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
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

<table>
<thead>
<tr>
<th>Oregon</th>
<th>California</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordinated care organizations (CCOs) responsible for improving care and reducing costs</td>
<td>Whole Person Care (WPC) pilots to coordinate health care, behavioral health and social services</td>
</tr>
<tr>
<td>Alternative payment models for providers—eg capitation for community health centers</td>
<td>County partnerships of health care, local government, and community based organizations</td>
</tr>
</tbody>
</table>
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)
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)

*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

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

**Supported by**

**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
Partnership with CBOs to deliver services

- Direct services

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

- Contracting with CBOs
  Eg—social service providers reimbursed for care coordination
Partnering with CBOs to deliver services

Direct services

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

Contracting with CBOs
Eg—social service providers reimbursed for care coordination

Cross-sector governance structures
Supporting CBOs as organizations

Capacity building
Supporting CBOs as organizations

Capacity building

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

Capacity building

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

Strengthening CBO capabilities
Eg—investing in new infrastructure, support for managing contracts
# Medicaid funding options

<table>
<thead>
<tr>
<th>Conventional options</th>
<th>Alternative models</th>
<th>Savings (from Medicaid contracts—eg managed care or WPC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(eg covered benefits, in-lieu of services, MAA)</td>
<td>(eg WPC bundled payments, APM in OR)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Less flexible</th>
<th>More flexible</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eg</strong>—connections with housing supports</td>
<td><strong>Eg</strong>—intensive care coordination, on-site supports, expenses</td>
</tr>
</tbody>
</table>
Findings
Health care-CBO partnerships
### Five broad themes

<table>
<thead>
<tr>
<th>1</th>
<th>Support for collaboration</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Differences in language, aims, approaches</td>
</tr>
<tr>
<td>3</td>
<td>Resource and capability issues</td>
</tr>
<tr>
<td>4</td>
<td>Unintended consequences</td>
</tr>
<tr>
<td>5</td>
<td>Risk of medicalization</td>
</tr>
</tbody>
</table>

...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
<table>
<thead>
<tr>
<th>Five broad themes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Support for collaboration</td>
<td>“They are small organizations with, you know, small HR departments and small finance departments and all of a sudden there, they have these really really complicated government contracts”</td>
</tr>
<tr>
<td>2. Differences in language, aims, approaches</td>
<td></td>
</tr>
<tr>
<td>3. Resource and capability issues</td>
<td></td>
</tr>
<tr>
<td>4. Unintended consequences</td>
<td></td>
</tr>
<tr>
<td>5. Risk of medicalization</td>
<td></td>
</tr>
</tbody>
</table>

—Health care interviewee
## Five broad themes

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Support for collaboration</td>
<td>“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”</td>
</tr>
<tr>
<td>2</td>
<td>Differences in language, aims, approaches</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Resource and capability issues</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Unintended consequences</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Risk of medicalization</td>
<td></td>
</tr>
</tbody>
</table>

—CBO interviewee
**Five broad themes**

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>Support for collaboration</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Differences in language, aims, approaches</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Resource and capability issues</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Unintended consequences</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Risk of medicalization</td>
<td></td>
</tr>
</tbody>
</table>

“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

**Funders:** the research presented here was funded by the Commonwealth Fund and the Blue Shield of California Foundation, and carried out while Hugh was a Harkness Fellow at UCSF.
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
National & state policy trend to align health care and social services

Pennsylvania Wants to Use Federal Funds to Cover Poor

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

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

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

<table>
<thead>
<tr>
<th>Community Based Organization (CBO) Sector</th>
<th>No of People Interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food</td>
<td>6</td>
</tr>
<tr>
<td>Housing</td>
<td>16</td>
</tr>
<tr>
<td>Community centers</td>
<td>8</td>
</tr>
<tr>
<td>Legal services</td>
<td>2</td>
</tr>
<tr>
<td>Multi-service centers</td>
<td>7</td>
</tr>
<tr>
<td>Transportation</td>
<td>1</td>
</tr>
<tr>
<td>Workforce development</td>
<td>5</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>1</td>
</tr>
<tr>
<td>Early childhood education</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>47</strong></td>
</tr>
</tbody>
</table>
FINDINGS
Five Emergent Themes

1. Health care and CBOs have different values
2. How CBOs perceive health care SDOH strategy
3. Policy is moving the right direction
4. CBOs position themselves to partner with health care
5. Fears, risks or unintended consequences
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.
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.

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.
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.
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.

“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.
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.
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.
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?”
“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.
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.
Policy Strategies

- Policy & grant flexibility
- Common measures
Acknowledgements

Co-Investigator
Lauren Taylor MPH MDiv, Harvard Business School

Funder
Blue Cross Blue Shield of MA Foundation
Kaitlyn Kenney Walsh & Jessie Gottsegen

Advisory Board
Robert Torres, Lisa Schorr Kaplan, Paul Hattis, Chris Sieber, Jean Terranova, Megan Sandel, Joanne Hilferty
Questions?

Follow up:

ebyhoff@tuftsmedicalcenter.org

@elenabyhoff
Questions?
Connecting with SIREN

Website: sirenenetwork.ucsf.edu
Email: sirenen@ucsf.edu
Twitter: @SIREN_UCSF
LinkedIn: Social Interventions Research & Evaluation Network