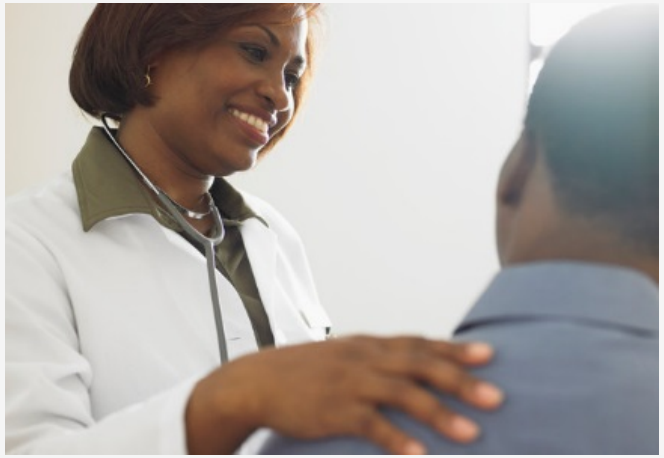
AMERICA'S PHYSICIAN GROUPS



ADDRESSING SOCIAL DETERMINANTS OF HEALTH IN GOVERNMENT-SPONSORED PROGRAMS

A Presentation to America's Physician Groups' 2018 Colloquium

June Simmons, President
Partners In Care Foundation

John Gorman

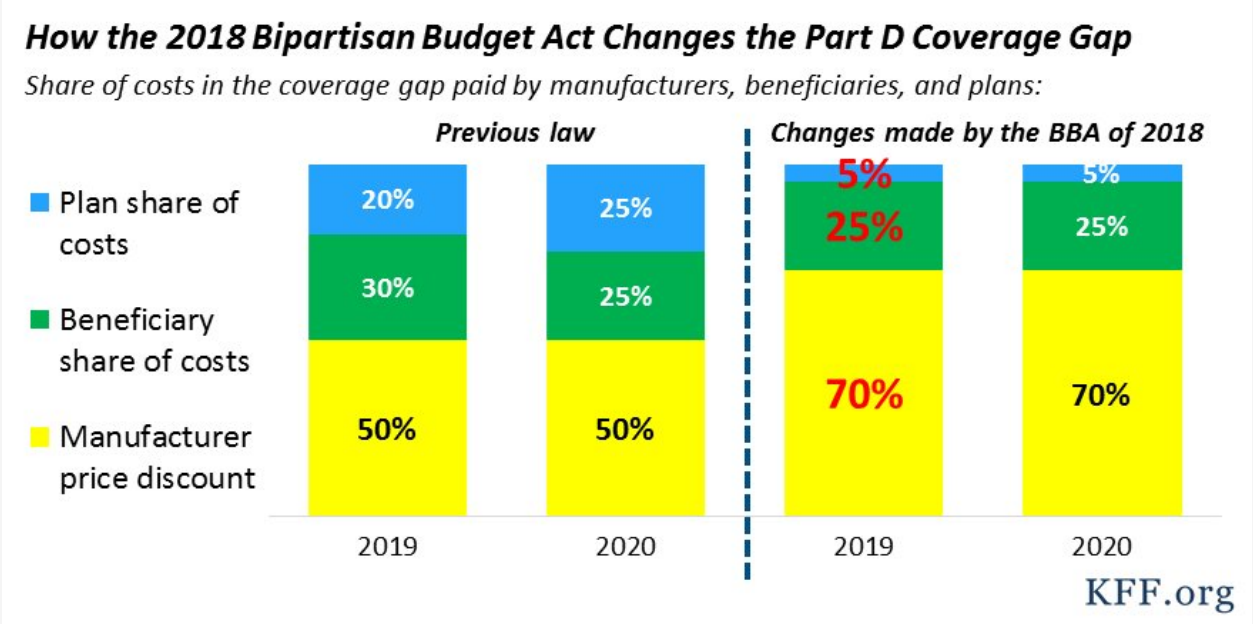
October 11, 2018

MEDICARE ADVANTAGE SUPPLEMENTAL BENEFITS POLICY CHANGE IS A GAME CHANGER

- CMS seeks to allow for benefits which “diagnose, prevent, or treat an illness or injury, compensate for physical impairments, act to ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and healthcare utilization.”
- Opportunity for plans to offer more meaningful benefits that address social determinants of health, and include in the bid:
  - Assistive devices in the home
  - Food security
  - Transportation to doctor’s appointments or to urgent care
  - Telehealth

2019 BUDGET RESOLUTION = GOODIE BAG FOR MA

- Permanent Special Needs Plan (SNP) reauthorization
- CHRONIC Care Act (expand MA-VBID to all 50 states by 2020)
- Codifies expansion of supplemental benefits
- Allows plans to build telehealth into MA bid
- Jelly in the Donut Hole:

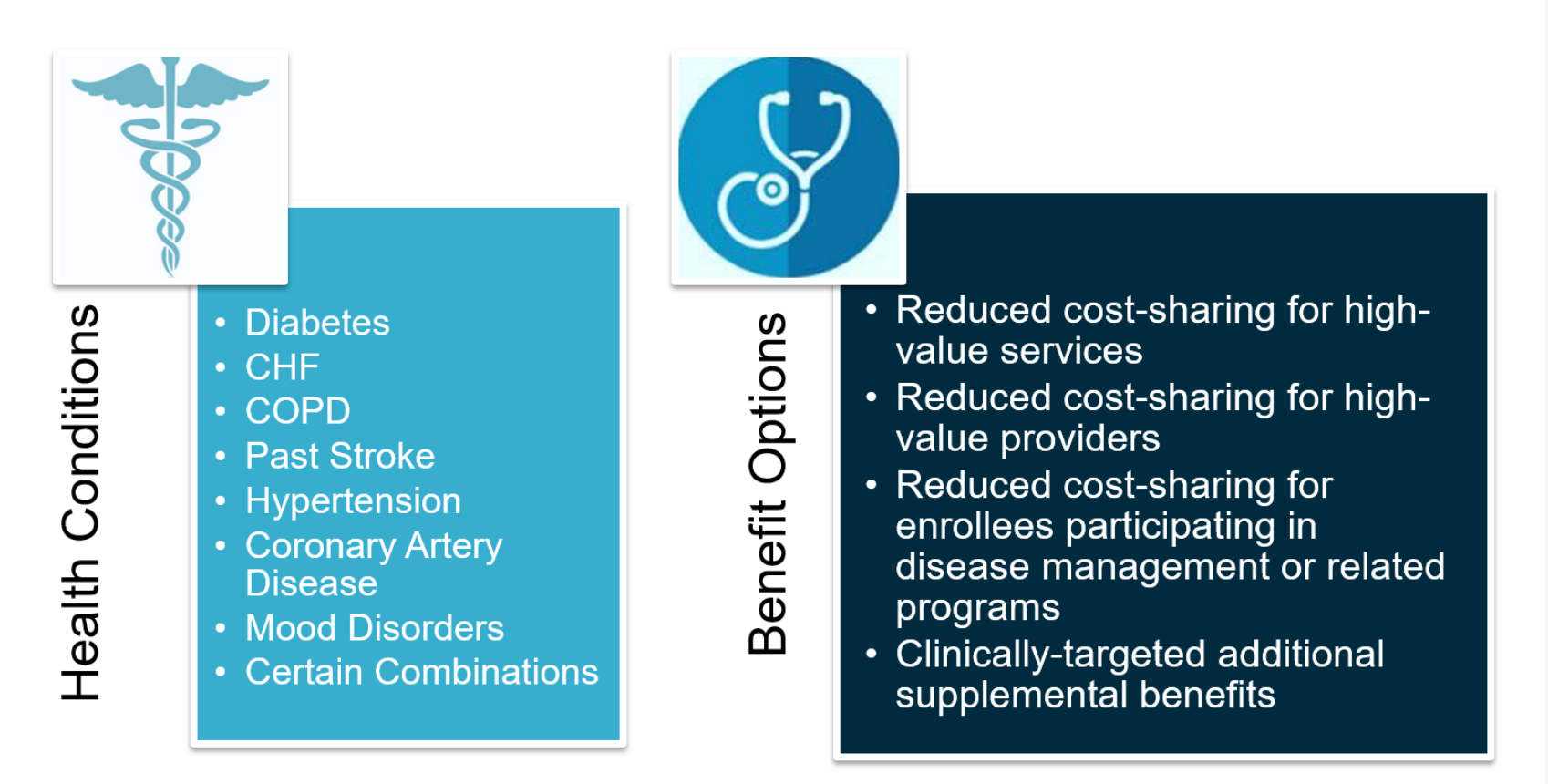


VALUE-BASED INSURANCE DESIGN (VBID) IN MEDICARE ADVANTAGE

- The VBID model will test structuring benefits for individuals with certain conditions in ways expected to have the greatest potential to positively impact enrollee health relative to cost.
- 5-year demonstration expanded to all 50 states
- The plan is an HMO, HMO-POS, or local PPO plan type
  - Must have been operating for at least 3 years
  - Must have at least 2,000 members
  - Must have 3+ Stars
  - No open compliance issues

VALUE-BASED INSURANCE DESIGN (VBID) IN MEDICARE ADVANTAGE

Design Options to Choose From If Plan Meets VBID Criteria



WHY FOCUS ON SOCIAL DETERMINANTS OF HEALTH (SDOH)?

New Medicare Advantage and Medicaid policies now enable benefit designs to address SDOH

New sources of cheap capital can help pay for new services and interventions

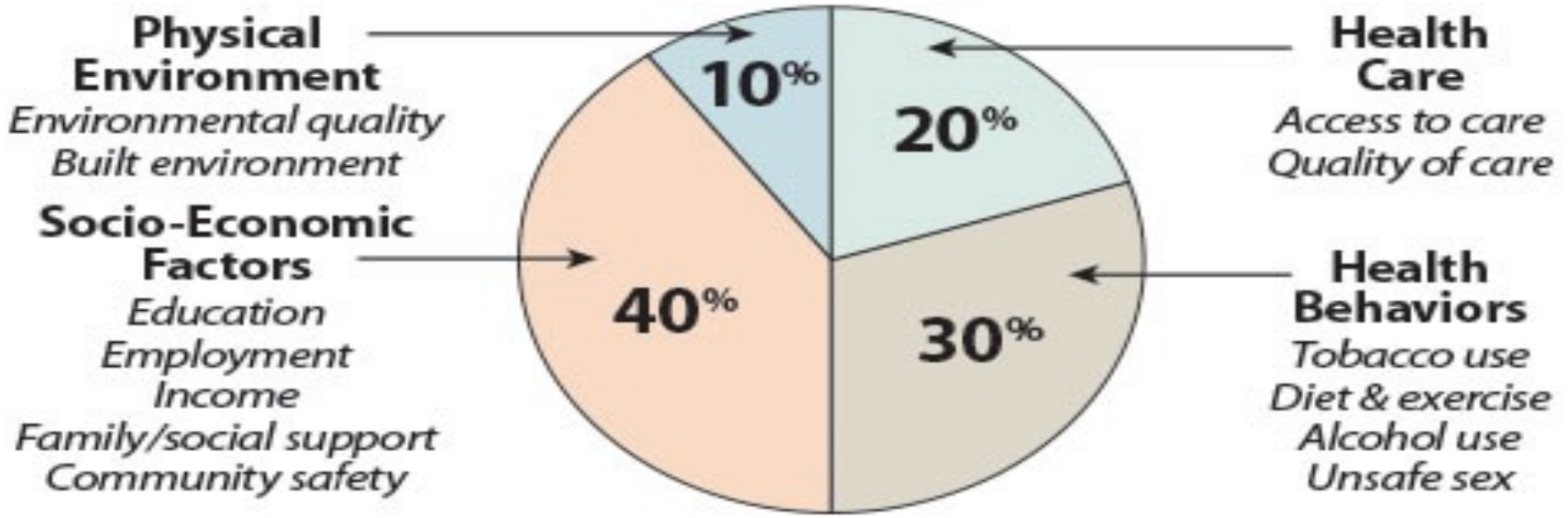
SDOH are responsible for half of all health care expenditures

At-risk Physician Groups must improve quality while managing medical expense within a global budget

POVERTY CHARGES INTEREST in health care. Addressing SDOH makes business and medical sense.

Social Determinants of Health

Population Health



Source: Authors' analysis and adaption from the University of Wisconsin Population Health Institute's *County Health Rankings* model ©2010, http://www.countyhealthrankings.org/about-project/background

THE IMPORTANCE OF SOCIAL DETERMINANTS

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education			
Support	Walkability				

Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Some studies attribute as much as 50% of healthcare outcomes to social determinants of health.

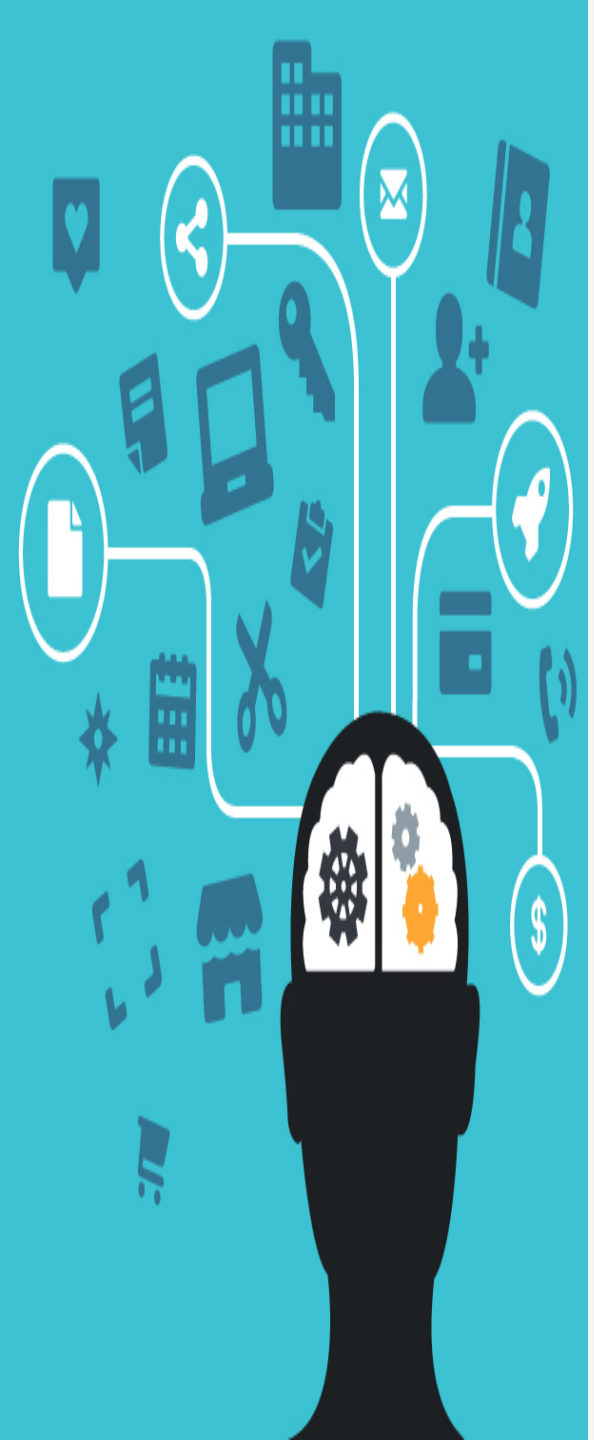
THE HENRY J. KAISER FAMILY FOUNDATION

GETTING A SHARPER PICTURE OF THE POPULATIONS YOU SERVE

- Obtaining available information on membership's income, race, ethnicity, home ownership rate, language
- Best practices for data collection, tracking, and reporting
- Strategies for effectively conducting your own research
- Understanding the factors that motivate healthcare decision-making for your primary member groups

INFORMATION ALREADY AVAILABLE

- Claims and encounter data
- Hierarchical Condition Categories (HCC)
- Health Risk Assessments (HRAs)
- Other clinical assessments
- Pharmacy data
- Lab encounters and results
- Data required to meet federal and state requirements:
  - Healthcare Effectiveness Data and Information Set (HEDIS)
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS)
  - Health Outcomes Survey (HOS)
  - Medical Management System
- Audit data
- Plan surveys
- Welcome call
- Call systems: customer service, medical management, pharmacy
- Home visit observations



COMMISSION A STUDY

- CMS Model of Care requirements for Special Needs Plans offer rigor to capture and address the non-clinical characteristics of your membership

- Publicly available data abounds! CDC, RWJF, KFF, Healthy People 2020, U.S. Census Bureau, state & local CHNAs….
  - Disease prevalence
  - Neighborhood and lifestyle conditions (including property and mortgage data, types of homes, distance to public transportation)
  - Racial and cultural diversity
  - Income levels, credit attributes and bankruptcy history
  - Education and literacy levels
  - Presence of children in the home
  - Criminal convictions and incarceration history
  - Purchasing habits

- Flexible, customized health risk assessments offer high-ROI opportunity to identify each member's needs

- Vendors are beginning to capitalize on technology to enable efficient use of member-specific information

OBTAINING AND USING INFORMATION

- Does your data warehouse and technology tools/systems integrate data obtained from inside and outside the organization?
- Do your staff know how to identify a member's SDOH and personalize interventions accordingly? Do they have the time to make a meaningful impact and to influence member behavior?
- Is your QI staffing level adequate to allow robust collection and analysis of the data?
- Do your reports and dashboards allow segmented tracking and monitoring of groups sharing similar characteristics?
- Do you have P&Ps or program evaluations that reinforce at least annual evaluations that are reported to committees and BOD?

EXAMPLE: USING DATA TO FORMULATE STRATEGY

Measure	Rate HS Education or Above	Rate No HS Diploma/GED
Breast Cancer Screening	74%	62%
Colorectal Cancer Screening	55%	40%
Diabetes Care – A1c Controlled	86%	78%
Medication Adherence	78%	72%
Plan All-Cause Readmissions	12%	16%

THE SCIENCE OF MOTIVATING MEMBERS TO IMPROVE HEALTH

HIGHLY ENGAGED

- I follow my doctor's orders religiously.
- I take my medications as prescribed.
- I seek ways to improve my health.
- I have resources to meet my needs.

ENGAGED

- I know how to improve my health.
- I generally follow my doctor's orders.
- I appreciate reminders from my MA plan.
- I use good judgment regarding my health.

ALMOST ENGAGED

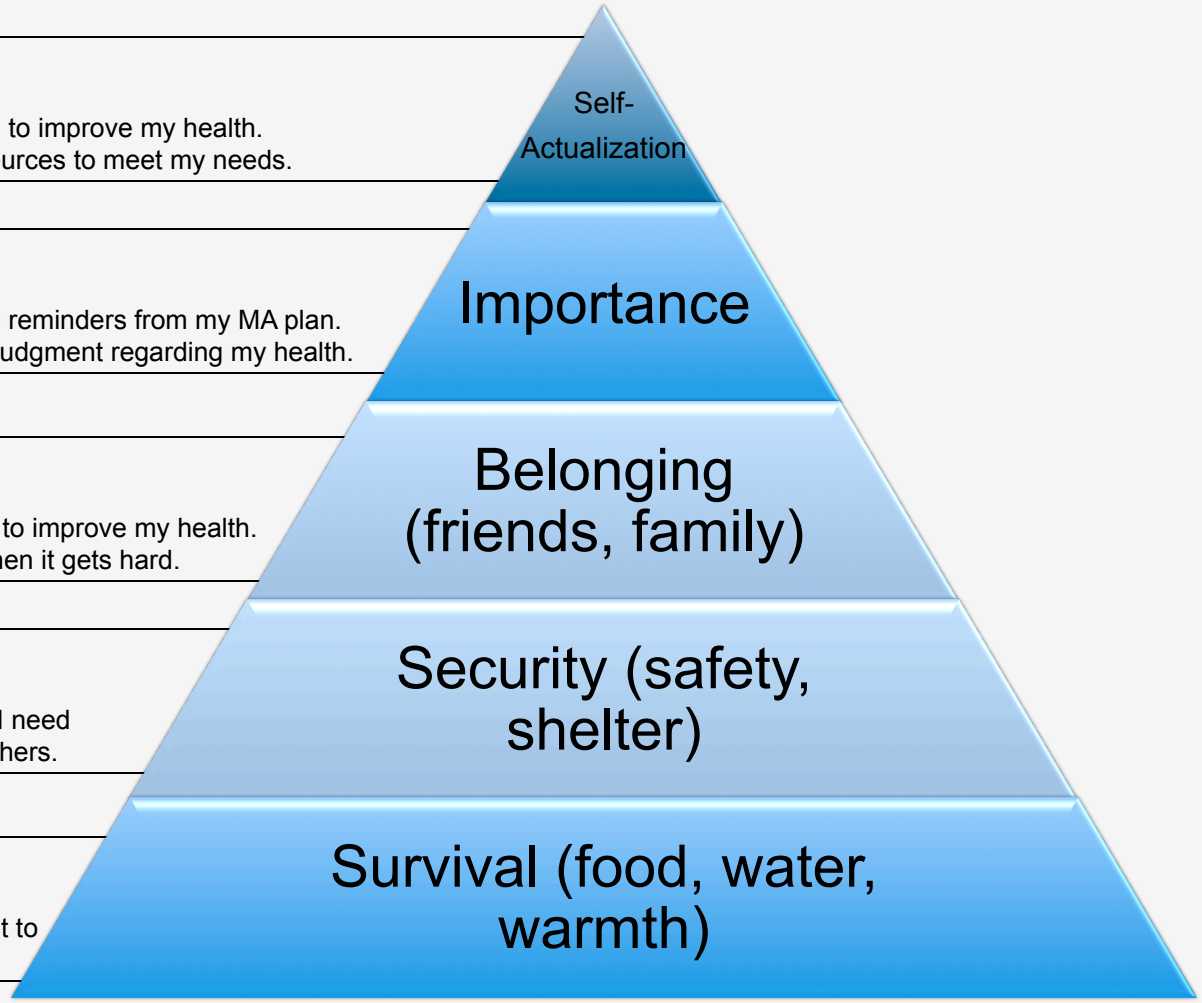
- I know I should improve my health.
- Sometimes I don't make good choices.
- I know how to improve my health.
- I give up when it gets hard.

NOT ENGAGED

- I'm not willing to change my behavior.
- I don't know how to manage my health.
- Sometimes I need help from others.

DISENGAGED

- I don't have resources to meet my needs.
- I rely on others for many daily activities.
- I do not want to change.



STORIES FROM THE FIELD:
SETTING STRATEGIES THAT MOTIVATE MEMBERS

40% of the members in a D-SNP are illiterate (to the extent that they sign their name with an “X)

Vast majority of the members of a D-SNP reside in multi-story, aging, inner-city apartment buildings with unreliable elevators

Almost 50% of a D-SNP plan’s members rely on public transportation and live in neighborhoods where gang/gun violence is at an all-time high

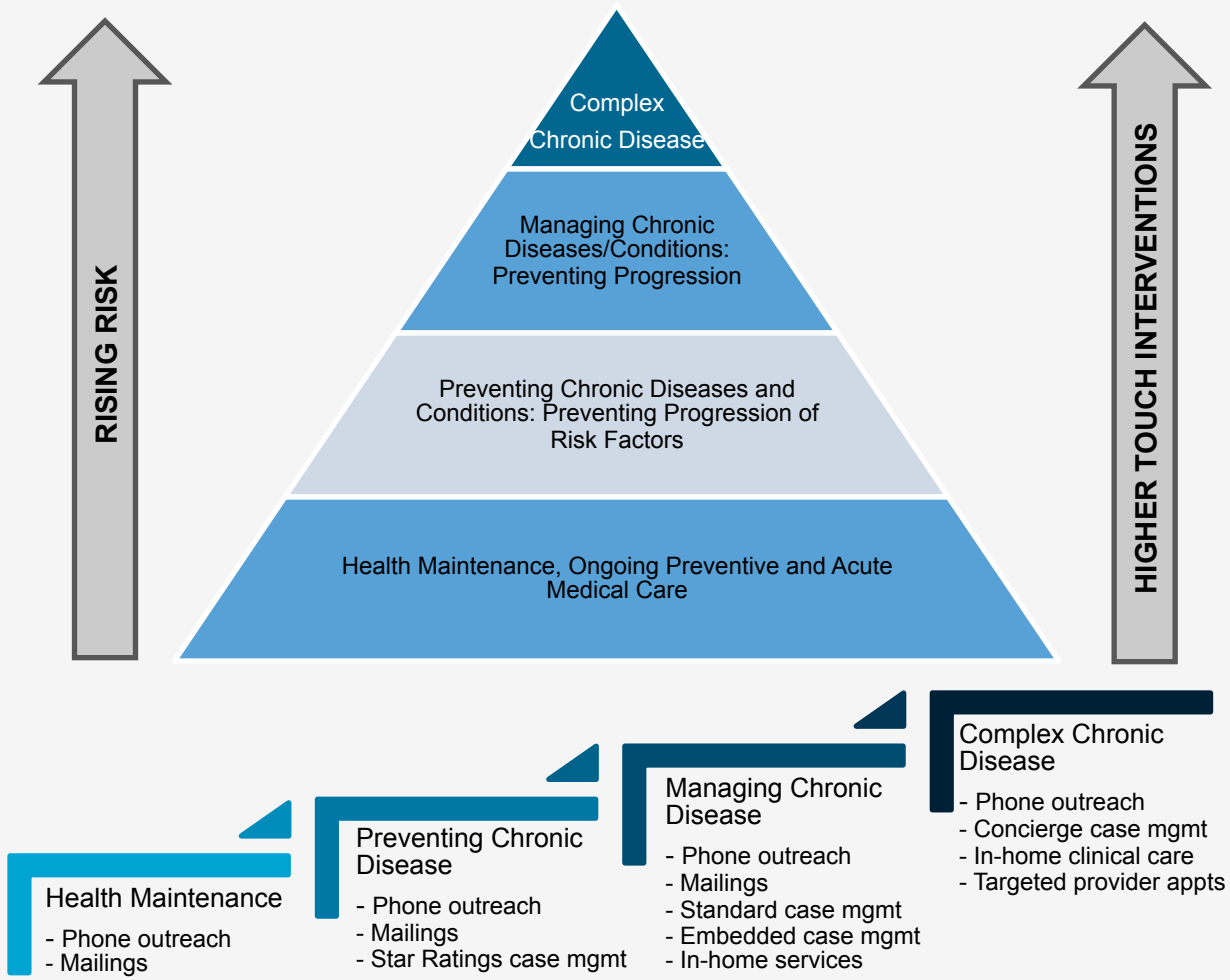
60% of a Medicaid plan’s members struggle to find providers with appointments available after 4pm

10% of an MA-PD plan’s members use a church-based clinic staffed by locums tenens physicians

Almost 50% of an MA-PD plan’s members report being uncertain of having access to enough food to satisfy their hunger.

68% of an MA-PD report not being able to afford the medications prescribed by their doctor using their plan’s formulary structure

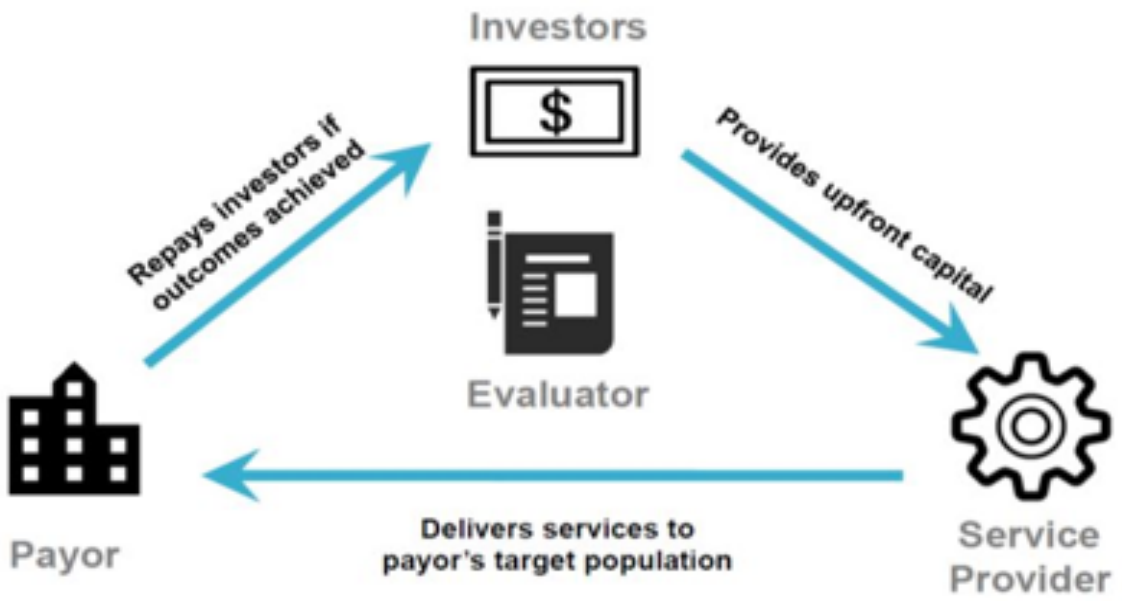
PERSONALIZING CARE TO IMPROVE OUTCOMES



SOCIAL IMPACT INVESTING:
WORKING CAPITAL FOR CLINICAL INNOVATION

- *$50 Billion in Funding Available in 2019*
- *Principal +5% Interest Expected After 8 Years*

1. **Investors** provide principal funding to scale the Service Provider's intervention
2. **Intermediary** issues funding to the Service Provider as agreed upon
3. **Service Provider** delivers services to the **Population in Need**
4. **Evaluator** measures and monitors outcomes achieved
5. **Payor** issues success payments as outcomes are achieved
6. **Investors** receive a return on their principal investment



POTENTIAL IMPACT INVESTMENTS FOR SOCIAL DETERMINANTS

- “A Medication Helping Hand”
- Adult Day/ Eldercare Services
- Healthcare “Uber”
- “A Healthcare Helping Hand:” Health Activity Coordination
- Embedded Inpatient & Post-discharge Patient Support Services
- Health Resource Centers
- Food Security Support in Food Deserts
- Senior-focused Urgent Care & Care Coordination Clinics
- Mobile Quality Measure Gap Closure
- Coalition-based Community Health Care

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AMERICA'S PHYSICIAN GROUPS

Addressing Social Determinants through Community Partnerships

June Simmons, CEO

Partners in Care Foundation

Partners in Care FOUNDATION

Between Medical Care and Social/Behavioral Determinants of Health

Health Happens at Home

Partners in Care Foundation

Changing the Shape of Healthcare

- Partners is a **think-tank** and a **proving ground**
- Partners changes the shape of health care by **creating high-impact, innovative ways of bringing more effective clinical and social services to people and communities**
- Partners' direct services **test, measure, refine and replicate innovative programs and services**, and **bring needed care to diverse populations**

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changing the shape of health care
AMERICA'S PHYSICIAN GROUPS

What changes do we want to see

- Integration of medical care and social services
- Enhanced self-management/empowerment of consumers
- Integration of behavioral health
- Evidence-based interventions
- Community Agencies forming into regional delivery systems Networks, like IPA' s

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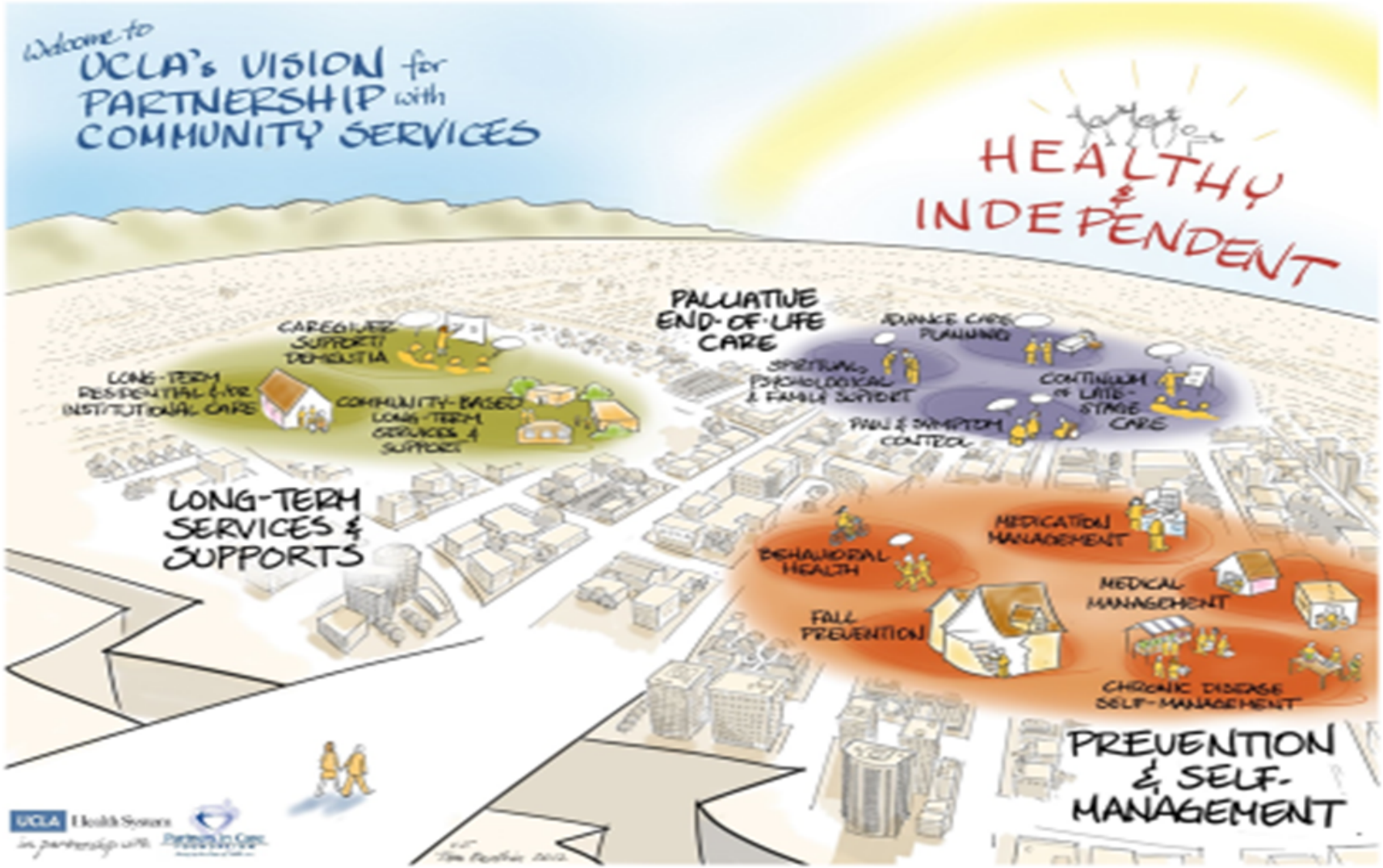
Selected by UCLA as their Community Partner in 2012



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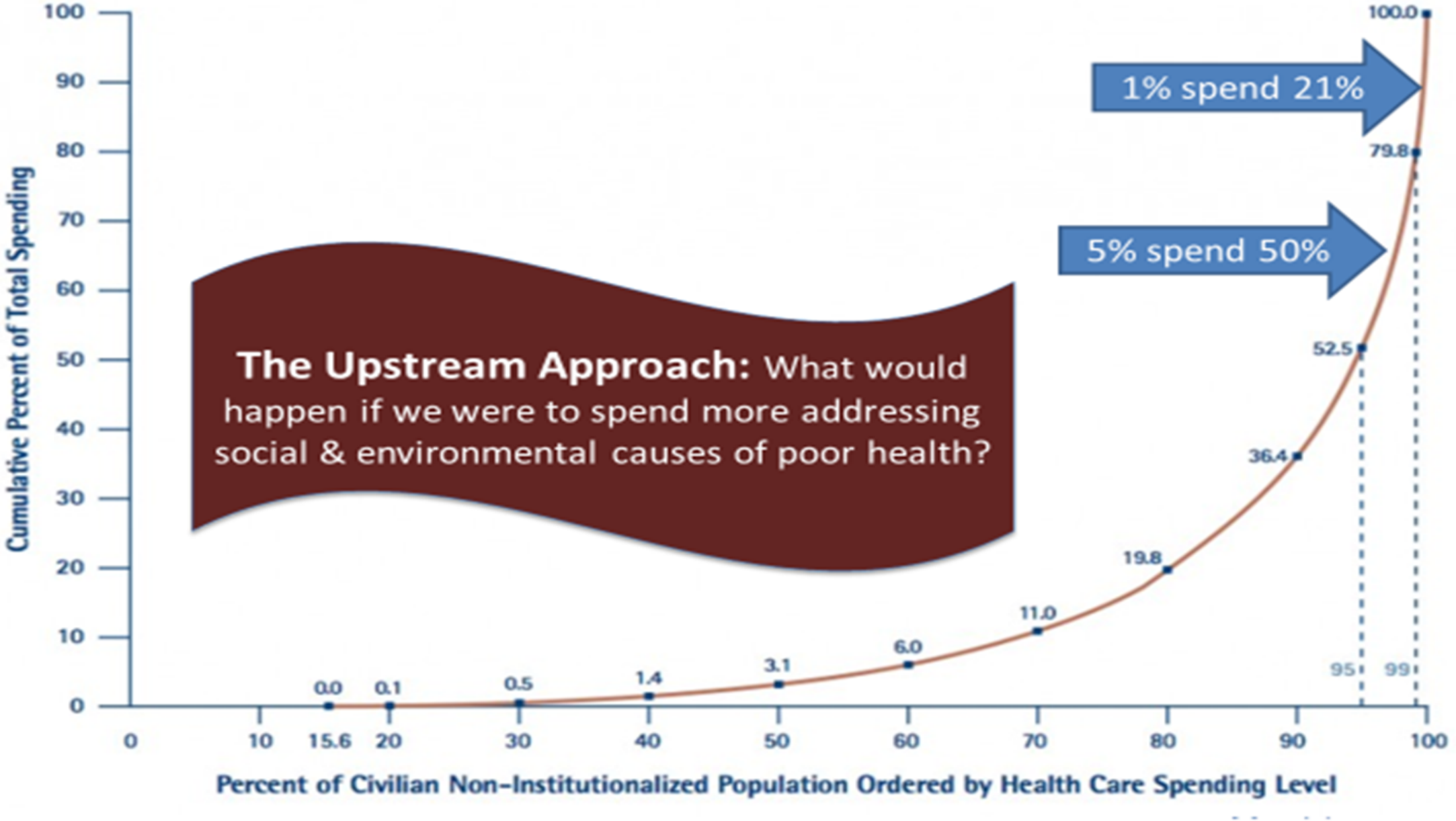

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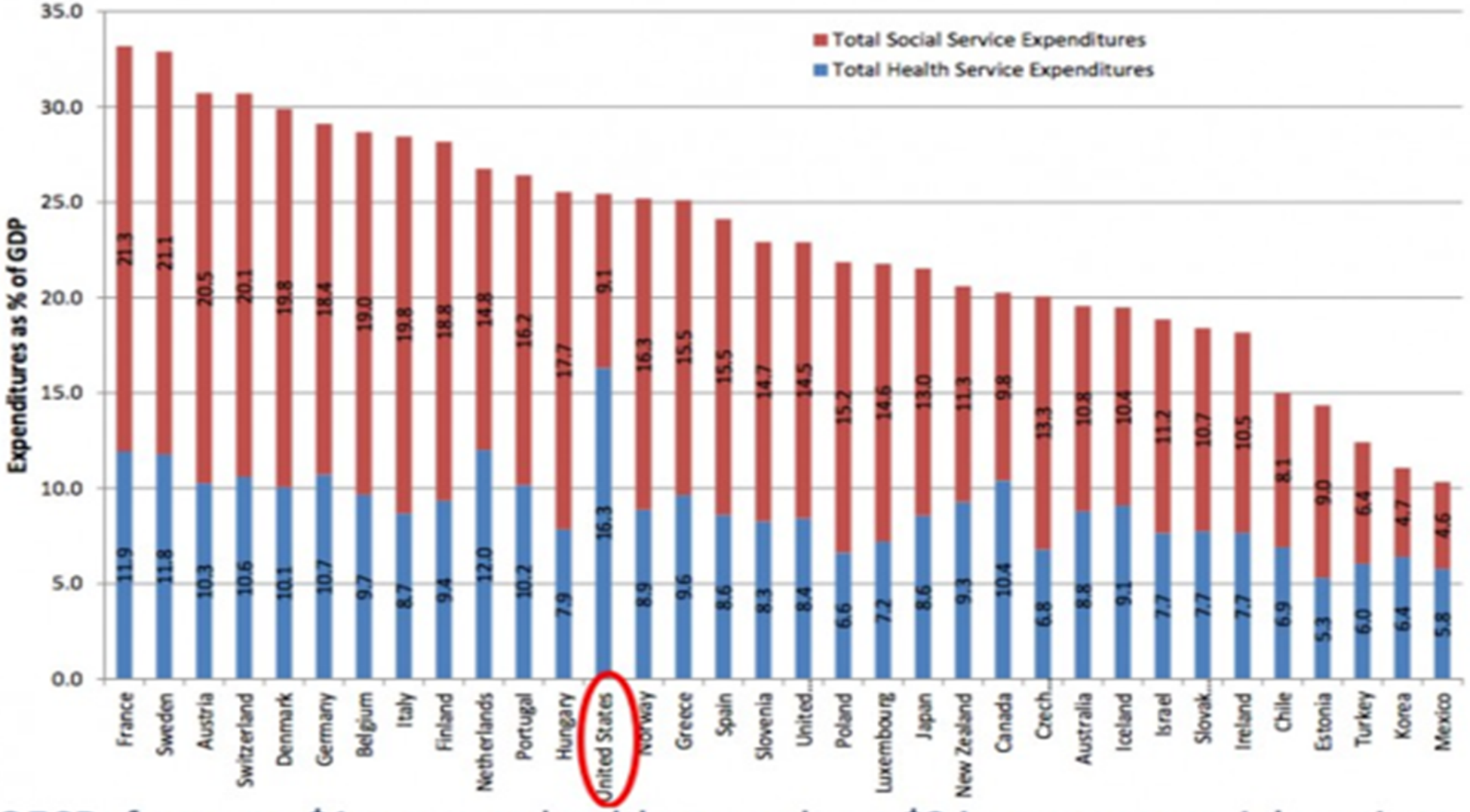
Total health care investment in US is *less*



In OECD, for every $1 spent on health care, about $2 is spent on social services

In the US, for $1 spent on health care, about 55 cents is spent on social services

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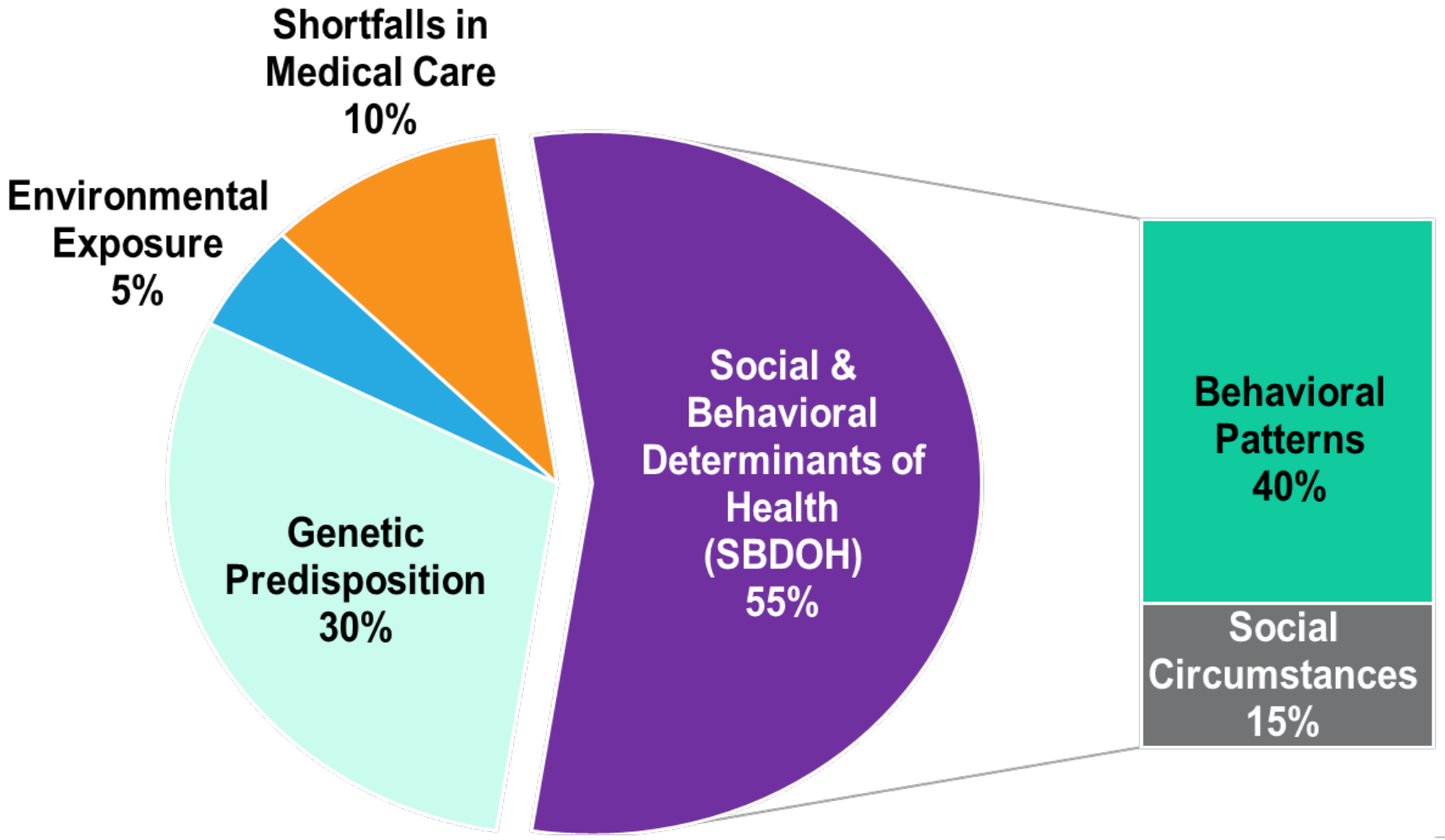
Factors in Premature Death, USA



Adapted from McGinnis JM, Williams-Russo P, Knichman JR. The case for more active policy attention to health promotion. Health Affairs (Millwood) 2002;21(2):78-93

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Social & Behavioral Determinants of Health (SBDOH)

What Home- & Community-based Services Do to Address SBDOH

New Roles for the Medical System

- Risk Stratification – Active Screening & Targeting
- Continual Monitoring for "trigger events" that could change a risk category
- Build comprehensive partnerships with community providers as part of the delivery system for population health

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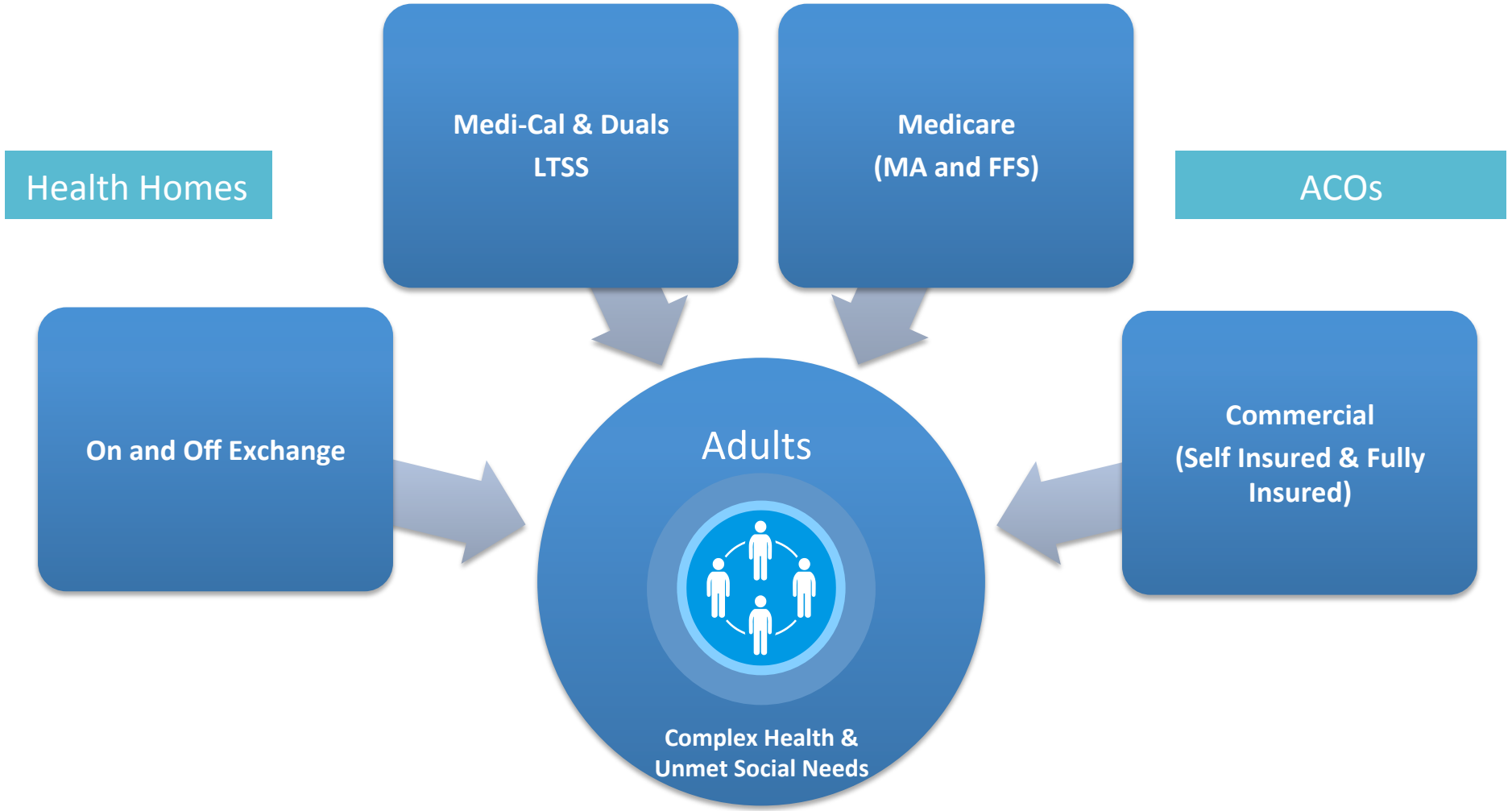
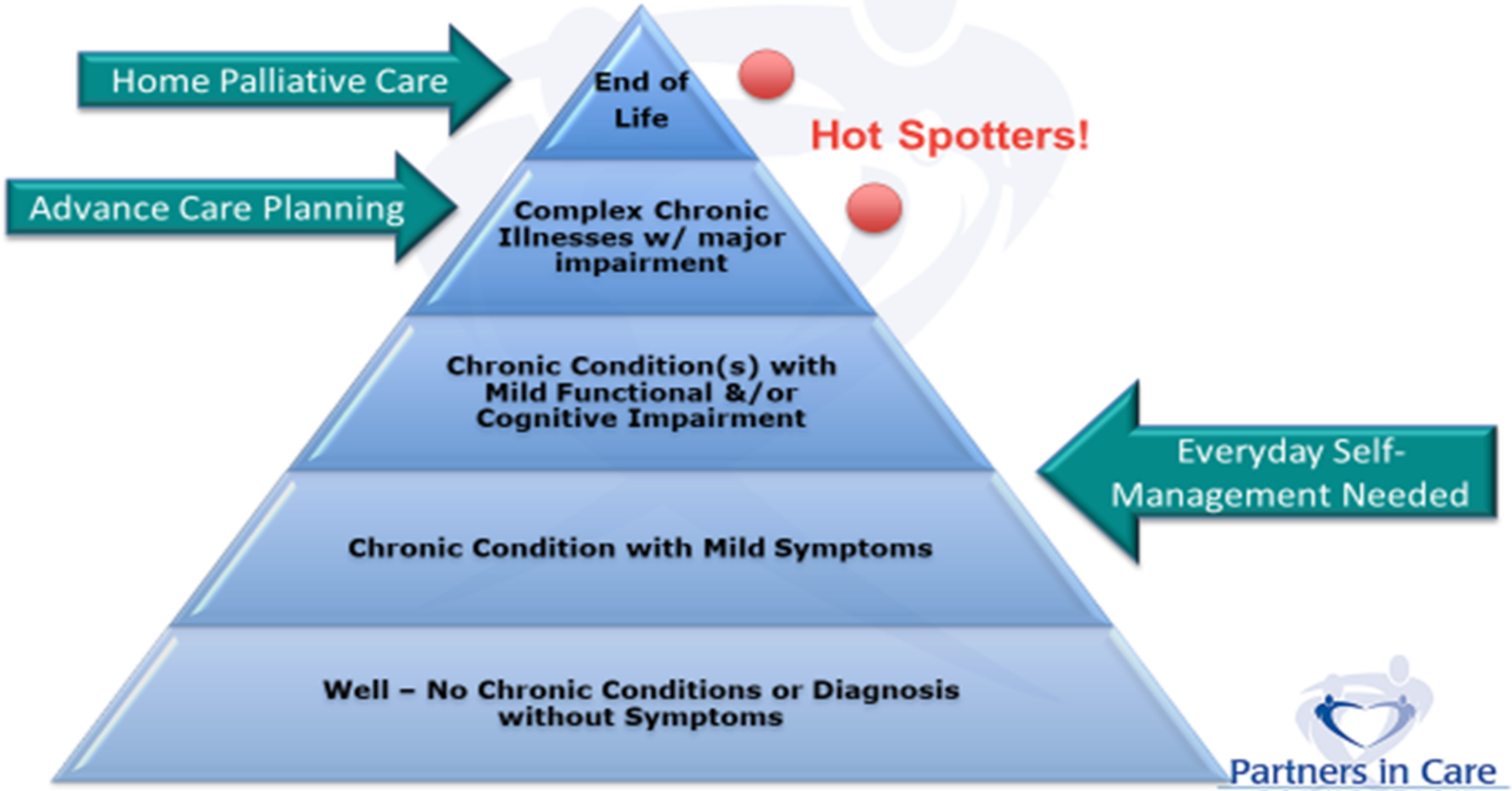
For High-Risk Patients with Complex Health and Unmet Social Needs



Targeting for Better Population Health Management



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Targeting the *right* people

Short-Term Care Management / Care Transition

- Multiple hospitalizations or ED visits in last 6 months
- 5+ meds (or any psychoactive/CNS-affecting medication)
- Cognitive impairment
- Functional impairment
- Lives alone
- Inadequate caregiver support
- Comorbidity: depression &/or anxiety

LTSS

- ADL/IADL impairment
- Needs in-home care/supervision
- At risk for nursing home placement

Health Self-Management Workshops

- For people with 1+ chronic condition

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Services for Diverse Populations

Tier 1 & 2 Moderate Risk – *Chronic Diseases w/o disability*

- Evidence-Based Self-Management
- HomeMeds

Tier 3: Complex – *Eyes & Ears in the Home*

- HomeMedsPlus Assessment & Services
- Care Transitions

Tier 4: Frail – *Long term services & supports*

- Ongoing care management
- Purchase of services

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CBOs: Bridge to the Home

- CBOs have worked to improve health and functioning at home for decades
- Local trust, history and community support
- Know the lay of the land – quality of services
  - Not a call center approach – local employees
- Mobility and flexibility – responsive, nearby
- Health coaches, navigators, social workers, community health workers - an alternative and affordable workforce
- Culturally & linguistically matched

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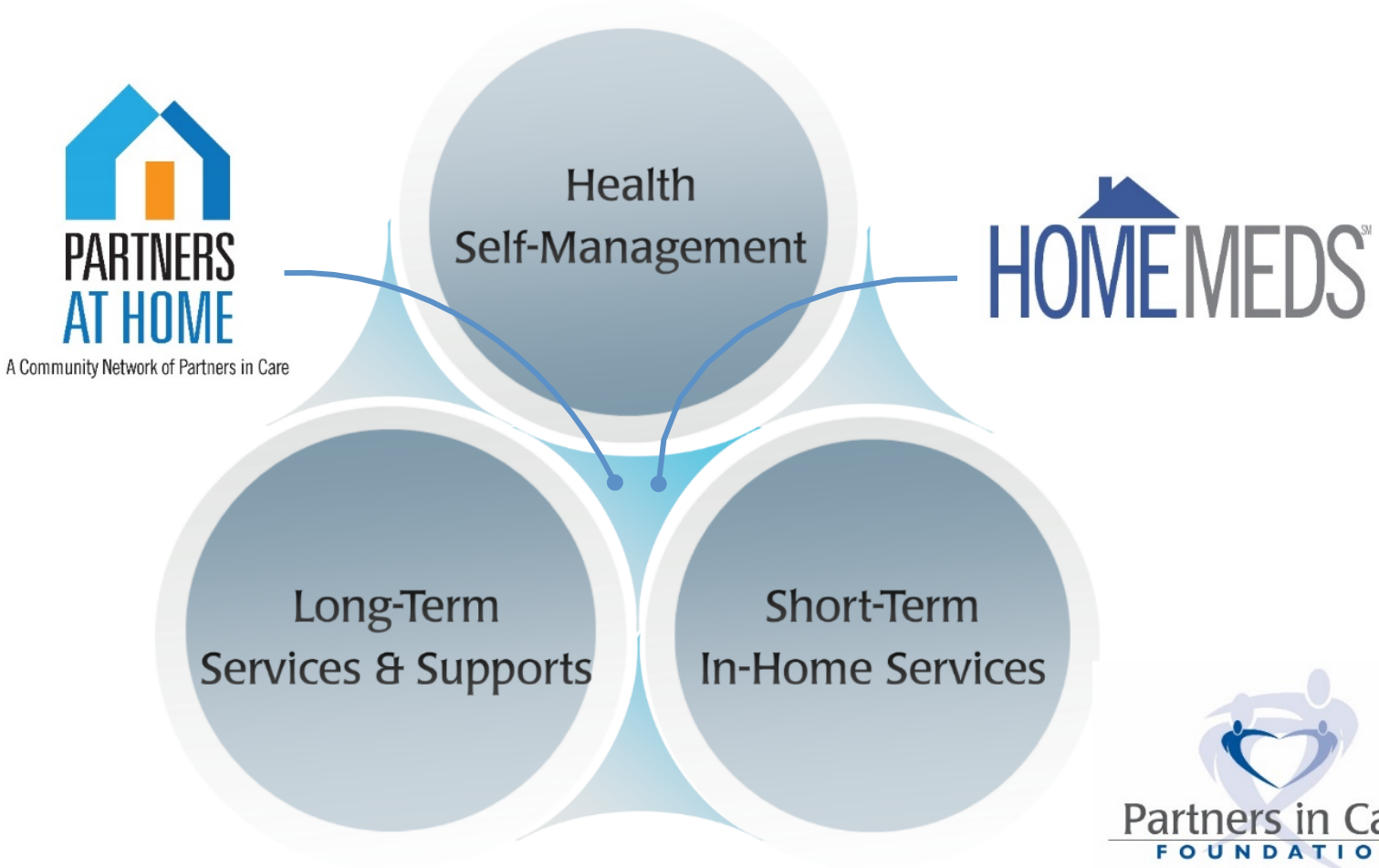
CBO Service Lines: Overview



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CBOs Are "Eyes and Ears" in the Home

- Gather data and information typically not shared in a medical setting or encounter:
  - Comprehensive psychosocial and functional assessment
  - Home safety and fall-risk evaluation
  - Link medication issues with evidence-based pharmacist intervention
  - Advance directives
- Service coordination and connection to benefits/discounts
- Attention to caregivers – education/training, support, respite
- Evidence-based health self-management and fall-prevention workshops

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Community Care Management Structure

- **Comprehensive Psychosocial Assessment**
  - Social determinants of health
  - Home Safety Assessment
  - PHQ9 (Depression Screening Tool)
  - SPMSQ (Mental status questionnaire)
- **HomeMeds**
  - Comprehensive medication inventory
  - Computerized risk assessment and alerts
  - Pharmacist review and recommendations for improvement
- **Person-Centered Care Coordination Plan**
- **30/60/90 day implementation**

Who Delivers Social Care Management

- **Alternative workforce** for non-medical in-home interventions
  - Experienced coach/navigator with a Bachelor's degree in human services
- We're the "eyes and ears" in the home
  - Gather data and information that is not shared in a medical setting or encounter
  - Able to pay close attention to members and caregivers in their home setting, leading to proactive interventions
  - Trust and knowledge of local communities and available resources
  - Cultural/linguistic competence

Medications & Care Transitions

- 72% of post-discharge adverse events are related to medications—and close to 20% of discharged patients suffer an adverse event. *
- Medication reconciliation and risk assessment is a core element of every care transition intervention

*Mary Andrawis, PharmD, CMMI, presentation to Drug Safety Panel, May 10, 2011 (Forster et al. Annals of Internal Medicine. 2003; 128: 161-167./ CMAJ FEB 3, 2004;170-3)

What Electronic Health Records Don't See

Photo sources: stock and other source images

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Medication Non-Adherence Accounts for 30% to 50% of Treatment Failures

- Increases Hospital admissions by 40%
- 89,000 premature deaths could be avoided with adherence

- Source:
  - National Council Medical Director Institute September 2018

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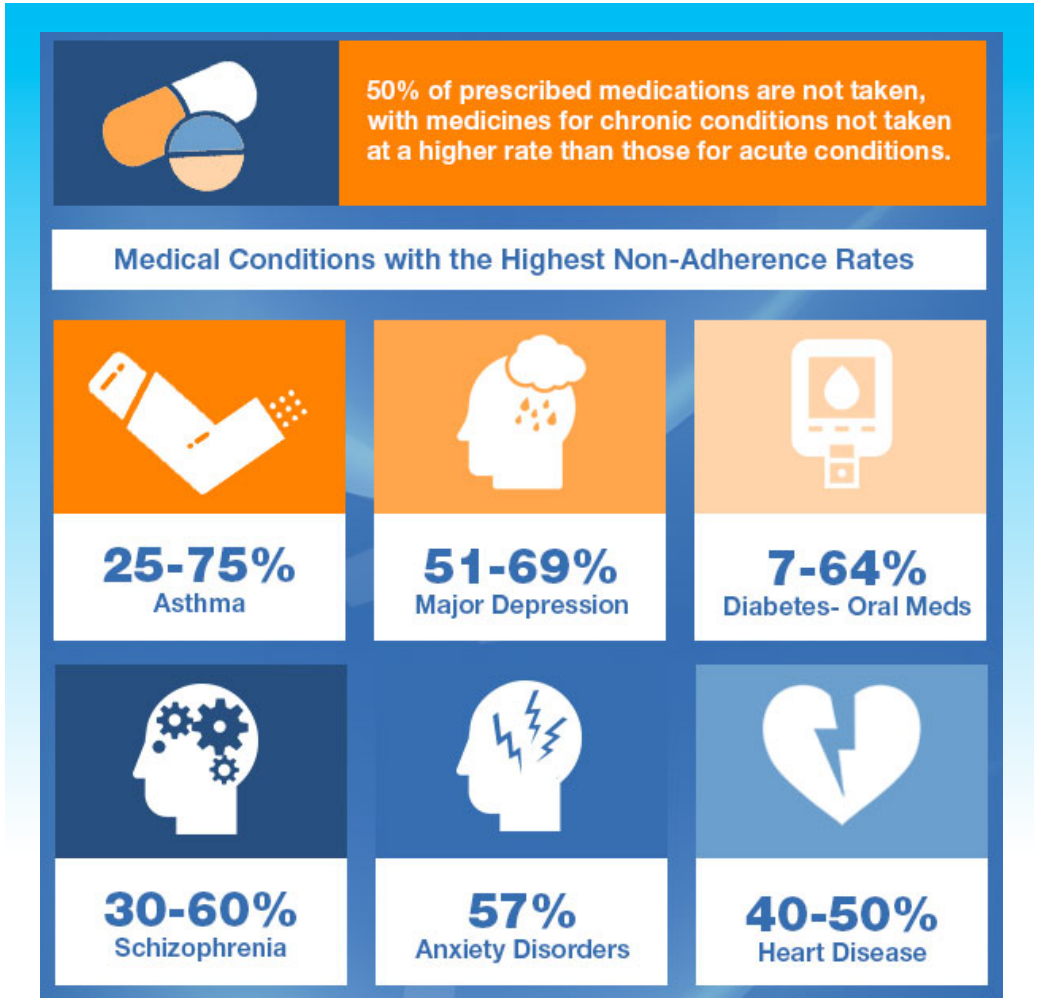
Medication Non-Adherence Rates



Source: MCOL; National Council Medical Director Institute, www.nationalcouncildocs.net

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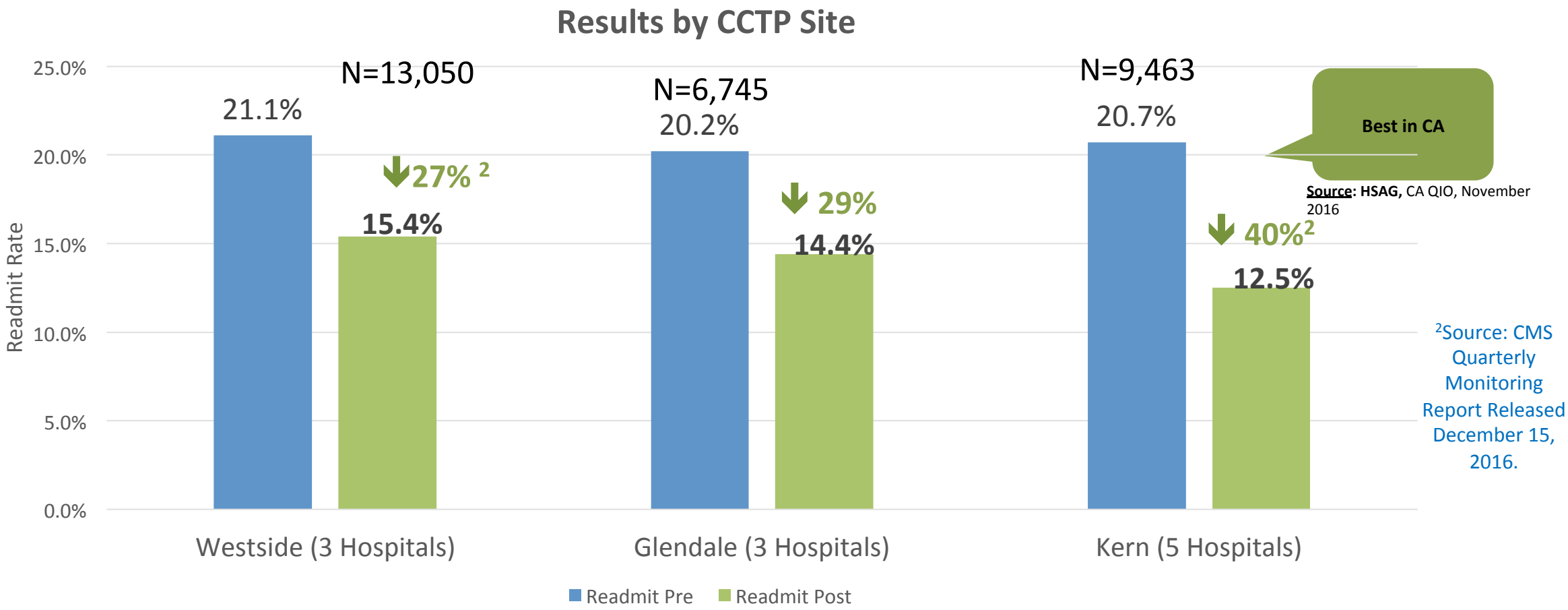
32,000 patients – 16 million saved

Care Transitions: Dr. Eric Coleman's Coaching & Rush University Bridge Models



[2]Source: CMS Quarterly Monitoring Report Released December 15, 2016.

*Program to Date through Jul 2016

[1] Baseline (Pre): All-Cause, All-Condition, Medicare FFS: Westside & Glendale = Jan – Dec 2012; Kern = Apr 2012-Mar 2013

[2] CCTP (Post): Medicare High-Risk FFS Population, Readmission Rate to Date (Westside= May 2013 – Jul 2016; Glendale = May 2013-Mar 2016; Kern = Nov 2013 – Jul 2016

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Outcomes of Partnership with UCLA

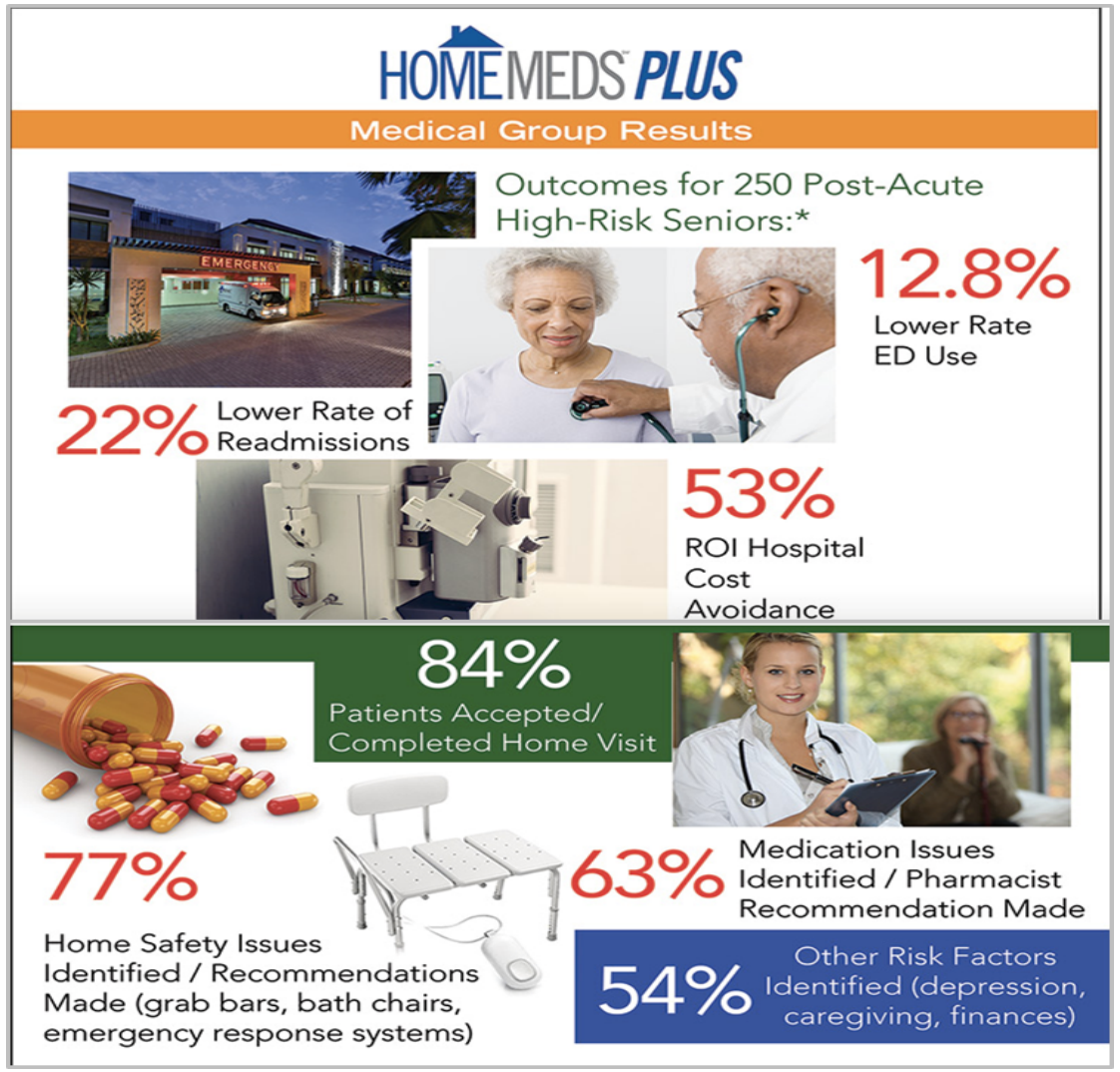
- >8,300 patients helped by *Partners* in CMS-funded Community-based Care Transitions Program
  - Average 34% reduction in readmission rate vs. baseline
  - New propensity-score-matched study found substantial & significant decreases in 30, 60 and 90-day readmissions and 30-day ED use
  - Innovative partnership between health coach and UCLA MyMeds Pharmacists using *Partners'* nationally recognized HomeMeds program
- Over 1,000 Medicare Advantage/Medical Group patients paid by UCLA
  - >60% reduction in pre-post readmission rate within high-risk group

"Concerning the 10 cases that you pulled of the Medicare Advantage intervention:

This appears to be the sort of post-discharge intervention that a high risk patient should receive."

Evidence-Based Programs and Services

Impressive Results for 250 post-acute high-risk seniors for a large SoCal Medical Group



* Compared to patients who did not receive a home visit

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Chronic Disease Self-Management Program (CDSMP) – Clinical Outcomes

- **Population:** 571 union members w/chronic conditions in MCO
- **Intervention**: CDSMP + monthly meetings + incentives
- **Outcomes**:
  - **Compared to baseline, after 12 months**
    - **Self-rated health** good or excellent: 60% vs. 32% at baseline
    - **BMI** ↓ 1 point
    - **A1C** ↓ 1 point
    - **Systolic BP** ↓ 11 points
    - **Depression** score ↓ from 5.8 at baseline to 3.2
    - **Pain** ↓ from 3.2/10 to 2.0/10
  - **Compared to baseline, after 12 months**
    - ↑ **aerobic exercise** from 51 to 75 minutes per week
    - ↑ **stretching/strength** exercise from 21 to 35 minutes per week

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Long Term Supports & Services

- Move to massive Medicaid enrollments of highest risk populations – especially Duals
- Dramatic expenditures over time for homeless, behavioral health, addiction, dementia, disabling conditions
- Move to integrated and supported housing + services – ongoing care coordination

Partners at Home Network:
Delivery System for Integrated Community Care

One Call Does it All!

Why a network?

- Health plans and providers have large service areas
- Offer variety of skills, ethnicities, languages
- Shared accreditation, IT, sales, billing, contract negotiation, compliance, quality
  - Members focus on service provision

Value Proposition

- Improves quality outcomes/HEDIS measures
- Improves after-discharge patient satisfaction
- Manages ED/inpatient throughput
- Improves patient mix – tertiary & quaternary rather than chronic
- Meets new discharge planning requirements in proposed rule CMS-3317-P
- Enhances interprofessional alliances and partnerships

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Programs Contribute to improving Quality/HEDIS Measures and STAR Ratings

- Fall risk management
- Medication reconciliation post-discharge
- Potentially harmful drug-disease interactions
- Blood pressure control
- Antidepressant medication management
- Older adults receive :
  - Advance care planning
  - Medication review
  - Functional status /Home Safety assessment
  - Pain assessment

And, optimize physician performance under MACRA

Providing services through our statewide community network, covering a large geographic footprint

- Care & Service Coordination
- Evidence-based Self-Mgt Workshops
- Comprehensive Assessments
- LTSS: Meals, transportation, home mods, etc.
- HomeMeds/Med Reconciliation
- Behavioral Health Specialists

ACCREDITED NCQA CASE MANAGEMENT

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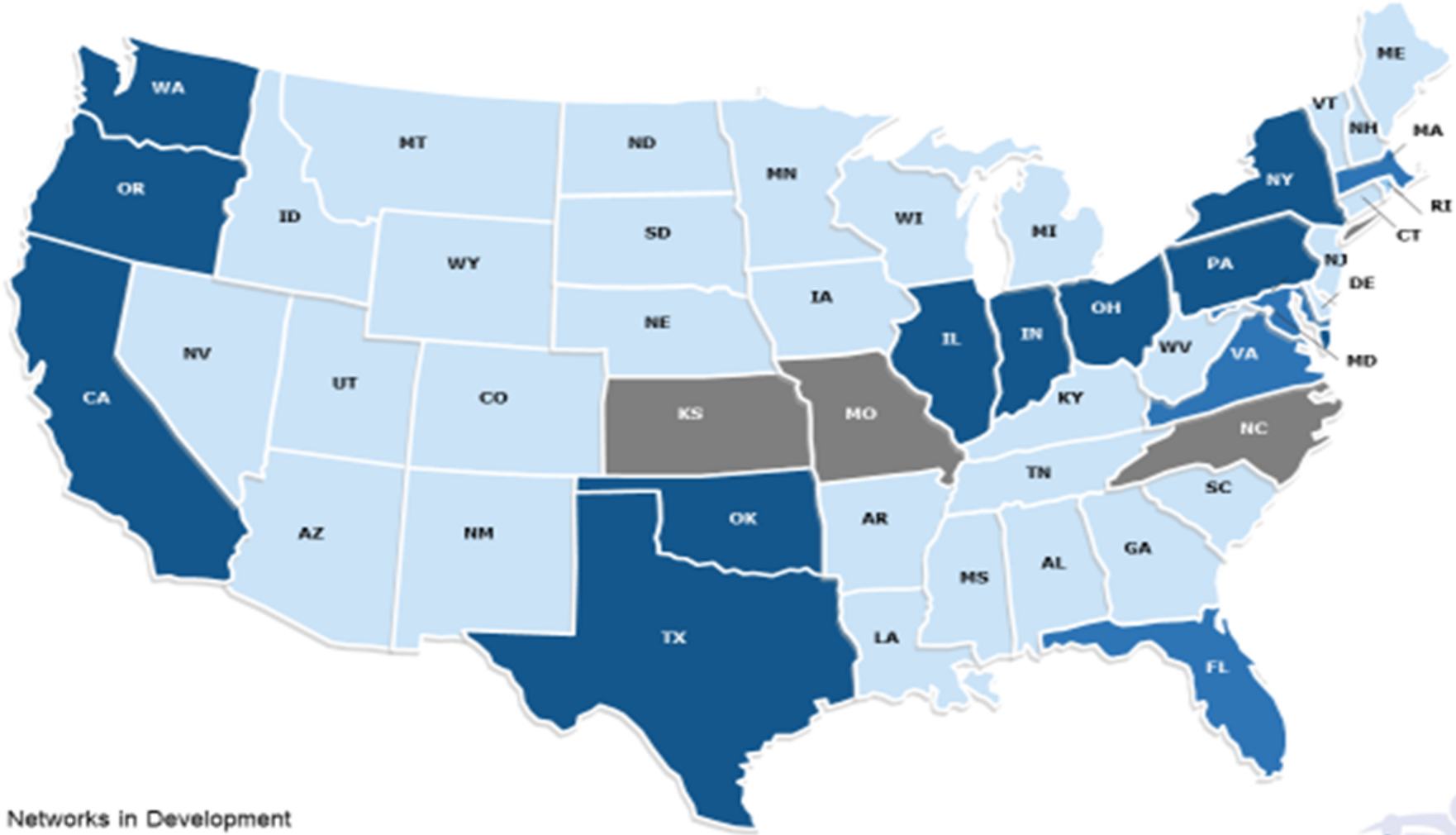
A National Network of Partnerships



Networks in Development

[1] Not a full statewide network

Sources: n4a and Aging & Disability Business Institute

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Now is the time!
CMS: Financial & policy alignment

- **2019 Advance Notice and Call Letter & 2020 CHRONIC Care Act**
  - Expands scope of "primarily health-related supplemental benefit standard" allowing those that "have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee
  - Uniformity: supplemental benefits can be provided to all beneficiaries who meet certain health status criteria
  - Permanently authorizes MA SNP-D & SNP-C
- **Medicare FFS Physician Fee Schedule**
  - Transitional Care Management
  - Chronic Care Management
  - Dementia Assessment & Care Plan
  - Behavioral Health Care Management

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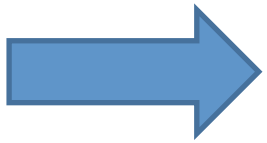
Now is the time!
Population Health &
Value-based Payment

- **Medicaid Waivers**
- **Dual eligible plans**
- **MA SNP-D & SNP-C**



<u>Exactly</u> the populations where SBDOH impede success of medical care and where CBOs excel at providing home and community-based services

Whither goes Medicare…there goes Commercial!

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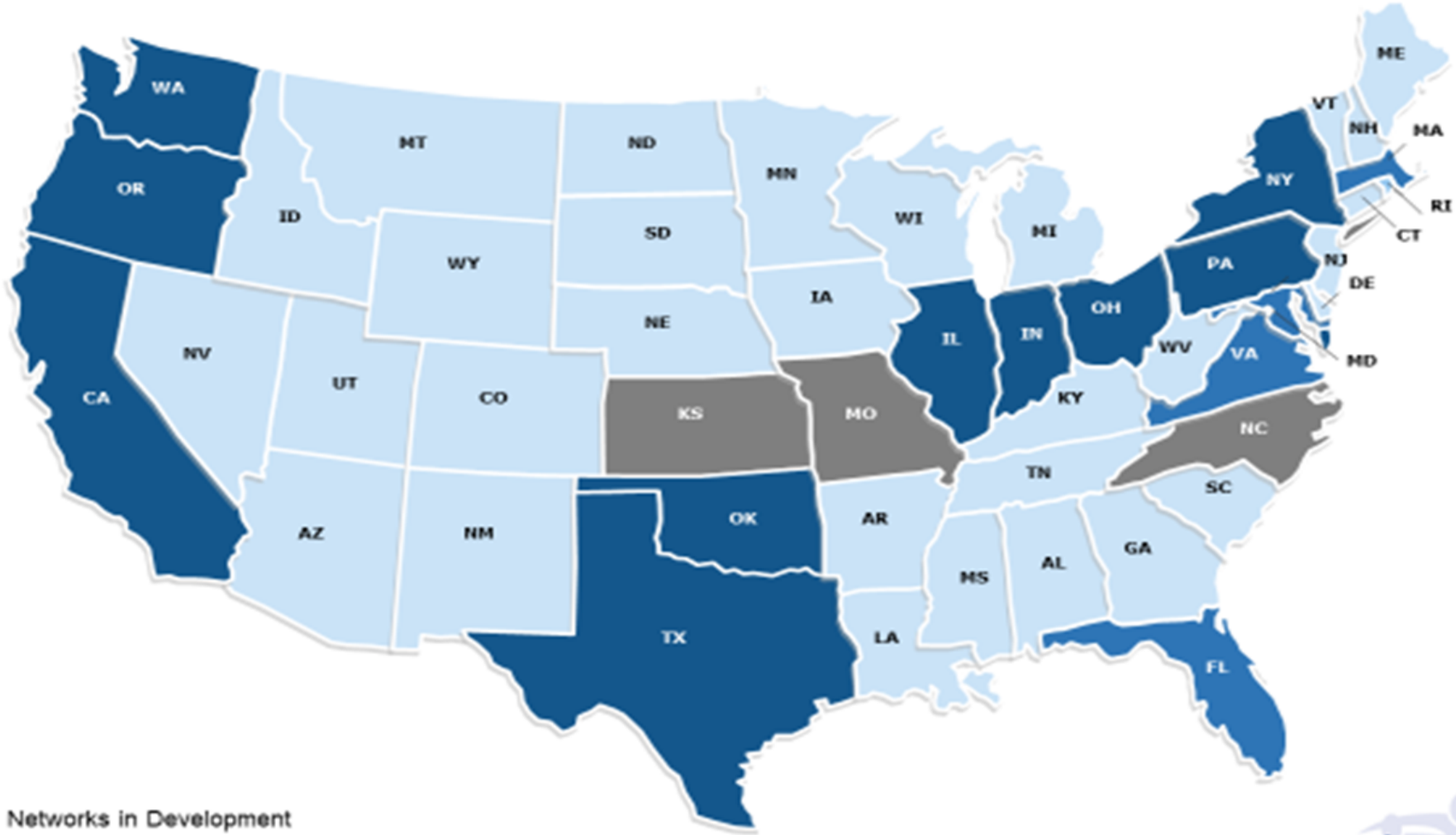
Recognition growing/adoption slow

- These are “foreign” approaches – especially going into homes
- Adoption is occurring – mostly pilots
- True proof of impact requires significant populations
- Too small an intervention group won’t impact population outcomes as fully as needed

A National Network of Partnerships



Networks in Development

[1] Not a full statewide network

Sources: n4a and Aging & Disability Business Institute

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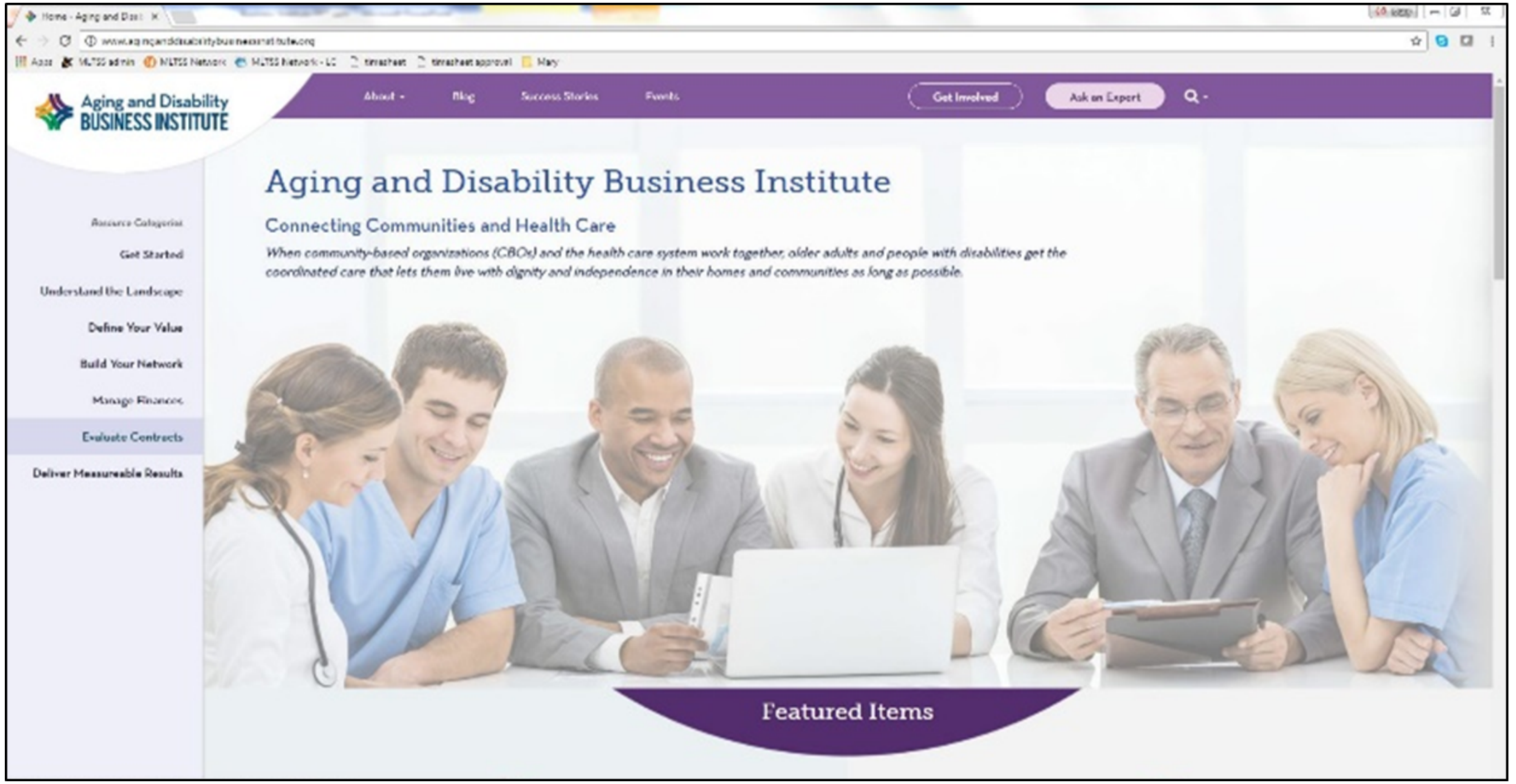
aginganddisabilitybusinessinstitute.org



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Thank you!!

Feel free to follow up for more information with:

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