Building CBO Capacity – A Journey toward Value Based Payment

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Mission in Action
1.9 MILLION MEALS

7,600 CLIENTS, CHILDREN AND CAREGIVERS

15,700 VOLUNTEERS

SPECIAL TOUCHES SUCH AS BIRTHDAY CAKES AND HOLIDAY MEALS

180 LINKAGE AGREEMENTS with other CBOs

30 HEALTH CARE CONTRACTS

FOOD IS MEDICINE MOVEMENT GAINING GROUND

18,000 DONORS SUPPORTING OUR WORK
Clients are referred by medical personnel/health plans

Nutrition assessments are conducted by our team of Registered Dietitian Nutritionists (RDNs)

Meal plans are individually-tailored for specific medical circumstances and cooked from scratch in our kitchen in lower Manhattan

Meals are cooked and flash frozen, then home-delivered in our refrigerated vans

Clients enjoy healthy, great tasting meals, and the support of our staff and community

Ongoing nutrition education and counseling
Our Clients

7,600+ people served annually, including clients, children, and caregivers
200+ different primary diagnoses

Comorbidities:
• 90% of clients have a Secondary Diagnosis
• 43% with 5+ conditions
Why Medically Tailored Meals?
The Problem

Food insecurity leads to:

- Poor medication adherence
- Reduced control of chronic conditions
- Poor engagement in medical care
- ER/inpatient/institutional use
- Increased fatigue

Malnutrition results in:

- 50% more likely to be readmitted
- More than 2 million hospital stays annually (nationally)
The Solution

For people with serious illness, medically-tailored meals result in:

- 16% net savings in healthcare costs
- 50% fewer hospital admissions
- 23% more likely to be discharged to home and not an institution

Studies focused on specific illnesses show that people who get meals:

- Adhere to medication
- Improved lab results
- Have better health functioning
A Journey of Innovation
God’s Love: Healthcare Innovation

1. Medicaid Managed Long Term Care
   - 15 years of contracted service
   - ~400K meals/year to 1500 high risk enrollees

2. Balancing Incentives Program (MLTC)
   - Expansion to new counties and creation of an MTM referral tool

3. DSRIP – Involved since the beginning…
   - 12 PPS and multiple committees on each
   - 5 evaluation projects within various populations
   - CBO Trainer – multiple presentations to build fellow CBO contracting capacity

4. Value Based Payment
   - 4 contracts with Mainstream plans
   - 1 contract with MLTC plan

5. NYSDOH SDH Innovation Award Winner
Innovative Partnerships

- **Partner Type:** Provider
- **DSRIP Project**
- **Food as Health Program:**
  - Onsite and home delivery provides fresh fruits, vegetables and non-perishables.
  - God’s Love provides medically tailored meals for non-ambulatory patients

- **Partner Type:** Plan
- **VBP Arrangement**
- **MTM Program**
  - 165 clients served
  - Preliminary analysis conducted
Northwell Health Food as Health Program

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Food as Health: Addressing Food Insecurity

Inpatient/Outpatient eligibility by nutrition-related diagnosis

Food Insecurity assessed using Hunger Vital Sign tool.

CBO dietitian provides nutrition education, navigation to community resources, and telephone follow up.

Food as Health “Rx” given to patient.

Food as Health onsite and home delivery provides fresh fruits, vegetables and non-perishables. GLWD provides home delivered meals for non-ambulatory. Patients authorized for 2 follow-up visits.
Why God’s Love we Deliver?

• Community Hospital - address entire community’s needs

• Older population, compounding conditions - Lower Mobility

• Inability to ambulate to Food as Health on-site Center
All Patients Screened with Hunger Vital Sign

TWO ITEM FOOD INSECURITY SCREENING TOOL:

1. “We worried whether our food would run out before we got money to buy more.”
   **Often True, Sometimes True, or Never True** for your household in the last 12 months?

2. “The food we bought just didn’t last, and we didn’t have money to get more.”
   **Often True, Sometimes True, or Never True** for your household in the last 12 months?

**Scoring:** A response of “Often”, “True”, or “Sometimes True” to either question = Positive screen for Food Insecurity
Food as Health-Success

Program Outcomes:

- 100% of patients report improved disease self-management
- 73% significantly improved food security status
- 95% ate more healthy food since attending FAH
- 75% utilized community food resources provided

Outcomes assessed at each visit, 3 months, 6 months

Addressing Social Determinants:

- Food insecurity Screening- all patients
- SNAP enrollment
- 40% received help with other social needs at FAH
- Connection to long-term resources in community
- Employee Engagement- food drives
Food as Health Challenges

- **Patient clinical outcomes** – many social determinants of health

- **Hospital workflow** - working with the electronic medical record, staff buy-in. It takes a village!

- **Awareness of program, development of relationships**

Confirm the right resources, to the right patient, at the right time
### Summary: Food as Health Workflow, Data

<table>
<thead>
<tr>
<th><strong>Food As Health Data through Aug 29, 2019</strong></th>
<th><strong>TOTAL</strong></th>
</tr>
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<tbody>
<tr>
<td>Patients <strong>screened</strong> for food insecurity</td>
<td>2188</td>
</tr>
<tr>
<td>Positive FI surveys prior to nutritional assessment</td>
<td>618</td>
</tr>
<tr>
<td>Patient <strong>discharged</strong> prior to nutritional assessment</td>
<td>132</td>
</tr>
<tr>
<td>Patient refer to <strong>Social Work</strong> (no nutrition DX)</td>
<td>43</td>
</tr>
<tr>
<td>Positive FI &amp; discharged <strong>care/skilled nursing</strong> facility</td>
<td>43</td>
</tr>
<tr>
<td>Patient <strong>Eligible</strong> for <strong>Food As Health</strong> center</td>
<td>283</td>
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<tr>
<td>Patient <strong>Seen</strong> at LIJVS <strong>Food As Health</strong> center</td>
<td>124</td>
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<tr>
<td>Patient <strong>2nd visits</strong></td>
<td>54</td>
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<tr>
<td>Patient <strong>3rd visits</strong></td>
<td>20</td>
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<tr>
<td>Refer to <strong>Meals on Wheels</strong></td>
<td>2</td>
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<tr>
<td>Refer to <strong>GLWD</strong></td>
<td>4</td>
</tr>
<tr>
<td><strong>Opt out/Decline</strong></td>
<td>23</td>
</tr>
<tr>
<td><strong>No consult</strong></td>
<td>106</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>16</td>
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We’re missing pts here!
Patients who are non-ambulatory:
- GLWD referral, assessment
- 30-day supply of MTM
- Food as Health and Transitional Care Management

Outcomes:
- Same outcomes survey as all FAH patients
- Satisfaction with GLWD meal delivery service
- Anecdotal- do patients request additional services from GLWD?

Challenges:
- Eligible for GLWD, but didn’t make it to FAH referral (social work
- Elderly, medically complex require more than 30 days of services
- Measuring impact- many social determinants of health, what is success?
- TCM population is new- development of metrics
MetroPlus and God’s Love We Deliver Partnership

November 12, 2019
Who is MetroPlus Health Plan?

- MetroPlus (MHP) is a health services plan, wholly-owned subsidiary of the New York City Health and Hospitals, the largest municipal healthcare organization in the United States.

- For over 30 years, MetroPlus has been providing affordable, quality care to residents of Brooklyn, Bronx, Manhattan, Queens and most recently Staten Island.

- MetroPlus primarily provides insurance coverage through the following governmental programs:
  - Medicare Advantage, Medicaid, Child Health Plus, HIV/Special Needs Program, HARP and MLTC.

- MetroPlus offers Health Insurance coverage to NYC Health and Hospitals employees and retirees as well as several New York State Marketplace plans.

- MetroPlus has over 1200 dedicated employees that help manage over 500,000 members.
Partnership with God’s Love

- This initiative is incorporated in our Transition of Care (TOC) Program.
- Our TOC Program fosters face-to-face interaction to provide comprehensive support for vulnerable members recently discharged from the hospital and are at risk for readmission.
- Research has shown that medically tailored meals reduce readmission.
- During the home visit a Care Manager (CM) completes the assessment and offers meal delivery services as appropriate.
- TOC members are medically complex and many live with multiple co-morbid conditions, including behavioral health diagnoses.
- Services are provided for 1 – 3 months to allow CMs to arrange for long-term solutions (i.e. SNAP, food pantry).
Partnership with God’s Love

- Ramp up time 4 – 5 months
- Strategies implemented to increase enrollment:
  - Staff Training
  - CMs facilitating initial intake when God’s Love had difficulty contacting members.
  - Expanded the eligibility criteria – members without a recent hospitalization with food insecurity were also offered the program.
- Initial monthly enrollment went from 5 to 15 in March to 30 in April. Monthly sustained average: ~22.
Given the claim lag and program ramp up time, we elected to look at readmissions.

- 104 members in the TOC Program received GLWD meal services.
- Utilization/month:
  - 35% 1 month
  - 30% 2 months
  - 35% 3 months

<table>
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<th>Readmissions</th>
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<tr>
<td>30 Days</td>
<td>3.85%</td>
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<tr>
<td>60 Days</td>
<td>9.62%</td>
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MetroPlus Average 30-day readmission rate: 14%

- Encouraging first pass at evaluation
- As the program continues and claims data becomes available, a pre/post analysis is planned
➢ Incorporating this program with our field base TOC Program;
➢ Ongoing Staff training and support;
➢ CM actively facilitating initial intake and member engagement;
➢ Ongoing communication between MetroPlus and God’s Love We Deliver.
Next Steps

Conduct a Comprehensive Program Evaluation:

- Acute Inpatient Admissions
- Emergency Room Visits
- Urgent Care Visits
- Primary Care Visits
- QARR/HEDIS measures (i.e. HbA1c, Medication Adherence)
What We’ve Learned
DSRIP Barriers to CBO Participation

Building the Field as We Go…

Barriers to CBOs Being Effective Partners in DSRIP
• Assessment and Referral Processes
• Care Coordination Duplication
• Funding
• Staff turnover

Barriers to Effective Evaluation of SDH Interventions
• Lack of clarity on HIPAA/privacy and data sharing between providers, payers and community
• Clinical and cost/utilization outcomes not available to CBOs. They rest with the hospitals and plans
• Therefore = CBOs are asked to prove the efficacy of services without access to outcomes data
CBO Collaboration Solutions

**TRACKING SERVICES**
Confirm populations to be served and services to be reported on, consider data sharing

**COLLABORATION**
Make sure that both decision makers and line staff are all on the same page for both organizations

**RESEARCH**
Stay tuned to research and work with the MCO on quality and impact reporting and publishing

**COMMUNICATION**
Stay in contact with each other, lots of check-ins and emails. Confirm a meeting structure to modify accordingly

**REPORTING**
Establish reporting needs: Medicaid Numbers, etc.

**BRANDING**
Establish early on how you will showcase the partnership

**PAYMENT & BILLING**
Determine how you will bill and get reimbursed

**MEDICAL INSIGHTS**
Stay in touch on any health discoveries with the patient
Transition to Value-Based Services

• DSRIP as laboratory for new models of care
• Value Based Payment Roadmap brings plans into the vision for delivery system reform
• Bureau of Social Determinants of Health – VBP Requirements
  • A contract with a Tier 1 CBO
  • An SDH Project
• Challenges with the VBP/CBO model
  • Success with contracting
  • Lack of service delivery and evaluation
• How do we meaningfully involve CBOs?
Toward a Better System of Care

• Meaningful involvement of CBOs from the beginning
  • Governance
  • Funding
  • Evaluation

• Service and evaluation
  • Require delivery and explicit evaluation of SDH in all value-driven contracts
  • Data and evaluation planned from the outset

• Uniform, streamlined SDH referral pathways

• Limitation on care coordination duplication

• Data and technology
  • Increased clarity on HIPAA/privacy and data sharing between providers, payers and community
  • SDH-specific value measures
Contacts

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