Partnering for the Future

LAN SUMMIT

Health Care Payment Learning & Action Network

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

OCTOBER 22, 2018 | SHERATON TYSONS HOTEL | TYSONS, VA

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

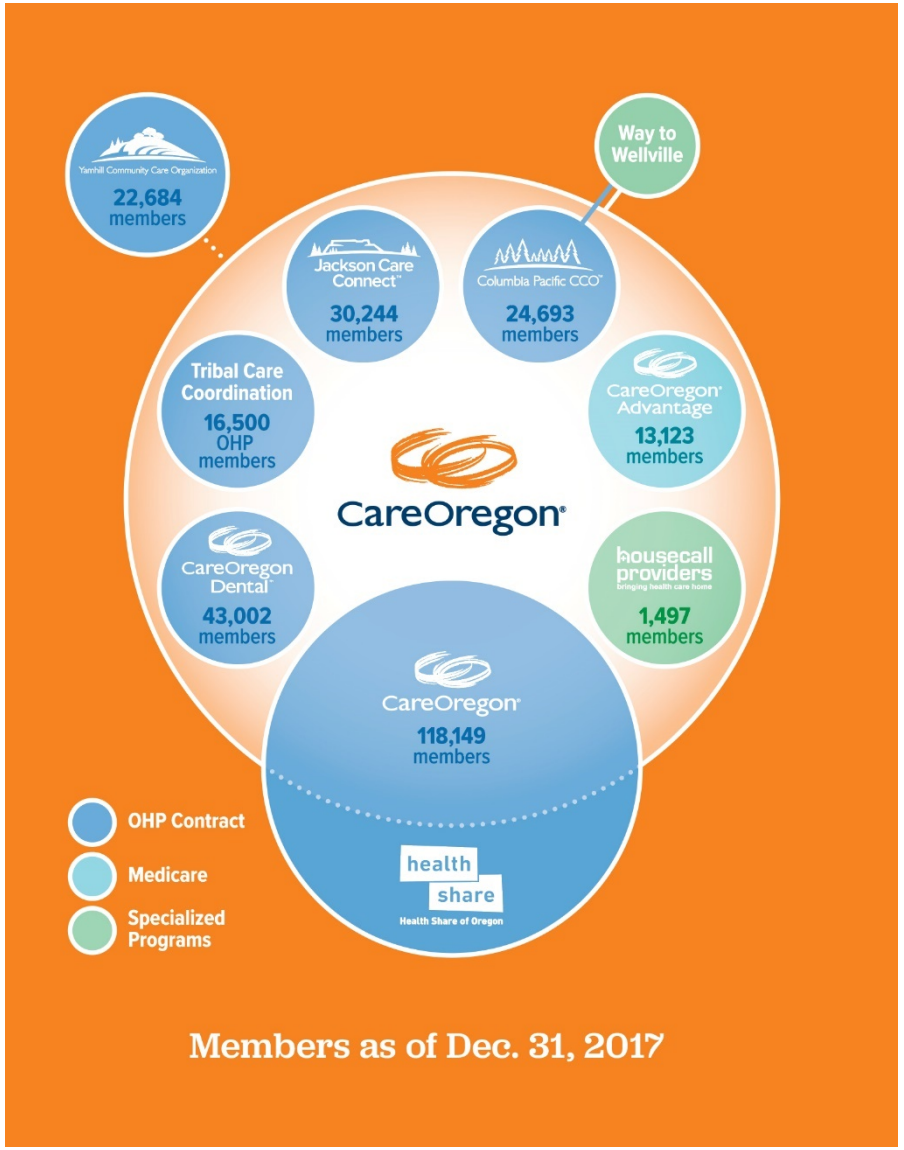
Executive Director of Medicaid and Network Services, CareOregon

CareOregon

CareOregon is a non-profit, public benefit corporation that manages Medicare and Medicaid services for more than 270,00 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



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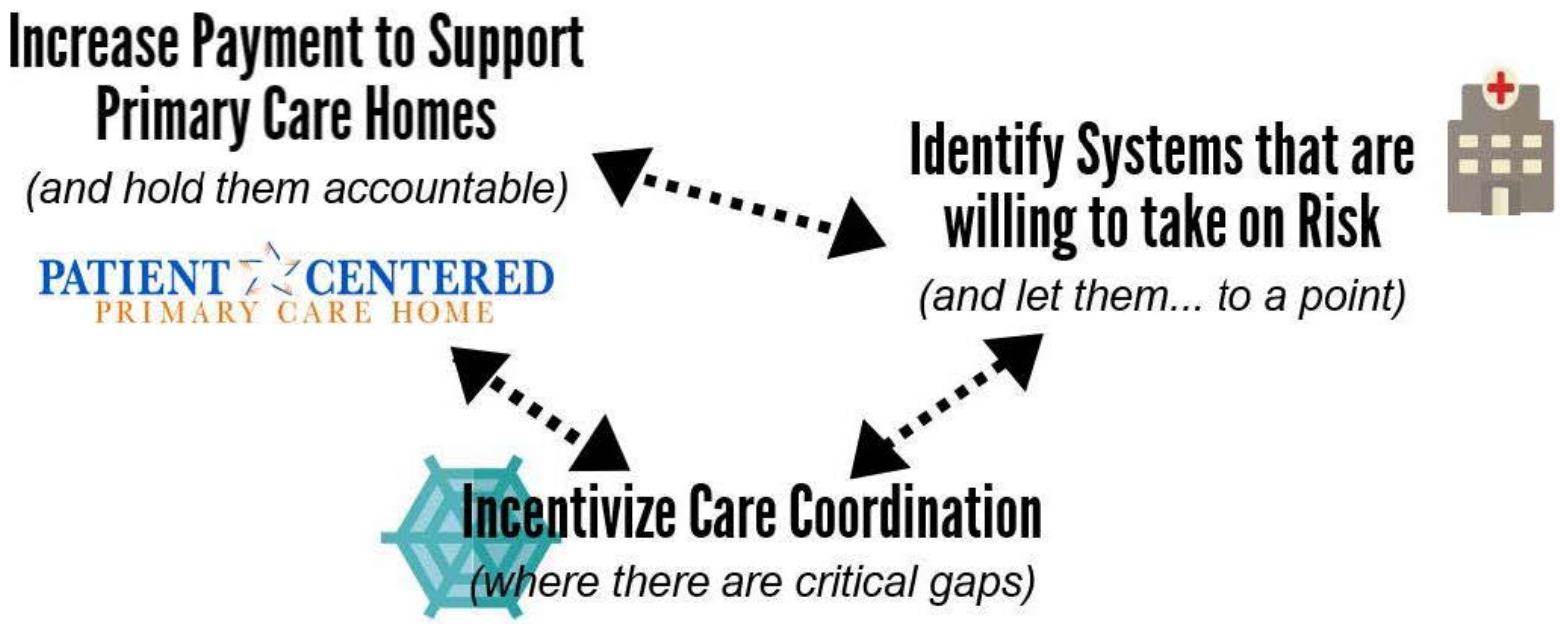
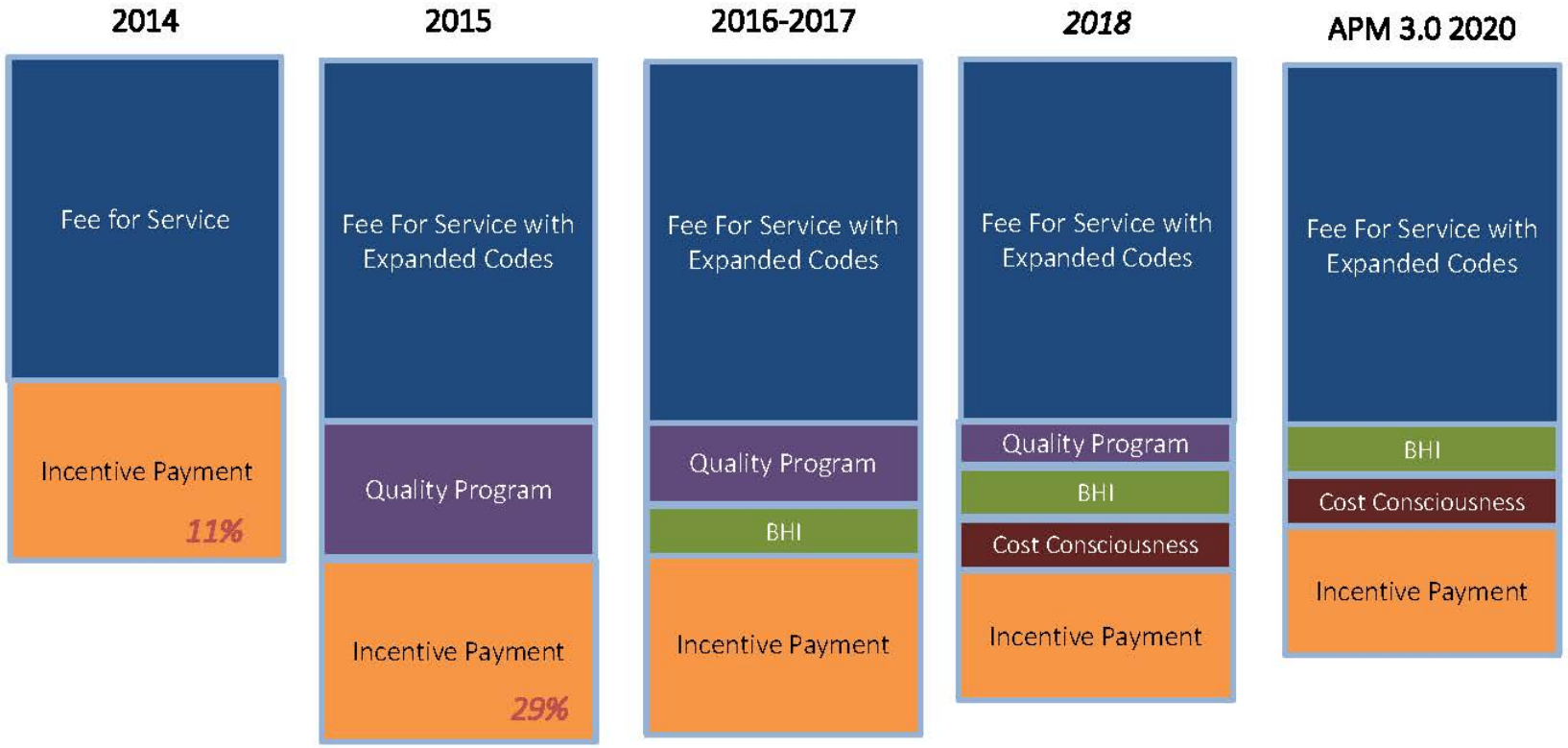
APM Domains


Increase Payment to Support Primary Care Homes
(and hold them accountable)
PATIENT CENTERED PRIMARY CARE HOME
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



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

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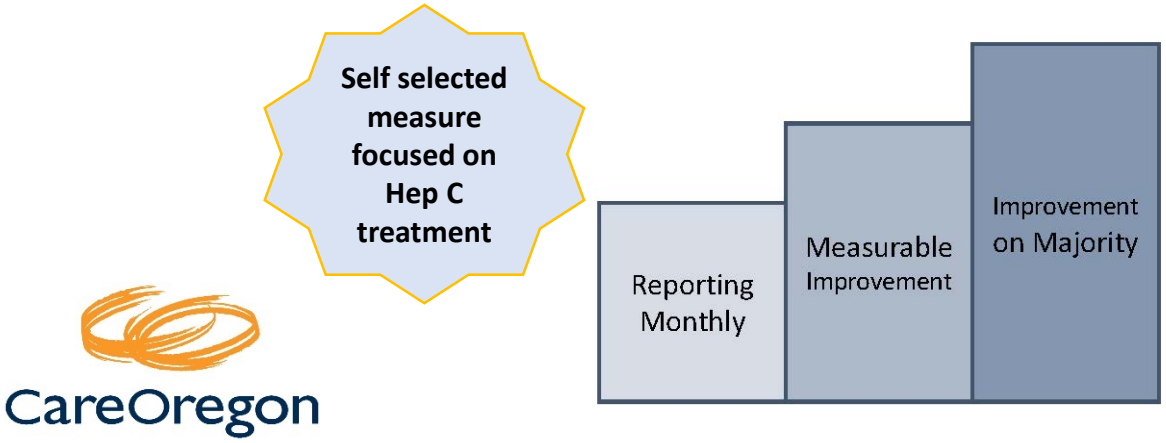
Primary Care Development

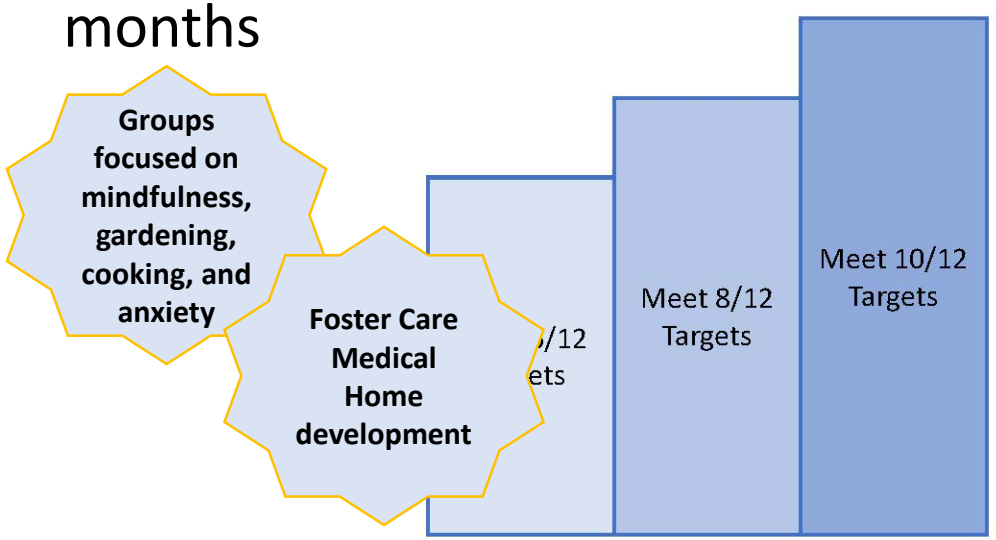
Improvement Focused

- 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



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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

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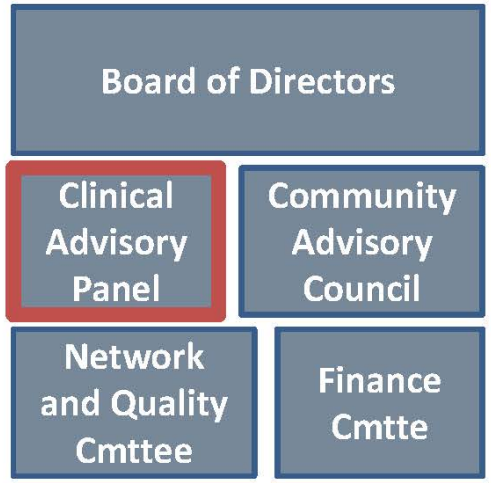
The HOW Matters Most

Portland Metro

Risk Model:

- System level risk contracts
- Shared decision making on underwriting gain

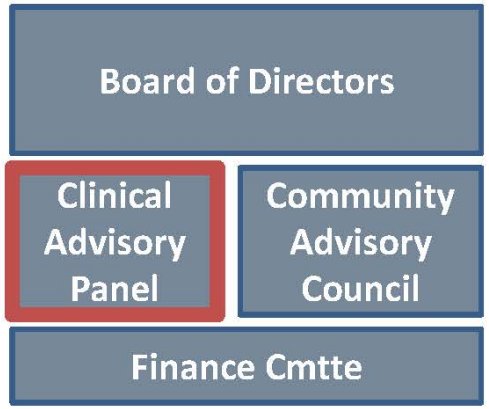
Jackson



Risk Model:

- Shares risk between CCO and CO
- Incentivizes local resource allocation
- MLR target

Columbia Pacific



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

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Welcome

Steven Cha

Chief Medical Officer,
UnitedHealthcare
Community & State

Addressing the Social Determinants of Health

Dr. Steve Cha

Chief Medical Officer, UnitedHealthcare Community & State

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

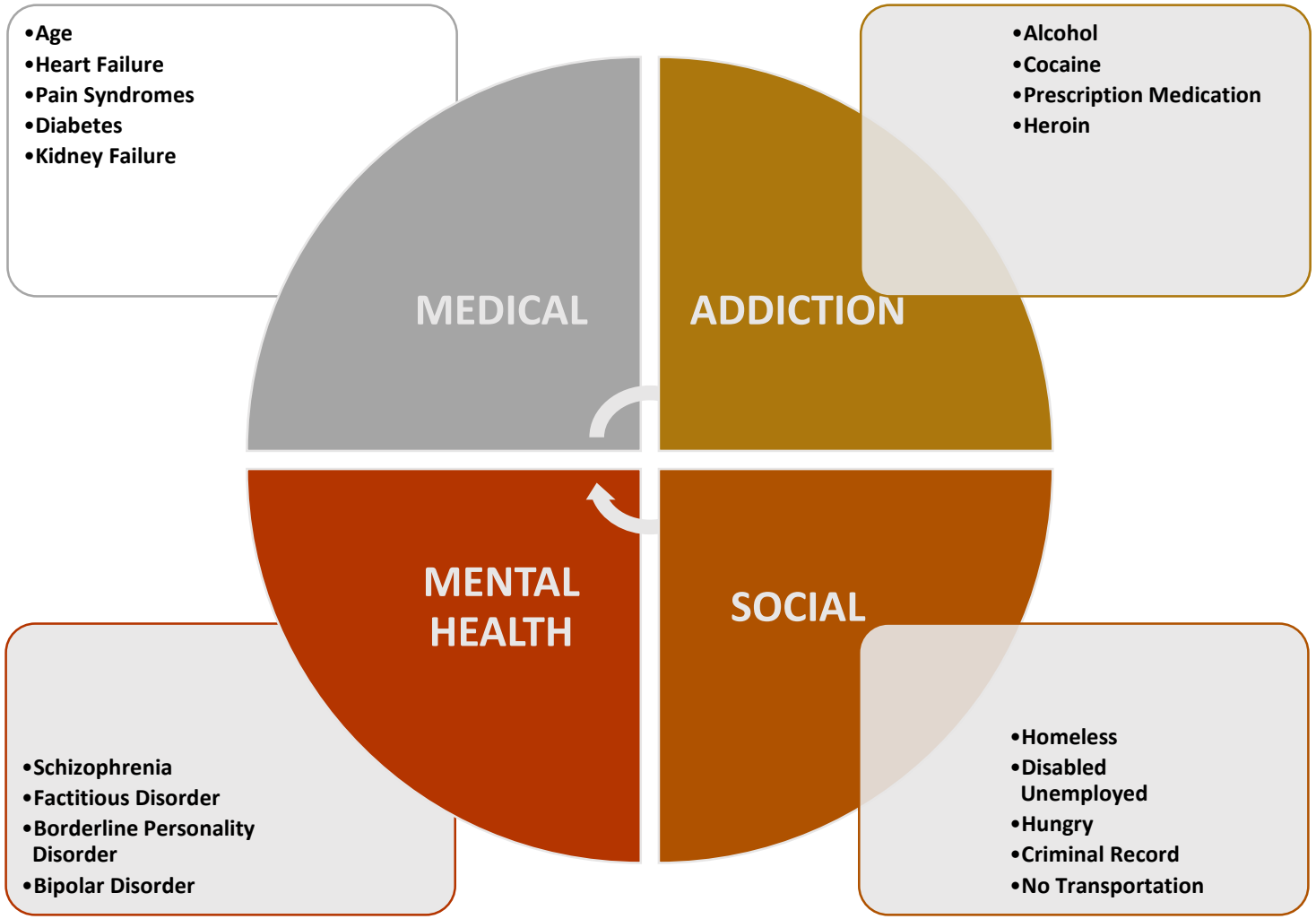
Health care utilization doesn’t equal good health.

A Trend Guiding the Vision

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

	# of Members	Total ER Visits	Avg. ER Visits	Total Admits	Avg. Admits	Total Paid	Average Paid
Not Homeless	305,196	187,433	**0.61**	50,790	**0.17**	$1,163,643,237	$3,813
Homeless (Z59.0)	185	1,008	**5.45**	195	**1.05**	$2,230,321	$12,056

High Acuity Snap Shot



Set-aside Integrated Care Housing Community

Phoenix, AZ

Set-aside Integrated Care Housing Community

myConnections™

- 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

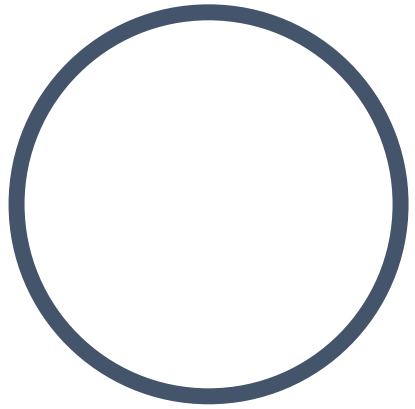
myConnections Outcomes in Arizona

55%

ER visits

71%

hospital admits



81%

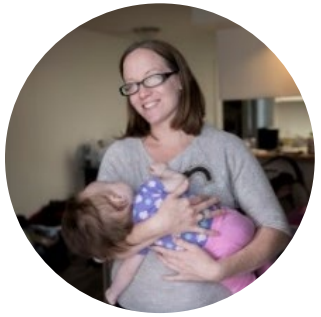
hospital days

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

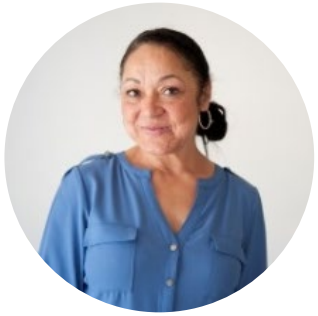
myConnections

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

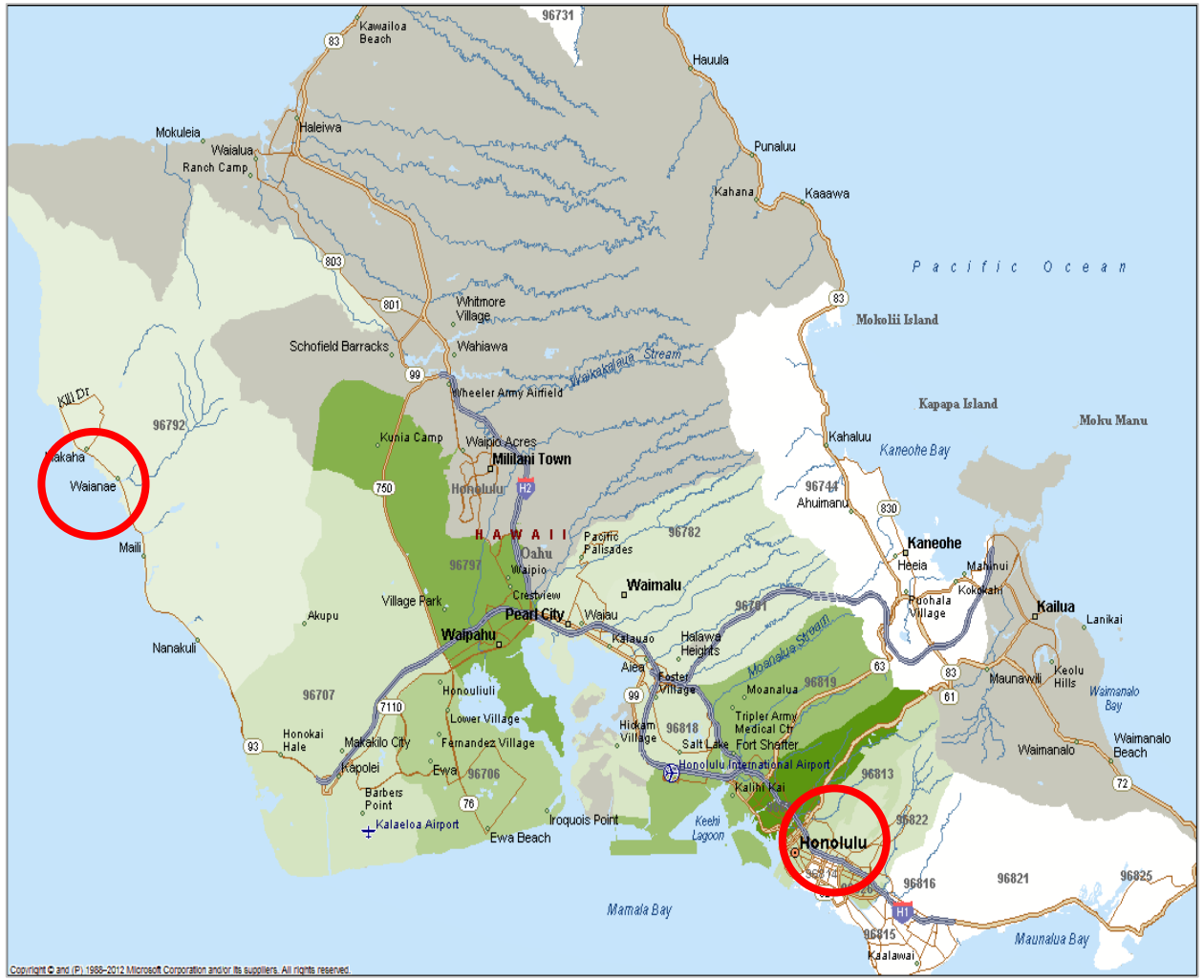
Current Markets

- 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

UnitedHealthcare®
COMMUNITY & STATE

Welcome

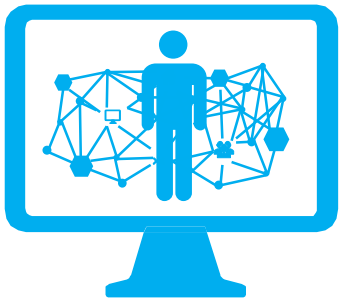
Trenor Williams

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

No infrastructure to address

Dearth of Infrastructure

Payers, providers, and Pharma ALL lack system of measurement, putting $$billions at risk

Our Process

Mine

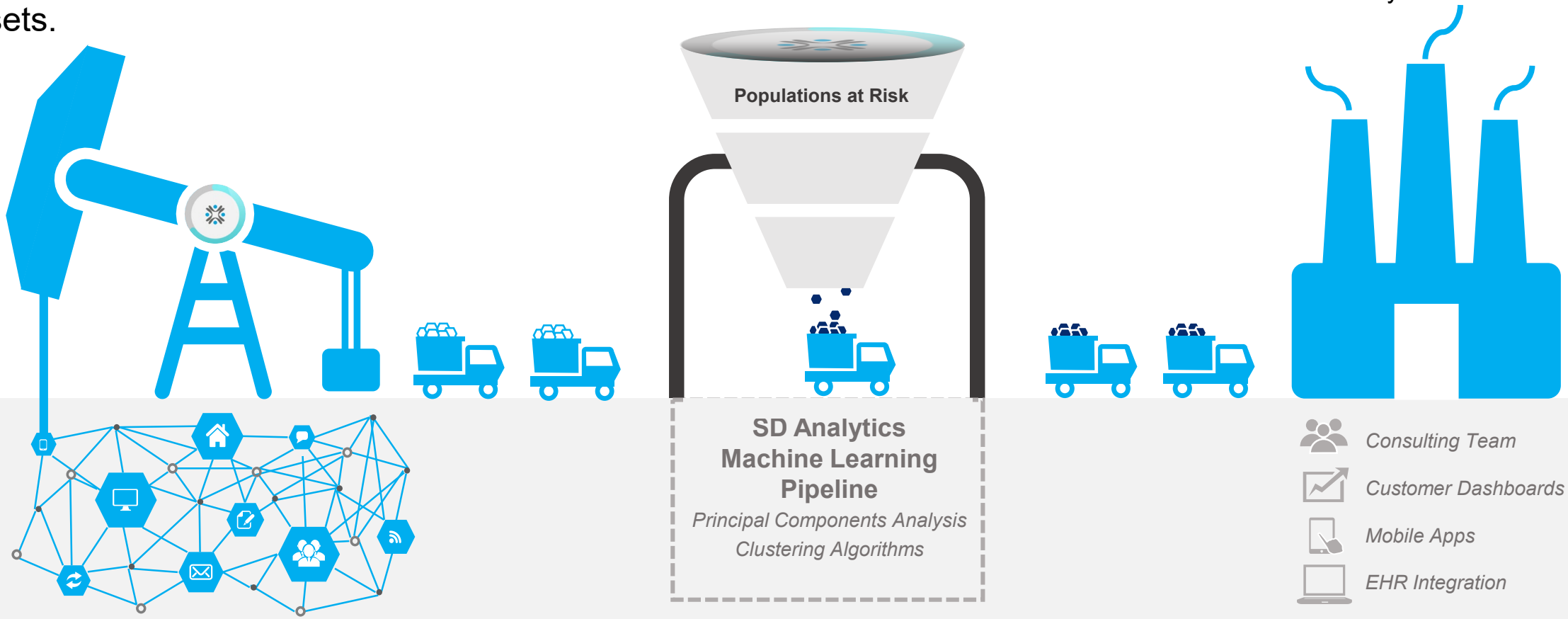
Socially Determined collates EHR information, claims, & commercially available data sets.

Refine

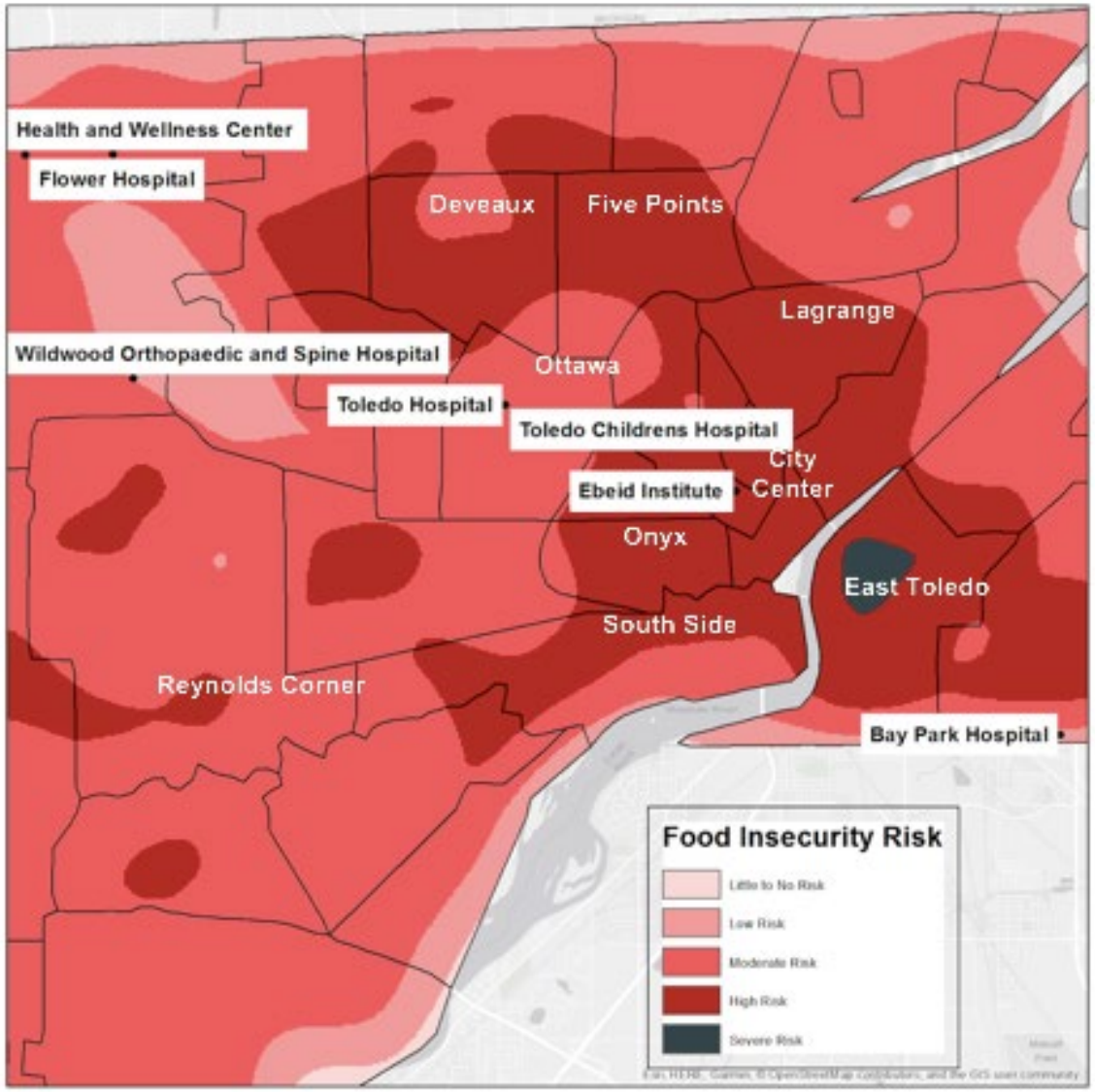
SD's advanced analytics fuse clinical, financial, SDOH, and person data to identify cohorts at risk. and quantify opportunities for intervention.

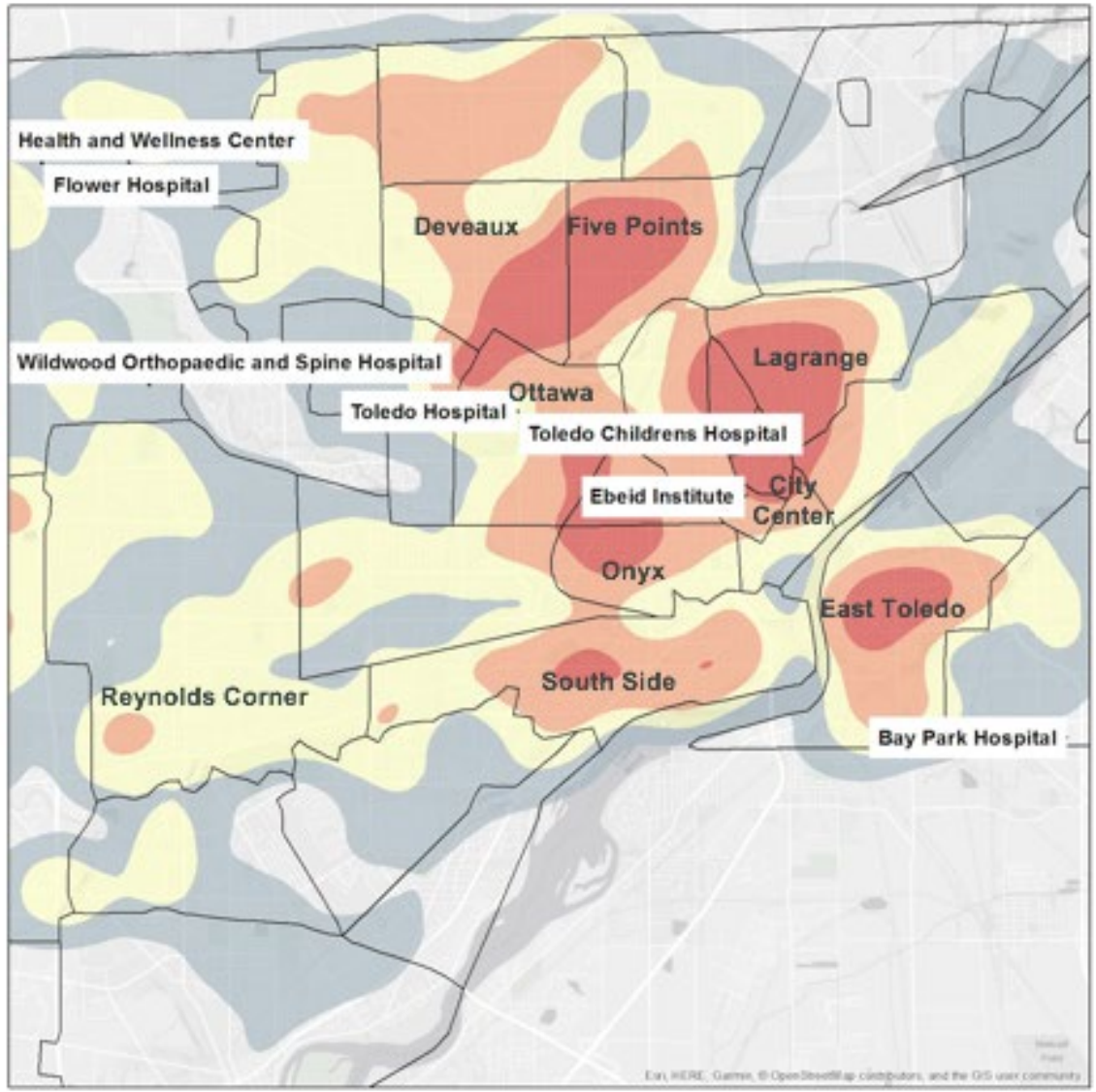
Deploy

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

	Clinical Reality
Makes less than $27,500 per year	1 in 4 have mental illness or substance abuse issues
85% **do not** have bank accounts or credit	Likely has one or more conditions (diabetes, hypertension) complicating pregnancy
Low Educational Attainment	Typically will not attend all pre-natal appointments
40% Evicted **at least** once	Many have a previous child delivered by C-Section
9 out of 10 are **unwed**	

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

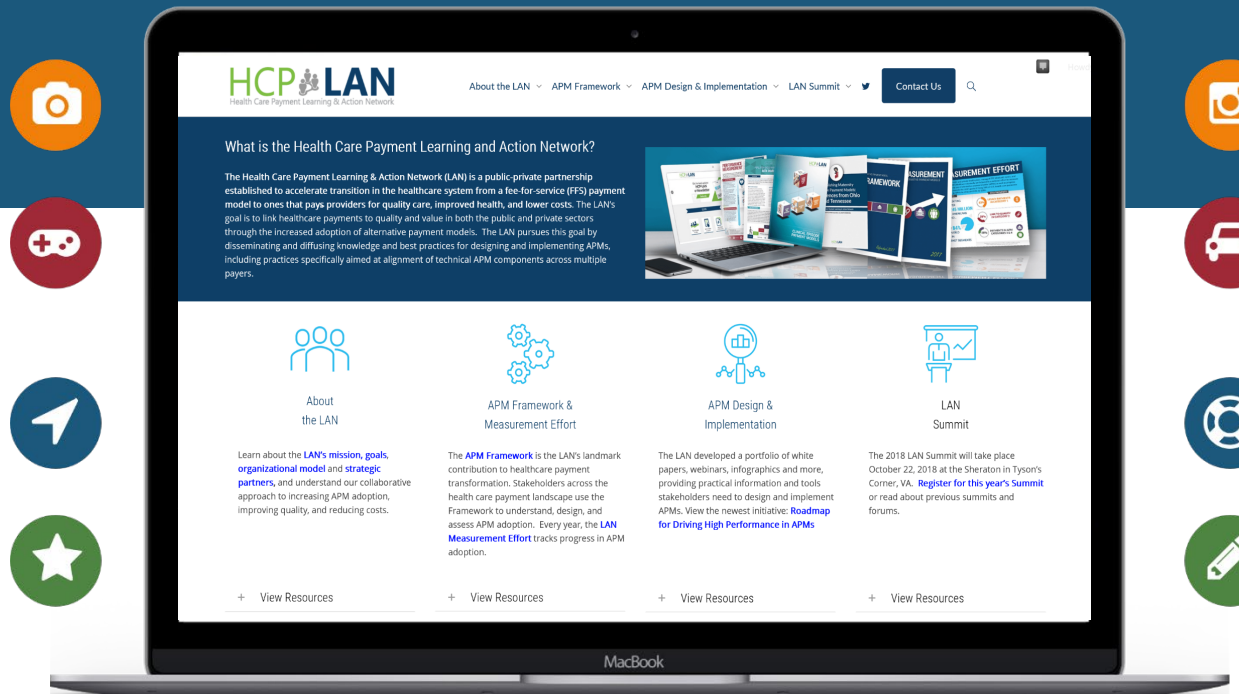
Social Support Networking Center(s) – In-Person and Virtual

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

@Payment_Network

PaymentNetwork@mitre.org

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Thank You!