Department of Health | Office of Health Insurance Programs

VBP Lessons Learned:
Social Determinants of Health Contracting

October 30, 2018

VBP Pilot and Social Determinants of Health General Overview

- Ryan Ashe: Director of Medicaid Payment Reform, DOH
- Rachel Hajos, Director of VBP Pilots, DOH
- Emily Engel, Deputy Director of the Bureau of Social Determinants of Health, DOH

Agenda

1. Welcome and Introductions
2. VBP Pilot Overview
3. Social Determinants of Health Requirements
4. SOMOS Community Care - Moisés Pérez-Martínez, Vice President of Workforce, Community & Government Relations
5. Northern Manhattan Improvement Corporation - Greg Bangser, Chief Program Officer

VBP Transformation: Overall Goals and Timeline

Goal: To improve population and individual health outcomes by creating a sustainable system through integrated care coordination and rewarding high value care delivery.

April 2017

Performing Provider Systems (PPS) requested to submit growth plan outlining path to 80-90% VBP

April 2018

≥ 10% of total Managed Care Organization (MCO) expenditure in Level 1 VBP or above

April 2019

≥ 50% of total MCO expenditure in Level 1 VBP or above.
≥ 15% of total payments contracted in Level 2 or higher *

April 2020

80-90% of total MCO expenditure in Level 1 VBP or above
≥ 35% of total payments contracted in Level 2 or higher *

* For goals relating to VBP level 2 and higher, calculation excludes partial capitation plans such as MLTC from this minimum target.

VBP Pilot Program Overview

VBP Pilot Program is a two-year program intended to create momentum and support the transition to VBP, establishing best practices and sharing lessons learned. It is also intended to test new outcome measures, and where necessary improve design of VBP arrangements. The Pilots are required to:

- Adopt on-menu VBP arrangements, as per NYS VBP Roadmap guidelines
- Submit a VBP contract (or contract addendum) by April 1, 2017, and through December, 2018 (2 year program)
- Report on all reportable Category 1 and a minimum of one (1) distinct Category 2 measures for each arrangement being contracted, or have a State and Plan approved alternative
- Move to Level 2 VBP arrangements in Year 2 of the Pilot Program
- Present webinars on their lessons learned from the contracting process and participation in the program

Value Based Payments Social Determinants of Health and Community Based Organization Requirements

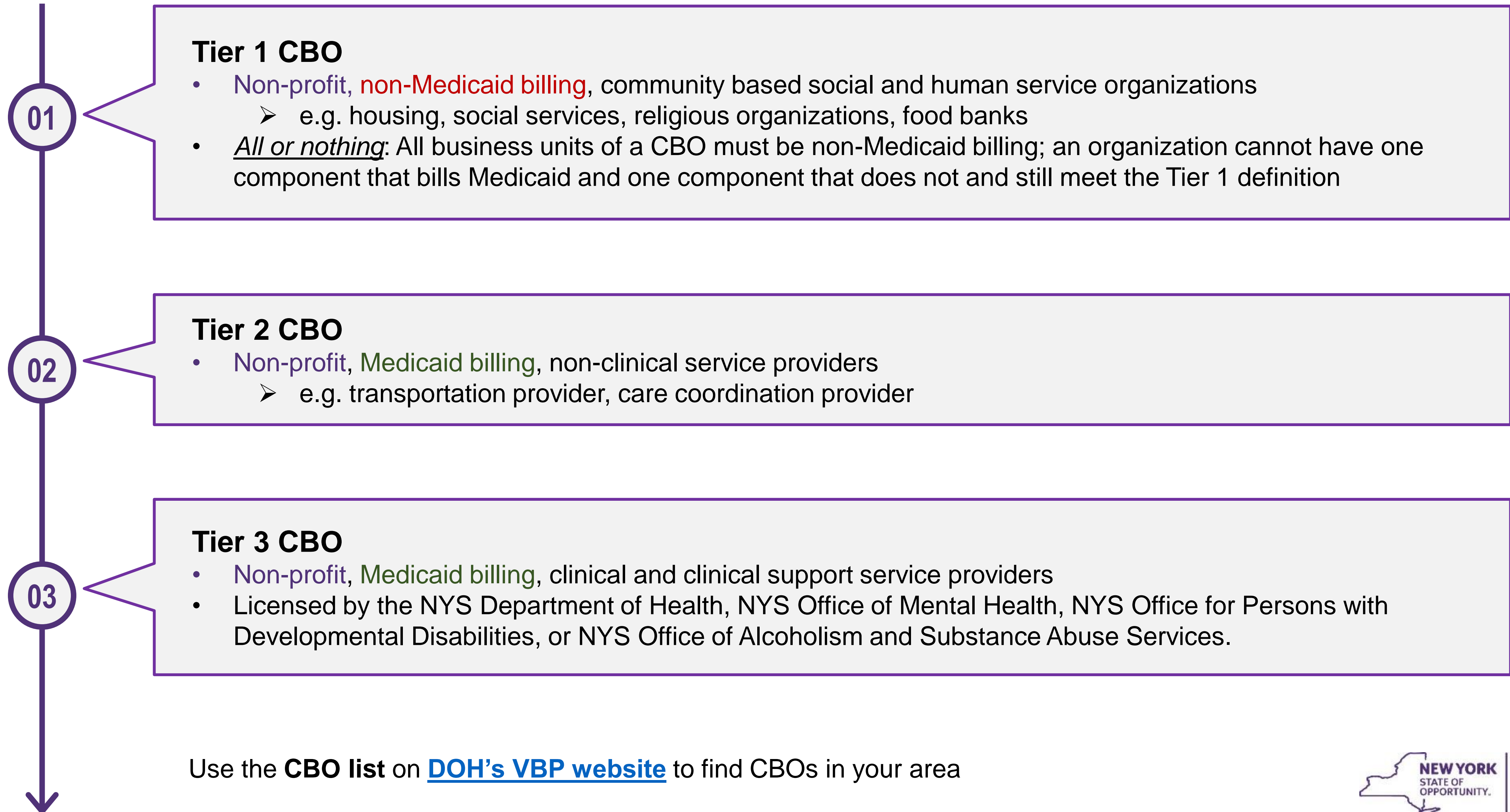
1. All new and existing VBP Level 2 & 3 arrangements MUST include:
   1. At least one Social Determinant of Health Intervention
   2. At least one Tier 1 Community Based Organization (this does not exclude Tier 2 and 3 CBOs)

2. The MCO/MLTC/VBP Contractor may decide on their own SDH intervention. Interventions should be measurable and able to be tracked and reported to the State. SDH Interventions must align with the five key areas of SDH, which includes:
   - *1) Education, 2) Social, Family and Community Context, 3) Health and Healthcare 4) Neighborhood & Environment and 5) Economic Stability*

3. MCOs must provide upfront funds or start up funding to the provider/CBO for the social determinants of health intervention.

4.VBP Level 2 & 3 contracts without SDH and CBO requirements will not meet the definition of VBP.

Tier 1, Tier 2, and Tier 3 CBO Definitions



Use the **CBO list** on **DOH's VBP website** to find CBOs in your area

Foundation of Creating Effective Partnerships

1. Have all the key decision makers at the table
2. Utilize clear and concise contracting terms that address: terms, parties, scope of project, geographical locations, payment method or fee structure, reporting and data
3. Create measurements and milestones for project
4. Share data between the Plan, VBP Contractor and CBO
5. Meet on a regular basis to check in on the progress of the SDH project and modify as needed

Innovative SDH CBO Projects

A.I.R NYC and HealthFirst

- A two part intervention that focuses on improving engagement and self-management for pediatric asthma patients. CHWs perform health education and home environment assessment to identify triggers. Also assess for other SDH needs and make appropriate referrals.

ArchCare Community Life and Catholic Managed Long Term Care Inc.

- Timebank connecting plan members with volunteers to provide companionship. Goal is to prevent loneliness, depression and prevent hospitalization among the elderly.

Schenectady City Mission and Eddy Senior Care

- Empower Health program, provides ambassadors and health coaches to engage with clients in the field to access their needs and then provide immediate referral to community resources and/or refer client to a Health Coach for addition support. Intervention helps clients navigate and address SDH needs such as housing, food, transportation, health insurance, and accessing primary care..

Northern Manhattan Improvement Corporation and SOMOS Community Care

- Intervention focuses on assisting patients to maximize entitlement support, incentivize medication adherence and to mitigate the impact of housing and food insecurity through direct service delivery and referrals. Intervention will target the top 5% high utilizers that consume approximately 50% of the total medical expenditure.

DOH has approved 46 SDH CBO contracts to date

VBP Pilot Program Webinar Q&A Process

- Please submit questions via **Q&A function** and we will do our best to move through all of the questions
- We will address questions at the conclusion of the webinar

VBP Pilot Presenters

- **Moisés Pérez Martínez**, Vice President of Workforce, Government, and Community Relations, SOMOS Community Care
- **Greg Bangser**, Chief Program Officer, Northern Manhattan Improvement Corporation

Addressing Social Determinants of Health

What We Know
What We're Doing

Moisés Pérez-Martínez
Vice President of Workforce, Community & Government Relations
Ricardo A. Rivera-Cardona
Chief Business Development Officer

Purpose and Objectives

PURPOSE

To highlight the importance of addressing social determinants of health (specifically those related to Economic Stability) to improve quality of care and reduce healthcare costs.

OBJECTIVES

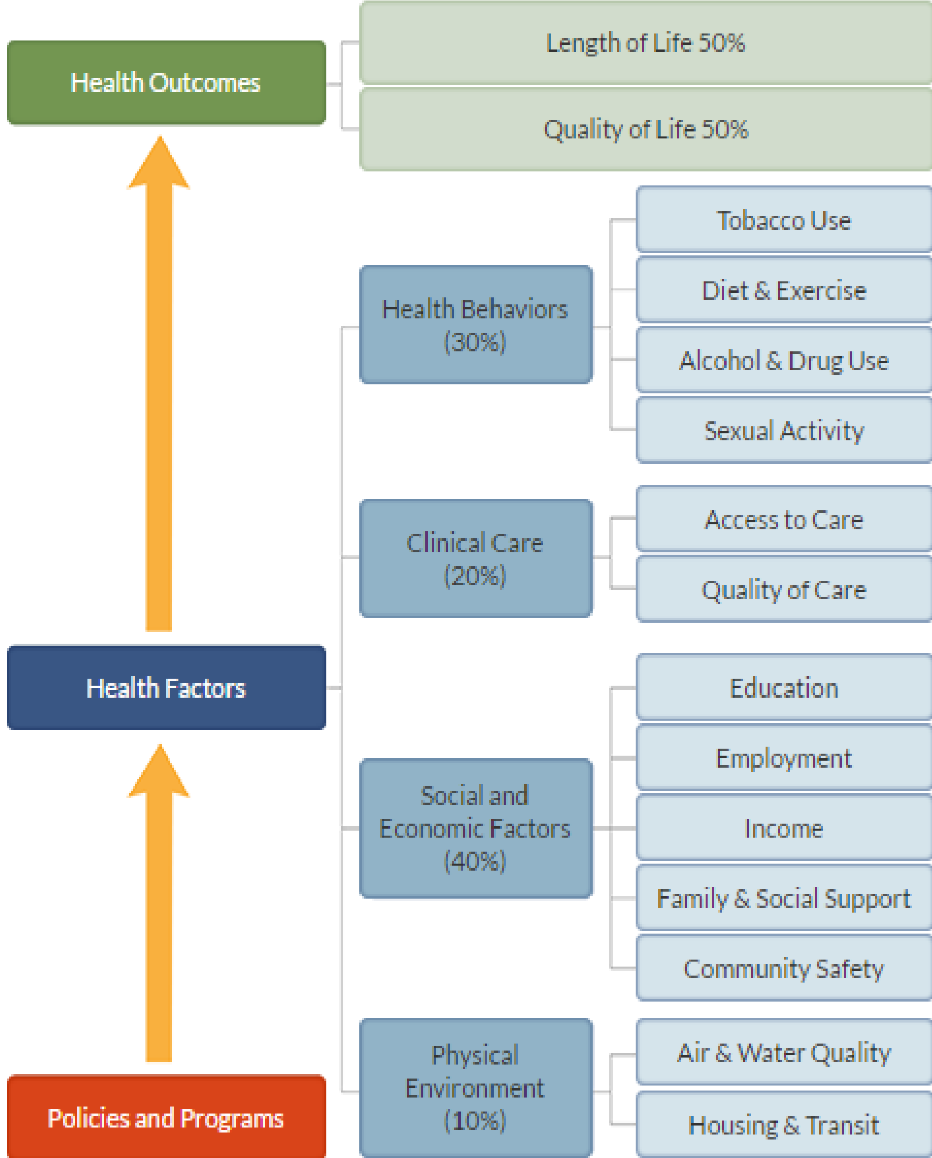
- Establish the link between ‘Economic Instability’ and poor health outcomes.
- Introduce SOMOS’s integrated approach to connect patients and their primary care physicians through CBO to community-based resources and social services in the Greater New York Area.

What is SOMOS Community Care?

SOMOS Community Care is a provider network on the forefront of health care innovation. We are a provider-led, professionally managed organization organized to accomplish the mission of delivering value-based care to New York's most vulnerable and under-served populations.

Framework for assessing and describing health status and what influences health

Only 20 percent of factors affecting health outcomes are related to clinical care.



Source: Hood, C. M., K. P. Gennuso, G. R. Swain, and B. B. Catlin. 2016. County health rankings: Relationships between determinant factors and health outcomes. *American Journal of Preventive Medicine* 50(2):129-135.

Understanding the impact of poverty is key!

- A "Hotspot" Analysis of SOMOS' targeted Medicaid population, of over 650,000 patients under the network physicians' care, brought to light valuable insights.
- Twenty-nine (29) zip codes or "Hotspots" were identified in New York City neighborhoods with some of the most pressing health and social challenges throughout the State.
- Fifteen (15) of the 29 hotspots (or approximately 52%) are located in the Bronx, the epicenter of poverty in NYC and NYS.

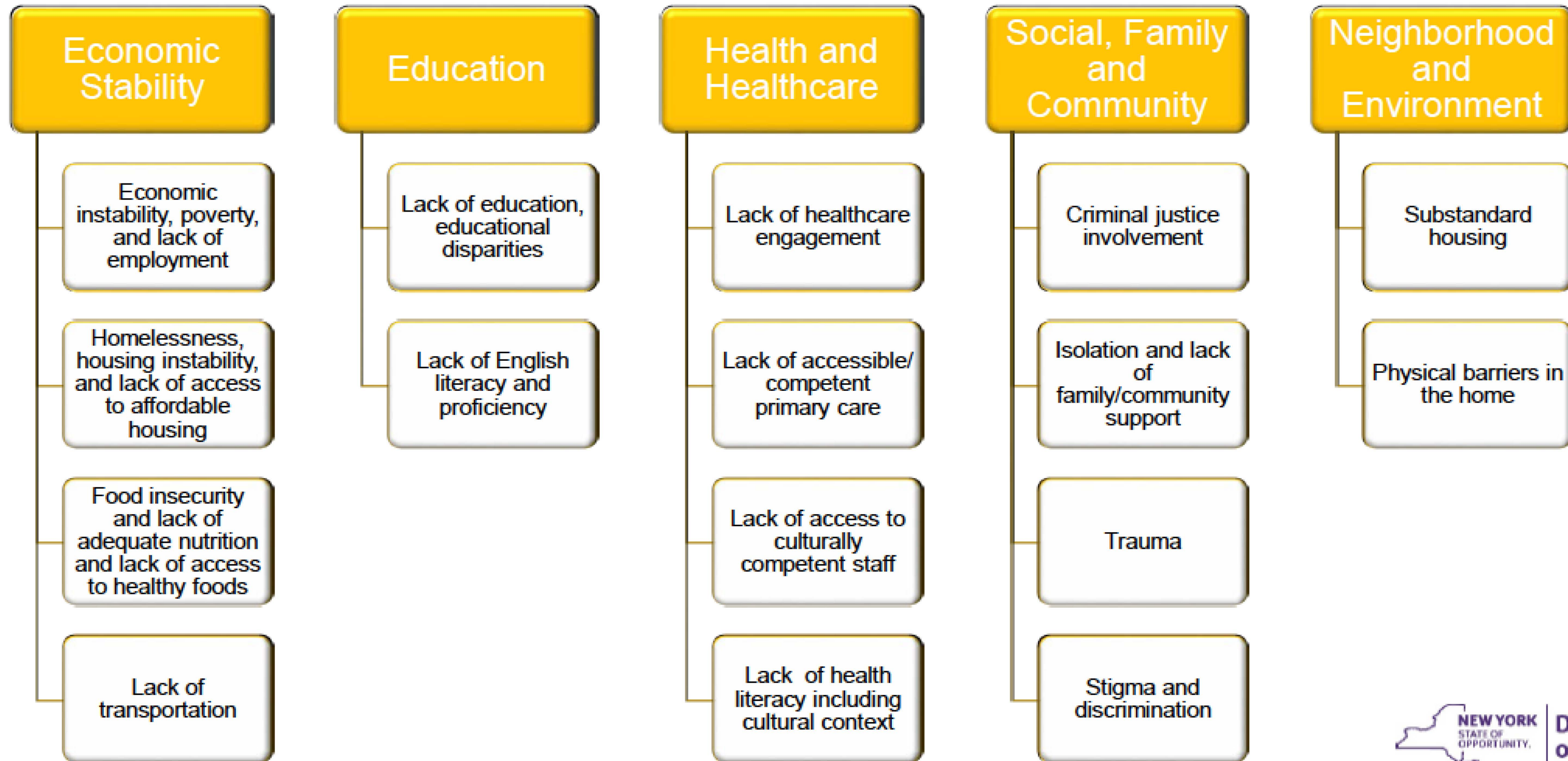
Source: Advocate Community Providers, *Understanding Our Health Disparity Hotspots*, September 2015

Understanding the impact of poverty is key!

- From a total of 62 counties in NYS-the Bronx ranks dead last in health outcomes:
  - The residents of the hotspots identified in the Bronx visit the Emergency Room at rates ranging from 18.8% to 36.8%
  - 20 to 46% of this population lives below the poverty line
  - 20 to as high as 77.6% are Medicaid beneficiaries
  - 20 to over 50% receive Food Stamps
  - 11 to 20.8% are unemployed
  - 30 to over 50% have not completed high school

Source: Advocate Community Providers, *Understanding Our Health Disparity Hotspots*, September 2015

Identifying Effective Interventions – SDH Categories Expanded



NEW YORK STATE OF OPPORTUNITY. | Department of Health

Economic Stability

Poverty is the leading underlying cause of premature death.

- Those with lower SES were 1.5 times more likely to die before age 85 than those with higher SES.
- Interventions that provided financial assistance to low-income families, had significant associations with higher birth weights.
- A simulation raising the minimum wage to $15 prevented 5500 to 2800 deaths among low SES individuals.

Source: Daniel, H., Bornstein, S., & Kane, G. C. (2018, April 17). Addressing Social Determinants to Improve Patient Care and Promote Health Equity: An American College of Physicians Position Paper. Retrieved from http://annals.org/aim/fullarticle/2678505/addressing-social-determinants-improve-patient-care-promote-health-equity-American

Housing Insecurity

- Various research studies have demonstrated that children and families who face unstable, unaffordable housing were at a greater risk of having poor health and developmental delays.
- Individuals who are housing unstable have also been found to be more likely:
  - to visit an emergency room,
  - have longer hospital stays once admitted
  - have higher likelihoods of readmission.

Source: National Quality Forum. A Framework for Medicaid Programs to Address Social Determinants of Health: Food Insecurity and Housing Instability. Washington, DC: National Quality Forum; 2017. Available online.

Medication Adherence

- Evidence suggests that up to 50% of patients fail to adhere to their prescribed long-term treatments for chronic conditions.
- Not only does non-adherence of medications lead to less effective treatment, it can cause a dramatic increase in healthcare costs.

Source: Sabaté E. Adherence to long-term therapies: evidence for action. Geneva: World Health Organization; 2003. http://www.who.int/chp/knowledge/publications/adherence_introduction.pdf. Accessed 15 June 2018.

Food Insecurity

"Food insecurity — lack of access to affordable, nutritious food — can be harmful to the health and well-being of children and adults, resulting in negative outcomes such as poor academic performance, chronic medical conditions, such as diabetes, hypertension, and poor oral health, and increased risk of behavioral health conditions, such as depression and anxiety."

- **Food insecurity has been associated with decreased nutrient intakes, mental health problems, diabetes, hypertension, and worse outcomes on health exams.**

Source: Kaiser Permanente Community Health. Hunger Free Colorado: Connecting Vulnerable Patients to Food and Nutrition Resources. 2-1-1 San Diego: Connecting Partners through the Community Information Exchange; August 2018. Available online.

SOMOS Economic Stability SDH Intervention

- According to the AHRQ Medical Expenditure Panel Survey, the top 5% of high-utilizers consumes approximately 50% of total medical expenses.

- SOMOS is targeting four components within the Economic Stability domain that includes:
  - Economic Instability
  - Housing Instability
  - Food Insecurity
  - Medication Adherence

- Through this initiative, SOMOS will gain a better understanding of the process for integrating medical and social interventions to achieve positive health outcomes.

Key Elements of the Project

- This project will be implemented with community-based organizations. Patient demographic information will be extracted using data analysis tools to create a list of high-cost and high-need patients. Some of the major goals of this initiative include:
  - maximizing entitlement supports
  - incentivizing medication adherence
  - mitigating the impact of housing and food insecurity through direct service delivery and referrals

MCO-Patient Identification

SOMOS Community Care - Patient Distribution

Medical Practice – Patient Verification

Patient Assignment & Distribution to CBO

CBO - Provides services to patients.

CBO reports back to SOMOS

Patient – Completes Satisfaction Survey

Process Workflow

1. Patient Identification based on Super Utilizer formula.
2. Sorting out patient list.
Creating individual trackers for the PCPs.
3. Cleaning lists at the medical practice.
 Verifying Physician and Patient Practice, Patient Information, Patients insurance carrier & Doctor is the Patients Primary Care Provider by SOMOS CHW.
4. Assign List to CBO.
CBO/CHW follows up with every single patient assigned to them by outreaching and doing the assessments (phone calls) as well as making referrals.
5. CBO Services provided.
6 CBO reports to SOMOS.

Payment Model

- Two Major Factors:
  - Based on VBP concept-earned income on completion of milestones (added value to the providers)
  - Cost of an FTE and operating costs for the CBO

Contracting

- “Hablando la gente se entiende”
- “Through dialogue people reach agreements”

  - Being honest about the fact that there are no answers…paving new ground
  - Willingness to embark on new journey
  - VBP nuances and specifics are yet to be discovered
  - Past relationships/experiences working together were key

SDH		VBP Funded Intervention	Activities	Intervention Goals	Frequency of SDH Review	Score Value	Maximum Yearly Incentive Dollars
Economic Stability	Economic Instability	Case management support	Conduct eligibility assessment for public assistance and social services.	90% of patients connected to PCPs for annual wellness visits and preventative care 90% of eligible patients receiving entitlements and supportive services	Quarterly	50	
		Financial incentives for Medication Adherence	Create incentive model	25% increase medication adherence over baseline	Quarterly	5	
	Housing Instability Lack of access to affordable housing	Legal Services	Provide legal service to patients facing eviction proceedings	40% reduction of preventable evictions over baseline 100% of effected patients connected to legal services for housing	Quarterly	15	
		Housing-related case management services	Provide Case management support for patients in unstable housing conditions	100% assigned a case manager 100% living environment assessment completed	Quarterly	15	
	Food Insecurity	Providing access to meal and home meal delivery services	Provide nutritional services Coordinate meal delivery	100% of eligible patients connected to meal delivery services	Quarterly	15	
					Total	100	

COMMUNITY CARE

Criteria for CBO Selection

- Strong connection to the community
- Track record
- Broad relationships with providers locally and beyond
- Multi borough/community presence
- Comprehensive/integrated service delivery capacity
- Programming in key areas: Food and nutrition, legal services, housing services
- Technological competence/data sharing capabilities
- Cultural and linguistic competence
- Funding stability(as well as can be expected in current funding environment for CBOs)!

Current Project Partnerships

SOMOS is initially partnering with four Community Based Organizations in the Greater New York Area to help implement a demonstration project:

- Manhattan: Northern Manhattan Improvement Corporation, Inc.
- Bronx: R.A.I.N, Inc (Tolentine Senior Center)
- Brooklyn & Queens: Make the Road N.Y. Inc
- Citywide: God's Love We Deliver, Inc

Contact information

For further information, contact:

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- Somoscommunitycare.org

NMIC

NMIC Overview

CRISIS → *SELF-SUFFICIENCY*

Legal Services

- Housing
- Immigration
- Public Benefits
- Consumer Debt

Weatherization

- Weatherization
- Cooling

Community Organizing

- Tenant Organizing
- Housing Development

Benefits Access

- SNAP
- EITC
- Health Insurance
- Housing Benefits

Education & Career Services

- Education (ABE/HSE, ESOL)
- Professional Certification
- Job Readiness
- Internships
- Job Placement
- Retention/Advancement

Specialized Case Management

- Medical
- Mental health
- Domestic Violence

SDH Interventions

SDH	Intervention	Resource	Type
Economic Instability	Entitlement Access	NMIC Single Stop	Existing/Expanded
	Wellness Visits	NMIC experience	New
	Medication Adherence	SOMOS tool	New
Housing Insecurity	Legal Services	NMIC Legal Services	Existing (limited)
	Case Management	NMIC experience	New
Food Insecurity	Meal Delivery	SOMOS referral resource	Referral
	Pantry Access	NMIC referral resource	Existing (limited)

NMIC

Contracting Mindset

- **Realism**
  - Does this partnership makes sense?
- **Education**
  - Research
  - Ask questions
- **Transparency**
  - Partnership
  - Manage expectations
- **Priority**
  - Authority
  - Efficiency

NMIC

Contracting Considerations

- **Costs**
  - Ensure they’re covered
  - Share what they are
- **Services**
  - Current in-house
    - What exists?
    - What is available? (3 tiers)
  - External referral
  - Prospective in-house
- **Staffing**
  - Dedicated staff

NMIC

Barriers

- **Risk**
  - Mitigation by design
- **Valuing Benefits**
  - Logic trail
  - Cost savings
- **Defining Service Scope**
  - % vs #
  - 100% isn't feasible
- **Agency structure**
- **Database**
  - Communication

Thank you!

SDH Contact Information: SDH@health.ny.gov
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SDH CBO Website: https://www.health.ny.gov/mrt/sdh