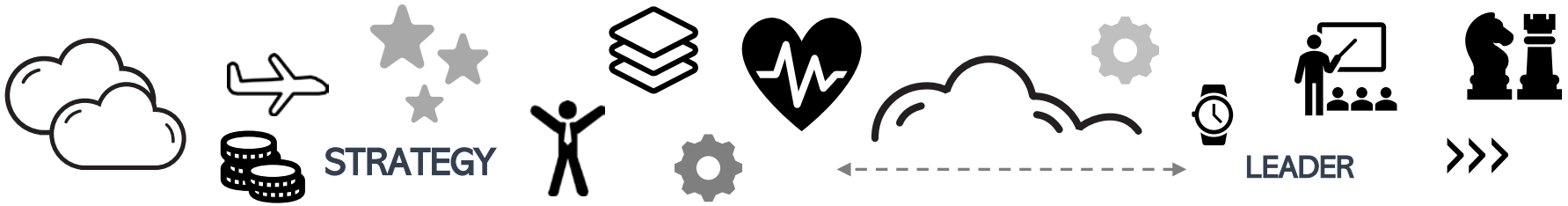


Creating Value Propositions

April 2020
NYAPRS Executive Seminar

Kristin Woodlock
CEO, Woodlock & Associates
917-244-4221
woodlockk@gmail.com

Knowledge is only rumor until it lives in the bone.

~The Asaro tribe of Indonesia and Papua New Guinea

Public Good or a Value-Based Payment?

Public Good

- For years Federal, State and County governments and philanthropy have funded an array of services to address social, health and community challenges.
- These services comprise an essential safety net. Many of these services have evolved into performance-based contracts. Measures are usually based in performance metrics, but not necessarily health outcomes.
- (ex. Entitlement counseling, outreach, drop-in center, peer support, youth development, etc.)

Public Good Services are essential YET not all of them may be a VBP Innovation.

Value-Based Payment

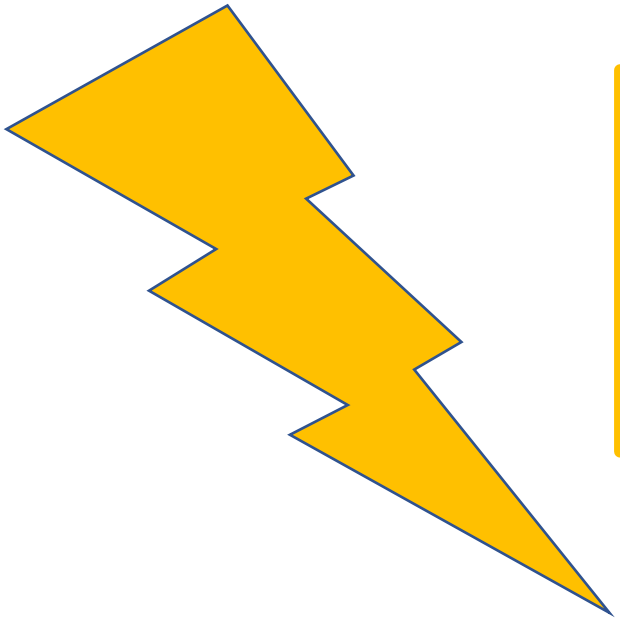
- VBP Innovations are designed to result in measurable impact on health outcomes in a short timeframe (usually not longer than 12 months.)
- (ex. Medically tailored meals with a senior check-in to prevent unnecessary ED visits, Recovery coaches in the ED to improve engagement in outpatient treatment, Culturally Relevant Meal Preparation Classes for Newly Diagnosed Diabetics, etc.)

Is it a Public Good or a VBP?

Peer Advocacy

Substance Use Prevention

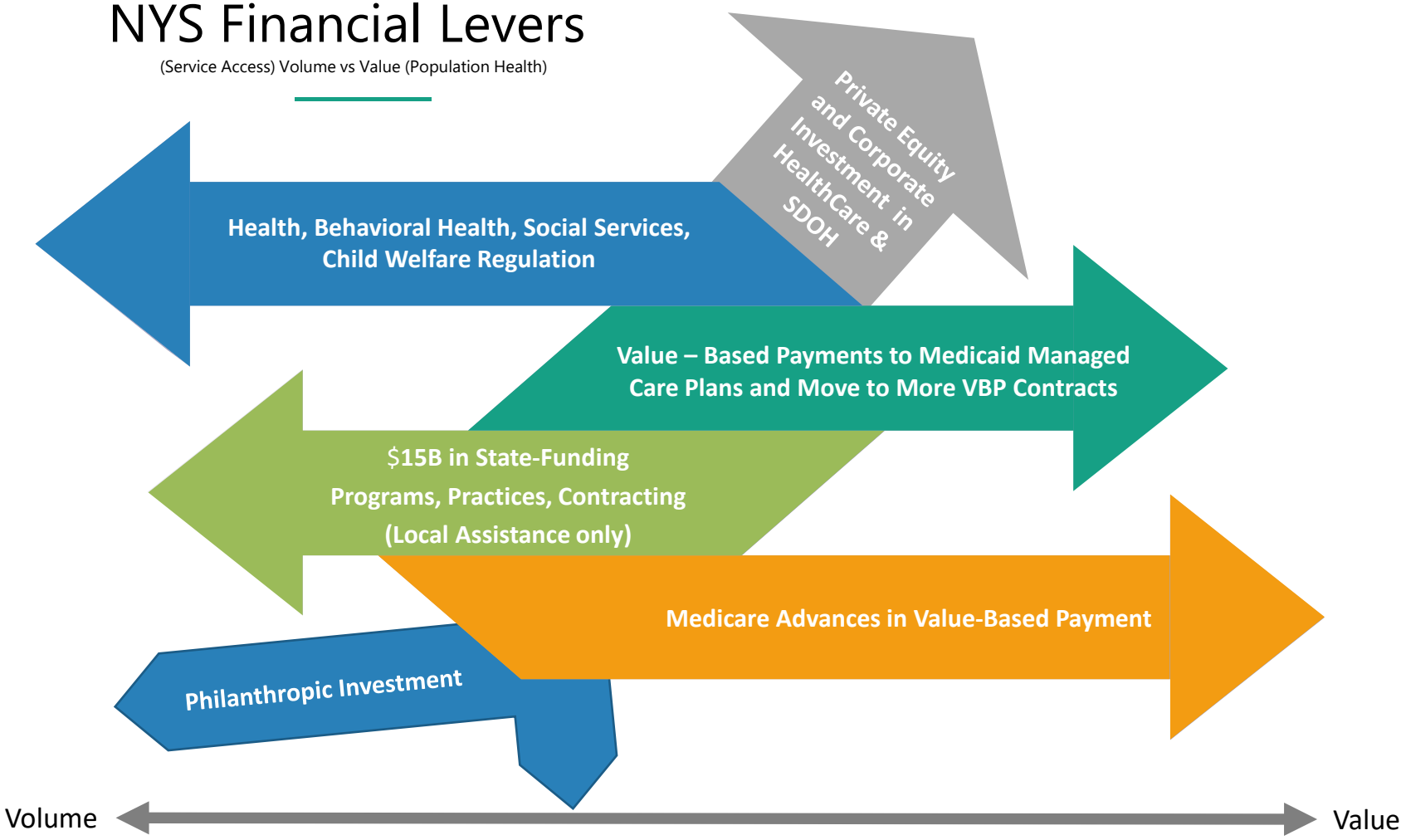
Recovery Coach



Public Good or VBP
Lightning Round

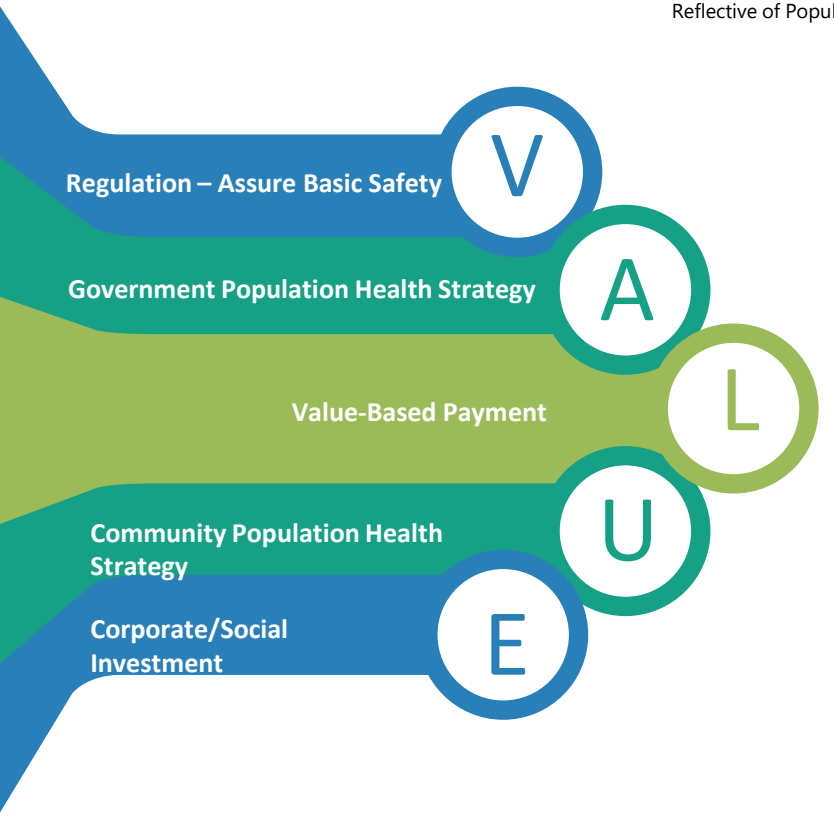
NYS Financial Levers

(Service Access) Volume vs Value (Population Health)



Holistic Road Map from Volume to Value

Reflective of Population Health – Social Determinants of Health



Population Health as the Unifying Strategy

Directional Alignment

Data-Driven

Value = Outcomes/Cost

Balance of Long-Term Investment and Short-Term Gains for Population Health

Background

Introduce your organization:

1. Who you are in the context of improving health outcomes for your community.
2. Distinctiveness.
3. Demonstrate your understanding of VBP.
4. Start a conversation and build relationship – don't look for a contract on day 1.

Concept

DEFINE the problem or need for improvement:

1. Tell a story using National and Local data, experience and inspiration. Ground in research and pragmatic impact.
2. Make a compelling argument for why "it" costs the consumer and payor financially and in immediate/short term health outcomes.
3. Talk about why the lack of "it" or the current "it" creates a priority/urgent problem.

Deliverables

What would "we" measure and deliver:

1. **Developmentally appropriate metrics with data definition and accountable party.**

Methods

Walk through how what you are doing will work from the payor's perspective:

1. **Keep it simple.**
2. **What are you doing with more specificity to engage me and have me understand if this will work in my organization or system.**
3. **Builds credibility in pitch.**

Return

What will this cost and why should I open my wallet:

1. **What is the cost?**
2. **What can I reasonably expect to gain from investing in your work?**
3. **Be realistic. Under promise and over deliver.**

MHA in Chautauqua County
Recovery Coaches

Concept

Recovery Coaches in New York State and across the country are delivering results for SUD Treatment Providers, Hospitals, Emergency Departments and Primary Care Practices. Performance metrics are tailored to the unique needs of provider partners or payer, but may include:

- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)
- Initiation and Engagement in MAT
- Detox admissions
- Residential program admissions
- Hospital admissions
- Mortality rate from overdose and from all causes
- Preventable Emergency Room Visits
- Follow-up Post Hospital (7-day & 30-day)
- Pre-Natal HEDIS data set

Peer support has long been viewed as a foundational component to recovery from substance use disorders. In the era of value-based payment, peer support has grown into defined practice referred to as Recovery Coaches. Recovery Coaching is a form of strength-based supports for persons in or seeking recovery from alcohol and other drugs, and other addictions.

Recovery Coaching is a type of partnership where the person in or seeking recovery self directs his/her recovery while the coach provides expertise in supporting successful change. Recovery Coaching focuses on achieving any goals important to the individual. The coach asks questions and offers suggestions to help the person in recovery begin to take the lead in addressing his/her recovery needs. Recovery Coaching focuses on honoring values and making principle-based decisions, creating a clear plan of action, and using current strengths to reach future goals. The coach serves as an accountability partner to help the person sustain his/her recovery. The Recovery Coach helps the person access recovery, as well as access systems needed to support recovery such as benefits, health care, etc.

Most Recovery Coaches are *Certified Recovery Peer Advocates (CRPA.) CRPA's are individuals who hold an OASAS approved certification as a peer advocate. Within an outpatient program, Peer advocates must be supervised by a Qualified Health Professional (QHP) staff member to provide peer support services based on clinical need as identified in the patient's treatment/recovery plan.*" CRPAs may also work within other recovery support service providers and not be supervised by QHPs.

Recovery Coaches Hospital Units or Emergency Departments:

KEY IMPACTS: Engagement, Initiation of MAT, Connection to Outpatient Treatment

In this setting, Recovery Coaches engage individuals in the hospital unit or emergency department prior to discharge, and typically within 24 hours of receiving a referral. Recovery Coaches help individuals to recognize that recovery is possible, and when individuals express interest in entering the next stage of treatment, Recovery Coaches facilitate access.

Recovery Center or Clinic-based Settings:

KEY IMPACTS: Engagement, Adherence, Identification-Resolution of Social Determinants of Health

Recovery Coaches in community-based settings make connections via referrals from affiliated health centers, inpatient programs, center directors or Recovery Coach supervisors, warm hand-offs from clinical staff in other settings, walk-ins, and outreach sessions in the community, jails or prisons

Primary Care Collaborations with Recovery Coaches:

Recovery Coaches work with primary care practices to engage, re-build relationships with providers and to coach patients towards healthier lifestyle choices. As an example, we frequently encounter patients who have unpaid

co-pays or perhaps have been argumentative. Often what can appear as disinterest or aggression is rooted in the person's experience of poverty, trauma or a behavioral health issue. We can sort this out, mediate solutions and get the patient back on track.

Metrics

Data	Data Point
Readmission to Detox	Peer Survey
Avoidable ED Use	Peer Survey
Readmission to SUD Hospitalization	Peer Survey
Engagement	Specific criteria to be defined by MHA
Updating Contact Information with Insurer/Hospital/PCP	# Updates/Current
PCP (if relevant to the payor you are pitching)	Has PCP? Physical 1yr? New Appt?
WRAP (A plan to improve health, support and reduce avoidable high cost utilization)	Y/N has plan.

Return on Investment

MHA co-designs impact measures, costs and return on investment (ROI) with each individual provider and/or payor. The metrics outlined above offer a starting point for data of primary interest to payors. Return on investment calculations vary depending on the payment structure of our partners. A practice struggling with engagement will find increased visits and patient activation leading to improved quality metrics and increased billable visit volume. A practice or health system in a partial or full-risk contractual arrangement may want to focus on reduced ED or hospital visits in its ROI.

EDUCATE TO PREVENT

Southern Tier Pediatrics: Advancing Adolescent Health Outcomes, Strengthening PCMH and Improving Practice Efficiency

Background

The Chautauqua Alcohol and Substance Abuse Council, a grass-roots organization working in Chautauqua County since 1974 to help prevent substance abuse recently became Prevention Works. Prevention Works is a trusted provider using evidence-based services to drive results and is the only New York State Office of Addiction Services and Supports (OASAS) approved prevention provider in Chautauqua County

Screening	CASAC Staff facilitate the administration of the CRAFFT tool, score results and communicate results to the STP Provider, Youth and Family.
Referral for Serious Mental Health & Substance Use Treatment	CASAC Staff will review findings from screening tools and/or STP Provider referrals. In working with the Youth and Family a personalized referral for treatment with supports to ensure engagement will be offered.
9 Month Intervention for Adolescents with Mild-Moderate SUD	CASAC Teen Intervene
Practice Support in Engagement, Communication and Referral for Mental Health and SUD	CASAC Staff receives referrals from STP Providers. Manages referrals and communication with Foster Care, Schools, Probation, Courts on MH and SUD. Offers skill and support groups.

Concept

There is a convergence of challenges facing Patient Centered Medical Homes (PCMH) serving adolescents. Engaging, screening and intervening with young people between 12 – 19-years of age (adolescents) to reduce risk and promote health is one such challenge. Ideally, adolescents with emerging, mild or moderate substance use would be identified by their primary care provider who would then engage them in health promoting behaviors which result in a reduction of use or abstinence. If only it were that easy.

Screening, prevention and early intervention of substance use is foundational to clinical care and a requirement of PCMH. Yet it is stressful for providers and their operational workflows and is highly dependent on being able to access needed community services and supports. The cost of not identifying or treating emotional health issues are dramatic for the adolescent, health care practice and health care system. Prevention Works proposes a comprehensive solution for Southern Tier Peds.

Prevention Works will deliver substance use screening, early intervention through an evidence-based practice (Teen Intervene), personalized referral for treatment or needed community supports and on-going practice support. Offerings include facilitation and scoring of the CRAFFT screening; engagement of the youth and family with a positive screen or a referral from Southern Tier Peds Provider, personalized referral for the youth and family with continuous support until engaged, communication with school, probation, court and PCP. Prevention Works will obtain necessary consents to documents within the Southern Tier Peds EHR.

Deliverables

Data Point	Definition	Source/Responsible Party
Facilitation and Scoring of CRAFFT Screen	# Completed	Prevention Works
Referral to Treatment	# Referred (Specify by MH/SUD) # Engaged (First Visit) within 7 Days # Engaged (>1 Visit) within 30 days	Prevention Works
Community Support Referrals (Social Determinant)	# Referred by Organization # Connected by Organization (Definition TBD)	Prevention Works
Decreasing Preventable Emergency Department Visits	PPV	Southern Tier Peds Definition and Data Set
Decreasing Preventable Inpatient Hospital Days	PPR	Southern Tier Peds Definition and Data Set
SUD Use, Level, Frequency Reports	Personalized to the Patient	Prevention Works
Parental Engagement	# Family Survey Completed # Family Rules Developed Family Rules Used # Participate in Parent Education Grp	Prevention Works

Cost and Return on Investment

An investment in the Prevention Works service package has significant returns for primary care practices. These include:

- Improved patient experience and care
- Support towards achieving/sustaining PCMH status
- New Medicaid and Commercial Billing for Substance Use Screening
- Clinicians working at top of license – improving morale and financial performance
- Ability to drive new/current performance contracts with payors

Cost Estimation Table		
Service	**Unit**	**Cost**
SBIRT/CRAFFT Screen	Per Completed Screen	$24.00 (Off Set by Revenue Billed by Southern Tier Peds)
Teen Intervene	9 Month Evidence Based EI	$1,600 per youth per 9-month package
Practice Support Emotional Wellness	8.75 hours/week	$45,000 per 1-year contract

Recovery Coaches Building the Bridge for Care Transition: Keeping Patients Engaged in Outpatient Care

Eric D'Entrone[1], Tammy Bender[1], Eric Altman[2], Damara Gutnick MD[3], Tamar Wolinsky[3,4], Allison McGuire MPH[3], Kristin Woodlock RN[2]

[1]Arms Acres, [2]Woodlock and Associates, [3]Montefiore Hudson Valley Collaborative [4]Albert Einstein College of Medicine

Background

Deaths related to opioid overdoses continue to rise in New York State, increasing to 2,185 in 2015 (NYS DOH, 2017), and evidence has demonstrated that integration of Recovery Coaches into the care team facilitates more effective transitions between inpatient and outpatient care (Tracy 2011).

At Arms Acres, a New York State licensed provider of inpatient and outpatient substance use treatment services, only 47% of patients discharged from inpatient substance use treatment actually attended their first follow-up outpatient treatment visit. In many cases, this number was achieved due to staff driving patients to their first visit.

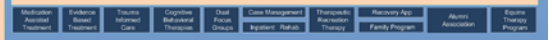
With a goal of improving transitions of care between inpatient and outpatient treatment, the Montefiore Hudson Valley Collaborative- one of 25 Performing Provider Systems (PPS) participating in the New York State Delivery System Redesign Incentive Payment (DSRIP) program- provided innovation funding for a novel pilot project that integrated Recovery Coaches into the care team at Arms Acres.

Project Aim

To improve 7 and 30-day follow-up HEDIS metrics (follow-up care after discharge to improve transitions of care between inpatient and outpatient substance use treatment) by adding a Recovery Coach to the multidisciplinary team and testing changes utilizing rapid cycle improvement methodology.

Setting

Arms Acres is a New York State licensed provider of inpatient and outpatient substance use disorder treatment. They provide comprehensive treatment services for patients residing in all 7 Hudson Valley counties utilizing a multidisciplinary team model incorporating physicians, psychiatrists, nurses, certified alcoholism and substances use counselors, social workers, family specialists, and activities specialists.



Intervention

In an effort to improve care transitions between inpatient and outpatient substance use disorder treatment providers, Arms Acres paired Recovery Coaches (Peers) with consenting patients who clinicians identified as having a high risk of recidivism. The Recovery Coach met with patients prior to discharge to collaboratively develop recovery goals and assist with linkages to harm reduction, local or online support groups, family support and education. Recovery Coaches were also available to accompany patients to their first outpatient appointment and self-help meetings. Over the first 9 months of this ongoing innovation pilot project, two Recovery Coaches worked with 106 recoverees to not only improve 1st outpatient appointment adherence, but also to increase patient engagement in care for the longer term.

The following data was collected: adherence to outpatient treatment (1st and 2nd outpatient visit adherence), long term patient engagement in care, routine discharge and readmission rates.

Results

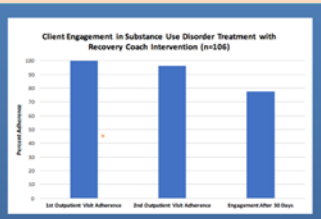


Figure 1: This graph demonstrates engagement in outpatient care for patients with Recovery Coaches. 30 day engagement was defined as attending group and individual SUD treatment at a NYS Oasis licensed outpatient provider post-discharge.
*Pre-intervention, patients only had a 47% adherence rate to 1st outpatient appointments (included all aftercare appointments: behavioral, medical, substance use).

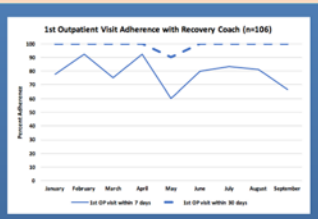


Figure 2: This graph demonstrates high visit adherence throughout the first 9 months of project implementation (n=106 recoverees engaged by two Recovery Coaches).

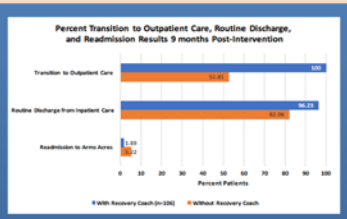


Figure 3: Recovery Coach intervention improved transition to outpatient care (1st outpatient appointment adherence)** by 89.4%, increased routine discharge from inpatient care by 17.3%, and reduced readmission within 90 days by 63.8%.
** Intervention Groups only looked at substance use follow up appointments while non Recovery Coach group looked all aftercare appointments (behavioral, medical, substance use)

Conclusions and Discussion

Utilization of Recovery Coaches to support transitions of care for patients with addiction led to higher routine discharge rates, improved transitions to outpatient care, and decreased readmission rates. It is important to note a limitation of the data that may explain why the group without Recovery Coaches also demonstrated slight improvement in first visit follow-up rates. First, outpatient visits for the group without Recovery Coaches included medical, behavioral and substance use follow up appointments, whereas only substance use follow up appointments were captured in the measure for the group with Recovery coaches. In addition, providers selected patients at highest risk of recidivism for the intervention group (Recovery Coach), thereby removing the most non-adherent patients from the group without Recovery Coaches.

Overall, the Recovery Coach intervention improved patient engagement in care leading to positive outcomes for the patients themselves. It also has clear implications for the reduction of downstream healthcare costs. We estimate that the innovation program prevented approximately 63 ED visits and 315 inpatient days in the first year, with an ROI of over $225,000. Next steps include continuing to collect and analyze data on ROI, and considering the various settings in which the use of Peers could be spread.

References:
New York State Department of Health. Opioid-related Data in New York State (2017). Available at: https://www.health.ny.gov/statistics/opioid/.
Tracy K, Burton M, Nich C, et al.: Utilizing peer mentorship to engage high recidivism substance-abusing patients in treatment. **American Journal of Drug and Alcohol Abuse** 37:525–531, 2011.

Innovation Fund Pilot Project- Recovery Coaches

- Baseline: **46.77%**.
- Fall 2017: Received Funding from MHVC as part of Innovation Fund to hire two recovery coaches.
- Goal: improve the *Care Transition* from inpatient to outpatient.
- Coaches were integrated into workflow at Arms Acres.
- Patients had to meet certain criteria.
- Introduced coach to patient.

Arms Acres

Montefiore HUDSON VALLEY COLLABORATIVE

RESEARCH ROADMAP

The Outcomes:

From January 1st, 2018 through December 31st, 2018

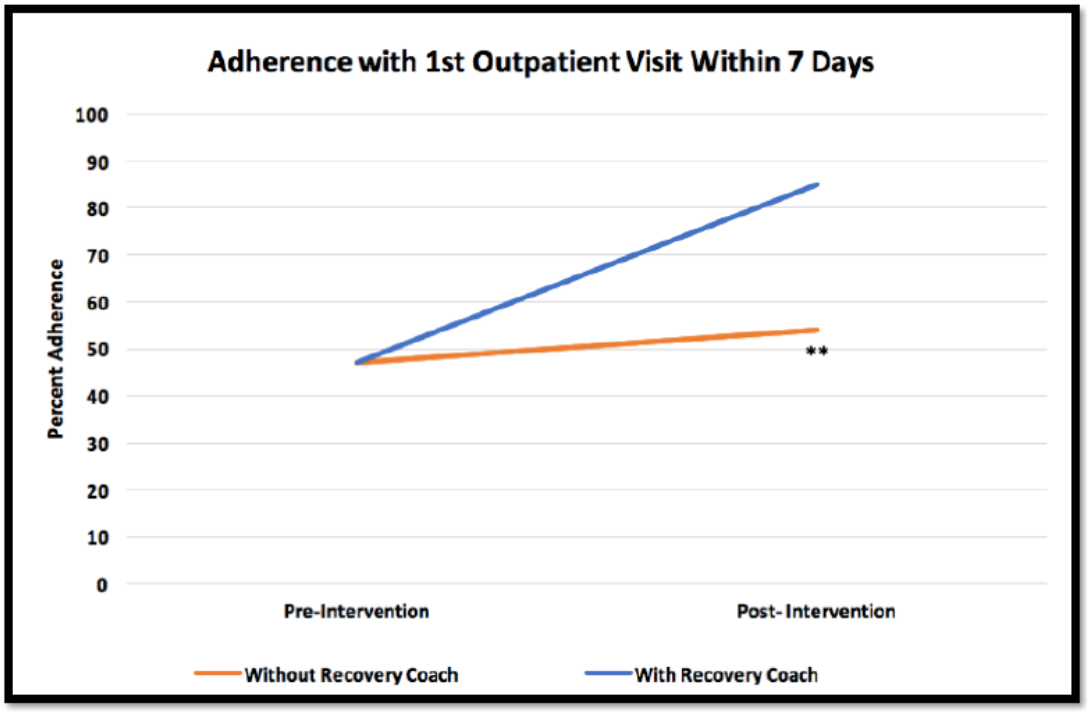
- Total Recovery Coach Patients (Recoverees): 122
- Total Kept 1st OP Visit: 122, for a rate of **100%**.
- For overall patient population (same date range): 53.40%
- Total Kept 1st OP Visit *within 7 days* of discharge: 98, for a rate of **80.34%.**
- Total Kept 2nd OP Visit: 117, for a rate of **95.90%.**

Arms Acres

Montefiore HUDSON VALLEY COLLABORATIVE

RESEARCH ROADMAP

Recovery Coaches Increased Adherence with First Outpatient Visit (85.11% vs. 54%)



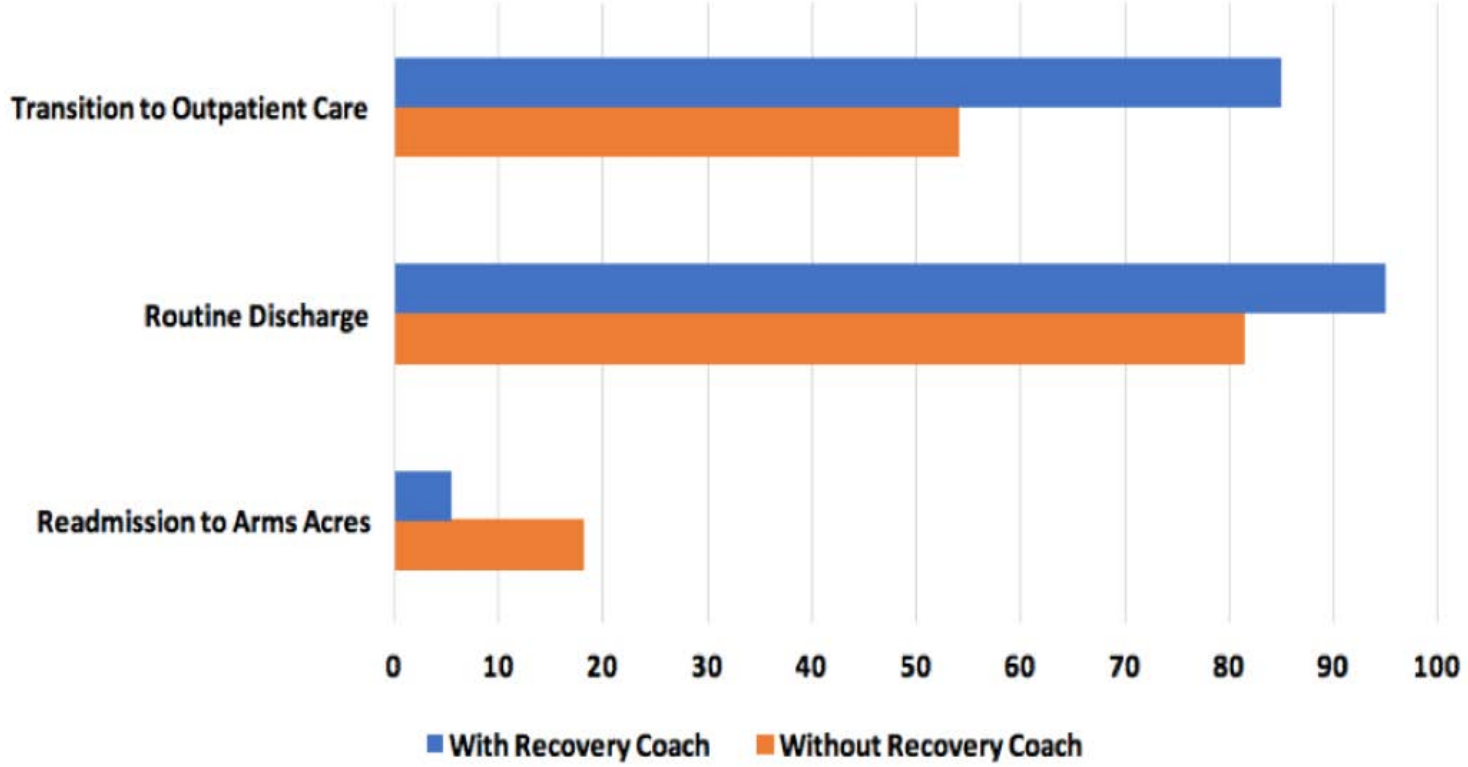
** Intervention Groups only looked at substance use follow up appointments while non-Recovery Coach group looked all aftercare appointments (behavioral, medical, substance use)

Arms Acres

Montefiore HUDSON VALLEY COLLABORATIVE

RESEARCH ROADMAP

Transition to Outpatient Care, Routine Discharge, and Readmission Results 4 months Post-Intervention



Arms Acres

Montefiore HUDSON VALLEY COLLABORATIVE

RESEARCH ROADMAP

Improving Engagement

- 30 Day Outreach Calls
- For January 1st through December 31st, 2018, there were 117 follow up calls made to track engagement in treatment 30 days post-discharge from Arms Acres.
- Of those 117 follow up calls made, 90 patients were *still engaged with their aftercare treatment provider after 30 days*, a rate of **76.92%**.

Arms Acres

Montefiore HUDSON VALLEY COLLABORATIVE

RESEARCH ROADMAP

Return On Investment

- In year one, our two recovery coaches worked closely with 122 patients. Virtually all recoverees in our program were connected to and remained in outpatient care.

- Without these services, approximately 65 would not have been connected to care. Therefore, we prevented 65 ED visits and 325 inpatient days for the first year, and yielded an ROI of **$237,378**.

- With a relatively low cost intervention like this, overall healthcare costs can be reduced significantly and many lives can be saved and significantly improved.

Arms Acres

Montefiore HUDSON VALLEY COLLABORATIVE

RESEARCH ROADMAP

NEIGHBORHOOD LEGAL SERVICES, INC.

Medical Legal Partnership

Since 1976, NLS' mission has been to ensure justice through free legal representation of Western New York residents who, due to financial vulnerability, disability, discrimination, or abuse, require assistance and protection of their civil legal rights. NLS' mission also includes providing outreach and training services to underserved populations and the community agencies that serve them. The work of NLS benefits over 15,000 people annually in matters including income maintenance, housing, family, health, and consumer law.

Medical Legal Partnership is about building an integrated health care system that better addresses health-harming social needs by leveraging legal services and expertise to advance individual and population health. NLS has brought Medical Legal Partnerships to Western New York through our work with Evergreen Health and Roswell.

How can legal services help address social needs?

Medical Concern	Common Social Determinant of Health	How Legal Services Can Help	Impact of Legal Services on Health / Health Care
Darnell is an uncontrolled diabetic. He is motivated and wants to eat healthy. He just can't afford to do it.	**INCOME** Resources to meet daily basic needs	• Appeal denials of food stamps, health insurance, cash benefits, and disability benefits	1. Increasing someone's income means s/he makes fewer trade-offs between affording food and health care, including medications. 2. Being able to afford enough healthy food helps people manage chronic diseases and helps children grow and develop.
Gladys has COPD and is on O2. She has been in the ED 4x this year. Just before each visit her electricity was shut off for nonpayment.	**HOUSING & UTILITIES** A healthy physical environment	• Secure housing subsidies • Improve substandard conditions • Prevent evictions • Protect against utility shut-off	1. A stable, decent, affordable home helps a person avoid costly emergency room visits related to homelessness. 2. Consistent housing, heat and electricity helps people follow their medical treatment plans.
David is 30 and just hurt his back lifting a box. He works so hard. His employer will not allow him to use PTO for his physical therapy.	**EDUCATION & EMPLOYMENT** Quality educational and job opportunities	• Secure specialized education services • Prevent and remedy employment discrimination • Enforce workplace rights	1. A quality education is the single greatest predictor of a person's adult health. 2. Consistent employment helps provide money for food and safe housing, which also helps avoid costly emergency health care services. 3. Access to health insurance is often linked to employment.
Imani had a tough time when deployed to Syria. I don't understand why, but her Veteran's benefits can't be accessed.	**LEGAL STATUS** Access to jobs	• Resolve veteran discharge status • Clear criminal / credit histories • Assist with asylum applications	1. Clearing a person's criminal history or helping a veteran change their discharge status helps make consistent employment and access to public benefits possible. 2. Consistent employment provides money for food and safe housing, which helps people avoid costly emergency health care services.
Nia is so frightened of her partner and I feel badly for her. I don't know what to do.	**PERSONAL & FAMILY STABILITY** Safe homes and social support	• Secure restraining orders for domestic violence • Secure adoption, custody and guardianship for children	1. Less violence at home means less need for costly emergency health care services. 2. Stable family relationships significantly reduce stress and allow for better decision-making, including decisions related to health care.

Marple, Kate. Framing Legal Care as Health Care. Washington, DC: The National Center for Medical-Legal Partnership, January 2015

Legal expertise and services can play a critical role in helping the health care system address the root cause of some of the most challenging problems related to health and health care utilization.

The impact of Medical Legal Partnership for your patients is extraordinary.

People with chronic illnesses are admitted to the hospital less frequently.
Studies showed that legal assistance targeted at improving housing conditions improved the health of asthma patients (*Journal of Asthma* and *Journal of Health Care for the Poor and Underserved*), and another study showed medical-legal partnership's positive impact on the health of sickle cell patients (*Pediatrics*).

People more commonly take their medications as prescribed.
(*Journal of Health Care for the Poor and Underserved* and *Journal of Clinical Oncology*)

People report less stress and experience improvements in mental health. (*Journal of Health Care for the Poor and Underserved, Behavioral Medicine*, and *Health Affairs*)

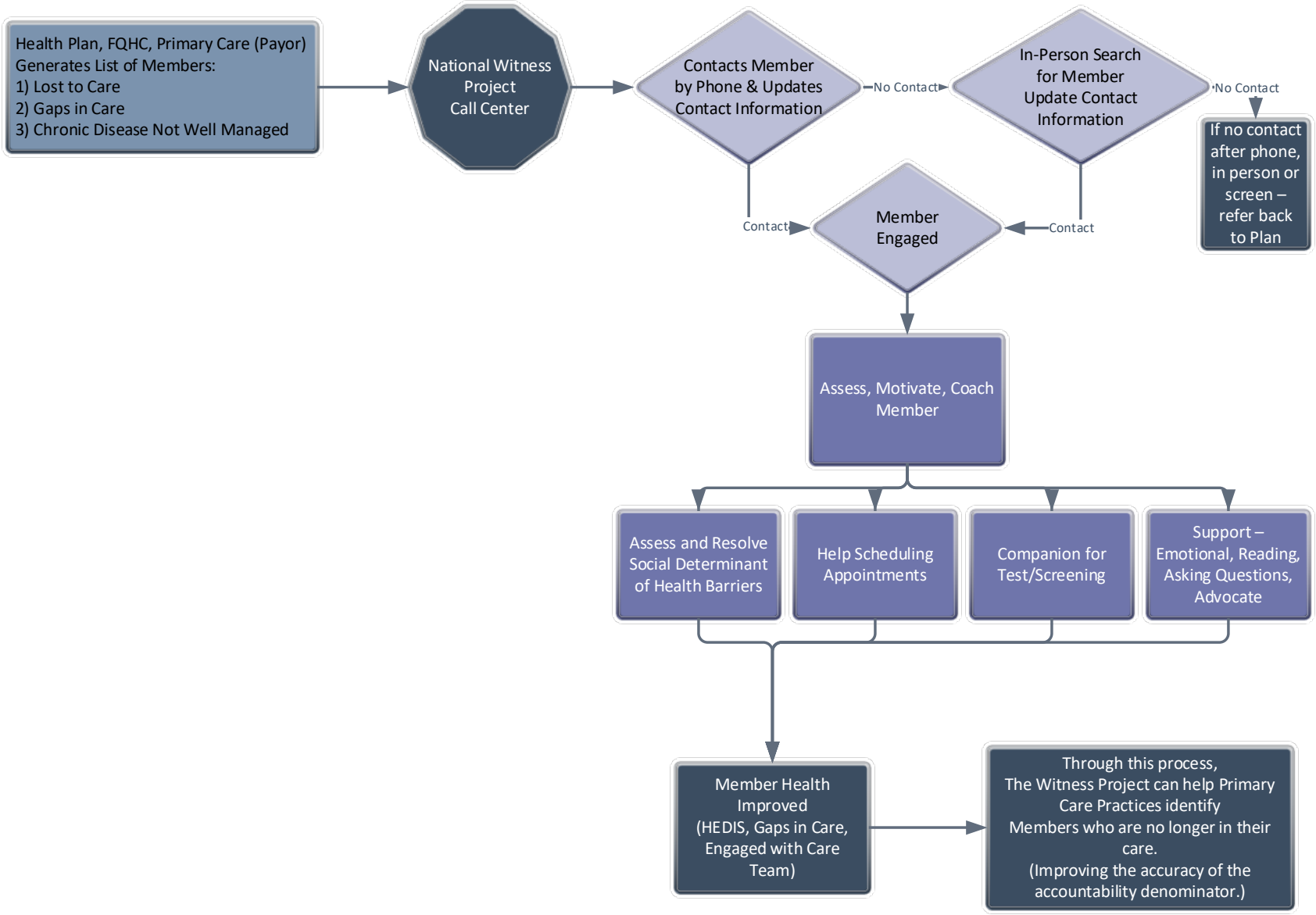
Less money is spent on health care services for the people who would otherwise frequently go to the hospital, and use of preventative health care increases. A study showed that MLP services reduce health care spending on high-need, high-cost patients (*Health Affairs*), and a randomized control trial found families of healthy newborns increased use of preventive health care after MLP services (*Pediatrics*).

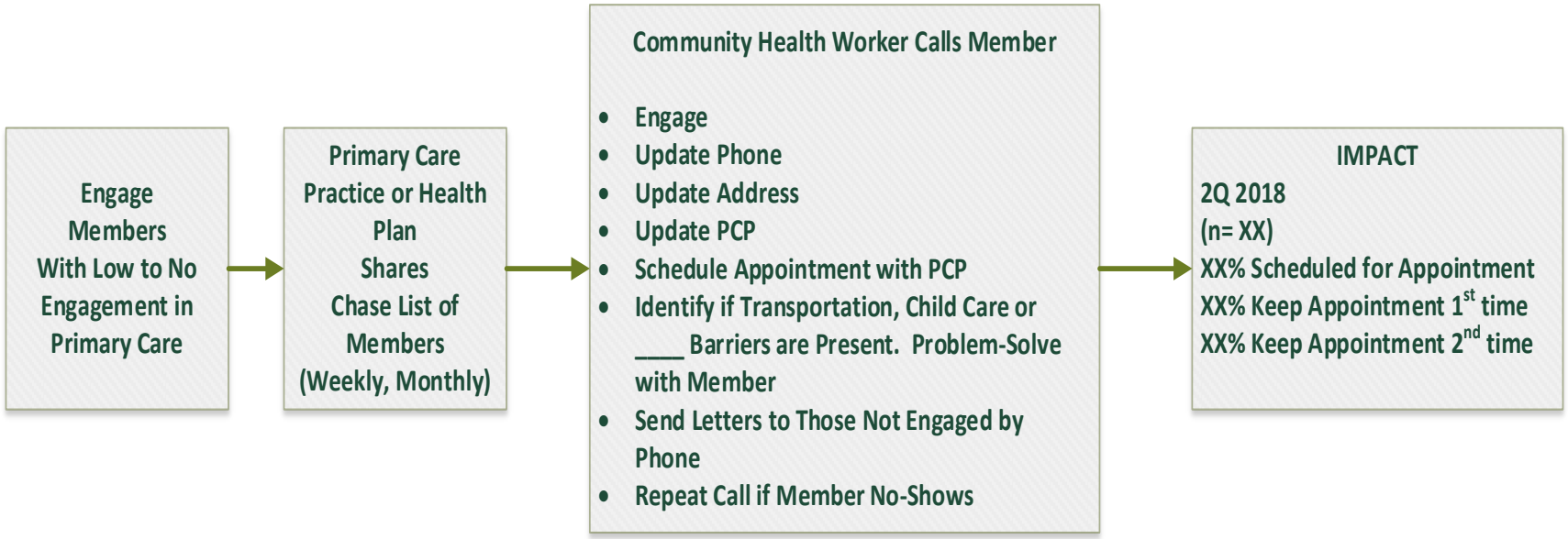
Clinical services are more frequently reimbursed by public and private payers. Medical-legal partnerships have been shown to save patients health care costs and recover cash benefits (*Journal of Health Care for the Poor and Underserved* and *Journal of Palliative Medicine*).

Creating Your Medical Legal Partnership

NLS has a 3-phase approach. The first is to tailor the Medical Legal Partnership to the unique patient population, needs and workflows of your practice. Through a consultation with the Practice Manager, NLS will facilitate the tailoring of identification of legal issue impact health outcomes, referrals and ongoing communication to existing practice workflows. In the second phase, NLS will offer a meet/greet and orientation session (between 30-50 minutes) for Providers. These sessions typically cover Medical Legal Partnership, Workflow Modifications (co-presented with Practice Manager), Tips for identification of medical/legal issues, the referral process and ongoing communication methods. The third phase is ongoing communication through resolution of the issue for your patient. The investment for launching a Medical Legal Partnership is $3,000.

Move Marple citation and add that the impact is from the website.


Health Plan, FQHC, Primary Care (Payor)
Generates List of Members:
1) Lost to Care
2) Gaps in Care
3) Chronic Disease Not Well Managed
National Witness Project Call Center
Contacts Member by Phone & Updates Contact Information
No Contact
In-Person Search for Member Update Contact Information
No Contact
If no contact after phone, in person or screen – refer back to Plan
Contact
Member Engaged
Contact
Assess, Motivate, Coach Member
Assess and Resolve Social Determinant of Health Barriers
Help Scheduling Appointments
Companion for Test/Screening
Support – Emotional, Reading, Asking Questions, Advocate
Member Health Improved (HEDIS, Gaps in Care, Engaged with Care Team)
Through this process, The Witness Project can help Primary Care Practices identify Members who are no longer in their care. (Improving the accuracy of the accountability denominator.)



- All Ages
- Schedule Via Practice Systems
- Hot Spot Zip Code Map by Practice
- Highly Trained, Culturally Competent Community Health Workers
- Serving: Cattaraugus, Southern Erie, Northern Chautauqua, Western Alleghany

- Healthy Community Alliance Identifies and Updates the Top 3 Social Determinants of Health Impacting PCP Engagement Annually.
- Develops Pathways and Connections for Members.