Department of Health | Medicaid Redesign Team

Social Determinants of Health and Community Based Organizations

Subcommittee Meeting #6

December 16, 2015

Agenda

1. CBO Recommendations
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2. SDH Recommendations
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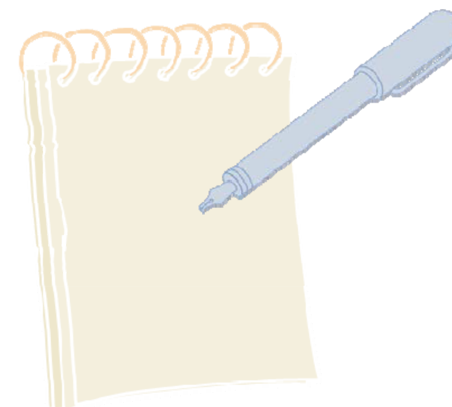

1. CBO Recommendations

Current CBO Recommendations

The subcommittee workgroups created one recommendation and revised five since the last meeting. Please see the table below. Grey highlight indicates a revision and orange indicates a new recommendation. The recommendations are further outlined on slides 5-10.

No.	Recommendations	Change
25	Develop educational materials on VBP for CBOs, providers/provider networks, and MCOs	Yes
26	Link member SDH information to the appropriate CBO through bidirectional system	Yes
27	Create a “Design and Consultation team” to support CBOs	Yes
28	Develop criteria for CBOs to help determine readiness for VBP arrangements	No
29	State funding should be made available to CBOs	New
30	Encourage the integration of community-based care teams into the clinical care setting	Yes
31	VBP providers/provider networks should contract with a minimum of one CBO	Yes

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Recommendation #25: Develop Educational Materials

Current Recommendation:

The State or a third party should develop educational materials on VBP that focuses on both CBOs' part in the system and guidance on the value proposition CBOs should expect to provide when contracting with providers/provider networks.

Proposed Recommendation:

The State **and/**or a third party should develop educational materials on VBP that focuses on both CBOs' part in the system and guidance on the value proposition CBOs should expect to provide when contracting with providers/provider networks **and MCOs. Additionally, the State should provide technical assistance for the providers/provider networks/MCOs (non-CBO) contracting entities on how to work effectively with CBOs.**
The State: Recommendation

Description:

This recommendation aims to achieve several objectives. First, it will explain the changes that CBOs can expect to see from VBP and managed care (e.g. healthcare delivery changes, payment structure changes, more focus on preventive medicine). Second, it should provide guidance on how an organization could self-assess its readiness to overcome potential challenges. Third, educational materials should outline interventions (program initiatives) a CBO could consider as part of its "value proposition" to potential payers (e.g. fees for the CBOs services, outcome measurements, possible savings) as well as methods to assess contracting opportunities. Basic educational information could be communicated over several mediums (e.g. webinars, forums, a VBP CBO page on the DOH website, frequently asked questions, readiness checklist). **Fourth, providers/provider networks/MCOs should be educated about potential CBO partners, how to work with CBOs and what benefits they offer.**

Note: For your reference, please refer to the Draft Recommendations document (pg. 17) for the complete current recommendation and description.

Recommendation #26: Link Member SDH Information to CBOs

Revised

Current Recommendation:

The State should create a workgroup to determine the possibility of, or options for, developing a user-friendly system for providers to link members' SDH(s) to the appropriate CBO(s). The providers/provider networks will be responsible for implementing the system within their networks.

Proposed Recommendation:

The State should create a workgroup to determine the possibility of, or options for, developing a user-friendly, **bidirectional** system **that enhances communication between providers/provider networks and CBOs to better address members' SDH needs. Once the system has been developed, the State should ensure providers/provider networks implement the system within their networks. The providers/provider networks should collaborate with CBOs to ensure the correct and relevant SDH information is collected.**

The State: Recommendation

Description:

The workgroup should not only research what is needed in this new system but also determine if there are systems currently available that could provide some of the needed information in the interim. Consideration should be given to a system that meets some of the criteria and has the ability to be implemented at low cost and within a short timeframe, while an ideal system is being created. Linking members to the proper resources, primarily local CBOs, is necessary to better address SDH. This proposed system should interface with existing EMRs and provide data on both a member's assessment and the provider's success of linking the member to an organization that meets the member's needs. Further, CBOs will need to be heavily involved in the linking of SDH to CBOs to ensure the system covers all of the services necessary.

The State could explore the use of the Regional Health Information Organizations (RHIO) and State Health Information Network of New York (SHIN-NY) as the data repository for CBOS to share data where SDH can be measured against DSRIP goals. The local Offices for the Aging could be consulted about the data they collect through their various CBO agencies and how that data can be shared to determine their impact on SDH and DSRIP goals.

Note: For your reference, please refer to the Draft Recommendations document (pg. 17) for the complete current recommendation and description.

Recommendation #27: Create a Design and Consultation Team to Support CBOs

Current Recommendation:
The State should create a “design and consultation team” comprised of experts from relevant State agencies and advocacy and stakeholder groups to provide focused consultation and support as requested by CBOs who are either involved or considering involvement in VBP.

Proposed Recommendation:
The State should create a “design and consultation team” comprised of experts from relevant State agencies and advocacy and stakeholder groups to provide focused consultation and support**, at no cost,** as requested by CBOs who are either involved or considering involvement in VBP.
The State: Recommendation

Description:
The goal of the “design and consultation team” will be to prepare CBOs with the information and support needed to create effective partnerships with health care entities (e.g. health plans, providers, provider networks). The team of experts should include individuals with knowledge in VBP, finance, operations**, legal,** and contracting, to provide the appropriate support to CBOs through structured management, education and technical assistance.

Note: For your reference, please refer to the Draft Recommendations document (pg. 18) for the complete current recommendation and description.

Recommendation #29: State funding should be made available to CBOs

Proposed Recommendation: State funding should be made available to CBOs to help prepare them for their participation in VBP arrangements.
The State: Recommendation

Description:
CBOs will need funding for infrastructure development, to include IT systems (e.g. ability to do measurement and data collection to demonstrate their value), contracted services (e.g. fiscal and legal expertise), and other areas needing assistance. In addition, the State should explore mechanisms for how it could assist and support CBOs if payment or cash flow issues arise.

Note: For your reference, please refer to the Draft Recommendations document (pg.19) for the complete current recommendation and description.

Recommendation #30: Encourage the integration of community-based care teams into the clinical care setting

Current Recommendation:
The State should require integration of CBO Case Managers in the acute care setting.

Proposed Recommendation:
The State should **encourage** integration of **community-based care teams into the clinical** care setting.
The State: Recommendation

Description:
Given the vast array of community based services, acute care Case Managers may not fully understand the ever-changing services and admission criteria of CBOs. Integrating **community-based care teams** from CBOs into the **clinical** care setting will improve efficiency in finding and transferring members to lower levels of care where they can receive the treatment needed and may ultimately decrease costs. The **community-based care teams** should provide training to the non-CBO Case Managers to strengthen the Case Management Department.

Note: For your reference, please refer to the Draft Recommendations document (pg. 20) for the complete current recommendation and description.

Recommendation #31: Contracting with a Minimum of one CBO

Current Recommendation:
Every VBP contracting entity (e.g. providers, provider networks) will contract and engage with a minimum of one CBO in a way that the CBO considers meaningful.

Proposed Recommendation:
Every VBP contracting entity (e.g. providers, provider networks) will contract and engage with a minimum of one CBO.
VBP Level 1 Providers: Guideline; VBP Level 2 or 3 Providers: Guideline; ***The State: Recommendation***

Description:
Every VBP contracting entity seeking to decrease costs of healthcare and improve overall health in the community should contract and engage with a minimum of one CBO. **Many CBOs have years of experience improving SDH. This expert understanding of community needs, coupled with support and clinical expertise of a provider/provider network, could make a significant positive impact on population health and generate savings for the entities involved. Providers/Provider networks should partner with organizations that have objectives aligning with their own, the community needs, and member goals. The CBO should work with the providers/provider networks to deliver interventions that support SDH and advance DSRIP goals. After a period of two to three years, the State should create a process, which would include an independent retrospective review of the role of the CBO, to determine if the VBP providers are adequately leveraging community based resources. The review would also identify best practices and determine if further guidance or technical assistance is needed to maximize utilization of community resources.**

Note: For your reference, please refer to the Draft Recommendations document (pg. 20) for the complete current recommendation and description.

2. SDH Recommendations

Current SDH Recommendations

The subcommittee revised seven and created four new recommendations since the last meeting. Please see the table below and on the following slide. Grey highlight indicates a revision and orange indicates a new recommendation. The recommendations are further outlined on slides 14-25.

No.	Recommendations	Change
1	Implement interventions on a minimum of one SDH	No
2	SDs to address should include both needs and goals of individuals and the community	Yes
3	Invest in ameliorating an SDH at the community level	Yes
4	Incentivize and reward providers for taking on a member and community-level SDH	No
5	Maintain a robust catalogue of resources to connect individuals to community resources	Yes
6	Employ a workforce that reflects and is culturally sensitive to the community served	Yes
7	Create a data system and dashboard that displays cultural competence performance measures	New
8	Form a taskforce of experts focused on children and adolescents in the context of VBP	No
9	Utilize an assessment tool to measure and report on SDs that affect members	No
10	Set up a system to track what interventions are successful and how they are measured	Yes
11	Track discrete outcomes of interventions and use a CQI model for enhancing them	No
12	Incorporate SDH into QARR Measures	No
13	Form a taskforce to identify standard SDH data sources to include in acuity calculation	New

Current SDH Recommendations

The subcommittee revised seven and created four new recommendations since the last meeting. Please see the table below and on the previous slide. Grey highlight indicates a revision and orange indicates a new recommendation. The recommendations are further outlined on slides 14-25.

No.	Recommendations	Change
14	Create a standard set of SDH measures	New
15	Require Medicaid providers, MCOs, and the State to collect standardized housing stability data	No
16	Provider, provider networks and MCOs should coordinate with Continuum of Care (COC) entities, where they exist, when considering investments to expand housing resources	No
17	New York City, the State, and other involved localities should update the NY/NY agreements to give priority to homeless persons who meet HARP eligibility criteria without regard for specific diagnoses or other criteria	Yes
18	Submit a NYS waiver application to CMS that tracks the June 26, 2015 CMCS Information Bulletin	No
19	Leverage the Medicaid Reform Team housing work group money to advance a VBP-focused action plan	No
20	Submit a waiver application that challenges the restrictions on rent in the context of VBP	Yes
21	Provider networks could participate in a co-investing model	No
22	Provider networks could participate in innovative contracting	No
23	Provider networks could invest in one or more social impact bonds	No
24	The State should assess economic development investments	New

Recommendation #2: Member and Community Goals

Current Recommendation:

The SD(s) chosen to be addressed by providers/provider networks should be based on the results of an assessment of individual members, their health goals and the impact of SDs on their health outcomes, as well as an assessment of community needs and resources.
VBP Level 1 Providers: Guideline; VBP Level 2 or 3 Providers/Provider Networks: Standard

Proposed Recommendation:

The SD **interventions selected** by providers/provider networks should be based on the results of **an SDH screening** of individual members; **member** health goals; and the impact of SDs on their health outcomes; as well as an assessment of community needs and resources.

Description:

It is important to recognize that no one SD can necessarily be prioritized over others. Rather, the priorities will vary based on personal circumstances, including health factors. For example, if a person is homeless, housing is likely to be the top priority but not necessarily that person's only need. Indeed, many SDs are both co-occurring and co-factors in other SDs. Thus, prioritizing which SDs a VBP network should address should depend upon **the results of an SDH screening** of individual members; **member** health goals; and the impact of SDs on their health outcomes. In addition to the individual member's **screening**, there should be an assessment of community needs and resources. The DSRIP community needs assessment could provide a starting point for a more detailed assessment **of the community cared for by the providers/provider networks.** Further information can be gained by completing a focused needs assessment by the particular providers/provider networks with emphasis on the chronic illness(es) or populations chosen in their VBP agreement. The decision of which SD(s) to address should be based on both the members' goals and the community needs of the provider's members. The prioritization must happen with a flexible approach and at a local level, balancing both individual needs with overall population health. Eighteen specific SDs have been identified under five key domains of SDH and are believed to have the greatest impact on health outcomes for Medicaid beneficiaries (see Appendix 1: SDH Interventions Menu).

Note: For your reference, please refer to the Draft Recommendations document (pg. 3) for the complete current recommendation and description.

Recommendation #3: Invest in ameliorating an SDH at the community level

Current Recommendation:

Providers/provider networks and MCOs should invest in ameliorating a SDH at the community level.
VBP Level 1 Providers: Guideline; VBP Level 2 or 3 Providers/Provider Networks: Standard; MCOs: Standard

Proposed Recommendation:

Providers/provider networks and MCOs should invest in ameliorating a SDH at the community level **employing a community participatory process.**
VBP Level 1 Providers: Guideline; VBP Level 2 or 3 Providers/Provider Networks: Standard; MCOs: Standard

Description:

Providers/provider networks and MCOs should invest in effective interventions that have a meaningful impact on the overall population health and the overall wellbeing of the community in which it serves. The nature of the interventions(s) should be negotiated between the VBP contractor and MCO, taking into account population health and preventive health needs identified by the community. **This community participation will lead to a more culturally competent, effective intervention. A participatory approach is one in which everyone who has a stake in the intervention has a voice, either in person or by representation.** Provider/provider networks and MCOs may wish to collaborate with CBOs to support, develop, and broaden their reach to more communities. To that end, networks should consider larger partnerships and advocate for systemic improvements that might not be easily quantified on the individual member level immediately or in the short-term. For example, participating in a campaign to make fresh produce available in a "food desert" would not only have an impact on members with specific nutritional deficits, but would also contribute to overall population health and community well-being. The same can be said for participation in efforts to improve air quality, housing stock and many other SDs that contribute to overall population health. Ultimately the goal should be to track the impact of interventions, not just on an individual level, but on a population level.

Note: For your reference, please refer to the Draft Recommendations document (pg. 4) for the complete current recommendation and description.

Recommendation #5: Maintain a robust catalogue of resources to connect individuals to community resources

Current Recommendation:

Providers/provider networks should maintain a robust catalogue of resources in order to connect individuals to community resources that are expected to address SDH.

VBP Level 1 Providers: Guideline; VBP Level 2 or 3 Providers/Provider Networks: Guideline

Proposed Recommendation:

Providers/provider networks should maintain a robust catalogue of resources in order to connect individuals to community resources that are expected to address SDH.

VBP Level 1 Providers: Guideline; VBP Level 2 or 3 Providers/Provider Networks: Guideline; ***The State: Recommendation***

Description:

By creating a catalogue or living library of resources, providers can quickly and easily refer members to appropriate and effective community based organizations. Members can also take a more active role in their healthcare if they are provided information on community resources that they can use to better improve their quality of life and health outcomes. The providers/provider networks should maintain an up-to-date, robust catalogue of resources that should align with the information from the assessment tool and the SDH Interventions Menu (Appendix 1). **In the longer term, the State, together with payors, providers, community-based organizations, and municipalities, should create a usable, universal, electronically supported system for assessing individual patients' needs and providing automatic links to vetted resources to address patients' SDH at the individual level.**

Note: For your reference, please refer to the Draft Recommendations document (pg. 5) for the complete current recommendation and description.

Recommendation #6: Employ a workforce that reflects and is culturally sensitive to the community served

Current Recommendation:
Providers/provider networks should employ a workforce that reflects and is culturally sensitive to the community served.
VBP Level 1 Providers: Guideline; VBP Level 2 or 3 Providers/Provider Networks: Guideline

Proposed Recommendation:
Providers/provider networks should employ a **culturally competent and diverse** workforce that reflects the community served.
VBP Level 1 Providers: Guideline; VBP Level 2 or 3 Providers/Provider Networks: Guideline

Description:
Cultural Competence is a broad term, however there are several widely-accepted definitions that can be used in the VBP context (e.g. National CLAS Standards). Lack of access to culturally competent staff has been identified as a barrier to better health**. It is critical for providers/provider networks to understand cultural competence and incorporate accepted cultural competence standards in their practice. To better serve the community, and provide the best healthcare, providers/provider networks should use data from demographic reports and hire staff that reflect, and is culturally sensitive to the community served.**
The SDH Interventions Menu (Appendix 1) includes recommended interventions for this SD.

Note: For your reference, please refer to the Draft Recommendations document (pg. 5) for the complete current recommendation and description.

Recommendation #7: Create a data system and dashboard that displays cultural competence performance measures

Proposed Recommendation:

The State should create a data system and dashboard that displays providers/provider networks' cultural competence performance measures. MCOs should monitor and report on outcomes based on race, ethnicity, disability, sexual orientation, etc.

MCOs: Guideline; The State: Recommendation

Description:

Due to it's length, the description is on the next slide.

Note: For your reference, please refer to the Draft Recommendations document (pg. 6) for the complete current recommendation and description.

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Recommendation #7 continued

Description:
Performance metrics and dashboards can be used to define and communicate strategic objectives tailored to individuals and the organizations where they receive services. Establishing goals, measuring progress, rewarding achievement and displaying results in a way that is accessible and transparent can accelerate change and drive positive outcomes.
The State should create a data system and dashboard that encapsulates key performance metrics in a layered and visual information delivery system, allowing users to identify disparities in health and health care and to measure the effectiveness of interventions and strategies aimed at achieving equitable outcome for population being served.

Steps could include:

- Use available Medicaid data to construct performance metrics where appropriate, including the ability to view metric by race, ethnicity, disability, sexual orientation, etc.
- Work with the Office of Minority Health and community stakeholders to further define performance goal and identify performance measures to tracked
- Join multiple data sources, where feasible to better describe populations and understand outcomes
- Use measures to track disparities in a dashboard format, such as web-based provider report stratified by demographic variables
- Track performance, examine trends, make comparisons, and identify strong performers
- DOH will incentivize provider based on improved CC score

Additionally, MCOs should monitor outcomes based on race, ethnicity, disability, sexual orientation, etc. to inform negotiations regarding performance metrics.

Note: For your reference, please refer to the Draft Recommendations document (pg. 6) for the complete current recommendation and description.

Recommendation #10: Set up a system to track what interventions are successful and how they are measured

Current Recommendation:
Set up a system to track what interventions are successful and how they are measured.
The State: Recommendation

Proposed Recommendation:
The State should design and implement a system that aims to track what interventions are successful and how they are measured. **This should include, but not be limited to, systematically collecting and publicly reporting on member experience with any service, whether from a CBO, hospital, behavioral health provider or primary care practice. Members need this information to inform their own decisions and payment reform needs this level of transparency in order to drive change and inform future contracting.**
The State: Recommendation

Description:
The description was not changed.

Note: For your reference, please refer to the Draft Recommendations document (pg. 8) for the complete current recommendation and description.

Recommendation #13: Taskforce to identify standard SDH data sources to include in acuity calculation

Proposed Recommendation:
The State should form a taskforce to identify standard data sources and points that can be utilized to provide a consistent and reliable SD adjustment to the member acuity calculation prior to attribution, and establish an adjusted acuity calculation which takes SDs into consideration when establishing member acuity.
The State: Recommendation

Description:
Given the central role of member acuity to VBP arrangements, and the fact that acuity calculations by the state are limited to claims data and do not include an assessment of non-clinical SDs, a taskforce should be established to identify standard data sources and points that can be utilized to provide a consistent and reliable SD adjustment to the member acuity calculation prior to attribution. Data may include history of incarceration (Corrections), housing status, and other SES indicators (TANF, etc.) that can be collected by the state. Following the establishment of standard collectable data points, the acuity calculation should be adjusted. This process should be transparent throughout and include multiple opportunities for community discussion and review.

Note: For your reference, please refer to the Draft Recommendations document (pg. 10) for the complete current recommendation and description.

Recommendation #14: Create a standard set of SDH measures

Proposed Recommendation:
The State should develop a standard set of measures for SDH that can be added to existing data collection and electronic health record systems.
The State: Recommendation

Description:
A standard set of measures for SDH is important for reporting baseline data and outcomes, recognizing trends, and identifying best practices in care. The State could leverage existing systems that measure SDH, such as the Statewide Planning and Research Cooperative System (SPARCS) Health Data Query System. Medicaid claims data could also be used in the development of the standard measures.

Note: For your reference, please refer to the Draft Recommendations document (pg. 10) for the complete current recommendation and description.

Recommendation #17: Housing – NY/NY Agreements

Current Recommendation:

New York City, the State, and other involved localities should update the NY/NY Agreements to give priority to homeless persons who meet HARP eligibility criteria without regard for specific diagnoses or other criteria. For units that do not include HUD capital or operating dollars, the definition of "homeless" should be modified to include persons who are presently in institutional or confined settings so they are considered for housing before discharge.
New York City, the State, and other involved localities: Recommendation

Proposed Recommendation:

New York City, the State, and other involved localities should update the NY/NY Agreements to give priority to homeless persons who meet **Health and Recovery Plan** (HARP) eligibility criteria **or other serious supportive housing needs** without regard for specific diagnoses or other criteria. **The definition of "homeless" should be modified (for units that do not receive US Department of Housing and Urban Development (HUD) capital or operating dollars) to include persons who are presently in institutional or confined settings.**
New York City, the State, and other involved localities: Recommendation

Description:

Currently, the NY/NY **Agreements attach units to specific agencies, such as OMH, OASAS and HASA, and attach additional criteria such as length of homelessness, creating an "obstacle course" for persons seeking housing. Because NY/NY uses the HUD definition of homelessness, persons leaving incarceration and other institutional settings are completely precluded from this program.** New York City, the State, and other involved localities should amend the NY/NY Agreements so that those members who also have chronic **conditions that require supportive housing** who are facing homelessness are given priority for supportive housing **regardless of type of condition or other criteria.** Additionally, the definition of "homeless" used in the NY/NY Agreements should be expanded to include those persons leaving institutional settings so they are considered for housing prior to discharge.

Note: For your reference, please refer to the Draft Recommendations document (pg. 12) for the complete current recommendation and description.

Recommendation #20: Submit a Waiver Application to Challenge Restrictions

Current Recommendation: The State should submit a waiver application that challenges the restrictions on rent in the context of VBP.
The State: Recommendation

Proposed Recommendation:
The State should submit a waiver application that challenges the restrictions on rent **and home modifications** in the context of VBP.
The State: Recommendation

Description:
The description was not changed.

Note: For your reference, please refer to the Draft Recommendations document (pg. 13) for the complete current recommendation and description.

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Recommendation #24: Assess Economic Development Investments

Proposed Recommendation:
The State should assess economic development investments
The State: Recommendation

Description:
Community conditions' impact on residents' health is well documented. The State should assess economic development investments for their impact on SDH and require that Regional Economic Development Councils undertake the same assessment. The Rochester-Monroe County Anti-Poverty Initiative is a current example of how this type of assessment may lead to investments that directly target poverty, poor housing stock and other drivers of SDH. The State of New York is significantly investing in improving the economic development climate in specific regions and across the state. The Upstate Revitalization Initiative (https://www.ny.gov/sites/ny.gov/files/atoms/files/2015UpstateRevitalizationInitiative_FINAL1.pdf), for example, identifies Medicaid Redesign as a State initiative that can be leveraged to enhance economic development investments.

Note: For your reference, please refer to the Draft Recommendations document (pg. 16) for the complete current recommendation and description.

3. Final Step

Final Step

The five Subcommittees’ final recommendations will be consolidated into a Recommendations Report that will be submitted to the VBP Workgroup and incorporated in the roadmap.

Thank you for all of your help and support!

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