Implementing Behavioral Health Value-Based Payment Programs in New York

March 20, 2019
Agenda

1. Introduction to Value-Based Payments
2. New York State VBP
3. Building VBP for Behavioral Health
4. What’s Next: The Future of VBP
Chapter 1

Introduction to Value-Based Payments
VBP Objectives

- Improve quality and outcomes
- Reduce overall spend
- Empower providers & community orgs
- Generate new revenue streams
History of VBP

- Pay for Performance
- Patient Centered Medical Homes
- Hospital Readmissions Reduction Program
- Hospital Value-Based Purchasing Program
- Comprehensive Primary Care
- Medicare Shared Savings Program
- Accountable Care Organizations
- Bundled Payments for Care Improvement
- MACRA/MIPS
VBP Concepts

- Transactional → Longitudinal
- Volume → Outcomes
- Individual-based → Population-based
- Fee for service → FFS+ incentives/risk
- Rising spend → Cost savings
- Payor-driven UM → Provider-driven UM
- Clinical services → Social determinants of health
## Goals and Benefits of VBP Programs

### Providers
- Allows greater flexibility to strategically invest in areas with greater return (i.e., Information Technology investments, Clinical Decision Support Tools, Patient Engagement and Care Coordination Functions, Telehealth, Home Visits, Additional Office Hours)
- Enables providers to treat patients holistically and encourage care coordination

### Members
- Enhanced person centered care
- Better care that is specific to their individual needs (less need to abide by prescriptive care guidelines)
- Access to innovative programs

### Beacon
- Provider compensation aligned with quality of care
- Reduced role of utilization management - clinicians become more focused on broader measures of clinical quality and real-time membership-specific reporting
## Medical vs. Behavioral VBP

<table>
<thead>
<tr>
<th>Medical</th>
<th>Behavioral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large spend and potential savings</td>
<td>Limited spend and savings</td>
</tr>
<tr>
<td>Organized ACO’s and IPA’s</td>
<td>Primarily individual providers</td>
</tr>
<tr>
<td>Primary Care attributions</td>
<td>Attribution challenges</td>
</tr>
<tr>
<td>History of success</td>
<td>Limited history</td>
</tr>
<tr>
<td>Short-term episodes of care</td>
<td>Long-term episodes of care</td>
</tr>
</tbody>
</table>
Behavioral Health VBP Challenges

• Attribution methodology
• Complexity and number of state programs
• Fit with other programs
  o ACO
  o IPA’s
  o Collaboratives
• Scale of spend in behavioral health vs. medical
• Achieving critical mass of members
• Participating in savings from total spend
• Integrated care
Chapter 2

New York State VBP
In NYS, Medicaid members with a BH diagnosis account for:

- 21% of the population but 60% of Medicaid expenditures
- 53.5% of hospital admissions
- 45% of ED visits
- 82% of all readmissions within 30 days of the original admission
- 59% of those readmissions were for a medical condition
- The average length of stay per admission for BH Medicaid users is 30% longer than for the overall Medicaid population
- People with a BH conditions experience poor inpatient to outpatient connection

Key Elements of New York VBP

• History of overall success dating back to 2016
• Behavioral health lagging behind medical
• Targeted populations
  o HARP
  o Developmentally Disabled
  o Medicaid
• MCO’s and providers are allowed to structure VBP arrangements with broad guidelines
• Emphasis on incentivizing community-based organizations to participate in VBP
# New York Medicaid VBP Program

<table>
<thead>
<tr>
<th>Description</th>
<th>Level 1 VBP</th>
<th>Level 2 VBP</th>
<th>Level 3 VBP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>FFS with upside-only shared savings available when outcome scores are sufficient</td>
<td>FFS with risk sharing (upside available when outcome scores are sufficient)</td>
<td>Prospective capitation PMPM or Bundle (with outcome-based component)</td>
</tr>
<tr>
<td>Payment Methodology</td>
<td>Fee For Service</td>
<td>Fee For Service</td>
<td>Prospective total budget payments</td>
</tr>
<tr>
<td>Risk Sharing</td>
<td>Upside Only</td>
<td>Upside and Downside</td>
<td>Upside and Downside</td>
</tr>
<tr>
<td>Total Spend Objective:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>April 2019</td>
<td>50%</td>
<td>15%</td>
<td>N/A</td>
</tr>
<tr>
<td>April 2020</td>
<td>80-90%</td>
<td>35%</td>
<td>N/A</td>
</tr>
</tbody>
</table>
HARP, Health Homes and HCBS

- Focused program for management of high-need serious mental illness individuals
- Well-developed infrastructure for population health management
- Risk-based reimbursement
- Opportunities for developing broader total health management VBP programs
Behavioral Health Care Collaboratives (BHCC)

- New York State is investing $60 million over three years to support BH providers transitioning to VBP
- Funds reinvested from Medicaid managed care savings
- The final BHCC deliverable is participation in a VBP arrangement
- BHCCs must:
  - Provide the full spectrum of BH services available in a region
  - Promote social determinants of health (SDH), physical health, and prevention through community partnerships
  - BHCCs may take on a variety of forms ranging from loosely structured to incorporated entities
BHCC’s Include, as Available:

- A full spectrum of regionally available BH service types
- Peer-run agencies
- CCBHCs
- Community rehabilitation providers
- Primary care providers

- Community-based programs addressing social determinants of health
- Hospitals or Article 28 licensed providers including hospital operated Article 31/32
- Health Homes (HH)
- Performing Provider System (PPS)
BHCC Goals

• Enable providers to measure and achieve clinical quality outcomes for BH populations
• Promote and develop provider capacity to show value and track quality
• Develop infrastructure to support data collection, reporting, and analytics

• Enhance BH Provider readiness to participate in VBP arrangements
• Demonstrate value of rehabilitation and recovery
BHCC VBP Partnerships with Contracting Partners

<table>
<thead>
<tr>
<th>BHCC Provider</th>
<th>Partner</th>
<th>Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>BH/Disability Services Provider</td>
<td>FQHC</td>
<td>Joint IPA</td>
</tr>
<tr>
<td>SUD Specialty BHCC</td>
<td>Special Needs Plan</td>
<td>HIV Total cost of Care</td>
</tr>
<tr>
<td>SUD Specialty BHCC</td>
<td>Hospital</td>
<td>DSRIP project 3.a.i</td>
</tr>
<tr>
<td>SUD Specialty BHCC</td>
<td>Hospital</td>
<td>Addressing opiates in the ER</td>
</tr>
<tr>
<td>SUD Specialty BHCC</td>
<td>PPS</td>
<td>Health home outreach</td>
</tr>
</tbody>
</table>
Potential Contracting Relationships for VBP
Chapter 3

Building VBP for Behavioral Health
Behavioral Health VBP Objectives

- Ensure continuity of care following inpatient episodes
  - Detox
  - Mental health illness
- Connect patients with outpatient treatment
- Reduce ER visits and hospital readmissions

- Incentivize evidence-based best practices, ie Medication-Assisted Treatment (MAT)
- Engage and empower providers to take a broader role in utilization management
- Initiate transition of payment system away from volume-based to incentive/value-based
Beacon’s VBP Models Across the Country

- Colorado: Provider Partner Sub-cap
- California: Case Management Bundle
- Texas: Outpatient Case Rates
- Illinois: Complex mental illness case rate
- New Hampshire: Sub-cap with CMHCs
- Massachusetts: Opioid Case Bundles
- Florida: Provider Sub-cap
## Beacon’s VBP Programs

### Pay for Performance
- Incentive payments tied to achieving key performance metrics
- HEDIS/QUARR-type measures
- MAT initiation and long-term program management
- Social determinants of care

### Shared Savings
- Payments generated from savings against a pre-defined target
- Gateway measures
  - Readmissions
  - Follow-up visits after admissions

### Case Rates
- Grouping of agreed-upon services for defined patient population and set of services
- Claims payments to ensure maintenance of effort
- Quality targets
- No pre-authorization required

### Total Health
- Shared risk for total health of a defined population with significant behavioral health issues, e.g. SMI
- Savings from medical and behavioral utilization
- HARP
# Pay for Performance

<table>
<thead>
<tr>
<th>Measure</th>
<th>Member Qualifications</th>
<th>Target</th>
<th>Incentive</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAT Education</td>
<td>% OUD members receiving MAT Education in the IP Detox setting/ for members with an OUD diagnosis</td>
<td>95%</td>
<td>5%</td>
<td>BH Encounter</td>
</tr>
<tr>
<td>Exposure IP to MAT</td>
<td>Members in IP detox that had one prescription filled for MAT within 30 days post discharge</td>
<td>70%</td>
<td>15%</td>
<td>RX &amp; BH Claims</td>
</tr>
<tr>
<td>Next Day Follow up to Outpatient MAT clinic</td>
<td>Members discharged from IP detox or Rehab who have an OP visit for MAT within 24 hours of discharge, OP visit with OUD diagnosis</td>
<td>90%</td>
<td>15%</td>
<td>BH Claims</td>
</tr>
<tr>
<td>30 day Readmission Rate</td>
<td>Members discharged from an Inpatient Detox or SA Rehabilitation Facility who have a readmission to the same Level of Care within 30 days of discharge for SUD diagnosis</td>
<td>30%</td>
<td>10%</td>
<td>BH Claims</td>
</tr>
<tr>
<td>90 day Readmission Rate</td>
<td>Members discharged from an Inpatient Detox or SA Rehabilitation Facility who have a readmission to the same Level of Care within 90 days of discharge for SUD diagnosis</td>
<td>37%</td>
<td>5%</td>
<td>BH Claims</td>
</tr>
</tbody>
</table>
VBP Shared Savings Process

Provider Selection

- Critical mass
- Appropriate clinical service configuration
- Collaborative history
- Claims accuracy
- High performing or needs improvement

Attribution Methodology

- Inpatient incident
- Multiple outpatient visits
- Episode of care
- HARP

“Gateway” Measures

- QARR
  - FUH
  - Other HEDIS
- Readmissions
- MAT initiation
- Outpatient follow-up visits

Shared Savings Distribution

- Tiered percentages based on performance against measures
- Flat percentages
## Shared Savings-Mental Health Illness

<table>
<thead>
<tr>
<th>Gateway Measures</th>
<th>Member Qualification</th>
<th>Provider Action</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow-up After Hospitalization for Mental Illness (FUH) 7-day</td>
<td>Members ages 6 and older who were discharged from an Acute Inpatient Psychiatric Facility</td>
<td>Member scheduled and sees a licensed clinician within 7 days post-discharge</td>
<td>78%</td>
</tr>
<tr>
<td>Follow-up After Hospitalization for Mental Illness (FUH) 30-day</td>
<td>Members ages 6 and older who were discharged from an Acute Inpatient Psychiatric Facility</td>
<td>Member scheduled and sees a licensed clinician between 8 and 30 days (inclusive) post-discharge</td>
<td>80%</td>
</tr>
<tr>
<td>7/30/60/90 day Readmission</td>
<td>Members discharged from an Acute Inpatient Psychiatric Facility who do not have a readmission to any Inpatient Facility within 30 days of discharge</td>
<td>Ensure member receives appropriate levels of care to remain within the community.</td>
<td>TBD</td>
</tr>
</tbody>
</table>
## Shared Savings-Detox and Follow-up

<table>
<thead>
<tr>
<th>Gateway Measure</th>
<th>Definition</th>
<th>Numerator/Denominator</th>
<th>Target</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmissions</td>
<td>No admissions for any 24 LOC 30/60/90; where SUD is dx1/dx2</td>
<td>30/60/90/ Members not BH IP / Members in program</td>
<td>90% 30 80% 60 80% 90</td>
<td>BH Claims</td>
</tr>
<tr>
<td>Follow-Up After Hospitalization</td>
<td>Follow-up visits within 7 and 30 days of discharge</td>
<td>7/30 FUH Members/Members in Program</td>
<td>90% 7 80% 30</td>
<td>BH Claims</td>
</tr>
<tr>
<td>ED reductions for SUD dx AND overdose</td>
<td>Measures reductions in ER visits of SUD and overdose</td>
<td>Members not seen in ER with SUD primary or overdose / Members in program</td>
<td>90%</td>
<td>Medical Claims</td>
</tr>
</tbody>
</table>
# Shared Savings Financial Model

<table>
<thead>
<tr>
<th>DETOX MEMBERSHIP</th>
<th>738</th>
</tr>
</thead>
<tbody>
<tr>
<td>AVERAGE COST PER DETOX STAY (ALOS 4.02 DAYS)</td>
<td>$1987.49</td>
</tr>
<tr>
<td>DECREASED MEMBERSHIP ADMITTING</td>
<td>279</td>
</tr>
<tr>
<td>ATTRIBUTED SAVINGS</td>
<td>$555,904.93</td>
</tr>
<tr>
<td>50% ELIGIBLE TO PROVIDER</td>
<td>$277,952.49</td>
</tr>
</tbody>
</table>

## Measure | Bonus | Total |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MAT EDUCATION</td>
<td>5%</td>
<td>$27,795.25</td>
</tr>
<tr>
<td>INITIAL DOSE OF METHADONE IN IP FACILITY</td>
<td>15%</td>
<td>$83,385.74</td>
</tr>
<tr>
<td>NEXT DAY FOLLOW-UP TO OP MAT CLINIC</td>
<td>15%</td>
<td>$83,385.74</td>
</tr>
<tr>
<td>30 DAY READMIT</td>
<td>10%</td>
<td>$55,590.49</td>
</tr>
<tr>
<td>90 DAY READMIT</td>
<td>5%</td>
<td>$27,795.25</td>
</tr>
</tbody>
</table>

30 DAY RATE 48.9% → 30%
90 DAY RATE 56% → 37%

PROPOSED TARGETS FOR 30 AND 90 DAY READMISSIONS RESULT IN A 37.9% OVERALL REDUCTION TO ADMISSIONS RATES.
Case Rates

• Outpatient case rates
  o To achieve the full case rate, providers must submit claims to meet maintenance-of-effort targets as well as to achieve certain quality targets.
  o The case rates can be tied to the total population being served by a provider or a defined subset, such as individuals with severe mental illness (SMI).

• Inpatient case rates
  o In exchange for case rates, providers agree to a readmission guarantee as well as focus on follow-up after discharge.
  o Inpatient providers that offer step-down (e.g., partial hospitalization programs) may have the continuum of services included in their case rates.
Case Rate Financial Model

Costs:

<table>
<thead>
<tr>
<th>LOC</th>
<th>Limited Cases</th>
<th>Targeted Case Rate (Midpoint)</th>
<th>Expected Bundle Payout</th>
<th>Previously Paid</th>
<th>Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential</td>
<td>4892</td>
<td>$6,775.06</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IP</td>
<td>817</td>
<td>$8,727.77</td>
<td>$7,130,588.09</td>
<td>$10,850,607.06</td>
<td>$3,720,018.97</td>
</tr>
<tr>
<td>IOP</td>
<td>247</td>
<td>$8,916.18</td>
<td>$2,202,296.46</td>
<td>$3,487,608.52</td>
<td>$1,285,312.06</td>
</tr>
<tr>
<td>PHP</td>
<td>90</td>
<td>$6,406.72</td>
<td>$576,604.80</td>
<td>$892,893.24</td>
<td>$316,286.44</td>
</tr>
<tr>
<td>Outpatient</td>
<td></td>
<td></td>
<td>$84,977.85</td>
<td></td>
<td>$84,977.85</td>
</tr>
<tr>
<td>Totals</td>
<td></td>
<td>$9,909,489.35</td>
<td>$15,316,086.67</td>
<td></td>
<td>$5,406,597.25 Est. Savings</td>
</tr>
</tbody>
</table>

Bundle Ranges:

Potential Bonus Calculations ** - 10 basis points:

<table>
<thead>
<tr>
<th>Performance Outcome</th>
<th>Basis Points for Measure</th>
<th>Follow-up After Hospitalization for Mental Illness (FUH) 7-day – Target Met</th>
<th>Estimated Annual Bundle Payments</th>
<th>Bonus Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAT Education</td>
<td>.01</td>
<td>$9,909,489.35</td>
<td>99,094.89</td>
<td></td>
</tr>
<tr>
<td>MAT Engagement</td>
<td>.03</td>
<td>$9,909,489.35</td>
<td>297,284.68</td>
<td></td>
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<tr>
<td>HIV testing/HCV screening</td>
<td>.02</td>
<td>$9,909,489.35</td>
<td>198,188.78</td>
<td></td>
</tr>
<tr>
<td>Primary Care Follow-up</td>
<td>.02</td>
<td>$9,909,489.35</td>
<td>198,188.78</td>
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</tr>
<tr>
<td>Outcome Tool</td>
<td>.02</td>
<td>$9,909,489.35</td>
<td>198,188.78</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total Payout</td>
<td>990,048.90</td>
<td></td>
</tr>
</tbody>
</table>

**Assumes quality performance targets are met to qualify for the incentive payout.
Total Health/Cost of Care

• 100% risk for total medical care services for HARP population
• Medical, behavioral and Rx
• Qualifies as Level 2 VBP
Total Health/Cost of Care

- Development of new clinical processes and a realignment of resources to better address the total health of the HARP population connecting them to Health Home Services

- The **success of the HARP model is contingent upon the success of the health homes** through effective solution-based relationship management and support

- NYS health homes provide the “feet on the street” community-based care management to HARP members

- Engagement in health home care management remains a goal of this model; however it is clear that **there is a need for an enhanced collaboration with the health homes and the case management agencies**

- **Beacon takes an active role in health home oversight.**
### BH-HCBS Service Category Distribution

<table>
<thead>
<tr>
<th>BH-HCBS Service Category</th>
<th>% of Total Paid</th>
<th>% of Units Paid</th>
<th>% # of Claim</th>
<th>Distinct Utilizer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosocial Rehabilitation (PSR)</td>
<td>29.8%</td>
<td>10.5%</td>
<td>21.7%</td>
<td>27</td>
</tr>
<tr>
<td>Peer Supports</td>
<td>22.2%</td>
<td>41.8%</td>
<td>28.8%</td>
<td>44</td>
</tr>
<tr>
<td>Non-Medical Transportation</td>
<td>20.9%</td>
<td>41.3%</td>
<td>30.9%</td>
<td>51</td>
</tr>
<tr>
<td>Community Psychiatric Support and Treatment (CPST)</td>
<td>9.7%</td>
<td>3.8%</td>
<td>5.9%</td>
<td>5</td>
</tr>
<tr>
<td>Short-Term Crisis Respite</td>
<td>4.3%</td>
<td>0.1%</td>
<td>1.5%</td>
<td>3</td>
</tr>
<tr>
<td>Pre-vocational/Employment Services</td>
<td>4.1%</td>
<td>0.4%</td>
<td>4.2%</td>
<td>9</td>
</tr>
<tr>
<td>Family Support &amp; Training</td>
<td>4.0%</td>
<td>1.6%</td>
<td>4.4%</td>
<td>5</td>
</tr>
<tr>
<td>Intensive Crisis Respite</td>
<td>3.7%</td>
<td>0.1%</td>
<td>1.4%</td>
<td>3</td>
</tr>
<tr>
<td>Intensive Supported Employment</td>
<td>1.0%</td>
<td>0.3%</td>
<td>1.0%</td>
<td>2</td>
</tr>
<tr>
<td>On-going Supported Employment</td>
<td>0.3%</td>
<td>0.0%</td>
<td>0.1%</td>
<td>1</td>
</tr>
</tbody>
</table>

| Total                                                      | 100.0%          | 100.0%          | 100.0%       | 101               |
Performance Measures

• Antidepressant Medication Management (AMM)
• Initiation and Engagement of Alcohol and Other Drug Abuse and Dependence Treatment (IET)
• Follow-up after hospitalization for mental illness (FUH)
• Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
• Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)
Chapter 4

What’s Next: The Future of VBP
Future of VBP in New York

- Focus on outpatient services
- Broaden potential VBP contracting partners
- Collaborate more closely with medical and primary care
- Incorporate social determinants in moving into Level 2 VBP
- Encourage shared savings arrangements between providers and supporting community-based organizations
Thank You

Contact

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bob.edmondson@beaconhealthoptions.com
Building Sustainable Partnerships for Improved Patient Outcomes through Value based Payment

Presenters:
Emily Pape, Director of Population Health, Care Compass Network
Shelbi DuBord, Regional Performing Unit Lead, Care Compass Network
Presentation Objectives

1. Learn how to achieve improvements in patient outcomes using a coordinated network approach.

2. Learn how to effectively broker partnerships among organizations with varying level of experience with VBP contracts.

Emily Pape
Director of Population Health Care Compass Network

Shelbi DuBord
Regional Performing Unit Lead Care Compass Network
About Us and Program Overview

**Cohort Management Program** is CCN’s capstone project to put into place an Integrated Delivery System

- VBP pilot program
- Partners form Networks to integrate services
- Networks actively manage a defined patient population cohort
- CCN incentivizes improvements in patient outcomes

**Phases:** Planning and Active Management

**Activities:** Network and Partner levels
Health Impact Pyramid

- Medical Care
- Mental Health Treatment & Recovery
- Substance Use Disorder Treatment & Recovery
- Health Literacy skills
- Self Management and coping skills
- Medical/Dental Prevention
- Address food insecurity
- Material support
- Family and community support
- Transportation assistance

Adapted from “A Framework for Public Health Action: The Health Impact Pyramid” Thomas Friedan (AJPH 100(4) 2010).
Cohort Management Program - Planning Phase

Planning Collaboration

- Convene the Network
- Define cohort inclusion criteria
- Set goals for improved outcomes
- Identify core services and strategies to achieve goals
- Address logistics of funds flow and data sharing
Designed to Improve Outcomes

Networks must have alignment among:
- Clinically high-needs cohort definitions
- Goals for improved outcomes
- Core services and strategies to achieve goals

Cohort Inclusion Criteria
- Behavioral Health
- Chronic Conditions
- Gaps in Primary Care
- Multi-Visit Patients
- Other
- Number of Networks Serving

Geographic Coverage, by Number of Networks and Type of Cohort
Develop Partner Competencies for VBP

Helpful Skills for VBP:
• Broker partnerships to address gaps and improve outcomes
• Actively manage a defined population cohort
  o Aggregate
  o Individual
• Flow funds
• Share data
• Manage Network resources
Core Services for Patients

Clinically-oriented Interventions
  - SUD and MH Treatment and Recovery Services
  - Peer support, Case Management, Care Coordination
  - Disease Management
  - Primary Care services

Interventions on Social Determinants of Health
  - Family/community support services
  - Navigation to Primary Care
  - Patient self-management skills
  - Patient health literacy skills
  - Transportation assistance
Identify a Priority Cohort

• Think of a patient group important to you.
• How do you describe them?
• What are the key needs of your priority cohort?
• Who do you need as partners to help you address your patients’ needs?
• Which organizations are well suited to help make an impact?
Networks – Expanded Care Teams

- Clinical Team
- Employment and Vocational Programs
- Housing Services
- Nutrition and Food Security Partners
- Community Health Worker
Case Study

• Lourdes Opioid Use Disorder Cohort
**Workflow**

**Goal:** to improve the health and well being of cohort members by designing a more cohesive system of care delivery

**Opioid Population**

**Track 1:** Needle Exchange

**Track 2:** Hospital (ED, IP, Walk-In) or Discharge from Detox

**Track 3:** Disengaged from Treatment

**Consent to sharing info among care team?**

- **YES**
  - Patient Graduates
  - Fully Coordinated Service
  - Consent to sharing info among care team?
  - YES
    - Creates an Integrated Longitudinal Plan that includes:
      1. SDOH Intervention
      2. Addiction Treatment
      3. Medical Care
  - NO
    - Outreach only
- **NO**
  - Patient will be added to track 3 and CBO CHW will try to engage patient again.

**Health Needs Assessment**

- Community Health Worker CBO Based

**Address other needs**
## Network Partners

<table>
<thead>
<tr>
<th>Organization Name</th>
<th>Network Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our Lady of Lourdes Memorial Hospital, Inc.</td>
<td>VLC</td>
</tr>
<tr>
<td>REACH Medical</td>
<td>Tier 1 CBO</td>
</tr>
<tr>
<td>Rural Health Network of South Central NY</td>
<td>Tier 1 CBO</td>
</tr>
<tr>
<td>Addictions Center of Broome County</td>
<td>Other</td>
</tr>
<tr>
<td>Truth Pharm</td>
<td>Tier 1 CBO</td>
</tr>
<tr>
<td>Southern Tier AIDS Program</td>
<td>Other</td>
</tr>
</tbody>
</table>
## Network Funds Flow

<table>
<thead>
<tr>
<th>Needs Assessment</th>
<th>PMPM</th>
<th>SDOH Interventions</th>
<th>Performance Incentive</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Paid to partner completing</td>
<td>• Paid to partner performing coordination of care plan</td>
<td>• Reimbursement as pre-approved by Clinical Governance Committee</td>
<td>• Split equally 1/6 among 6 partners</td>
</tr>
<tr>
<td>Goal Description</td>
<td>Indicators of Success</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Lower the number of ED visits for the identified population by 10% from the baseline.</td>
<td>Lourdes has identified 88 patients with OUD. For those 88 patients there were 198 total ED visits. This is broken down into 2.3 ED visits per year per person. We would like to reduce the ED visits by 10 percent.</td>
<td></td>
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</tr>
<tr>
<td>2. Increase patient engagement with primary care provider and available resources by 10% from the baseline.</td>
<td>Ten percent of our patient panel to see a primary care provider twice a year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Increase patient engagement with community health worker and available resources.</td>
<td>80 percent of the identified cohort will be engaged by the community health worker.</td>
<td></td>
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<tr>
<td>4. Lower the number of hospitalizations by 10% from the baseline.</td>
<td>Lourdes has identified 88 patients with OUD. Out of those 88 patients, 53 unique patients had a total of 800 days hospitalized.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Increase provider and community education regarding how to best engage the target population.</td>
<td>We will provide 5 ten week educational events on OUD to patients and community members. We will provide 25 OUD educational sessions to health care workers, reflective of an estimated 500 contact hours.</td>
<td></td>
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</tr>
<tr>
<td>6. Creating acceptance and remove the stigma associated with OUD patients</td>
<td>Cohort members and care providers will do a pre and post survey to measure the level of stigma and acceptance associated with the treatment of OUD patients.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Increase the number of providers who are waiver trained and have DEA X license.</td>
<td>We will add 5 providers who are waivered and licensed to write buprenorphine/suboxone.</td>
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</tr>
</tbody>
</table>
## Data Sharing

<table>
<thead>
<tr>
<th>Data Sharing Requirements and Processes</th>
<th>Responsible Partners</th>
<th>Frequency of Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Upload to the CCN sFTP secure site- shared folder</td>
<td>ALL</td>
<td>Monthly</td>
</tr>
<tr>
<td>2. Data sharing consent form. The cohort member will have to sign consent form for partners to share data.</td>
<td>ALL</td>
<td>Monthly</td>
</tr>
<tr>
<td>3. BAA established between Lourdes and all partners</td>
<td>ALL</td>
<td>Once</td>
</tr>
<tr>
<td>4. Monthly data stakeholders meeting. The network will review the Cohort Services Tracker (provided by CCN).</td>
<td>ALL</td>
<td>Monthly</td>
</tr>
</tbody>
</table>
Lessons learned
Lessons Learned

1. Partnering is an art and a science
Partnerships or transactional relationships?

**Transactional relationships**
- Service delivery
- Sub-contracted work
- Funding relationships
- Transferred risk

**Partnerships**
- Co-created activities
- Mutual accountability
- Complex relationships
- Shared risk

By helping transactional relationships become genuine partnerships where appropriate.

By re-positioning relationships that are inaccurately described as partnerships.
ART
• Insight / imagination / feeling
• Vision (of the future)
• People skills
• Active listening
• Personal engagement

SCIENCE
• Action / practice-based research
• Knowledge / analysis / thinking
• Understanding (of the past)
• Administrative / technical skills
• Precise speaking
• Professional detachment
Lessons Learned

Partnering may require organizational adjustments
Organizational Adjustments

- Changes in mindsets, behaviors and relationships
- Partners have new capabilities
- Sharing risks and rewards
Lessons Learned

3 Prepare for a business case
Return on Investment

Measuring the impact of SDOH interventions on DSRIP Metrics

Tracking interventions to goals