Aledade

Beyond Clinic Walls:

How ACOs Address Social Drivers of Health

ACOs have the infrastructure, expertise and commitment to make longer term investments in population and community health.

In healthcare, you get what you pay for: in the traditional fee-for-service (FFS) system, the Current Procedural Terminology (CPT) **codebook** lays out what the health care system pays for in meticulous detail. However, the effectiveness of the FFS system is reliant on mission-oriented clinicians who go above and beyond CPT codes to improve health outcomes.

With the growing understanding in the last decade of the role of social drivers of health,* **primary care physicians recognize what they do within their clinic's four walls may not be enough for many patients to improve their health.** To have an effect on health-related social needs, clinicians need to participate in community initiatives that connect patients with social services.

The Accountable Care Organization (ACO) model creates the possibility of a return on investment. In an ACO, clinicians may have greater flexibility in how they spend their time and resources as they aren't solely reliant on the narrow margins of FFS.

Our collaboration with physician-led ACOs has illuminated how the ACO model incentivizes clinicians to invest in infrastructure beyond the CPT

codebook to address social drivers of health in their patients and communities.

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At Aledade, value-based care and health equity are inextricably linked, and we are committed to working with practices and clinics to invest in community health and improve the well-being of vulnerable populations. As social drivers of health are a growing area of focus not only for our network but for primary care at large, we set out to capture success stories and best practices from our member practices and health centers. These initiatives focus on:

- Fighting **food insecurity** and promoting healthy eating through food banks and community gardens
- Targeting transportation support to the primary care office or pharmacy, and offering offsite services such as health fairs in the community, blood pressure initiatives in local barbershops and free clinics
- Creating community networks and other community partnerships related to social drivers of health

1We define social drivers of health as the conditions in which people are born, grow, live, work and age, and include factors like socioeconomic status, education, neighborhood and physical environment, employment and social support networks, as well as access to health care.

Our research shows four common threads in ACO community initiatives.

We conducted interviews with primary care organizations in ACO markets nationwide to determine what kinds of initiatives are being implemented, their effectiveness and the policies needed to support their adoption in other markets. While the programs identified during these interviews differed in their approach, amount of resources, community need addressed, size, scale and scope, there were four common threads across each of them:

A data-driven approach

They value being in an ACO; working with Aledade affords them access to a data-driven platform and infrastructure that they may not previously have had. These practices and health centers want actionable data and insights on what is happening with their patients and their community beyond the office visit.

Consideration of patients' holistic health

Participation in accountable, value-based care models means moving beyond CPT-driven, procedure-based medicine and caring for the whole patient. It also enables clinicians to address food insecurity, lack of transportation, barriers to accessing health care and more.

Thrive through local partnerships

The traditional health care system is siloed, which can complicate primary care physicians' ability to coordinate care. ACOs prioritize data-sharing, data transparency and care coordination across the health system. Additionally, collaboration with community-based organizations and volunteers is essential to addressing health-related social needs.

Thrive through local partnerships

Clinicians who join ACOs are willing to upend how they practice medicine and run their organizations in service of higher quality care and true population health. They are primed to work together to improve clinical outcomes for patients, and to take on complex health and social challenges in their communities.

Finally, we outline policy recommendations to support primary care and the physician-led ACO. These include short-term policies such as increased funding as well as longer-term policies like supporting the primary care workforce with a focus on diversity and equity, and supporting and growing ACOs in underserved communities.

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Health equity and value-based care are inextricably linked.

At its core, value-based payment is about leveling the playing field of patient care. In a world of volume-driven reimbursement, clinicians may feel incentivized to deliver more services than necessary. This can also lead to higher out-of-pocket costs for patients - a common deterrent for returning to the doctor's office, particularly for vulnerable populations.

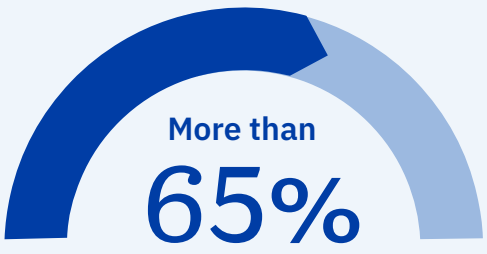
In contrast, clinicians participating in an ACO are incentivized to ensure all patients receive higher-quality, evidence-based care at lower costs. By gaining a deeper understanding of patients' health and social risks through enhanced data streams and preventive services like annual wellness visits, clinicians have an unprecedented opportunity to reduce health disparities.

Although ACO quality measures vary across payers, health equity is an emerging theme in value-based care programs. A prime example is CMS's ACO REACH model, which requires participants to develop and carry out a robust health equity plan to identify underserved communities and implement initiatives to measurably reduce health disparities for beneficiaries.

If health equity is our destination, value-based care is the road that gets us there. Only when clinicians are accountable for the outcomes of their care rather than its delivery can equitable, whole-person care be realized.

Aledade ACO member practices are working to advance equity and address the social of drivers of health in their communities.

In interviewing a small sample of Aledade ACO member practices about what kinds of initiatives they were developing and implementing in their communities, we found four common themes in all programs.



of the primary care organizations that we worked with in 2021 are in a Primary Care Health Professional Shortage Area.

A data-driven approach

A family-run practice in Arkansas tackles a range of social drivers through clinic work and their foundation.

For **Dr. Derek Lewis and his son, Derek Lewis II**, primary care and family medicine is a family affair.Derek Lewis II works with his father to run both their family medicine practice at the Arkansas Primary Care Clinic and the Derek Lewis Foundation. Derek Lewis II said thinking about social drivers of health and health equity is baked into everything they do as a clinic and as a foundation. They work with community organizations to take on issues ranging from health literacy and housing to food insecurity, transportation and more.

The practice sees many uninsured and underinsured patients. Lewis II noted the structural issues in his community such as access to primary care and the longevity of the independent primary care workforce, as well as a shortage of behavioral health specialists.

Being a part of Aledade and a member of an ACO helps the practice address some of these structuralbarriers by supporting improved care delivery through better processes and data. The structure of Annual Wellness Visits (AWV) and Transitional Care Management (TCM) visits, which are incentivized in the ACO model, gives the clinicians insight into their patients' lives beyond the four walls of the practice.

"The work that we do from an ACO perspective is an opportunity to have these difficult conversations with our patients," Lewis II said. "We have to think about why we have no-shows and help them get to their appointments."

The ACO infrastructure provides actionable insights that shape patient care beyond the four walls of the clinic.

Dr. Randy Walker has been practicing in De Queen, Ark., for 20 years, and his wife Angie serves as office manager of their clinic, Dr. Randy Walker Family Practice and Allergy Clinic. The clinic offers several community-based initiatives, including an onsite food pantry, a dedicated transportation service for patients who are unable to attend appointments or obtain prescriptions, and community health fairs that offer free screenings and opportunities for individuals to learn about community-based services.

Angie Walker shared how being part of an ACO has helped the clinic be proactive about the challenges their patients face. Joining an ACO gave the care team access to more data, which showed there were five times the number of diabetic patients as initially estimated. Working with Aledade has enabled staff to reach out to patients who aren't regularly seeking treatment.

A similarly proactive approach has been adopted for specialist visits. "We used to refer patients all the time, but we often couldn't close the circle. Did the specialist take over? What happened?" she said. "Getting into value-based care, we can close that circle. We know what happens and can follow the patient [through the care journey]."

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> **– Angie Walker, Office Manager at Dr. Randy Walker Family Practice and Allergic Clinic**

Thrive through local partnerships

Providing a network of community volunteers for a Colorado community.

Dr. Glenn Kotz runs a solo practice in Basalt, Colo., that is involved in several community-based initiatives:

- Helping a local mobile home community build a network of community support to depend less on emergency services like EMT and ambulances for nonemergencies
- A food bank staffed by volunteers from the local family medicine residents program, pharmacy and physician assistant students, and licensed clinical social worker interns
- A long-standing, grant-funded substance use disorders program that provides outpatient detox services and, in partnership with a community organization, offers peer support for patients in recovery

The practice's community initiatives began long before joining an ACO, although the ACO model helps with data infrastructure and supporting patient needs. Dr. Kotz acknowledged that the practice does not receive sufficient reimbursements to fund these programs and emphasized the need for ongoing advocacy to ensure primary care practitioners get paid enough to keep their doors open. It is central to Aledade's mission to advocate for independent primary care and CHCs to be paid fairly, and to evolve the chronic underinvestment in primary care through advocacy around mandated primary care investment at the state and federal level. Dr. Kotz's practice is valued in the community.

The practice receives grant funding from trusted community partners, but there have been times when funding they relied on went away, like in the case of a behavioral health program started a few years ago. The practice had to get creative and leverage relationships to keep offering these services that are critical to the community.

A community garden depends on the community to thrive.

Dr. Oscar Lovelace, the founding partner of Lovelace Family Medicine in Prosperity, S.C., has a two-acre community garden, which supplies three area food banks with fresh, organic produce. The work of launching the garden was initiated through a charitable organization created to assist patients with their medical needs, the Living Water Foundation.

"We have close ties to the community. People trust us. They are willing to donate. They want to be part of improving the health of the community," Dr. Lovelace said.

Dr. Lovelace partners with Clemson University's Creative Inquiry Project to allow student and professor involvement to facilitate and learn from the community project. Clemson students studying food and nutrition sciences and food anthropology have served as volunteers and offered helpful resources.

Much of the maintenance work is sustained by community volunteers lending their time and expertise to making the garden thrive. Dr. Lovelace and his team hold fundraisers to raise money to support the garden and food banks.

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Consideration of the patient's holistic health

Connecting patients to volunteer services helps them to avoid unnecessary Emergency Room use.

Dr. Joseph Weidner runs Stone Run Family Medicine Practice in Rising Sun, Md. In addition to serving patients with health-related social needs, the practice provides ongoing support for the Clinica Medica Primary de Rising Sun, a charitable clinic that serves the local Spanish-speaking community. Through their work in the community, the practice connected with The Open Table, a nonprofit that supports solutions for patients' complex needs and social challenges.

The practice and the clinic recruit patients eligible for The Open Table network partially through standardized social drivers of health screening tools. Those identified with health-related social needs, barriers to care and/or high health care utilization are referred to a support network of volunteers (Network TablesTM), many outside the traditional health care system.

Dr. Weidner notes that being part of an ACO means the practice has resources for care managers to be able to address social needs. This has led to more satisfied patients who recognize that the primary care team's scope of care extends beyond the office visit.

"Patient satisfaction is high from the program, and patients are reporting improvements in health," he said.

Cancellation rates for follow-up care have also dropped. Remarkably, the program has seen a 22% reduction in annualized total health care expenses for Medicare patients who have had their primary support needs met.

Dr. Weidner acknowledges that while the numbers to date are small, these findings have remained consistent as the program grows.

"Being part of the ACO community means we have a group of like-minded individuals with the same incentives (to improve health outcomes), and robust data analytics and tools to measure the outcomes and savings," he said.

The practice had a Maryland Community Health Resources Commission grant that funded the program for two years, with a current one-year extension. Dr. Weidner thinks once the health care savings are realized, he will be able to better sustain the program in the long term.

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– Dr. Joseph Weidner, Stone Run Family Medicine

Drive toward innovative solutions

Clinicians drawn to the ACO model are driven to take on hard challenges.

Dr. Daryl Hershberger runs Redi-Care, Inc., Primary Care, a rural health clinic in LaGrange, Ind., and launched a plant-based diet program after being inspired by a nurse practitioner intern.

The intern connected Dr. Hershberger with Nelson Campbell, President of PlantPure, Inc. and founder of PlantPure Communities, who was filming a documentary on plant-based diets and health. The documentary features Dr. Hershberger and several of his patients who were trying the whole food, plant-based diet. In just 10 days, many of the patients saw their LDL cholesterol drop 30-50 points and lost 8-10 pounds.

Although the practice has been effectively saving the system money by providing excellent patient care, it has been challenging to grow programs like the plant-based diet initiative due to lack of financial return. The practice has had to rely on grant funds to sustain the program, which now includes a support group as well as educational resources, meal starters and recipes. Dr. Hershberger joined Aledade in 2023 and, as a new member of the ACO community, hopes to be able to expand the program by securing more resources, training additional staff, and focusing on strategies to promote long-term sustainability.

The ACO model helps with sustainability.

Dr. Oscar Lovelace talked about how it can be difficult to find sustainable funding for innovative community initiatives like his community garden.

In the early years of his practice, he had a partnership with a university that was supporting rural medicine training programs. This partnership enabled him to help train residents in rural primary care. But, as sometimes happens when priorities or leadership of big organizations change, the program was abruptly canceled and the practice could no longer count on those resources.

Working with the ACO and with Aledade, who have shared goals and are in it for the long term, is helpful to independent practices working on community programs that address social needs. The mindset to take on risk and try new programs, based on the evidence, is prevalent in the kinds of organizations that join an ACO. The ACO and Aledade community have the mission and vision to support independent primary care and help transform the system for patients and communities.

The ACO model helps extend a practice's reach into the community.

Dr. Sanjay Batish, of Batish Family Medicine in Leland, N.C., wanted to launch a program targeting the identification and control of hypertension in Black men in his community.

Fifty-nine percent of Black men in the U.S. are living with hypertension – clearly, innovative solutions are needed. Researchers have been

studying whether or not addressing hypertension outside the traditional health care system, in a familiar and comfortable location like the local barbershop, could be an effective intervention. A 2018 study in the New England Journal of Medicine demonstrated success, and communities around the country are trying to scale the intervention.

For Dr. Batish's program, which is in its early stages, medical assistants spend time in a Black-owned barbershop to obtain and monitor the blood pressure of the patrons who opt to be screened. When elevated blood pressure readings are discovered, patrons are encouraged by the medical assistant and the barber to make lifestyle changes or seek care from their primary care team.

Aledade recognized the challenge of controlling hypertension in Black populations and worked to provide education and resources to primary care organizations to address this issue.

"We as the Aledade community of clinicians are trying to think creatively about solutions to real problems. Prior to Aledade, I had to think of everything. Being part of this ACO community, I had ready-made resources and materials, experts and encouragement for my idea," Dr. Batish said.

While the challenge of hypertension in health care was not new, Aledade's focus enabled Dr. Batish to more closely examine barriers in his community and patient population. Dr. Batish also had the benefit of having an Aledade intern, Neil Khot, working with his practice. Neil was able to handle the logistics so Dr. Batish could focus on patient care.

The Aledade intern program was piloted in North Carolina, and there are plans to expand in the coming months. It is one example of an initiative that Aledade has rolled out to ease **primary care workforce shortages.**

The program places interns – students in pre-med programs or who are pursuing nursing, pharmacy and other allied health professional degrees – into Aledade ACO member organizations to provide them real-world experience in independent primary care and accountable care models. The interns work on an initiative that benefits the community, such as the barbershop program.

A CHC takes on the challenge of food insecurity during the pandemic.

Judd Semingson is the chief operating officer of Community Clinic NWA, the youngest Federally Qualified Health Center in the state of Arkansas. As for many across the country, the height of the COVID-19 pandemic was challenging for northwest Arkansans. Community Clinic partnered with other groups in the area and began a meal delivery program for patients in quarantine.

This has developed into an enhanced case management program that involves working with local growers and participating in a community-supported agriculture (CSA) program to help patients access fresh fruits and vegetables. Given that many of the clinic's patients work in food plants, improving their health has the potential to benefit the broader community by ensuring the availability of food produced in northwest Arkansas.

The grant-funded CSA program and community partnerships are very successful, and Semingson aims to create more customized opportunities as they expand. This includes tailored meal plans to help patients with diabetes and high blood pressure stay healthy.

Semingson appreciates the collaborative approach that comes with participating in an ACO and values learning from similarly missioned organizations working to enhance patient health in Arkansas, while improving quality and reducing costs. Having access to best practices helps him and the Community Clinic continue their work at a high level.

Drive toward innovative solutions

We put forth the following policy recommendations legislators and regulators should consider to advance the ACO enablement model of going beyond the codebook to address social drivers of health.

Incentivize primary care organizations to join ACOs. ACOs are designed to solve for the "you get what you pay for" shortcomings of the CPT codebook-based system of care. Recognizing this, CMS has **set a goal** of having 100% of Medicare beneficiaries in an accountable care model by 2030. To reach this goal, CMS and Congress should work to create a viable environment for practices and health centers in rural areas as well as health professional shortage areas to join ACOs.
This means:

- Addressing benchmarking policy flaws in the Medicare Shared Savings Program such as the **"rural glitch"** and the regional **risk cap** issue that systematically penalizes certain ACOs when they are successful at delivering better care at lower costs. Many of the ACOs affected by these policies are located in areas where there is a shortage of health professionals, such as rural areas and underserved communities. Fixing these policy flaws can potentially increase participation in accountable care in underserved communities and rural areas.
- Investing in primary care and ACOs by ensuring financial feasibility for physicians through incentives like student loan forgiveness programs for new physicians practicing independent primary care, county-based workforce assistance funds and rural physician tax credits, including for rural physician preceptors who help train medical students.

Waive cost-sharing for patients in primary care value-based models. These case studies highlight the fact that addressing social drivers of health requires trust and commitment from primary care teams.

We should be using incentives to encourage longitudinal primary care relationships. Eliminating cost-sharing for patients in accountable care and advanced alternative payment models where there are no incentives for overuse makes good policy sense. It will also reduce administrative burden for practices that spend unnecessary and costly time and energy chasing after payments from low-income patients that may eventually be forgiven.

Use Medicaid levers to advance the transition to value including investment in data and technology infrastructure to facilitate screening and navigation. Bolstering the Medicaid program is essential to addressing social drivers of health. Policies should focus on strengthening primary care relationships and connecting patients to not only high quality preventive care and chronic care management services, but also social services. Policies to advance value and social drivers of health infrastructure in Medicaid include:

- Allow states to use their 90% Federal Medical Assistance Percentage (FMAP) funds to invest in data infrastructure to link together providers and social services and facilitate a closed loop referral platform
- Use Section 1115 waivers to enable clinicians in underserved communities to transition to value-based care with upfront state investment (North Carolina is an example of a state using a 1115 Waiver to integrate a standardized screening process, referral system, care coordination and enhanced programming within the Medicaid program through its innovative Healthy Opportunities Pilots program.)
- Establish state-specific enforceable medical loss ratios and risk corridors to encourage Medicaid managed care plans to focus on value arrangements while ensuring financial protection in the initial learning phase

The physician-led ACO model aligns financial incentives with incentives of mission-driven primary care clinicians.

These case studies are just a snapshot of how independent primary care practices and CHCs are leveraging the ACO model to extend services beyond the clinic and their patient population to address social drivers of health.

Advancing these and other initiatives will require data sharing and analytics that deliver actionable insights to clinicians, trusted partnerships with other health care and community stakeholders, the ability to have a holistic view of an individual's health and social needs, and innovative, creative ideas.

We look forward to continued collaboration with our ACO members, fellow travelers in the accountable care community, health plans and policymakers to build the evidence base around improving the landscape for ACOs and tackling social drivers of health.

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