Prioritizing Solutions

American Heart Association. 100 YEARS Bold Hearts

pcc primary care collaborative

Prioritizing Prevention: Lessons from Million Hearts

1:00 ET, March 21, 2024

Thank You to Our Funders

Arnold Ventures

The Commonwealth Fund

About Million Hearts

- Founded in 2012
- Aim of preventing 1 million heart attacks and strokes over 5 years
- Focus on prevention at both community and clinical level

Valiree's Story:

PCC & Patients for Primary Care (P4PC.org)

Lessons from Million Hearts

Dr. Tom Frieden

President & CEO
Resolve to Save Lives

Dr. Eduardo Sanchez

Chief Medical Officer for Prevention
American Heart Association

Laura Blue, Ph.D.

Principal Researcher
Mathematica

Dr. Nkem Okeke

Founder and CEO
Medicalincs

THE HEART OF THE MILLION HEARTS MATTER

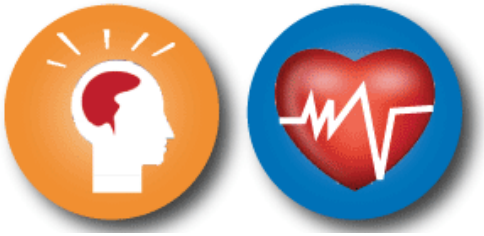
Why it didn't succeed… and how we can do better

RESOLVE TO SAVE LIVES

Tom Frieden, MD, MPH

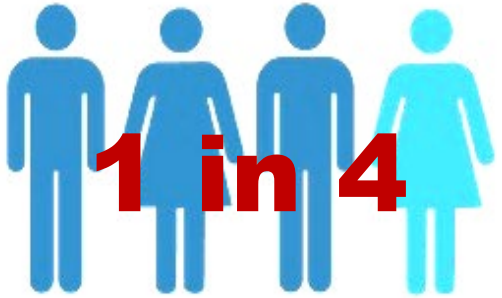
President and Chief Executive Officer

CARDIOVASCULAR DISEASE IS THE #1 KILLER IN THE U.S. AND WORLDWIDE



2M

Each year, nearly 2 million people in the U.S. suffer from heart attacks and strokes



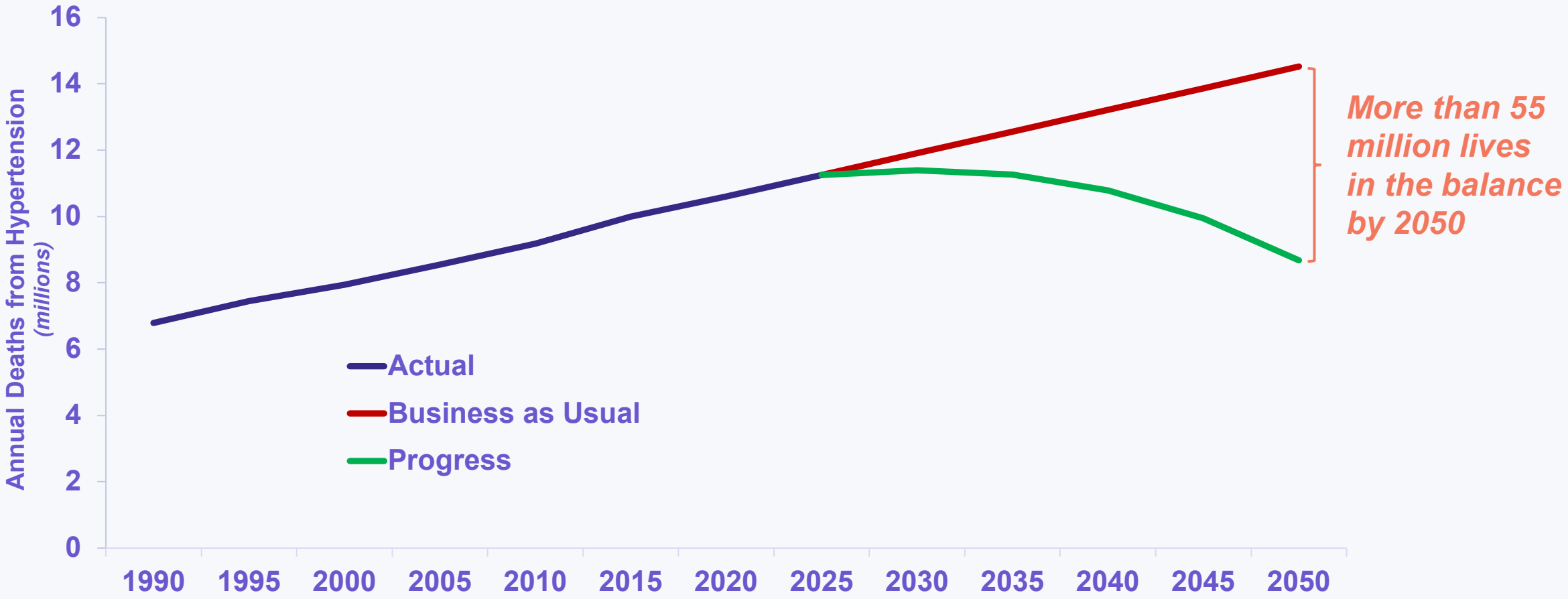
Every year 930,000 people die from cardiovascular disease (1 in every 4 deaths)

$407B

These conditions incur $251 billion in direct medical costs and $156 billion in indirect costs every year and account for the largest single portion of racial disparities in life expectancy

American Heart Association. Heart Disease & Stroke Statistics – 2023 Update

PROGRESS IN CONTROLLING HYPERTENSION CAN SAVE MILLIONS OF LIVES A YEAR



MILLION HEARTS RELIES ON BOTH COMMUNITY AND CLINICAL PREVENTION

Public health and health care must work together to *maximize health* and *save lives*

COMMUNITY PREVENTION
Reduce need for treatment

Tobacco control

Sodium reduction

Trans fat elimination

CLINICAL PREVENTION
Improve treatment

Focus on ABCS

Health information technology

Clinical innovations

With a focus on the *ABCS* of heart health

Aspirin when appropriate

Blood pressure control

Cholesterol management

Smoking cessation

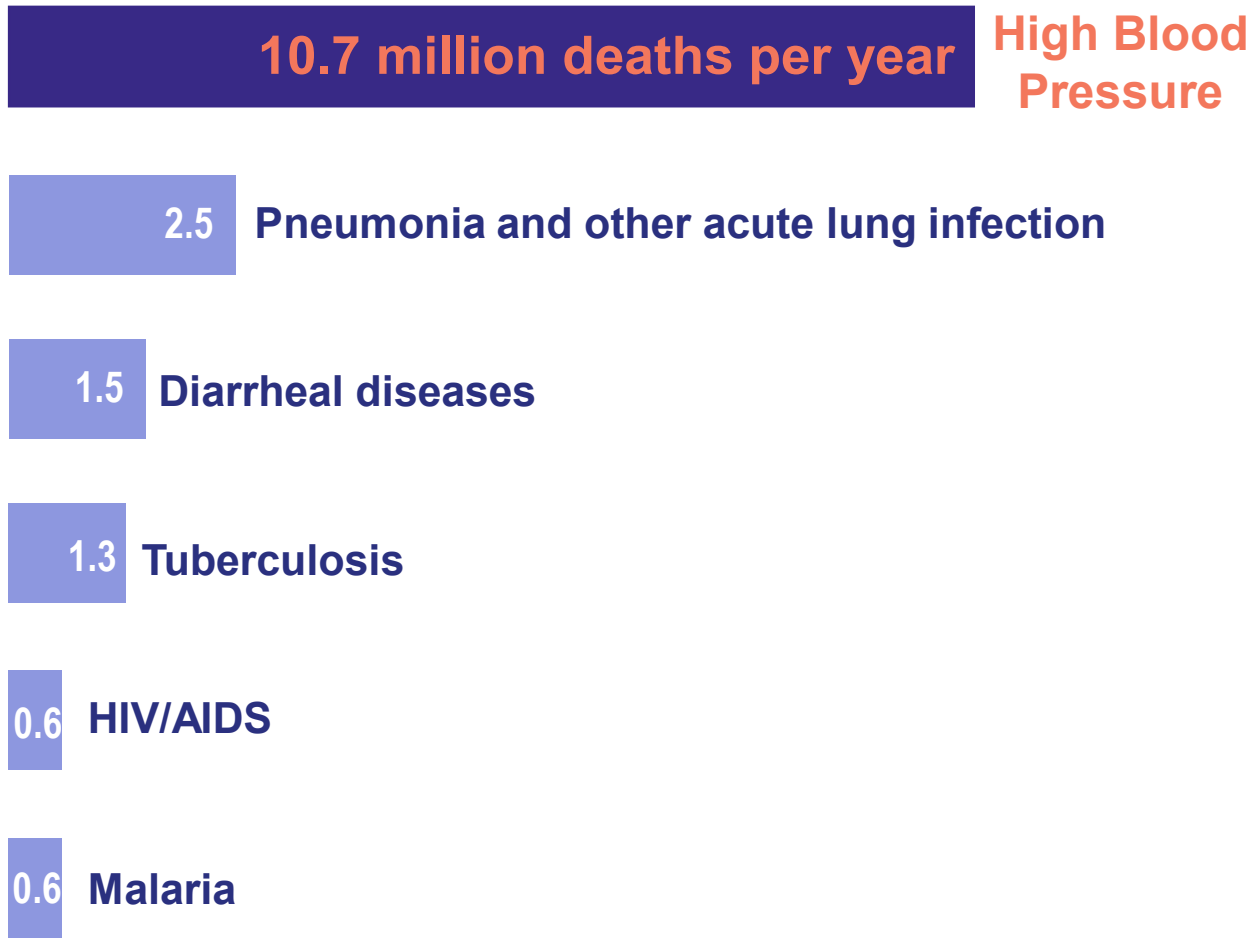
HYPERTENSION CONTROL CAN SAVE MORE LIVES THAN ANY OTHER HEALTH CARE INTERVENTION

High blood pressure kills more people than any other condition – and more than all infectious diseases combined

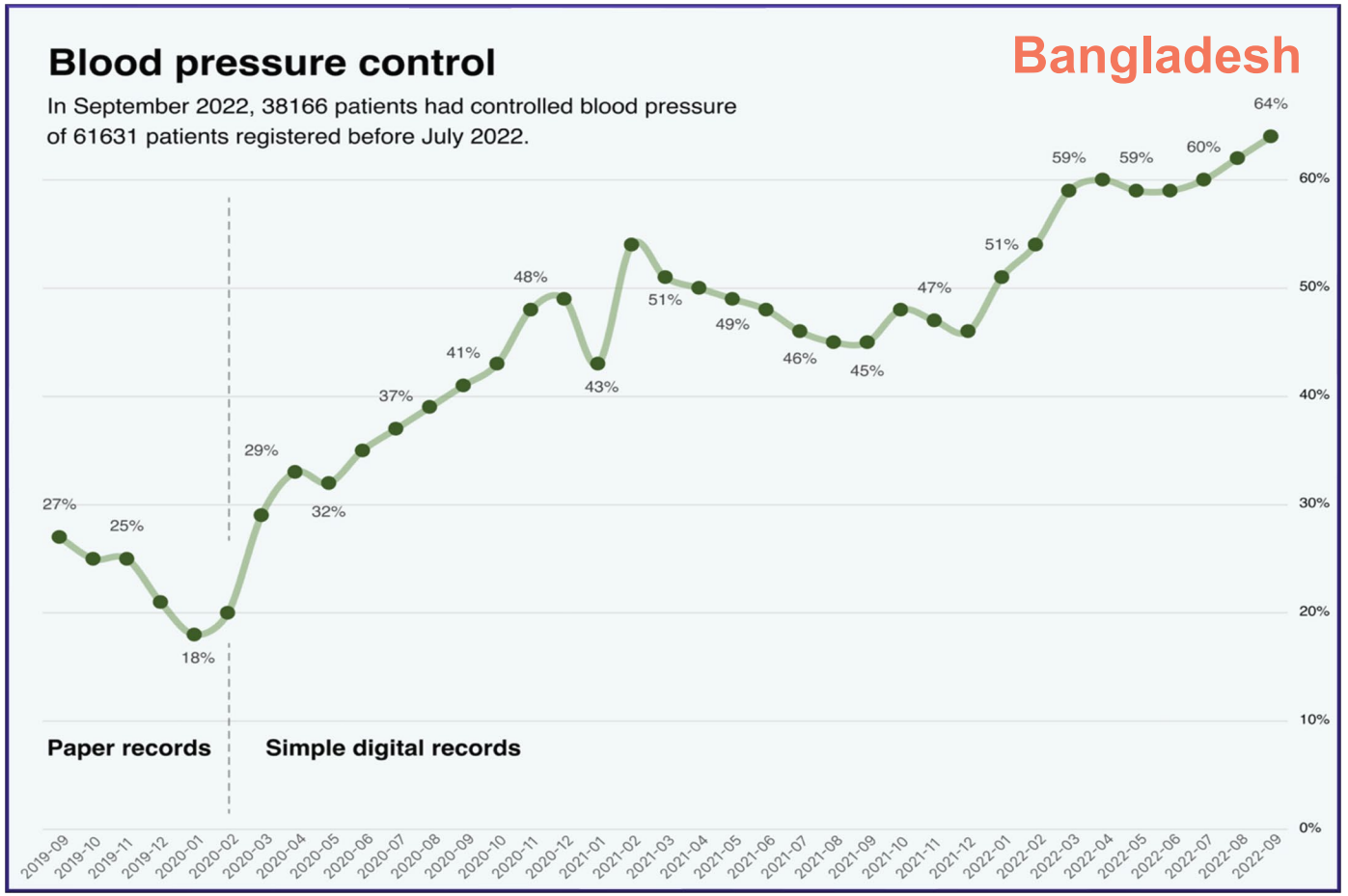
Every 20 mm increase in systolic blood from 115/75 **doubles** vascular mortality at ages 35-69

Lewington et al. Lancet. 2002;360:1903-1913.

Hypertension is the leading risk factor for preventable deaths worldwide



THE WHO HEARTS STRATEGY CAN *TRIPLE* BLOOD PRESSURE CONTROL RATES



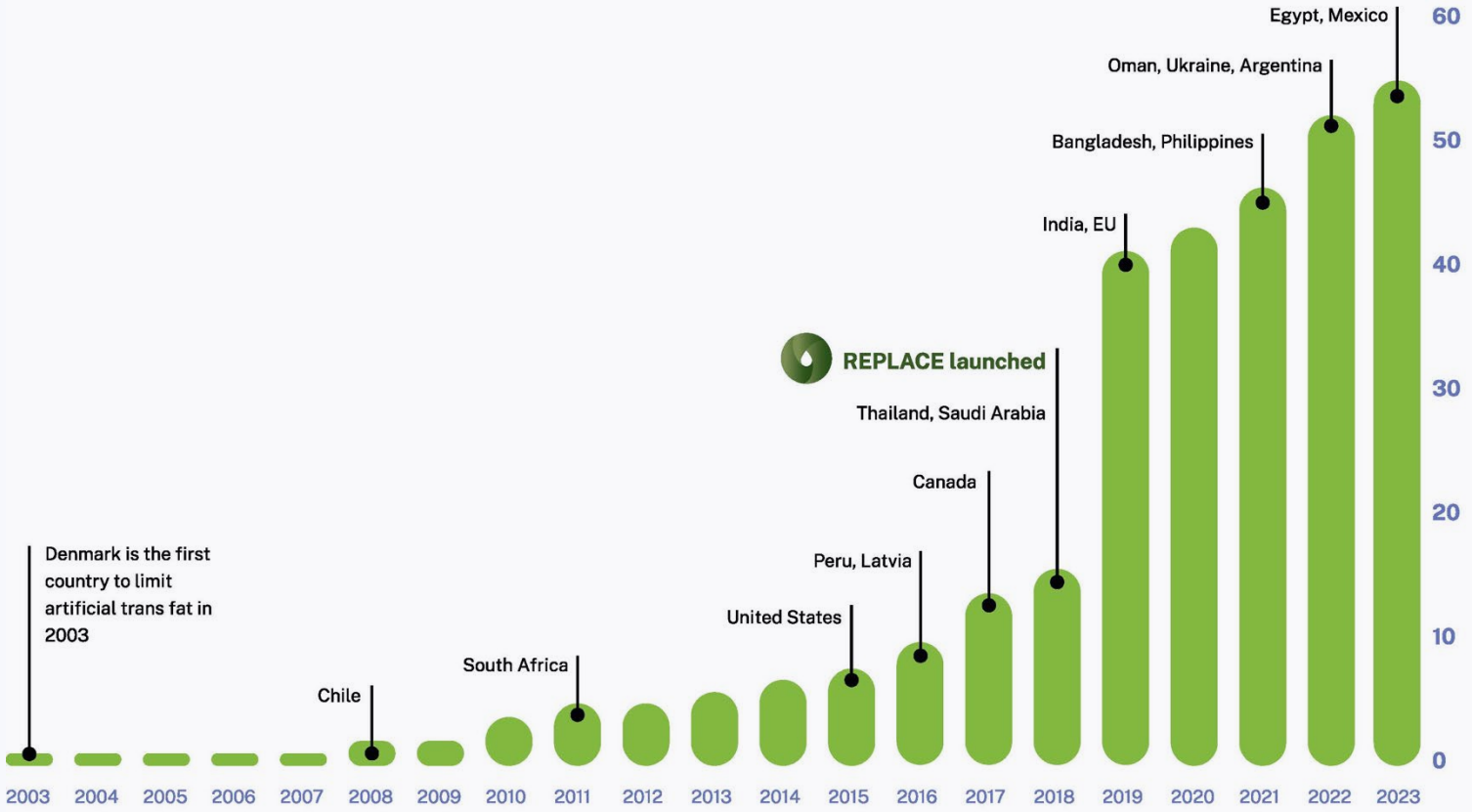
SMOKING CESSATION MET THE 2022 TARGET

- Adult smoking prevalence dropped a relative 22% (vs the goal of 20%) – to an all-time low
- More can be done – the FDA has authority to regulate nicotine in combustible tobacco products to non-addictive levels
  - This could substantially reduce cardiovascular mortality as combustible tobacco presents the greatest health risk
  - FDA has been working on nicotine regulation but progress has been slow
  - Competing priorities, industry opposition, and court challenges have prevented action

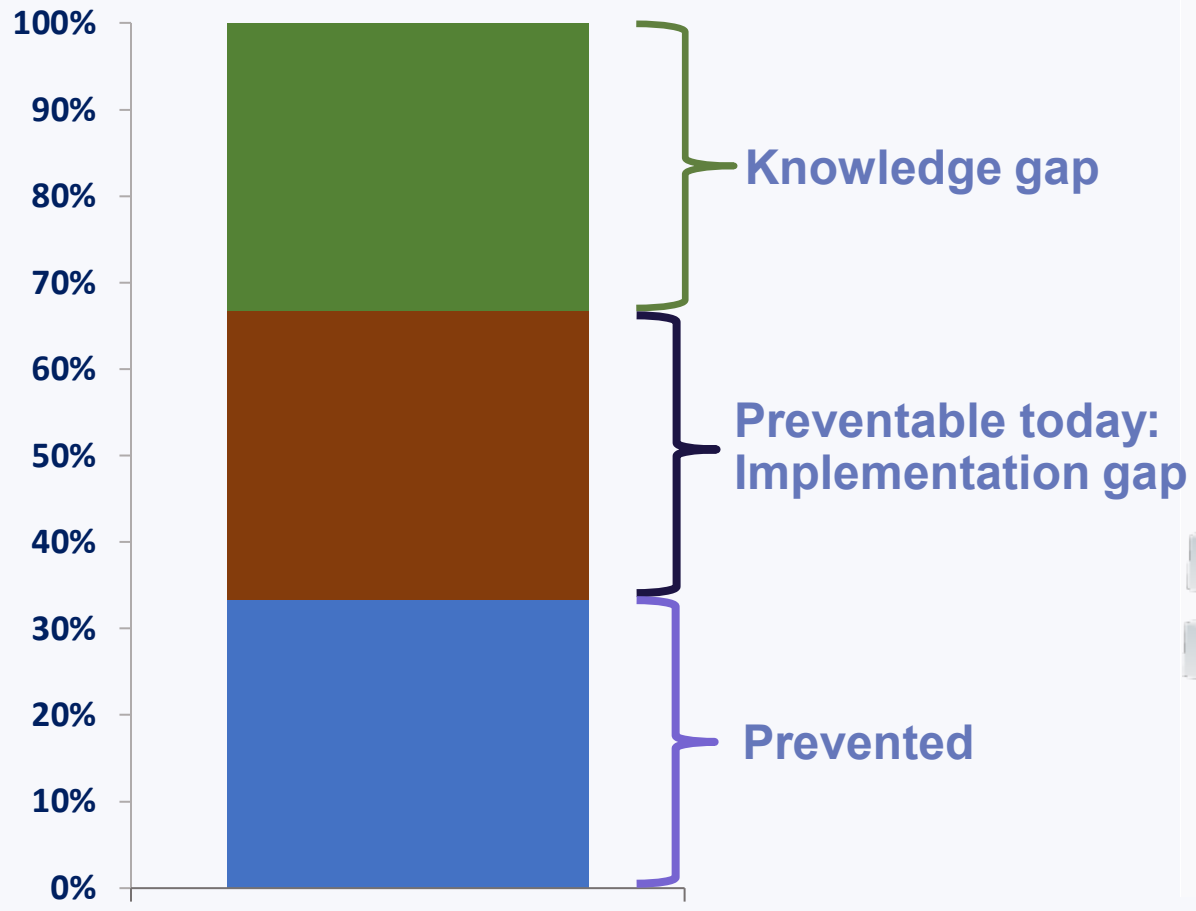
PROGRESS ON ARTIFICIAL TRANS FAT ELIMINATION

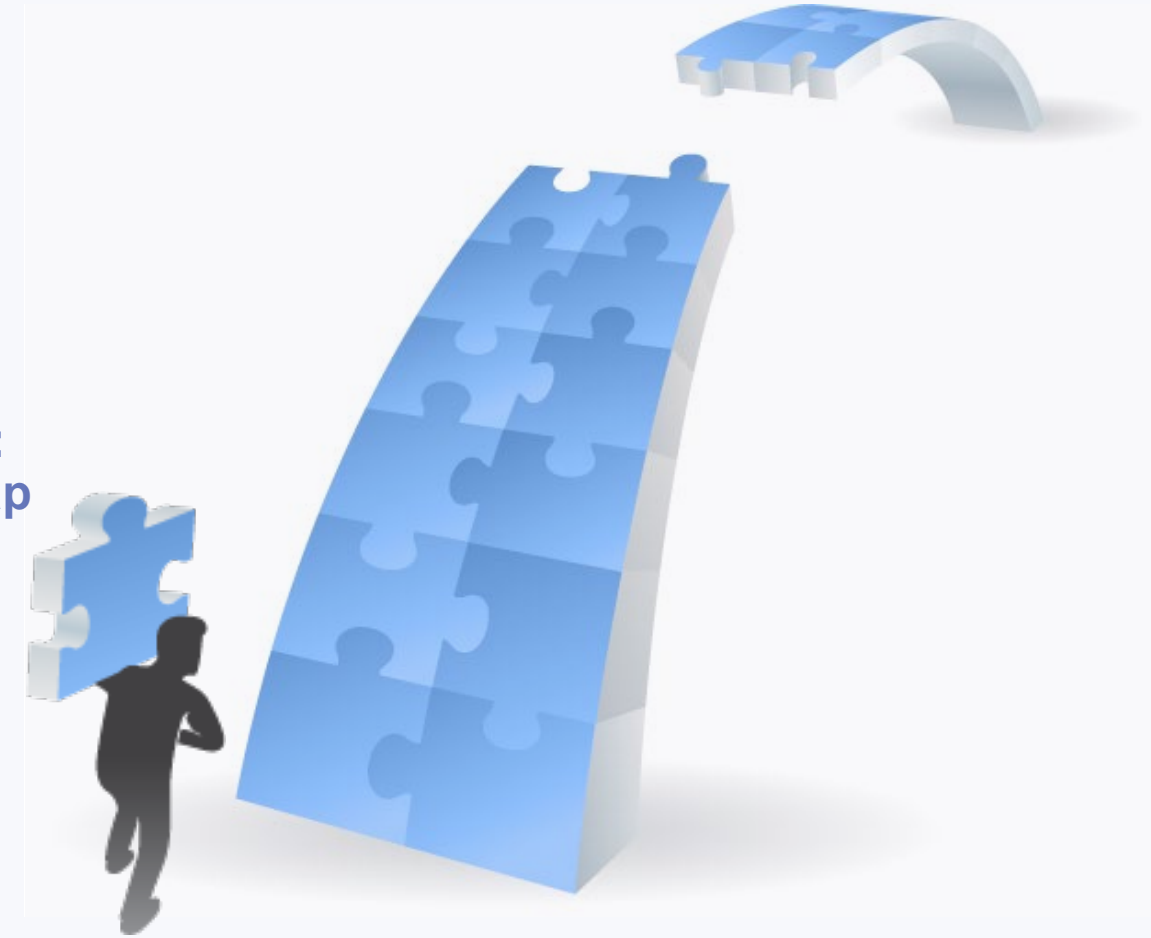
- 2015 ruling to eliminate artificial trans fat from the U.S. food supply fully implemented by 2021
- In line with global elimination efforts (REPLACE)
- Will prevent 250,000 heart attacks & 50,000 deaths per year in U.S. alone

3.7 billion people – just under half the global population – live in countries with best practice trans fat elimination policies in place



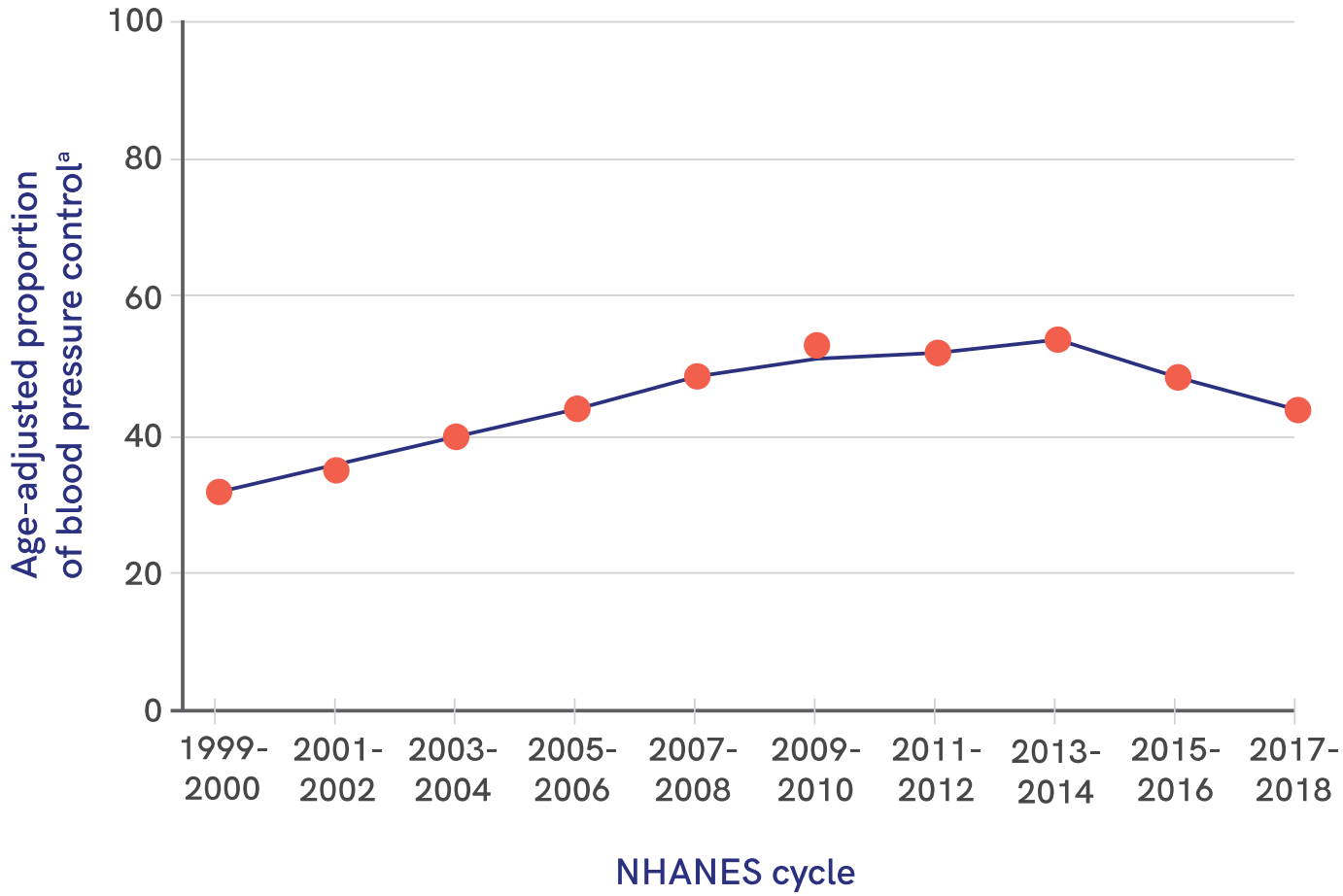
WE HAVE NOT YET BRIDGED THE IMPLEMENTATION GAP BETWEEN WHAT WE KNOW AND WHAT WE DO





LOST MOMENTUM IN ACHIEVING U.S. HYPERTENSION CONTROL GOALS

After decades of steady improvement, blood pressure control in the U.S. declined starting in 2015



NCHS Data Brief No. 364, April 2020

MILLION HEARTS DID NOT SUCCEED IN MEETING ITS GOALS – *WHY?*

Goal was to prevent one million heart attacks and strokes between 2012 and 2016

Prevented ~135,000 cardiovascular events

Blood pressure control *decreased* despite increased insurance coverage, and the decades-long decline in the CVD death rate stalled and began to increase

The bottom line is the bottom line:

Exhortation fails

Health system financing needs to make prevention pay and impose meaningful financial penalties for failure of prevention

Health care systems should pay for the heart attacks, strokes, and dialysis they fail to prevent

Frieden TR & Foti KE. JAMA. 2021;325(14):1391-1392.

SODIUM REDUCTION

- FDA guidance on voluntary sodium reduction targets issued 2021
  - Mandated reductions with mandatory maximums more effective
  - New interim targets needed (first 2.5-year period ends next month)
- Front-of-Pack Warnings
  - Regulatory process is slow and obstructed by industry interests and current judicial context
- Promotion of potassium-enriched, low-sodium salt

resolvetosavelives.org

Systems, Standards, Protocols: Start with Blood Pressure Control

Prioritizing Prevention: Lessons from Million Hearts
March 21, 2024

Eduardo Sanchez, MD, MPH,FAHA
Chief Medical Officer for Prevention
American Heart Association

Disclosure:

Principal Investigator - National Hypertension Control Initiative
Strategic Partner – Million Hearts Initiative

American Heart Association (AHA)
U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH)
Health Resources and Services Administration (HRSA)

The NHCI initiative is supported by a cooperative agreement with the Office of Minority Health (OMH) of the U.S. Department of Health and Human Services (HHS), as part of a financial assistance award totaling $12.2 million in partnership with the Health Resources and Services Administration (HRSA). The contents do not necessarily represent the official views of, nor an endorsement by OMH/OASH/HHS or the U.S. Government. For more information, please visit https://www.minorityhealth.hhs.gov/

AHA Mission Statement

… to be a relentless force for a world of longer, healthier lives

AHA Vision

Advancing health and hope for everyone everywhere.

Life's Essential 8™

Your checklist for lifelong good health

Sign up for health & well-being tips

American Heart Association.

Leading Risk Factors for CVD

Population Attributable Fraction (PAF)

Rank	Risk Factor	PAF (95% CI)
1	**Hypertension**	**22.3% (17.4-27.2)**
2	High non-HDL cholesterol	8.1% (3.1-13.2)
3	Household air pollution	6.9% (4.7-9.1)
4	Tobacco use	6.1% (4.5-7.6)
5	Poor diet	6.2% (2.8-9.5)
6	Low education	5.8% (2.8-8.8)
7	Abdominal obesity	5.7% (1.7-9.8)
8	Diabetes	5.1% (2.9-7.4)
9	Low grip strength	3.3% (0.9-5.7)
10	Low physical activity	1.5% (0.3-2.7)

Source: Yusuf et al., Lancet, 2020

American Heart Association.

The Surgeon General's Call to Action to

Control Hypertension

U.S. PUBLIC HEALTH SERVICE 1798

U.S. Department of Health and Human Services

World Health Organization

Global report on hypertension

The race against a silent killer

National Hypertension Control Initiative (NHCI) Demonstration Project – 2021-2023

Federally Qualified Heath Centers
(funded by HHS HRSA)

- Eligible with control rates <58.9% in 2019
- Goal of offering SMBP devices to majority of patients with uncontrolled BP
- Funded $60M for 350 community health centers over 3 years (2021-23)

American Heart Association
(funded by HHS OMH/HRSA)

- Provide technical assistance and training
- Support community outreach, patient/ public education, and evaluation
- Funded $32M over 3 years (2021-23)

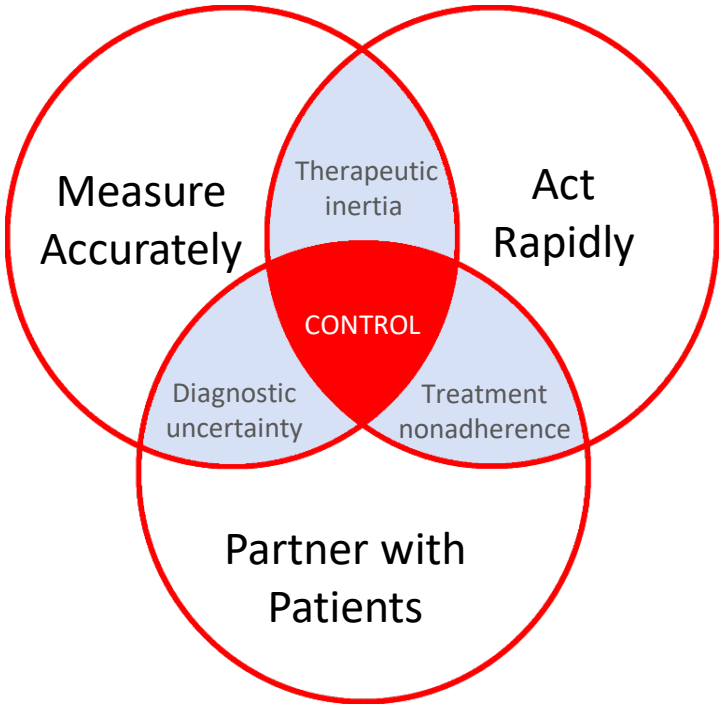
Blood Pressure Control among Adults with Hypertension in the US (2017-2018)

Characteristic	Control Rate (%)
Less than high school graduation	**40.5**
High school and some college	46.2
College graduation	48.0
< $20,000 annual household income	**39.4**
$20,000 - $44,999 annual household income	45.1
$45,000 - $74,999 annual household income	49.2
> $75,000 annual household income	50.2
Private health insurance	48.2
Medicare	53.4
Medicaid	41.1
Uninsured	**24.1**
Usual health care facility	48.4
No usual health care facility	**26.5**
No healthcare in past 12 months	**8.0**

Source: Muntner, JAMA, 2020.

NHCI: MAP + SMBP

- Good blood pressure measurement technique
- Use of treatment algorithm
- Optimized activation of health team



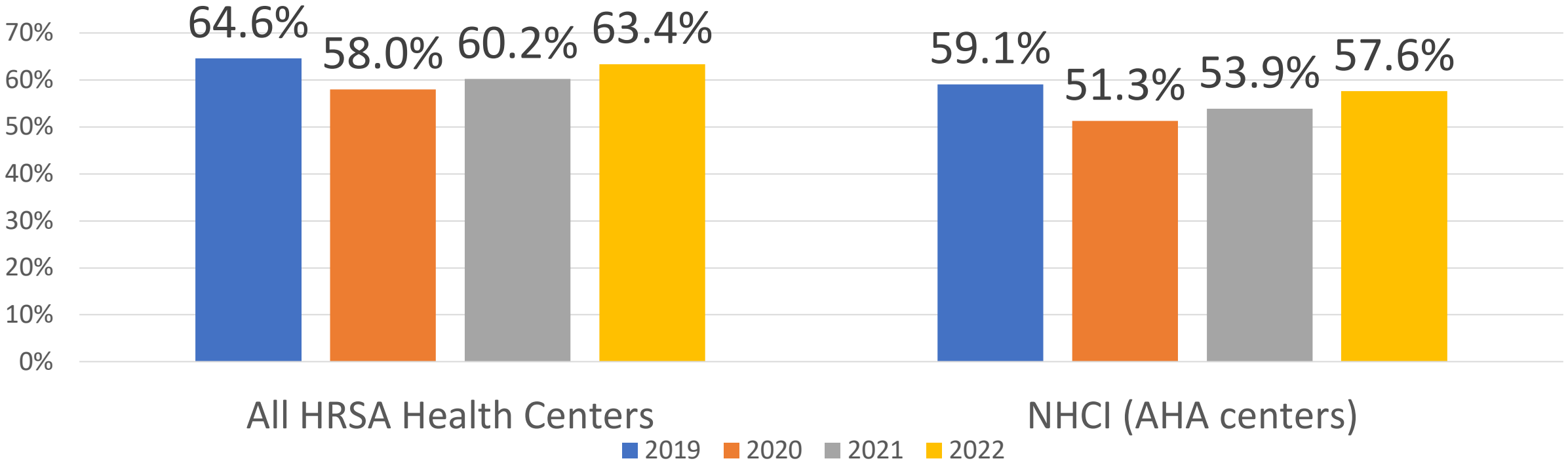
M Measure Accurately every time to obtain accurate, representative BPs, reducing clinical uncertainty

A Act Rapidly to diagnose and treat hypertension, reducing diagnostic and therapeutic inertia

P Partner with patients to activate patients to activate them to self-manage (including Self-Measured Blood Pressure) and promote adherence to treatment

SMBP Self-measured blood pressure monitoring

NHCI: Blood Pressure Control Rates* 2019-2022
All HRSA Centers, NHCI Centers**



	Absolute Change *From 2020 - 2022*	Relative Change *From 2020 - 2022*
All HRSA Health Centers	5.4%	**9.3%**
NHCI (AHA centers)	6.3%	**12.3%**

*Data source UDS 2019-2022

** 350 NHCI Centers with 2019 BP control rates <58.9% are receiving HRSA funding and AHA T/TA from 1/2021 – 12/2023.

Target: BP™

Target: BP™ is a national initiative created by the American Heart Association (AHA) and the American Medical Association (AMA) in response to the high prevalence of uncontrolled blood pressure (BP). Committed to advancing health equity, we support health care organizations and communities to improve blood pressure control for the patients they serve with the latest scientific evidence from AHA, AMA, and other experts.

Leverages AHA guidelines and scientific statements and the AMA MAP™ framework

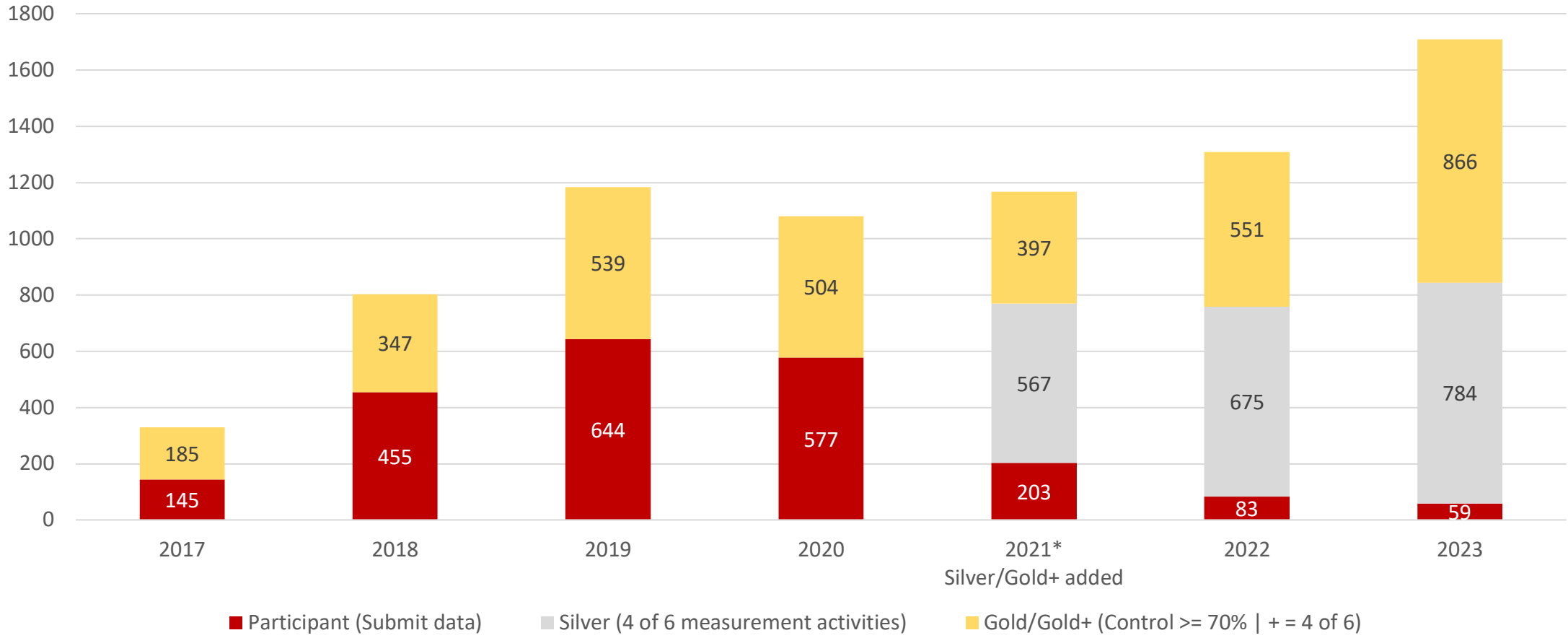
Assists health care organizations in their journeys to improve and sustain BP control

Recognizes health care organizations annually with achievement awards

Target: 2017 to 2023

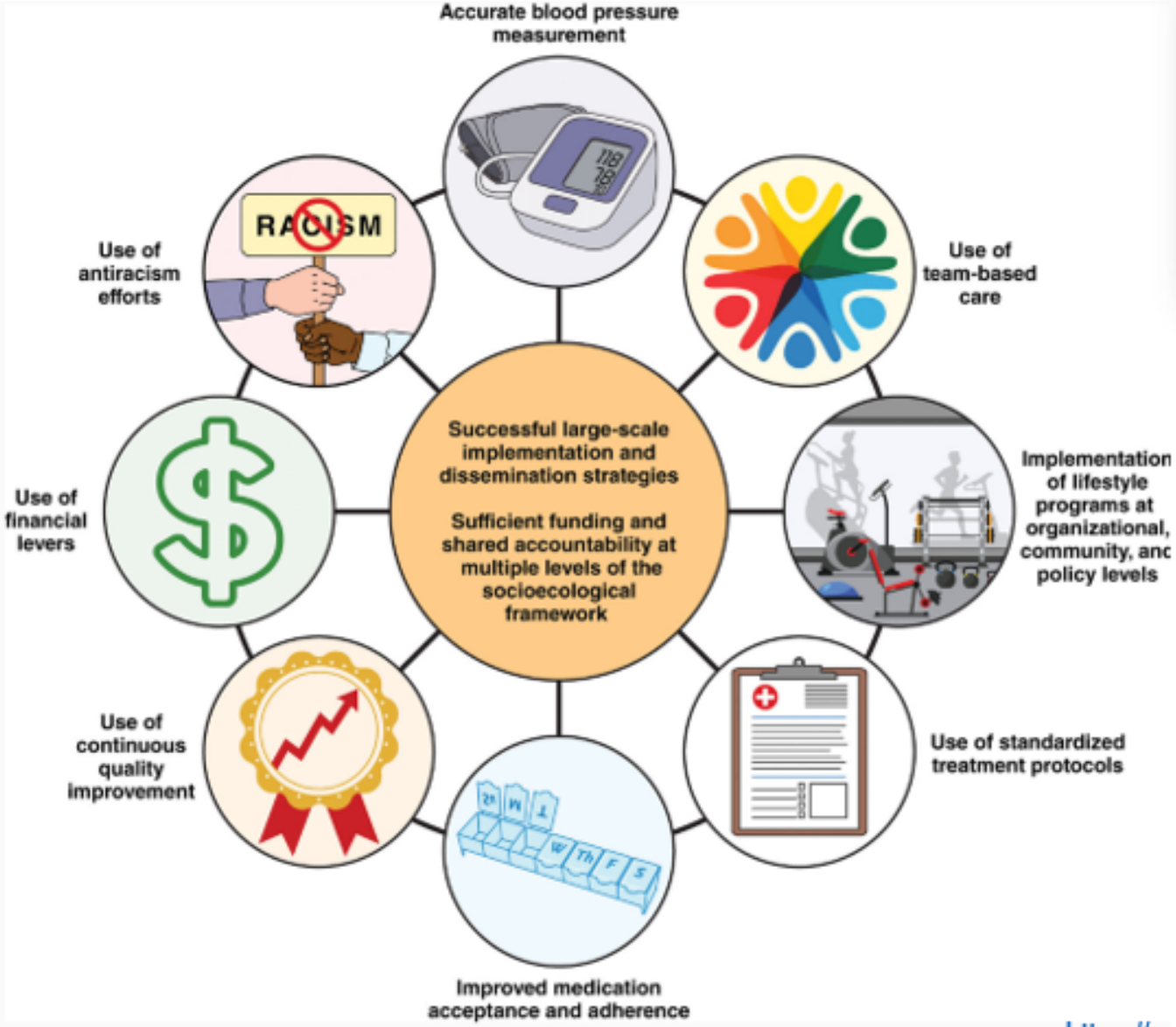
Target: BP participating HCOs reach 32 million total patients and 8.6 million patients with hypertension

Target: BP Award Achievement (2017 – 2023)



TARGET: BP™ | American Heart Association. AMA

Strategies to Improve Blood Pressure Control



AHA/AMA SCIENTIFIC STATEMENT

Implementation Strategies to Improve Blood Pressure Control in the United States: A Scientific Statement From the American Heart Association and American Medical Association

Marwah Abdalla, MD, MPH; Vice Chair; Shari D. Bolen, MD, MPH; Jeffrey Brettler, MD; Brent M. Egan, MD; Keith C. Ferdinand, MD; Cassandra D. Ford, PhD; Daniel T. Lackland, DrPH; Hilary K. Wall, MPH; Daichi Shimbo, MD, Chair; on behalf of the American Heart Association and American Medical Association

Emphasis on translating science into practice:

- Health equity efforts
- Accurate BP measurement
- Evidence-based SMBP and lifestyle change programs
- Team-based care models
- Treatment protocols
- Medication adherence strategies
- Data-driven continuous quality improvement

https://www.ahajournals.org/doi/10.1161/HYP.0000000000000232

“I’m not an optimist.
I’m a very serious possibilist.”

Hans Rosling (1948-2017)

Findings from the Million Hearts® Cardiovascular Disease Risk Reduction Model, 2017–2021

March 21, 2024

Laura Blue

Acknowledgments and disclaimer

Acknowledgments: Findings are based on research conducted by a team at Mathematica, the RAND Corporation, and the University of Colorado.

Funding: U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, contract HHSM-500-2014-00034I/HHSM-500-T0019.

Disclaimer: Views expressed are solely the responsibility of the author and do not necessarily represent views of the research team or funder.

The Million Hearts Cardiovascular Disease Risk Reduction Model

- **One component of the broader Million Hearts® initiative**
- **Five-year randomized trial (2017–2021)**
- **Run by the Innovation Center at the Centers for Medicare & Medicaid Services (CMS)**
- **Results: The model reduced incidence of first-time heart attacks and strokes, without statistically significant effects on Medicare spending**

The intervention

Million Hearts Model intervention: (1) Participant commitments

- **Participating health care provider organizations signed participation agreements, committing to provide care concordant with clinical guidelines on CVD primary prevention**
  - Calculate 10-year predicted risk of a heart attack or stroke (CVD risk score) for all eligible Medicare beneficiaries (ages 40–79 with no previous heart attack or stroke)
    - Risk scores calculated with the AHA/ACC 10-year ASCVD risk calculator
  - Discuss risk with people found to have high risk (defined for the model as >30%) and jointly develop care plan to reduce risk
  - Meet with these patients with high risk to reassess risk annually, using a novel longitudinal CVD risk calculator developed for the Million Hearts Model
  - Contact these patients at least twice in addition per year to monitor and encourage risk reduction

Million Hearts Model intervention: (2) CMS payments, tools, and supports

- **CMS paid participants to calculate and reduce CVD risk**
  - One-time $10 payments for each eligible Medicare beneficiary receiving a CVD risk assessment
  - 2017 only: cardiovascular care management fees of $10 per beneficiary per month (PBPM) for each beneficiary with high risk
  - Novel risk-reduction payments: up to $10 PBPM for each beneficiary with high risk, based on those beneficiaries' average improvement in risk score
- **CMS also provided non-financial tools and supports:**
  - A data registry to submit clinical data to CMS
  - Data feedback tools
  - Cross-participant learning events for model participants to share best practices

Participation

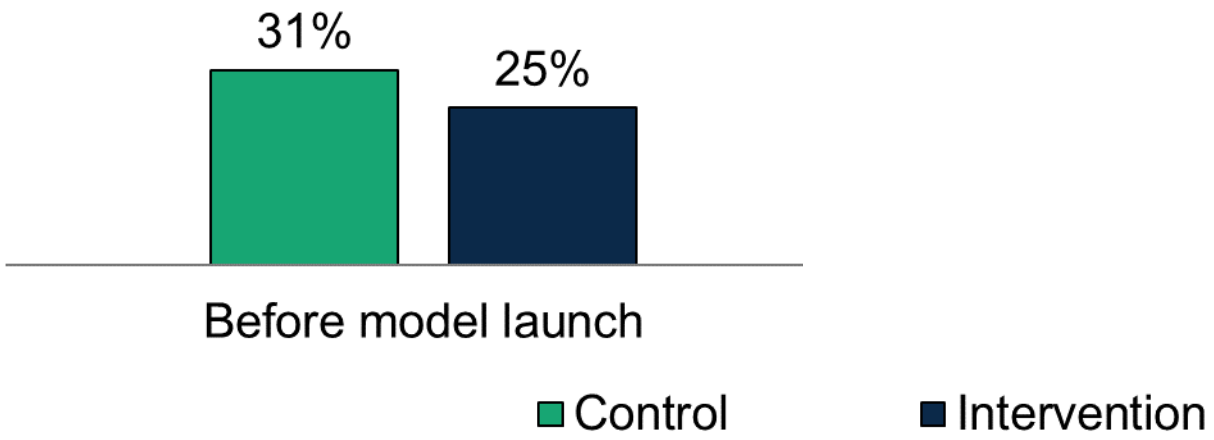
Participants and enrollment

- **345 health care provider organizations participated in the model, enrolling at least one Medicare beneficiary in 2017–2018**
  - 173 organizations in the intervention group; 172 organizations in the control
  - Diverse organizations: primary care practices, specialty practices, community health centers, and hospital outpatient departments, located across the U.S.
- **These participants enrolled hundreds of thousands of Medicare beneficiaries (ages 40–79 without previous CVD event)**
  - Including 218,864 with high or medium risk (risk score >15%)
- **Organizations withdrew from the model over time**
  - Only 46 of the 173 organizations in the intervention group actively participated through 2021, submitting data needed to receive model payments
  - Data reporting burden and modest payments cited as reasons for withdrawal
  - Reduced focus on the model during the Covid-19 pandemic

Model effects

The model substantially increased use of CVD risk assessment by 2018

Percentage of surveyed providers reporting they calculated CVD risk scores for at least half of their Medicare beneficiaries

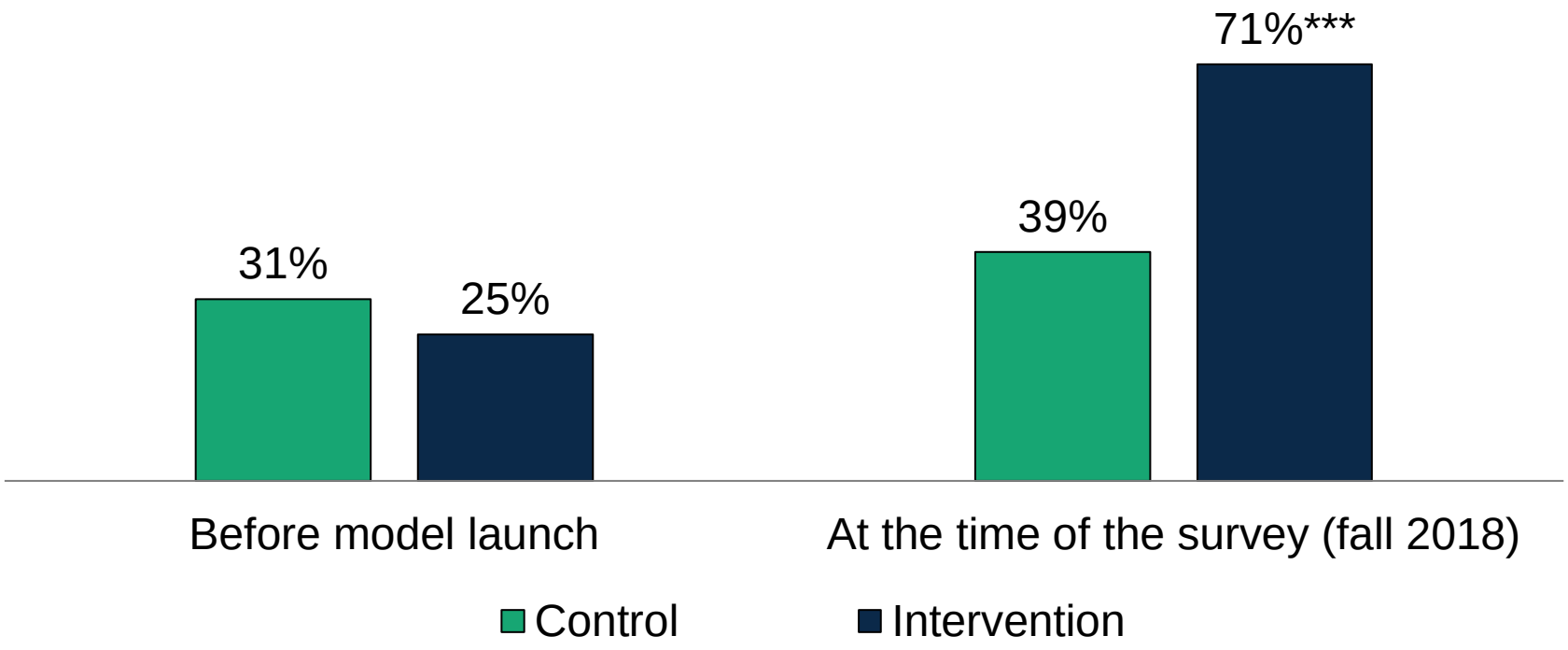


* = $p < 0.1$; ** = $p < 0.05$; *** = $p < 0.01$.

2016 rates were estimated from 2018 survey responses; respondents were asked to recall their care practices two years before the time of the survey.

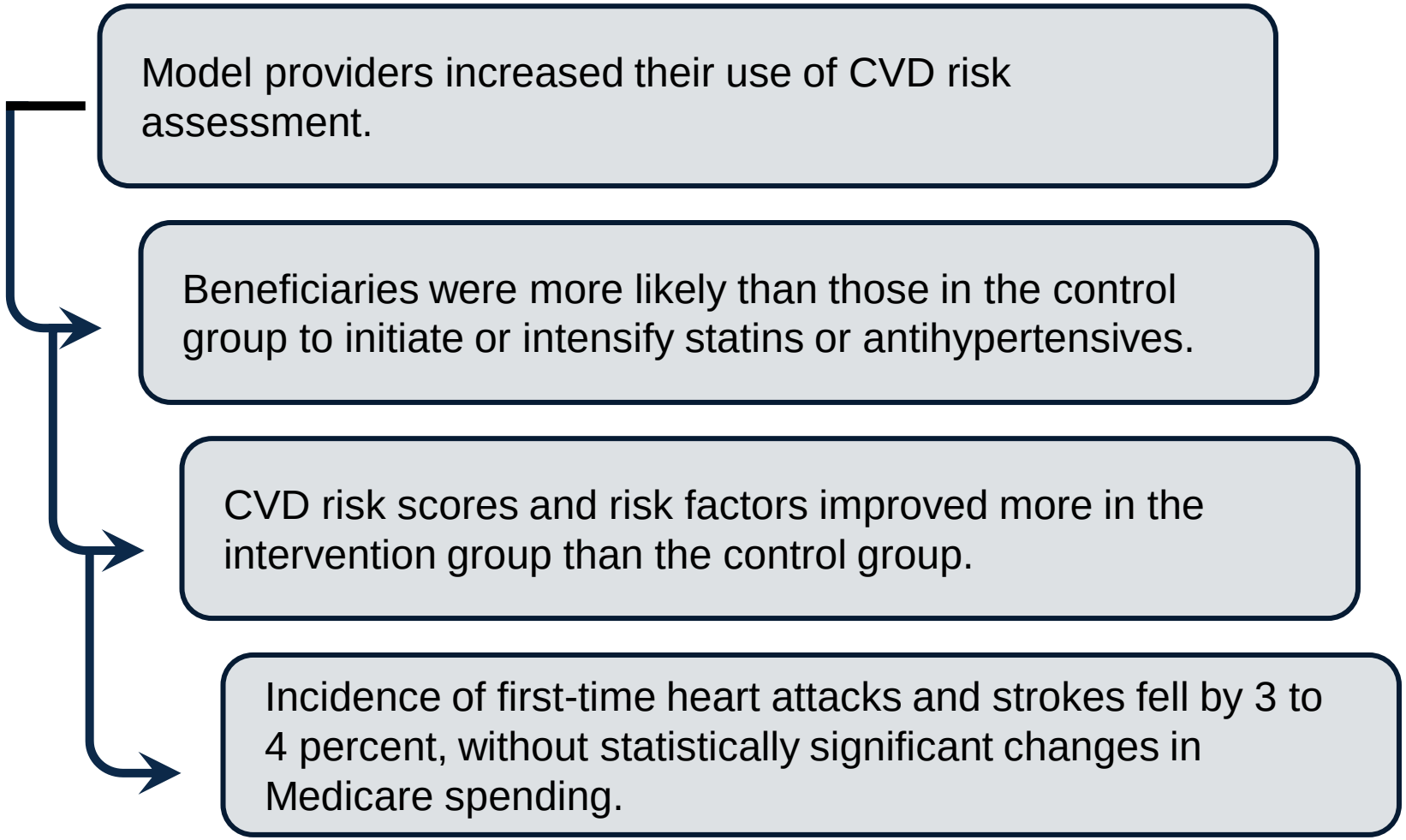
The model substantially increased use of CVD risk assessment by 2018

Percentage of surveyed providers reporting they calculated CVD risk scores for at least half of their Medicare beneficiaries



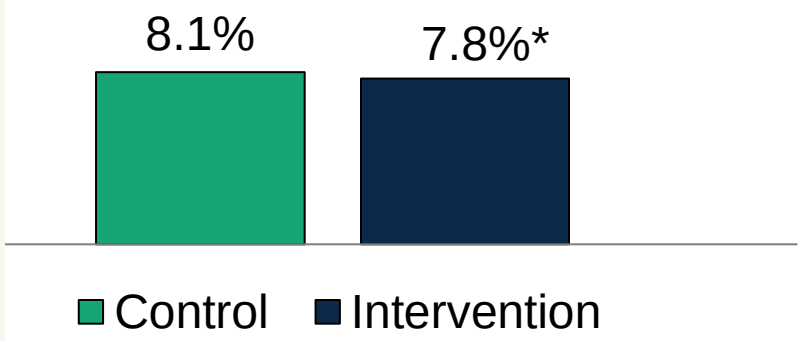
* = $p < 0.1$; ** = $p < 0.05$; *** = $p < 0.01$.

2016 rates were estimated from 2018 survey responses; respondents were asked to recall their care practices two years before the time of the survey.


Model providers increased their use of CVD risk assessment.
Beneficiaries were more likely than those in the control group to initiate or intensify statins or antihypertensives.
CVD risk scores and risk factors improved more in the intervention group than the control group.
Incidence of first-time heart attacks and strokes fell by 3 to 4 percent, without statistically significant changes in Medicare spending.

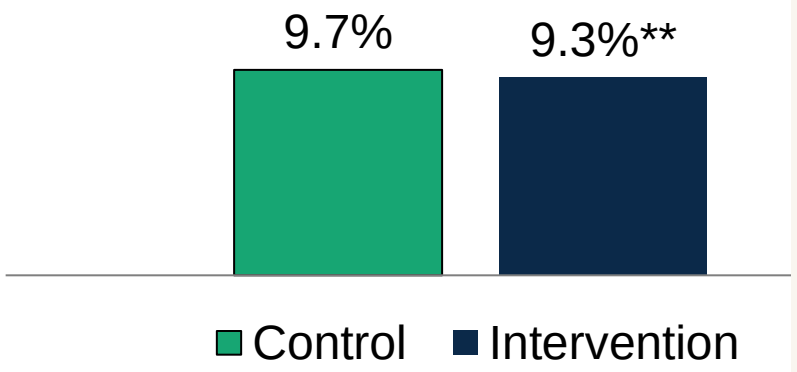
The model decreased incidence of first-time heart attacks and strokes over 5 years

Percentage of people with a first-time heart attack or stroke, as measured in claims, within 5 years



- (8.1–7.8)/8.1 ≈ 3.3% relative reduction
- Suggests roughly 1 averted event per 400 enrolled

Percentage of people with a first-time heart attack or stroke, or death due to CHD or cerebrovascular disease, within 5 years



- 4.2% relative reduction
- Suggests roughly 1 averted event per 250 enrolled

Measured among beneficiaries with high or medium risk

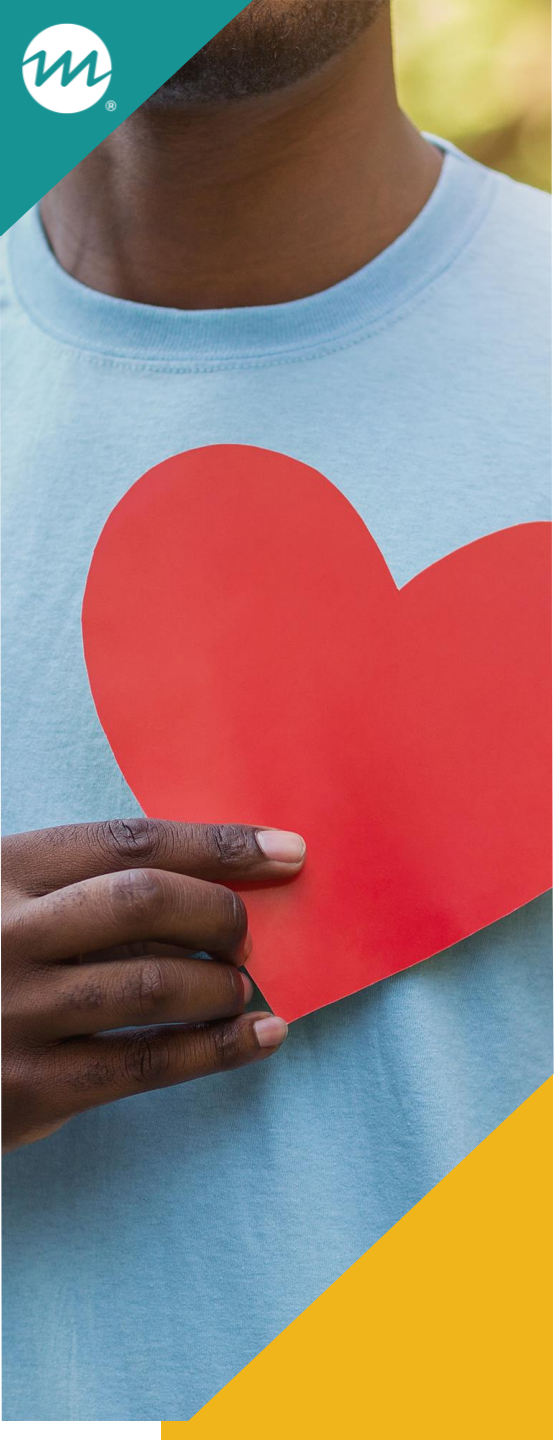
* = $p < 0.1$; ** = $p < 0.05$; *** = $p < 0.01$.

CHD = coronary heart disease.

Summing up

Summary of findings

- **Participants' commitment to CVD risk assessment and follow-up, coupled with CMS payments and supports, reduced first-time heart attacks and strokes over 5 years**
- **Effects on first-time heart attacks and strokes were small at an individual level, but meaningful over a large population**
- **Organizations' participation in the model waned over time**
  - Effort needed to meet data reporting requirements
  - Challenges prioritizing the model during the pandemic



The Million Hearts Model in context

- **Novel risk-reduction payments reflected patients' overall CVD risk, rather than individual risk factors**
- **They also rewarded patients' *improvement* rather than getting to target**
- **The model focused on a primary prevention for a single condition**
- **Current CMS Innovation Center models to advance primary care seek to improve whole-person care**

medicalincs

Prioritizing Prevention: Lessons from Million Hearts

Primary Care Transformation for Preventive Care (& Value Based Care)

Presenter:

Nkem Okeke, MD, MPH, MBA, MSPM, CCMP
Founder/CEO, Medicalincs
Faculty, Harvard Medical School Center for Primary Care

Disclosure

Nkem Okeke, MD, MPH, MBA, MSPM

Dr. Nkem Okeke is the Founder & CEO of Medicalincs (a population health management company) and works with healthcare organizations (government health organizations, payer & provider health systems, independent physician groups, and FQHCs).

Dr. Okeke is also a faculty affiliate of Harvard Medical School Center for Primary Care.

PRIORITIZING PREVENTION: VALUE BASED CARE

medicalincs

The Changing Tide of Healthcare Delivery

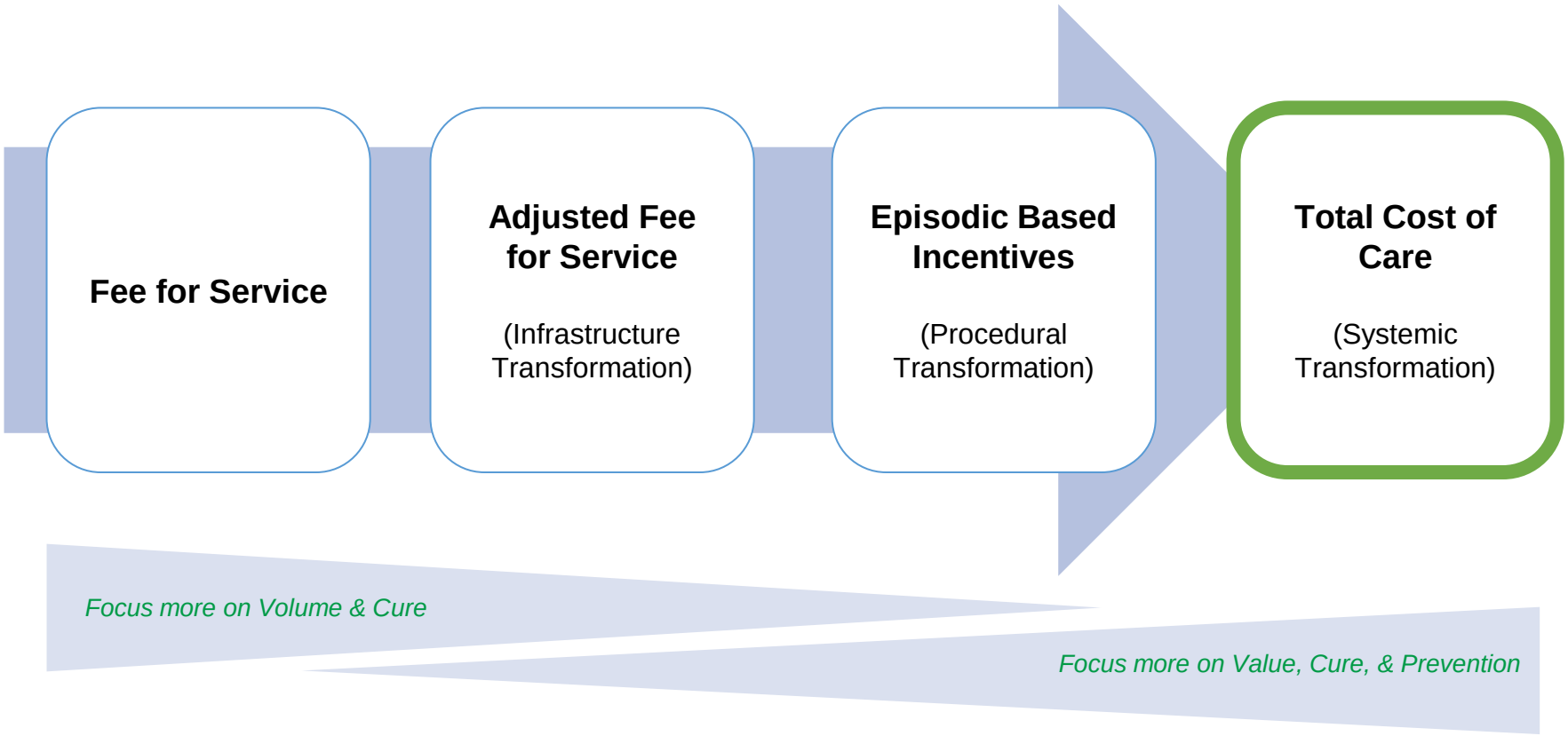


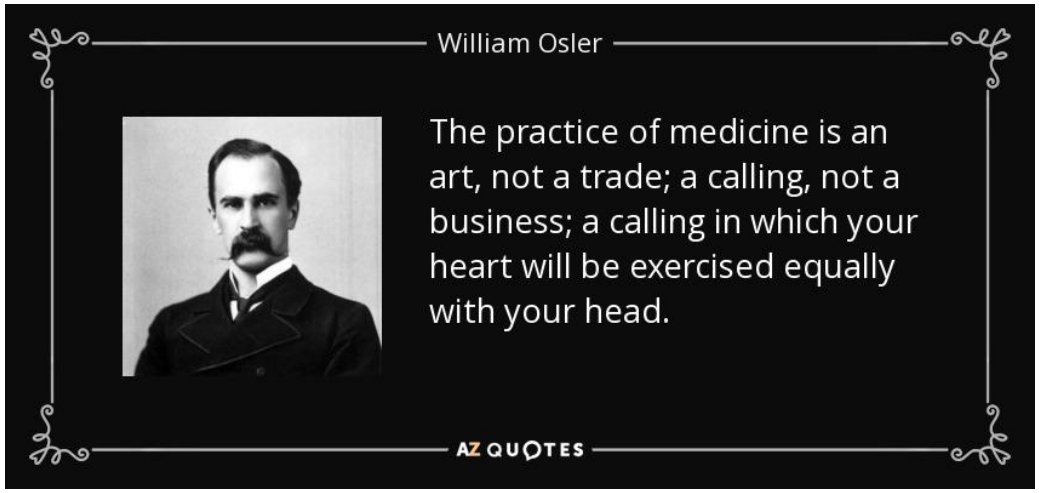
Image Credit: CMMI

Funding for Preventive & Equitable Care (Value-Based Care)

Image Credit: AHIP

Food for Thought …

Perception vs. Reality



In Reality … Our healthcare system is also a Business

Looking into the Future

Vision: What's to Come Over the Next 10 Years

Image Credit: CMMI

The Future is Here!
Example Pioneer Model - Maryland TCOC

Maryland Total Cost of Care (TCOC) Model is a New Model in Maryland Covering Full Continuum of Care

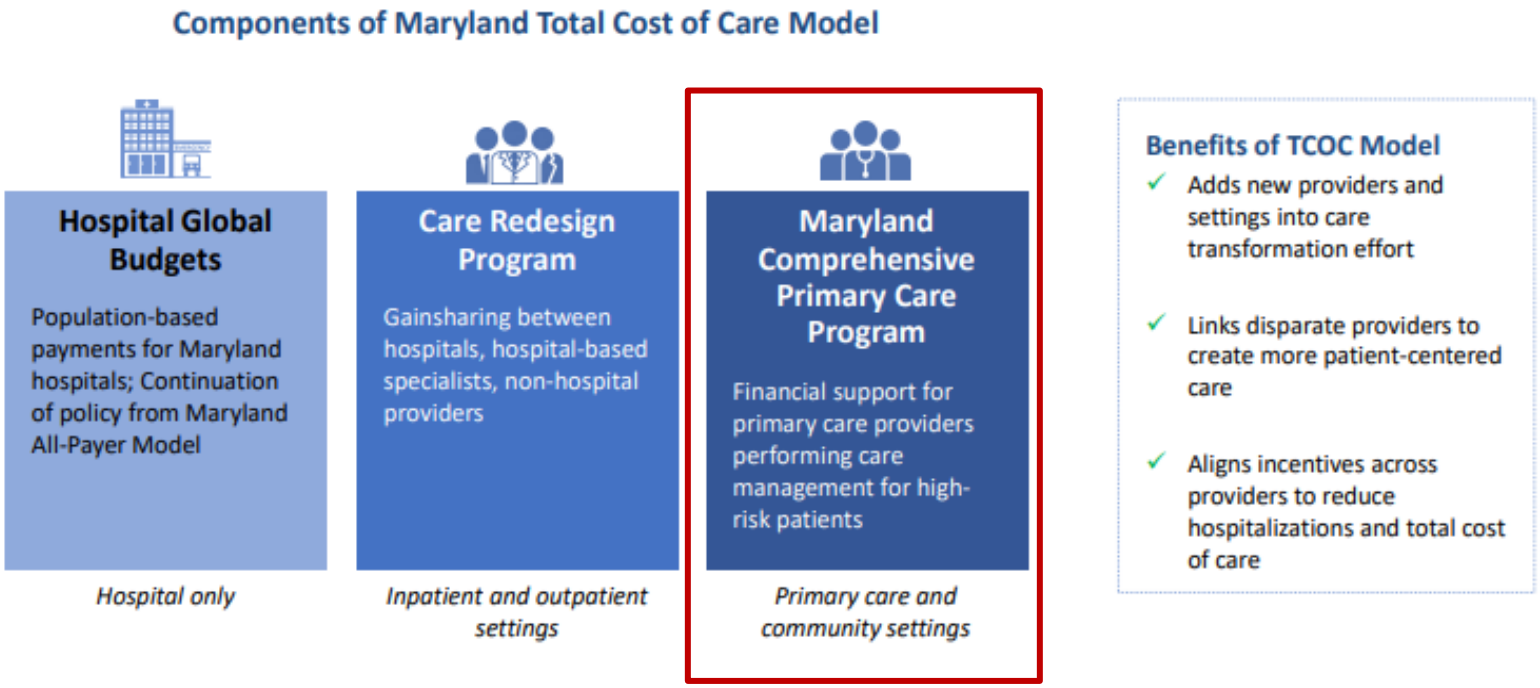
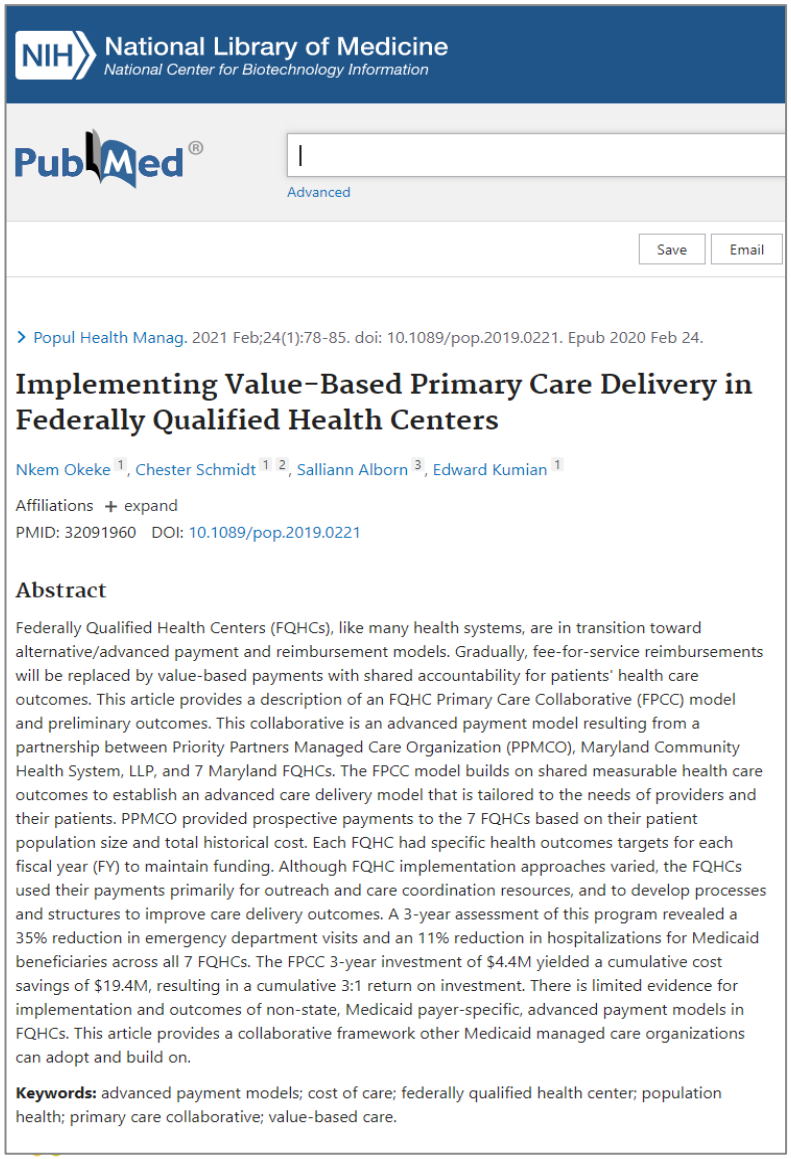


Image Credit: CMMI

Maryland FQHC Care Collaborative as a Catalyst
for Participation in MDPCP (Maryland TCOC)



NIH National Library of Medicine
National Center for Biotechnology Information

PubMed®

Advanced

Save Email

Popul Health Manag. 2021 Feb;24(1):78-85. doi: 10.1089/pop.2019.0221. Epub 2020 Feb 24.

Implementing Value-Based Primary Care Delivery in Federally Qualified Health Centers

Nkem Okeke [1], Chester Schmidt [1 2], Salliann Alborn [3], Edward Kumian [1]

Affiliations + expand

PMID: 32091960 DOI: 10.1089/pop.2019.0221

Abstract

Federally Qualified Health Centers (FQHCs), like many health systems, are in transition toward alternative/advanced payment and reimbursement models. Gradually, fee-for-service reimbursements will be replaced by value-based payments with shared accountability for patients' health care outcomes. This article provides a description of an FQHC Primary Care Collaborative (FPCC) model and preliminary outcomes. This collaborative is an advanced payment model resulting from a partnership between Priority Partners Managed Care Organization (PPMCO), Maryland Community Health System, LLP, and 7 Maryland FQHCs. The FPCC model builds on shared measurable health care outcomes to establish an advanced care delivery model that is tailored to the needs of providers and their patients. PPMCO provided prospective payments to the 7 FQHCs based on their patient population size and total historical cost. Each FQHC had specific health outcomes targets for each fiscal year (FY) to maintain funding. Although FQHC implementation approaches varied, the FQHCs used their payments primarily for outreach and care coordination resources, and to develop processes and structures to improve care delivery outcomes. A 3-year assessment of this program revealed a 35% reduction in emergency department visits and an 11% reduction in hospitalizations for Medicaid beneficiaries across all 7 FQHCs. The FPCC 3-year investment of $4.4M yielded a cumulative cost savings of $19.4M, resulting in a cumulative 3:1 return on investment. There is limited evidence for implementation and outcomes of non-state, Medicaid payer-specific, advanced payment models in FQHCs. This article provides a collaborative framework other Medicaid managed care organizations can adopt and build on.

Keywords: advanced payment models; cost of care; federally qualified health center; population health; primary care collaborative; value-based care.

2014 FQHC Primary Care Collaborative (FPCC) VBC Agreement

- **FQHC Primary Care Collaborative** (FPCC) Model with a **Medicaid MCO & 7 FQHCs**
- The FPCC model built on **shared** measurable health care outcomes tailored to the needs of providers and their patients.
- MCO provided **prospective payments** to the 7 FQHCs based on their patient population size and total historical cost.
- **Each FQHC had specific health outcomes targets** for each fiscal year (FY) to maintain funding **(only upside risk)**
- **Results:**
  - **35%** reduction in emergency department visits
  - **11%** reduction in hospitalizations for Medicaid beneficiaries across all 7 FQHCs.
  - The FPCC 3-year investment of $4.4M yielded a cumulative cost savings of $19.4M, resulting in a cumulative **3:1 return on investment.**

Be Prepared … Stay Prepared!

FQHCs Participation in MDPCP (Maryland TCOC)

COMPARISON WITH STATE ADVANCED PRIMARY CARE MODEL (MDPCP)		
	PPMCO-FQHC Collaborative	**MDPCP**
Model	▪ Like Advanced PCMH Model ▪ Identified POC for each CHC	▪ Advanced PCMH Model ▪ Identify POC for Practice (and CTO)
Performance Measures	▪ **Utilization**: Reduce Inpatient admission rates & ED utilization ▪ **CQMS**: Improve Value-Based Purchasing Performance ▪ Improve Access to Care ▪ Bi-directional Data Sharing	▪ **Utilization**: Reduce unnecessary IP admissions & ED utilization ▪ **eCQMS**: Hb A1c control, Hypertension Control, Initiate Rx for substance abuse ▪ Patient Experience
Payments	▪ Payment: PPMCO payout to FQHCs ▪ Frequency: Upfront (Quarterly) ▪ Methodology: Based of attribution volume ▪ Report expenditures to PPMCO/MCHS ▪ Must meet performance thresholds to avoid reduction in payments	▪ Payment: CMS payout to Practices & CTOs ▪ Frequency: Upfront (Quarterly) ▪ Methodology: *CMF: PBPM rate based on risk-level of attributed beneficiaries; PBIP: PBPM rate based on quality/patient experience of care, AND on utilization performance; CPCP: Hybrid Payment* ▪ Report expenditures to CMS ▪ Must meet performance thresholds to keep PBIP

- The FQHCs participation in a Payer-Provider care collaborative, demonstrated that the FQHCs in Maryland were prepared to be involved in the Maryland Primary Care Program.
- This was because, the Payer-Provider collaborative was a value-based care model – **which also focused on preventive care & closely monitoring key eCQMs such as hypertension control, diabetes control,** and substance abuse Rx initiation.

medicalincs

Care Delivery Transformation
Key Capacities/Capabilities

1. Leadership
2. Culture of Quality Improvement
3. Investment (Reformed payment structure)
4. Access to Care (Empanelment, Team-based care, Alternative visit types)
5. Care Management / Care Coordination / Comprehensiveness
6. Patient & Family Engagement
7. Population Health Management
8. Data Management, Performance Reporting, & Health IT

Reference: Elements of PCMH model, Elements of Maryland Primary Care Model

VBC Readiness Assessment Summary:
Know where you stand

VBC Implementation Readiness Assessment	Practice/Center A	Practice/Center B	PAYER
1. Leadership	■	■	■
2. Culture of Quality Improvement	■	■	■
3. Investment (Reformed payment structure)	■	■	■
4. Access to Care (Empanelment, Team-based care, Alternative visit types)	■	■	■
5. Care Management / Care Coordination / Comprehensiveness	■	■	■
6. Patient & Family Engagement	■	■	■
7. Population Health Management	■	■	■
8. Data Management, Performance Reporting, & Health IT	■	■	■

- VBC Readiness varies by practice and by center
- VBC Readiness also varies by payer

Knowing the readiness level for your practice/center and the partner partner payer, allows you function & negotiate from a place of strength!

medicalincs

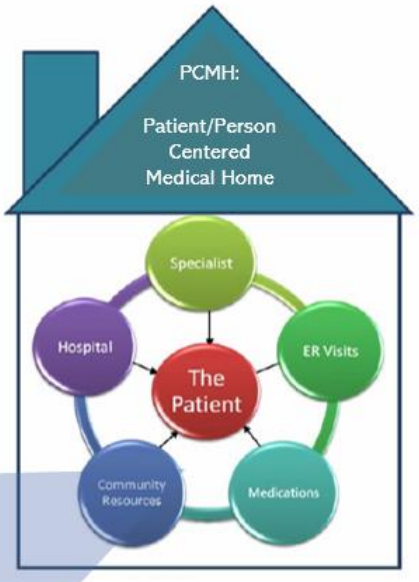
OVERVIEW MEDICALINCS

medicalincs

ABOUT

Medicalincs as a **Primary Care Transformation Organization**, applies a 360º Value Integration model that combines **patient/person centered medical home** and the **determinants of health** models to adequately address healthcare delivery and health disparities.

Medicalincs provides both **Administration Management** and **Care Delivery Management** to advance primary care delivery & value-based population health.



Reference: https://www.ahrq.gov/ncepcr/research/care-coordination/pcmh/index.html

Our Services

- Advanced Primary Care Services & Care Management
- Value-based Population Health
- Advisory & Management
- IT Support Services

Reference: The Health Equity Tool developed by the Moving Health Equity Forward Committee, an action group of the Bruce Grey Poverty Task Force.

WHO We Support?

medicalincs

- Federal Government Health Agencies
- State & Local Health Departments
- Health Insurance Organizations (Commercial, MCOs, & HMOs)
- Federally Qualified Health Centers
- Large Healthcare Systems
- Private Healthcare Practices
- Employers

CLIENTS

OUR Value-Add

Our work thus far with payers, providers, and integrated delivery networks (IDNs) improved performance in delivering patient-centered, value-based care …

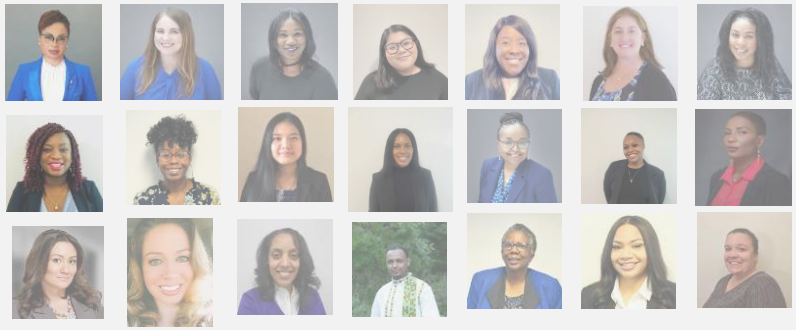
medicalincs

THANK YOU!

Connect with Us …

medicalincs

… We Link Silos, Sustain Systems, & Save Lives…



https://medicalincs.com/

240-200-0025

https://linkedin.com/company/medicalincs-llc

https://web.facebook.com/medicalincs

https://twitter.com/medicalincs

https://Instagram.com/medicalincs

info@medicalincs.com