VBP Lessons Learned: Social Determinants of Health Contracting
VBP Pilot and Social Determinants of Health General Overview

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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.

**New York State (NYS) Payment Reform**

**Towards 80-90% of Value Based Payments to Providers**

**VBP Levels 1 - 3 for CY 2015:** 33.82%

<table>
<thead>
<tr>
<th>Year</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>Performing Provider Systems (PPS) requested to submit growth plan outlining path to 80-90% VBP</td>
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<tr>
<td>2018</td>
<td>≥ 10% of total Managed Care Organization (MCO) expenditure in Level 1 VBP or above</td>
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</table>
| 2019 | ≥ 50% of total MCO expenditure in Level 1 VBP or above.  
≥ 15% of total payments contracted in Level 2 or higher * |
| 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:

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

Tier 1 CBO
- Non-profit, non-Medicaid billing, community based social and human service organizations
  - e.g. housing, social services, religious organizations, food banks
- All or nothing: All business units of a CBO must be non-Medicaid billing; an organization cannot have one component that bills Medicaid and one component that does not and still meet the Tier 1 definition

Tier 2 CBO
- Non-profit, Medicaid billing, non-clinical service providers
  - e.g. transportation provider, care coordination provider

Tier 3 CBO
- Non-profit, Medicaid billing, clinical and clinical support service providers
- Licensed by the NYS Department of Health, NYS Office of Mental Health, NYS Office for Persons with Developmental Disabilities, or NYS Office of Alcoholism and Substance Abuse Services.

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.

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

<table>
<thead>
<tr>
<th>Economic Stability</th>
<th>Education</th>
<th>Health and Healthcare</th>
<th>Social, Family and Community</th>
<th>Neighborhood and Environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic instability, poverty, and lack of employment</td>
<td>Lack of education, educational disparities</td>
<td>Lack of healthcare engagement</td>
<td>Lack of healthcare engagement</td>
<td>Substandard housing</td>
</tr>
<tr>
<td>Homelessness, housing instability, and lack of access to affordable housing</td>
<td>Lack of English literacy and proficiency</td>
<td>Lack of accessible/competent primary care</td>
<td>Isolation and lack of family/community support</td>
<td>Physical barriers in the home</td>
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<tr>
<td>Food insecurity and lack of adequate nutrition and lack of access to healthy foods</td>
<td>Lack of transportation</td>
<td>Lack of access to culturally competent staff</td>
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<tr>
<td>Lack of transportation</td>
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<td>Lack of health literacy including cultural context</td>
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<td></td>
<td>Trauma</td>
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<td>Stigma and discrimination</td>
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</table>
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.

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.

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.

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.

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
1. Patient Identification based on Super Utilizer formula.
2. Sorting out patient list.
3. Creating individual trackers for the PCPs.
4. 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.
5. 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.
6. CBO Services provided.
7. 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
<table>
<thead>
<tr>
<th>SDH</th>
<th>VBP Funded Intervention</th>
<th>Activities</th>
<th>Intervention Goals</th>
<th>Frequency of SDH Review</th>
<th>Score Value</th>
<th>Maximum Yearly Incentive Dollars</th>
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<tbody>
<tr>
<td>Economic Stability</td>
<td>Economic Instability</td>
<td>Case management support</td>
<td>Conduct eligibility assessment for public assistance and social services.</td>
<td>Quarterly</td>
<td>50</td>
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<td>90% of patients connected to PCPs for annual wellness visits and preventative care</td>
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<td>90% of eligible patients receiving entitlements and supportive services</td>
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<td></td>
<td>Financial incentives for Medication</td>
<td>Create incentive model</td>
<td>Create incentive model 25% increase medication adherence over baseline</td>
<td>Quarterly</td>
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<td></td>
<td>Adherence</td>
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<td>40% reduction of preventable evictions over baseline</td>
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<td>100% of effected patients connected to legal services for housing</td>
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<td></td>
<td>Legal Services</td>
<td>Provide legal service to patients facing eviction proceedings</td>
<td>Quarterly</td>
<td>15</td>
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<td>100% of eligible patients considered</td>
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<td></td>
<td>Housing-related case management services</td>
<td>Provide Case management support for patients in unstable housing conditions</td>
<td>Quarterly</td>
<td>15</td>
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<td>100% assigned a case manager</td>
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<td>100% living environment assessment completed</td>
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<td></td>
<td></td>
<td>Providing access to meal and home meal delivery services</td>
<td>Provide nutritional services</td>
<td>Quarterly</td>
<td>15</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>100% of eligible patients connected to meal delivery services</td>
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<td></td>
<td>Coordinate meal delivery</td>
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<td></td>
<td></td>
<td></td>
<td><strong>Total</strong></td>
<td></td>
<td>100</td>
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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:

Moisés Pérez Martínez, SOMOS Community Care
  • V.P. for Workforce, Community & Government Relations
  • 917 686 9784
  • mperez@somoscommunitycare.org
  • Somoscommunitycare.org
NMIC Overview

**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

**CRISIS**
- Tenant Organizing
- Housing Development

**SELF-SUFFICIENCY**
- Education (ABE/HSE, ESOL)
- Professional Certification
- Job Readiness
- Internships
- Job Placement
- Retention/Advancement
<table>
<thead>
<tr>
<th>SDH</th>
<th>Intervention</th>
<th>Resource</th>
<th>Type</th>
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</thead>
<tbody>
<tr>
<td>Economic Instability</td>
<td>Entitlement Access</td>
<td>NMIC Single Stop</td>
<td>Existing/Expanded</td>
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<td>Wellness Visits</td>
<td>NMIC experience</td>
<td>New</td>
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<tr>
<td></td>
<td>Medication Adherence</td>
<td>SOMOS tool</td>
<td>New</td>
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<tr>
<td>Housing Insecurity</td>
<td>Legal Services</td>
<td>NMIC Legal Services</td>
<td>Existing (limited)</td>
</tr>
<tr>
<td></td>
<td>Case Management</td>
<td>NMIC experience</td>
<td>New</td>
</tr>
<tr>
<td>Food Insecurity</td>
<td>Meal Delivery</td>
<td>SOMOS referral resource</td>
<td>Referral</td>
</tr>
<tr>
<td></td>
<td>Pantry Access</td>
<td>NMIC referral resource</td>
<td>Existing (limited)</td>
</tr>
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Contracting Mindset

- **Realism**
  - Does this partnership makes sense?
- **Education**
  - Research
  - Ask questions
- **Transparency**
  - Partnership
  - Manage expectations
- **Priority**
  - Authority
  - Efficiency
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
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
VBP Pilot Contact Information: VBP_Pilot@health.ny.gov

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