ☐ Other _____



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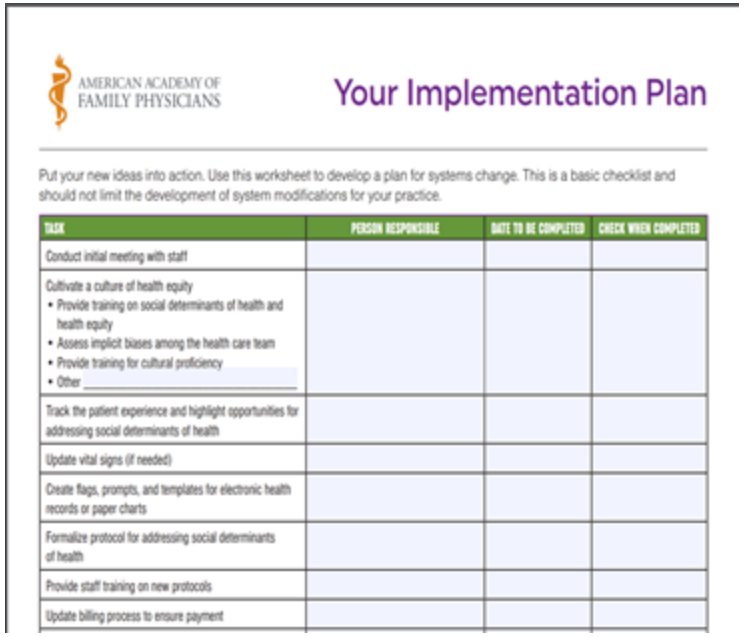
Evaluate Patient Flow

Take a moment to examine how patients flow through your office. This will help you and your practice team identify opportunities for addressing your patients' SDOH. Create a simple document that shows how patients advance through your system, from the time they enter until the time they leave.

Think about the following questions, relative to SDOH, as you and your practice team document your current patient flow.

- Where do patients go when they enter the office? What do they see and do before they are called back for their visit?
- Who do patients see before meeting the clinician?
- What questions are asked when vital signs are measured?
- What information is exchanged with patients before the patient-clinician encounter?

User's Own Workflow:



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Your Implementation Plan

Put your new ideas into action. Use this worksheet to develop a plan for systems change. This is a basic checklist and should not limit the development of system modifications for your practice.

TASK	PERSON RESPONSIBLE	DATE TO BE COMPLETED	CHECK WHEN COMPLETED
Conduct initial meeting with staff			
Cultivate a culture of health equity • Provide training on social determinants of health and health equity • Assess implicit biases among the health care team • Provide training for cultural proficiency • Other _____			
Track the patient experience and highlight opportunities for addressing social determinants of health			
Update vital signs (if needed)			
Create flags, prompts, and templates for electronic health records or paper charts			
Formalize protocol for addressing social determinants of health			
Provide staff training on new protocols			
Update billing process to ensure payment			

What about in your community?

A study looking at the prevalence of 48 chronic conditions in commuting zones:

- Showed prevalence of chronic conditions for older adults with low incomes is significantly lower in affluent commuting zones
- Low-income, older adults living in more affluent areas of the country are healthier, and areas with poor health in the low-income, older adult population tend to have a higher prevalence of most chronic conditions

> Up to 60 % of one's health is determined by one's zip code.

Annals of Internal Medicine
Polyakova M, Hua LM "Local Area Variation in Morbidity Among Low-Income, Older Adults in the United States: A Cross-sectional Study" Ann Intern Med 2019; DOI: 10.7326/M18-2800.

https://www.rwjf.org/en/library/interactives/whereyoulivaffectshowlongyoulive.html

Example of Tools used in VBC

PRIME Registry: designed to reduce burden & support comprehensive, relationship-rich care

- EHRs
- Registries/
- Population Health Tools

The nation's largest Primary Care Qualified Clinical Data Registry (QDCR)

American Board of Family Medicine

Established by the American Board of Family Medicine

- Patient and population tools
- Dashboards
- Customizable Reports
- Affordable
- Scalable
- Non-profit

Key Features

Easy-to-use tools improve patient care and lower burden

Quality Measure Dashboards

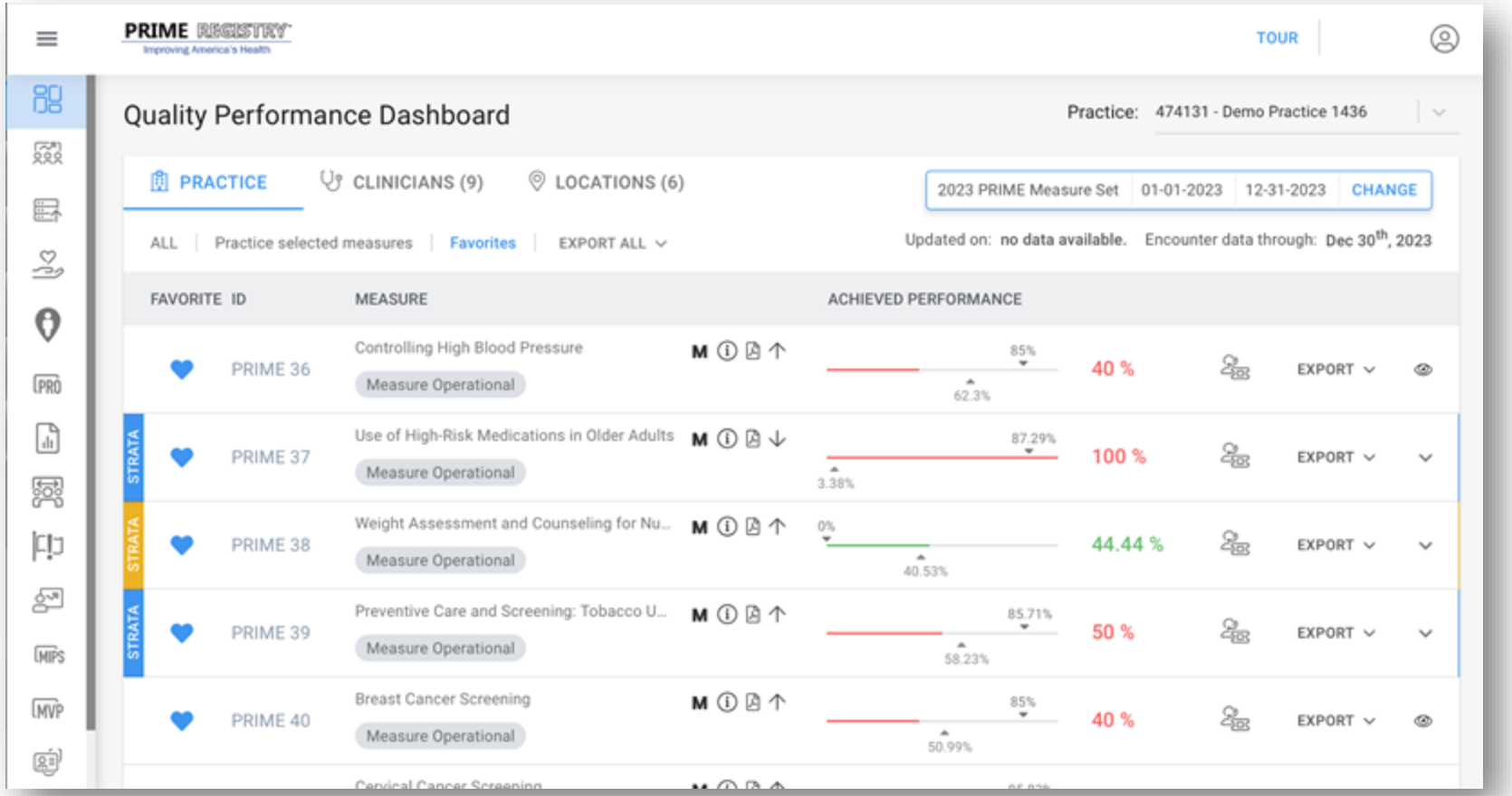
CareGap Tools

Population Health Mapping

Patient Reported Outcomes

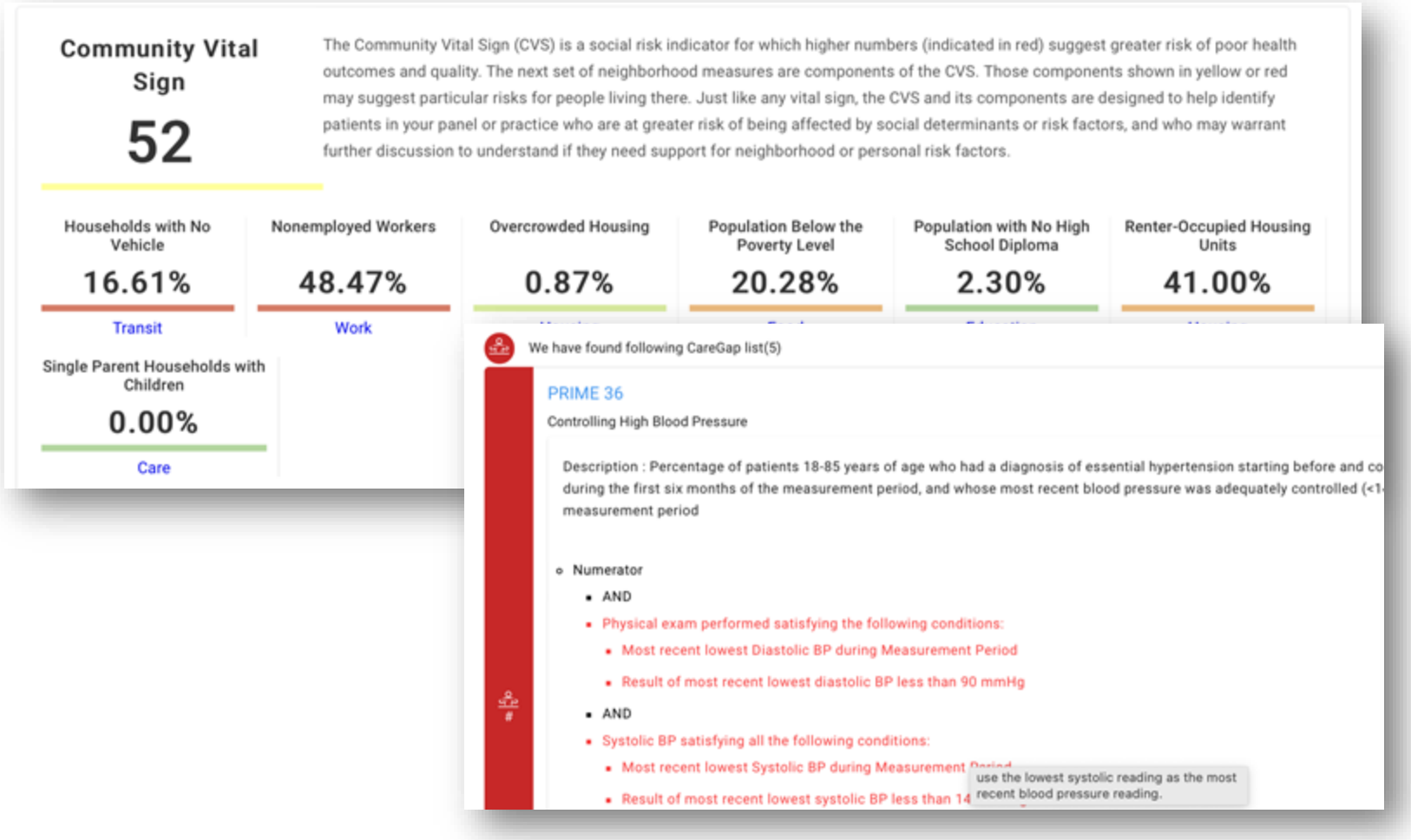
Key Features

User-friendly dashboards make measure performance easy to track



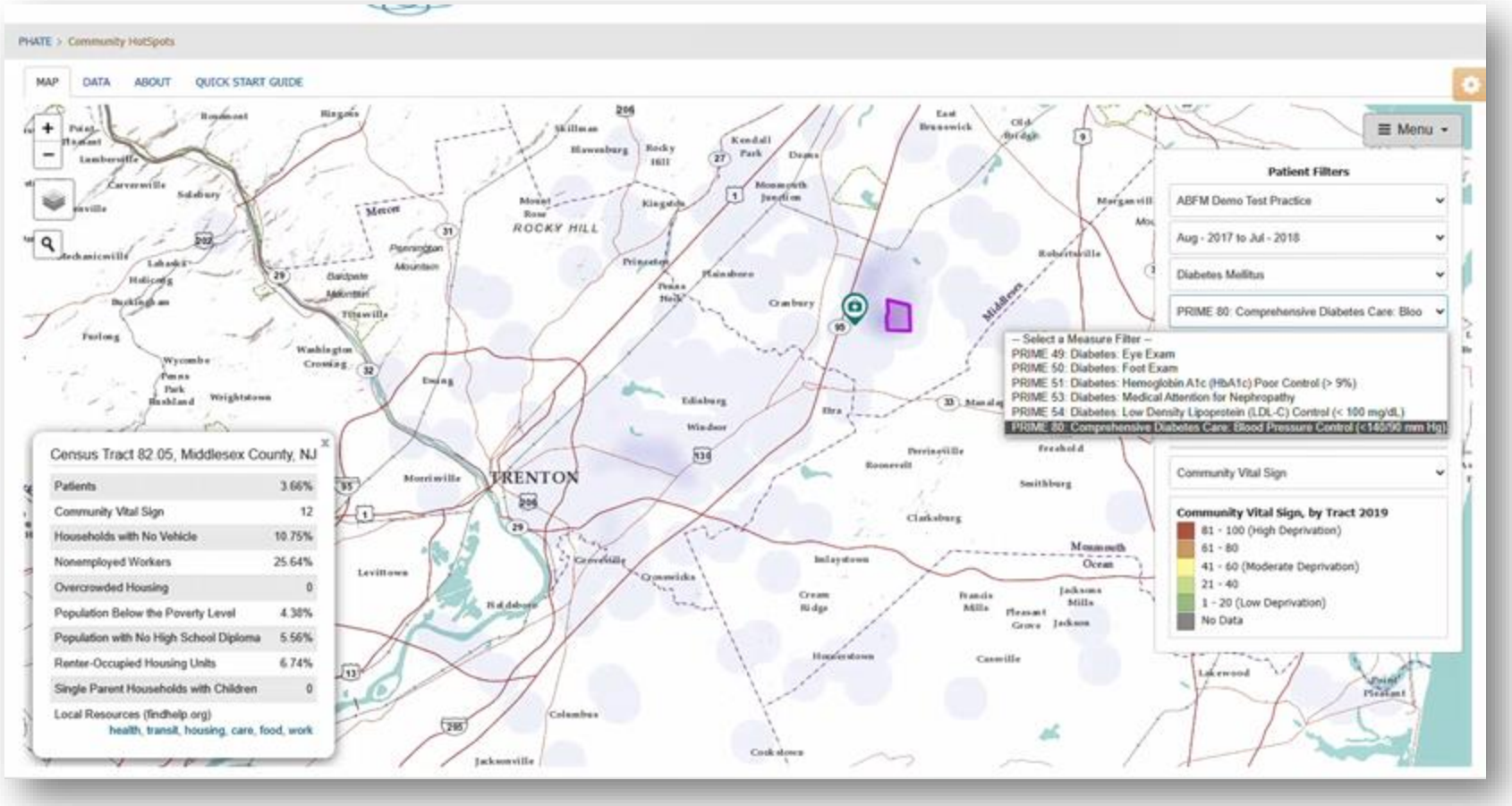
Key Features

Care gap tools integrate SDOH and improve patient care



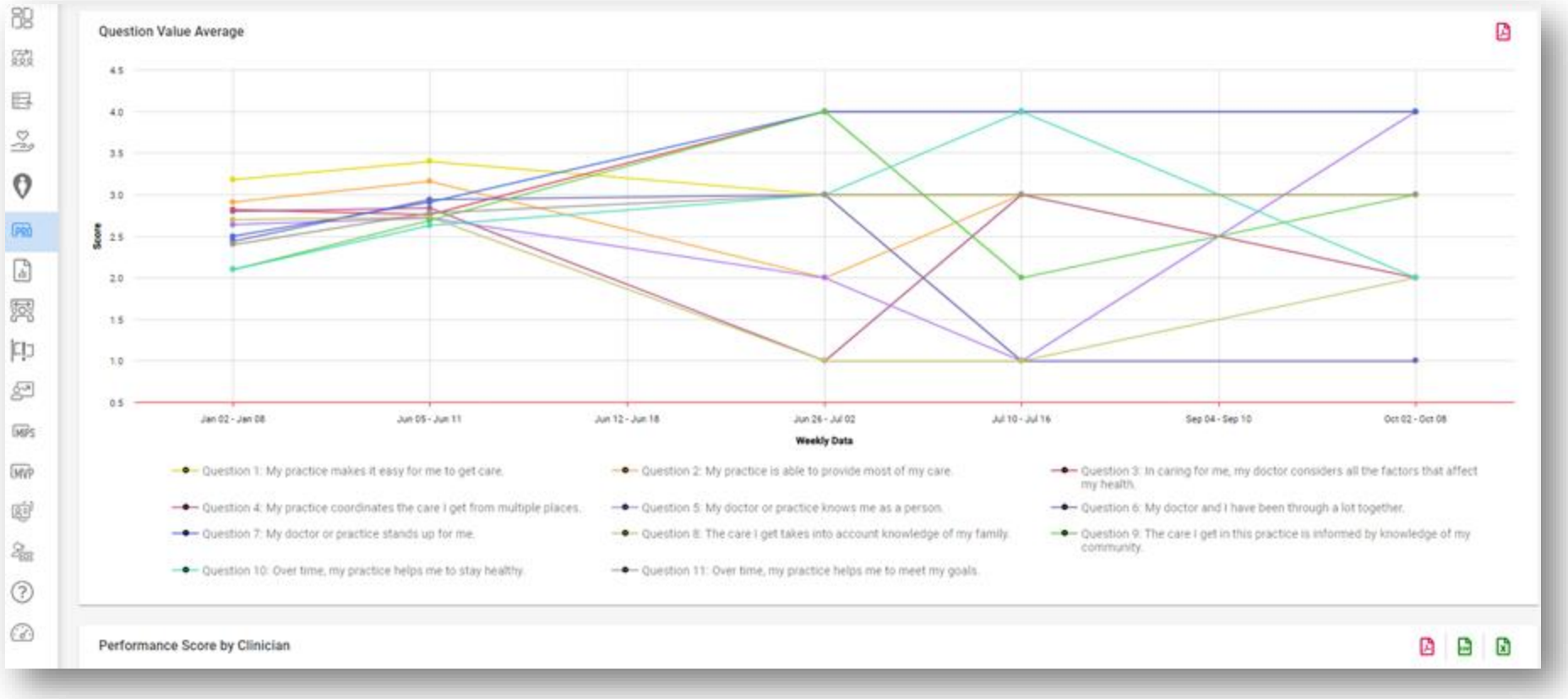
Key Features

Population health mapping: like an in-house social worker



Key Features

Patient reported outcomes: track survey responses over time



Compliance Program Support

Making compliance reporting easy

MSSP

MCP

PCF
Primary Care First

- **Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs)**: MVPs are a voluntary framework to help streamline CMS Quality Payment Program and a new option for MIPS reporting requirements. MVPs are a subset of measures and activities that are related to a given specialty or medical condition.
- **MSSP eCQMs**: To align Medicare Shared Savings Program (MSSP) quality with the Merit-Based Incentive Payment System (MIPS) approach, CMS has created a mandate for ACOs to transition to reporting via electronic clinical quality measures (eCQMs) or MIPS clinical quality measures (MIPS CQMs) by 2025.
- **Making Care Primary**: CMS's Making Care Primary model is a new 10-year multi-payer payment model that will be tested in eight states. Launching July 1, 2024, it will improve care management and care coordination, equip primary care clinicians with tools to form partnerships with health care specialists, and leverage community-based connections to address patients' health needs as well as their health-related social needs (HRSNs) such as housing and nutrition.
- **Primary Care First**: CMS's Primary Care First model is a voluntary 5-year alternative payment model that prioritizes the clinician-patient relationship; enhances care for patients with complex chronic needs, and focuses financial incentives on improved health outcomes. It is operating in 26 regions with 2,600 practices nationwide.

Five Steps to Transition your Practice to VBC

IDENTIFY HIGH UTILIZATION, HIGH-RISK PATIENT POPULATIONS

DESIGN THE CARE MODEL

OPTIMIZE TEAM-BASED CARE TO SUSTAIN YOUR MODEL

PARTNER FOR SUCCESS

DRIVE APPROPRIATE UTILIZATION AND QUANTIFY THE IMPACT

Value-Based Care: Physician-Led Models to Achieve the Quadruple Aim | Health Care Delivery Models | AMA STEPS Forward | AMA Ed Hub (ama-assn.org)

Tips for ACO Success in Value Based Care

Communication with patients

Clinical	Quality	Portal	Touchpoints
• Advanced Care Planning • Chronic Kidney Care • Medication Adherence • Skilled Nursing Facility • Health Assessments • MAT/Behavioral Health	• Wellness • Care Gaps • ED Prevention • Reminders for preventive care • Patient reported outcomes/surveys	• Do not have death by portal usage! • Med Refills • Lab results	• Evaluate every touchpoint

Think of IN CLINIC and OUT OF CLINIC Communications – what is being messaged to patients both from clinic staff and on emails, flyers, phone messages or advertisements

Workflow and Barriers

- Front Desk
- Phone Triage
- Rooming/Vitals
- Telehealth
- ADT/HIE
- EHR
- Lunch time/Breaks
- ED visits
- Inpatient/hospitalizations
- After hours

HUDDLE CHECKLIST

Things to discuss during your daily team huddle:
High-risk patients
Hospital, emergency department, or nursing facility follow-up visits
Results or referrals needed for the day
Patient-specific issues
Scheduling: clinician and staff
Scheduling: patients (back-to-back lengthy visits, openings, etc.)
Potential bottlenecks (work slowdowns)
Safety issues (sound-alike names, equipment issues, transportation, etc.)
Patient risk levels

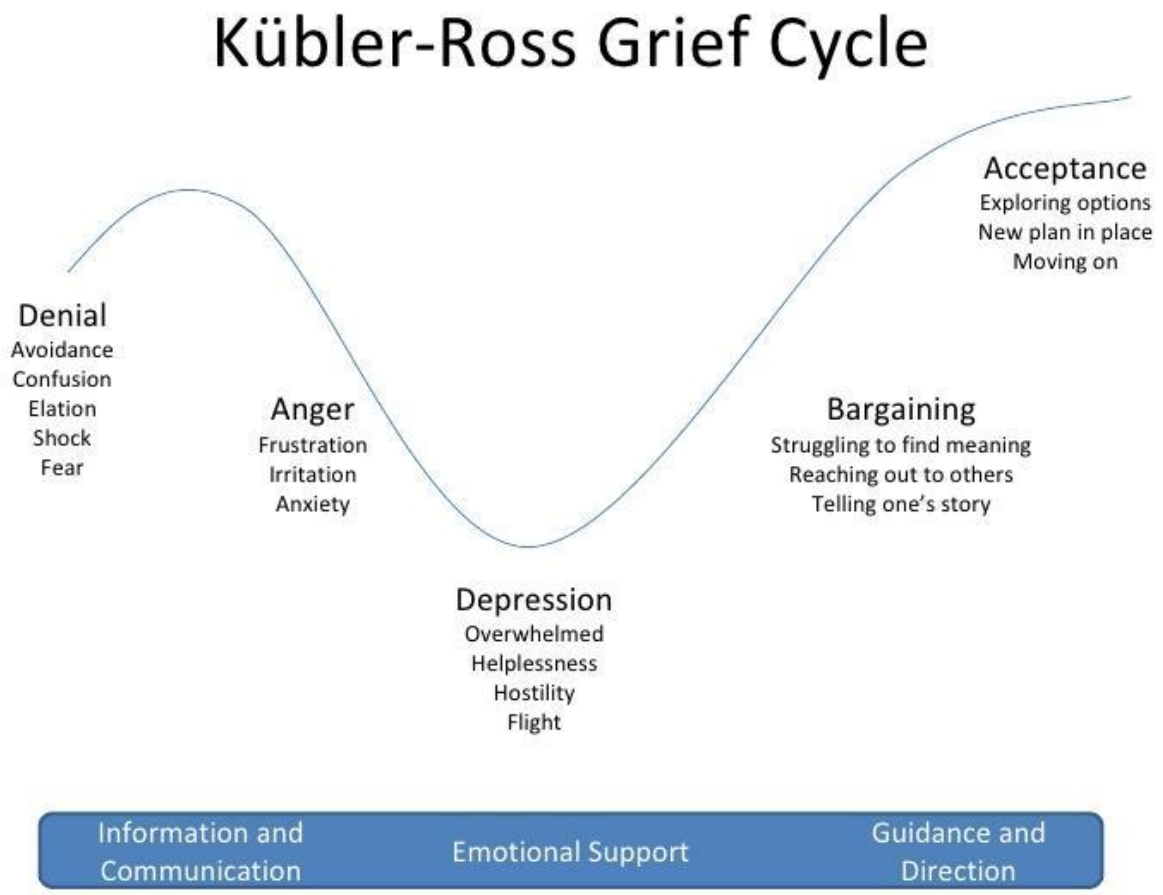
Quantifying Impact

- Routine use of dashboards and reports
- Evaluate metrics wisely
- Quality vs Costs

"VBC models now account for 36 percent of healthcare payments in the United States and cover more than 227 million Americans across federal, state and commercial payers. In 2018, Humana's Medicare Advantage plan had 20 percent lower medical costs than traditional Medicare, and their providers earned 10 cents more for every healthcare dollar spent. Moreover, 77 percent of payers noticed an improvement in care quality for patients when implementing VBC in partnership with physicians" - article - Modern Healthcare 2021

What does a practice need to thrive?

- Stable Financial
- Resources eg PPE
- Staff
- Morale
- Physical Health
- Emotional Health
- Safe physical environment
- Patients
- Innovation/Technology - resources, HIT, integration, data, TH
- Other
- YOU!



Things to do to thrive when you don't feel like it

- 6th stage of grief:

Kessler:

- **Finding Meaning**

“We are what we repeatedly do.
Excellence, therefore,
is not an *act*, but a *habit*.”

-Aristotle

Where do you stand?

Top 10 to take home

1. Goal setting - set specific, smaller, realistic measurable goals that are time limited, and share goals with your staff
2. Decide what you will use for population health and design programs for QI
3. Evaluate your health equity plan and the health equity lens of your practice
4. Reassess your payor panel, talk with your biller, consider VBC
5. Telehealth strategies and best practices
6. Focus on prevention, eg AWV, patient access/hours
7. Mark your progress - set a schedule when you will revisit this
8. Specialty care - evaluate
9. Assess your CBO partnerships
10. Take steps to recognize burnout, build staff morale, find your ikigai, reward work and steps to whack the WAC

Resources

- Value-Based Care: Physician-Led Models to Achieve the Quadruple Aim | Health Care Delivery Models | AMA STEPS Forward | AMA Ed Hub (ama-assn.org)
- How to Succeed in Value-Based Care | AAFP
- Put Your Clinical Data to Work With a Registry | AAFP
- AAFP Guiding Principles for Value-Based Payment. | AAFP
- Quantifying value - Modern Healthcare

Contact Info

- Kim Yu, MD, FAAFP
- Kyu@theabfm.org
- 2483452915
- Twitter/X:@KimYuMD
- Instagram: @drkkyu