PointClickCare®

Advancing Health Equity:
Solutions for ACO REACH

Introduction

In recent years there has been increased focus on creating a more equitable healthcare sector in the United States. As part of this effort, in February 2022, the Centers for Medicare and Medicaid Innovation Center (CMMI) introduced ACO REACH, the Accountable Care Organization Realizing Equity, Access, and Community Health Model, to promote greater health equity among the beneficiaries receiving care through accountable care organizations (ACOs).

While the application window is closed for ACO REACH, this marks the beginning of a larger movement for ACOs to focus on advancing health equity and addressing health disparities that impact their patient populations.

This guide offers an overview of what the ACO REACH Model is and gives insight into how health information technology (health IT) will play a critical role in supporting success for REACH ACOs, as well as ACOs striving to improve health equity and outcomes for their patients.

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What is ACO REACH?

The ACO REACH Model replaces the current Global and Professional Direct Contracting (GPDC) Model and is designed to advance health equity goals. The new program will help the Centers for Medicare and Medicaid (CMS) explore strategies aimed at addressing health disparities and improving quality and outcomes for underserved populations while enhancing support for provider-led organizations in risk-based arrangements.

The main goals of the CMS ACO REACH Model include:

1 Promoting Health Equity and Delivering Accountable Care in Underserved Populations

ACO REACH requires all participants to create and implement a health equity plan that identifies and delivers care to underserved communities in their patient population. Participants must provide measurable results showing that health disparities have been reduced through their health equity plan.

2 Supporting Provider Leadership and Governance

The ACO REACH Model requires at least 75% of the governing body of each ACO be made up of participating providers or their representatives and will require a minimum of two advocates for beneficiaries (one from Medicare, one consumer advocate) on the governing board.

3 Protecting Beneficiaries with Greater Participant Vetting, Monitoring, and Transparency

To protect beneficiaries, CMS increased the vetting process for ACO REACH applicants and will do robust monitoring of participants' progress during the program. CMS will provide greater transparency about the model's progress and will work to prevent inappropriate coding and risk score growth.

Risk-Sharing Options Under ACO REACH

The financial risk options under the ACO REACH model remain the same as those available in the GPDC Model: Professional, a lower risk-sharing arrangement, or Global, a higher risk-sharing arrangement.

Professional	Global
• 50% shared savings/losses with CMS	• 100% shared savings/losses with CMS
One payment option: • Primary Care Capitation Payment - a risk-adjusted monthly payment for primary care services provided by the ACO's participating providers	Two payment options: • Primary Care Capitation Payment (see left) • Total Care Capitation Payment - a risk-adjusted monthly payment for all covered services, including specialty care, provided by the ACO's participating providers

What is Health Equity?

The Centers for Disease Control and Prevention (CDC) defines health equity as when every person has the opportunity to "attain their full health potential" without being "disadvantaged from achieving this potential because of their social position or other socially determined circumstance." Addressing social determinants of health (SDOH), conditions in the places where people learn, live, and work that affect health outcomes, is an approach to understanding health disparities and promoting health equity.

How is the ACO REACH Model Different from Direct Contracting?

The primary difference between the GPDC, or the Direct Contracting Model, and ACO REACH is the focus on advancing health equity by design. The ACO REACH Model has three primary health equity components that did not exist in the Direct Contracting Model:

- REACH ACOs must establish a plan for promoting health equity by identifying health disparities and developing a strategy to mitigate those disparities.
- There will be a health equity beneficiary-level risk adjustment for better care delivery and coordination for patients in underserved communities.
- ACOs participating in the program need to collect beneficiary-reported demographic and social determinants of health data as a key starting point for addressing health equity.

To view a comprehensive comparison of ACO REACH vs Direct Contracting, CMMI created a table that you can view here.

Who Can Participate in ACO REACH?

According to CMS, the ACO REACH Model is aimed at provider-based organizations with direct patient care experience and a strong track record serving underserved communities. There are the three types of participants CMS has selected for ACO REACH:

Standard ACOs	• ACOs with experience serving Original Medicare beneficiaries
New Entrant ACOs	• ACOs that have not traditionally provided services to Original Medicare beneficiaries
High Needs Population ACOs	• ACOs that serve Original Medicare beneficiaries with complex needs

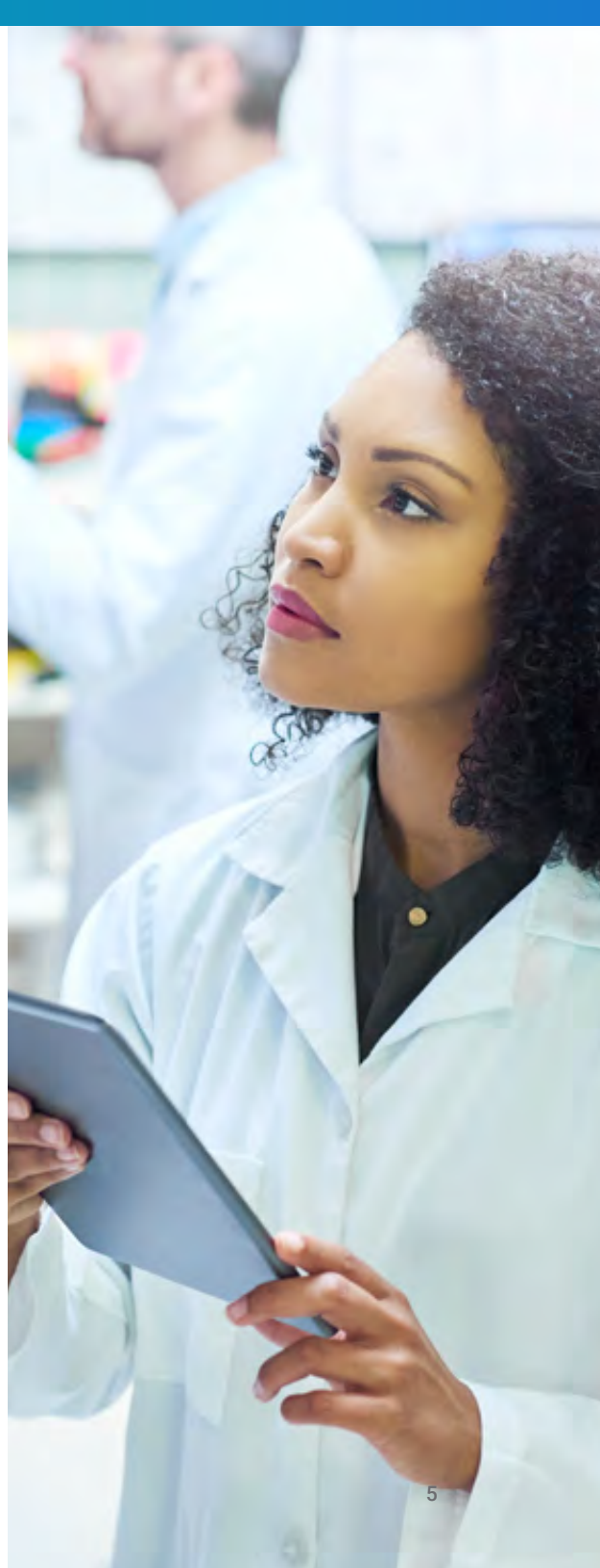
For more detailed information about the types of participants, visit the CMMI **ACO REACH page**.

When Does the ACO REACH Program Start?

The first Performance Year of ACO REACH begins January 1, 2023, and it will run for four Performance Years: Performance Year 2023 (PY2023) through PY2026.

CMS announced the ACO REACH Program and Request for Applications (RFA) in February 2022 and began accepting applications in March. The application period closed in April 2022 and CMS selected REACH ACOs in June 2022.

Accepted applicants were given the option of participating in an Implementation Period leading up to PY2023 from August 1, 2022, through December 31, 2022.



Advancing Health Equity: The Role of Data and Interoperability

For participants in the ACO REACH Model, data quality and interoperability will be key to complying with the health equity goals of the program that focus on identifying and supporting underserved patients in their beneficiary population.

Any successful strategy for advancing health equity will depend on the collection and exchange of accurate, complete, and standardized data as the foundation. Without it, identifying beneficiaries with high-priority or unmet healthcare needs can be burdensome, time-consuming, or fraught with errors, making efforts to provide outreach and proactive interventions ineffective.

ACOs participating in the REACH program will need to implement solutions that will allow them to collect demographic and SDOH data and identify their underserved beneficiaries to address health disparities they face. A good starting point would be to make sure that patient data maps to **United States Core Data for Interoperability (USCDI)** V2 demographic data. The USCDI is a set of standardized health data classes and elements that are the basic health data required in health IT systems to support nationwide, interoperable health information exchange.

Collecting and sharing this data across the care network will help ACOs to develop meaningful outreach campaigns and risk-mitigation strategies that can address things like language barriers, health insurance and cost of care, transportation to medical appointments, housing insecurity, dietary support, and medication access. By recognizing and removing barriers to care, ACOs can work towards reducing health disparities and increasing health equity to improve patient outcomes.

ACOs should work with health IT providers to implement solutions that support collection of SDOH and demographic data and enhance interoperability in their care network. These data feeds should integrate into existing electronic health record (EHR) and health IT systems with the goal of seamless data exchange across the continuum of care. This ensures that throughout the care network, providers can collaborate to support social, as well as clinical needs of patients.

The Four-Step Approach to Health IT for Health Equity

1 Identify

Use demographic data elements to understand population composition, especially as it relates to those who have been affected by persistent poverty and inequality.

2 Exchange

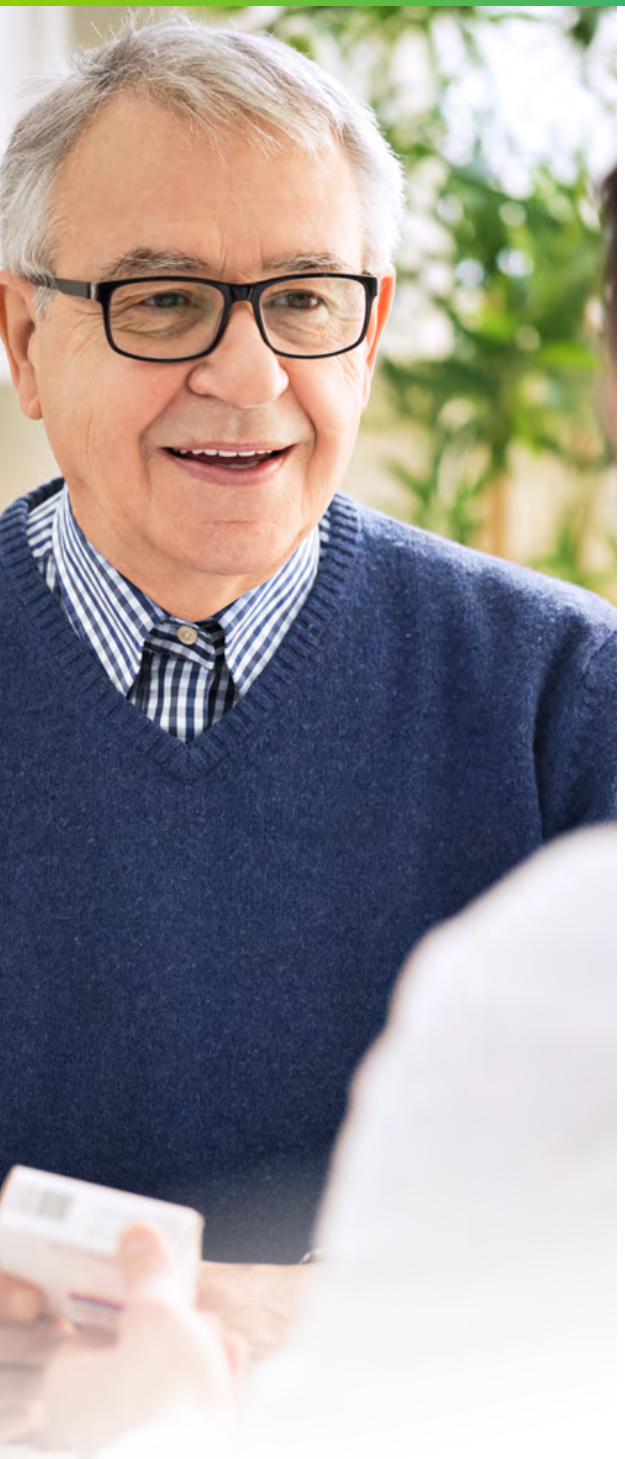
Establish secure data exchange capbabilities to share those demographic data elements with care team members throughout the entire continuum of care.

3 Analyze

Conduct simple and statistical analyses, alongside clinical data, to identify disparities among populations.

4 Intervene

Use the analysis to develop, execute, and evaluate interventions designed to promote health equity.



Why Strong Health IT Solutions are Key to ACO REACH Success

Both new participants in the program and those that transitioned from the Direct Contracting Model will need to develop a strategy that allows them to remain compliant with ACO REACH health equity requirements while balancing revenue goals. Because shared savings are tied to quality measures, ACOs need health IT tools in place that facilitate data exchange and care collaboration among care team members for better health outcomes and improved performance. By implementing strong health IT solutions, ACOs can target risk-mitigation strategies for the patients who need it most and improve care coordination by breaking down data silos and preventing gaps in care with real-time access to patient health information throughout the care continuum.

Criteria-Based Alerts for At-Risk Populations

ACOs should implement health IT solutions that enable them to identify and monitor at-risk populations among their beneficiaries for proactive engagement designed to reduce readmissions and avoidable utilization. Preventing frequent emergency department visits and readmissions not only reduces costs, but improves patient health, satisfaction with care they receive, and can help boost quality measures that impact revenue.

Quality measures of focus for REACH ACOs and ACOs seeking to improve health equity may include:

- Risk-standardized, all-condition readmissions
- All-cause, unplanned admissions for patients with multiple chronic conditions
- Days at home for patients with complex, chronic conditions
- Timely follow-up after acute exacerbations of chronic conditions
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

A solution that allows ACOs to set up criteria-based alerts within the provider workflow can help care teams to track high-risk beneficiaries and target outreach and resources to those patients with the greatest need for support and interventions. ACOs can work with a health IT vendor to set up population-level reporting of demographic and SDOH data through admission, discharge, transfer (ADT) feeds to understand demographic themes of the beneficiaries they serve and to support participating providers in tracking this data in their own ADT feeds.

> For example, helping patients manage chronic conditions is a key theme for all providers but especially for any risk-bearing providers like ACOs. To consider how health IT can help, we might look at a chronic condition with demonstrated SDOH impacts like diabetes. According to the American Diabetes Association, adults with a household income below the federal poverty level have twice as high a risk of diabetes-related mortality compared with those from the highest income levels. Low-income levels also increase the risk of experiencing diabetic ketoacidosis, which requires immediate medical attention.

An ACO could work with a health IT provider to create a cohort for diabetic patients with designated care coordinators assigned to beneficiaries with high-risk medical and/or social conditions that lead to poor outcomes and health disparities. The care team assigned to that panel can receive real-time encounter notification alerts when those patients are admitted, discharged, or transferred to a hospital to provide proactive care coordination and support to manage their diabetes for improved healthcare outcomes.

Care Coordination Tools for Safer Care Transitions

Improved care coordination can help ACOs to reduce avoidable utilization, ensure safer care transitions, and create better health outcomes for patients. Implementing an encounter notification system with customized, actionable clinical data feeds that notify care teams when their patients are hospitalized, transferred, or discharged can ensure that providers know what is happening with their patients in real time to prevent gaps in care.

These are some ways ACOs can benefit from care coordination tools:

- Setting up data feeds for ADT alerts directly in provider workflows makes it easier for care teams to keep track of their patients as they move through the care continuum, collaborate on care coordination, and engage with patients when it matters—not days or weeks later.
- Ensuring that care teams have access to accurate contact information for a prompt follow-up call after a patient is discharged from the hospital is key for improving quality measures.
- Utilizing multiple data sources to fill information gaps and improve the quality of the data can also support better identification of at-risk groups and appropriate risk-mitigation strategies.

In addition to real-time encounter alerts, it is important for providers to have access to clinical data for their patients, especially for post-acute care management when the opportunity to prevent a readmission and support patient health outcomes is most critical. Setting up an automated discharge document retrieval system can play a pivotal role in enhancing care coordination efforts because care team members can reinvest time that may have been spent trying to track down clinical information and discharge documents to engage with and treat patients in their care.

Finding the Right Health IT Partner for ACO REACH

Health IT solutions can allow REACH ACOs, and others embarking on the mission to improve health equity, to provide proactive outreach that reduces avoidable utilization and hospital readmissions with the ultimate goal of ensuring more equitable care for beneficiaries.

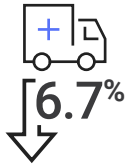
When considering a health IT provider or partner, ACOs need to determine what their current data collection and exchange capabilities are within their provider network and what their top priorities are for quality measures and outcomes during the program. Each health IT vendor will have strengths in particular capabilities and may have solution sets designed for different needs, so finding the right fit is key.

For some ACOs, this may mean working with their current health IT partner to ensure that the solutions they provide can meet their needs for data collection and targeting quality measures of priority like reduced readmissions and better transitional care management.

In other cases, ACOs may need to search for a new health IT partner that has solutions that will fill capability gaps needed to comply with ACO REACH requirements.

PointClickCare has worked with ACOs and risk-bearing entities to support better care coordination with strong network connectivity and care collaboration solutions that make it easier for care teams to track patients and provide targeted outreach in a timely manner.

For example, we worked with an integrated health system in Cincinnati that needed a way to enhance patient data sharing among providers to prevent gaps in care and offer proactive outreach to patients at high-risk for readmissions. The health system implemented our **PAC Network Management** solution that eliminated data silos for better patient tracking and automated data exchange between facilities in their network.



As a result, the health system was able to reduce readmissions by 6.7% among participating facilities by ensuring that crucial clinical data travels with patients to mitigate risk as they move through the continuum of care.

REACH ACOs preparing for the REACH program should consider what challenges they hope to solve and what goals they want to achieve as the basis for finding the right health IT provider to partner with for success.

About PointClickCare

PointClickCare is a leading healthcare technology platform enabling meaningful collaboration and access to real-time insights at every stage of the patient healthcare journey. More than 27,000 long-term and post-acute care providers, over 3,100 hospitals and health systems, over 3,600 ambulatory clinics, every major U.S. health plan and over 70 state and government agencies use PointClickCare, enabling care collaboration and value-based care delivery for millions across North America.

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