204 Panel: Exploring Social Determinants of Health in Value-Based Care
Welcome

Nina Brown-Ashford  
Deputy Director for the Prevention and Population Health Group, Centers for Medicare and Medicaid Innovation
Panel Speakers

Steven Cha  
Chief Medical Officer, UnitedHealthcare  
Community & State

Mindy Stadtlander  
Executive Director of Medicaid and Network Services, CareOregon

Aza Nedhari  
Founding Executive Director, Mamatoto Village

Trenor Williams  
Founder & CEO, Socially Determined
Welcome

Aza Nedhari

Founding Executive Director, Mamatoto Village
Welcome

Mindy Stadtlander

Executive Director of Medicaid and Network Services, CareOregon
CareOregon

CareOregon is a non-profit, public benefit corporation that manages Medicare and Medicaid services for more than 270,000 Oregon Health Plan (Medicaid) and 13,000 Medicare Advantage members.

Our primary care delivery system includes:

• Federally qualified Health Clinics (50% of our members)
• Commercial, private and Hospital-based clinic systems
APM Domains

Increase Payment to Support Primary Care Homes
(and hold them accountable)

Identify Systems that are willing to take on Risk
(and let them... to a point)

Incentivize Care Coordination
(where there are critical gaps)
Primary Care Development

2014
Fee for Service
Incentive Payment
11%

2015
Fee for Service with Expanded Codes
Quality Program
Incentive Payment
29%

2016-2017
Fee for Service with Expanded Codes
Quality Program
BHI
Incentive Payment

2018
Fee for Service with Expanded Codes
Quality Program
BHI
Cost Consciousness
Incentive Payment

APM 3.0 2020
Fee for Service with Expanded Codes
BHI
Cost Consciousness
Incentive Payment

Base FFS payment structure with Primary Care Incentive Program
Base FFS payment structure that supports alternative care delivery models with expanded incentives
Layered with portion of payment at risk for quality and utilization outcomes
Primary Care Development

**Improvement Focused**
- Entire clinic population-focused
- Self reported data
- Capitated payment, adjusted every 6 months

**Outcomes Focused**
- Payer-specific population
- Combination claims and clinical data
- Capitated payment, adjusted every 6 months

Self selected measure focused on Hep C treatment

Groups focused on mindfulness, gardening, cooking, and anxiety

Foster Care Medical Home development
Supporting Patients with Complex Needs

Complex Care Teams
• Additional capitation for complex care management
• Tiered for length of program enrollment
• Regular inter-disciplinary care team meetings between health plan and provider

Addressing Housing Needs
• Leverage Community Benefit dollars to contribute to community solutions
• Tiered case rate for recuperative care beds for discharging homeless members
The HOW Matters Most

**Portland Metro**
- **Steering Committee**
  - Major Network partners and Hospital systems
  - Share financial data, agree on network investments, provide feedback on CO policy
- **Clinical Workgroup**

**Jackson**
- **Board of Directors**
- **Clinical Advisory Panel**
- **Community Advisory Council**
- **Network and Quality Cmtee**
- **Finance Cmte**

**Columbia Pacific**
- **Board of Directors**
- **Clinical Advisory Panel**
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**Risk Model:**
- System level risk contracts
- Shared decision making on underwriting gain

**Risk Model:**
- Shares risk between CCO and CO
- Incentivizes local resource allocation
- MLR target

**Risk Model:**
- Shares risk between CCO, CO, GOBHI, and delivery system
- Incentivized local systems of care to work together
- MLR trigger and target pmpm for each community
Welcome

Steven Cha

Chief Medical Officer, UnitedHealthcare Community & State
Addressing the Social Determinants of Health

Dr. Steve Cha
Chief Medical Officer, UnitedHealthcare Community & State
Homeless vs. averages of all members in Maricopa County:

- Use the ER nearly 9x more
- Admitted nearly 6x the average
- Spend more than 3x more
Health care utilization doesn’t equal good health.
## A Trend Guiding the Vision

Homeless Spend Compared to County Averages of All Members in Maricopa County

<table>
<thead>
<tr>
<th></th>
<th># of Members</th>
<th>Total ER Visits</th>
<th>Avg. ER Visits</th>
<th>Total Admits</th>
<th>Avg. Admits</th>
<th>Total Paid</th>
<th>Average Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Homeless</td>
<td>305,196</td>
<td>187,433</td>
<td>0.61</td>
<td>50,790</td>
<td>0.17</td>
<td>$1,163,643,237</td>
<td>$3,813</td>
</tr>
<tr>
<td>Homeless (Z59.0)</td>
<td>185</td>
<td>1,008</td>
<td>5.45</td>
<td>195</td>
<td>1.05</td>
<td>$2,230,321</td>
<td>$12,056</td>
</tr>
</tbody>
</table>
High Acuity Snap Shot

MEDICAL
- Age
- Heart Failure
- Pain Syndromes
- Diabetes
- Kidney Failure

ADDICTION
- Alcohol
- Cocaine
- Prescription Medication
- Heroin

MENTAL HEALTH
- Schizophrenia
- Factitious Disorder
- Borderline Personality Disorder
- Bipolar Disorder

SOCIAL
- Homeless
- Disabled
- Unemployed
- Hungry
- Criminal Record
- No Transportation
Set-aside Integrated Care Housing Community
Phoenix, AZ
Set-aside Integrated Care Housing Community

- Partnership with community organization Chicanos Por La Causa
- 100 set-aside units for UHC members
- Targeting complex Medicaid members
- Full wrap-around behavioral health clinical model and wellness recovery pathway
Jeff
50, Medicaid, Phoenix, AZ
Jeff’s Story

Socio-clinical Complex Needs:
- Chronic kidney disease
- Gastrointestinal issues
- Serious foot injury
- Homeless and unemployed

Pre-intervention:
- $20,400 average monthly cost of care
- 1 ER visit  |  10 hospital admits  |  81 inpatient days

Post-intervention:
- $400 average monthly cost of care
- 0 ER visits  |  0 hospital admits  |  0 inpatient days
Carol
54, Medicaid, Phoenix, AZ
Carol’s Story

Socio-clinical Complex Needs:

- Rheumatoid arthritis
- Cellulitis
- Diabetes
- Gastrointestinal issues
- Inconsistent medication management
- Uses a wheelchair
- Trauma from physical and sexual violence
- Homeless and unemployed

Pre-intervention:

- $7,400 avg. monthly cost of care
- 35 ER visits | 8 hospital admits | 113 inpatient days

Post-intervention:

- $2,000 avg. monthly cost of care
- 5 ER visits | 0 hospital admits | 0 inpatient days
myConnections Outcomes in Arizona

N=41 members who lived in set-aside housing and received wrap-around care services for the entirety of 2017.
myConnections

A data-driven, flexible and scalable housing and social services solution for frequent utilizers of the health care system.

Population Focus

- Addicted Parents or Pregnant Women
- Jail Transition
- Homeless Adults

Current Markets
- Arizona
- Nevada
- Wisconsin
- Hawaii

2018 Expansion
- Nebraska
- Michigan
- Washington
- New York
CMMI Accountable Health Communities Grant

• myConnections identifies and addresses health-related social needs of Medicare and Medicaid beneficiaries

• Impacts to health care quality, utilization, costs, and experience

• Waianae Coast and Honolulu

• April 1, 2017-March 31, 2022

• Goals:
  − 75,000 screenings per year
  − Provide tailored, streamlined referral and navigation services
  − Align the efforts of community-based organization partners
  − Perform continuous quality improvement and gap analysis
Thank you
Welcome

Trenor Williams

Founder & CEO,
Socially Determined
Socially Determined

Purpose-built social determinant analytics platform creating the science of SDOH

Connecting SDOH insights to high-ROI value creation for payers, providers, employers and life science companies

Flexible delivery model for products and services to drive value for customer Social Determinant needs
Why Does This Matter

SDOH are driving up costs
50% to 70% of health care costs are driven by SDOH

Fragmented approaches abound
State-of-the-art is disparate social programs and single issue initiatives

Nearth of Infrastructure
Payers, providers, and Pharma ALL lack system of measurement, putting $$billions at risk
Our Process

Mine
Socially Determined collates EHR information, claims, & commercially available data sets.

Refine
SD’s advanced analytics fuse clinical, financial, SDOH, and person data to identify cohorts at risk. and quantify opportunities for intervention.

Deploy
SD deploys this net new detailed insight into clients’ investment strategies and adds precision to the chosen community interventions.
Food Insecurity and Diabetes
## Understanding Factors Driving Risk of NICU Births

### Social Challenges
- Makes less than $27,500 per year
- 85% do not have bank accounts or credit
- Low Educational Attainment
- 40% Evicted at least once
- 9 out of 10 are unwed

### Clinical Reality
- 1 in 4 have mental illness or substance abuse issues
- Likely has one or more conditions (diabetes, hypertension) complicating pregnancy
- Typically will not attend all pre-natal appointments
- Many have a previous child delivered by C-Section
### Social & Clinical Intervention Campaign

#### Featured Interventions
- Food Prescription Program
- Transportation
- Stable Housing
- Integrated Behavioral Health and Addiction Services

#### Key Design Elements
- Personalized Wellness and Social Care Plan
- Social Support Networking Center(s) – In-Person and Virtual
- Technology Enabled Care Ecosystem
- Meaningful Patient Incentives
Visit the LAN Website for our Resources

https://hcp-lan.org/
Exit Survey

We want to know what you think!

Please take a moment to complete the exit survey so we can continue to improve and enrich the LAN. Use the link in Guidebook for this session to provide us your feedback.
Contact Us
We want to hear from you!

www.hcp-lan.org

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Search: Health Care Payment Learning and Action Network
Thank You!