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Accountable Care

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ACCOUNTABLE CARE INDUSTRY NEWS

Medical Home Network REACH ACO Partners with Community Health Centers in New York and Oklahoma to Improve Care for Medicare Beneficiaries

Medical Home Network REACH ACO is partnering with community health centers in New York and Oklahoma under CMS's new ACO REACH model, a value-based payment model with an emphasis on advancing equity, access, and community health. Medical Home Network REACH ACO, which is focused on community health centers, will use the Medical Home Network (MHN) team-based care model to support the efforts of participating ACO providers to improve care delivery and coordination for Medicare beneficiaries in underserved communities.

Patient Care Network of Oklahoma, a clinically integrated network of community health centers, and New York's The Institute for Family Health and Sun River Health are part of the newly formed Medical Home Network REACH ACO, which is governed and led by its community health center partners.

Care Coordination Builds Patient Trust, Results in Better Care

ACO REACH emphasizes health equity and attention to social determinants of health. Through the MHN model, practice-based care managers help patients navigate the health care system and coordinate care across all venues and settings to help deliver whole person care. By working closely with a trusted care manager, patients develop a stronger relationship with their primary care medical home. This aims to make care less confusing and lead to better overall health.

Medical Home Network REACH ACO supports health centers in investing, hiring and developing their care management resources to meet patient needs. In addition to supporting community health centers in developing care management resources, Medical Home Network REACH ACO also assists health center leadership and clinical staff with training and education as they work to improve care for Medicare beneficiaries.

In a statement, MHN President and CEO Cheryl Lulias said, "The MHN model is closely aligned with the goals of ACO REACH and complements the efforts of community health centers to provide equitable, whole person care. Our approach to team-based care also builds capabilities for value-based arrangements for all populations."

"We look forward to benefiting from MHN's model, which is focused on coordinated care for chronic diseases based on a sophisticated risk assessment and interventions for both social determinants of health and clinical needs," said Dr. Neil Calman, CEO, The Institute for Family Health.

"Sun River Health is committed to evolving our model of care to ensure the best possible resources and results for our patients," said Anne Kauffman Nolon, MPH, CEO, Sun River Health. "Participation in ACO REACH gives Sun River Health the opportunity to work closely with health centers across the country and share best practices to improve the health of Medicare populations."

"With MHN's care management model and program support we can develop more comprehensive and holistic care for our patients," said Brian Carter, executive director, Patient Care Network of Oklahoma.

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Three Winners Selected to Receive the 2023 NAACOS Leaders in Quality Excellence Awards

The National Association of ACOs established the NAACOS Leaders in Quality Excellence Awards in 2021, to recognize ACOs working to improve the quality and safety of patient care and advance population health goals. Following an open call for nominations, the NAACOS Quality Committee has selected the top three submissions for 2023. The three winners—Delaware Valley ACO, UT Southwestern ACO, and University of California San Francisco Health—exemplify how ACOs across the country are closing gaps in care, improving care coordination for complex patients, and addressing disparities in care.

Home-Based Palliative Care—Delaware Valley ACO created a home-based palliative care strategy to improve care for patients and families facing serious illness or nearing the end of life. A collaborative team of clinicians and analysts built clinically relevant claims-based views of end-of-life care among the ACO's Medicare patients and national benchmarks, finding, for example, that almost half of the ACO's patients (47%) received hospice care for a week or less before death, much higher than the 28% nationally. Further analysis showed that longer hospice stays helped reduce the total cost of care. The ACO used the findings to build the case with key stakeholders for earlier activation of palliative care. Along with providing more positive end-of-life experiences for patients and families, the ACO found that the share of patients receiving hospice for one week or less before improved from 47% to 32%. An analysis also found that patients receiving home-based palliative care resulted in savings of about $9,000 in the last 90 days of life compared to similar patients who didn't receive palliative care.

Using Machine Learning to Pinpoint Patients at High Risk of Unplanned Hospitalizations—UT Southwestern ACO, also referred to as Southwestern Health Resources, developed a novel risk stratification algorithm using artificial intelligence machine learning techniques to identify and match high-risk patients with complex care management services to prevent avoidable hospitalizations and emergency department visits. The ACO built predictive models integrating claims and electronic health record data with information from publicly available health data sets, such as the Social Vulnerability Index and the Area Depravation Index, to identify socioeconomic barriers to care at the individual level. The ACO then encouraged patients to enroll in a longitudinal complex care management program. Patients received tailored support and care coordination for clinical, social, pharmaceutical, and behavioral health needs. An analysis six months after the intervention found two unplanned hospital admissions among the 25 patients who received complex care management compared to 31 unplanned hospital admissions among 91 patients who did not receive enhanced care management. The ACO is scaling the intervention and plans to enroll 1,800 people in complex care management in 2023.

Reducing Disparities in Hypertension Control—After identifying a 10-point gap in 2020 between Black/African-American (67.6%) and White patients (77.8%) with controlled high blood pressure, University of California San Francisco Health made reducing disparities in hypertension a key health equity goal. Working with UCSF health disparities researchers, the ACO conducted interviews with Black/African-American patients to better understand their preferences, barriers, and competing priorities. Based on patient input, the ACO designed interventions, including culturally tailored hypertension educational materials. The ACO also designed a team-based intervention to help patients manage their hypertension. Patients with uncontrolled hypertension were offered an intensive program with telehealth pharmacist visits and coaching from health care navigators to encourage healthy behaviors. The ACO launched a separate effort for patients with hypertension and no recent blood pressure reading. Health navigators mailed home blood pressure monitors, taught patients to use them via the phone and video conferencing, and collected remote blood pressure readings. Patients with out-of-range readings were scheduled for primary care appointments. A year after implementation, the gap in blood pressure control narrowed significantly across the ACO, with 73.1% of Black/African American patients attaining blood pressure control compared with 74.3% of the overall population.

The following criteria were used to evaluate submissions:

- *Innovation*—in processes or technology used to improve performance.
- *Improvement*— in quality as a result of the intervention or innovative strategies used.
- *Scalability and long-term contributions*—how can the project's work can be continued, is it scalable, sustainable, transferrable and what was the return on investment.

Visit naacos.com/.

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Steward Health Care Completes Sale of its Utah Health Care Sites to CommonSpirit Health

Steward Health Care, one of the nation's largest accountable care organizations, announced that it has completed the sale of its Utah health care sites to CommonSpirit Health, through its wholly owned subsidiary, Catholic Health Initiatives Colorado. The hospitals and clinics will be managed under Centura Health, the region's leading health system. This strategic transaction allows for Steward to reinvest in providing value-based care in communities across the other regions it operates, a statement says.

Effectively immediately, Steward's Utah health care sites – including five hospitals, over 35 medical group clinics, imaging and urgent care centers, and other outpatient ventures are part of CommonSpirit Health's national health system. This includes Davis Hospital and Medical Center, Salt Lake Regional Medical Center, Jordan Valley Medical Center, Jordan Valley Medical Center-West Valley Campus, and Mountain Point Medical Center and associated clinics and outpatient centers.

In a statement, Brian Dunn, Regional President, Steward Health Care said, "We are pleased to have found the right partner for our Utah hospitals. We are extremely proud of what we've accomplished in Utah since acquiring the system in 2017, and we want to extend our deep thanks to our colleagues whose commitment and excellence has made a difference to patients and the local community every day since."

"This transaction continues Steward's stated strategic plan to focus on and invest in value-based care. We look forward to increasing our presence and financial commitment in our holistic integrated care model, for which we continue to lead the industry," said Ralph de la Torre, Chairman of Steward Health Care.

Kelsey-Seybold Announces New Tanglewood Clinic

Kelsey-Seybold Clinic has announced plans to build a 20,000-square-foot clinic in Mid-West Houston near Hunters Creek Village and Tanglewood. The new clinic will be located at 6401 Woodway Drive, Houston, TX 77057, near the Second Baptist Church Woodway Campus and replaces the current Tanglewood Clinic, which has served patients for nearly 50 years at 1111 Augusta Dr., Houston, TX 77057. Patients will continue to receive care at the current Tanglewood Clinic until the new clinic opens in Q1 2024.

The new Tanglewood Clinic will serve the Mid-West Houston community, including residents living in the nearby areas of Tanglewood, Hunters Creek Village, Piney Point Village, Briar Grove, West Oakes, and Mid-West.

When completed, the clinic will have space for up to 11 providers offering comprehensive care for adults and children, including primary care providers in Family Medicine, Internal Medicine, and Pediatrics, as well as specialists in OB/GYN, Dermatology, Rheumatology, Gastroenterology, and Neurology.

Patients will also have access to on-site X-ray and ultrasound and an extensive referral network of Kelsey-Seybold specialists with offices at neighboring locations, including Memorial Villages Campus, Memorial City, and the Spencer R. Berthelsen Main Campus.

In a statement, Tony Lin, M.D., chairman and C.E.O., Kelsey-Seybold Clinic said, "As we continue to grow in Mid-West Houston and the Greater Houston areas, ensuring our patients living and working nearby continue to receive care in their community is important to us."

"Kelsey-Seybold has looked after the health and well-being of West Houston residents for decades," said Kenneth Janis, MHA/MBA, chief operating officer, Kelsey-Seybold Clinic. "This new location is another example of our dedication to the people living and working here, and part of a larger strategy to bring more specialties and services to West Houston."

Founded in 1949, Kelsey-Seybold includes more than 650 physicians and allied health professionals practice at 35 locations in the Greater Houston area. Kelsey-Seybold has been recognized by the National Committee for Quality Assurance (NCQA) as the nation's first accredited Accountable Care Organization and a Patient-Centered Medical Home. Visit kelsey-seybold.com.

MSSP Profile: Cleveland Clinic Medicare ACO, LLC (Cleveland Clinic)

ACO Name (and DBAs)	Cleveland Clinic Medicare ACO, LLC (Cleveland Clinic)
Primary State Served	OH
Service Area	Northeast Ohio
MSSP Type	MSSP Enhanced Track High Revenue ACO
Start Date with Medicare	1/1/2015
ACO Beneficiaries	78,051
Participating Physicians	4,647
Primary Contact	Scott Dynda 216.445.3666 ccaco@ccf.org
Recent Shared Savings Amounts	Performance Year 2021, N/A Performance Year 2020, $9,556,622.94
Recent Shared Savings Distribution	Performance Year 2021 Proportion invested in infrastructure: N/A Proportion invested in redesigned care processes/resources: N/A Proportion of distribution to ACO participants: N/A Performance Year 2020 Proportion invested in infrastructure: 15% Proportion invested in redesigned care processes/resources: 10% Proportion of distribution to ACO participants: 75%

Accountable for Health Launches to Accelerate Transition to Coordinated, Convenient, and Affordable Care

A4H will promote greater understanding and adoption of accountable care

Accountable for Health (A4H) has officially launched to help accelerate the transition from fee-for-service to more accountable health care models that improve outcomes and care experiences for people, expand access, and control costs. The new nonpartisan national advocacy and policy analysis organization and its membership will focus on advocacy, research, and education in support of effective accountable care.

A4H is led by CEO Mara McDermott, an experienced health care executive with a background in federal health care law and policy, along with health care leaders across the country who are committed to improving and transforming the way health care is delivered. To date, over 30 companies have joined A4H. A full list of A4H members is available here.

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Accountable for Health Launches …. continued from page 4

A Policy Council of former government officials and thought leaders is tasked with developing and advising A4H on a policy agenda informed by accountable care practitioners. The Policy Council is co-chaired by Dr. Mark McClellan, Director and Robert J. Margolis, MD, Professor of Business, Medicine and Policy at Duke-Margolis Center for Health Policy, and former Administrator of the Centers for Medicare & Medicaid Services (CMS) and Melanie Bella, Head of Partnerships and Policy at Cityblock Health, and former Director of the Medicare-Medicaid Coordination Office at CMS. A current list of Policy Council experts is available on the A4H website here.

A4H aims to work closely with policymakers, prominent health care sector decision makers, and the individuals they serve, to demonstrate how accountable care improves health care experiences and outcomes for individuals and populations. The organization and its membership will also be a leading force accelerating continuous improvement in accountable care design and implementation, helping improve patient care across the country and address challenges in access and affordability, a statement says.

"Well-designed accountable care delivery models have been improving people's lives across the country for decades, but this transformation is not easy and needs champions to advocate for faster, broader adoption," said A4H CEO Mara McDermott.

"The critical transition from fee-for-service to models that are accountable for health is vulnerable due to a lack of awareness and understanding of the benefits it will produce. Drawing on our deep bench of experts and members, we will promote greater understanding of the impact of accountable care on patients' lives and how to advance its adoption. Our goal is to serve as a resource for crucial solutions for a better future in health care, one that provides convenient, coordinated and outcomes-driven care."

A4H Policy Council Co-Chair Melanie Bella said, "Accountable for Health has an extremely important role to play, building support for improved health outcomes across policymakers, the full spectrum of payers and programs, and participants in our health care system. We look forward to learning from our members to bring critical perspectives and data for the benefit of states, business leaders, health care organizations, clinicians, patients and caregivers."

"Health costs are rising, population health trends are worsening, and health care organizations are increasingly stretched under fee-for-service models," said A4H Policy Council Co-Chair Dr. Mark McClellan. "This presents a critical window for policymakers to promote and adopt effective, accountable care models to improve care coordination, reduce waste, and make care more accessible. Accountable for Health brings together a wide range of perspectives to advance accountable care, as we seek to ensure the sustainability of a high-quality health system and improve the lives of millions of patients."

Visit accountableforhealth.org.

MaineHealth Names Colorado Physician Leader to Role of Chief Medical and Transformation Officer

MaineHealth has announced the appointment of Dr. Chris Thomson as its new chief medical and transformation officer. In this newly-created role, Thomson will assume duties previously assigned to the system's chief medical officer, but will have added responsibility for innovating care delivery.

Since 2021, Thomson has been vice president & physician executive with Centura Health in Denver, Colo., with responsibility for that large health system's operations in Colorado and Kansas. Prior to that, he was with Centra Health in Lynchburg, Virginia for 12 years, in roles of increasing responsibility culminating in his being named senior vice president and system chief medical officer.

Thomson holds a bachelor's degree in biology and psychology from The College of William & Mary in Williamsburg, Virginia, a doctor of medicine from the Medical College of Virginia, in Richmond, Virginia, as well as a masters' in business administration from the University of Virginia, Darden School of Business in Charlottesville, Virginia.

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MainHealth Names Colorado Physician …. continued from page 5

In his new role, Thomson will be responsible for the system's team of chief medical officers at hospitals across its service area, and will also oversee research and academic affairs. In addition to those duties previously assigned to the system CMO, he will take on additional accountabilities supporting organizational transformation. This could take the form of new partnerships or new delivery models focused on value based care, where the health system is rewarded for keeping patients well instead of treating them when they are sick.

Dr. Chris Thomson

"This is a tremendous opportunity to be on the forefront of innovation in health care, all in service to the clear and meaningful vision of working together so our communities are the healthiest in America," said Thomson.

In a statement, Dr. Andrew Mueller, chief executive officer of MaineHealth said Thomson is an ideal physician leader for the role. "An emergency physician by training, all along the way, Chris has been an innovator in areas such as service line development, population health and clinical documentation," said Mueller.

Thomson replaces Dr. Doug Sawyer, MaineHealth's chief academic officer, who has been serving as system chief medical officer on an interim basis since November 2021.

Maine Health is a significant stakeholder in the MaineHealth Accountable Care Organization in Portland. Visit MainHealth.org.

CareSource Partners with the Children's Care Network in Metro Atlanta to Improve Pediatric Clinical Outcomes

CareSource, a mission driven Medicaid plan serving more than 500,000 Georgians, announced a new agreement with The Children's Care Network. The value-based agreement between CareSource and TCCN will provide physicians with data and analytics to better manage and coordinate patient care, while promoting healthy behaviors,such as preventative well-checks, to improve outcomes for children.

TCCN is a physician-led, clinically integrated network with over 1,400 physicians, including more than 175 community practices and physicians from the Children's Healthcare of Atlanta network. TCCN's vision is to improve quality by strengthening the pediatric system of care for the benefit of the patients and communities we serve.

"We are excited to about this agreement with TCCN to improve outcomes for Georgia's infants, children and adolescents," said Jason Bearden, CareSource Georgia market president. "Many of our young members are assigned to health care practices within TCCN, and we believe this will help them lead healthier lives."

This value-based care agreement emphasizes a proactive approach based on prevention and will benefit individuals who are served and seen by the organizations.

"This agreement between TCCN and CareSource is an important step in facilitating high quality care for our patients, providing value for our members, and promoting a sustainable clinical integration model" said Brad Weselman, MD, Executive Director of TCCN. "Our mission is to preserve and support the highest quality of pediatric care for all Georgians."

The agreement will address physical, social/emotional, developmental, and behavioral health conditions through promoting preventative services including screenings aimed at identifying at-risk children. Early detection leads to early intervention and treatment thereby providing Georgia's children with the greatest chance for positive health outcomes.

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Atlantic Health System Partners with NeuroFlow …. continued from page 6

The Children's Care Network is a URAC accredited clinically integrated network and is a subsidiary corporation of Children's Healthcare of Atlanta. It is governed by a physician-led board of directors, composed of independent community physicians and System-employed physicians dedicated to advancing pediatrics in our state.

The Children's Care Network (TCCN) was created through a partnership of community physicians—both primary care and specialists—and Children's to strengthen pediatrics in Georgia and ensure better health outcomes for patients. At the core of TCCN is a commitment to the belief that children should receive the highest level of care from pediatricians and pediatric hospitals. Preserving the quality of care provided to patients and families is the driving force behind the creation of this network.

Atlantic Health System Partners with NeuroFlow to Launch and Scale Collaborative Care Management Program

Innovative platform will screen and triage patients with behavioral health symptoms

Atlantic Health System, a not-for-profit health system providing care for more than half the state of New Jersey, parts of New York and Pennsylvania, has partnered with behavioral health infrastructure company NeuroFlow to launch and facilitate the use of the collaborative care model ("CoCM") across 16 accountable care organization (ACO) sites..

The partnership will be activated with an initial focus on migrating clinical workflows to NeuroFlow's registry, or caseload management tool, providing care team members with the ability to track and measure patient progress in between appointments and improve resource allocation. The initial rollout of NeuroFlow to support behavioral health screening for adult patients in the ACO will begin in June. The additional enrollment of younger patients and launch of collaborative care programs will take place in subsequent months.

NeuroFlow was selected as a partner for its ease of use and dual-purpose in serving both patients and clinicians, leveraging its technology to risk-stratify populations in real-time and alert care teams about high and rising-risk patients. NeuroFlow will also provide behavioral health care managers to be embedded within Atlantic Health's primary care setting in order to help monitor treatment outcomes. This tech-enabled approach has been proven to reduce emergency department visits by 34%.

The partnership will initially focus on supporting 30,000 patients and will involve accountable care organizations – both AMG and independent practices from Atlantic ACO and the Optimus Healthcare Partners ACO.

In a statement, Atlantic Health System Vice President of Physician Value-Based Programs and CMO, Accountable Care Organizations, Jim Barr, M.D. said, "A key part of our quadruple aim is the provider's satisfaction and additional support to their practices. Given the rising demand for behavioral health services, we were looking for a solution that could streamline behavioral health screenings, provide customized patient education and coaching, along with access to BH collaborating professionals. The NeuroFlow platform identifies and prioritizes behavioral health concerns in our populations, collects data to help us understand the whole person, and supports management with clinical decision insights and performance frameworks."

"Technology is the force-multiplier needed to advance behavioral health care and close the care gaps that exist for patients," said NeuroFlow Chief Medical Officer Tom Zaubler, MD.

"This partnership will support the clinical team at Atlantic Health as they launch the collaborative care model and work toward improving access for their adult and pediatric patients as demand for services continues to increase."

Visit atlantichealth.org.

Shore Quality Partners Taps Spatially Health's Innovative Technology to Improve Health Equity and Address Social Determinants of Health

Spatially Health's Equity Equalizer will integrate its advanced technology with Shore Quality Partners to identify obstacles related to social determinants of health.

Shore Quality Partners, an Accountable Care Organization comprised of more than 200 physicians and 42,000 Medicaid patients in New Jersey, has tapped Spatially Health, a cloud-based, health equity platform focused on identifying and addressing social determinants of health (SDOH) and health equity barriers.

Spatially Health will support Shore Quality Partners in identifying and tackling health equity obstacles that affect its patients. This will be achieved by using Spatially Health's Equity Equalizer platform, to identify patient-specific health equity barriers and recommend customized interventions. This approach will encourage patient engagement and help optimize medical management initiatives, ultimately leading to improved health outcomes, a statement says.

Shore Quality Partners will incorporate Spatially Health's advanced technology platform, to conduct a thorough assessment of each patient's social determinants of health (SDoH) and propose personalized interventions to overcome their specific barriers. The platform adapts dynamically with every new patient dataset, with precise recommendations for enhancing patient health outcomes. The platform has undergone significant enhancements, now equipped to measure the cost implications of health barriers, meet CMS compliance standards, and offer advanced tools to mitigate risks and improve quality in the context of SDOH health barriers. Visit shorequalitypartners.com and SpatiallyHealth.com.

OneCare Vermont Announces Abe Berman as Interim Chief Executive Officer

OneCare Vermont has announced that Abe Berman has been selected as Interim Chief Executive Officer of the organization. Berman replaces Vicki Loner, who will step down from the role at the end of May.

Berman currently serves as Vice President of Revenue Strategy for the University of Vermont Health Network, where he is focused on the transition toward value based and fixed revenue streams. Prior to his current role, he was instrumental in the early development and launch of OneCare, and served as Director of ACO Finance for several years before moving on to progressive executive leadership roles in network management for a large commercial insurer.

OneCare is an accountable care organization that partners with local health care providers to transform Vermont's health care system to one that focuses on health goals, by providing actionable data and innovative payments that foster better health outcomes for all. OneCare establishes value-based care contracts with insurance payers (Medicaid, Medicare, and commercial insurers) on behalf of over 5,000 participating providers from the full continuum of care.

OneCare's Board of Managers is undergoing a strategic planning process to identify how to efficiently and effectively continue OneCare's work. Berman has been charged with leading the implementation of the plan. The OneCare Board of Managers will seek a permanent CEO after implementation of the upcoming strategic plan.

In a statement, Interim OneCare CEO Abe Berman said, "I am ready to keep OneCare moving forward on its goal of providing the greatest value to participating providers and, through them, all Vermonters. I've been involved in value-based care for much of my career and I am excited to take on this important role in health care reform."

Visit onecarevt.org.

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