AHE 2024 Fall Convening

Learning Collaborative Team Posters

AHE Advancing Health Equity
Leading care, payment, and systems transformation

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AHE Advancing Health Equity

The District of Columbia Team's Journey Through the Advancing Health Equity (AHE) Learning Collaborative

Population Focus

The District team joined the AHE learning collaborative without an existing project, excited to use the collaborative to drive a new effort. The team first narrowed down focus to the overlapping populations of organizational team members:

United Healthcare District Choice Dual-Eligible Special Needs Plan (DSNP) enrollees who were patients at MedStar Washington Hospital Center

Root Cause Identification

The team struggled with root cause identification – identifying deeply structural issues outside the scope of the collaborative to address. Ultimately the team documented and planned to address these issues in other forums, and decided to focus on:

Increasing access to and continued adherence to best-practice evidence-based and patient-centered treatment for SUD.

Payment Design

The team identified a payment model that would create the base structure to support increased Medication for Opioid Use Disorder (MOUD) initiation, a best practice treatment for patients with SUD, at MWHC. This model is a starting point for continued iteration to address ongoing connection to community supports.

Equity Issue Focus

The team considered qualitative and quantitative data identifying known disparities that organizational participants have the levers and capacity to address within the parameters of the AHE Learning Collaborative.

"Reducing disparities and improving outcomes for DSNP enrollees with substance use disorder (SUD) and other comorbid health conditions and health-related social needs (HRSNs) who frequently present at MWHC"

Care Delivery Design Exploration

The team looked to understand what other efforts were already happening to address similar or related issues to understand what was working, where there were opportunities for improvement, and how to build on existing efforts and expertise. The team continues to learn and iterate on care delivery design.

Driving Towards a More Equitable Future

The District team plans to continue work to on care delivery design and payment design to implement the hospital-based payment model and continue to explore opportunities to build further community follow up and support and engage individuals with lived experience and those at various levels of the care delivery system in design and development.

DCPCA District of Columbia Primary Care Association · MedStar Washington Hospital Center · United Healthcare · DHCF Department of Health Care Finance

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Delaware Learning Collaborative

Our Team

- The Delaware Department of Health and Social Services—Division of Medicaid & Medical Assistance (DMMA)
- AmeriHealth Caritas Delaware
- Nemours Children's Health

Background

Our team began collaborating in 2019 where we diagnosed a disparity in both preventive care and ED utilization for the Black/African American pediatric population. Nemours launched an ACO in January 2021, which resulted in a change to their patient population and broadened the scope of our focus to also include the Hispanic pediatric population.

In 2023, all Medicaid MCOs in Delaware were required to obtain NCQA Health Equity Accreditation. DMMA also required MCOs to stratify eight HEDIS and CMS Core Set measures to ensure health disparities were addressed more effectively statewide. This reinforced our team's focus on equitable healthcare delivery.

Throughout our work together, our team's main goal has been to reduce health disparities for the Black/African American and Hispanic pediatric populations, but it has not been an easy task. We were faced with several challenges, such as:

1. **Turnover of team members at each organization.** This led to historical knowledge being lost and slowed forward progression.
2. **Competing priorities.** This has created barriers to acting on new ideas.
3. **Inconsistent REL data.** This has made it difficult to capture age-related differences reported for certain vaccines, for example.

Although our approach began very linearly (identify disparity > determine root causes > execute value-based agreement), we eventually realized that we would need to revisit some stops on the health equity roadmap to fully address the care delivery aspect of our project, especially as it related to the expanded focus population. **As a result, we went back to the drawing board, developed a new plan of action, and are currently taking steps towards implementation.**

Implementing Change

After the launch of Nemours' ACO, we created a new structure to foster collaboration between partner organizations. **We adopted an "equity by design" approach to value-based care** by identifying disparities, expanding resources, and adding financial incentives for reductions in disparities and SDOH assessment and reporting.

We have been successful at reducing disparities in several areas, including the CIS Combo 7 vaccine series, demonstrating our commitment to advancing preventive care and health equity across the state. At AmeriHealth, this initiative has created additional opportunities to partner with providers to improve equity in maternal care in Louisiana and Michigan, for example.

We recently refreshed and consolidated a list of resources offered by each organization to identify opportunities to further reduce inequities experienced by our focus population. In addition, **we are gearing up for an in-person visit, where our team will meet with community partners** to discuss these interventions. We will also work to enhance our value-based agreement by adding a process measure aimed at tracking and incentivizing the work that leads to reductions in disparities.

Illinois Learning Collaborative

About Us

The Illinois AHE team is composed of **Access Community Health Network**, **Center for Health and Housing**, **Cook County Health**, **CountyCare**, and the **Illinois Department of Healthcare and Family Services**. Our initiative is informed by our belief that health and stable, safe, long-term housing go hand-in-hand. We hope to realize a decrease in utilization and overall health care costs by addressing housing deficiencies. The IL team serves two primary groups: CountyCare members experiencing homelessness and severe mental illness, and families with children.

Overcoming Challenges

Programmatic challenges related to staffing and communications are not unique, yet in the context of working with unhoused individuals, they can negatively impact outreach and housing placements, among other disruptions. Increased housing costs and the limited number of subsidies to cover rental costs also present significant barriers to overcome.

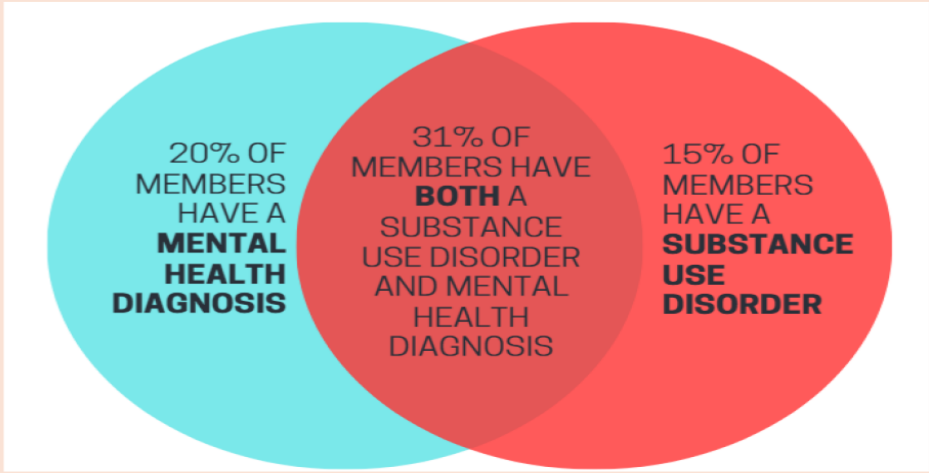
Team Successes Since 2020

- Policy/protocols for referral of MCO members for targeted housing & tenancy supports
- Better integration of MCO care management and CCH housing services
- A mixed methods study led by CountyCare to understand the extent to which its involvement in the FHP improved the health and quality of life for members included in the CountyCare Targeted Cohort
- FHP partnership with the Loyola Center for Urban Research and Learning to examine program processes and outcomes from the perspectives of FHP stakeholders and participants

What's On the Horizon

In Spring 2024, CountyCare released a request for proposals (RFP) to strengthen its partnerships with organizations that could help the team extend the provision of housing services offered such as: eviction prevention services, housing support, supportive housing wrap-around services, legal aid and workforce development.

Flexible Housing Pool Mental Health Profile



FHP Targeted Cohort Health Profile

- 7% FHP members have Asthma
- 16% FHP members have Diabetes
- 24% FHP members have Obesity
- 38% FHP members have Hypertension

Maine Post-Incarceration Incentive Payment

Where we have been

The Maine Advancing Health Equity (AHE) project team was formed in 2019, and included a targeted group of partners spanning physical & behavioral health:

- MaineCare (Maine's Medicaid Program),
- Aroostook Mental Health Centers,
- Maine Primary Care Association,
- Alliance for Addiction and Mental Health, and
- Community Care Partnerships of Maine.

Team goal: Address health disparities for MaineCare members who have experienced incarceration. Individuals who are incarcerated face many health disparities including high rates of substance use disorder other mental health disorders, chronic conditions, risk of homelessness and additional justice involvement. Individuals who have been formerly incarcerated face barriers to medical care including costs, stigma, and long wait times, which may result in a gap or not receiving care.

The team identified root causes for these disparities and then designed an intervention intended to improve access to care for this population after release.

The Maine AHE team transitioned to an internal team within the Department of Health and Human Service to identify funding, implement the intervention pilot, and conduct broad stakeholder engagement. Through the American Rescue Plan Act of 2021, under Section 9817, Maine was able to fund the Post Incarceration Incentive Payment Pilot Project that started January 2024.

Post Incarceration Incentive Payment Pilot

What is it?

- This is an incentive payment that is from March 2024 to March 2025 that encourages providers to connect with individuals being released from incarceration within two calendar days of their release.

How Does it Work?

- It's easy! If a provider submits an eligible claim for an eligible member, with a date of service within two calendar days of release from prison or jail, this claim may count for an incentive payment!

How much can providers get payment through this incentive payment?

- Providers can receive $236.77 per eligible claim.

Why are providers getting this incentive payment?

- People who have a history of incarceration face barriers to health care including costs, stigma, and long waiting times. MaineCare is encouraging providers to connect with these members to improve care transitions.

Where we are

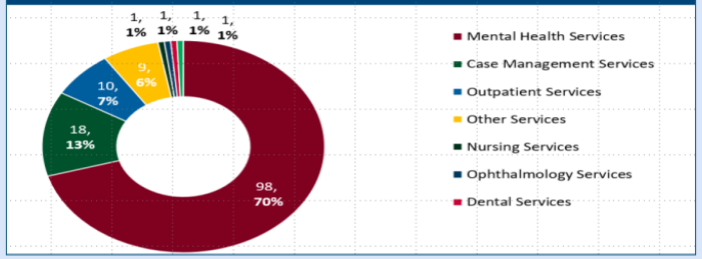
We have successfully completed 2 quarters of payments. The next incentive payment is scheduled for September 2024.

Payment Overview

March Payment Overview	Payment Total: $19,888.68	Total Organizations: 34	Total Members: 84
June Payment Overview	Payment Total: $32,911.03	Total Organizations: 46	Total Members: 139

- The incentive payment increased by 66% from the baseline payment in March.
- In July 2024, we met with the top providers who qualified for the incentive payment and had the highest volume of claims. At this meeting we provided an overview of upcoming Justice Initiatives coming to the State of Maine.
- In August 2024, the Department started individual meetings with the top 10 providers to gather and understand current practices and barriers.
- In September 2024, the Department will contract with a community-based organization to conduct focus groups with incarcerated residents and residents who have been through reentry.

Overview of the top Services the Incentive Payment Covered



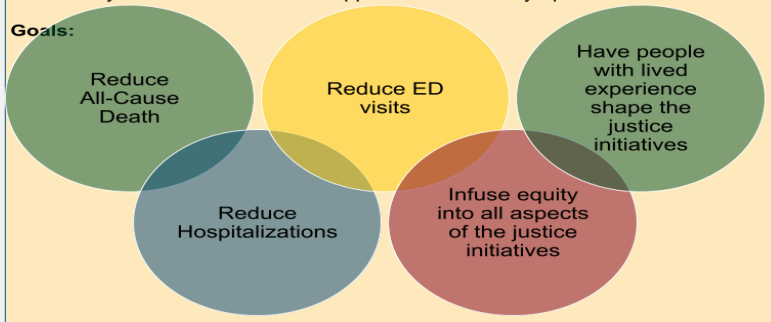
Where we are going

The State of Maine is committed to increasing equitable health outcomes for people who have been justice impacted by improving the transition between jails and prisons to the community. Maine believes that everyone has inherent dignity and worth and deserves the opportunity to be their healthiest selves.

Maine plans to:

- Design and implement structures to provide care coordination and treatment to juvenile justice involved youth.
- Strengthen the partnerships between the Department of Health and Human Services and the Department of Corrections and Maine's local county jails.
- Build and strengthen relationships with community-based organizations including substance use and mental health organizations, FQHC's, sober living homes and local housing authorities, to improve the continuity of care.
- Ensure meaningful engagement with justice involved individuals as well as create a feedback loop to assure transparent communication. We are developing a strategy to compensate justice involved individuals for their time and expertise.
- Standardize a process to determine Medicaid eligibility and/or enrollment pre-release and build communication between key departments.
- Foster a quality continuum of care across the correctional health care system, state and local health and human services system, and the corrections, public safety, and community supervision systems to facilitate seamless transition from corrections to communities.
- Develop, advance, and begin to implement a data strategy, including for automated information exchange.
- Formally submit an 1115 waiver application to CMS by April 2025.

Goals:



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Advancing Health Equity in Medicaid: Mississippi Bridges the Gap Using Trusted Community Partners

Jennifer Brumfield, RN, CCRC, MHS[1], Dana Carbo-Bryant, MD[1], Sonja Fuqua, Ph.D, RN, PCMH CCE [2], Angel Greer, MPH[3], Gladys Peters, Ed.D., MPH[4], Christopher Roby, Ph.D [2], Angelica Trieu, APRN, DNP[3]

[1]United Healthcare Community & State - Mississippi, [2]Community Health Center Association of Mississippi, [3]Coastal Family Health Center & [4]Mississippi State Department of Health

Strategy

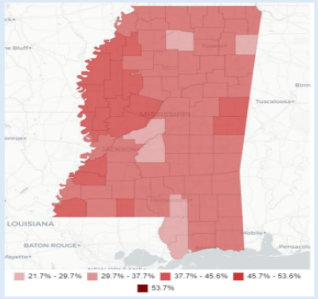
To design and implement this initiative, the team:

- Collaborated with a variety of stakeholders to benefit from unique perspectives
- Will partner with Community Health Workers (CHWs), using an evidence-based CHW model, to address social risk factors and improve patient health outcomes.

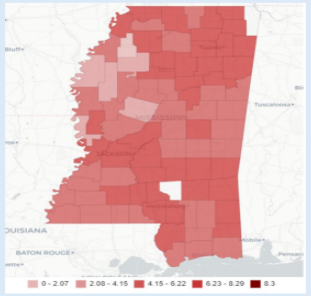
Project Focus

Adoption of a reimbursement payment model framework that supports the value of a CHW as part of the multidisciplinary care team for African Americans at high risk for chronic conditions.

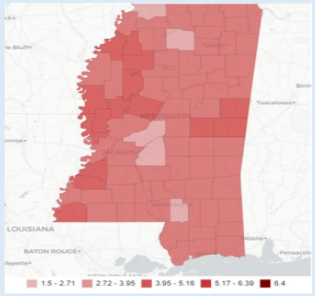
Mississippi: Background and Significance



In 2022, the percentage of the adult population (age 18 and older) that reported a body mass index (BMI) greater than or equal to 30 kg/m2 (age-adjusted) was 41.2%.



In 2022, the index of factors that contributed to a healthy food environment (from 0-worst to 10-best) was 3.8.



In 2022, the reported average number of physically unhealthy days reported in past 30 days (age-adjusted) was 4.11.

Measures		Rating	State Rank	State Value	U.S. Value
SOCIAL & ECONOMIC FACTORS*		+	45	-0.522	
Community and Family Safety	Occupational Fatalities (deaths per 100,000 workers)	+	43	6.8	3.9
	Public Health Funding (dollars per person)	+++	30	$114	$116
	Violent Crime (offenses per 100,000 population)	++++	14	291	399
Economic Resources	Economic Hardship Index (index from 1-100)	+	48	99	—
	Food Insecurity (% of households)	+	50	15.3%	10.4%
	Income Inequality (80/20 ratio)	+	46	5.33	4.96
Education	Fourth Grade Reading Proficiency (% of public school students)	++	32	30.6%	32.1%
	High School Graduation (% of students)	+++	29	85.0%	85.8%
	High School Graduation Racial Disparity (percentage point difference)**	+++++	4	6.5	15.1
Social Support and Engagement	Adverse Childhood Experiences (% ages 0-17)	++	35	17.2%	14.0%
	High-speed Internet (% of households)	+	50	85.2%	92.4%
	Residential Segregation — Black/White (index from 0-100)	+++++	3	52	—
	Volunteerism (% ages 16+)	+	47	26.6%	33.4%
	Voter Participation (% of U.S. citizens ages 18+)	++++	17	62.3%	60.1%
PHYSICAL ENVIRONMENT*		+	47	-0.436	
Air and Water Quality	Air Pollution (micrograms of fine particles per cubic meter)	++	33	8.2	7.8
	Drinking Water Violations (% of community water systems)	+	48	6.3%	0.8%
	Risk-screening Environmental Indicator Score (unitless score)	++++	16	1,647,155	—
	Water Fluoridation (% of population served)	++	35	60.7%	73.0%
Housing and Transit	Drive Alone to Work (% of workers ages 16+)	+	50	83.0%	67.8%
	Housing With Lead Risk (% of housing stock)	++++	11	10.7%	16.9%
	Severe Housing Problems (% of occupied housing units)	+++	29	14.6%	17.0%

In 2022, Mississippi ranked 49th for general population health, 45th for social and economic factors, 47th for physical environment, 48th for clinical care, 49th for behaviors, and 46th for health outcomes.

Challenges

- Designing payment transformation without State's Division of Medicaid participation
- Project funding
- Finding an appropriate validated discrimination tool
- Lack of health information exchange
- Project data collection and repository

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Medications for Opioid Use Disorder (MOUD) Programs for Pregnant Persons Within New Jersey

Objective

To improve the accessibility of MOUD treatment to pregnant persons within New Jersey by training OBGYN and related fields on Office Based Addiction Treatment (OBAT).

Background and Landscape

Literature

- Roughly 1 in 5 patients diagnosed with an OUD did not receive MOUD during pregnancy
- Persons receiving MOUD during pregnancy tend to be White and older
- A recurring theme across the literature is that obstetricians do not feel confident prescribing MAT
- Providers may not be aware of resources that are available to them
  - Many respondents in a cross-sectional survey administered to OBGYNs (n=462) were not aware that the ACA provides coverage of comprehensive substance use services for Medicaid individuals
- A childhood history of abuse, trauma, and mental health issues were each associated with OUD in adults
  - May suggest that screening for these areas at OBGYN appointments may be beneficial for connecting patients with care

Stakeholder Interviews

- Camden Coalition engaged in 12 Stakeholder Interviews with clinical providers and maternal health social service providers
- Siloed care creates challenges with provider-to-provider communication and consistency of patient engagement with prenatal care
- Providers held a perception that prescribing and managing pregnant patients on MOUD will be complex
- When specialty care is less accessible, OBGYN practices may be more motivated to initiate OBAT programs

Maternity Care Data within New Jersey

- Average distance to maternity care is 5.2 miles, taking 11 minutes
- Nearly all births (98.2%) within NJ were born in locations with access to prenatal and post-delivery services
- There are a relatively high availability of reproductive services within NJ
- BIPOC populations have lower rates of adequate prenatal care and are less likely to receive services such as health screenings

Landscape of Other States

- Massachusetts, New York, and Maryland were examined
- Common initiatives included the following:
  - Making providers more comfortable engaging with OUD treatment and encouraging screenings for substance use
  - Increasing access to home-based services
  - Following care through pregnancy and post-partum
- Massachusetts
  - Moms Do Care and First Steps Together - a home visiting program to support pregnant and post-partum people with SUD
- New York
  - Drug User Health Hub – online resource where physical and mental health, MAT, and related services are shared with providers and prospective patients
- Maryland
  - Maryland Maternal Opioid Misuse Model Provider Incentive Program – financial incentives and tax credits for providers that partake in pilot program

Partners

- Department of Medical Assistance and Health Services, New Jersey Medicaid
- Horizon Blue Cross Blue Shield of New Jersey
- Camden Coalition
- Jefferson Hospital
- AHE

Root Causes

Priority Matrix	Very Important	Less Important
Very Feasible to Address	• Siloed Care • Concerns Regarding how to Successfully Transition/Bridge Forms of Care	• Real/Perceived Liability for Providers when they do not Refer to Specialty Care
Less Feasible to Address	• Patients Prioritizing One Form of Treatment Over Another • *Systemic Racism and Stigma* • Lack of Adequate Support Services	

Timeline Examples

June

- Landscape analyses from Camden Coalition and NJ Medicaid

July

- Root Cause Analysis completed

September

- Share Pilot Plan with NJ Medicaid leadership

November

- Camden Coalition pilot project launch

Identified Barriers

Barriers identified among patients from literature

- Stigma
- Systemic racism
- Lack of knowledge of available resources

Barriers identified among providers from literature

- Real or perceived liability for providers when they do not refer a patient to specialty care
- Lack of knowledge of available resources
- Community and support services may not be available within the area
- Fear that patients will prioritize one form of treatment over another

Camden Coalition OBAT Pilot

Creating Safe Care Toolkit

- Strategies to equip healthcare providers with the knowledge and tools they need to support pregnant and parenting people who use drugs

Session 1

- Overview of MOUD/MAT and harm reduction strategies
- Developing tools to shift biases across clinical settings

Session 2

- Understanding when and how to issue drug screenings
- Examining structural racism in healthcare and its relation to screening and child welfare reporting

Session 3

- Examining the current resource landscape within NJ for pregnant and parenting persons living with use disorders
- Identifying best practices for planning for transitions of care

Ideas for the future

- Establish current pilot site providers as champions, supporting recruitment of new sites
- Develop a Resource Guide that is specific to supporting pregnant and parenting persons living with use disorders

Sources

1. March of Dimes 2023 Data
2. Maternal and Infant Network to Understand Outcomes Associated with Medication for Opioid Use Disorder During Pregnancy (MAT-LINK)
3. Obstetrician-Gynecologists' practice patterns related to opioid use during pregnancy and postpartum
4. Medication-assisted treatment vs. detoxification for women who misuse opioids in pregnancy: Associations with dropout, relapse, neonatal opioid withdrawal syndrome (NOWS), and childhood sexual abuse
5. Moms Do Care and First Steps Together
6. Review of Maternal Health Services (2023)
7. New York State Opioid Use Disorder in Pregnancy & Neonatal Abstinence Syndrome Project
8. Drug User Health Hub
9. Maryland Maternal Opioid Misuse (MOM) Model Provider Incentive Program

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Sun River Health

Our Journey

Commitment and Shared Purpose ❁ Building/Training ❁ Accountability and Sustainability

Maternal Health

Project Cohort

Number of patients: 100

Race/Ethnicities: Black/African American, Indigenous/Native Alaskan, Hispanic

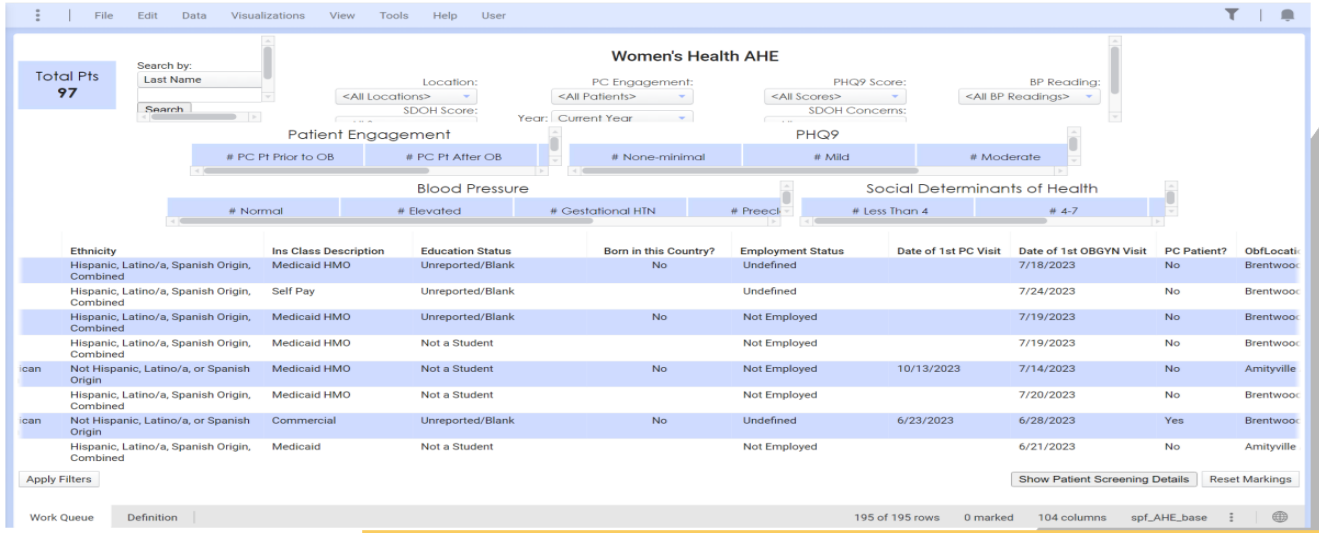
Gestational age: 36 weeks

Enrollment gestational age: 28 to 32 weeks

Study period from: 36 weeks of pregnancy to 84 days Postpartum

Established prenatal care: 1st and 2nd trimester of pregnancy

Sites: 4 Sun River Health Sites



Key Elements of the Innovation

The Use of Technology to Achieve Positive Health Outcomes

- Remote patient monitoring of hypertensive women at risk for maternal complications with wireless Blood Pressure Devices
- Perinatal Mental health disorders using PHQ-9 Screening and monitoring using iPads merging into the EHR
- Creation of a project dashboard to monitor SDOH referral cycles to identify and close gaps in care
- Transitions of Care upon delivery via Virtual Care appointments within 48 hours upon discharge
- Data serving as a foundation to determine gaps in care and support services
- Patient Focus groups and surveys serve as the vehicle to ensure patient demographics and community needs are captured

Our Partners

VeeOne HEALTH

healthfirst Health Insurance for New Yorkers

CWHA Caribbean Women's Health Association, Inc.

Challenges and Opportunities

❁ Technology Focus ❁ Providers ❁ Staff Training ❁ Replication

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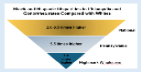
ADDRESSING RACIAL/ETHNIC DISPARITIES IN SEXUALLY TRANSMITTED INFECTION SCREENINGS AND DIAGNOSIS RATES AMONG 15-<21 YEARS OLD MEDICAID MANGED CARE BENEFICIARIES

OBJECTIVE

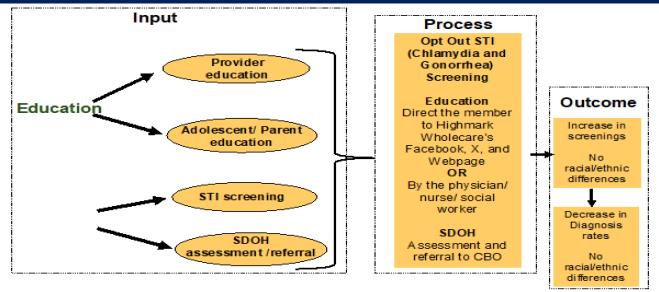
To design, implement, and evaluate an intervention to reduce racial/ethnic disparities in Sexually Transmitted Infection (STI) screenings and diagnosis rates among adolescents aged 15-<21 years, through Medicaid payment contracting models and addressing health-related social needs.



PARTNERS

- ❑ Office of Medical Assistance Programs (OMAP)
- ❑ Highmark Wholecare
- ❑ Northside Christian Health Center
- ❑ UPMC Children's Hospital, General Academic Pediatrics Clinic

INTERVENTION



Service Limits

- ❑ STI screening once per calendar year
- ❑ Social needs screening and referrals once in six months

INTERVENTION

Payment Incentives

	%	EPSDT Payment $100
White Member		
STI Screening	0.10	$10.0
SDOH screening and referral	0.10	$10.0
Total		**$20**
People of color		
STI Screening	0.30	$30.0
SDOH screening and referral	0.10	$10.0
Total		**$40**

Note: The amount mentioned here is to provide an example on how the incentives are calculated

Educational Interventions

PROVIDER EDUCATION

- ❑ Webinar with CME credits
- ❑ Data sharing on physician performance
- ❑ Highmark Wholecare's provider engagement staff

ADOLESCENT/PARENT EDUCATION

- ❑ Newsletter
- ❑ Social Media
  - ❑ Facebook
  - ❑ "X"
  - ❑ Highmark Wholecare webpage videos on STIs
- ❑ Talking points for care management/outreach staff

CHALLENGES

- ❑ Data driven identification of population of interest
- ❑ COVID pandemic
- ❑ Change in leaderships
- ❑ Transformation of IT platforms
- ❑ Team attrition
  - ❑ Provider team
  - ❑ Staff turnover
- ❑ Medicaid population and approvals
  - ❑ Member surveys, education on social media

HIGHLIGHTS

- ❑ Racial/ethnic disparities is a quality-of-care issue, but never addressed with incentives before.
  - ❑ We are addressing racial/ethnic disparities in STI screenings through payment models.
  - ❑ First time, there is payment for providers to collect data on members' social needs.
- ❑ STI screenings are part of Early and Periodic Screening Diagnostic and Treatment (EPSDT) benefit. It is up to physicians to screen members based on history and symptoms. Age and type of STI to be screened is not specified.
  - ❑ With this project, we have the STIs, and age group defined to be screened as part of EPSDT.
- ❑ In Medicaid, screenings for chlamydia are included as a Healthcare Effectiveness Data and Information Set (HEDIS) measure, the measure only includes females ages 16-24 years old.
  - ❑ Estimates show chlamydia rates are higher in females (666/100,000), but chlamydia is existent in males (333/100,000), yet no screening for males are included in HEDIS measures. This project focusses on both males and females.
- ❑ We found there is provider hesitancy to talk about STI screenings to members and provider biases are prevalent on who may or may not get STIs
  - ❑ To overcome this, we have 'opt out' STI screenings in the intervention clinics, similar to opt out HIV screening where everybody is screened, unless and otherwise opted out.

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Value-Based Payment Model to Improve Health Equity

Pennsylvania 2.0 Team Partners

- Pennsylvania Department of Human Services (DHS), The Office of Medical Assistance Programs
- Geisinger Health Plan (GHP Family)
- Geisinger Women and Children's Institute
- Healthy Start, Inc.
- UPMC Community Care Behavioral Health Organization
- UPMC *for You*
- UPMC Magee-Womens Hospital

Introduction

- Geisinger Health Plan (GHP Family) and UPMC *for You* have implemented a maternity care bundled payment with the guidance of the Pennsylvania DHS in partnership with hospitals in their integrated delivery and finance systems (IDFS).
- The maternity bundle is focused on improving health outcomes for birthing persons, with a focus on reducing disparities for Black, African American, and Hispanic members.
- Clinical and social support services have been implemented to further support the health equity goals of the maternity bundle.

Equity Goals

- Reduce health disparities in pregnancy associated hypertension
- Reduce health disparities in premature delivery
- Implement payment models that improve health equity

Considerations

- The maternity bundle became a statewide Medicaid contractual requirement for MCOs in 2021. UPMC *for You* implemented a maternity bundle in 2020, and Geisinger implemented a maternity bundle in 2021. We are still learning from our experiences.
- Readiness to address health equity increased provider willingness to enter a maternity bundle with a health equity component. Both Geisinger and UPMC *for You* built this foundation through health equity strategies supported by the organizational DEI strategies, which include components such as staff training, infrastructure, supplier diversity, community, culture, and talent.

Maternity Bundled Payment

Care Team:

The following care team model is a requirement for participating providers. Providers must also have 20 births to be eligible for the maternity bundle.

Clinicians	Access	Support
• Qualified/licensed to provide prenatal care • Qualified/licensed to assist in vaginal delivery of babies • Qualified/licensed to provide newborn services	• 1 + physician(s) qualified to treat high-risk pregnancies and perform C-sections • 1+ hospital(s) able to perform C-sections and treat complications of labor/delivery • 1 + Anesthesiology practice(s) • 1 + entity to perform laboratory tests or imaging studies	• Doula • Community Health Worker • 1 individual (social worker, peer specialist) to provide care coordination and assist with SDOH, substance abuse, etc.

Payment Methodology:

Services included in bundle

- Prenatal care
- Labor and delivery
- Care coordination
- Care for mother and baby up to 60 days postpartum

- A target price for bundle is developed between the MCO and Provider, considering which trimester the pregnant person is engaged in care and historical spend, factoring in acuity
- Providers receive fee for service (FFS) payments for services
- The MCO compares the FFS cost to the target price. If the FFS costs are less than the target price, those dollars enter a pool of shared savings.
- The MCO calculates the percentage of shared savings in the pool to share with providers based on their performance on the quality metrics below.

Health Equity metrics:
- Timeliness of Prenatal Care
- Postpartum visit between 7 - 84 days after delivery
- Prenatal Immunization Status - Combination

For the Health Equity measures, providers seek to improve rates for their Black and African American patients. They can earn points to achieve a greater percentage of the shared savings if they meet the NCQA national 75th percentile for the measures.

Full list of quality metrics:
- Social Determinants of Health Screening
- Timeliness of Prenatal Care
- Postpartum visit between 7 - 84 days after delivery
- Prenatal Depression Screening Follow Up
- Postpartum Depression Screening Follow Up
- Prenatal Immunization Status – Combination

These measures are applied to all members in the bundle population.

Clinical and Social Support Interventions:

Payer	Provider	CBO
• Maternity Care Management – Black and African American members are prioritized for outreach and engagement • SDOH screening and referral	• Doula Services (offered to all Black/African American pregnant patients) • Postpartum Hypertension Remote Monitoring • Lactation Consultants, including telelactation support • SDOH screening and referral	• Doula Services • SDOH assistance

Highlighted Outcomes:

- For hospitals and members participating in the maternity bundle, the largest disparity for the health equity qualify measures impacts Black/African American birthing persons.
- UPMC Magee-Womens Hospital's Doula Program showed for every 100 deliveries under doula care, there were 13-34 more VBACs, 7-11 more breastfeeding at discharge, 5-7 more postpartum visits, and 3-4 less preterm births.
- At Geisinger, from 2022 to 2023, social needs screenings show that over 21.6% of patients, who have been screened as part of the maternity bundle in clinical settings, have at least one social need. The number increases to 29.3% for GHP Family members, and 41.8% for Black/African American GHP Family members. Top needs include: employment, food, and transportation and top needs wanting resources include: housing assistance, utilities, food.
- Both Geisinger and UPMC prioritize Black and African American members in the stratification for their maternity care management teams to ensure they are encouraged to engage in the program.
  - Results from UPMC's care management program show significant impacts to prenatal and postpartum visit rates for Black and African American members who participated in the program vs. members who did not participate in the program. Based on CY23 data, there was a 6-point improvement for prenatal care and an 18-percentage point improvement for postpartum care for those who participated in the program.
  - As part of Geisinger's support for pregnant members, community health workers outreach to educate pregnant members on maternal health warning signs.

Looking Forward to 2025

- We will develop an VBP roadmap and implementation toolkit that can be leveraged by organizations when working with MCOs and providers to implement value-based payment approaches that improve health equity.

AHE Leading care, payment, and systems transformation

Pennsylvania Department of Human Services

Geisinger

Robert Wood Johnson Foundation

UPMC *for You* Affiliate of UPMC Health Plan

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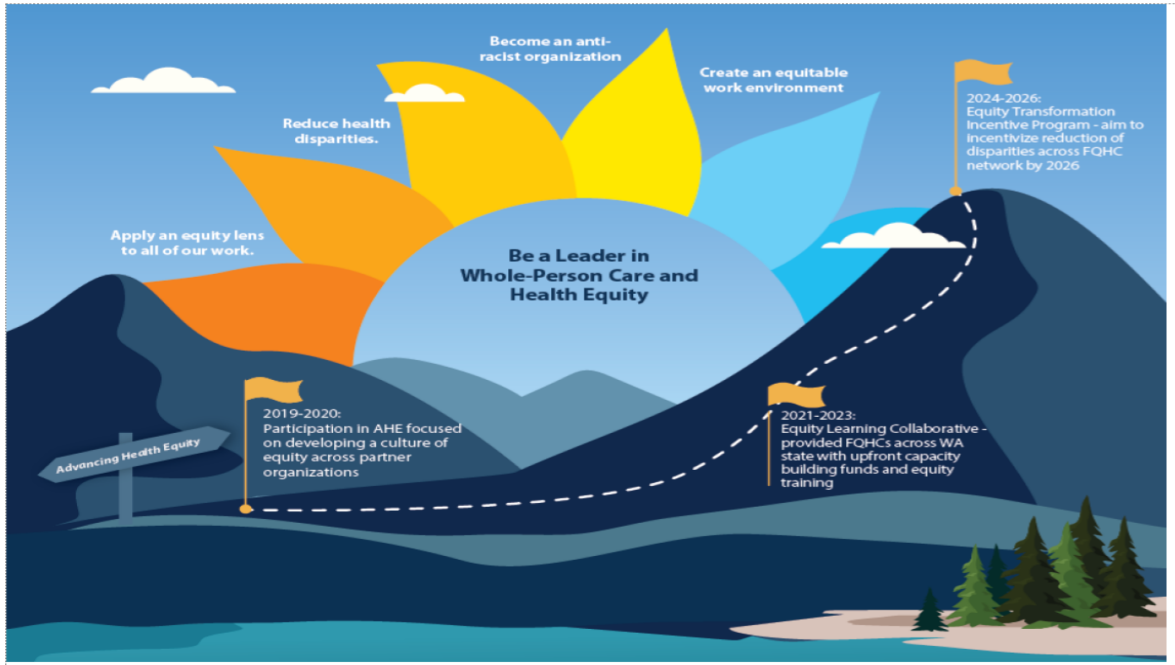


Washington State AHE Team

About Us

The Washington AHE team is comprised of Community Health Plan of Washington (**CHPW**), Community Health Network of Washington (**CHNW**), and the Washington State Health Care Authority (**HCA**). As part of the AHE Learning Collaborative, CHPW designed a care transformation program in partnership with HCA and CHNW leaders called the Equity Learning Collaborative program. The program consisted of:

- **$50,000 upfront capacity building funds** available annually to the 21 Washington State FQHCs that make up CHNW
- **Peer-to-peer cohort structure** for best practice sharing and support
- **Learning Series** sessions focused on health equity knowledge building

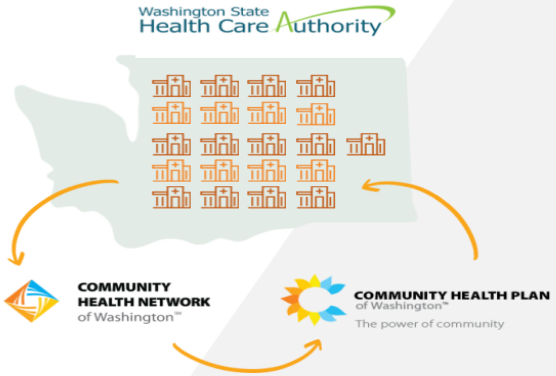
$2.3M invested over three years in FQHCs across Washington to advance equity within clinical outcomes, expand collection of social drivers of health data and address social needs, and invest in organizational equity infrastructure.

Lessons Learned

Building a culture of equity is key. Learning Series and peer-to-peer learning facilitated knowledge growth.

Upfront funding and flexibility necessary to support health equity foundational capacity building.

Designing a single payment model for 21 independent FQHCs is complex, requiring ample time for design and adoption.



What's Next

In 2024, the program was renamed to Equity Transformation Incentive to signify a transition from capacity building to action. By 2026, CHPW will provide FQHCs with **financial incentives for the reduction in health disparities** as part of an existing Pay for Performance quality incentive program.

Year 1: Assessing organization cultural responsiveness
Year 2: Identifying disparities and developing an intervention
Year 3: Incentives for reducing disparity

"This 3 year program, brought CHCs through the process gently, to ensure the investment, structure and buy-in was there to support this kind of work. I truly believe if we hadn't had the time to truly build a culture of equity, that we wouldn't be where we are and people might have felt intimidated about what was being asked of them."
– 3 year FQHC Participant

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