The Grove
Bamboo Health

Incorporating Social Drivers to Create More Impactful Outcomes for Value Based Care

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VP Value Based Care & Population Health

Leadership
Summit

Advocate Aurora Health & Atrium Health - TOGETHER

5.5M UNIQUE PATIENTS

148K TEAMMATES

7.6K EMPLOYED PHYSICIANS

18.5K ALIGNED AND MEDICAL STAFF PHYSICIANS

41K NURSES

$4.8B COMMUNITY BENEFIT

1K+ AMBULATORY LOCATIONS

67 HOSPITALS

$27.1B REVENUE

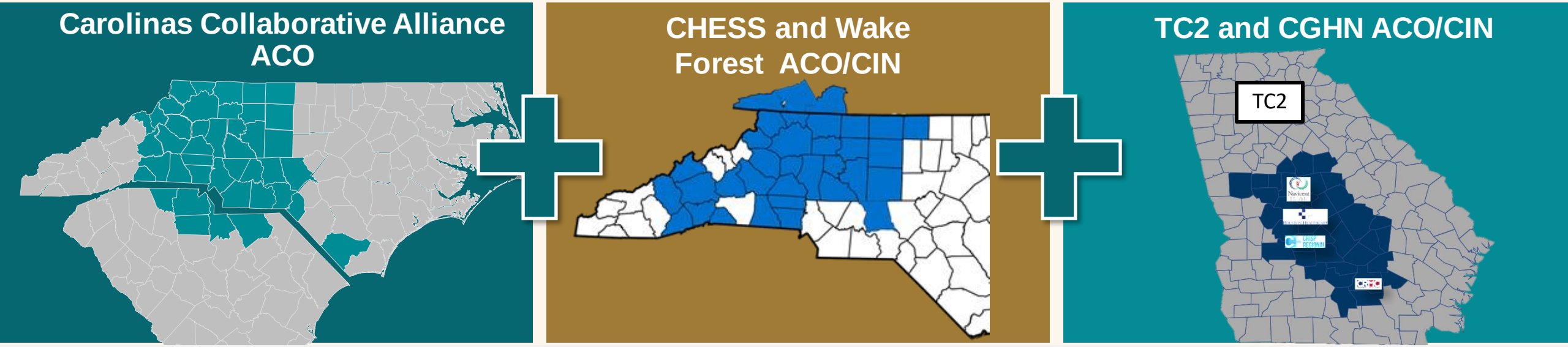
AdvocateAuroraHealth

- **2.6M** unique patients
- **75K** teammates
- **3.6K** employed physicians
- **9.5K** aligned and medical staff physicians
- **22K** nurses
- **$2.5B** community benefit
- **500+** ambulatory locations
- **27** hospitals
- **$14.1B** in annual revenue

Atrium Health

- **2.9M** unique patients
- **73K** teammates
- **4K** employed physicians
- **9K** aligned and medical staff physicians
- **19K** nurses
- **$2.3B** community benefit
- **500+** ambulatory locations
- **40** hospitals
- **$13B** in annual revenue

Advocate Health- SE Atrium Population Health



- **6,500+** Participating Physicians
- **450+** Physician Practices
- **700,000+** Lives in Value Based Agreements (and growing)
- **5** ACOs/CINs with various Local Chapters

- Employer partnerships with various relationships at **over 130 employers**
- **Increasing Scale and Performance** in Value Based Agreements in Commercial, Medicare, Medicaid
- **Value-Based Enablement** Services

ACO REACH Overview

Accountable Care Organization **R**ealizing **E**quity, **A**ccess, and **C**ommunity **H**ealth

The Center for Medicare & Medicaid Services (CMS) is driving Health Equity into all programs. ACO REACH is the first health equity model to allow providers to participate to transform care.

Aligns with Advocate Health Strategies

Advance Health Equity

- Develop and implement a Health Equity Plan to **reduce health disparities**
- Identify and manage **Social Drivers of Health** (SDOH)

Improve Affordability

- **Transform** fee for service into value-based care
- Benefit design allows for the opportunity to **reimagine primary care delivery**

Patient Engagement

- **Scale** allows us to **innovate**, reach more patients, and serve underserved populations
- **Tailored approach** to meet local needs
- **Listen to and engage** patients in their care

Share best practices and learnings across regions

Wake Forest Equity Approach and Population Focus

Measure	ACO REACH Population	Population 2 (Dual Eligible & High ADI*)	
	Pass Rate	Pass Rate	Δ
Breast Cancer Screening	74%	50%	24%
Colorectal Cancer Screening	66%	54%	12%
Hypertension	47%	37%	10%
Diabetes	59%	41%	18%

*Area Deprivation Index

ACO REACH Care Model Overview – Combining Clinical Care Model & Social Impact

IHI Pathways to Population Health Framework

Intended to support health care professionals in identifying opportunities for their organizations to make practical, meaningful, and sustainable advancements in improving the health and well-being of the patients and communities they serve.

Linkages to Community and Addressing Social Drivers of Health

Source: IHI Pathways to Population Health

Social Impact Strategic Areas – Population Health Engagement

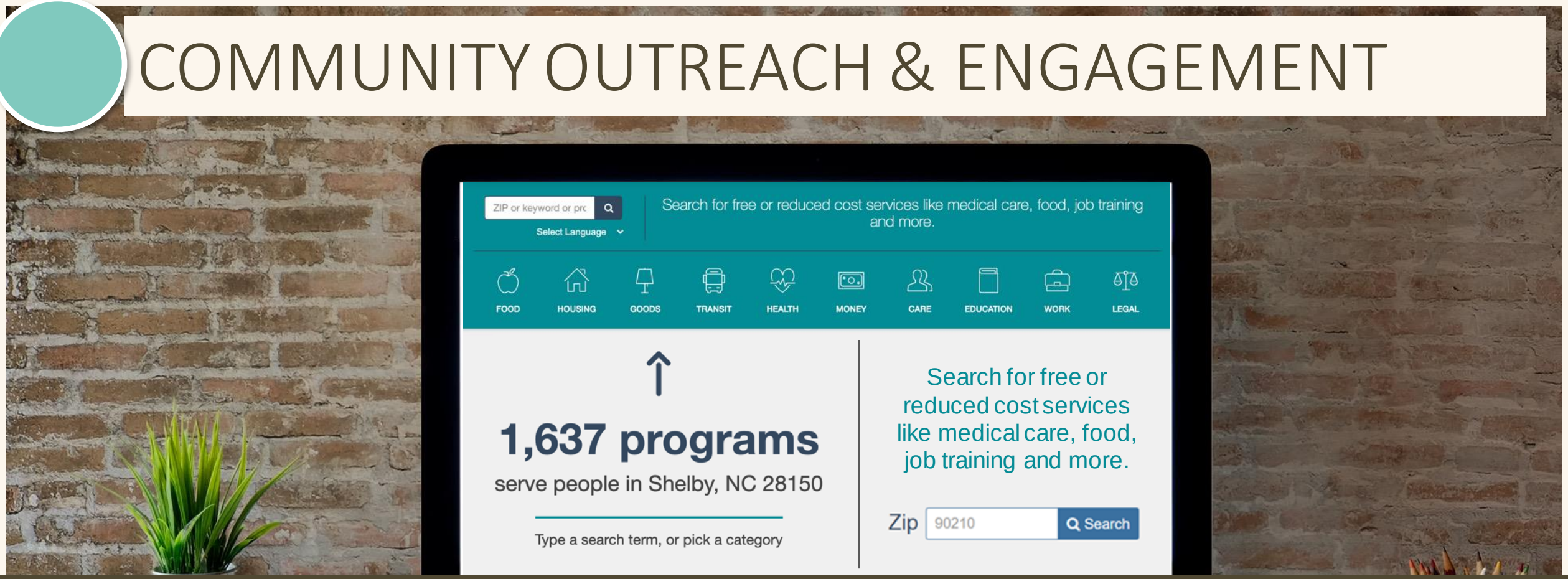
OUR STRATEGIC PRIORITES

- **Access Investments**
- **Quality & Equity Outcomes**
- **Support Partners**
- **Care Team/Workforce Investment**

OUR PATHWAYS FOR IMPACT

Community Clinics	Virtual Care	Mobile/ Home Health/Paramedicine
Colorectal & Mammography Screening	BP Control	Medication Adherence
FindHelp Platform	Community Partnerships	Community Program Investments (link to CHNA)
Community Health Workers	FaithHealth/ Supporters of Health	Social Work

COMMUNITY OUTREACH & ENGAGEMENT



Find Help/Community Resource Hub | A Prescription for Meeting Social Needs… One Patient at a Time

The Community Resource Hub is an online platform that assists providers and patients in locating free or reduced social care services like food, utilities support, housing assistance and so much more.

Find Help Searches by Category

Rural Counties:

- Watagua, Randolph, Alexander, Alleghany, Rockingham, Ashe, Burke, Stokes, Wilkes, Surry, Yadkin, Caldwell

Urban Counties:

- Forsyth, Guilford, Catawba, Rowan, Davidson, Iredell

- Health was the top category in both urban and rural counties.
- Housing and Food were 2nd and 3rd , respectively, for both urban and rural counties
- The difference in proportion of searches between urban and rural counties ranged from 0.3% to 7.4%

Searches by Category in WFB Region Urban and Rural Counties*		
	Rural	Urban
Category	% Categorized Searches	% Categorized Searches
Food	16.99%	22.90%
Housing	23.23%	26.58%
Goods	5.30%	3.50%
Transit	6.16%	8.06%
Health	26.16%	27.36%
Money	11.18%	3.80%
Care	6.74%	5.24%
Education	1.86%	0.93%
Work	1.00%	0.71%
Legal	1.36%	0.91%

Access- Population Health & Community Partners

Mobile Health Clinic

University Partnerships


Screening Programs

Community programming partners


FQHC partners


Remote Patient Monitoring

Maya Angelou
Center for Health Equity (MACHE)

Advancing Health Equity and Population Health Research

Wake Forest® School of Medicine

MACHE supports the health of communities by:

- Building and nurturing mutually beneficial relationships,
- Respecting and honoring community as experts and equal partners
- Engaging, educating, and empowering communities
- Cultivating leadership
- Creating a culture of transparency and fairness in research
- Promoting advocacy and policy change

Designated NIH-funded Center of Excellence with National Institute of Minority Health & Health Disparities (NIMHHD)

3 strategies:

- Translational research navigation to impact population health
- Health & biomedical science pipeline programming
- Health equity education & training

Faith Health NC

A Shared Mission of Healing

Our Faith Health Ministry Helps Bridge Faith, Health & Community

Faith Health

526 Congregations

86,482 Members

90 Chaplains

8 Community Chaplains

2,927 Visiting Clergy

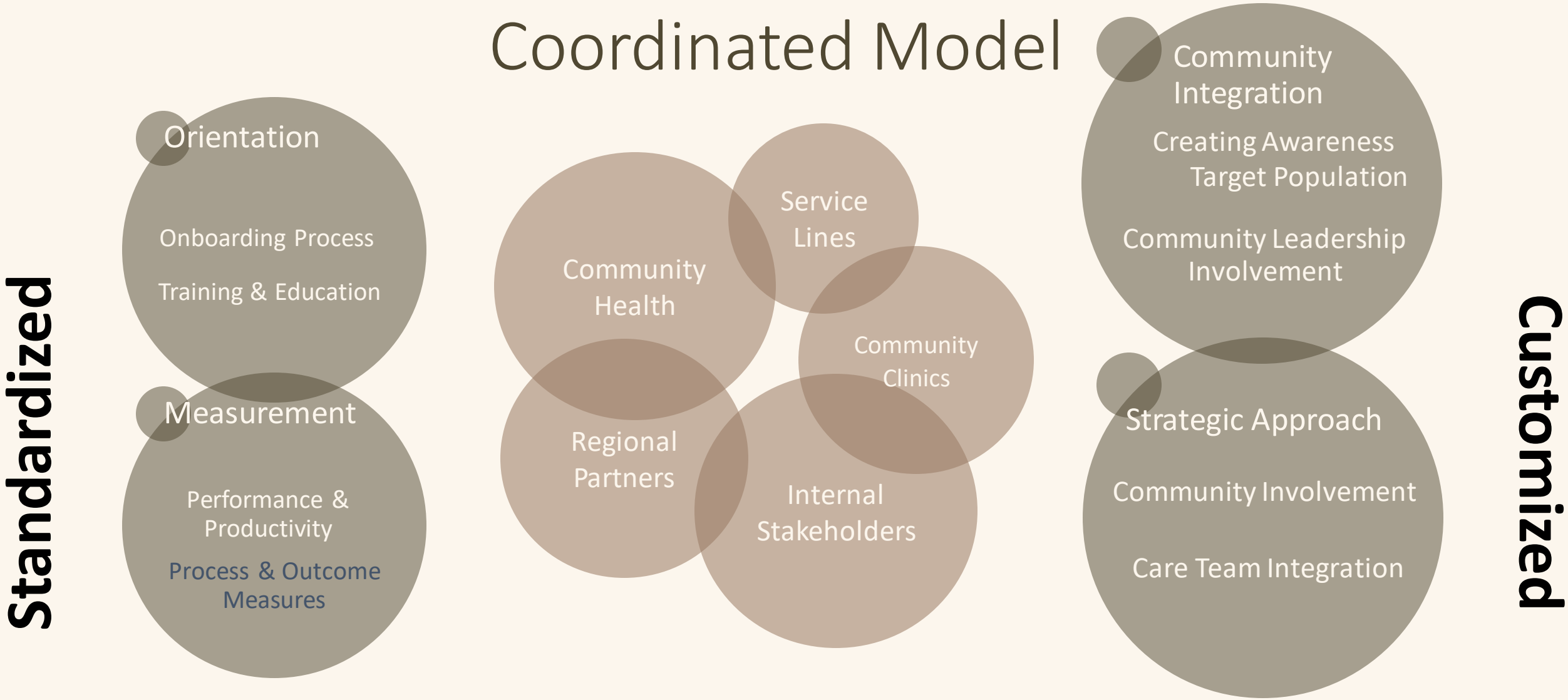
14 Faith Health Fellows

Population Health Ambulatory Care Team
Clinical Care + Social Care = Positive Patient Outcomes

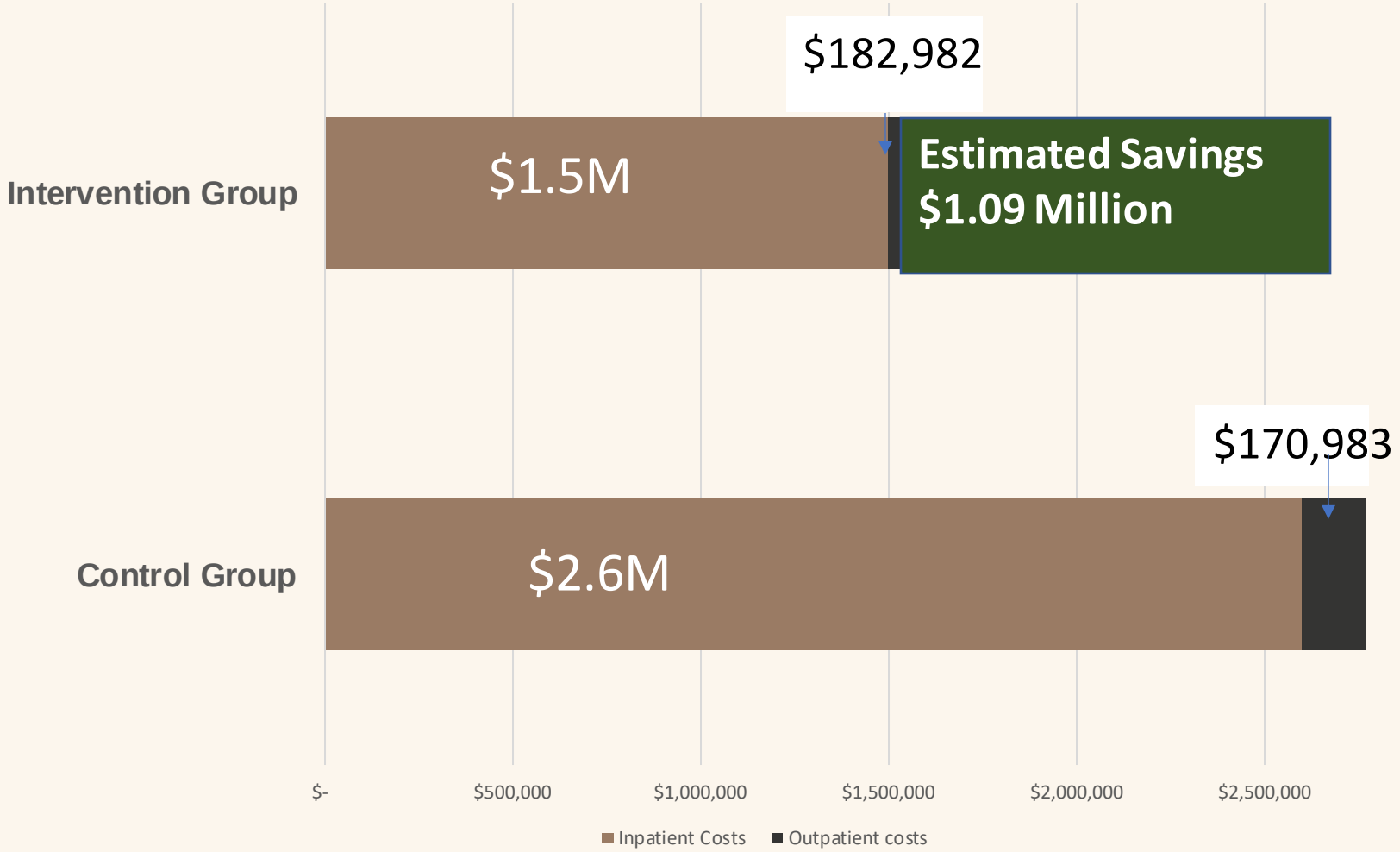
Connect patients with internal and external resources

Nurse Navigators	Extended Care Nurses	Social Work	CHWs
• Embedded in clinics • Liaisons between primary care and high risk patients • Facilitate care coordination • Face to Face and telephonic engagement	• Embedded in the ED • Right care, right time, right setting • MVP • Face to face and telephonic engagement	• Supports primary care practices • Perform psychosocial assessments and care coordination	• Find Help community ambassadors • Referral partner to RN, SW and pop health pharmacy team • Documents in EMR as part of care team

Community Health Workers | A Centralized & Coordinated Model



Upenn IMPaCT Community Health Worker Model



IMPaCT unlocks the power of the grassroots community health workforce.

IMPaCT's standardized, scalable program transforms the effectiveness of the CHW workforce by reimagining each step, from how to identify the right CHWs, to how to train, develop, manage, and empower them with technology and evidence-based best practices.

Kangovi S, Mitra N, Grande D, Long JA, Asch DA. Evidence-Based Community Health Worker Program Addresses Unmet Social Needs And Generates Positive Return On Investment. Health Aff (Millwood). 2020 Feb;39(2):207-213. doi: 10.1377/hlthaff.2019.00981. PMID: 32011942; PMCID: PMC8564553.

Care plus- imbedded primary care model for clinically and socially complex

A primary care based medical home model located at Downtown Health Plaza for frequent inpatient and ED utilizers serving high numbers of Medicaid and Dually eligible patients implement in 2015

Services provided:

- ✓ Comprehensive SDOH screening
- ✓ Weekly multidisciplinary care coordination meetings
- ✓ Longer, more frequent visits
- ✓ Home visits
- ✓ Comprehensive needs assessment to look at food/ housing/ transportation
- ✓ Resources to assist with medication, transportation, food pantry
- ✓ Population management including outreach to patients who miss primary care and subspecialty appointments
- ✓ **Focuses on high risk ACO REACH, Medicaid and MA patients**

Early ACO REACH Successes & Opportunities- *building out resourcing model*

Early Successes:

- **Development of Community Health Worker integrated within the Ambulatory Care Management Team**

- **Embedded or supporting in all primary care clinics**
  - **Onsite at clinics with higher volumes of vulnerable patients**
  - **FindHelp Ambassadors**
- **Community Engagement Ambassadors**

Continuing Opportunities:

- **Enhance documentation for evaluation**
- **Increase alignment with the UPenn model while respecting the unique needs of our various regions and practice models (academic, community, rural, etc.)**
- **Further collaboration with faith networks and Maya Angelou Center for community and patient engagement for care gaps**

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Bamboo Health

Questions

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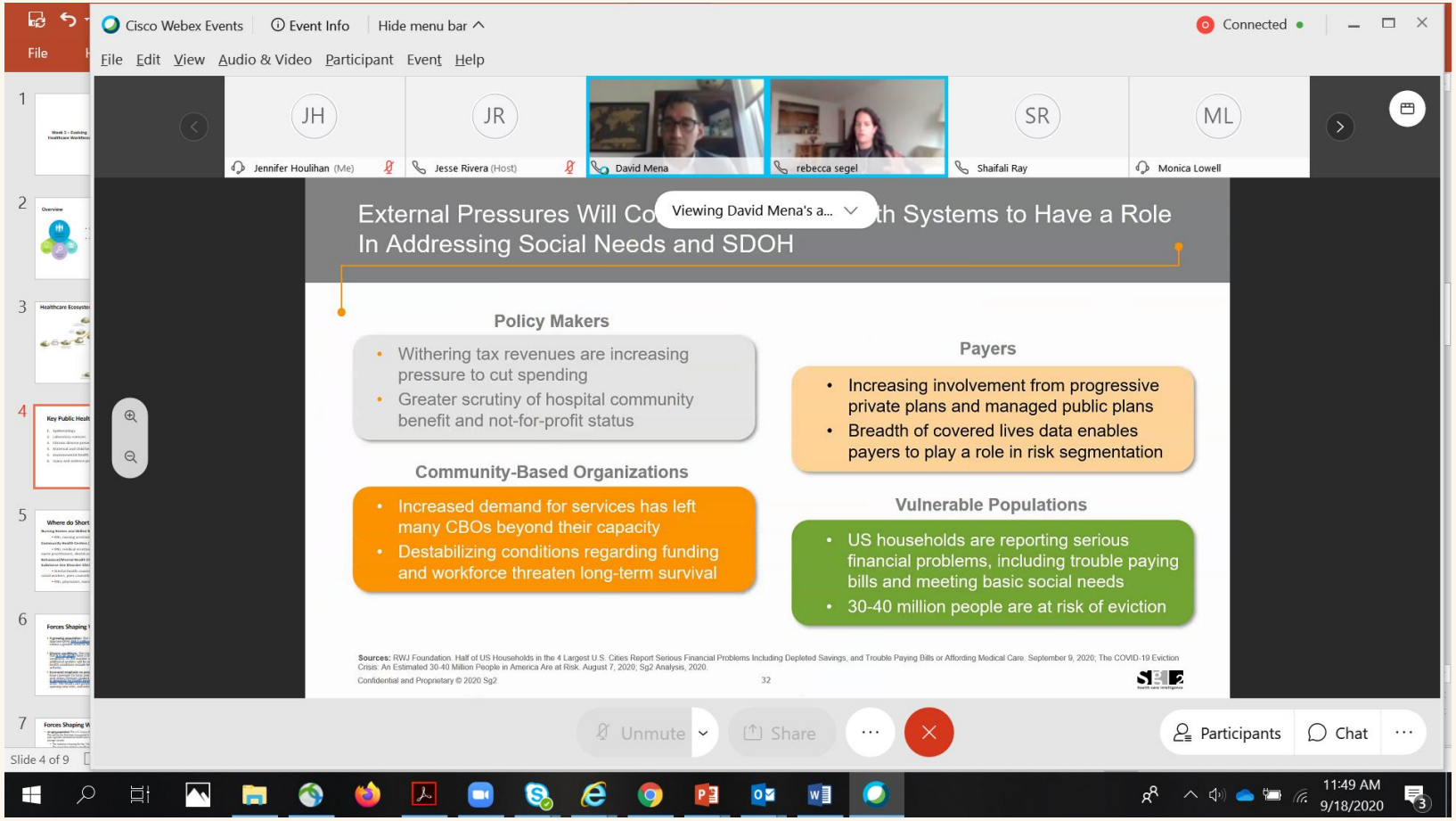
Leadership
Summit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Jesse Rivera (Host)
David Mena
rebecca segel
Shaifali Ray
Monica Lowell
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External Pressures Will Co th Systems to Have a Role In Addressing Social Needs and SDOH
Policy Makers
Withering tax revenues are increasing pressure to cut spending
Greater scrutiny of hospital community benefit and not-for-profit status
Payers
Increasing involvement from progressive private plans and managed public plans
Breadth of covered lives data enables payers to play a role in risk segmentation
Community-Based Organizations
Increased demand for services has left many CBOs beyond their capacity
Destabilizing conditions regarding funding and workforce threaten long-term survival
Vulnerable Populations
US households are reporting serious financial problems, including trouble paying bills and meeting basic social needs
30-40 million people are at risk of eviction
Sources: RWJ Foundation. Half of US Households in the 4 Largest U.S. Cities Report Serious Financial Problems Including Depleted Savings, and Trouble Paying Bills or Affording Medical Care. September 9, 2020; The COVID-19 Eviction Crisis: An Estimated 30-40 Million People in America Are at Risk. August 7, 2020; Sg2 Analysis, 2020.
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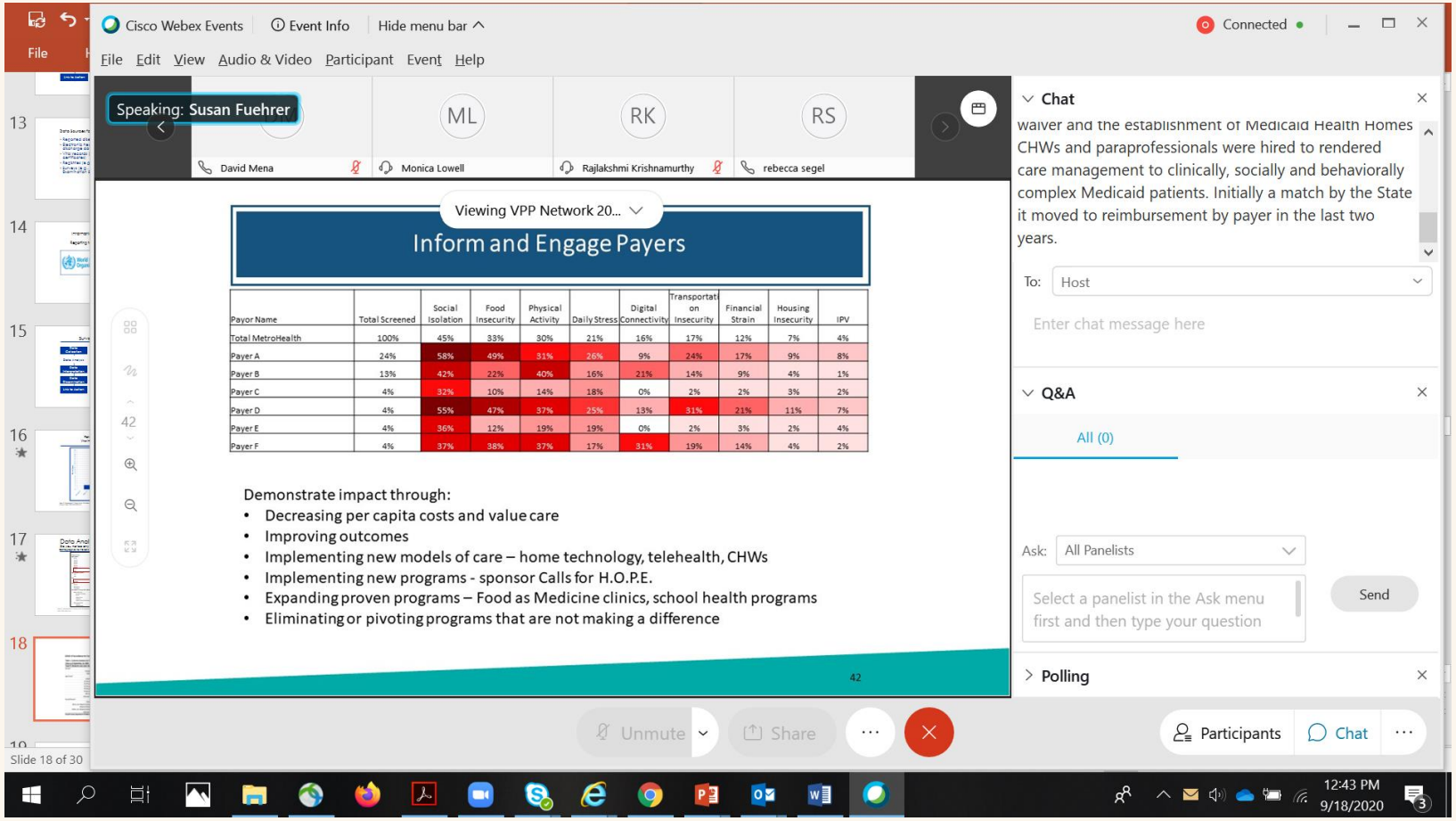
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David Mena
Monica Lowell
Rajlakshmi Krishnamurthy
rebecca segel
Viewing VPP Network 20...
Inform and Engage Payers
Payor Name | Total Screened | Social Isolation | Food Insecurity | Physical Activity | Daily Stress | Digital Connectivity | Transportation Insecurity | Financial Strain | Housing Insecurity | IPV
Total MetroHealth | 100% | 45% | 33% | 30% | 21% | 16% | 17% | 12% | 7% | 4%
Payer A | 24% | 58% | 49% | 31% | 26% | 9% | 24% | 17% | 9% | 8%
Payer B | 13% | 42% | 22% | 40% | 16% | 21% | 14% | 9% | 4% | 1%
Payer C | 4% | 32% | 10% | 14% | 18% | 0% | 2% | 2% | 3% | 2%
Payer D | 4% | 55% | 47% | 37% | 25% | 13% | 31% | 21% | 11% | 7%
Payer E | 4% | 36% | 12% | 19% | 19% | 0% | 2% | 3% | 2% | 4%
Payer F | 4% | 37% | 38% | 37% | 17% | 31% | 19% | 14% | 4% | 2%
Demonstrate impact through:
• Decreasing per capita costs and value care
• Improving outcomes
• Implementing new models of care – home technology, telehealth, CHWs
• Implementing new programs - sponsor Calls for H.O.P.E.
• Expanding proven programs – Food as Medicine clinics, school health programs
• Eliminating or pivoting programs that are not making a difference
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Chat
waiver and the establishment of Medicaid Health Homes CHWs and paraprofessionals were hired to rendered care management to clinically, socially and behaviorally complex Medicaid patients. Initially a match by the State it moved to reimbursement by payer in the last two years.
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Q&A
All (0)
Ask: All Panelists
Select a panelist in the Ask menu first and then type your question
Send
Polling
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Share
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