PREVENTING CHRONIC DISEASE IN THE RISING-RISK POPULATION:

THREE STRATEGIES FOR ACOs BEFORE, DURING, AND AFTER THE PATIENT ENGAGES IN THE CLINICAL CARE SETTING

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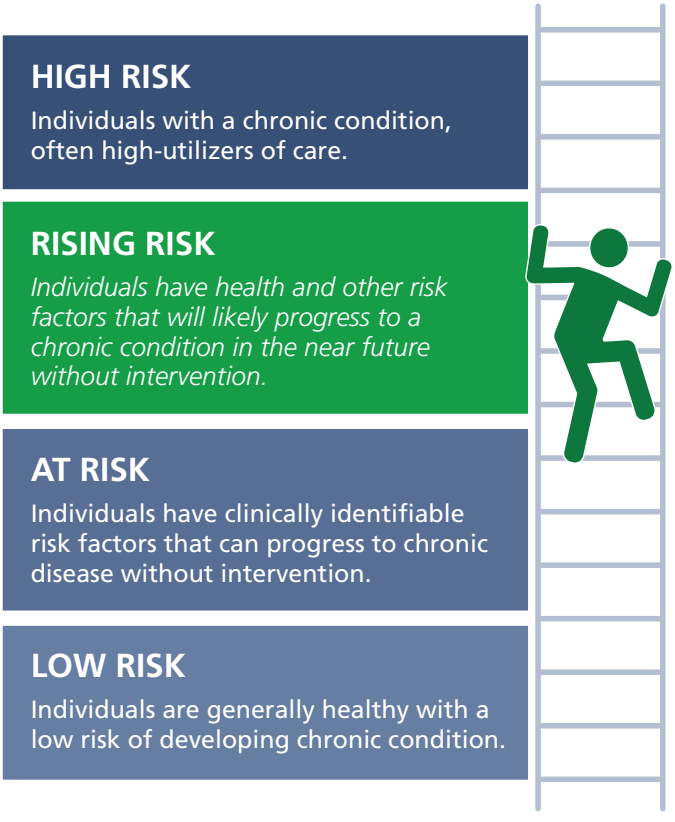
BACKGROUND AND OVERVIEW

Most patients don't develop a chronic condition overnight but experience a compounding series of health, lifestyle, and societal factors as they progress up the risk spectrum. However, traditional payment systems that pay for individual services that *treat* disease—but generally do not pay for care that *prevents* disease—hamper efforts to provide preventive services that seek to keep an individual's risk from rising. As a result, health care delivery systems often employ a downstream approach: only once an individual exhibits a chronic condition is a treatment plan initiated.

Consider a patient who has several risk factors for metabolic syndrome, including elevated blood-glucose levels, inconsistent exercise habits, and unhealthy dietary choices. The patient's body mass index (BMI) has increased 4 points over the past few years to 25.5. Given the patient's lab values (A1C between 5.7 percent and 6.4 percent), poor health behaviors, and the upward trend of their BMI, this patient is at an increased risk of developing type 2 diabetes. Proactive intervention, with the goal of preventing the onset of diabetes, is indicated. And yet, until this individual develops diabetes, he or she may not receive the care they need to manage their rising risk of developing a chronic condition. An estimated 84.1 million individuals in the U.S. have prediabetes,[1] which—without intervention—could progress to type 2 diabetes (report here). One study found that annual expenditures for patients who developed diabetes were one-third higher than those who do not progress from prediabetes to diabetes, with an average difference of $2,671 per year (abstract here).[2] Health systems that address a patient's risk factors *before* they develop into a chronic condition such as diabetes could experience significant improved patient health outcomes, cost savings, and a reduced burden on provider resources.

Fortunately, new alternative payment models (APMs), including payment arrangements found in accountable care organizations (ACOs), are helping health systems proactively keep their patients—and the communities they serve—healthy. APMs often provide greater flexibility to manage the health of patient populations by aligning provider incentives with cost and quality goals. Providers are financially rewarded for keeping patients healthy, which may be accomplished by providing preventive

RISK SPECTRUM OF PATIENTS



While there are several approaches to value-based payment, with a variety of alternative payment model (APM) types and designs, accountable care organizations (ACOs) to date have been a major vehicle for value-based payment adoption, with over one thousand ACOs covering approximately 33 million lives across the country.

An alternative payment model (APM) is a broad term that refers to innovative payment strategies designed to incentivize care delivery practices that reduce overall costs while improving health outcomes.

An accountable care organization (ACO) is a collection of providers who together agree to assume financial responsibility for the cost and quality outcomes of a defined population of patients.

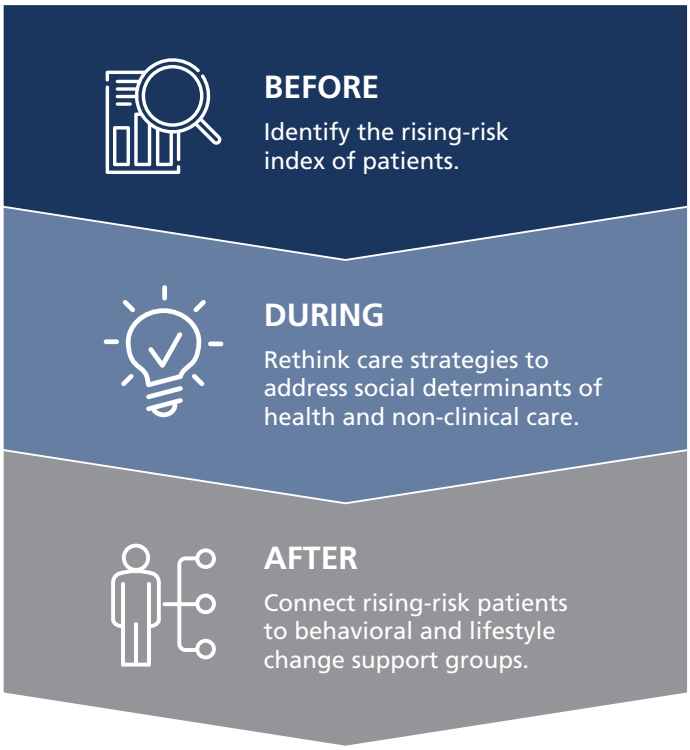
For more information on ACOs, see Leavitt Partners' latest research at www.leavittpartners.com/tag/acos/.

care, improved care coordination and management, and addressing patients' social determinants of health. APMs contrast with the traditional fee-for-service payment model that pays providers for *volume* rather than the *value* of care provided. In other words, traditional fee-for-service payment systems pay for individual, face-to-face services on a piecemeal basis. APMs, on the other hand, support other important services—such as care coordination, proactive outreach to patients, and treatment planning—that can significantly improve patient health outcomes.

To take advantage of the flexibility and focus on value enabled by APMs, physicians and health systems should embrace chronic disease prevention—before, during, and after an individual enters the clinical care setting—to address the needs of this rising-risk population.

In this paper, the American Medical Association and Leavitt Partners offer actionable recommendations for health care organizations working within an APM as they incorporate new care delivery strategies that target the rising-risk population.

STRATEGIES TO ADDRESS THE NEEDS OF THE RISING-RISK POPULATION BEFORE, DURING, AND AFTER THE CLINICAL CARE SETTING



The Accountable Care Learning Collaborative (ACLC) is a non-profit organization with a mission to accelerate health care organizations' readiness and abilities to succeed under value-based payment models. Founded by former U.S. Department of Health and Human Services Secretary Mike Leavitt and former Centers for Medicare & Medicaid Services Administrator Mark McClellan, MD, PhD, the ACLC identifies:

1. *What* care delivery competencies providers need for sustainable success under value-based payments
2. *When* they will need these competencies
3. *How* to approach competency implementation within their organizations

ACLC members represent several sectors of the health care industry—including providers, payers, associations, and consultants—allowing for comprehensive, co-produced solutions from industry-wide thought leaders.

The ACLC created the Accountable Care Atlas ("the Atlas," linked here), a collection of competencies that provider organizations should consider when pursuing value-based care. They also began publishing "Case Study Briefs" that provide real-world examples of how a specific provider organization has successfully implemented a specific competency. Several of these briefs are mentioned in this paper.

https://www.accountablecarelc.org/case-study-briefs

BEFORE: IDENTIFY THE RISING-RISK INDEX OF PATIENTS.

Instead of waiting for the clinical setting, ACOs should leverage health registries, electronic health records (EHR), and data analytics tools to stratify patients into different risk categories, including those with rising risk. For example, an ACO could query an EHR for lab values to identify those with prediabetes. The care team could then connect these patients with the National Diabetes Prevention Program (National DPP)—a lifestyle change program recognized by the Centers for Disease Control and Prevention (described in more detail below)—to keep their condition from progressing from prediabetes to diabetes.

Consider the following examples of how health systems are analyzing data to identify their rising-risk population.

1. **Identify rising-risk patients using health registries, claims data, risk assessments, and predictive analytics.**

   a. Health registries: The Henry Ford Macomb Hospital created an algorithm within their EHR to generate a list of patients with prediabetes. They are currently collaborating with the AMA to use this technology as part of a pilot registry, which could become a national model for enrolling patients with prediabetes into CDC-recognized National DPP lifestyle change programs that aim to reduce patient risk of developing type 2 diabetes (article here).[4]

   b. Predictive analytics: Atrius Health launched Clinical RISk Prediction Initiative (CRISPI) in 2016 to pull EHR and claims data and incorporate real-time data sources. CRISPI uses 138 variables—which slice across medical and pharmacy utilization, diagnoses, and sociodemographic factors—to predict a patient's risk of hospitalization within six months. These predictive analytics helped Atrius Health prioritize their population health management resources for patients who could most benefit from those services (ACLC Case Study Brief available here).[5]

2. **Use health risk assessments to gather more information from patients.**

   In 2009, the United States Preventive Task Force updated its recommendations for breast cancer

In September 2016, the Association of American Medical Colleges and the National Association of Accountable Care Organizations interviewed hospitals and providers participating in risk-based payment programs to learn more about risk assessments.[3] During the interviews, five organizations were identified that used risk-stratification models to segment their patient population. Collectively, these organizations identified the following mechanisms they used to identify the rising risk:

- number of chronic conditions
- past utilization
- whether health goals are being achieved
- standard claims-based risk score
- medical and pharmacy claims
- custom health assessment including psychosocial factors or proxy psychosocial factors
- external lab results, including change in lab values or abnormalities
- multiple gaps in care
- change in risk score (movers)
- inpatient and emergency department use

screening to include women starting at age 40. However, a community health system in Wisconsin recognized that screening rates were not increasing. They began offering free monthly breast cancer screenings and updated their health risk assessment to include questions surrounding breast cancer risk. Leveraging the patient-provided information, within one month, 856 patients completed a health risk assessment and 61 of these patients were identified as having a risk of breast cancer. With the information provided through the risk assessment, including updated contact information, the health system could identify and reach out to these high-risk patients to encourage early screening and intervention (summary here).[6]

3. **Develop treatment plans and options to mitigate risk for individual patients.**

In addition to identifying rising-risk patients, provider organizations working within APMs have new opportunities to better manage these patients' health. For example, population management and quality performance dashboards have been highly effective in managing patients with high blood pressure (BP) and identifying those at risk of cardiovascular disease and stroke. The AMA, in collaboration with the Care Coordination Institute, identified more than 130 South Carolina primary care practices that qualified for the American Heart Association/AMA "Target: BP Recognition Program" by achieving at least 70 percent hypertension control. A research study conducted in 16 community-based clinical sites in South Carolina using the AMA's "MAP" protocol (Measure accurately, Act rapidly, Partner with patients) showed BP control improved from 64.4 percent at baseline to 74.3 percent at six and 73.6 percent at 12 months. The MAP program included monthly dashboards reports. Even in a short six-month window, efforts to measure accurately and partner with patients can contribute to improved diagnosis and management of cardiovascular risk.[7]

In addition, the 2017 Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines reclassifies 32.3 million U.S. adults as newly hypertensive and recommends BP-related treatment of 133.7 million adults, including 57.8 million with uncontrolled BP recommended to initiate or intensify pharmacologic treatment, and another 50.5 million individuals newly recommended lifestyle modification alone.[8,9]

Recommendations

As a first step, ACOs and other entities adopting APMs should invest in opportunities to identify—or better identify—the rising-risk population. ACOs should leverage data registries, EHRs, and paper or digital questionnaires to proactively segment populations with rising-risk factors, such as prediabetes, breast cancer, and elevated blood pressure.

ACTIONS TO CONSIDER:

- **Establish algorithms, data needs, and reporting methods to identify patients**
- **Educate health care providers on how to access and use reports and data**
- **Align interventions or referrals for rising-risk patients to facilitate action steps**
- **Leverage EHR systems to establish a feedback mechanism to keep referring physicians in the loop**

DURING: RETHINK CARE STRATEGIES TO ADDRESS SOCIAL DETERMINANTS OF HEALTH AND NON-CLINICAL CARE.

In addition to proactively identifying patients with risking risk, APMs are enabling health systems to broaden their interpretation of prevention to include non-clinical factors—such as social determinants of health (SDOH)—and to rethink care management strategies to address these factors.

Consider the following examples of how health systems are rethinking strategies to address SDOH during the clinical care setting.

1. **Align payment structures to address SDOH.**

   Traditional fee-for-service arrangements can hamper prevention, but ACOs are well positioned not only to implement preventive care mechanisms at the clinical setting through initiatives like screenings, counseling, vaccinations, and health risks assessments, but also to address SDOH that impact health status and health care outcomes (social determinants of health are described here).[10] Because these factors can significantly influence health, not taking advantage of opportunities to screen for and address these issues can—and often do—lead to increased long-term costs.[11,12,13,14] Several federal initiatives are encouraging innovative ways to use available resources, making it easier for entities involved in APMs to invest in flexible care management strategies. Consider the following examples:

   a. Accountable Health Communities: An innovative Centers for Medicare and Medicaid Innovation model, called "Accountable Health Communities," tests the idea of identifying unmet needs in the primary care setting and connecting them with community services (initiative explained here).[15] Using this holistic approach to health indicators demonstrated statistically significant improvements in blood pressure and cholesterol levels for those enrolled in the program versus those who were not.[16]

   b. Comprehensive Primary Care Plus (CPC+): CPC+, Medicare's most recent medical home model pilot, is a collaboration between Medicare, Medicaid, and commercial payers. The pilot program includes two payment structures that allow providers greater flexibility to offer preventive care for individuals in the rising-risk population (CMS explanation here; Leavitt Partners research here).[17] Both alternative payment models provide flexible revenue not tied directly to face-to-face treatment services, allowing providers to invest in non-reimbursable population health strategies, such as developing care plans, convening multidisciplinary teams, educating patients in risk reduction strategies and self-management of their conditions, investing in behavioral health strategies, and incorporating new technologies.

2. **Equip health systems to identify and deploy resources.**

   Assessing patients for SDOH factors may not be an appropriate role for physicians. An interdisciplinary team involving other clinicians, case workers, care coordinators, or non-traditional support systems to address SDOH factors can help reduce physician burden while still meeting the needs of the rising risk. This team-based approach leverages the highest skills of all care team members and supports physicians leading the management of a rising-risk patient's health. Consider the following examples of how health systems are addressing SDOH in the rising-risk population:

   a. Use an interdisciplinary team. Signature Medical Group is a program that provides prenatal and maternal care for Missouri Medicaid recipients using an interdisciplinary team of nurses, care coordinators, and physicians. After a physician's visit, a care coordinator spends 30 minutes with the patient and connects them to resources

ALTERNATIVE PAYMENTS MODELS TO TREAT OPIOID ADDICTION

Patient-Centered Opioid Addiction Treatment APM

The AMA and the American Society of Addiction Medicine jointly created the Patient-Centered Opioid Addiction Treatment payment model. This model increases access to comprehensive medical and biopsychosocial services to treat opioid use disorder through new payments tied to quality, service use, and outcomes. The model authorizes two new provider payments:

1. initiation (a one-time reimbursement for evaluation, diagnosis, and treatment planning), and

2. maintenance (a monthly reimbursement for the provision of ongoing outpatient care).

The plan incents delivery of medical, psychological, and social support services through non-face-to-face services (e.g., telehealth) and increased provider coordination. (Press release here; full description of APM here.[18,19])

Addiction Recovery Medical Home APM

A multi-sector alliance of industry leaders—including Leavitt Partners, Facing Addiction with NCADD (the National Council on Alcoholism and Drug Dependence), and Remedy Partners—engineered the Addiction Recovery Medical Home (ARMH) model to provide patients with a long-term, comprehensive, and integrated pathway to treatment and recovery.

The ARMH carves out financial resources for addiction treatment and recovery services; establishes quality requirements across payment, network, and care teams; integrates clinical resources with assets to address SDOH; establishes engagement protocols for the care recovery team; and adopts an evidence-informed structure that includes key recovery dimensions and recovery planning in collaboration with the patient. Reimbursement is comprised of three mechanisms:

1. an episodic bundled payment that is patient-severity stratified,

2. a quality achievement payment, and

3. a coordinated care shared savings performance bonus payment.

(Press release here; full description of APM here.[20,21])

such as diapers, fresh food, and laptop repairs. Because of these interventions, C-section rates in their target population have declined by 23 percent and NICU use by 25 percent. Consequently, the State of Missouri saved an estimated $10–15 million per 1,000 patients (ACLC Case Study Brief available here).[22]

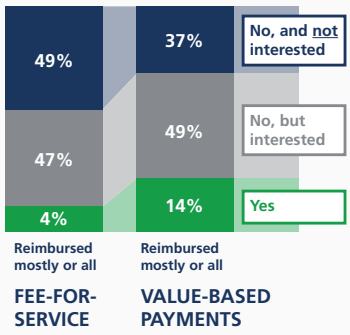
b. Implement medical legal partnerships to improve health. Medical legal partnerships (MLPs) embed legal professionals into health care settings to provide relevant assistance to disproportionately affected patients (article here).[23] These patients include populations of children with asthma triggered by unsafe housing conditions, homeless

PHYSICIAN SURVEY ON SOCIAL DETERMINANTS OF HEALTH

In 2018 Leavitt Partners surveyed a national sample of patients and physicians as part of its Health Intelligence Partners program to understand practices related to SDOH. Of the 2,152 patients who had seen a doctor within the past three months, only 5 percent had been asked about finances and only 6 percent had been asked about food. Many patients who were not asked struggle with these factors, which could influence their health. Of this patient sample, that's over 700 patients struggling with finances who may not be able to afford medication or treatment options; 450 patients dealing with stress that might manifest itself as increased heart rates, depression, anxiety, or chronic headaches; or 300 people who may not be able to get to an appointment or hospital because of a lack of transportation.

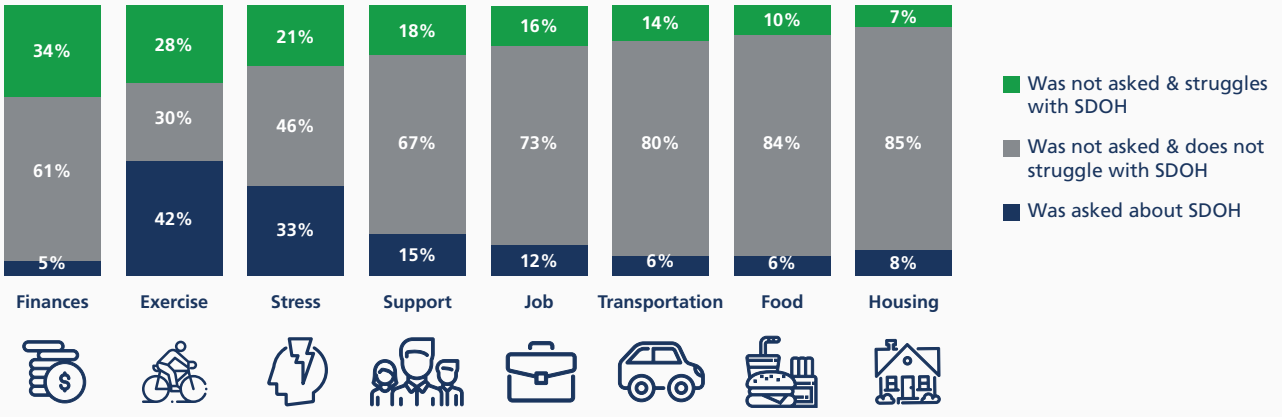
Provider organizations that have adopted APMs have more flexibility to allocate resources to proactively address SDOH factors for patients with rising risk. Leavitt Partners' survey found that physicians who were mostly or completely reimbursed through value-based payments were more likely to report reimbursement for SDOH factors and expressed more interest in doing so. Of physicians getting paid through a fee-for-service model, only 4 percent are getting reimbursed for addressing SDOH compared to 14 percent of those under a value-based payment model. These results are indicative of the increased flexibility and incentives for physicians in an ACO model to transform their practices and incorporate the care patients need—medical and social—to maintain their health.

Do you participate in payment arrangements that reimburse for social determinants of health activities?



Leavitt Partners' annual Health Intelligence Survey found that physicians that are paid mostly or completely through value-based payments arrangements are more likely to be reimbursed for addressing SDOH and are more likely to be interested in doing so.

Patients Screened for SDOH Factors



Doctors are missing opportunities to screen patients for SDOH challenges. Very few patients that saw a doctor within the past three months reported that their doctor screened for SDOH factors.

people, and those with physical and mental disabilities. A pilot program organized by Lancaster General Health found that of the 55 patients enrolled, 52 had two or more civil legal problems that had an impact on their health care use. Connecting these patients to legal help has led to a healthier set of patients and, consequently, less health care dollars spent.

Recommendations

As provider organizations target the rising-risk population, they should consider that some patients may require non-clinical interventions to address SDOH factors to meet their health care goals. ACOs should develop a care model designed to identify patients affected by SDOH, involve an interdisciplinary team to meet their needs, and allocate resources to support these efforts.

ACTIONS TO CONSIDER:

- **Seek payment relationships that allow for flexible revenue to invest in resource-rich services that aren't tied to a face-to-face treatment service**
- **Form teams with other health professionals—such as dieticians, therapists, and community health workers—to complement care provided in the physician's office**
- **Collaborate with community-based social service providers who are well suited to address social support needs**

AFTER: CONNECT RISING-RISK PATIENTS TO BEHAVIORAL AND LIFESTYLE CHANGE SUPPORT GROUPS.

After a patient leaves the clinical setting, health care providers often find it difficult to provide the ongoing support that rising-risk patients may need, including behavior and lifestyle changes and coaching. To promote health decisions that could keep a patient's risk from progressing, ACOs can facilitate patient access to that necessary, continuing support outside of the clinical setting. Incorporating community services with traditional clinical care can help to extend preventive care plans into a patient's daily life. To inform their community partnership strategy, ACOs should analyze which community organizations and services can meet these needs that impact clinical outcomes.

Entities adopting APMs are finding creative and meaningful ways of connecting with community partners, connecting the rising-risk population to prevention and lifestyle programs that target healthy living goals, such as smoking cessation or weight loss. Consider the following examples.

1. **Encourage fitness and healthy living.**

   The West Baltimore Primary Care Access Collaborative, composed of 16 provider systems and community organizations, was awarded a $5 million grant in 2013 to reduce cardiovascular disease in West Baltimore.

As part of this program, they sent community health workers into the community to establish fitness classes (such as community dance exercises and yoga) to create fun, culturally accessible ways to exercise (article here).[24]

2. **Encourage healthy eating.**

   The Montefiore Health System ACO, which serves over 400,000 patients in the Bronx, partners with community organizations to address the complex health and social needs of Montefiore's patients (article here).[25] They have deployed creative solutions to promote healthy eating, including working with local bodega owners to stock fresh fruits and vegetables, distributing "Health Bucks" to use at farmers' markets, and experimenting with fruit and vegetable "prescriptions."

3. **Refer patients to the CDC's National DPP lifestyle change program.**

   Loma Linda University Health (LLUH) recently implemented a National DPP lifestyle change program that helps patients understand their nutritional and exercise options and how those options can slow or halt the progression of prediabetes. With AMA support, LLUH launched a program targeted to select individuals with prediabetes (article here).[26] The 12-month program includes 29 classes and financial incentives for hitting certain metrics. LLUH hopes the program will lead to more funding and greater access for those with rising risk of developing diabetes.

Recommendations

Providing ongoing support to patients—especially the rising-risk population—beyond the clinical setting can be daunting if ACOs only consider their current resources. ACOs should identify gaps in their ability to provide behavioral support to patients after the clinical care setting and partner with community organizations to help patients make lifestyle changes outside of the clinical care setting.

ACTIONS TO CONSIDER:

- **Establish proactive, creative strategies to encourage healthy living at home**
- **Map options for offering these lifestyle change programs, whether within the health system or contracting with a community or a virtual provider**
- **Evaluate your options; the AMA can consult with you to help frame a decision and get started**

NATIONAL DIABETES PREVENTION PROGRAM (NATIONAL DPP) LIFESTYLE CHANGE PROGRAM

The CDC-recognized National DPP lifestyle change program is a structured program—in person or online—for people who have prediabetes or are at risk for type 2 diabetes (outlined here).[27] Studies suggest these programs can help patients reach health goals. One study demonstrated that patients who attend 17 or more sessions average 5 percent weight loss (abstract here).[28] Another study through a digital behavioral counseling service found that, within 12 months, the average participant lowered their five-year risk for diabetes (-30 percent), stroke (-16 percent), and heart disease (-13 percent) (article here).[29]

To help health systems, physicians, and care teams bring a diabetes prevention program to rising-risk patients with prediabetes, the AMA developed an initiative to prevent type 2 diabetes (available here).[30]

CONCLUSION

Both the AMA and Leavitt Partners believe that effectively identifying and addressing the health needs of the rising-risk population will lead to overall population health gains. Health systems that have adopted APMs are signaling that improved population health is of value.

ACOs should continue to pursue strategies that give flexibility to care not only for the sick, but also for a population's health. For guidance and support, physicians and health system leaders who are committed to adopting a prevention strategy can turn to the AMA, Leavitt Partners, and the Accountable Care Learning Collaborative to help transition toward creating healthier communities.

ACKNOWLEDGEMENT

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Abbreviation	Meaning
ACO	Accountable care organization
AMA	American Medical Association
APM	Alternative payment models
BMI	Body Mass Index
BP	Blood Pressure
CDC	Centers for Disease Control and Prevention
CMMI	Center for Medicare & Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
CPC+	Comprehensive Primary Care Plus
CRISPI	Clinical RISk Prediction Initiative
DPP	Diabetes prevention program
FFS	Fee-for-service
EHR	Electronic health records
LLUH	Loma Linda University Health
MAP protocol	Measure accurately, Act rapidly, Partner with patients
MDPP	Medicare Diabetes Prevention Program
National DPP	National Diabetes Prevention Program
NICU	Neonatal, Intensive Care Unit
SDOH	Social determinants of health

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