Previous PTAC Proposal Submitter and Subject Matter Experts Listening Session on Payment and Data Issues Related to SDOH and Equity

Previous Submitter

- **Sarah L. Szanton, PhD, ANP, FAAN**, Patricia M. Davidson Health Equity and Social Justice Endowed Professor, Director, Center on Innovative Care in Aging, Johns Hopkins School of Nursing and **Kendell M. Cannon, MD**, Clinical Assistant Professor, Stanford School of Medicine, CERC Scholar, Stanford Clinical Excellence Research Center: *Community Aging in Place – Advancing Better Living for Elders (CAPABLE) Provider-Focused Payment Model* proposal

Subject Matter Experts

- **Jacob Reider, MD, FAAFP**, CEO, Huddle Health
- **Robert Phillips, MD, MSPH**, Executive Director, The Center for Professionalism & Value in Health Care
- **Toniann Richard**, CEO, Health Care Collaborative of Rural Missouri
- **Michael Hochman, MD, MPH,** CEO, Healthcare in Action (A Scan Group Member Organization)

Community Aging in Place-Advancing Better Living for Elders (CAPABLE) Provider Focused Payment Model

For information about PTAC's review of the *Community Aging in Place-Advancing Better Living for Elders (CAPABLE) Provider Focused Payment Model* proposal, visit the ASPE PTAC website: https://aspe.hhs.gov/collaborations-committees-advisory-groups/ptac/ptac-proposals-materials

- Preliminary Review Team Presentation
- Preliminary Review Team Report
- Report to the Secretary
- Public Comments
- Additional Information or Analysis
  (including an environmental scan and annotated bibliography)

CAPABLE reduces disability, improves SDOH, saves costs

Sarah Szanton, PhD, NP, FAAN

Kendell Cannon, MD

September 27, 2021

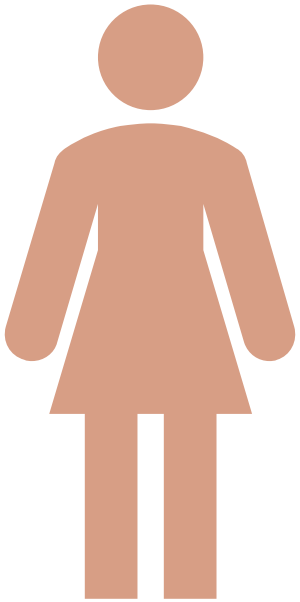
Meet Mr. A – a real CAPABLE client

Mr. A is a 75-year-old Veteran living at home. He has diabetes and was recently hospitalized for a small stroke, and before CAPABLE, had difficulty bathing. He has both Medicare and Medicaid coverage (i.e., dual eligibility).

Mr. A’s CAPABLE Success Story



CAPABLE addresses person and environment



Person's goals ↑ ability, address social determinants

CAPABLE is delivered in the home over 4 months by a team including:

Registered Nurse

Occupational Therapist

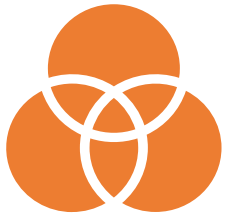
Handyworker

Participant

Health equity and social determinants through standardized tailoring

Home-based

Goals and self-efficacy



Integrated team

Data to address SDOH and equity

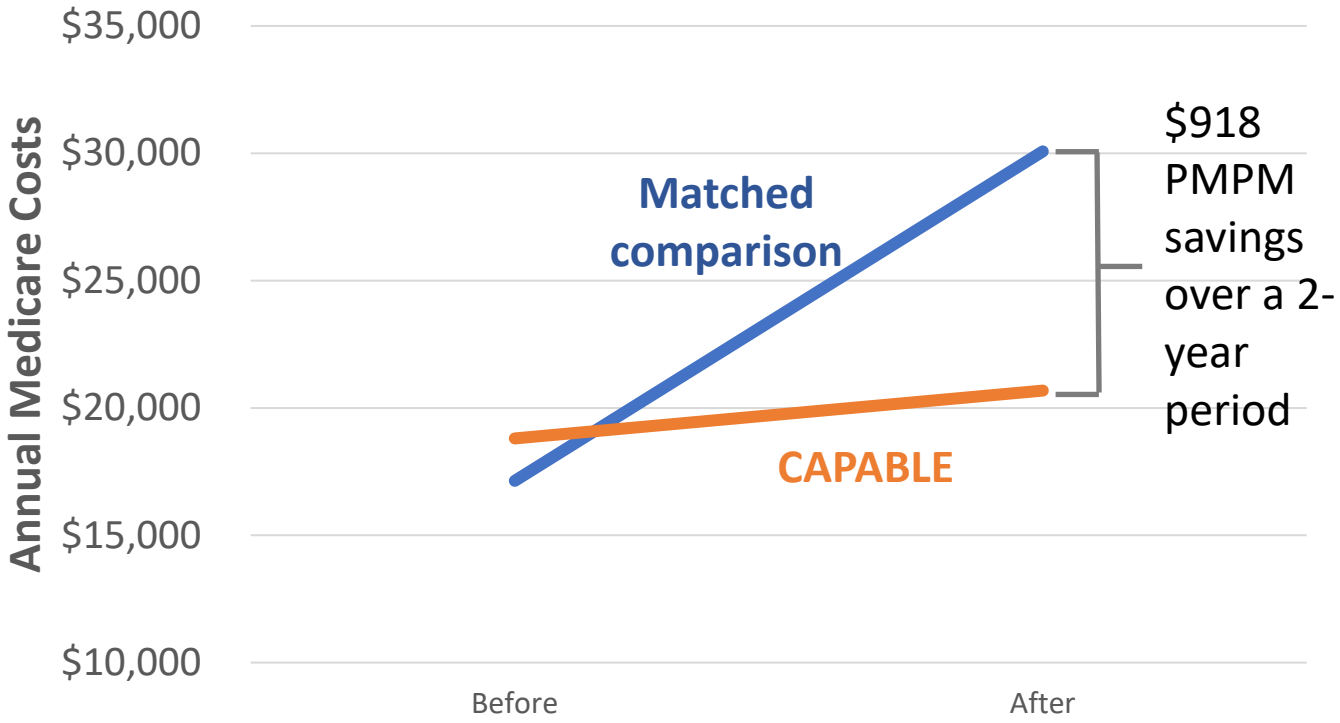
The CAPABLE difference

What makes CAPABLE work in a population where so much *doesn't* work?

Typical disease management/prevention intervention	**CAPABLE**
Designed to prevent a single event (e.g., a fall, a CHF exacerbation)	Designed to maximize independence, which has positive effects across an individual's risk factors for hospitalization and nursing home admission
Provider-driven (i.e., "you should do this")	Client-driven (i.e., "I want to do this.")
Focused on narrow risk factors (e.g., home safety, medical management)	Focused on person-environment fit, addressing physical function, the home environment, and social determinants through a holistic approach
Not sustainable (the effect only lasts as long as the intervention lasts)	Self-sustaining for long-term impact

CAPABLE can reduce costs by up to one-third.

CMS-funded analysis of CAPABLE's impact on Medicare costs among duals, published in a top-tier peer-reviewed journal



*Ruiz et al., Health Affairs, 2017

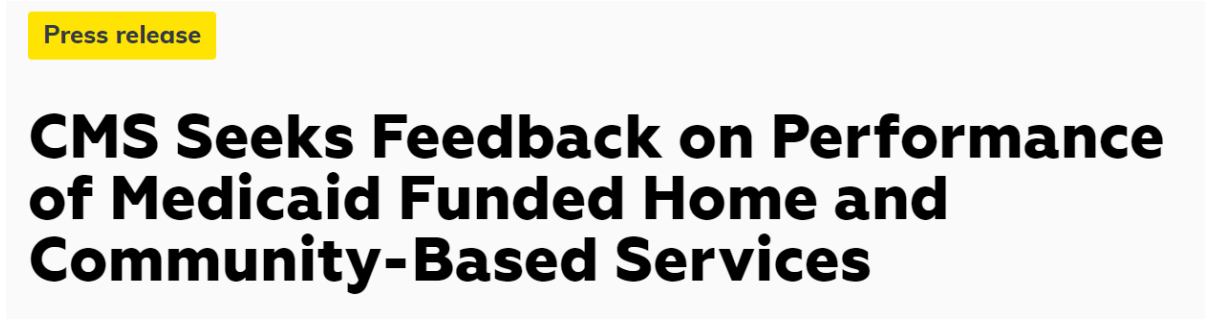
Modifiable disability is

- Highly predictive. Individuals with modifiable disability are typically on a downward spiral. In one study, dual eligible beneficiaries with modifiable disability had average costs at baseline, but those costs spiked 76% in a 2-year period.*
- Identifiable with the right data. A simple clinical algorithm identifies this group of beneficiaries – those with a disability living at home who could benefit from a functional intervention.
- Treatable. People can get better, and a functional intervention not only reduces disability, it results in a significant ROI.

*Ruiz et al., Health Affairs, 2017

Suggestions re data, APMs and health equity

- The number of older adults with disabilities living at home is growing.
- Implementers of CAPABLE can:
  - Identify whose costs will increase.
  - Intervene to prevent much of that increase, sharing the savings with Medicare while supporting the client at home.
  - Help payers get ahead of the curve on physical function.



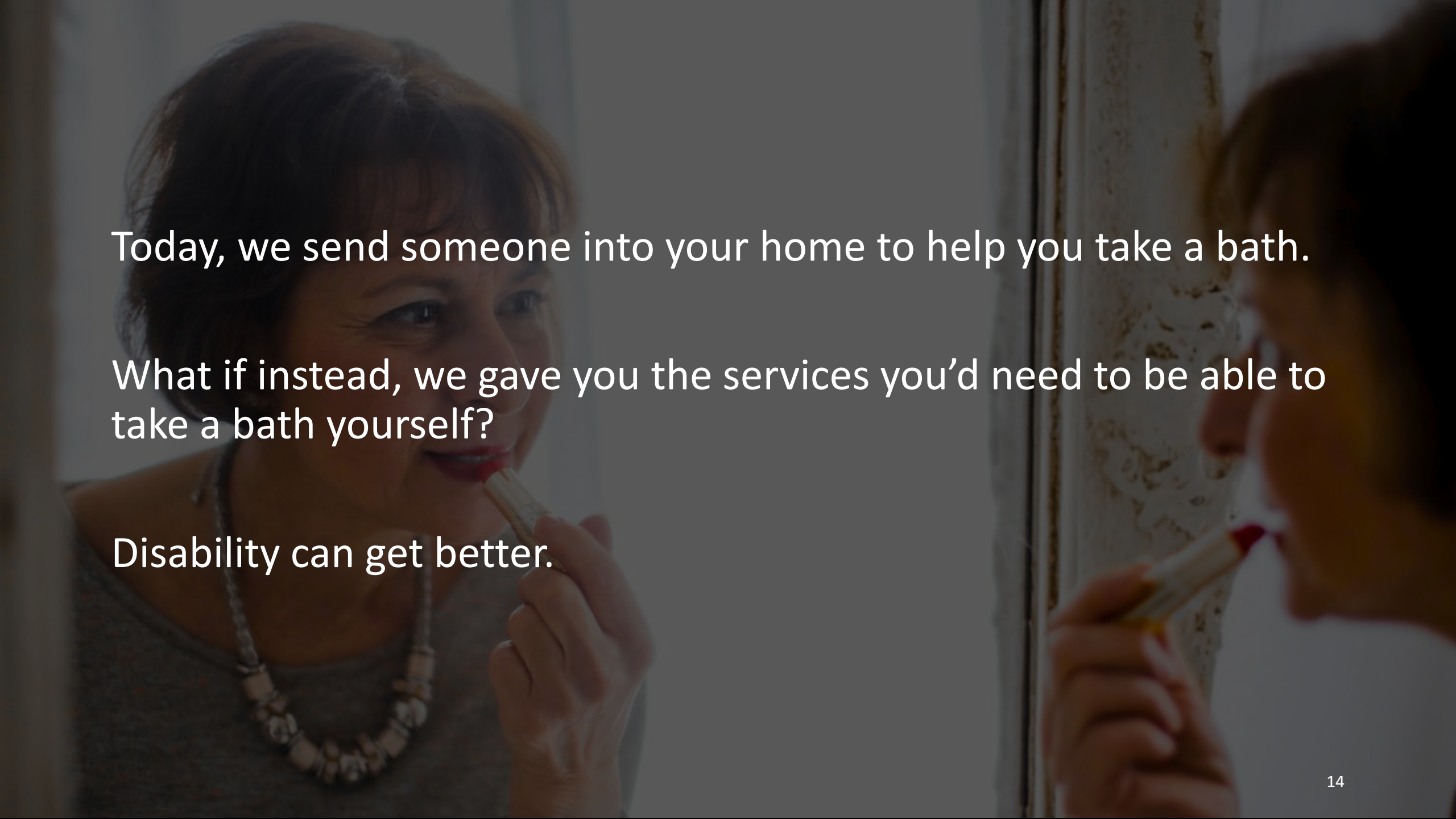
Function as ultimate health equity indicator

- In 2020, HHS released a major analysis in response to a Congressional request, looking at current gaps in risk adjustment. It found that **the single most important variable not currently included in risk adjustment was functional status**.
- CMS requested that the National Quality Forum work with industry to develop best practices for risk adjustment models that include physical function.
- The Centers for Medicaid and CHIP Services released a draft set of quality measures for HCBS, which included activities of daily living.
- The Functional Assessment Standardized Items (FASI) have been released for standard EHR use, which will enable improved targeting of patients by functional status.

Supplemental slides

7 million Medicare beneficiaries with modifiable disability live at home.

Their costs are **twice as high** as similar beneficiaries without disability.



Today, we send someone into your home to help you take a bath.

What if instead, we gave you the services you'd need to be able to take a bath yourself?

Disability can get better.

Core values

- Dignity: Every life deserves honor and respect.
- Humility: We don’t know best. Our clients do.
- Hope: Things can be better than they are today.
- Commitment to results: Human-centered doesn’t mean squishy. We bring a relentless focus on delivering outcomes to our clients and our customers.

Impact on hospitalization

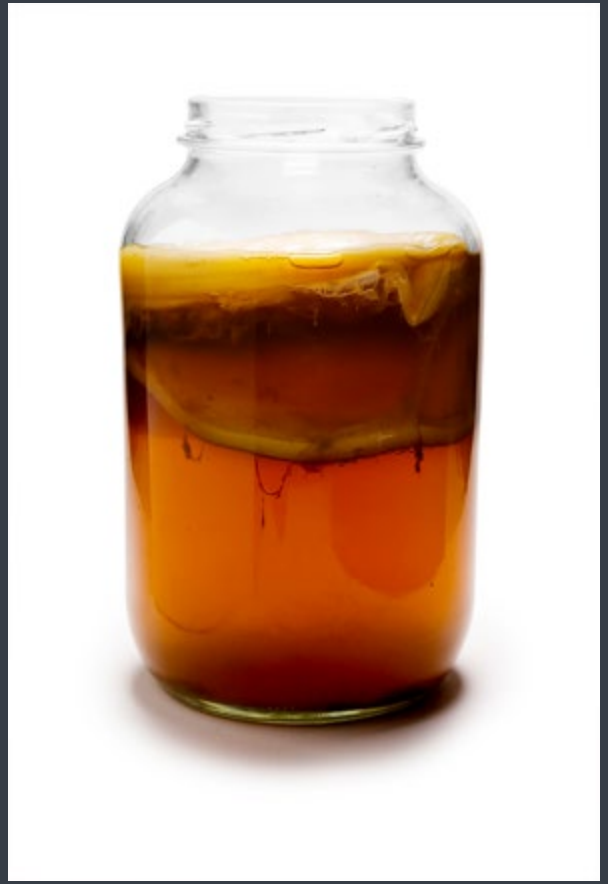
- In a Medicare ACO, CAPABLE reduced hospitalization rates by 60% (23% vs. 9%).
- Among dual-eligible beneficiaries, Medicaid inpatient spend was reduced by 61% per beneficiary.

SOCIAL CARE: THE SECRET WEAPON OF A HEALTHY COMMUNITY

JACOB REIDER MD

@JACOBR

SECRET TO A HEALTHY COMMUNITY?




Hospital

TODAY'S TOPICS

- Achieving Better Health is our shared commitment to the communities we serve
- Physicians are not the answer
- Hospitals are not the answer
- Change is hard for everyone
- Information Technology is an imperative component of success

Health Care

Social Health

Behavioral Health

Physical Health


Social Challenges
Behavioral Challenges
Physical Challenges

HOW

- Alcohol Use
- Child Care needs
- Clothing Needs
- Depression / Anxiety
- Disabilities
- Education
- Employment
- Food Insecurity
- Household Income
- Household Size
- Housing Insecurity
- Incarceration History
- Insurance Status
- Interpersonal violence / safety
- Literacy
- Health Literacy
- Migrant / seasonal worker
- Neighborhood Safety
- Physical Activity
- Primary Language
- Race / ethnicity
- Refugee status
- Social connections /isolation
- Stress
- Substance Use
- Tobacco use / exposure
- Transportation
- Utilities
  - Phone
  - Power
  - Heat
- Veteran status

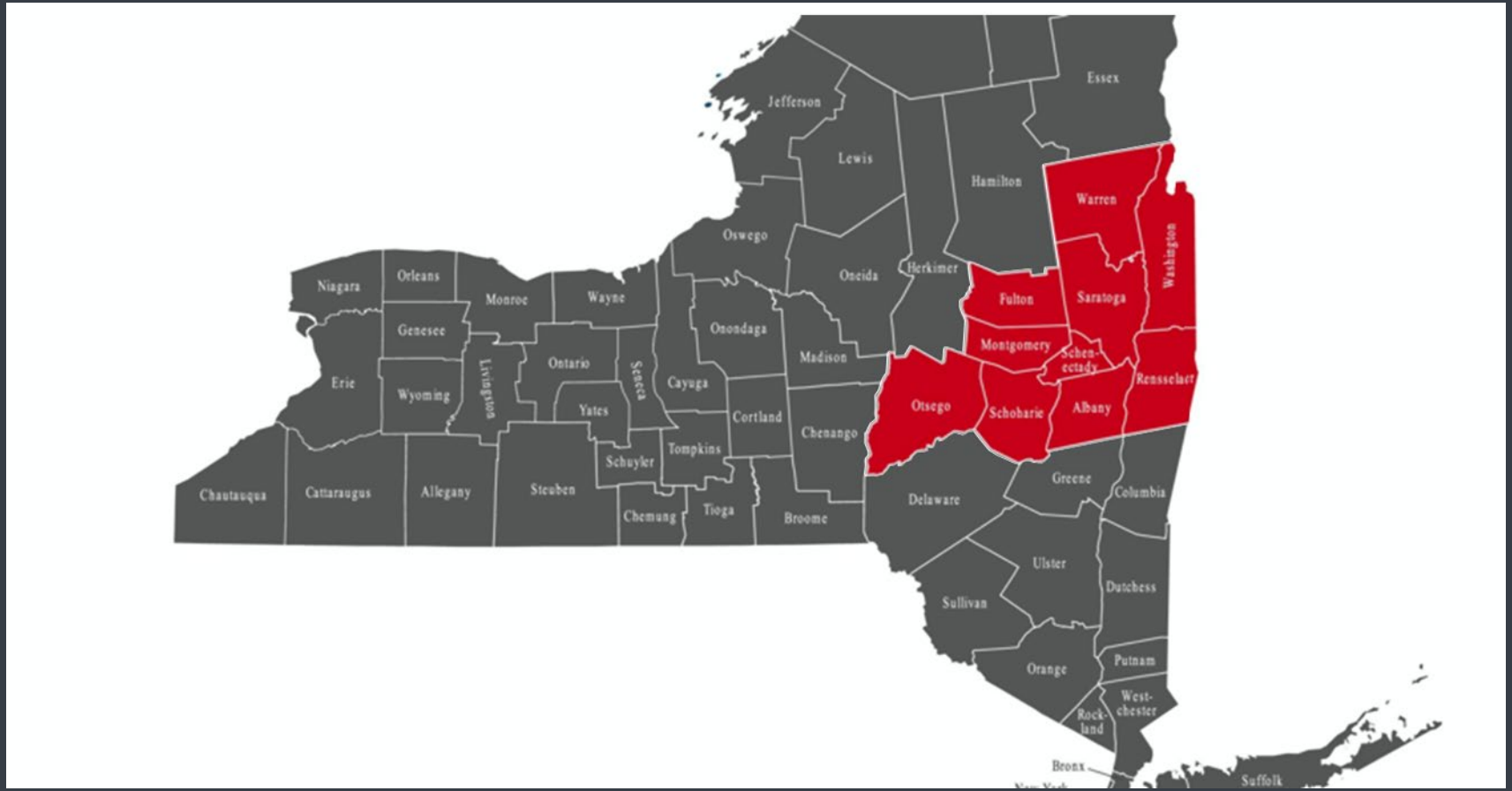
WHAT WE PICKED

Food

Housing / Respite

Transportation

Certified Recovery Peer Advocates (CRPA)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Monroe
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Genesee
Erie
Wyoming
Livingston
Ontario
Yates
Seneca
Onondaga
Cayuga
Madison
Cortland
Chenango
Tompkins
Schuyler
Chemung
Tioga
Broome
Chautauqua
Cattaraugus
Allegany
Steuben
Delaware
Greene
Columbia
Ulster
Dutchess
Sullivan
Orange
Putnam
West-
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Rock-
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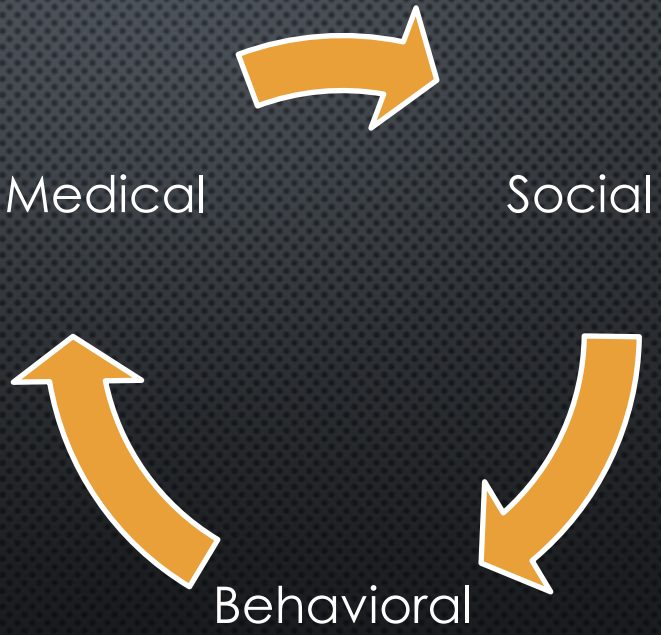
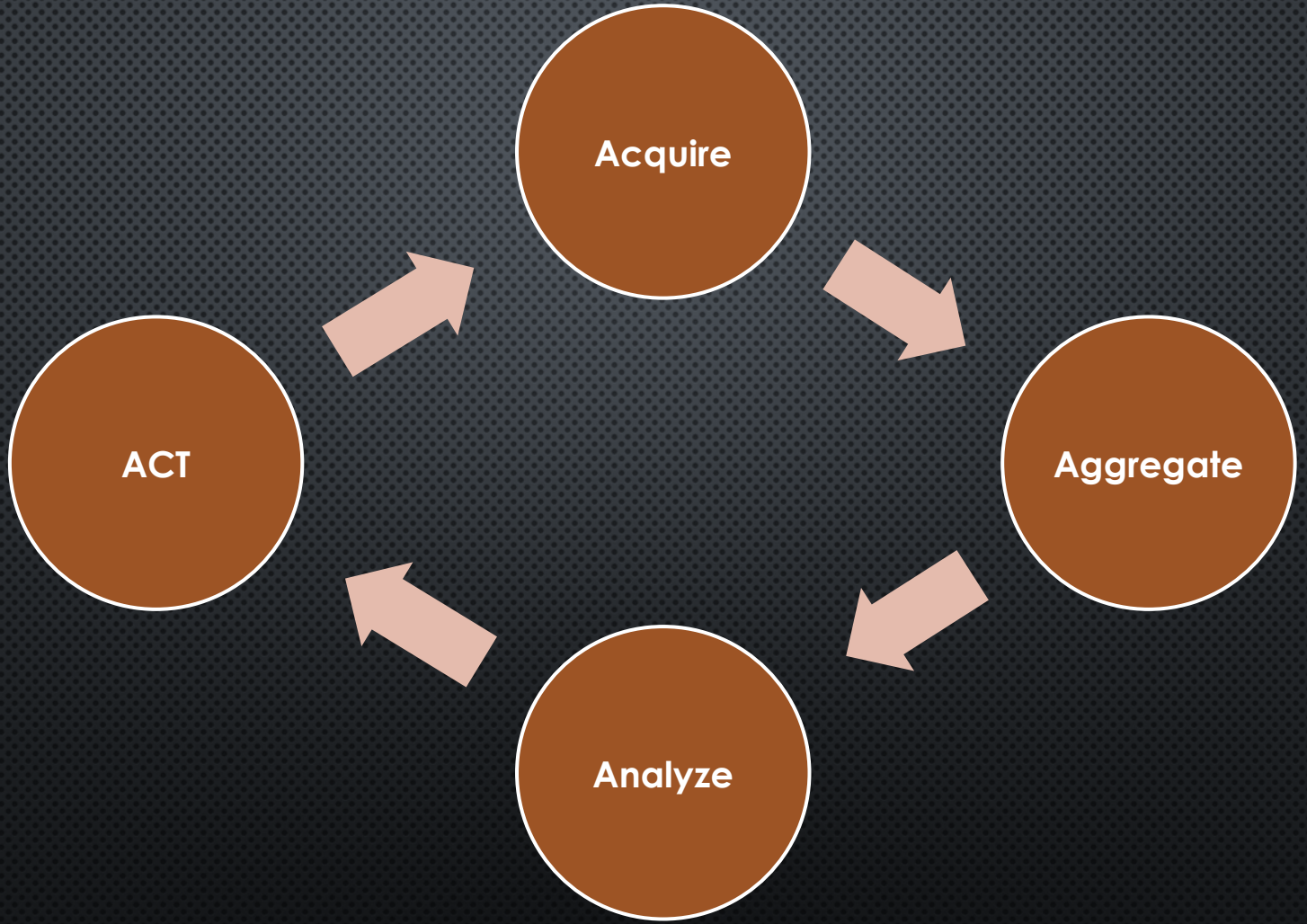
Bronx
Suffolk

CLOSED-LOOP REFERRALS:



MONITORING

DO SOCIAL INTERVENTIONS WORK?


Acquire
Aggregate
Analyze
ACT

WHAT DOESN'T WORK

SOCIAL NEEDS

Identify Understand Act


Brand
1340
IPA
INDIA PALE ALE
Brand
1340
BIERBROUWERIJ

Social Care

Behavioral

Primary

Specialty

Acute

Medications

PUBLIC UTILITY MODEL

RIGHT THING

EASY THING

SECRET TO A HEALTHY COMMUNITY?

Social Risk and Equity: We need Big Data Tools and Point of Care Solutions

Bob Phillips, MD MSPH
Executive Director
The Center for Professionalism & Value in Health Care

THE CENTER FOR PROFESSIONALISM & VALUE IN HEALTH CARE

We're not capturing SDOH in Clinical Care—and are not equipped

- Less than 4% of visits have Z-codes for SDOH [1, 2]
- Medicaid MA programs capturing best, because they have too (APMs/ACOs not so much)[3]
- Practices are not equipped or funded to manage social need
- We need to:
  - lower the burden of screening
  - resource adequately to meet needs
  - reduce capacity for gaming

1 https://doi.org/10.1007/s11606-019-05199-w
2 https://pubmed.ncbi.nlm.nih.gov/33350768
3 The Role of Value-Based Payment in Promoting Innovation to Address Social Risks: A Cross-Sectional Study of Social Risk Screening by US Physicians - PubMed (nih.gov)

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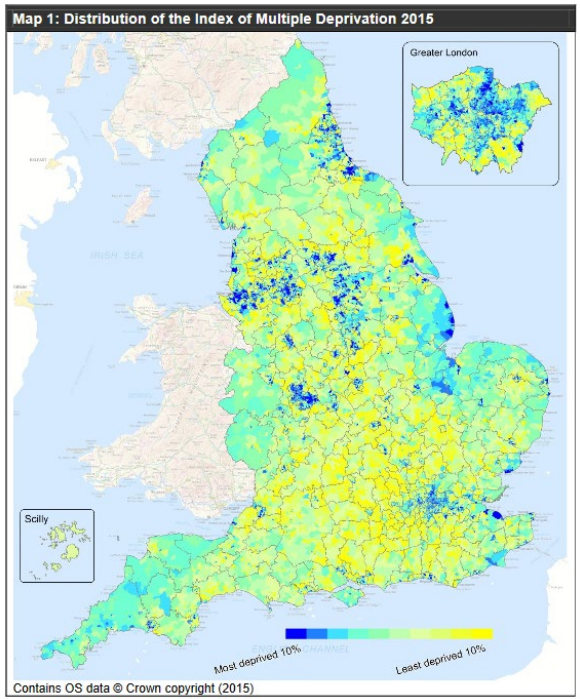
The UK and New Zealand figured this out on a Big Data Scale

Measure social risk for all, geographically

Measure social need for each

English index of multiple deprivation: Adjustments for Social Services

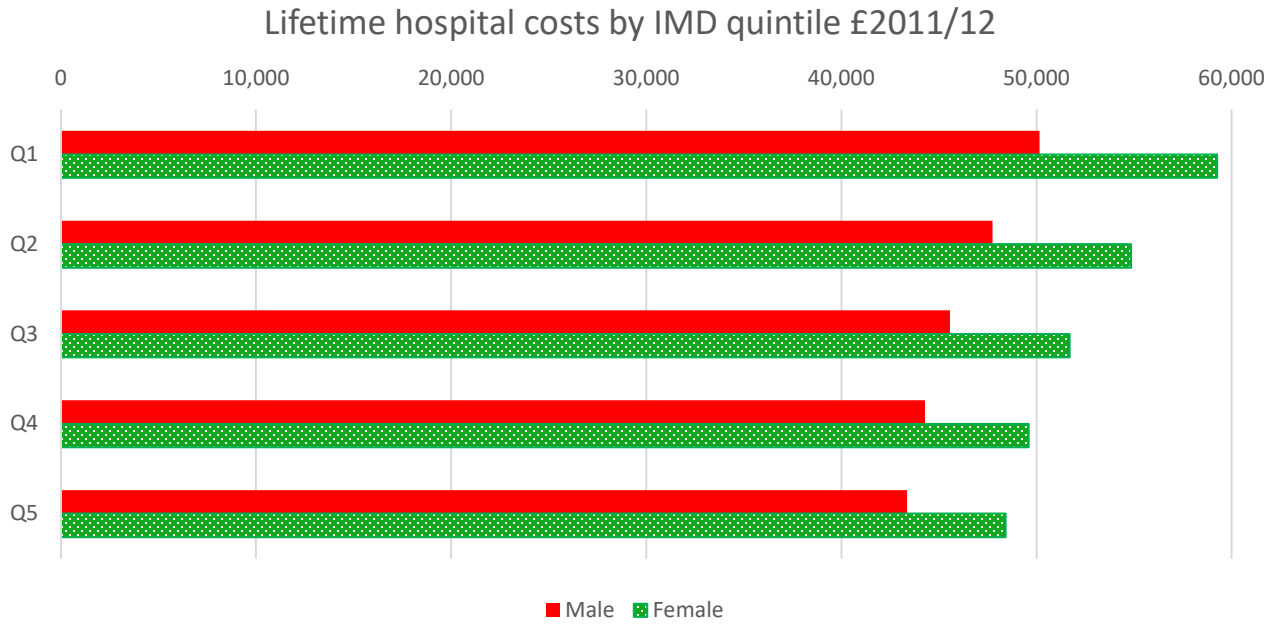


- Seven deprivation domains:
  - Income Deprivation (22.5%)
  - Employment Deprivation (22.5%)
  - Education, Skills/Training Deprivation (13.5%)
  - Health Deprivation and Disability (13.5%)
  - Crime (9.3%)
  - Barriers to Housing & Service (9.3%)
  - Living Environment Deprivation (9.3%)
- Each of these domains is in turn based on a basket of indicators

Thanks to Prof. Peter Smith, UK

Source: Ministry of Housing, Communities & Local Government (2015), English indices of deprivation 2015
https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

Hospital care higher, even though more deprived quintiles have lower life expectancy



Source: Asaria M, Doran T, Cookson R. 2016, “The costs of inequality: whole-population modelling study of lifetime inpatient hospital costs in the English National Health Service by level of neighbourhood deprivation”, J Epidemiol Community Health doi:10.1136/jech-2016-207447

Some criteria for funding formulae

- Based on universally available, validated data;
- Reflects the underlying social and medical needs in a locality;
- Independent of previous spending in a locality;
- Scientifically coherent and plausible;
- Feasible, with low administrative cost;
- Not vulnerable to manipulation or fraud;
- Encourages efficient delivery of health services, and free from perverse incentives;
- Transparent, verifiable, understandable and replicable;
- Parsimonious;
- Reflects policy intentions

NHS equity criteria shift

(This is REALLY Important)

- *The conventional criterion*: to allocate the fixed National Health Service budget to geographical areas:
  - to secure "equal opportunity of access [to NHS services] for those at equal risk"

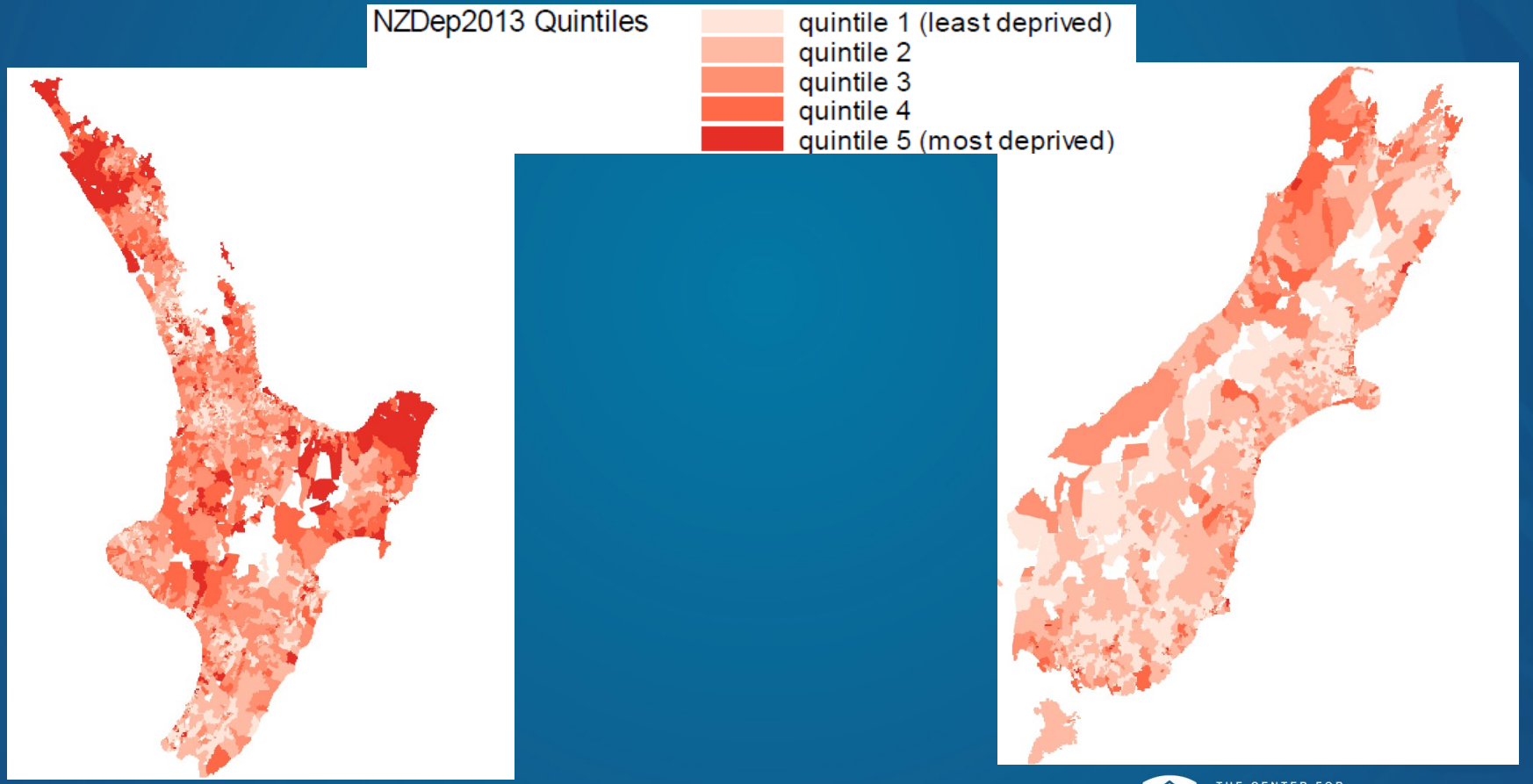
- *A revised criterion (2001):*
  - "to contribute to the reduction in avoidable health inequalities"

Current approach to allocating for ‘unmet need’

- Based on policy judgement, not evidence
- Applied to a percentage of the relevant budget:
  - General acute and mental health services 10%
  - Primary care 15%
  - Specialized services 5%
- Allocated according to standardized mortality rate (aged under 75) in small areas (average population 7,200)

- A weight per head 10 x higher for area with the worst SMR vs. area with the lowest SMR, exponential scale

New Zealand has done similar

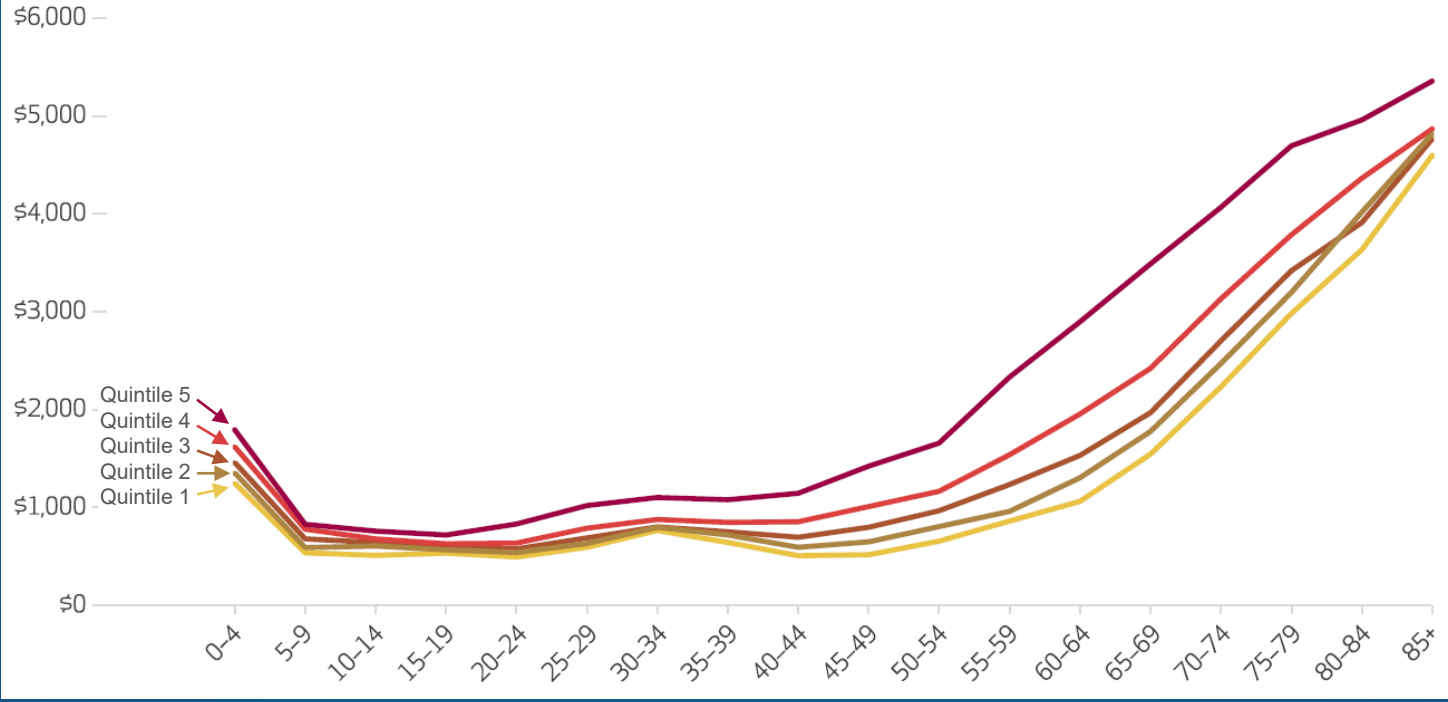


"NZDep2013 Index of Deprivation," June Atkinson, Clare Salmond, and Peter Crampton, published by the Department of Public Health, University of Otago, Wellington, May, 2014.
http://www.otago.ac.nz/wellington/otago069936.pdf

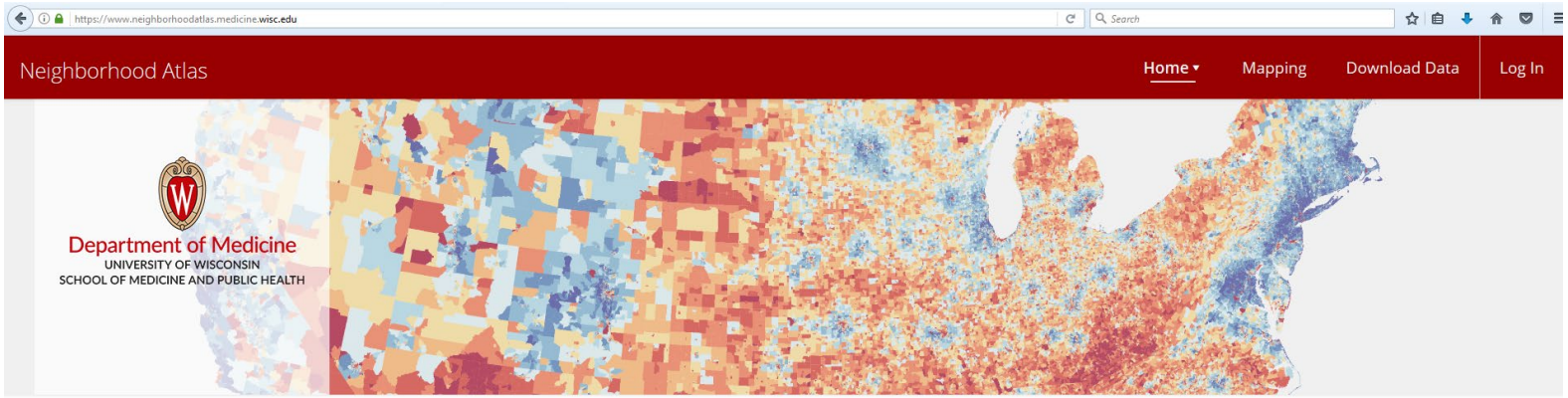
Payment adjustments geared to resolving inequity, nearly exponential for most deprived

EXHIBIT 3

Cost weights for hospital and community services, by 2013 New Zealand Index of Deprivation quintile



Neighborhood Atlas (Thanks to Dr. Amy Kind)



About the 2013 Area Deprivation Index (ADI)

The Area Deprivation Index (ADI) is based on a measure created by the Health Resources & Services Administration (HRSA) over two decades ago for primarily county-level use, but refined, adapted, and validated to the Census block group/neighborhood level by Amy Kind, MD, PhD and her research team at the University of Wisconsin-Madison. It allows for rankings of neighborhoods by socioeconomic status disadvantage in a region of interest (e.g. at the state or national level). It includes factors for the theoretical domains of income, education, employment, and housing quality. It can be used to inform health delivery and policy, especially for the most disadvantaged neighborhood groups.

Considerations for Use

The ADI is limited insofar as it uses 2013 American Community Survey Five Year Estimates in its construction. All limitations of the source data will persist throughout the ADI. The choice of geographic units will also influence the ADI value. In the case of the 2013 ADI the Census block group is the geographic unit of construction and all results are subject to the accuracy and errors contained within the 2013 American Community Survey data release.

How to Use This Site

This site offers several different ways to use the Area Deprivation Index (ADI).

- The Mapping function allows you to view a state or the entire country mapped by ADI. This will show areas of relatively high disadvantage as well as areas of moderate to less disadvantage. Neighborhoods may be ranked

https://www.neighborhoodatlas.medicine.wisc.edu/

Potential of Geospatial Metrics of Neighborhood Disadvantage

- Metrics of Neighborhood Disadvantage are Robust:
  - Generalizable to full US and Puerto Rico
  - Incorporate into predictive analytics
  - Facilitate mechanistic science across health conditions
  - Privacy-compliant
  - Strong track record of application – mostly abroad
- Translatable: Actionable at person, community, research and policy levels
  - Guide outreach, targeting- particularly through mapping
  - Influence intervention design, implementation
  - Policy-applicable: eligibility, adjustment, resources, etc
- Underutilized: Yet, despite all this potential, greatly underutilized in the US-- not easily accessible nor always in a format that allows wide applicability

Source: www.Pixabay.com– All images are released free of copyrights under Creative Commons CC0

Area Deprivation Index (ADI)

- Originally created by HRSA nearly three decades ago, county level
- 17 education, employment, housing-quality and poverty measures originally drawn from long-form Census
- Limitations mirror those of parent data
- Required updates for modern use
- UW team:
  - Updated to more recent and relevant data sources (American Community Survey, 2009-13)
  - Refined down to census block-group level (i.e. “neighborhood” ~ 1,500 persons) which is critical to more precisely measure exposure
  - NIH R01 to validated these changes with users across US

HSR Health Services Research

DOI: 10.1111/j.1475-6773.2012.01449.x
RESEARCH ARTICLE

Measures of Social Deprivation That Predict Health Care Access and Need within a Rational Area of Primary Care Service Delivery

Danielle C. Butler, Stephen Petterson, Robert L. Phillips, and Andrew W. Bazemore

Objective. To develop a measure of social deprivation that is associated with health care access and health outcomes at a novel geographic level, primary care service area.

Data Sources/Study Setting. Secondary analysis of data from the Dartmouth Atlas, AMA Masterfile, National Provider Identifier data, Small Area Health Insurance Estimates, American Community Survey, Area Resource File, and Behavioural Risk Factor Surveillance System. Data were aggregated to primary care service areas (PCSAs).

Study Design. Social deprivation variables were selected from literature review and international examples. Factor analysis was used. Correlation and multivariate analyses were conducted between index, health outcomes, and measures of health care access. The derived index was compared with poverty as a predictor of health

...tion/Extraction Methods. Variables not available at the PCSA level ... level, then aggregated to PCSA level.

... deprivation index is positively associated with poor ... tern holds in multivariate analyses control- ... measure of deprivation is more ... verty alone.

Social Deprivation Index

Population **H**ealth **A**ssessmen**T** **E**ngine

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What is PHATE?

Uses EHR and Community data to:

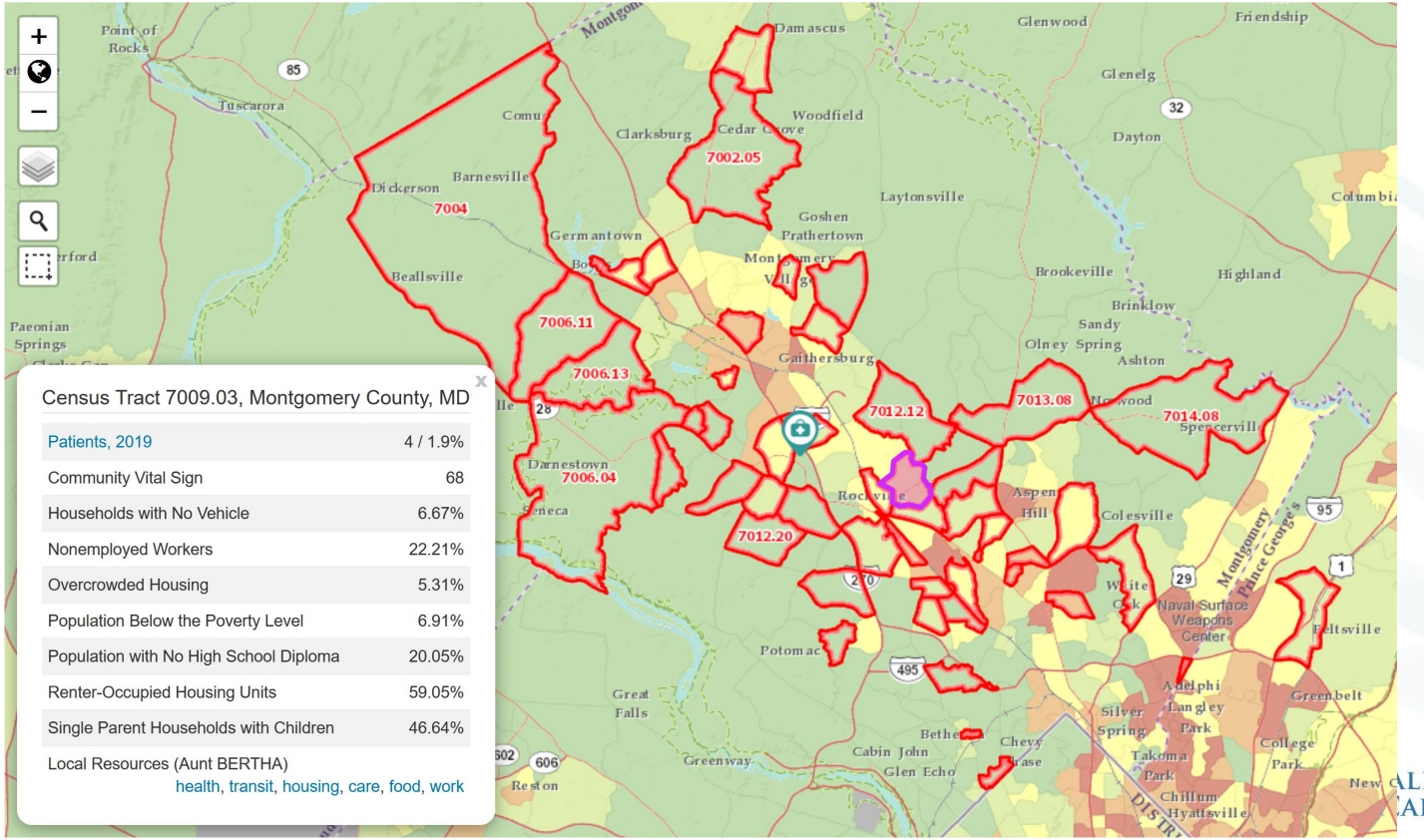
- Map physician or clinic service area
- Display “Community Vital Sign” and elements for each neighborhood
- “Community Vital Sign” for each patient
- Identify community partners (Aunt Bertha)

Preparing to align SDOH-adjusted payments with tools to identify patients with social needs

THE CENTER FOR PROFESSIONALISM & VALUE IN HEALTH CARE

Population Health Assessment Engine – Global Viewer

MAP DATA ABOUT



Research

JAMA Internal Medicine | Original Investigation | HEALTH CARE REFORM

Social Determinants of Health in Managed Care Payment Formulas

Arlene S. Ash, PhD; Eric O. Mick, ScD; Randall P. Ellis, PhD; Catarina I. Kiefe, PhD, MD; Jeroan J. Allison, MD, MS; Melissa A. Clark, PhD

Neighborhood Stress Score

Ash AS, Mick EO, Ellis RP, Kiefe CI, Allison JJ, Clark MA. Social Determinants of Health in Managed Care Payment Formulas. JAMA Intern Med. 2017 Oct 1;177(10):1424-1430.

UMASS MEDICAL SCHOOL

SDH Variables derived from **Administrative Data**

Individual Level

- Disability
  - Client of the Department of Mental Health
  - Client of the Department of Developmental Services
  - Medicaid due to disability
- Serious mental illness
- Substance use disorder
- Housing Problems
  - Homelessness by ICD-10 code
  - Housing instability (>3 addresses)

Neighborhood Stress Score

- A measure of "economic stress" summarizing 7 census variables:

  - % of families with incomes < 100% of FPL

  - % < 200% of FPL

  - % of adults who are unemployed

  - % of households receiving public assistance

  - % of households with no car

  - % of single parent households

  - % of people ≥25 without a HS degree

Policy Objectives

1. Payment should be adjusted for social determinants of health; the policy should aim to resolve patients' social risk and support community interventions
2. The degree of the adjustment should be proportional to area disadvantage and designed to address social needs, not just reflective of usual, related healthcare costs
3. Geographic, small-area indices should be created based on patient and population outcomes, and will be viable, reliable, sustainable mechanism for payment adjustments
4. The policy should reduce burden for providers, payers, states and reduce inequities between states created by the current process
5. Funders should predefine the goals of reduced total cost and improved patient health outcomes at the outset and use these to titrate funding rather than simply looking for cost offsets that do not align with accountability or expectations of meeting SDOH needs

Health Care Collaborative of Rural Missouri

Health Care Collaborative of Rural Missouri

HCC of Rural Missouri
www.hccnetwork.org

Our Mission: Cultivate partnerships and deliver quality health care to strengthen rural communities.

Market and Strategy Driven through programs like
School-based health clinics. Health transportation. Community innovation.

Fiscally Responsible by supporting sustainability efforts through
Network membership recruitment. Patient and community engagement through marketing and outreach.

Quality Workplace Focused by providing an environment that supports
Clinic staff retention and recruitment. Network staff retention and recruitment.

Grounded in Competent and Valued Health Care Practices that
Increase patient encounters. Provide quality improvements and risk management.
Promote ER diversion and effective care transition.

Guided by Rural Health Leadership Standards that are recognized
Nationally. Regionally. Locally.

Partner Roles and Responsibilities

Leadership. Mentorship. Advocacy.

Strategic Initiatives

- Quality Wellness and Healthcare: The HCC community receives quality healthcare and wellness services
- Development, Policy and Advocacy: Leverage partnerships to support the mission of HCC
- Excellent Workforce: Recruit and retain quality professionals
- Lean Operations: Implement/ innovate systems that create efficiencies, support our expertise, and strengthen our decision-making processes
- Strong Communications: HCC is a beacon for rural healthcare and wellness

Community Based Excellence

Building and Sustaining Partnerships. Future Models of Care.

Definitions of Safety Net Providers

Federally Qualified Health Centers
Critical Access Hospitals
Rural Health Clinics
Provider Based Rural Health Clinics

Impact Potential

Social Determinants of Health
Emergency Department Diversion
340B Drug Programs
Labs and Radiology Contracts
OB/GYN Contracts
Behavioral Health Contracts
Opioid and Addiction Services
Community Health Needs Assessment
Patient Centered Medical Homes
Value-based Health Care Models
Team Based Problem Solving
Improved Coordination (Multi-Sector)
Board Structure and Coordination
Peer Teams

Future Models of Care

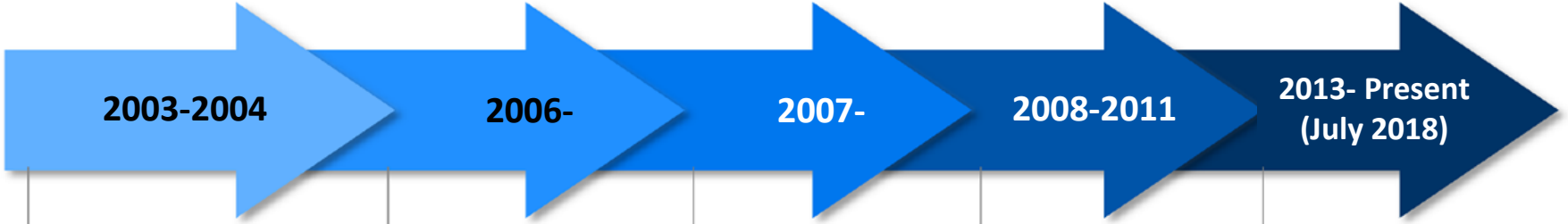
Community/Regional approach to Strategic Planning Engaged Partnerships

- Collective Strategy
- Managing Expectations
- Monitor Progress and Performance
- Shared Workforce

“Needs were varied, we knew none of us could do it all, and if we didn’t come together, there’d be unmet need. We knew it wasn’t always going to be fair. It wasn’t going to be like going out to dinner and splitting the bill six ways down to the penny. That’s not the kind of relationship that was going to be successful.” — Founding Rural Health Network member, and CEO of a Rural Provider Organization, reflecting on the origins for developing the Rural Health Network

HRSA Rural Collaboration Guide
https://www.hrsa.gov/sites/default/files/hrsa/ruralhealth/reports/HRSA-Rural-Collaboration-Guide.pdf

Collaboration Takes Time



2003-2004

- **Local Health Department Establishes Informal Coalition (Health Care Coalition of Lafayette County):** The coalition is focused on serving the needs of one county
- **Senior Center Planning:** Needs Assessment uncovers community needs
- **Coalition Wins First Grant Award** (state funding award)

2006-

- **Informal Coalition Becomes a 501c3 Rural Health Network** (Health Care Coalition of Lafayette County)
- **Lexington 4-Life Center Established**

2007-

- **501c3 Network Hires First Full Time Employee** (CEO)

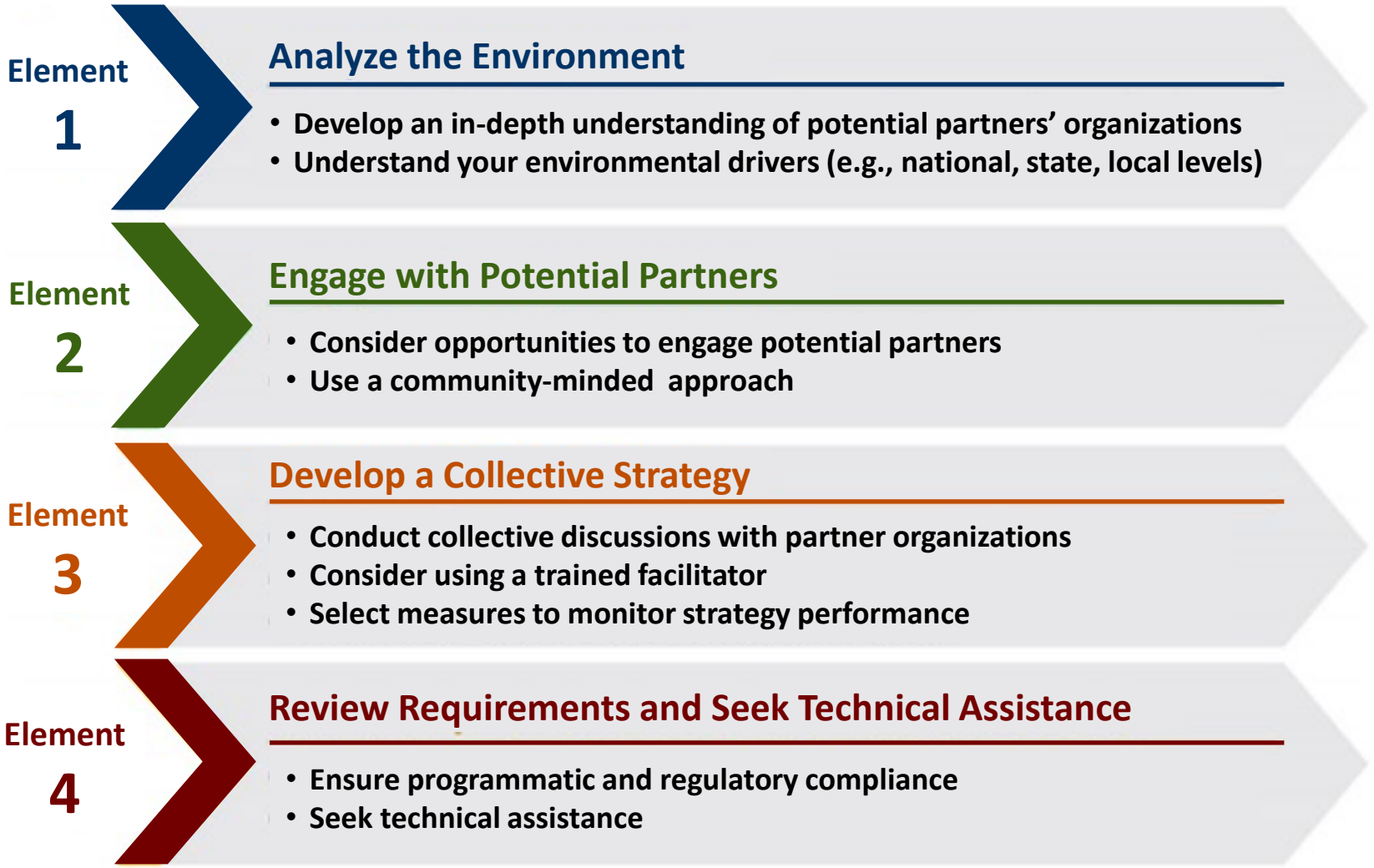
2008-2011

- **501c3 Network Wins HRSA Rural Network Development Planning Program Grant Award**
- **Network Wins HRSA Rural Network Development Grant**

2013- Present (July 2018)

- **501c3 Rural Health Network Awarded Health Center Program Funding and Certified as FQHC:** Two sites are opened in 2013 and two sites in 2015
- **501c3 Rural Health Network Includes Close to 50 Member Organizations**

Figure 1. Rural Health Care Collaboration and Coordination: Areas for Consideration



Building Communities

LiveWell
Community Health Center
Live Life Well

Toniann Richard
Chief Executive Officer
toniann@hccnetwork.org
admin: deana.loyd@hccnetwork.org
Facebook/HCCNetwork twitter:@hccnetwork YouTube:/HCCRuralHealth

Primary Care for Patients Experiencing Homelessness

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A Member Organization of SCAN Group

PTAC Listening Session on Payment and Data Issues Related to SDOH/Equity
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Agenda

- Overview
- Street Medicine Model
- Payment Implications

Key Facts About SCAN

OUR MISSION

Keeping Seniors Healthy and Independent

1977

Founded by seniors, for seniors; originally known as Senior Care Action Network (SCAN)

4.5 Stars

CMS Star Rating 2018 – 2021

220,000

SCAN Health Plan members

~14,900

SoCal duals in SCAN Connections

3rd largest in the nation

2nd largest in California

Among not-for-profit MAPD plans 2021

The Fundamental Challenge

Member Pain Points

Social Challenges

Access Challenges

Care Disjointed

Health System Pain Points

Limited Data

Disrupted Operations

Financial Losses

Homelessness and Health Disparities

Homelessness impacts every racial and ethnic group; it affects men, women and children; it impacts those of all sexual orientations; but it disproportionately affects groups that have historically faced discrimination in the U.S.

Street Medicine

Vision for Healthcare in Action

A non-profit, value-based, payer agnostic medical group with integrated primary care, mental health, substance use, and social work services

Street Medicine
Care delivered when, where and how patients want it

+

Managed Care
Financial mechanism to create a sustainable delivery system

=

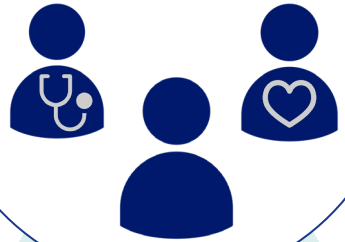
Sustainable Healthcare Model for Homeless Adults

Scope of Services

Clinical Care Services

- **Full Scope Primary Care**
- **Clinical Care Management**
- **Ambulatory mental health and substance use care**

Member-Centered Care Coordination

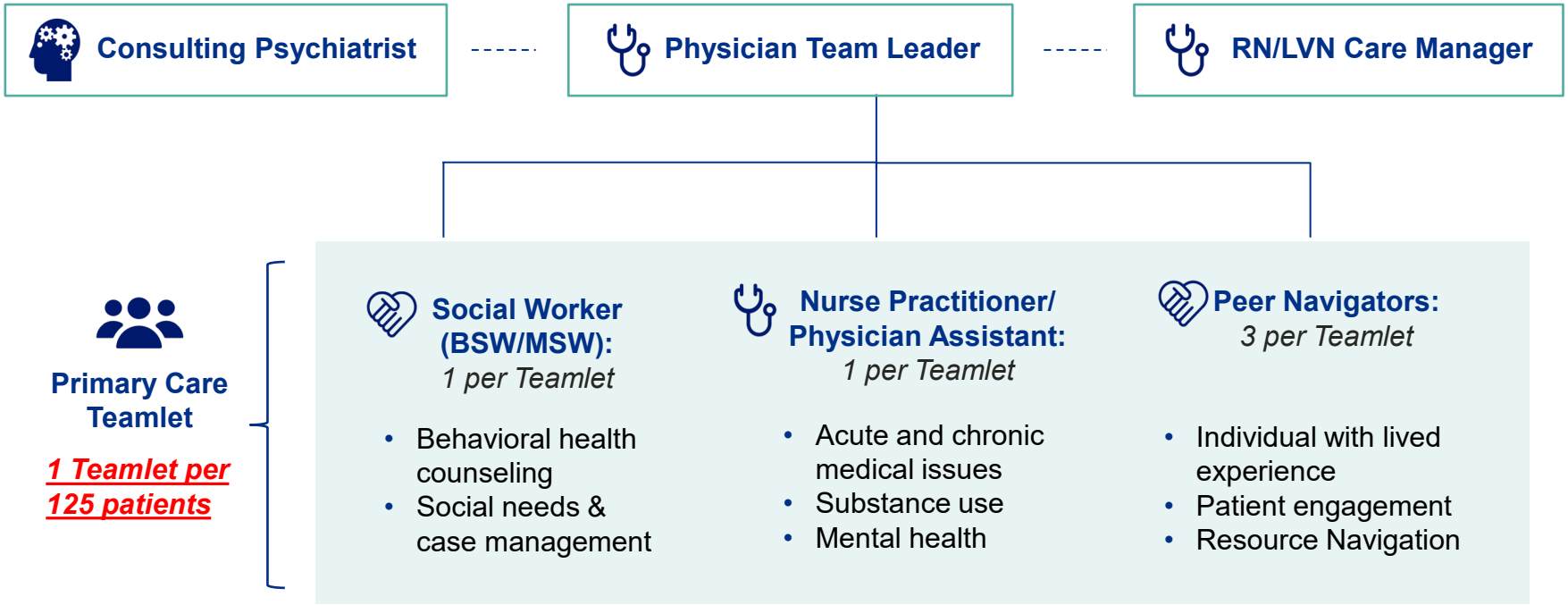


Wrap-Around Services

- **Case Management**
- **Social Work Support**
- **Transportation to Social Services and Key Appointments**
- **Longitudinal care (e.g., care transitions, facilities etc.)** (Healthcare in Action would NOT be hospitalist of record)

Full professional services in the future

Primary Care Street Team



Clinical Model

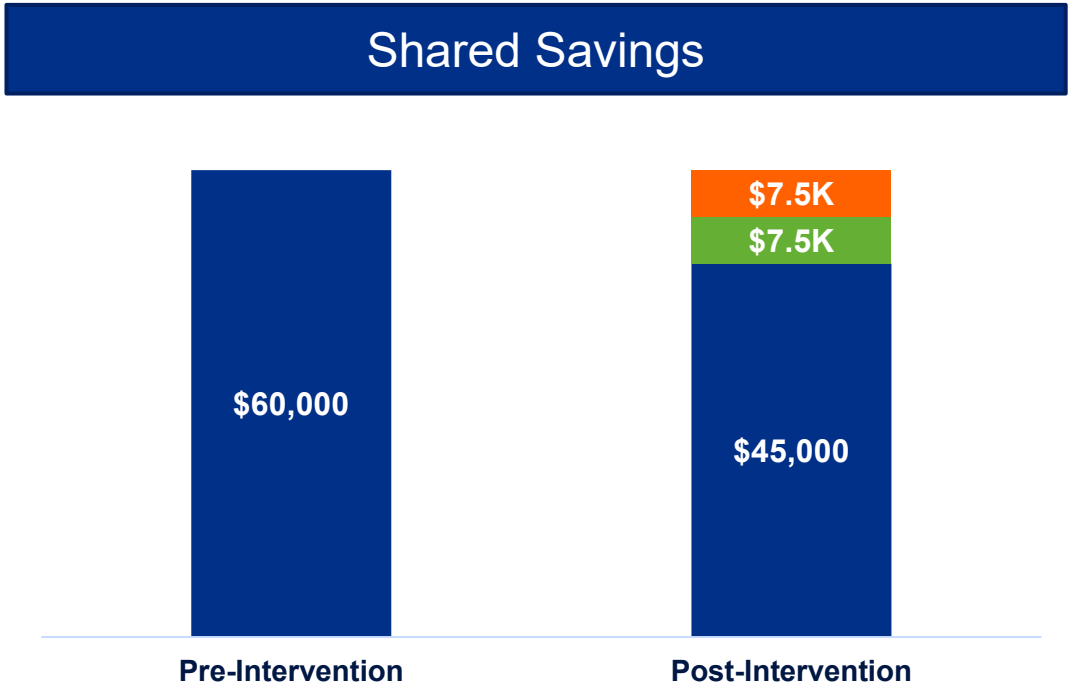
Prospective payments	▪ Allows creativity and flexibility to address social determinants
All-inclusive primary care	▪ Minimize referrals, perform navigation and coordination for the patient
Access to care	▪ 24/7 two-way communication between patients and primary care team
Urgent care services	▪ On the streets
Medication	▪ Reviewing, dispensing, and directly observed therapy
Behavioral health/substance use	▪ Fully integrated into the primary care model
Social work	▪ Fully integrated into the primary care model with strong linkages to community organizations
Longitudinal care	▪ Care provided across hospitalizations, post-acute care, recuperative care, and care transitions

Cost Considerations

Annual Healthcare Costs for Dually Eligible SCAN Member Experiencing Homelessness ~ $60,000

Per Member Per Year Cost of Street Medicine ~ $10,000

Business Model 1: Shared Savings



Business Model 2: Global Capitation

01

Payment modifier as a multiple of the premium (upfront cost)

02

Enhanced funding for health-related social services (upfront cost)

03

Flexibility for regulatory requirements and performance metrics to facilitate care for patients experiencing homelessness

Questions?

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