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Strategies to Achieve Alignment, Collaboration, and Synergy Across Delivery and Financing Systems

Integrating Health and Social Services through a Novel Independent Practice Association

Research In Progress Webinar
February 28th, 2024
12:00-1:00 pm ET/9:00-10:00 am PT

colorado school of public health

Agenda

Welcome: Carrington Lott, MPH, Program Manager at S4A

Presenters: Jonathan G. Shaw, MD, MS, and Todd Wagner, PhD from Stanford University School of Medicine and Elena Rosenbaum, MD from Healthy Alliance

Q&A: Carrington Lott, MPH, Program Manager at S4A

Presenter

Elena is the Medical Director at Healthy Alliance, an upstate NY organization focused on coordinating social, behavioral, and clinical services to enable people to lead healthy lives and reduce health disparities. Elena is also a family physician and an Associate Professor at the Department of Family Medicine and Community Medicine at Albany Medical College.

Elena Rosenbaum, MD
Medical Director
Healthy Alliance

Presenter

Jonathan is Associate Chair for Community Partnership in Stanford's Department of Medicine, a health services researcher, and a practicing family physician providing community-based primary care to patients of all ages. He practices at Ravenswood Family Health Center, a Federally Qualified Health Center (FQHC) serving the primarily immigrant communities of East Palo Alto. His research home is Stanford's Evaluation Sciences Unit, a multidisciplinary team focused on implementation science.

Jonathan G. Shaw, MD MS
Clinical Assoc Professor
Stanford University

Presenter

Todd is a health economist and Professor in the Stanford School of Medicine. He has a joint appointment as Director of the Health Economics Resource Center at the Palo Alto VA. He has more than 20 years of experience conducting economic analysis. In 2011, he co-led an analysis to understand why VA hospitals were divesting from substance use treatment, even though there was strong evidence that such treatment was cost-effective.

Todd Wagner, PhD
Professor, Dept of Surgery
Stanford University

Stanford MEDICINE | S-SPIRE
Stanford-Surgery Policy Improvement Research & Education Center

Commentator

Amanda Duff, PhD
Strategic Planning Director
Healthy Capital District Initiatives

Amanda is the Strategic Planning Director for Healthy Capital District, a regional public health planning nonprofit that support healthcare access through insurance enrollment, advocacy, regional planning, data, and training. Amanda supports HCD's new Certified Peer Development Program and activities related to regional success of the NYS 1115 Waiver. Amanda is a board member for the Saratoga Springs Rotary Education Foundation and volunteers with Special Olympics New York and North Country Wild Care.

Outline

1. Context and History of Healthy Alliance
2. Study aims
3. Early lessons learned
4. Future implications

Focus

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- Funded to study an innovative solution to the “Wrong Pockets” phenomena
- This occurs when one organization won’t fund a program that is socially beneficial because the returns come to another organization
- Since we were funded – we have seen dynamic changes in CMS and State policy

Healthy Alliance

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- Healthy Alliance focuses on addressing social drivers of health through an integrated network of health, behavioral health and social care providers.

- Currently serves Medicaid and uninsured clients in 25 counties in New York, representing a mix of urban/rural and historically underserved populations.

The Foundation

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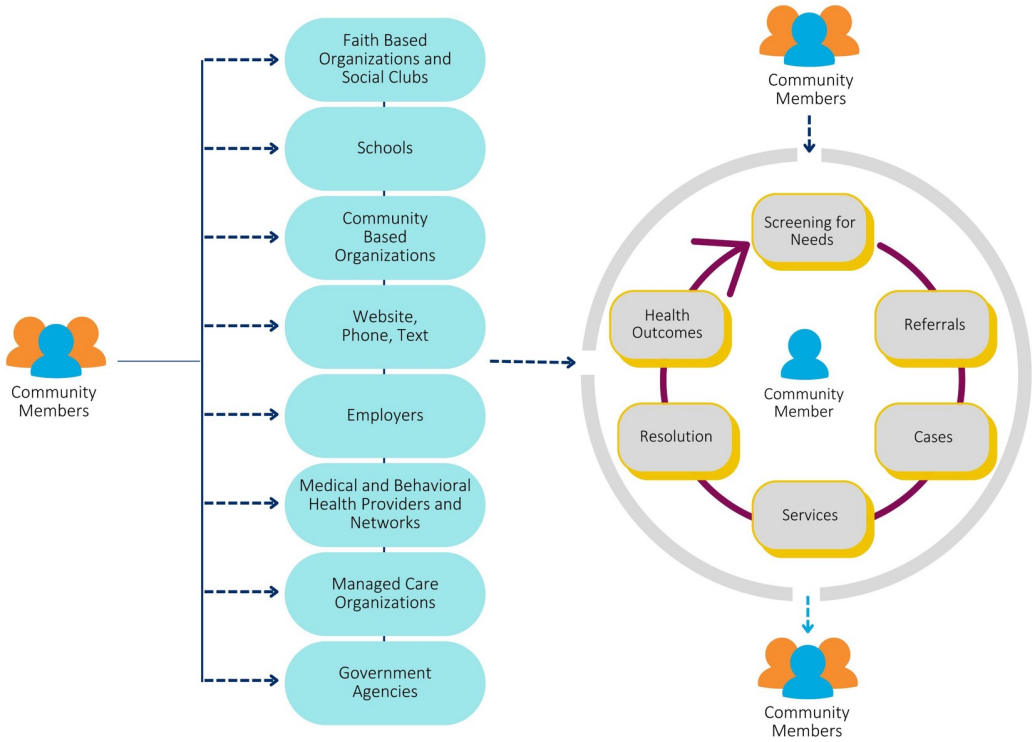
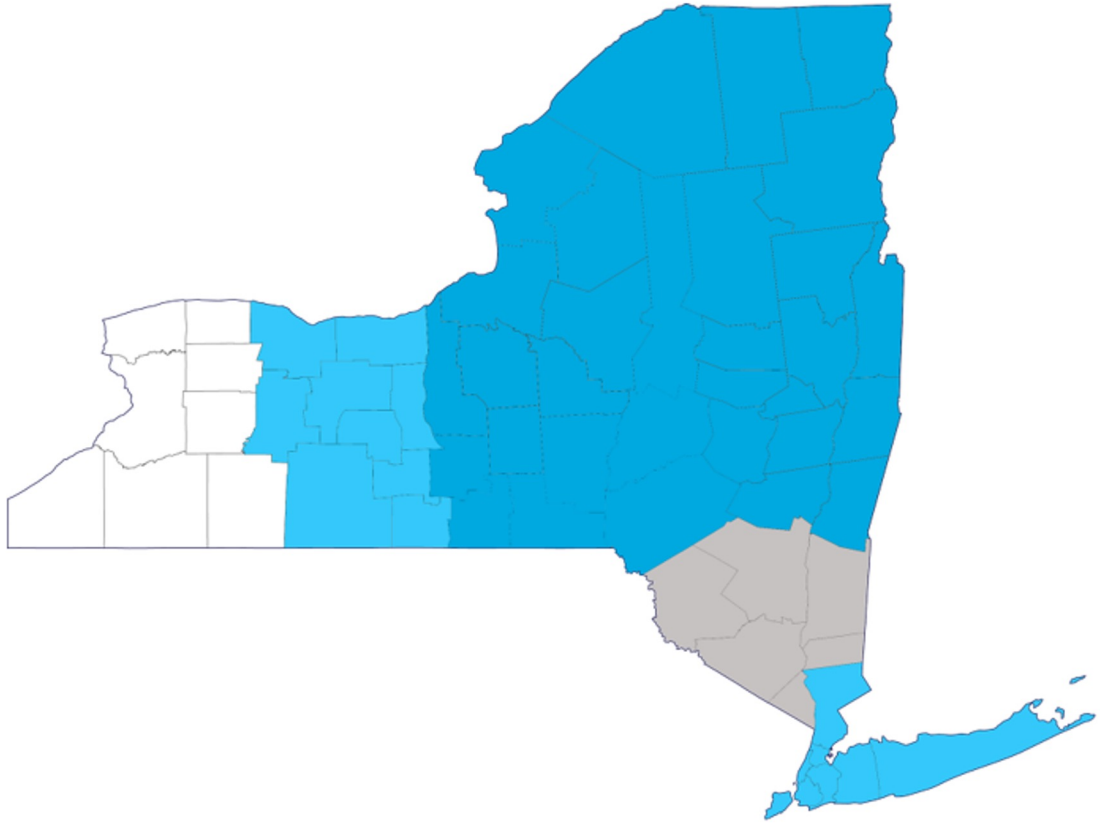
Facilitates "no wrong door" to services



Provider Coverage



Network overview

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450+
Parent organizations
medical/physical, behavioral, and social actively managed by Healthy Alliance

~1300
Physical partner locations
across New York State

25
Counties
in NYS where the network is operational

2305
Programs available
20% Behavioral Health
24% Physical Health
56% Social Care

~4,500
Users
on Unite Us

35k+
Community members
connected to services in Unite Us since 2018

90k+
Referrals sent
in Unite Us since 2018

11k+
Community members
screened for HRSN in Unite Us since 2022

275k+
Community members
served by network partners

Blending and braiding: Innovative solution

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ALLIANCE FOR BETTER HEALTH, LLC

- Founding Members applied for DSRIP (2014) for 6 counties.
- Alliance for Better Health Care, LLC formed as the PPS. Received funding from DOH DSRIP activities.

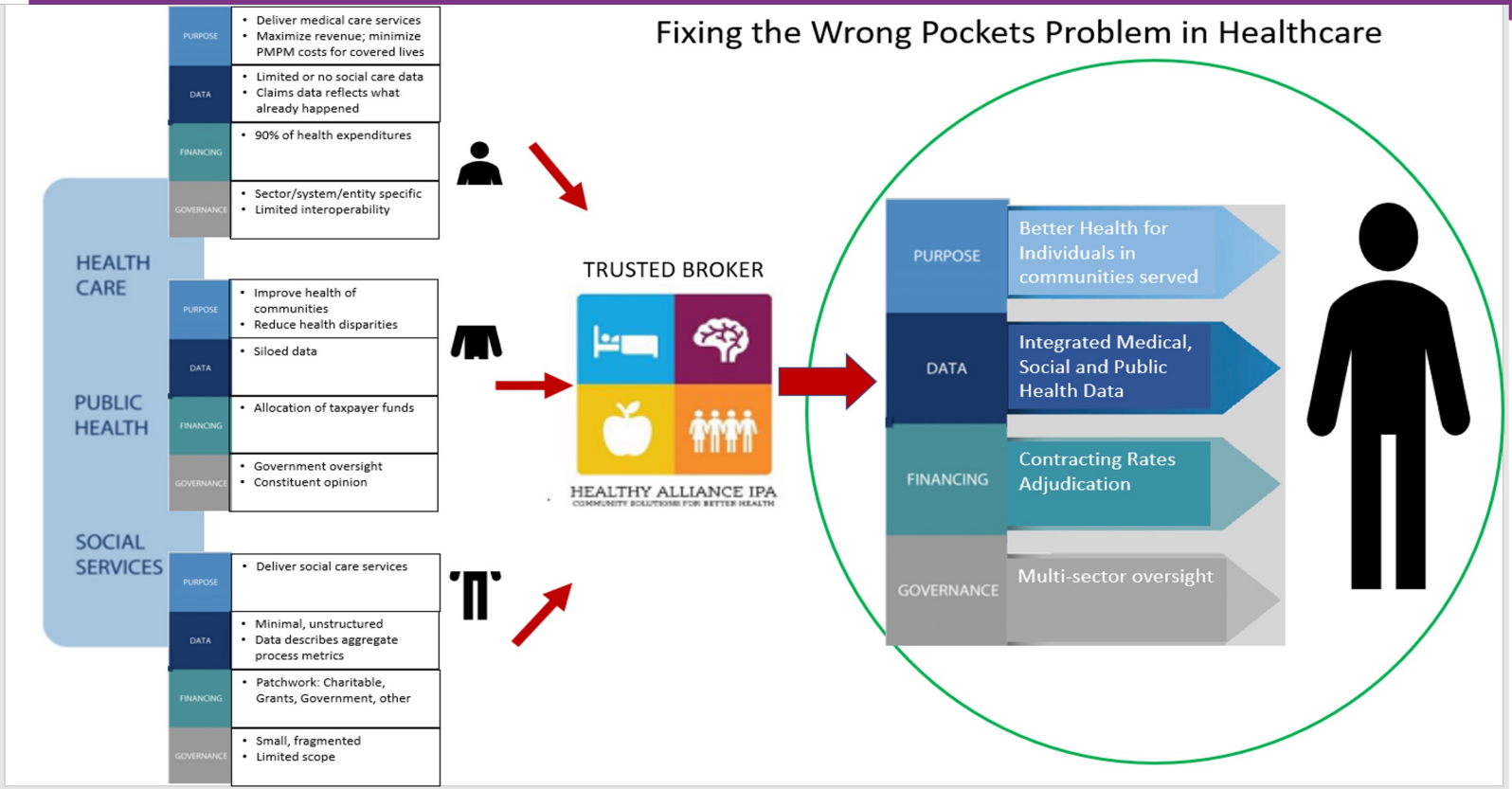
HEALTHY ALLIANCE IPA, LLC

- Founding Members authorized formation of Healthy Alliance IPA in December 2018.
- As a NYS recognized IPA, Healthy Alliance IPA is authorized to arrange for the provision of health-related services to members of managed care organizations (MCOs), providing funding vehicle for CBOs focused on social care interventions.

HEALTHY ALLIANCE FOUNDATION INC.

- IPA Members authorized formation of the not-for-profit affiliate (Aug. 2021) for the purpose of soliciting grants and other funding restricted to non-profits.
- Healthy Alliance Inc. provides additional funding vehicle for CBO partners.

Conceptual Model



Adapted from Landers et al "A Theory of Change for Aligning Health Care, Public Health, and Social Services in the Time of COVID-19", AJPH 2020

Healthy Alliance – a Social Care Network

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healthy alliance

Innovation: Healthy Alliance uses an IPA structure (Independent Practice Association) to

- Organize/curate a broad range (small & large) of regional social service agencies
- Effectively interface (negotiate, contract, closed loop referral) w/ health systems and insurers
- Originally 6 counties--> now covers 25 counties in NY State

Study Aim: by comparing Medicaid patients in counties with vs. without Healthy Alliance, evaluate its impact on:

1. total cost of health care
2. type of medical care received, and any shifts in use patterns
3. social service care and healthcare use, by race and socio-demographics

Study Aims

- Aim 1: Assess the impact of coordinated social care assistance interventions on total cost of health care.

- Aim 2: Compare the type of medical care received (i.e., ER, hospitalizations, ambulatory surgery, and outpatient care) and assess whether there has been a shift over time in cases relative to controls.

- Aim 3: Describe the effect of Healthy Alliance on social service care and health care using a health equity lens.

Methods

- Difference in differences (DD) design

	Before Healthy Alliance Pre 2018	After Healthy Alliance 2018 and After
Members in Healthy Alliance Counties	Average Cost, per-member per-month	Average Cost, per-member per-month
Matched Controls in other NY counties	Average Cost, per-member per-month	Average Cost, per-member per-month

Our Data- Probabilistic match

We link two datasets:

- **NY SPARCs:** Cost and utilization data from the state-wide All Payer Claims Database (2016 through 2021)
- **Healthy Alliance's** member and services files (*Unite Us*).
  - Demographics (race/ethnicity, insurance, housing status)
  - SDOH screening from Health Leads Screening Toolkit,
  - Date of screen, client status (active, inactive), service type and subtype received, date of service, name of service program.

Analysis:

- Individual clients' linked data, looking at county level

Data

- Two datasets
  - Cost and utilization data from the SPARCs All Payer Claims Database in NY (2011 through 2021)
  - Healthy Alliance's member and services files (*Unite Us*)
    - Demographics (race/ethnicity, insurance, housing status)
    - SDoH screening from Health Leads Screening Toolkit
    - Date of screen, client status (active, inactive), service type and subtype received, date of service, name of service program.

Cases

- Cases will include all persons in the *Unite Us* database during 2019-2021 that live in the six service counties: Albany, Rensselaer, Schenectady, Fulton, Montgomery, or Saratoga.

- We will link *Unite Us* platform data with the SPARCs data.

- *Unite Us* does not use SSN, so we will us a probabilistic match.

Controls

A comparison cohort will be selected as follows:

1. Comparable NY counties will be identified based on Census data

1. Counties that have the same service providers that are part of Unite Us will not be considered as a potential comparable county

1. Controls will be identified using propensity score matching based on age, gender and CMS V24 risk score, computed with SPARCs data prior to Healthy Alliance.

Study Aims

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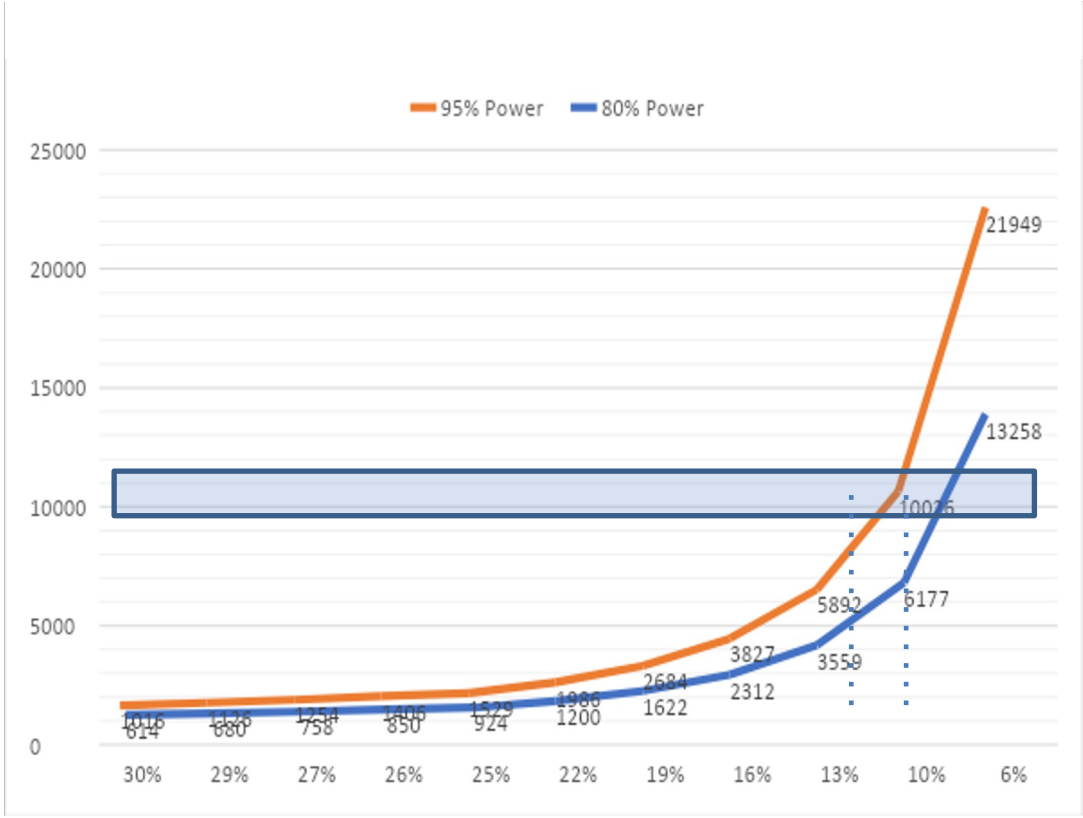
- **Aim 1: Total costs of care.** SPARCs reports total charges, so we will cost-adjust the charges

- **Aim 2:** Analyze subtotals to gain insights on appropriate / inappropriate utilization
  - ED visits
  - Hospitalizations
  - Ambulatory surgery
  - Adherence to medications for chronic conditions, specifically, COPD/asthma, high blood pressure, diabetes, mental health.

- **Aim 3:** We will conduct subgroup analyses with specific attention to higher deciles of risk (i.e., based on prior health care use) and race/ethnicity to assess whether the intervention is effectively targeting the most vulnerable subpopulations and underlying racial inequity.

Power Analysis

- Used data from other safety net provider (VA)
- We took five random selections of Veterans under age 65 and computed their monthly costs $663 (SD $1,231).
- We have the power to detect a ~9% change in costs. This is approximately a $60 change per member per month (at 80% power).
- At 95% power, we can detect a ~12% change in costs ($80 per member per month).



Early lessons from analyzing data

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- Demographic data necessary for health equity analysis can be challenging to collect

- Cross-sector data linkages are new and pose challenges

Problem 1- Data Linkage Challenges

- Standard health reliance on SSN or other Health IDs that may be missing in social care data

Cases will include all persons in the *Unite Us* database during 2019-2021 that live in the six service counties: Albany, Rensselaer, Schenectady, Fulton, Montgomery, or Saratoga.

We will link *Unite Us* with the SPARCs data.

Unite Us does not use SSN, so we will us a probabilistic match.

Problem 2. - Missing Core Data

- Issue capturing data and grassroots considerations such as:
  - Social care community-based organizations not being accustomed to collecting certain data elements:
    - Beyond SSN, also not consistently collecting e.g.
      - Health Insurance data
      - Health care provider / PCP
      - Race/ethnicity
      - …etc
  - Cultural and systems divide: PHI not typically shared; no expectation that these social services are linked to health insurance / healthcare
  - Personal Hesitancy to share such information with non-health social care organizations – both on CBO and client/patient side
  - Redundancy and reliability if collecting demographic elements

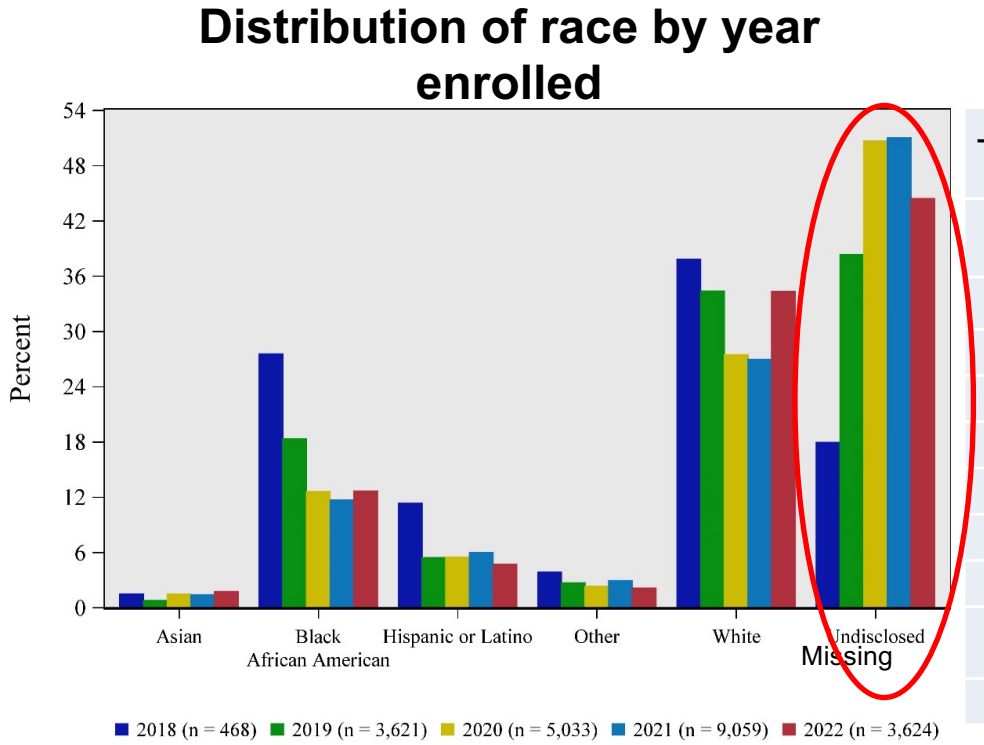
Problem 3 – Client/Patient Perspective & Privacy

Cuts in both directions

1. Clients' hesitancy to share personal identifiable/health information (PHI/PII) with non-health-related social care organizations

2. Patients’ hesitancy to share social needs information with their health team

Example of extent of missing race data



Type of Organization	N Missing Race	% Missing Race
CBO- Insurance Navigator	3158	88
Health care-related	653	72
CBO- Nutrition-related	481	95
Health care-related	376	35
CBO- Career Training	322	43
CBO- Food-related	297	87
Health care-related	290	42
Health care-related	226	74
Healthy Alliance referral center	214	76
Health care-related	189	99

Demographic data collection considerations

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- Changes to referral platform can improve data collection.
- Vulnerable populations may be most concerned about disclosure.
- Best practices for training individuals to ask questions.
- Who and which org type is best equipped to ask questions?
- Is there an ultimate source for data to avoid repeated questions?

Experiences from CBO and FQHC

- Demographics data collection
  - Client trust
    - History and relationships
  - Avoiding assumptions
    - "Look at me"
    - "You can't be both"
  - Front-line support
    - Leadership and communication

Implications of S4A work so far

Paper published helped solidify operational practices and requirements for a functioning SCN lead entity.

Preliminary work: Dissemination of Features of Healthy Alliance Model

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NEJM Catalyst | Innovations in Care Delivery

CASE STUDY

Breaking Down the Barriers Between Health and Social Care Services: Implementing a Social Determinants of Health Network

Elena Rosenbaum, MD, Jonathan G. Shaw, MD, MS, Todd H. Wagner, PhD, Stacie Vilendrer, MD, MBA, MS, Marcy Winget, PhD, MHS, Coretta Killikelly, MSN, RN, Lynne Olney, MBA, Erica Coletti, MBA, Michele Horan, RN, Michele Kelly, CPA, Steven M. Asch, MD, MPH

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Most determinants of health are social and not directly amenable to medical treatment. To improve equity, the medical delivery system must partner with social care services, but the institutional bridges are often lacking. Healthy Alliance — originally funded in 2015 by the New York State Department of Health's Delivery System Reform Incentive Payment program through the Medicaid Section 1115 demonstration waiver — in 2018 developed a social determinants of health network (SDHN) as a regional strategy to provide health-critical social care services in Upstate New York. After more than 4 years of implementation, Healthy Alliance's SDHN connects community members in need to more than 1,250 services across more than 580 partner organizations spanning 25 counties in New York State. Three managed care organizations have partnered with Healthy Alliance

Table 1. Key Solutions Contributing to Beneficiary–Service Connections Through Healthy Alliance's Network

Area	Feature of SDHN	Key Activities
Technology	Closed-loop referral platform (i.e., tracks referral status over time, through fulfillment of meeting the need)	• Tracks referral information • Facilitates referrals among sectors • Documents service connections • Provides data for identifying gaps in services
User support	Training and implementation support	• Assistance with technology adoption • Social needs screening best practices • Adoption and optimal use of Healthy Alliance
User support	Referral center	• Assists agencies in directing referrals to orga that are best suited for the community meml • Monitors all referral activity to ensure timely connections • Assigns Regional Referral Navigator to partne
User support	Performance optimization	• Regionally based performance consultants pr partners with ongoing feedback and workflow to support network adoption
Quality	Network-wide service standards	• Ensures partners are receiving and respondir referrals in a timely fashion • Ensures service connection success
Data management	Policy- and process-related management	• Clarifies data privacy issues around data capt sharing • Assists with data management and aggregati
Financing	Contracting	• Healthy Alliance provides a single point of ac MCO contracting with CBOs • Enables agencies not equipped to directly co MCO to receive funding
Governance	Board and committees	• Leverage CBO expertise in local and regional collaboration

In context of current health policy environment

- Aligns with CMS efforts on health equity
- Community care hubs and backbone organizations, such as Healthy Alliance, called out in *US Playbook to Address SDOH.*
- ONC: Breaking down siloes of government data- ONC now also in charge of human service data.

White House: US Playbook to Address SDOH

"Support the development of community backbone organizations and other community infrastructure to link health care systems to community service organizations."

US Playbook to Address SDOH Nov 2023.

Aligning with CMS efforts

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- All new programs include demographic data collection for health equity analysis and HRSN screening
- Referrals to services – Medicare /CMMI models
- Health equity plans
- Funding of HRSN through 1115 Waiver mechanism

State level Innovation: 1115 Waivers

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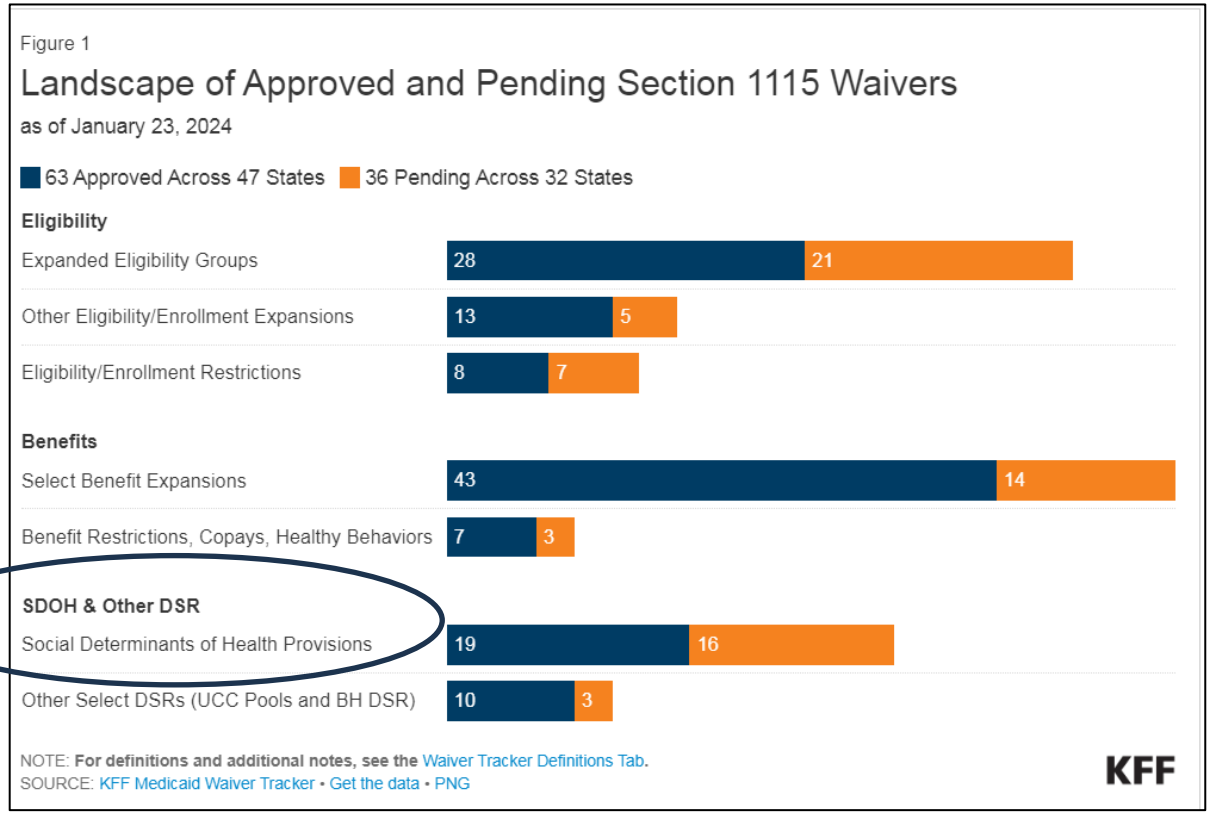


NY State 1115 Waiver

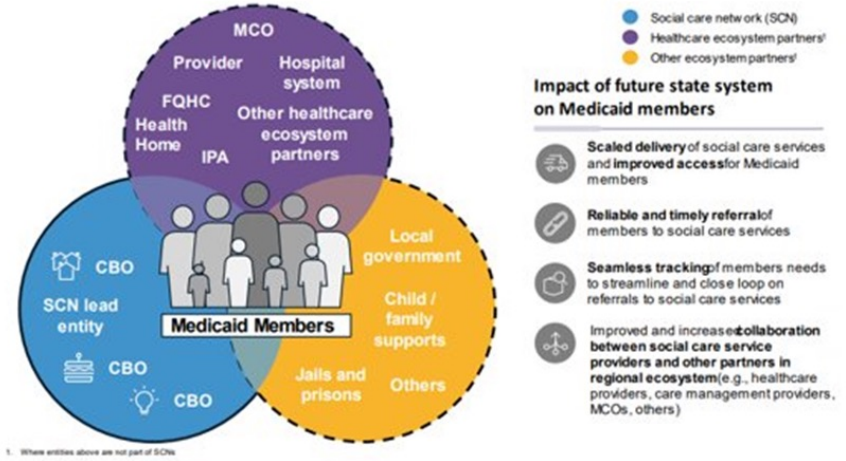
- Funds Social Care Networks in 9 regions across NY State. Creating the mechanism to integrate health, community social care and government human services.

- Funding for Medicaid beneficiaries:
  - HRSN screening and navigation
  - HRSN (nutrition, transportation, and housing) for special populations.

Potential impact of 1115 waiver funding on CBO

- Wellness dependent on both medical and social factors
- Value and need to integrate
- Importance of collaborating efficiently

Figure 1: Overview of SCNs in context of broader ecosystem and aspiration for impact on Medicaid members



Future direction of social care funding

- Health outcomes/economic analysis could help inform further social care funding policies.
- Health care is heavily regulated. It will be more efficient to have non-health care organizations address social services.
- Using health care funding to fund social care services through Social Care Networks or community care hubs can help solve for wrong pocket problem without adding operational costs of funding through health care.

Questions?

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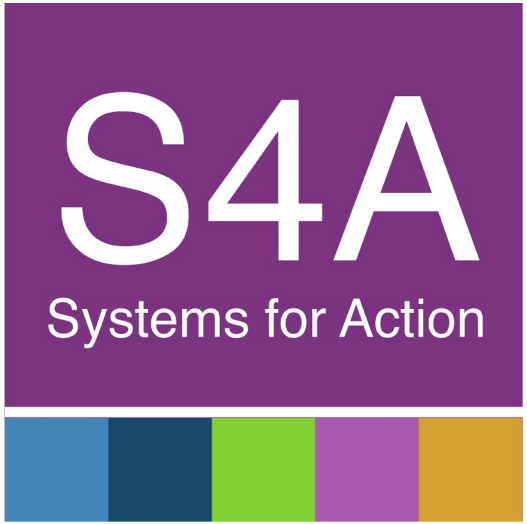

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