NEW YORK STATE | Department of Health | Medicaid Redesign Team

NYAPRS: 14th Annual Executive Seminar

Advancing the Social Determinants of Health Through Home & Community-Based Services

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April 19, 2018

Agenda

- Rethinking Healthcare in NYS
- Bureau of Social Determinants of Health
- New Opportunities in 2018 and Beyond

Rethinking Healthcare in NYS

What Are Social Determinants of Health and Why Are They Important?

Social determinants of health are the structural **conditions** in which people are **born, grow, live, work and age**

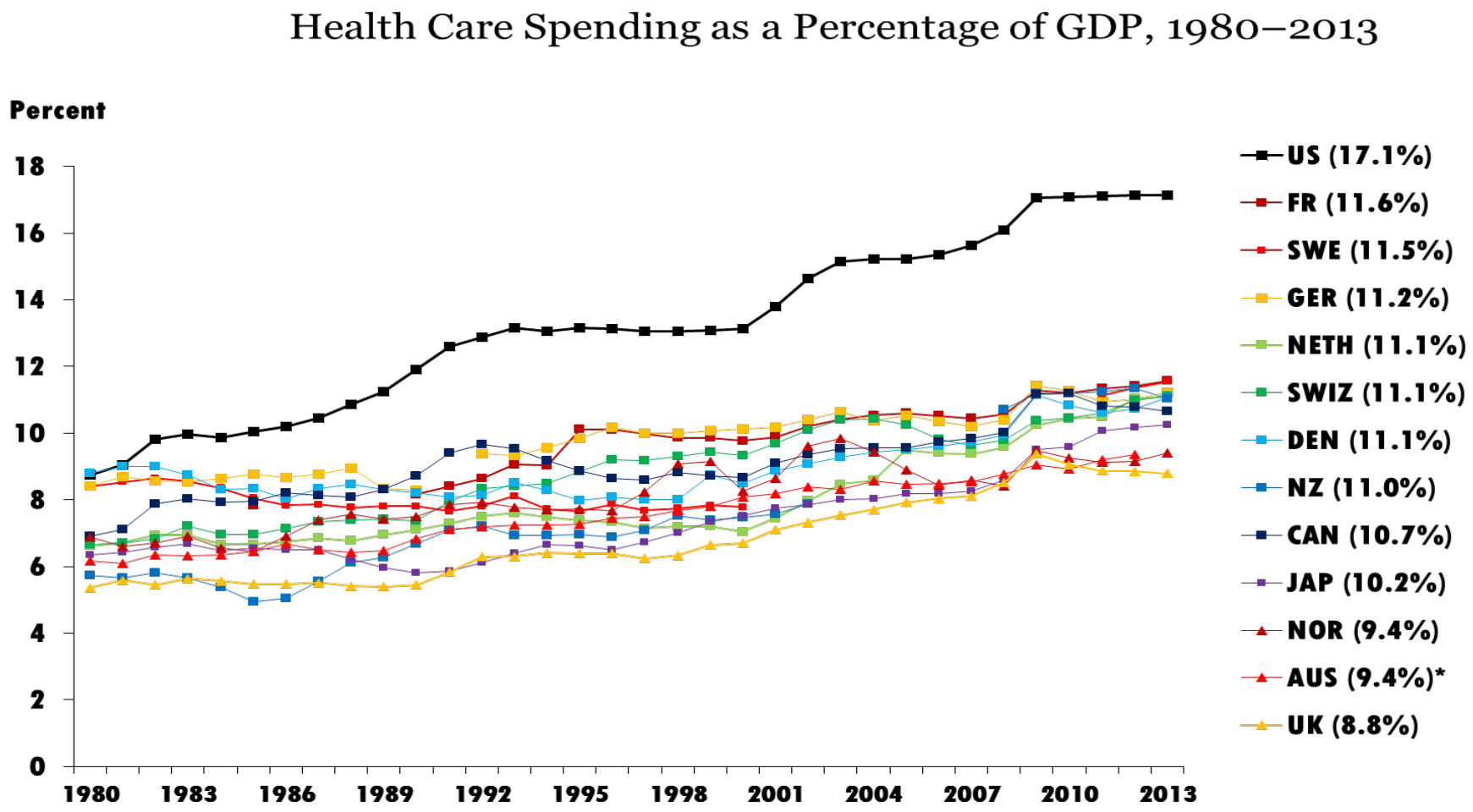
Addressing social determinants can have a significant **impact on health outcomes**

SDH Interventions can be **less costly** than traditional medical interventions

Under VBP, VBP contractors aim to **realize cost savings** while achieving **high quality outcomes**

- The VBP program design **incentivizes** VBP contractors to **focus on** the core underlying drivers of poor health outcomes—**the Social Determinants of Health**

Health Care Spending in US & Other Countries



* 2012.

Notes: GDP refers to gross domestic product. Dutch and Swiss data are for current spending only, and exclude spending on capital formation of health care providers.

Source: OECD Health Data 2015.

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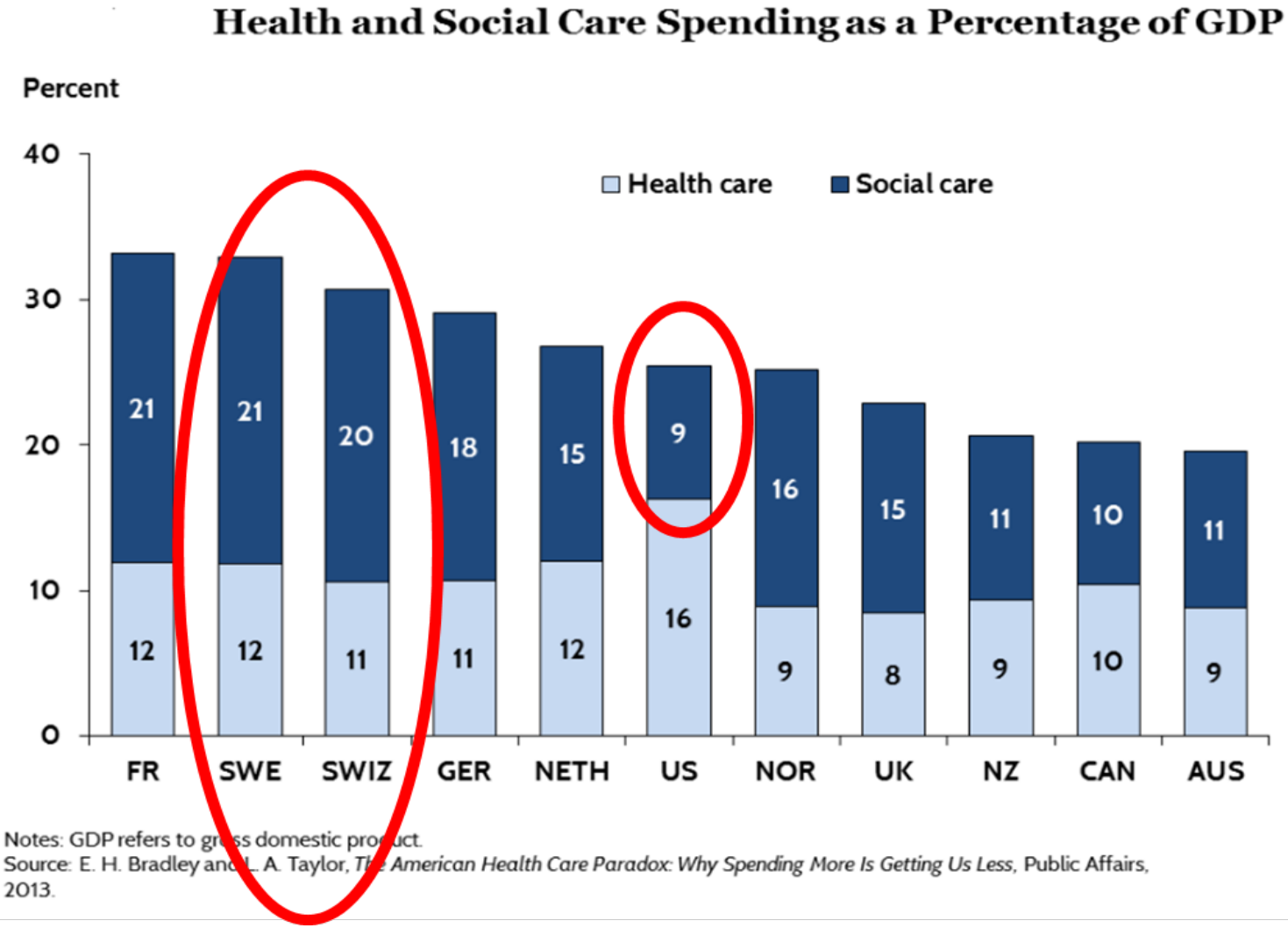
Health Care and Social/SDH Spending



Notes: GDP refers to gross domestic product.
Source: E. H. Bradley and L. A. Taylor, *The American Health Care Paradox: Why Spending More Is Getting Us Less*, Public Affairs, 2013.

Health Care Quality, Health Care Spending, and Social/SDH Spending

COUNTRY RANKINGS

Top 2*
Middle
Bottom 2*

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	$3,800	$4,522	$4,118	$4,495	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.
Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National Scorecard 2011;* World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data, 2013* (Paris: OECD, Nov. 2013).

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MRT Supportive Housing

- Medicaid Redesign Investment: **$641 Million over 7 years.**
- Funding is targeted to **high-cost Medicaid members.**
- MRT Supportive Housing investment targets **capital construction, rental subsidies and supports, and operating dollars.**
- **Outcomes, measures, research and evaluation are key components.**

3361 Third Avenue in the Morrisania neighborhood of the South Bronx.

Housing Security: Outcomes of MRT Supportive Housing

Number of high-need Medicaid recipients served to date: **11,656**

Objective

- Medicaid Redesign Team Supportive Housing invests in the social determinants of health to reduce avoidable hospital utilization for high-cost, high-need Medicaid recipients

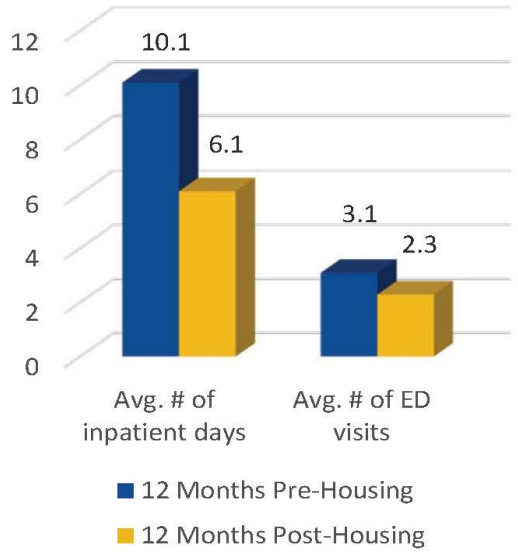
Accomplishments

- 40% reduction in inpatient days
- 26% reduction in emergency department visits
- 44% reduction in patients with inpatient rehab admissions
- 27% reduction in patients with inpatient psychiatric admissions
- Medicaid health expenditures reduced by 15% in one year (average decrease of $6,130 per person)
- Through strategic prioritization, the top decile of enrollees had average Medicaid savings of $23,000-$52,000 per person per year (varied by program)
- 29% increase in care coordination after housing enrollment
- MRT houses extremely vulnerable populations
  - 66% have a serious mental illness
  - 46% of a substance use disorder
  - 40% are HIV+
  - 53% have one or more other chronic medical conditions
  - 26% have at least three of these diagnosis types

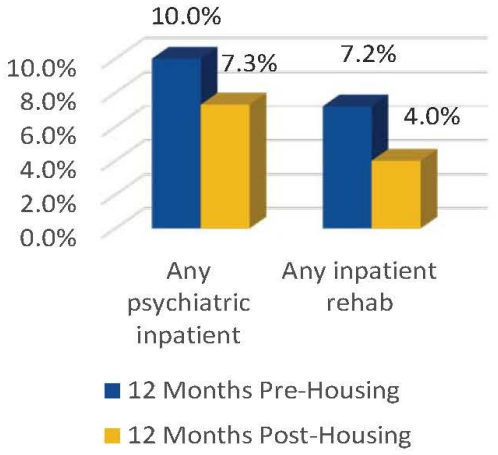
Benefits

- Reduce Medicaid health expenditures
- Improved participant health outcomes and quality of life
- Increased Olmstead compliance statewide

Decreased Inpatient, ED Use



Decreased Percentage of Recipients with Behavioral Health Admissions



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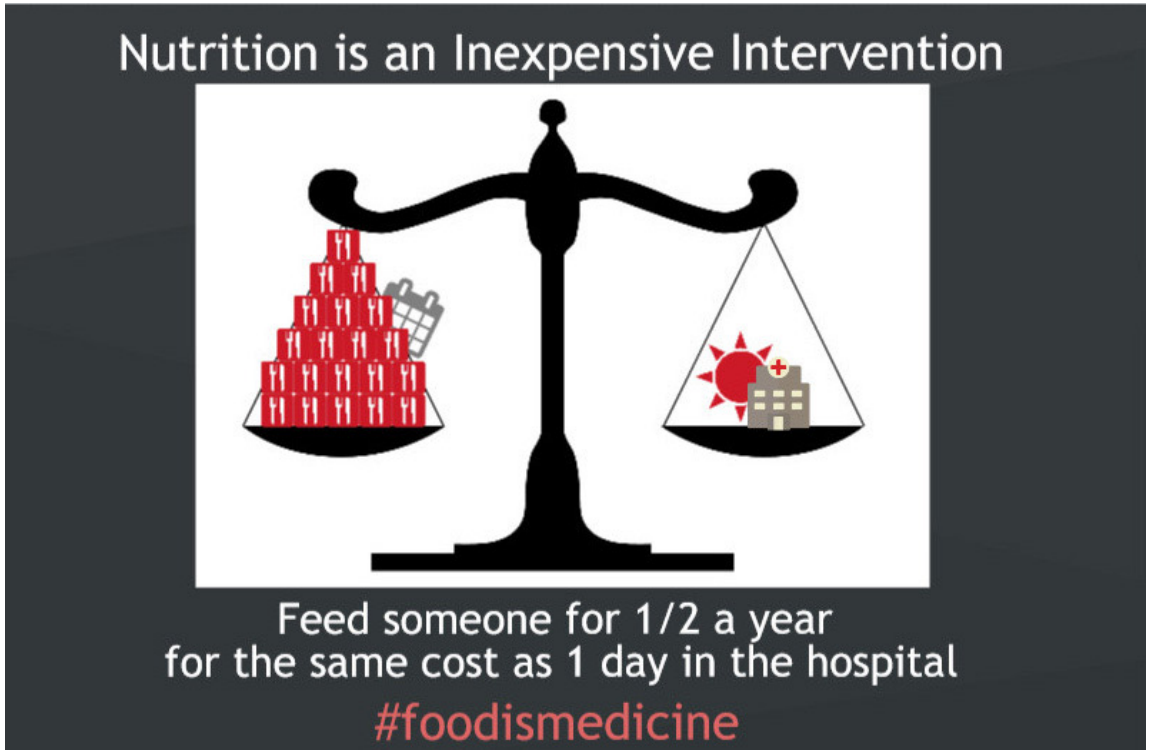
Food Security: Outcomes of Medically Tailored Meals (MTM)

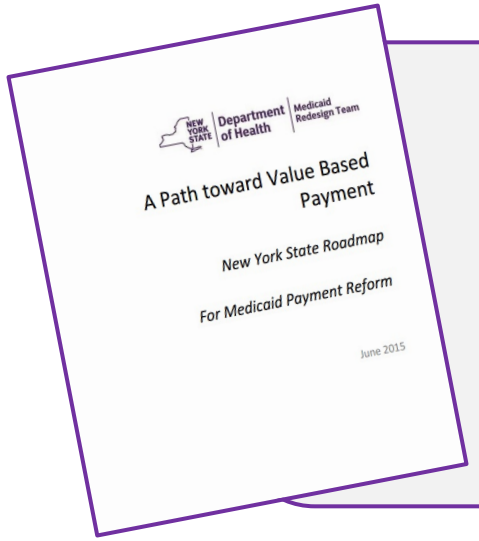
God's Love We Deliver Nutrition Intervention Outcomes

- Low-cost/High-impact intervention: Feed someone for half a year by saving one night in a hospital
- Reduce overall healthcare costs by up to 28% (all diagnoses compared to similar patients not on MTM)
- Reduce hospitalizations by up to 50% (all diagnoses compared to similar patients not on MTM)
- Reduce emergency room visits by up to 58% (pre-post MTM intervention)
- Increase the likelihood that patients receiving meals will be discharged to their home, rather than a long term facility (23%) (all diagnoses compared to similar patients not on MTM)
- Increase medication adherence by 50% (pre-post MTM intervention)



Community Based Organizations (CBOs) VBP Roadmap Standards & Guidelines

Standard: Inclusion of Tier 1 CBOs



"Though addressing SDH needs at a member and community level will have a significant impact on the success of VBP in New York State, it is also critical that community based organizations be supported and included in the transformation. It is therefore a ***requirement*** *that* ***starting January 2018, all Level 2 and 3 VBP arrangements include a minimum of one Tier 1 CBO****."*
(VBP Roadmap, p. 42)

Description:

Starting January 2018, VBP contractors in a Level 2 or 3 arrangement **MUST contract with at least one Tier 1 CBO**. Language describing this standard must be included in the contract submission to count as an "on-menu" VBP arrangement.

This requirement **does not preclude VBP contractors from including Tier 2 and 3 CBOs in an arrangement** to address one or more social determinants of health. In fact, **VBP Contractors and Payers are encouraged to include Tier 2 and 3 CBOs in their arrangements.**

CBO Engagement and Integration

CBO Survey was released earlier this year. The survey is used to understand CBO integration with the NYS VBP program and use information provided to build a public inventory of Tier 1, 2 and 3 CBOs that can be used to facilitate VBP contracting.

- **Total Responses:**
  - 480 Respondents to date

- **CBO Tier Designation:**
  - Tier 1: 33%
  - Tier 2: 13%
  - Tier 3: 44%

- **Have you met with a MCO/VBP Contractor to determine your role in VBP?**
  - 43%- Have met with an MCO and VBP Contractor
  - 12%- Currently participating in an SDH Intervention to support a VBP arrangement

- CBO Directory is posted on the VBP Resource Library under Social Determinants of Health and Community Based Organizations. Directory is updated bi-weekly.

Bureau of Social Determinants of Health

Bureau of SDH: 2018 Goals

Implement the VBP Roadmap Requirements Related to SDH and CBOs	• Review VBP Level 2 and 3 Contracts and Amendments • Track SDH Interventions and CBO • Provide support and technical assistance
CBO Engagement	• Learning collaboratives with MCOs, VBP contractors, CBOs, & health care providers • Maximize CBO and SDH interventions in the health care system.
Improve SDH Measures in Population Health and Payment Reform	• Increase data collection on SDHs (i.e. electronic health records) • Standardize SDH Quality Measures and incorporating into QARR • Risk Adjustment MMC Plans for SDH
Prevention Agenda	• The State intends to introduce a value based payment arrangement pilot to focus specifically on achieving potentially trailing Prevention Agenda targets through CBO-led community-wide efforts
Create a New Housing Referral Process	• Integrate MRT SH with PPSs, VBP Contractors, and Health Systems • Create a plan to expand to families to align with the First 1K Days

Upcoming Opportunities

- $44M has been earmarked for social determinants of health in the SFY 2019-20 budget

- The Health Home Supportive Housing Program (rental subsidies) is currently under re-procurement and is expanding to new areas of the state and including families

- The Nursing Home to Independent Living (rental subsidies) will be undergoing re-procurement and will be release this month

MRT Innovations in SDH Initiative

- The State will soon launch a Request for Innovation initiative that will solicit proposals from CBOs across New York, throughout the country, and from entities around the world that will be evaluated by a team of national experts.

- The initiative's primary goal is to help healthcare providers, Managed Care Organizations (MCOs), and DSRIP Performing Provider Systems (PPS) as they seek creative ways to address SDH needs of the members they serve.

- Top proposals will receive special recognition but all proposals will be made public

- Request for Innovation will be released May 2018

Other 2018 Goals

- Risk Adjust Medicaid Health Plans for Social Determinants of Health
- Data Collection, Utilization & Data Sharing
- Hotspotting
- SDH Assessment Tool
- Learning Collaboratives
- Housing Referral Connectivity with Health Care Providers and Plans

Thank you!

For Additional Information:

Value Based Payment (VBP) Resource Library

Contact Us:

Bureau of Social Determinants of Health

SDH@health.ny.gov

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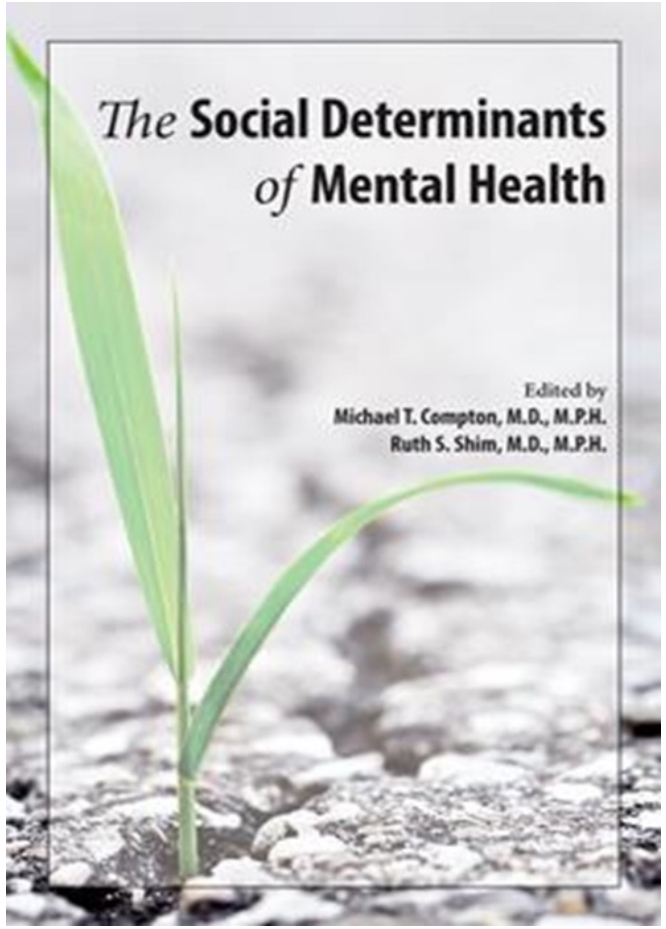
The Social Determinants and Adult Behavioral Health Home and Community Based Services (BH HCBS)

Nicole Haggerty, LMHC
Director, Bureau of Rehabilitation Services and Care Coordination
NYS Office of Mental Health (OMH)

The Social Determinants of Mental Health

Some slides were provided by Michael Compton, M.D., M.P.H. and
Ruth Shim, M.D., M.P.H.
(coeditor of *The Social Determinants of Mental Health*, APA Publishing, 2015)



The Social Determinants of Mental Health

Not distinctly different from the social determinants of health

But deserve special emphasis, because:

- *Mental illness challenges overall wellness, impacts functioning*.
- Mental illnesses and substance use disorders are highly prevalent and highly disabling.
- Behavioral health conditions are high-cost illnesses.
- They have been largely neglected.
- Mental illnesses are a major cause of morbidity and mortality.
- Without mental health there can be no health.

The Social Determinants of Mental Health (some examples)

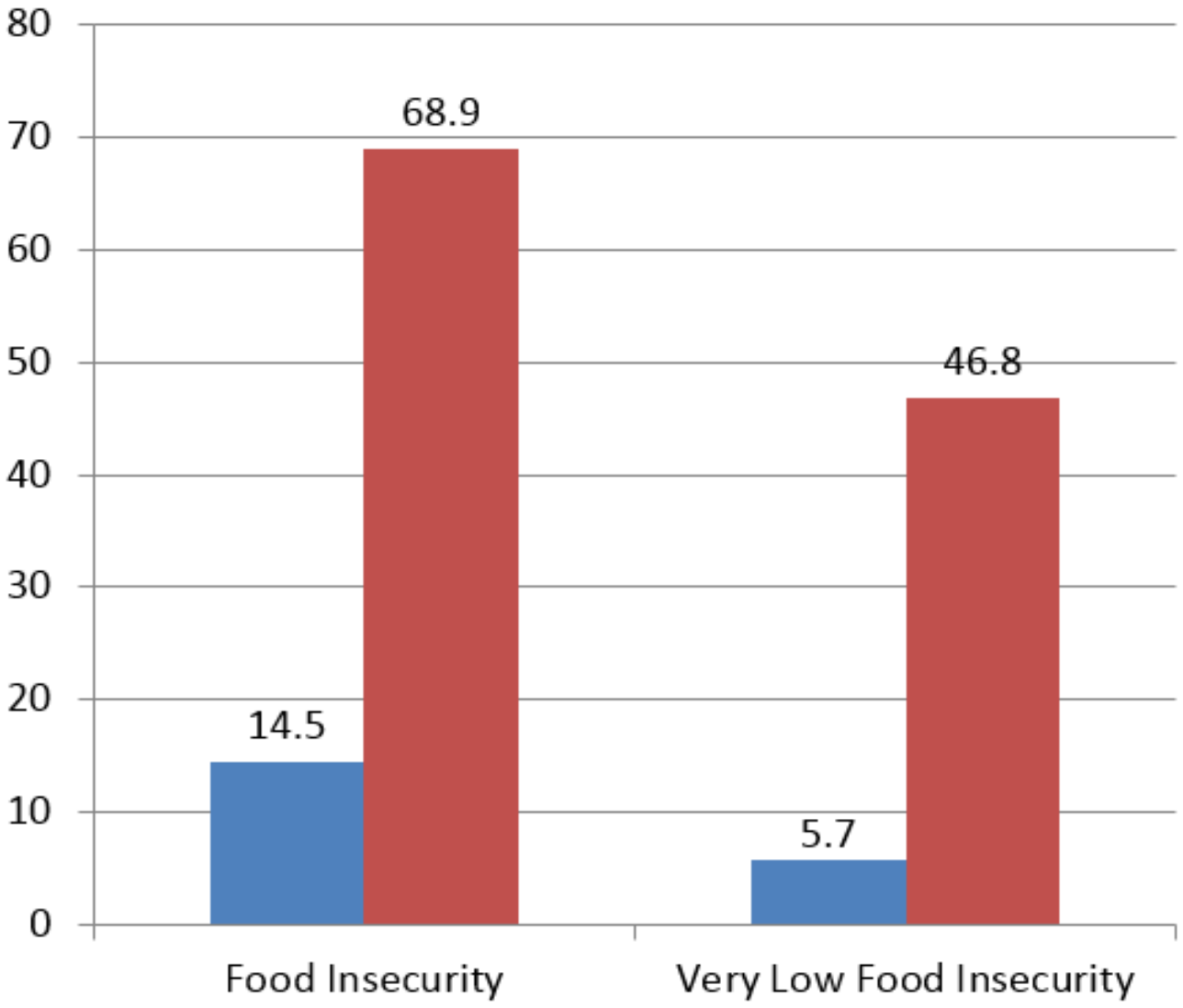
- Discrimination and Social Exclusion
- Adverse Early Life Experiences
- Poor Education and Educational Inequality
- Unemployment, Underemployment, and Job Insecurity
- Poverty, Income Inequality, and Neighborhood Deprivation
- Food Insecurity
- Poor Housing Quality and Housing Instability
- Adverse Features of the Built Environment
- Poor Access to Health Care

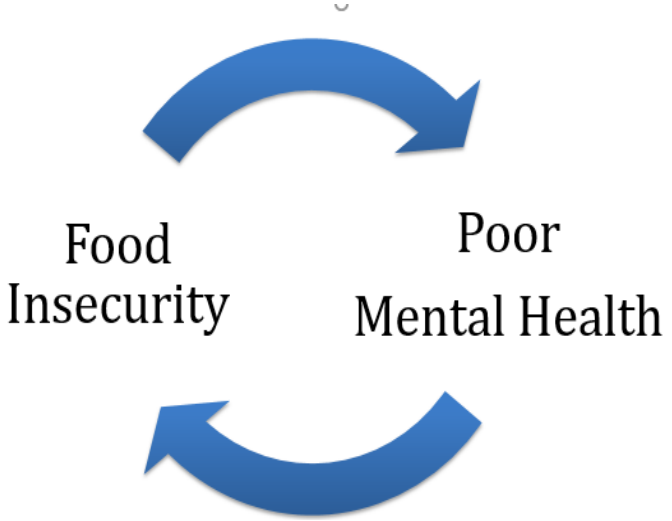
Extensive Research on Social Determinants

Some examples:

- *Suicide* (1897)demonstrated the relationship between social exclusion and suicide; described suicide as a social phenomenon.
- The Adverse Childhood Experiences (ACE) Study- numerous health problems associated with ACES (suicide, depression, hearing voices, substance use, COPD, STDs, early mortality, unintended pregnancy, liver disease, early smoking and more).
- Poverty: Poverty has been associated with numerous mental health outcomes.
- Food Insecurity: Significant factor in SMI population one study- 69% vs. 14.5% across U.S. population.

SDH showing greater impact on SMI Population





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How Can Adult BH HCBS Help?

- We are **bringing services to people** in their homes and community- wherever they feel comfortable learning new skills; getting support.

- BH HCBS focuses on **building the skills that may have been lost or impaired by behavioral health disorders.**

How Can Adult BH HCBS Help?

- BH HCBS is based on assisting people with achieving **meaningful life role goals**, including employment, educational attainment, and personal relationships (SDHs).
- BH HCBS is **person-centered**, **trauma-informed**, and relies on **evidence-based** approaches for adults with serious mental illness and/or substance use disorders.
- BH HCBS **reduces barriers** to accessing services (transportation, geography, stigma) by bringing rehabilitation and support into the **communities where people work and live.**

Adult Behavioral Health Home and Community Based Services (BH HCBS)

Find Housing. Live Independently.

- Psychosocial Rehabilitation
- Community Psychiatric Support and Treatment
- Habilitation
- Non-Medical Transportation for needed community services

Return to School. Find a Job.

- Education Support Services
- Pre-Vocational Services
- Transitional Employment
- Intensive Supported Employment
- Ongoing Supported Employment

Manage Stress. Prevent Crises.

- Short-Term Crisis Respite
- Intensive Crisis Respite

Get Help from People Who Have Been There and Other Significant Supporters.

- Empowerment Services – Peer Support
- Family Support & Training

BH HCBS: Real World Impact

BH HCBS has been successful in supporting individuals with attaining employment and education, building personal relationships, reintegrating in family life, and improving physical and mental health status

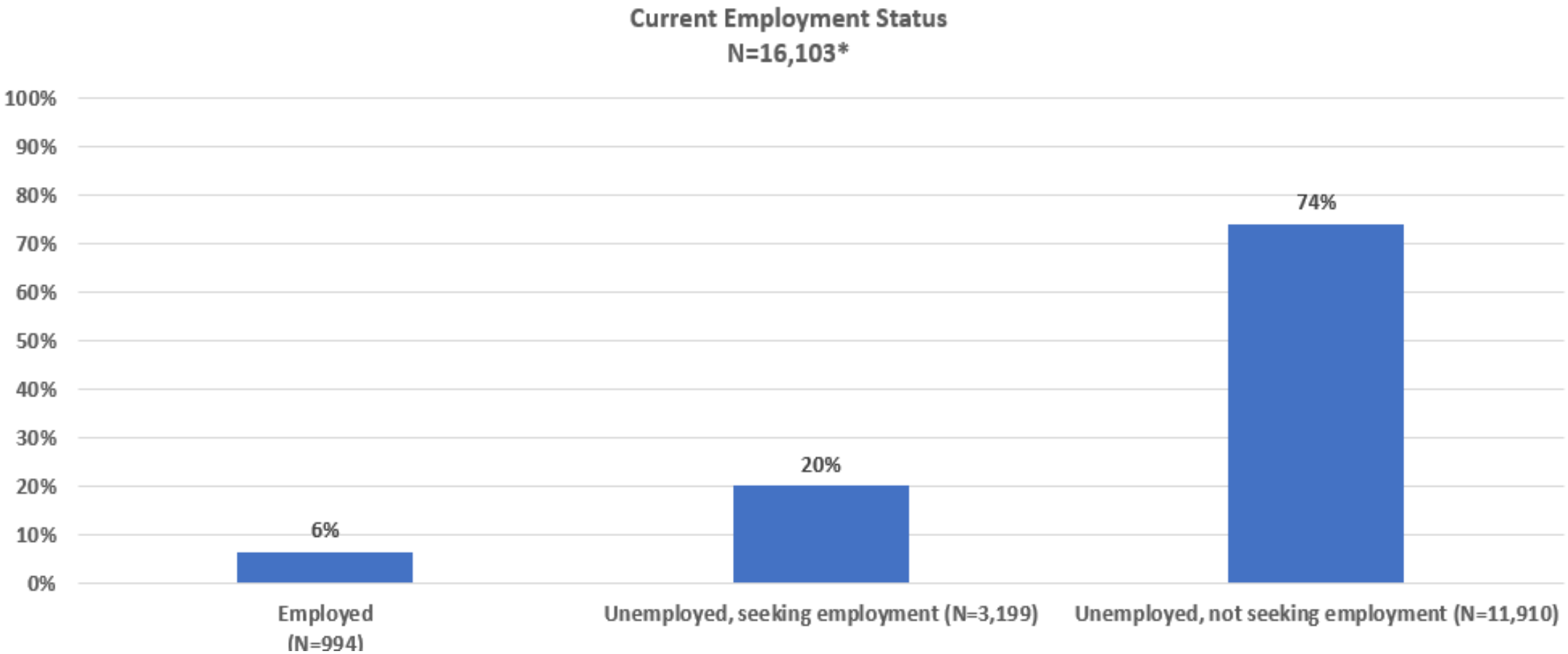
A woman residing in a rural community in upstate New York accessed BH HCBS through her Health Home Care Manager. She chose to receive Empowerment Services – Peer Support with a goals of improving her relationship with her adult children, building natural supports/ social relationships, and improving her physical health. Due to the geography of her community and barriers around transportation, she found it difficult to leave her home to exercise or socialize. Her children live in another state and she had not seen them in years. With the support of a Peer Specialist, she began attending mutual aid support groups, started working out at a local community center, and re-engaged in contact with her children. Within months, she was able to visit her children face-to-face, after working with her Peer Specialist to plan a trip and secure resources. Her Peer Specialist was a member of the community and was successful in using their shared lived experience to support her in making real, measurable progress toward her goals.

Data to Support HCBS Interventions for SDH

- OMH and OASAS are committed to a population health approach and will examine how HCBS can impact SDH to improve outcomes.
- All individuals enrolled in the HARP program will get annual screens
- The State will make available reports to support MCO and provider interventions.
- To date we have baseline screen data on ~15,000 HARP members which look at various domains including:
    - Employment Status
    - Life events: rates of HARP members who report experiencing stressful life events.
    - Housing stability
    - Criminal justice involvement
    - Social connectedness

The State will collect this data and report out on these factors

Examples of SDH/HARP Data Points



Examples of SDH/HARP Data Points