siren

Social Interventions Research & Evaluation Network

Addressing Patients' Social Needs: Opportunities and Tensions in Community-based Organization-Health Care Collaborations

September 24, 2019

Upcoming Events

National Academies Public Webinar Report Release: Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health

September 25, 8am – 9am PT/11am – 12pm ET

This event will present the new National Academies report, *Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health*. The webinar will include an overview of the report and discussion of the report's findings, recommendations, and key messages.

SIREN & America's Essential Hospitals: Interventions to Decrease Food Insecurity

October 28, 11am – 12pm PT/2pm – 3pm ET

This webinar will explore ways to help meet patients' food insecurity needs. This event will feature SIREN's own Emilia DeMarchis, MD, who will present the results of a systematic review of health-care based food security interventions. She will be joined by Larry Atlier of Lee Health who will share a firsthand account of experience delivering a food security intervention.

Moderator

Tricia McGinnis, MPP, MPH
Center for Health Care Strategies
Vice President and Chief Program Officer

Speakers

Hugh Alderwick
The Health Foundation
Assistant Director of Strategy and Policy

Elena Byhoff, MD, MSc
Tufts Medical Center
Assistant Professor

Medicaid's Focus on Social Determinants

Addressing beneficiaries' social service needs is a key Medicaid strategy for:

- Tackling immediate health-related needs of patients with complex needs
- Managing care for rising risk individuals
- Upstream prevention for kids and healthy adults

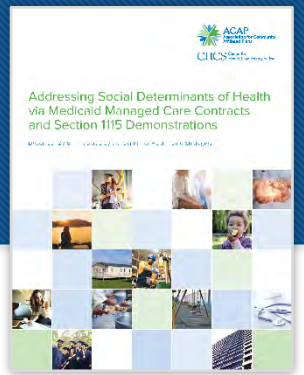
Value-based payment and care models for complex patients are key program drivers

Federal regulations, waivers, and messaging are supporting state innovation and experimentation

Medicaid Regulatory and Policy Context

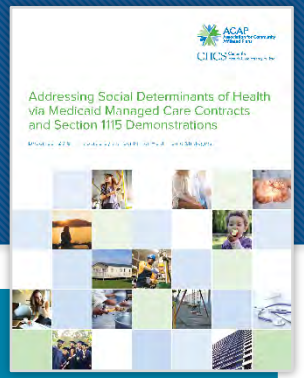
- **2016 managed care regulations** clarified that manage care organizations (MCOs) can pay for SDOH-related activities, including:
  - Community care coordination
  - Value-added services
  - In-lieu-of services
- **1115 Waivers** enable Medicaid to "waive" specific federal program rules
- **State Medicaid levers** can foster partnerships among providers, plans, and community-based organizations (CBOs), including:
  - MCO contracts
  - Delivery system program requirements
  - Financial incentives/value-based payment
  - Quality measurement
  - Rate setting

MCO Contracts and Waivers: Trends in CBO Partnerships



- Most common MCO contract requirements center around screening and referrals
- MCO SDOH contract language is flexible rather than prescriptive
- 23 state contracts require MCO relationships with social service agencies or CBOs to address social needs
- Seven delivery system reform 1115 demonstrations build partnerships with CBOs: CA, MA, NY, NH, NC, RI, and WA

State Examples: CBO Partnerships



Contract (Michigan)

- MCO must enter into agreement with CBOs to "coordinate Population Health improvement strategies[…] which address the socio-economic, environmental, and policy domains; as well as provide services such as care coordination and intensive care management[.]"

1115 (New York)

- Advanced value-based payment arrangements must include one SDOH intervention and one partnership with a CBO.
- MCOs must support SDOH intervention with a funding advance.

What Does the Future Hold?

- Continued innovation to test the right mix of incentives, funding, requirements, technical support, and flexibility needed to advance CBO partnerships
- Research on which state levers are most effective in promoting CBO partnerships
- New federal opportunities and guidance
- Evolving roles of MCOs and providers

Medicaid investments and partnerships to address patients' social needs

Hugh Alderwick
September 2019

Study context and methods

Medicaid reforms in Oregon and California

Oregon

Coordinated care organizations (CCOs) responsible for improving care and reducing costs

Alternative payment models for providers—eg capitation for community health centers

California

Whole Person Care (WPC) pilots to coordinate health care, behavioral health and social services

County partnerships of health care, local government, and community based organizations

Study methods

- **Aim**: understand how Medicaid $s support interventions to address social needs under reforms in Oregon and California
- **Sites**: 6 geographically-based communities—3 in each state
- **Data**: 55 in-depth interviews with:
  - Medicaid payers
  - Government agencies
  - Health care delivery organizations
  - Community-based organizations (CBOs)

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Focused on…

- Intervention content
- Medicaid funding
- Collaboration processes
- Contextual factors

Findings

Interventions and funding

Types of social needs interventions delivered

Direct services
Care coordination
(general and intensive)
Housing supports
Food supports
Legal services
Post-incarceration services

Supported by →

Capacity building
Staff training and new roles
(eg CHWs and peer support)
Strengthening CBOs
Community engagement
Data sharing systems
Case management systems

For: high health care utilizers, high utilizers of multiple services, homeless clients, behavioral health patients

Partnering with CBOs to deliver services

Direct services

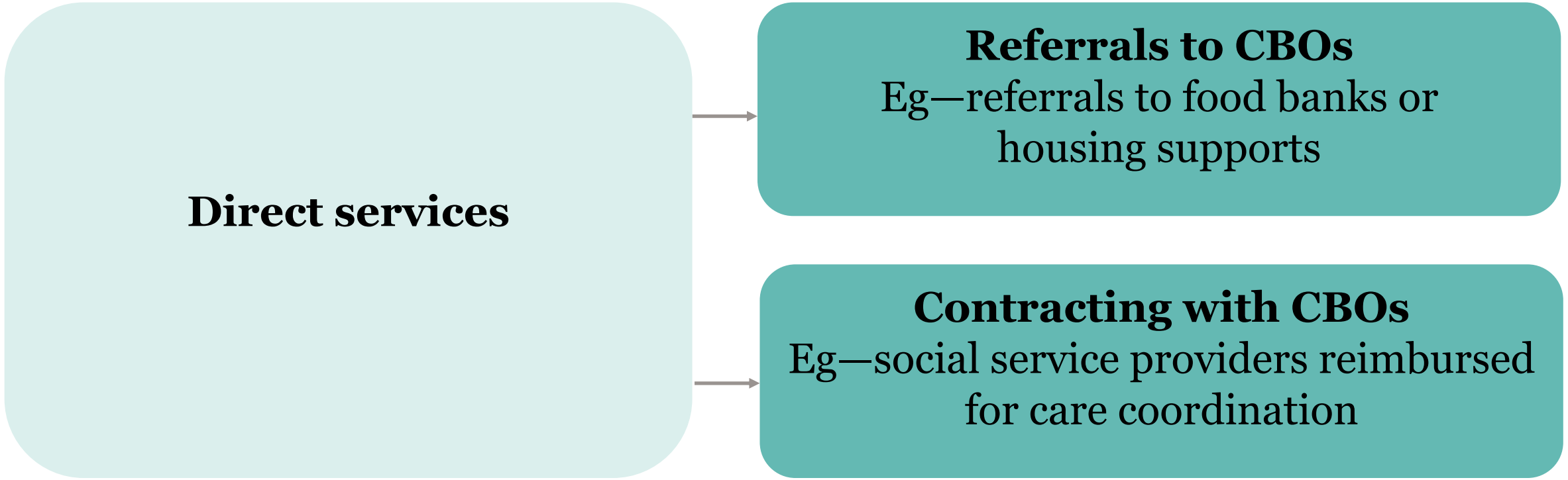
Partnering with CBOs to deliver services

Direct services

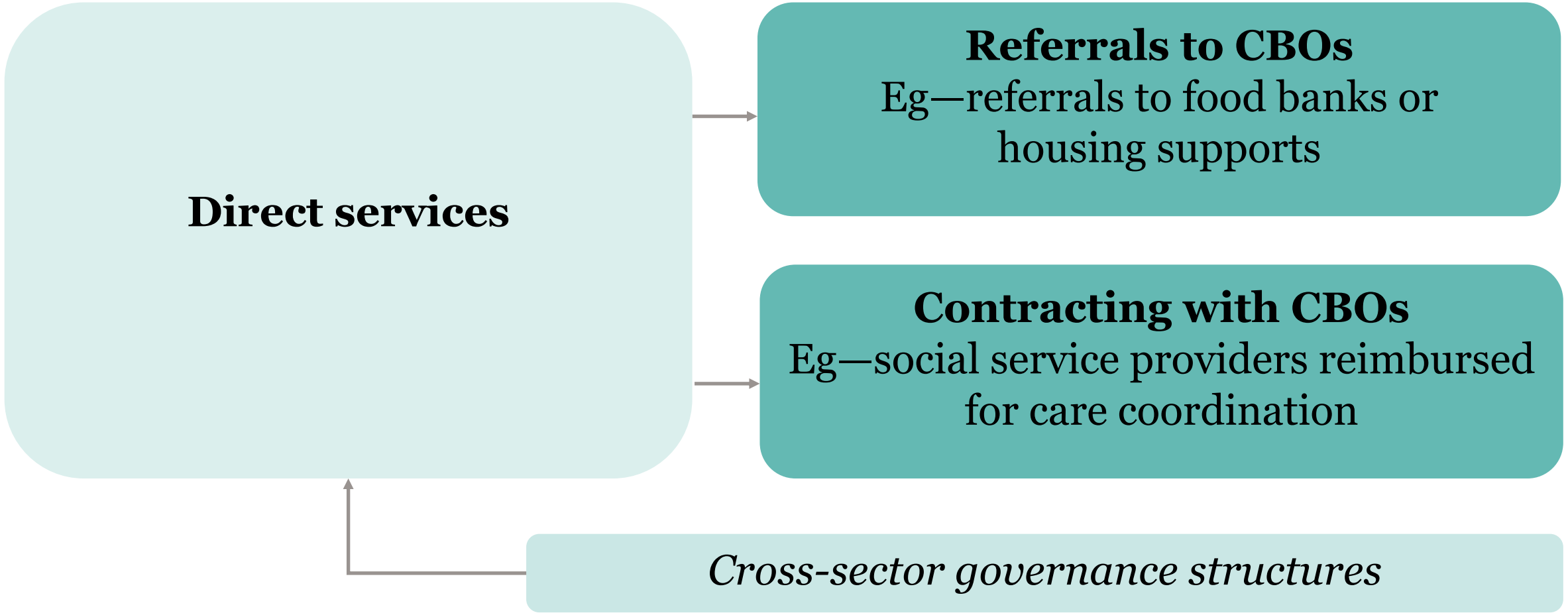
→

Referrals to CBOs
Eg—referrals to food banks or housing supports

Partnering with CBOs to deliver services



Partnering with CBOs to deliver services



Supporting CBOs as organizations

Capacity building

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Supporting existing work
Eg—contributing to costs of local shelter or family relief nursery

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Strengthening CBO capabilities
Eg—investing in new infrastructure, support for managing contracts

Medicaid funding options

Conventional options (eg covered benefits, in-lieu of services, MAA)	**Alternative models** (eg WPC bundled payments, APM in OR)	**Savings** (from Medicaid contracts—eg managed care or WPC)

Less flexible → More flexible

Eg—connections with housing supports	*Eg—intensive care coordination, on-site supports, expenses*	*Eg—new supportive housing units, ongoing rental subsidies*

Findings

Health care-CBO partnerships

Five broad themes

1. Support for collaboration
2. Differences in language, aims, approaches
3. Resource and capability issues
4. Unintended consequences
5. Risk of medicalization

…but levels of partnership in practice varied:

"[we're] right at the beginning of figuring out how to partner with CBOs"

—Health care interviewee

Five broad themes

1. Support for collaboration
2. Differences in language, aims, approaches
3. Resource and capability issues
4. Unintended consequences
5. Risk of medicalization

"we don't need to create 20 new [community health workers]. I have 20. How do I get them credentialed and how do I get them money? […] How do I get […] you to understand that's who they are?"

—CBO interviewee

Five broad themes

1. Support for collaboration
2. Differences in language, aims, approaches
3. **Resource and capability issues**
4. Unintended consequences
5. Risk of medicalization

"They are small organizations with, you know, small HR departments and small finance departments and all of a sudden there, they have these really complicated government contracts"

—Health care interviewee

Five broad themes

1. Support for collaboration
2. Differences in language, aims, approaches
3. Resource and capability issues
4. **Unintended consequences**
5. Risk of medicalization

"So, it cost about $5,000 to get them certified […]. I can't keep spending $5,000 for people to leave […]. I train them, and then they go to work for public entities for more pay and twice the benefits"

—CBO interviewee

Five broad themes

1. Support for collaboration
2. Differences in language, aims, approaches
3. Resource and capability issues
4. Unintended consequences
5. **Risk of medicalization**

"I also really don't believe that the medical system is an efficient one. So it's not like we want to medicalize poverty and start solving it through our clinics and hospitals."

—Health care interviewee

Discussion

Discussion

- Medicaid reforms offer opportunities to fund social interventions and support community partnerships
- Partnerships are complex—and they aren't always successful. Theory can help researchers understand partnership benefits and risks
- Studying impacts beyond the health care system is critical
- Partnerships operate within wider social policy context
- Need to recognize value of CBOs, but also their fragility

Acknowledgements

Co-authors: Carlyn M Hood-Ronick, senior manager, Oregon Primary Care Association; Laura M Gottlieb, associate professor, Department of Family and Community Medicine, UCSF

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MEDICAID

By Hugh Alderwick, Carlyn M. Hood-Ronick, and Laura M. Gottlieb

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HEALTH AFFAIRS 38,
NO. 5 (2019): 774–781

Medicaid Investments To Address Social Needs In Oregon And California

Hugh Alderwick (hugh.alderwick@health.org.uk) is assistant director of policy at the Health Foundation, in London, United Kingdom. He carried out the research for this article when he was a Harkness Fellow and visiting scholar in the Center for Health and Community, University of California San Francisco.

Carlyn M. Hood-Ronick is the senior manager, health equity, at the Oregon Primary Care Association, in Portland.

Laura M. Gottlieb is an associate professor in the Department of Family and Community Medicine, University of California San Francisco.

ABSTRACT Health care organizations across the US are developing new approaches to addressing patients' social needs. Medicaid programs are uniquely placed to support these activities, given their central role in supporting low-income Americans. Yet little evidence is available to guide Medicaid initiatives in this area. We used qualitative methods to examine how Medicaid funding was used to support social interventions in sites involved in payment reforms in Oregon and California. Investments were made in direct services—including care coordination, housing services, food insecurity programs, and legal supports—as well as capacity-building programs for health care and community-based organizations. A mix of Medicaid funding sources was used to support these initiatives, including alternative models and savings. We identified several factors that influenced program implementation, including the local health system context and wider community factors. Our findings offer insights to health care leaders and policy makers as they develop new approaches to improving population health.

Health care organizations across the US are increasingly experimenting with ways to address patients' social needs, such as housing and food insecurity, in an attempt to improve health and control costs.[1] This reflects growing awareness of the social determinants of health and the major role they play in shaping health outcomes.[2–4] At the same time, the growth of accountable care organizations and other value-based payment models has created new opportunities to use health care funding flexibly to improve population health.[5]

State Medicaid programs are uniquely positioned to support activities that address patients' social needs. Medicaid is the largest health insurer for low-income Americans, who disproportionately experience socioeconomic barriers to health.[2] The Affordable Care Act extended Medicaid coverage to previously ineligible populations, such as childless adults, with high rates of housing instability and other social needs.[6] These social needs can increase health care use and costs.[7,8]

Under current Medicaid regulations, all states have the option to pay health care organizations to connect patients with basic social supports, such as food or housing resources. For example, state plan amendments can be used to cover case management services, including assessing patients' social needs and making referrals to nonmedical services.[9] Medicaid managed care organizations may also provide additional social supports not covered under state contracts—for example, "in-lieu-of" services (cost-effective alternatives to covered services) or value-added services (extra supports that will improve care quality or reduce costs).[10]

Policy makers in several states—including California, Colorado, and Oregon—have also used Section 1115 waivers to extend Medicaid's role in addressing patients' social needs beyond

You Can't Scale Unicorns:

Community Based Organizations' Perspectives on Health Care's Entry into Social Determinants of Health Programming

Elena Byhoff, MD MSc

September 24, 2019

Tufts Medical Center

National & state policy trend to align health care and social services

CMS

Accountable Health Communities

WEBINAR

Addressing Social Determinants of Health through Medicaid ACOs: Early State Efforts

Pennsylvania Wants to Use Federal Funds to Cover Poor

By ABBY GOODNOUGH DEC. 6, 2013

WASHINGTON — The governor of Pennsylvania, Tom Corbett, released details on Friday of his proposal to use federal Medicaid funds to buy

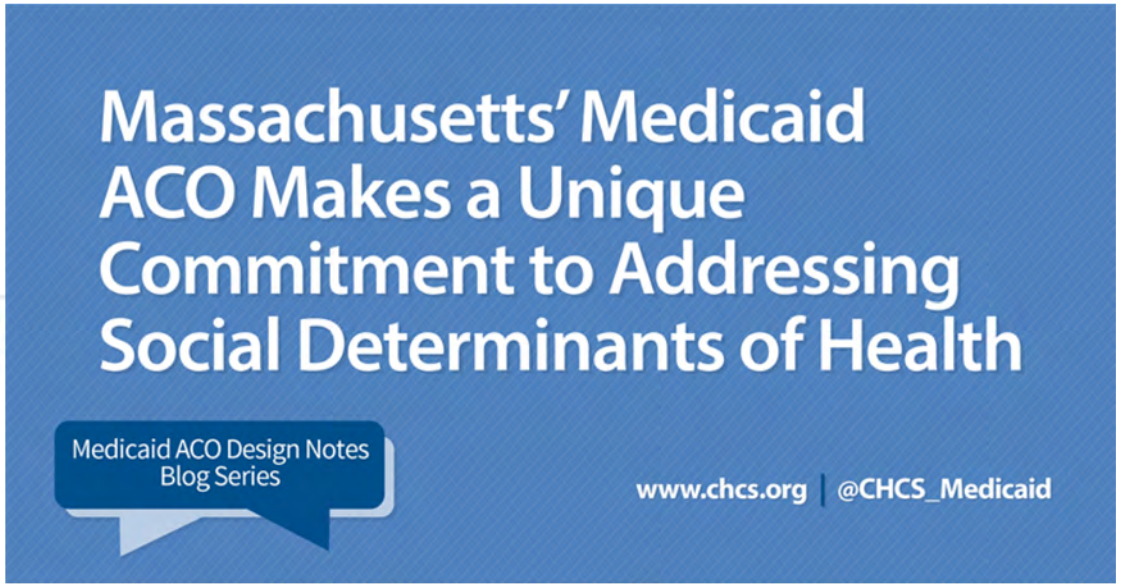
Massachusetts Medicaid Redesign

The Mass. Medicaid Program Is Changing How It Delivers Health Care

March 01, 2018 *Updated Mar 01, 2018 6:36 PM* | By WBUR Newsroom

It's being called the biggest redesign of the Massachusetts Medicaid program in over two decades.

Starting Thursday, more than 800,000 state residents whose health insurance



Partnership Literature to Date

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CULTURE OF HEALTH

By Beth Siegel, Jane Erickson, Bobby Milstein, and Katy Evans Pritchard

Multisector Partnerships Need Further Development To Fulfill Aspirations For Transforming Regional Health And Well-Being

ABSTRACT Regional multisector partnerships involving stakeholders in areas such as public health, health care, education, housing, and others are growing in number. These partnerships are pursuing increasingly comprehensive strategies to transform health and well-being in their communities. Most analyses of these groups rely on self-reports and case studies. These have led many in the field to form optimistic expectations about how well prepared the groups are to lead transformative efforts—that is, how "mature" they are. Few studies have systematically combined data from multiple perspectives to assess partnership characteristics against specific developmental criteria. In 2015–16 we gathered 145 nominations of regions (places) and partnerships with reputations for being relatively mature. Using a three-step assessment procedure, informed by eighty-five interviews with close observers and ten site visits, we found that most of these groups lacked certain characteristics that seem necessary to transform regional health systems. Even the more mature groups were not as well poised for transformation as their reputations implied. Our findings can help correct misperceptions and clarify ways to best support further partnership development.

Improving the health and well-being of all Americans remains elusive, in part because the best efforts to reverse many of the worst trends (such as rising health care costs, entrenched poverty, and social exclusion) have been narrow and disconnected.[1,2] To address this, stakeholders are increasingly embracing multisector collaboration with the goal of improving population health and well-being in their regions. In particular, they are attempting to strengthen connections across what have historically been fragmented health and social systems and exploring comprehensive strategies that will not only reform how health care is delivered but also build healthier, more equitable communities.[3,4]

Because such strategies are broad in scope and integrative by definition, they often are implemented through regional multisector partnerships: place-based reform efforts collaboratively led by stakeholders spanning public health; health care; and other sectors such as education, housing, transit, and social services.[5,6] Previous research suggests that there is a potentially powerful link between the presence of multisector partnerships and improved performance of a regional health system over time.[6,7] However, the urgency and complexity of America's health challenges demand that these alliances deliver not just incremental improvement but truly transformative solutions.

ReThink Health's recent *Progress along the Pathway for Transforming Regional Health: A Pulse Check on Multisector Partnerships* indicates that in

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Community based organization perspective?

Research Question

How are community based organizations (CBOs) perceiving and responding to health care's entry into social determinants of health (SDOH) programming?

Operational Definitions

Community Based Organization (CBO)

Nonprofit groups that work at a local level to improve life for residents and are not focused primarily on health care promotion or delivery.

Social Determinants of Health (SDOH)

Upstream environmental/social factors that influence health (housing, food, employment, safety, etc.)

METHODS

Sampling Frame: Social Service Delivery

Social service delivery organizations
(homeless shelters, food pantries, community centers etc.)

Umbrella social service organizations
(professional associations, feeder organizations etc.)

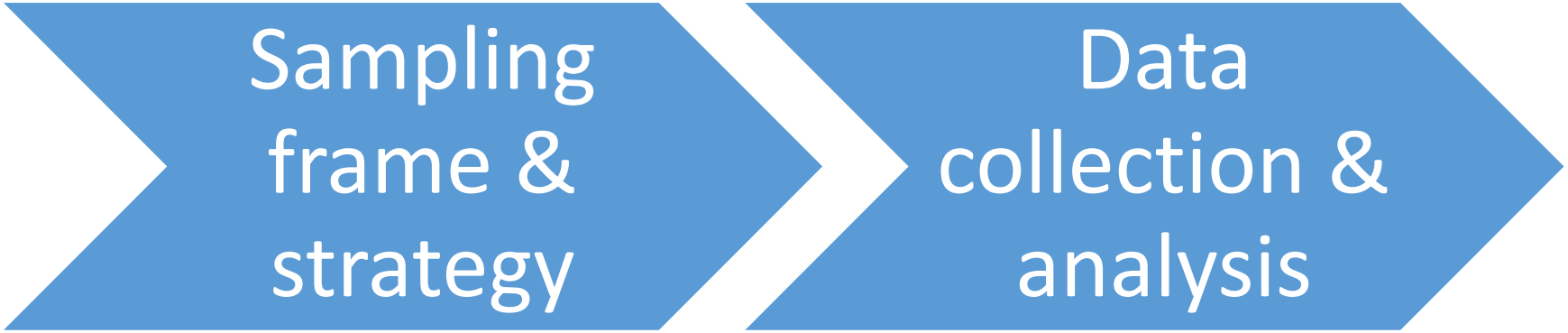
Methods

Sampling frame & strategy

Semi-structured interviews (n=47) with CBO leadership

Purposive sample with snowball strategy

Methods



Data collection from October 2017 to March 2018

Grounded theory approach, comparative coding

Methods

Advisory Board Members:

CBO leadership

Public Health

Health Care

Resulting Sample

Community Based Organization (CBO) Sector	No of People Interviewed
Food	6
Housing	16
Community centers	8
Legal services	2
Multi-service centers	7
Transportation	1
Workforce development	5
Domestic violence	1
Early childhood education	1
Total	**47**

FINDINGS

Five Emergent Themes

1 Health care and CBOs have different values

Outcomes that matter

The Department of Housing and Urban Development (HUD) measures the city on number of new people into homelessness. [So] I don't want Hospital A or Hospital B or anybody sending people here that aren't genuinely homeless. One of the things we worry about is driving our numbers up, inadvertently.

1 Health care and CBOs have different values

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Scale vs. flexibility

I think that the one thread that runs through everything we do is relationship, and I think that the idea of scaling and relationships are at odds.

2 How CBOs perceive health care SDOH strategy

Motivated by funding, ROI

We thought 5 to 10 years ago that it was time to talk to healthcare institutions and it was way too early. They weren't ready yet. Nor was it really in their financial interest. Now it's starting to be.

2 How CBOs perceive health care SDOH strategy

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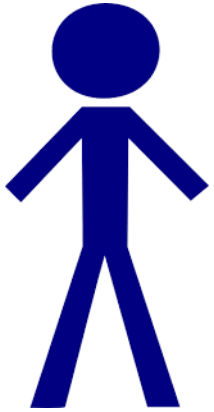


"Not at the table"

Honestly my fear right now, we are so late as a community. Like, quality metrics at MassHealth are being finalized right now. We were not invited to the party.

3 Policy is moving the right direction

Conceptual rationale

It's moving in the right direction. This idea of fracturing a person into medical care, and social care, is ridiculous. It doesn't make common sense, and it's not working. People need this service, and it should be just a part of holistic, patient-centered care.

4 CBOs position themselves to partner with health care

Measuring work in terms of health

…we are changing our metrics. We've gone from pounds of food…more towards healthy meals. When we do that…our numbers change and it's going to take a while for people to understand…that pounds doesn't really capture what we're doing.

4 CBOs position themselves to partner with health care

Creating service line menus

[Health Centers] all have different strengths and infrastructure, so when we offer this three prong program, we do it as a menu of options. We say, "Hey these are the three things that we can offer you, where are you guys at?"

5 Fears, risks or unintended consequences

"Trapped and vaporized"

My concern is that it's a money grab… That there won't be dollars for the services people on the ground need to have positive lived experiences… The medical industry will absorb the resources.

5 Fears, risks or unintended consequences

Loss of intrinsic value; medicalization of CBOs

I'm concerned that health care will want to make this into tight compartments …they'll want to define it, encapsulate it, put borders and boundaries around it and [it] will no longer be a social determinant. It will be a new service line.

IMPLICATIONS

Conclusions

Potential for loss of some intrinsic value of CBOs:

- community organizing & development
- cultural attentiveness
- pursuit of long-run outcomes
- attention to uninsured/ marginal groups

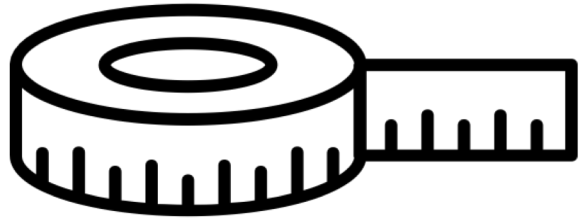
Conclusions

The social service workforce that's going to be partnered with health care… they need to be some special people. I call my team unicorns and I know ***you can't scale unicorns too well****.*

A unicorn is here to see you.

Policy Strategies

Policy & grant flexibility



Common measures

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