Previous PTAC Proposal Submitter and Subject Matter Experts Listening Session on Payment and Data Issues Related to SDOH and Equity

**Previous Submitter**
- **Sarah L. Szanton, PhD, ANP, FAAN**, Patricia M. Davidson Health Equity and Social Justice Endowed Professor, Director, Center on Innovative Care in Aging, Johns Hopkins School of Nursing and **Kendell M. Cannon, MD**, Clinical Assistant Professor, Stanford School of Medicine, CERC Scholar, Stanford Clinical Excellence Research Center: *Community Aging in Place – Advancing Better Living for Elders (CAPABLE) Provider-Focused Payment Model* proposal

**Subject Matter Experts**
- **Jacob Reider, MD, FAAFP**, CEO, Huddle Health
- **Robert Phillips, MD, MSPH**, Executive Director, The Center for Professionalism & Value in Health Care
- **Toniann Richard**, CEO, Health Care Collaborative of Rural Missouri
- **Michael Hochman, MD, MPH**, CEO, Healthcare in Action (A Scan Group Member Organization)
For information about PTAC’s review of the Community Aging in Place-Advancing Better Living for Elders (CAPABLE) Provider Focused Payment Model proposal, visit the ASPE PTAC website: https://aspe.hhs.gov/collaborations-committees-advisory-groups/ptac/ptac-proposals-materials

- Preliminary Review Team Presentation
- Preliminary Review Team Report
- Report to the Secretary
- Public Comments
- Additional Information or Analysis
  (including an environmental scan and annotated bibliography)
CAPABLE reduces disability, improves SDOH, saves costs

Sarah Szanton, PhD, NP, FAAN
Kendell Cannon, MD
September 27, 2021
Meet Mr. A – a real CAPABLE client

Mr. A is a 75-year-old Veteran living at home. He has diabetes and was recently hospitalized for a small stroke, and before CAPABLE, had difficulty bathing. He has both Medicare and Medicaid coverage (i.e., dual eligibility).
Mr. A’s CAPABLE Success Story
CAPABLE addresses person and environment

Person’s goals ↑ ability, address social determinants

CAPABLE is delivered in the home over 4 months by a team including:

Registered Nurse  Occupational Therapist  Handyworker  Participant
Health equity and social determinants through standardized tailoring

- Home-based
- Goals and self-efficacy
- Integrated team

Data to address SDOH and equity
The CAPABLE difference

What makes CAPABLE work in a population where so much doesn’t work?

<table>
<thead>
<tr>
<th>Typical disease management/prevention intervention</th>
<th>CAPABLE</th>
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<tbody>
<tr>
<td>Designed to prevent a single event (e.g., a fall, a CHF exacerbation)</td>
<td>Designed to maximize independence, which has positive effects across an individual’s risk factors for hospitalization and nursing home admission</td>
</tr>
<tr>
<td>Provider-driven (i.e., “you should do this”)</td>
<td>Client-driven (i.e., “I want to do this.”)</td>
</tr>
<tr>
<td>Focused on narrow risk factors (e.g., home safety, medical management)</td>
<td>Focused on person-environment fit, addressing physical function, the home environment, and social determinants through a holistic approach</td>
</tr>
<tr>
<td>Not sustainable (the effect only lasts as long as the intervention lasts)</td>
<td>Self-sustaining for long-term impact</td>
</tr>
</tbody>
</table>
CAPABLE can reduce costs by up to one-third.

CMS-funded analysis of CAPABLE’s impact on Medicare costs among duals, published in a top-tier peer-reviewed journal

$918 PMPM savings over a 2-year period

*Ruiz et al., Health Affairs, 2017
Modifiable disability is

• **Highly predictive.** Individuals with modifiable disability are typically on a downward spiral. In one study, dual eligible beneficiaries with modifiable disability had average costs at baseline, but those costs spiked 76% in a 2-year period.*

• **Identifiable with the right data.** A simple clinical algorithm identifies this group of beneficiaries – those with a disability living at home who could benefit from a functional intervention.

• **Treatable.** People can get better, and a functional intervention not only reduces disability, it results in a significant ROI.

*Ruiz et al., Health Affairs, 2017
Early adopters and endorsements

Suggestions re data, APMs and health equity

• The number of older adults with disabilities living at home is growing.

• Implementers of CAPABLE can:
  • Identify whose costs will increase.
  • Intervene to prevent much of that increase, sharing the savings with Medicare while supporting the client at home.
  • Help payers get ahead of the curve on physical function.

Best Practices for Developing and Testing Risk Adjustment Models

Press release

CMS Seeks Feedback on Performance of Medicaid Funded Home and Community-Based Services
Function as ultimate health equity indicator

- In 2020, HHS released a major analysis in response to a Congressional request, looking at current gaps in risk adjustment. It found that **the single most important variable not currently included in risk adjustment was functional status**.

- CMS requested that the National Quality Forum work with industry to develop best practices for risk adjustment models that include physical function.

- The Centers for Medicaid and CHIP Services released a draft set of quality measures for HCBS, which included activities of daily living.

- The Functional Assessment Standardized Items (FASI) have been released for standard EHR use, which will enable improved targeting of patients by functional status.
Supplemental slides
7 million Medicare beneficiaries with modifiable disability live at home.

Their costs are twice as high as similar beneficiaries without disability.
Today, we send someone into your home to help you take a bath. What if instead, we gave you the services you’d need to be able to take a bath yourself? Disability can get better.
Core values

• Dignity: Every life deserves honor and respect.
• Humility: We don’t know best. Our clients do.
• Hope: Things can be better than they are today.
• Commitment to results: Human-centered doesn’t mean squishy. We bring a relentless focus on delivering outcomes to our clients and our customers.
Impact on hospitalization

- In a Medicare ACO, CAPABLE reduced hospitalization rates by 60% (23% vs. 9%).
- Among dual-eligible beneficiaries, Medicaid inpatient spend was reduced by 61% per beneficiary.
SOCIAL CARE: THE SECRET WEAPON OF A HEALTHY COMMUNITY
SECRET TO A HEALTHY COMMUNITY?
Hospital
TODAY’S TOPICS

• **Achieving Better Health** is our shared commitment to the communities we serve

• **Physicians** are not the answer

• **Hospitals** are not the answer

• **Change is hard for everyone**

• **Information Technology** is an imperative component of success
Health Care

Social Health

Behavioral Health

Physical Health
Social Challenges

Behavioral Challenges

Physical Challenges
• Alcohol Use
• Child Care needs
• Clothing Needs
• Depression / Anxiety
• Disabilities
• Education
• Employment
• Food Insecurity
• Household Income
• Household Size
• Housing Insecurity
• Incarceration History
• Insurance Status
• Interpersonal violence / safety
• Literacy
• Health Literacy
• Migrant / seasonal worker
• Neighborhood Safety
• Physical Activity
• Primary Language
• Race / ethnicity
• Refugee status
• Social connections / isolation
• Stress
• Substance Use
• Tobacco use / exposure
• Transportation
• Utilities
  • Phone
  • Power
  • Heat
• Veteran status
WHAT WE PICKED

Food

Housing / Respite

Transportation

Certified Recovery Peer Advocates (CRPA)
CLOSED-LOOP REFERRALS:

Medical → Social → Behavioral → Medical
MONITORING
DO SOCIAL INTERVENTIONS WORK?
WHAT DOESN’T WORK
SOCIAL NEEDS
Identify  Understand  Act
PUBLIC UTILITY MODEL
RIGHT THING
EASY THING
SECRET TO A HEALTHY COMMUNITY?
Social Risk and Equity: We need Big Data Tools and Point of Care Solutions

Bob Phillips, MD MSPH
Executive Director
The Center for Professionalism & Value in Health Care
We’re not capturing SDOH in Clinical Care—and are not equipped

- Less than 4% of visits have Z-codes for SDOH \(^1, 2\)
- Medicaid MA programs capturing best, because they have too (APMs/ACOs not so much)\(^3\)
- Practices are not equipped or funded to manage social need
- We need to:
  - lower the burden of screening
  - resource adequately to meet needs
  - reduce capacity for gaming

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1 https://doi.org/10.1007/s11606-019-05199-w
3 The Role of Value-Based Payment in Promoting Innovation to Address Social Risks: A Cross-Sectional Study of Social Risk Screening by US Physicians - PubMed (nih.gov)
The UK and New Zealand figured this out on a Big Data Scale

Measure social risk for all, geographically

Measure social need for each
English index of multiple deprivation: Adjustments for Social Services

• Seven deprivation domains:
  – Income Deprivation  (22.5%)
  – Employment Deprivation  (22.5%)
  – Education, Skills/Training Deprivation  (13.5%)
  – Health Deprivation and Disability  (13.5%)
  – Crime  (9.3%)
  – Barriers to Housing & Service  (9.3%)
  – Living Environment Deprivation  (9.3%)

• Each of these domains is in turn based on a basket of indicators

Thanks to Prof. Peter Smith, UK

Source: Ministry of Housing, Communities & Local Government (2015), English indices of deprivation 2015
Hospital care higher, even though more deprived quintiles have lower life expectancy

Some criteria for funding formulae

• Based on universally available, validated data;
• Reflects the underlying social and medical needs in a locality;
• Independent of previous spending in a locality;
• Scientifically coherent and plausible;
• Feasible, with low administrative cost;
• Not vulnerable to manipulation or fraud;
• Encourages efficient delivery of health services, and free from perverse incentives;
• Transparent, verifiable, understandable and replicable;
• Parsimonious;
• Reflects policy intentions
NHS equity criteria shift
(This is REALLY Important)

• The conventional criterion: to allocate the fixed National Health Service budget to geographical areas:
  – to secure “equal opportunity of access [to NHS services] for those at equal risk”

• A revised criterion (2001):
  – “to contribute to the reduction in avoidable health inequalities”
Current approach to allocating for ‘unmet need’

• Based on policy judgement, not evidence
• Applied to a percentage of the relevant budget:
  – General acute and mental health services 10%
  – Primary care 15%
  – Specialized services 5%
• Allocated according to standardized mortality rate (aged under 75) in small areas (average population 7,200)

• A weight per head 10 x higher for area with the worst SMR vs. area with the lowest SMR, exponential scale
New Zealand has done similar
http://www.otago.ac.nz/wellington/otago069936.pdf
Payment adjustments geared to resolving inequity, nearly exponential for most deprived Quintile 5, Quintile 4, Quintile 3, Quintile 2, Quintile 1.
Neighborhood Atlas (Thanks to Dr. Amy Kind)

https://www.neighborhoodatlas.medicine.wisc.edu/
Potential of Geospatial Metrics of Neighborhood Disadvantage

- **Metrics of Neighborhood Disadvantage are Robust:**
  - Generalizable to full US and Puerto Rico
  - Incorporate into predictive analytics
  - Facilitate mechanistic science across health conditions
  - Privacy-compliant
  - Strong track record of application – mostly abroad

- **Translatable:** Actionable at person, community, research and policy levels
  - Guide outreach, targeting, particularly through mapping
  - Influence intervention design, implementation
  - Policy-applicable: eligibility, adjustment, resources, etc

- **Underutilized:** Yet, despite all this potential, greatly underutilized in the US-- not easily accessible nor always in a format that allows wide applicability
Area Deprivation Index (ADI)

- Originally created by HRSA nearly three decades ago, county level
- 17 education, employment, housing-quality and poverty measures originally drawn from long-form Census
- Limitations mirror those of parent data
- Required updates for modern use
- UW team:
  - Updated to more recent and relevant data sources (American Community Survey, 2009-13)
  - Refined down to census block-group level (i.e. “neighborhood” ~ 1,500 persons) which is critical to more precisely measure exposure
  - NIH R01 to validated these changes with users across US
Social Deprivation Index

Measures of Social Deprivation That Predict Health Care Access and Need within a Rational Area of Primary Care Service Delivery

Danielle C. Builer, Stephen Peterson, Robert L. Phillips, and Andria W. Bazemore

Objective. To develop a measure of social deprivation that is associated with health care access and health outcomes at a novel geographic level, primary care service area.

Data Sources/Study Setting. Secondary analysis of data from the Dartmouth Atlas, AMA Manefite, National Provider Identifier data, Small Area Health Insurance Estimates, American Community Survey, Area Resource File, and Behavioral Risk Factor Surveillance System. Data were aggregated to primary care service areas (PCSA).

Study Design. Social deprivation variables were selected from literature review and international examples. Factor analysis was used. Correlation and multivariate analyses were conducted between index, health outcomes, and measures of health care access. The derived index was compared with poverty as a predictor of health care access.

Conclusion/Execution Methods. Variables not available at the PCSA level, then aggregated to PCSA level.

Social deprivation index is positively associated with poor health outcomes. Findings hold in multivariate analyses controlling for age and gender. Measure of deprivation is more than poverty alone.
Population Health Assessment Engine
What is PHATE?

Uses EHR and Community data to:
- Map physician or clinic service area
- Display “Community Vital Sign” and elements for each neighborhood
- “Community Vital Sign” for each patient
- Identify community partners (Aunt Bertha)

Preparing to align SDOH-adjusted payments with tools to identify patients with social needs
Social Determinants of Health in Managed Care Payment Formulas

Arlene S. Ash, PhD; Eric O. Mick, ScD; Randall P. Ellis, PhD; Catarina I. Kiefe, PhD, MD; Jeroan J. Allison, MD, MS; Melissa A. Clark, PhD

Neighborhood Stress Score
SDH Variables derived from Administrative Data

Individual Level

- Disability
  - Client of the Department of Mental Health
  - Client of the Department of Developmental Services
  - Medicaid due to disability
- Serious mental illness
- Substance use disorder
- Housing Problems
  - Homelessness by ICD-10 code
  - Housing instability (>3 addresses)

Neighborhood Stress Score

- A measure of “economic stress” summarizing 7 census variables:
  - % of families with incomes < 100% of FPL
  - % < 200% of FPL
  - % of adults who are unemployed
  - % of households receiving public assistance
  - % of households with no car
  - % of single parent households
  - % of people >25 without a HS degree
Policy Objectives

1. Payment should be adjusted for social determinants of health; the policy should aim to resolve patients’ social risk and support community interventions.

2. The degree of the adjustment should be proportional to area disadvantage and designed to address social needs, not just reflective of usual, related healthcare costs.

3. Geographic, small-area indices should be created based on patient and population outcomes, and will be viable, reliable, sustainable mechanism for payment adjustments.

4. The policy should reduce burden for providers, payers, states and reduce inequities between states created by the current process.

5. Funders should predefine the goals of reduced total cost and improved patient health outcomes at the outset and use these to titrate funding rather than simply looking for cost offsets that do not align with accountability or expectations of meeting SDOH needs.
Health Care Collaborative of Rural Missouri
Our Mission: Cultivate partnerships and deliver quality health care to strengthen rural communities.

Market and Strategy Driven through programs like School-based health clinics. Health transportation. Community innovation.

Fiscally Responsible by supporting sustainability efforts through Network membership recruitment. Patient and community engagement through marketing and outreach.

Quality Workplace Focused by providing an environment that supports Clinic staff retention and recruitment. Network staff retention and recruitment.

Grounded in Competent and Valued Health Care Practices that Increase patient encounters. Provide quality improvements and risk management. Promote ER diversion and effective care transition.

Guided by Rural Health Leadership Standards that are recognized Nationally. Regionally. Locally.
Partner Roles and Responsibilities

Strategic Initiatives

- **Quality Wellness and Healthcare**: The HCC community receives quality healthcare and wellness services
- **Development, Policy and Advocacy**: Leverage partnerships to support the mission of HCC
- **Excellent Workforce**: Recruit and retain quality professionals
- **Lean Operations**: Implement/innovate systems that create efficiencies, support our expertise, and strengthen our decision-making processes
- **Strong Communications**: HCC is a beacon for rural healthcare and wellness
Community Based Excellence
Building and Sustaining Partnerships. Future Models of Care.

Definitions of Safety Net Providers
- Federally Qualified Health Centers
- Critical Access Hospitals
- Rural Health Clinics
- Provider Based Rural Health Clinics

Impact Potential
- Social Determinants of Health
- Emergency Department Diversion
- 340B Drug Programs
- Labs and Radiology Contracts
- OB/GYN Contracts
- Behavioral Health Contracts
- Opioid and Addiction Services
- Community Health Needs Assessment
- Patient Centered Medical Homes
- Value-based Health Care Models
- Team Based Problem Solving
- Improved Coordination (Multi-Sector)
- Board Structure and Coordination
- Peer Teams
Future Models of Care

Community/Regional approach to Strategic Planning Engaged Partnerships
• Collective Strategy
• Managing Expectations
• Monitor Progress and Performance
• Shared Workforce

“Needs were varied, we knew none of us could do it all, and if we didn’t come together, there’d be unmet need. We knew it wasn’t always going to be fair. It wasn’t going to be like going out to dinner and splitting the bill six ways down to the penny. That’s not the kind of relationship that was going to be successful.” — Founding Rural Health Network member, and CEO of a Rural Provider Organization, reflecting on the origins for developing the Rural Health Network

HRSA Rural Collaboration Guide
Local Health Department Establishes Informal Coalition (Health Care Coalition of Lafayette County): The coalition is focused on serving the needs of one county

Senior Center Planning: Needs Assessment uncovers community needs

Coalition Wins First Grant Award (state funding award)

Informal Coalition Becomes a 501c3 Rural Health Network (Health Care Coalition of Lafayette County)

Lexington 4-Life Center Established

501c3 Network Hires First Full Time Employee (CEO)

501c3 Network Wins HRSA Rural Network Development Planning Program Grant Award

Network Wins HRSA Rural Network Development Grant

501c3 Rural Health Network Awarded Health Center Program Funding and Certified as FQHC: Two sites are opened in 2013 and two sites in 2015

501c3 Rural Health Network Includes Close to 50 Member Organizations
Figure 1. Rural Health Care Collaboration and Coordination: Areas for Consideration

Element 1: Analyze the Environment
- Develop an in-depth understanding of potential partners’ organizations
- Understand your environmental drivers (e.g., national, state, local levels)

Element 2: Engage with Potential Partners
- Consider opportunities to engage potential partners
- Use a community-minded approach

Element 3: Develop a Collective Strategy
- Conduct collective discussions with partner organizations
- Consider using a trained facilitator
- Select measures to monitor strategy performance

Element 4: Review Requirements and Seek Technical Assistance
- Ensure programmatic and regulatory compliance
- Seek technical assistance
Primary Care for Patients Experiencing Homelessness

Michael Hochman, MD, MPH
Chief Executive Officer
Healthcare in Action Medical Group
A Member Organization of SCAN Group

PTAC Listening Session on Payment and Data Issues Related to SDOH/Equity
September 27, 2021
Agenda

• Overview

• Street Medicine Model

• Payment Implications
Key Facts About SCAN

OUR MISSION
Keeping Seniors Healthy and Independent

1977
Founded by seniors, for seniors; originally known as Senior Care Action Network (SCAN)

4.5 Stars
CMS Star Rating 2018 – 2021

220,000
SCAN Health Plan members

~14,900
SoCal duals in SCAN Connections

3rd largest in the nation
2nd largest in California
Among not-for-profit MAPD plans 2021
The Fundamental Challenge

Member Pain Points

Social Challenges Access Challenges Care Disjointed

Health System Pain Points

Limited Data Disrupted Operations Financial Losses
Homelessness impacts every racial and ethnic group; it affects men, women and children; it impacts those of all sexual orientations; but it disproportionately affects groups that have historically faced discrimination in the U.S.
Vision for Healthcare in Action

A non-profit, value-based, payer agnostic medical group with integrated primary care, mental health, substance use, and social work services

Street Medicine
Care delivered when, where and how patients want it

Managed Care
Financial mechanism to create a sustainable delivery system

Sustainable Healthcare Model for Homeless Adults
Scope of Services

Clinical Care Services
- Full Scope Primary Care
  - Ambulatory mental health and substance use care
- Clinical Care Management

Member-Centered Care Coordination

Wrap-Around Services
- Case Management
- Social Work Support
- Transportation to Social Services and Key Appointments
  - Longitudinal care (e.g., care transitions, facilities etc.)
    (Healthcare in Action would NOT be hospitalist of record)

Full professional services in the future
Primary Care Street Team

- **Consulting Psychiatrist**
- **Physician Team Leader**
- **RN/LVN Care Manager**

**Primary Care Teamlet**

1 Teamlet per 125 patients

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**Social Worker (BSW/MSW):**
1 per Teamlet
- Behavioral health counseling
- Social needs & case management

**Nurse Practitioner/Physician Assistant:**
1 per Teamlet
- Acute and chronic medical issues
- Substance use
- Mental health

**Peer Navigators:**
3 per Teamlet
- Individual with lived experience
- Patient engagement
- Resource Navigation
## Clinical Model

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
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<tbody>
<tr>
<td>Prospective payments</td>
<td>Allows creativity and flexibility to address social determinants</td>
</tr>
<tr>
<td>All-inclusive primary care</td>
<td>Minimize referrals, perform navigation and coordination for the patient</td>
</tr>
<tr>
<td>Access to care</td>
<td>24/7 two-way communication between patients and primary care team</td>
</tr>
<tr>
<td>Urgent care services</td>
<td>On the streets</td>
</tr>
<tr>
<td>Medication</td>
<td>Reviewing, dispensing, and directly observed therapy</td>
</tr>
<tr>
<td>Behavioral health/substance use</td>
<td>Fully integrated into the primary care model</td>
</tr>
<tr>
<td>Social work</td>
<td>Fully integrated into the primary care model with strong linkages to community organizations</td>
</tr>
<tr>
<td>Longitudinal care</td>
<td>Care provided across hospitalizations, post-acute care, recuperative care, and care transitions</td>
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Cost Considerations

Annual Healthcare Costs for Dually Eligible SCAN Member Experiencing Homelessness ~ $60,000

Per Member Per Year Cost of Street Medicine ~ $10,000
Business Model 1: Shared Savings

Shared Savings

Pre-Intervention: $60,000
Post-Intervention: $45,000

$7.5K
$7.5K
Business Model 2: Global Capitation

01. Payment modifier as a multiple of the premium (upfront cost)

02. Enhanced funding for health-related social services (upfront cost)

03. Flexibility for regulatory requirements and performance metrics to facilitate care for patients experiencing homelessness
Questions?

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