THE EVOLUTION & FUTURE OF VALUE-BASED CARE

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Foresight Health Solutions

WAIANAE COAST COMPREHENSIVE HEALTH CENTER

- Established 1972 as a community-driven response to the lack of health care providers available on the Waianae coast.
- In 2022, served over 35,000 patients through over 200,000 encounters from the main clinic and satellite sites.
- Largest employer on the Waianae coast with nearly 650 employees – most of them residents of the community.


Advertiser MORNING HOME

Waianae Sugar Plantation Will Quit Business

Labor Costs, Rising Prices Force Action

ADDRESSING SOCIAL DETERMINANTS OF HEALTH

COMMUNITY HEALTH SERVICES

ENABLING SERVICES

- Transportation, interpreter services, outreach, case management, eligibility services
- Added Patient Support

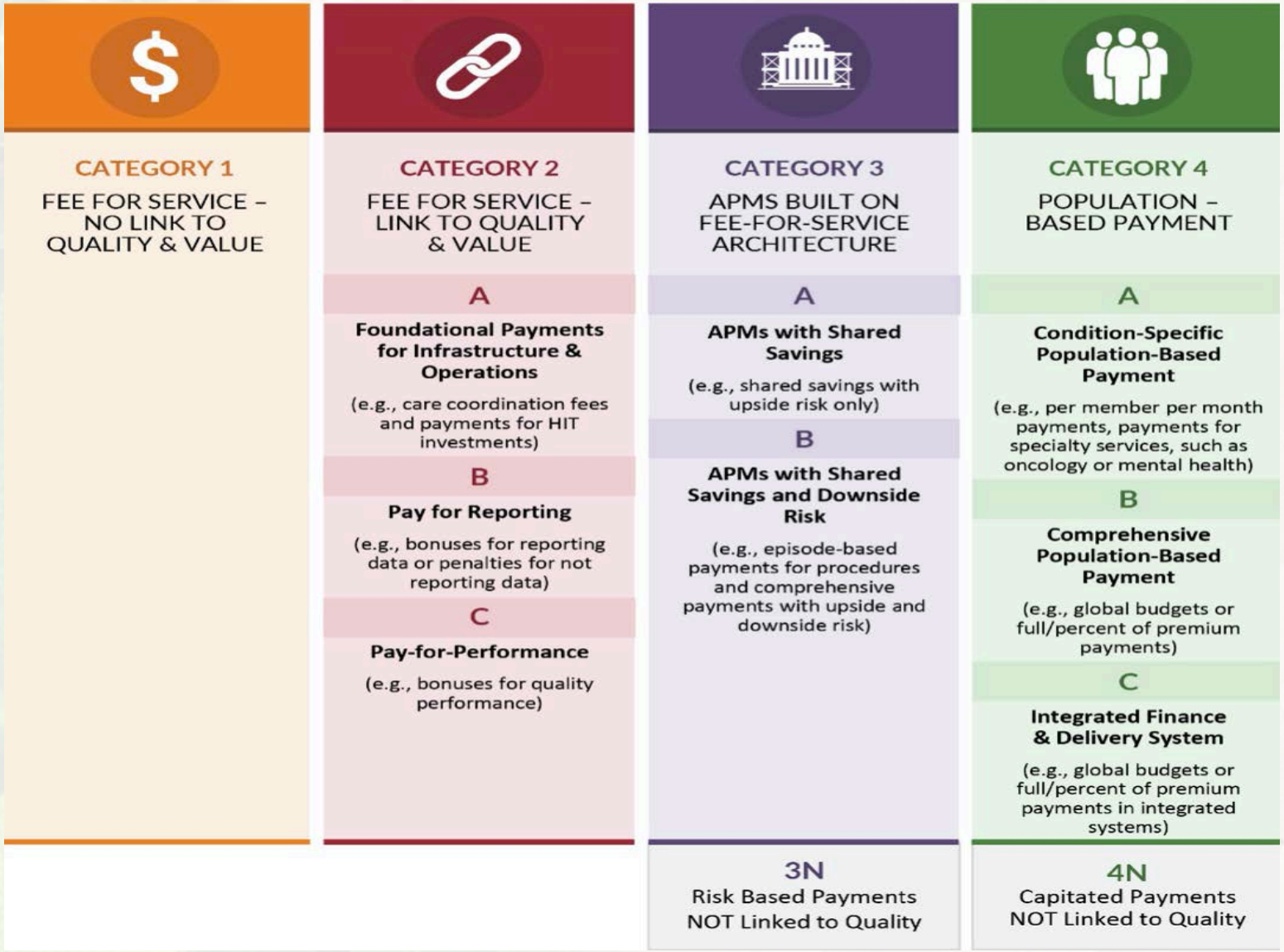
LONG HISTORY

- 1991 Perinatal program established
- 1995 Homeless Outreach

ADDRESSING SOCIAL DETERMINANTS OF HEALTH

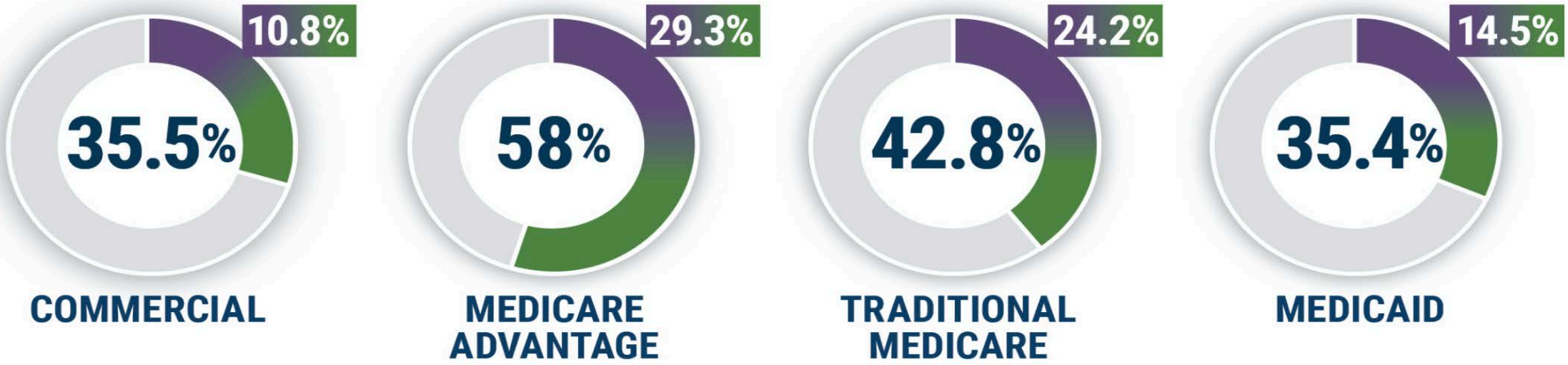
- Enabling codes
- Over 200+ enabling codes used to capture services
- Through Foresights analytic tools, consolidated codes to a list of manageable & impactful codes
- One of four sites Nationally funded to create, implement and promote a standardized patient risk assessment tool used to identify SDoH.
- Responding to positive survey results

VALUE-BASED PAYMENT CONTINUUM



CURRENT VALUE-BASED PAYMENT MODELS

In **2020**,
40.9% of U.S. health care payments, representing approximately **238.8 million** Americans and **80.2%** of the covered population, flowed through Categories 3&4 models. In each market, Categories 3&4 payments accounted for:

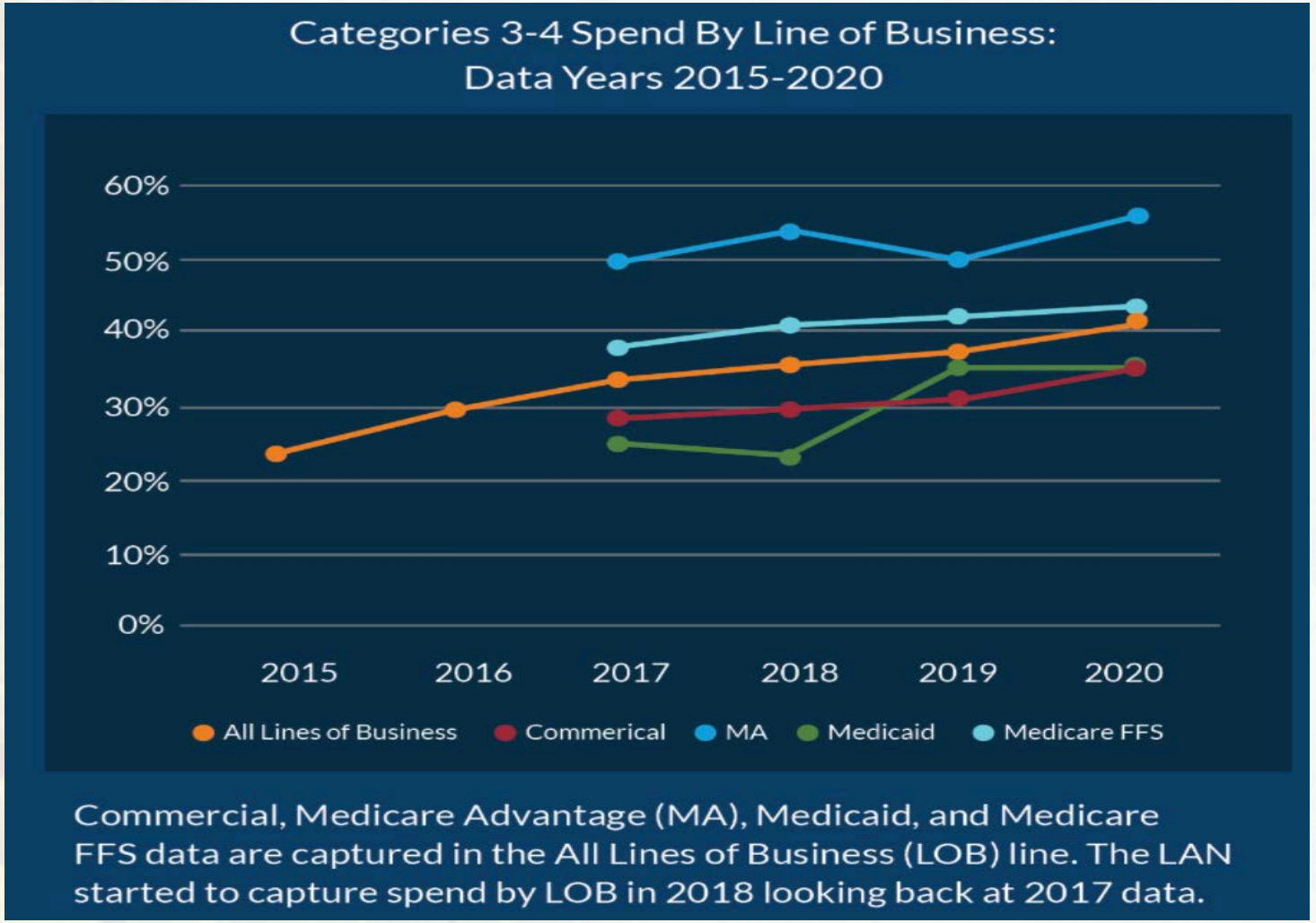


% *Combination of Categories 3B, 4A, 4B, & 4C Represents Two-Sided Risk APMs

Representativeness of covered lives: Commercial - 62%; Medicare Advantage - 67%; Traditional Medicare - 100%; Medicaid - 64 %

Source: *Measuring Progress: Adoption of Alternative Payment Models in Commercial, Medicaid, Medicare Advantage, and Traditional Medicare Programs*. Health Care Payment Learning & Action Network. 2020

TRENDS IN RISK-BASED VALUE-BASED PAYMENT MODELS



Source: *Measuring Progress: Adoption of Alternative Payment Models in Commercial, Medicaid, Medicare Advantage, and Traditional Medicare Programs*. Health Care Payment Learning & Action Network. 2020

CHALLENGES IN CURRENT VALUE-BASED MODELS

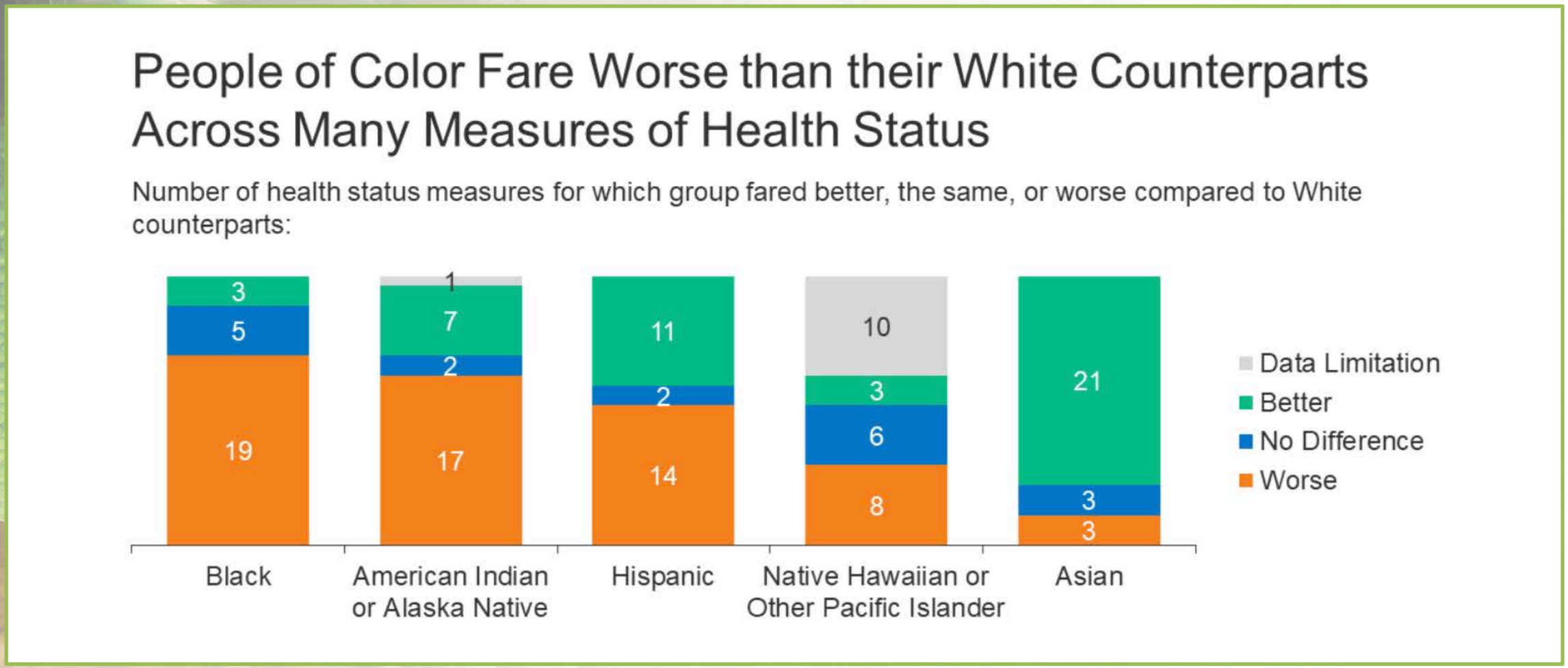
- **Fragmentation of medical services from social support services:**
  - Limited funding within VBC models for SDoH services
- **Conflict between value-based care's cost containment goals and health equity:**
  - Inherent tension between most value-based models that emphasize decreases in health service utilization/costs and health equity goals such as improving healthcare access
- **SDoH risk factors not factored into risk-adjustment of population-based VBC payments to providers**
- **Inconsistent inclusion and participation in VBC across different provider types:**
  - FQHCs have not been involved in many of the pilot VBC programs
  - Participating providers may serve clients with fewer social disparities and complexity, potentially resulting in growing health inequities

HEALTH EQUITY IN CURRENT VALUE-BASED PAYMENT MODELS

Very few Plans are risk-adjusting VBC payments for SDOH disparities

Source: *Measuring Progress: Adoption of Alternative Payment Models in Commercial, Medicaid, Medicare Advantage, and Traditional Medicare Programs*. Health Care Payment Learning & Action Network. 2020

GROWING HEALTH INEQUITIES IN MARGINALIZED GROUPS

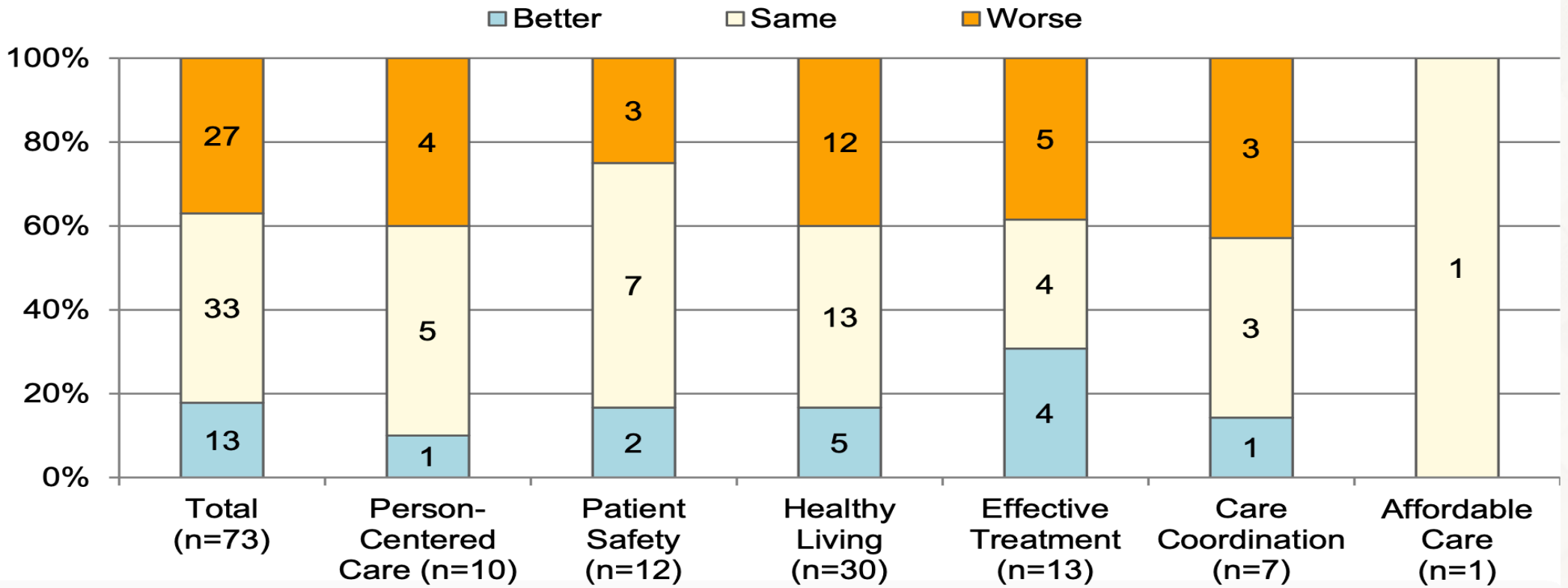


Source: *Kaiser Family Foundation and "Disparities" Healthy People 2020.*

GROWING HEALTH INEQUITIES IN MARGINALIZED GROUPS

Disparities in Quality of Care for Native Hawaiian and Pacific Islander Populations

Figure 24. Number and percentage of quality measures for which Native Hawaiian/Pacific Islander groups experienced better, same, or worse quality of care compared with White groups for the most recent data year, total and by priority area, 2018, 2019, or 2020



Key: n = number of measures.

Source: The *National Healthcare Quality and Disparities Report, AHRQ, November 2022*

IDEAL COMPONENTS OF VALUE-BASED PAYMENT MODELS

- **Address Fragmentation**: Manage medical, behavioral and social needs in an integrated care model
- **Fairness**: Ensure equity within vulnerable, marginalized patients by addressing those with significant SDoH risks
- **Funding:** Build adequate financial incentives for community-based organizations to address complex care and social support needs of high risk patients
- **Focus:** Targeted focus on marginalized communities and effective and impactful care enabling services

GOALS IN SEEKING A DIFFERENT APPROACH TO VALUE-BASED CARE

1. **Address the fact that typical attributed health plan risk pools are not adequately risk adjusted:**
    - Native Hawaiians experience early on-set of chronic disease not recognized by
    - Multi-generational Hawaii communities in rural areas experience more continuous utilization patterns than less stable urban populations.
2. **Prove the value of services we intuitively believe positively affect outcomes while not often supported by payers.**
    - Power of Community Engagement
    - Care Enabling Services
    - Social Services
3. **Support innovative network of early adopters actively engaged with community transformation.**
4. **Shift percentage of total VBC reimbursement to at least 20% revenue potential.**

PHASING ADOPTION OF INNOVATION

An FQHC Value-based Payment Model

- Health Centers can phase in level of engagement
- Project sets stage for research related activity and more effective risk adjustment
- Addresses unique cultural and epidemiological characteristics of multi-generational Hawaiian communities
- Model can be applied to other FQHCs willing to adopt rigorous data aggregation process

PHASE ONE	Establishing minimum data for FQHC (Care enabling codes, SDOH data, Financial Data – Foresight Analytics)
PHASE TWO	Partner with health plans in identifying high-risk cohort (Investing in systems to manage this cohort)
PHASE THREE	Initiate shared savings component linked to improvement over baseline on high-risk cohort
PHASE FOUR	Develop network of community-based social service agencies, agreeing to network services and share data

FORESIGHT HEALTH SOLUTIONS

Mission – To develop AI-driven analytic solutions to accurately predict and promote optimal health for vulnerable populations by:

- Collecting data from diverse and often non-traditional sources, including: claims, EMRs, care management, social, environmental and economic data;
- Using proprietary models to accurately predict health risks, costs, adverse outcomes and health disparities;
- Identifying the most effective actions to mitigate and reverse adverse outcomes, costs and disparities

CLINIC-PAYER PARTNERSHIP GOALS

- Collect and use SDoH, diagnostic, and demographic data to develop a comprehensive risk and impact score for all patients.
- Use this AI-based risk model to collaboratively identify a cohort for high-risk care coordination.
- Develop value-based contracts with financial incentives for health centers to address social inequities, medical risks and reduce costs.
- Collaboratively realize greater cost efficiencies and savings for optimal health outcomes through shared financial incentives.

FORESIGHT/WAIANAE – MINIMAL DATA REQUIREMENTS

REQUIREMENTS:

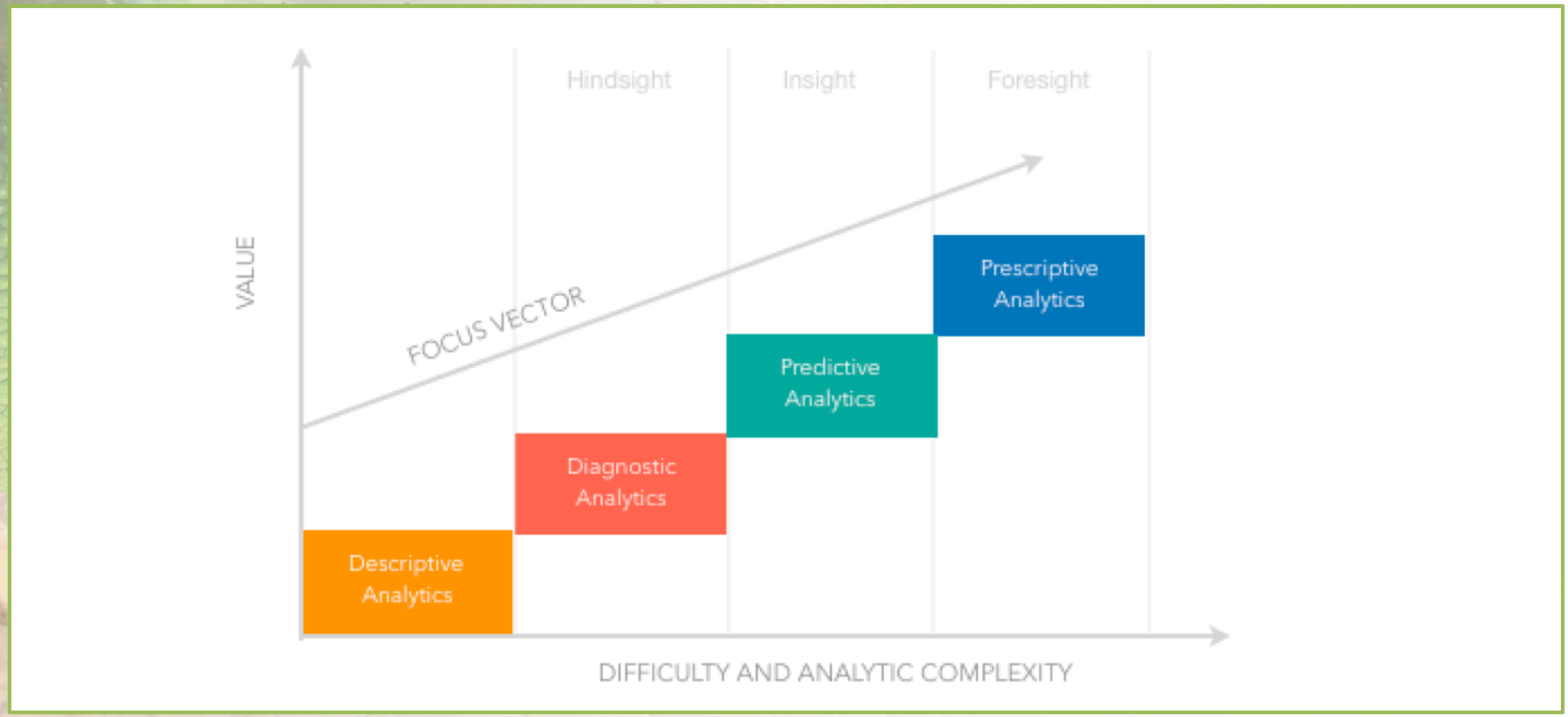
- Demographics
- SDoH data
- Diagnostics
- Care Interventions & Enabling Services – semantically grouped
- 1 year Patient Data
- Coverage: near complete data for 3,000 or more patients

DESIRED:

- Claims
- Cost
- 100% coverage
- 3 years data
- EMR notes
- Patient addresses
- Race and ethnicity
- Payer, health plan, Medicare/aid eligibility
- Enrolled periods
- Care coordinator attribution data

FORESIGHT HEALTH SOLUTIONS AI FOCUS

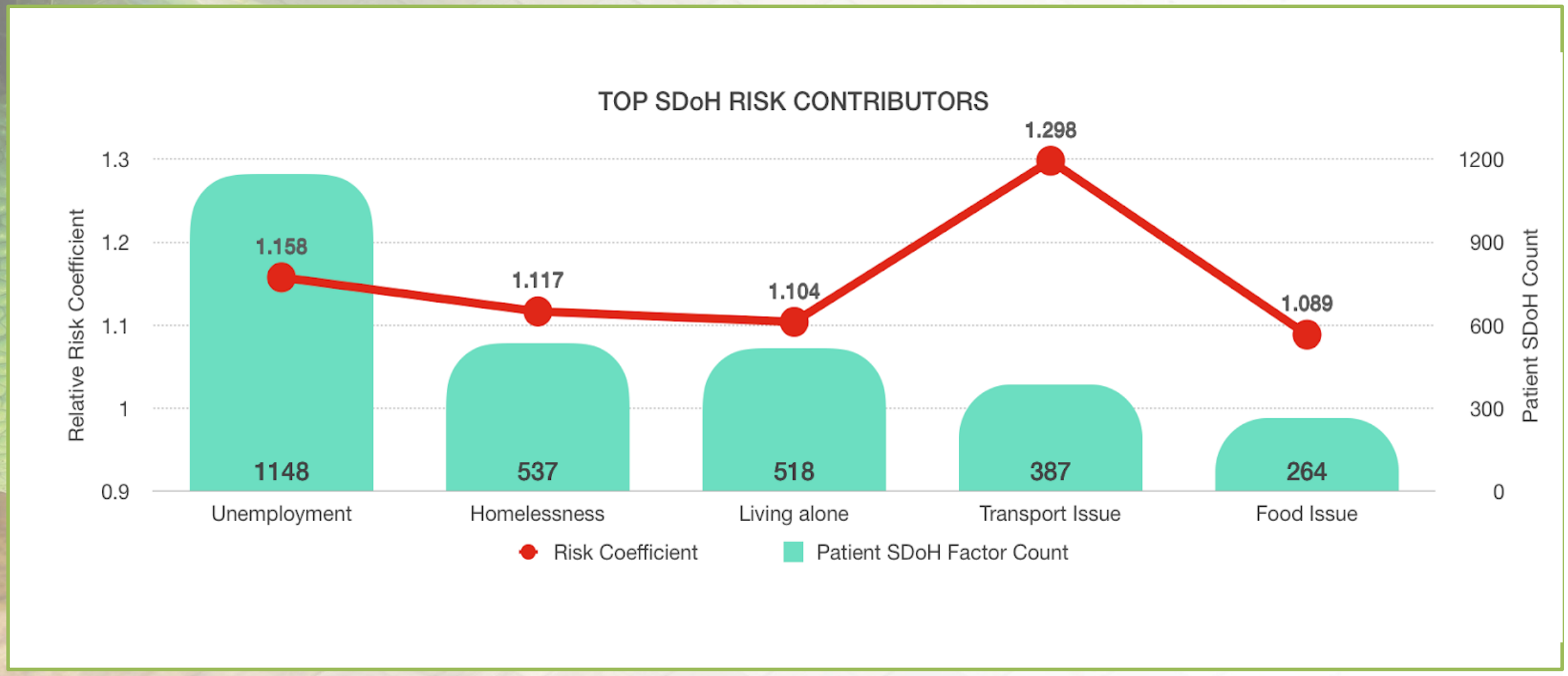
Mission *– Use AI-driven analytic solutions to predict, promote and preserve health for the vulnerable*



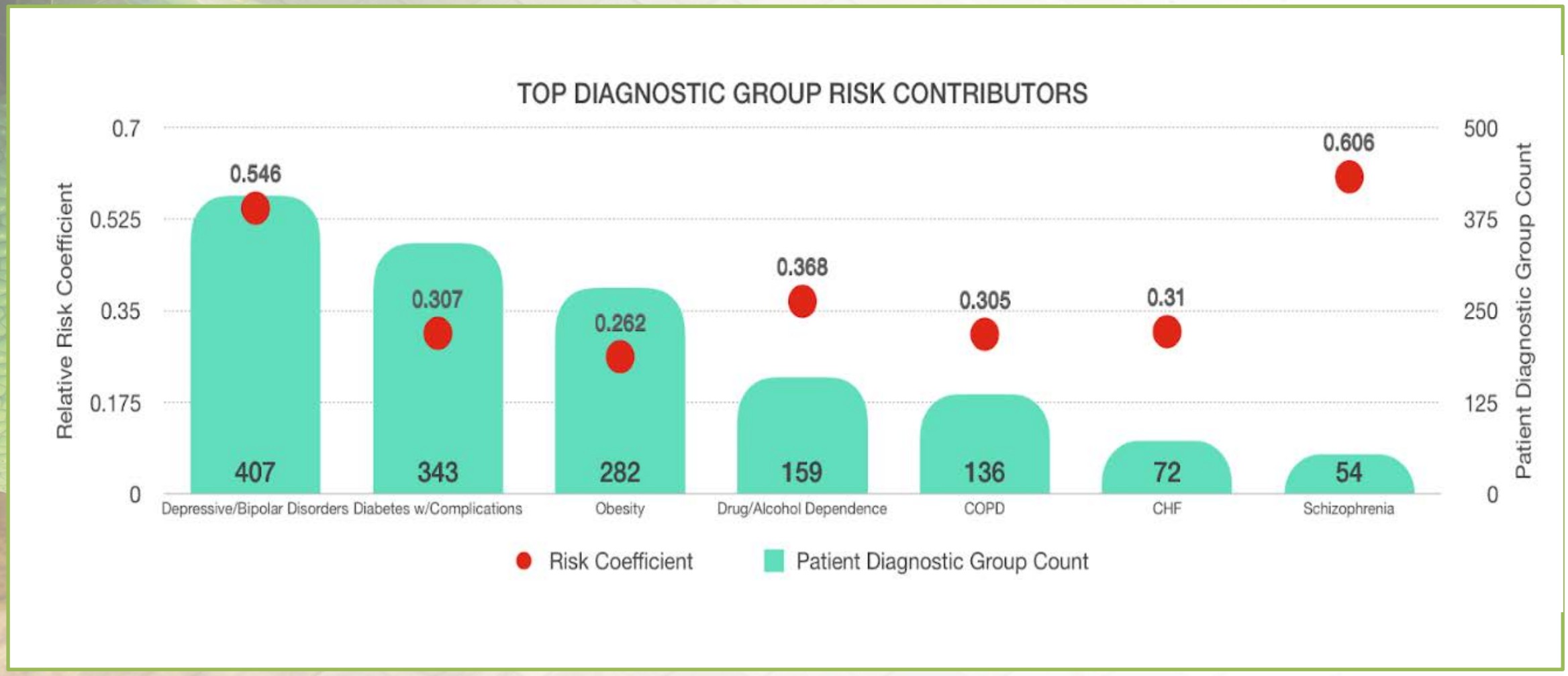
FORESIGHT'S COMPREHENSIVE RISK MODEL

- Predicts future claims costs per patient or per cohort:
  - ***Prediction accuracy within 6.9%*** *of actual, observed costs*
- Based on Social Determinants of Health (SDoH) *and* clinical data *and* other non-traditional data sources
- 60% greater accuracy (R^2) for the WCCHC population than the standard CMS clinical model

SDOH RISK CONTRIBUTORS



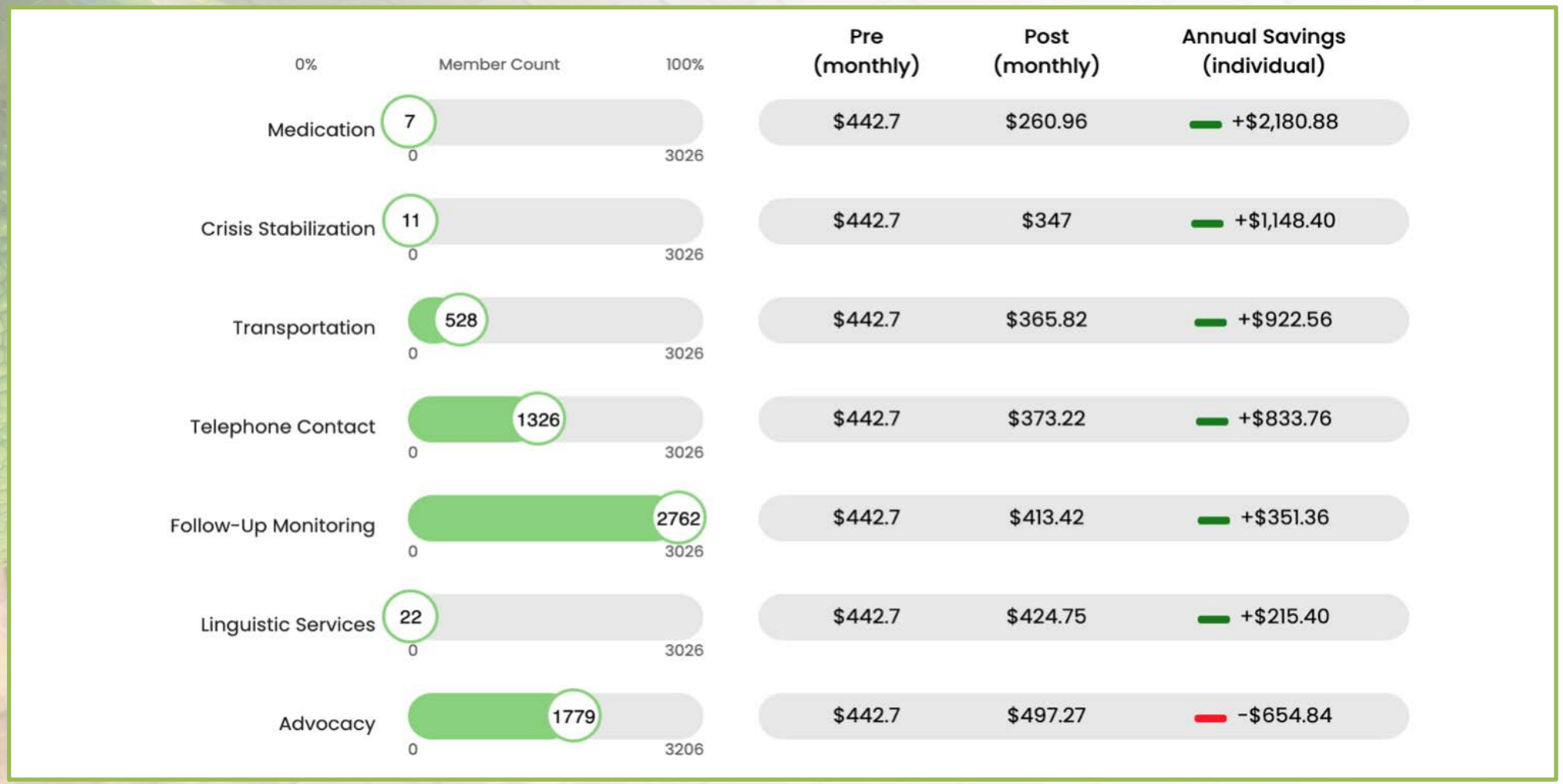
MEDICAL RISK CONTRIBUTORS



NATURAL LANGUAGE PROCESSING UNCOVERS SDOH LOCKED-AWAY IN EMR NOTES

Foresight Health Solutions & WCCHC 2022

SAVINGS DUE TO ENABLING SERVICES



PILOT CONTRACT DEVELOPMENT

- Value-based contracts implemented with 2 Health Plans on March 1, 2021
- High risk/high cost cohort populations were identified for each Health Plan
- Baseline risk levels and cost measured for cohorts for 2020
- Monthly claims combined with EMR data analyzed monthly to guide care coordination teams and monitor progress

FHS PATIENT IMPACTABILITY SCORE

- Complementary to the FHS Comprehensive Risk Score
- Expresses the probability with which care interventions will have a positive impact on each patient
- Considers factors such as the type of clinical and SDoH contributors, ER visit frequency, avoidable inpatient hospital admissions, and previously provided care services

BASELINE HIGH-RISK VALUE-BASED COHORT

High Risk Cohort Size

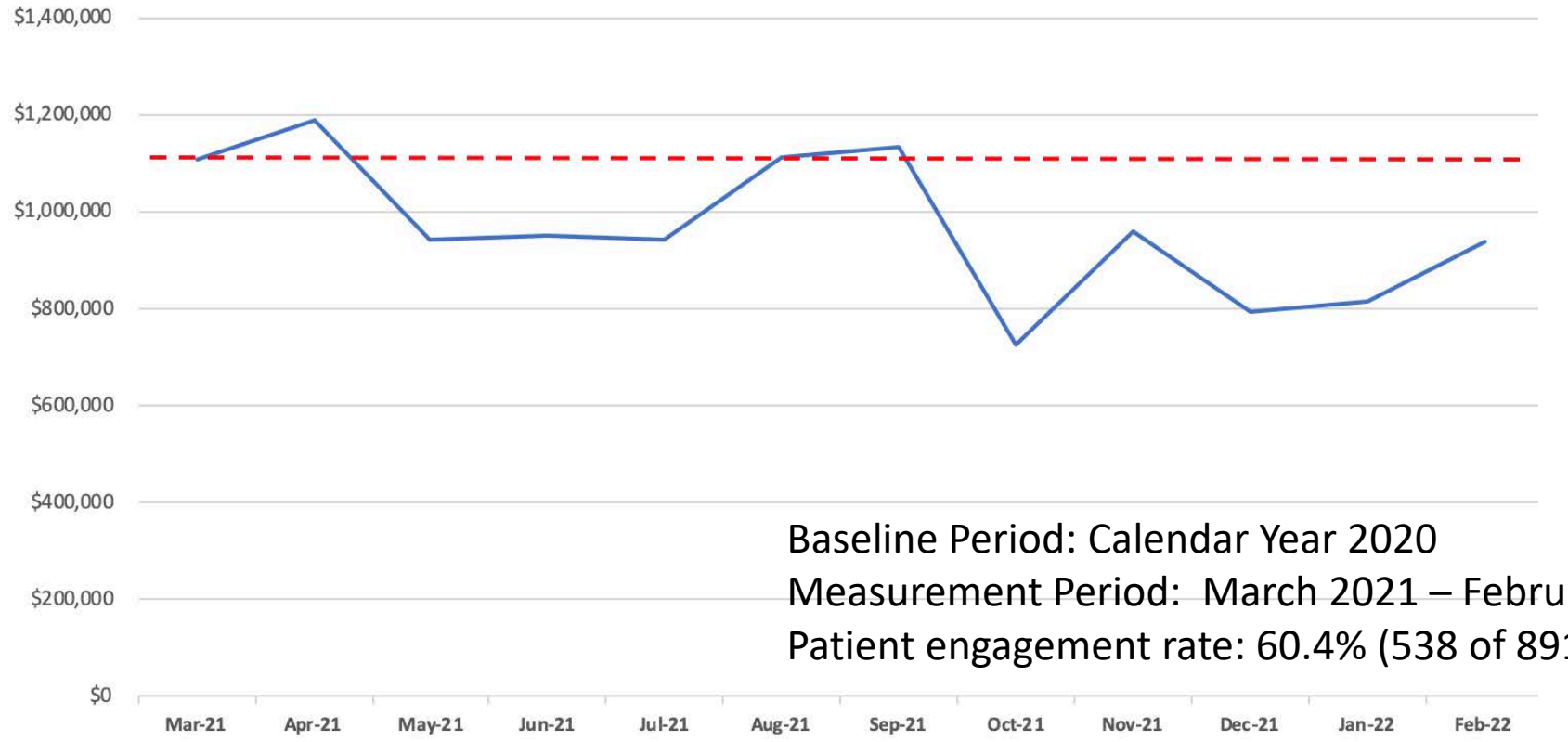
- Health Plan A – 891
- Health Plan B – 931

Baseline Costs in 2020

- Health Plan A – Total cost of $13,353,669
- Health Plan B – Total cost of $7,801,521

COHORT TOTAL COSTS – HEALTH PLAN A

Avg baseline monthly cost: $1.11 million

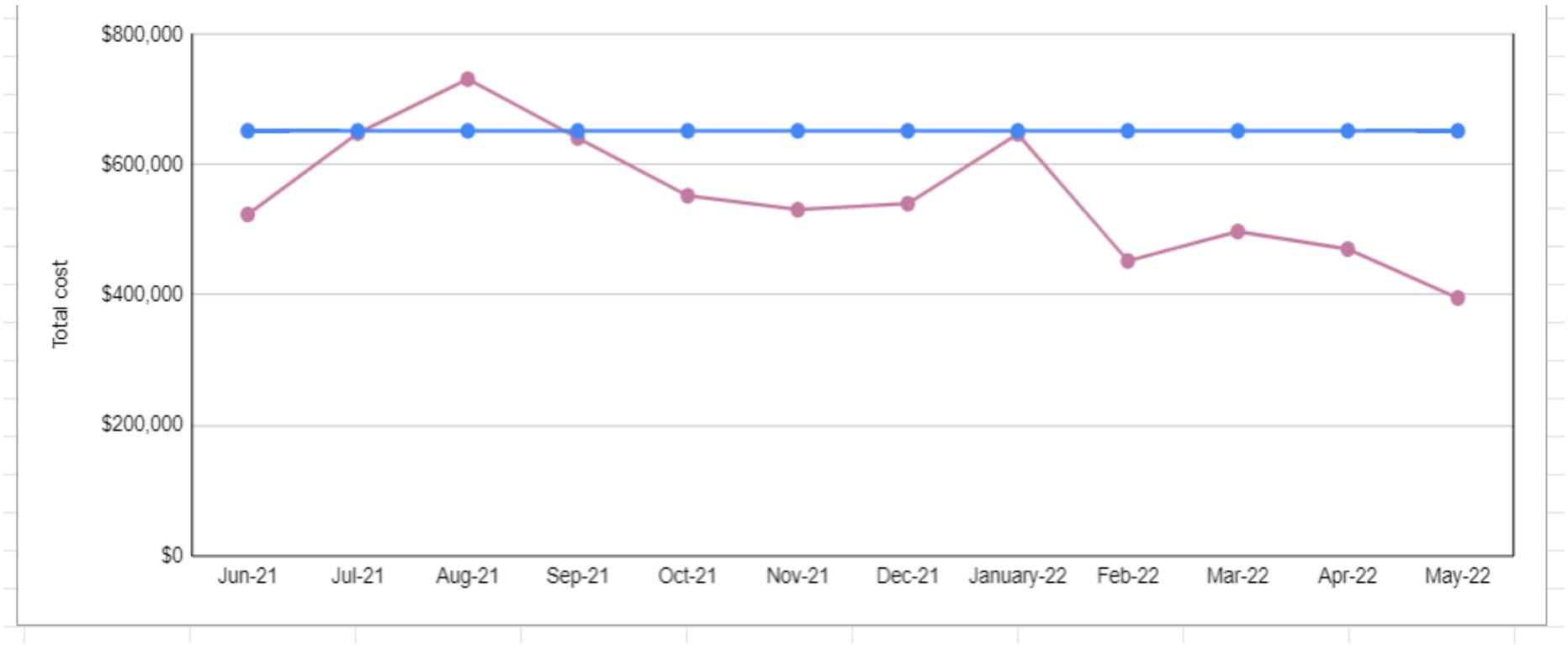


Baseline Period: Calendar Year 2020
Measurement Period: March 2021 – February 2022
Patient engagement rate: 60.4% (538 of 891)

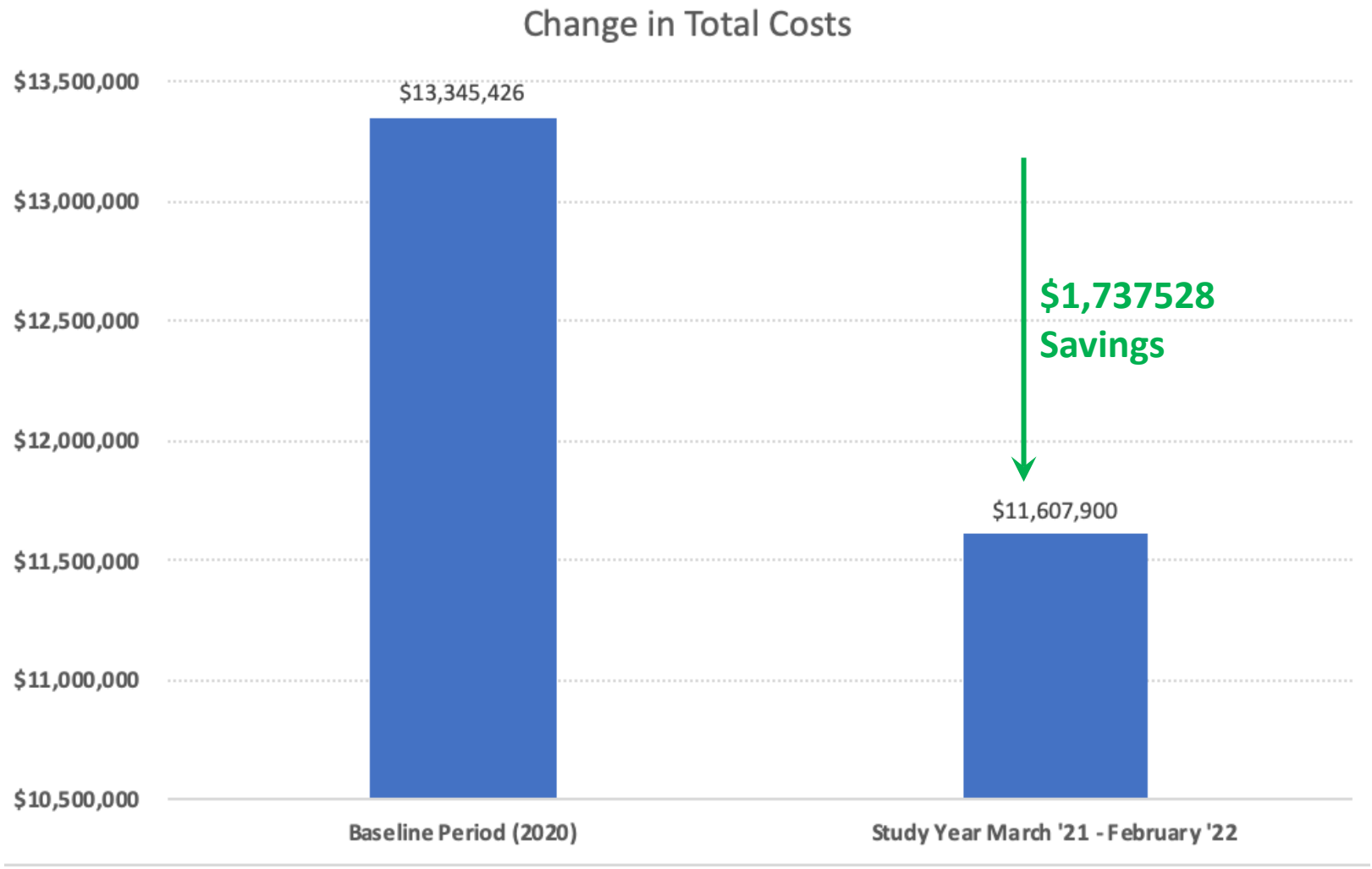
COHORT TOTAL COSTS – HEALTH PLAN B

Baseline Period: Calendar Year 2020
Measurement Period: June 2021 – May 2022
Patient engagement rate: 64% (599 of 931)

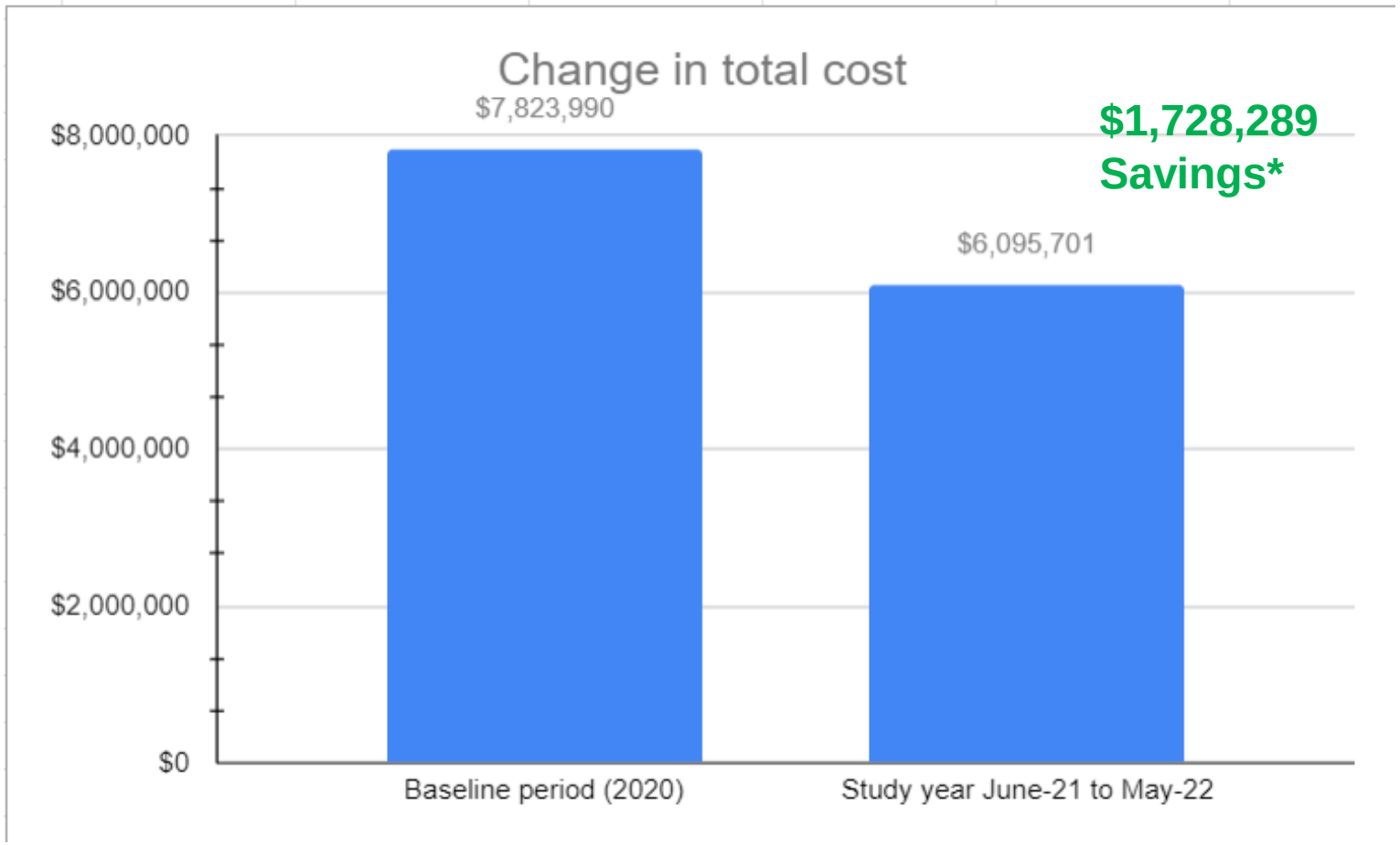
Avg. baseline monthly cost = $651,999



COST SAVINGS – HEALTH PLAN A



COST SAVINGS – HEALTH PLAN B



COMMUNITY HEALTH SERVICES STAFF

STAFF EXPERIENCE

- Part of the care team
- Staff are engaged
- Build rapport, talk-story approach
- Meet the patient where they're at
- Using data we've captured for over two decades
- Ability to prove our impact/worth
- Kawika*

PATIENT EXPERIENCE

Kawika* – 31yo Native Hawaiian male

- Uncontrolled hypertension, obesity
- Outstanding care gaps, chronic no-shows to specialty referrals, multiple ER visits
- Care Coordinator reached out post ER visit, completed PRAPARE survey
- Survey revealed ongoing unemployment issues, inability to pay rent & utilities, food insecurity
- Staff attempted to work on chronic conditions, patient refused
- Navigated unemployment issues together FIRST
- Connected patient to rent/utility assistance programs and food pantries
- Patient willing to discuss chronic conditions
- Met with resistance vs building trust/rapport
- How do we prove impact?

COMMENTS

PPS PLUS PAYMENT MODEL (APPENDIX 1)

1. **PPS FFS:** Provides base incentive to reach out to highest risk patients and funds basic service infrastructure.

2. **Capitation for Value Added Services and Investment in Care Coordination and HIT Infrastructure:** Defined by work plan co-developed with MCO partner. "Performance based" as failure to achieve work plan objectives cancels plan obligation for payment.

3. **Shared Savings Component:** In addition to any total attributed risk pool shared savings includes high-risk cohort "gain share" distribution.

QUESTIONS AND DISCUSSION

MAHALO

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