

Social Care Integration into Health Care Delivery System

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Select the number
that best
represents your
organization

1

Community Based
Organization

2

Health System

3

Health Plan

4

Pharmacy

5

Behavioral Health

6

Other

Healthy Alliance IPA



One of the first IPAs of its kind focused specifically on addressing social determinants of health (SDoH)



High-performing network of organizations providing social care services



At Healthy Alliance IPA's foundation is a company-wide belief that investing in social needs, before they turn into costly medical problems, creates *better health for all.*

We Can Only Manage What We Can Measure

Social Care + Medical Care = **Health Care**

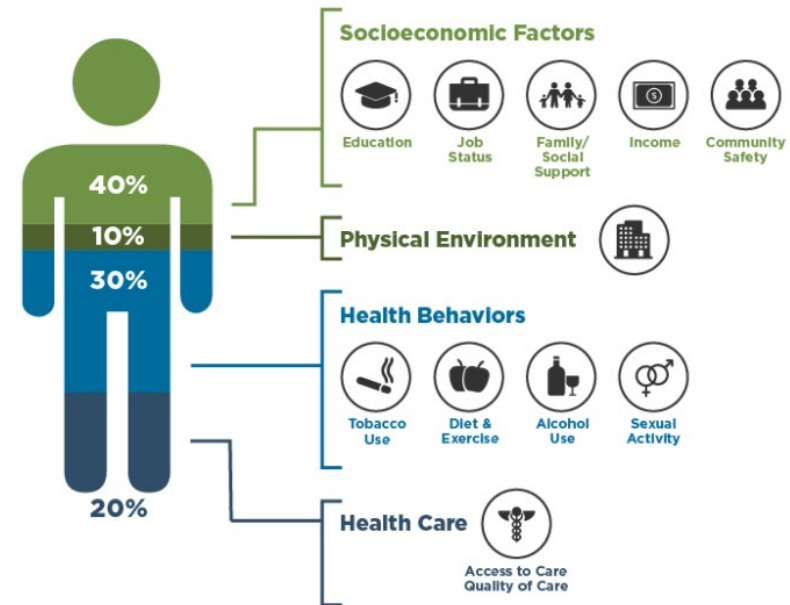


This screening tool is used to support you with your health goals. Your responses will not affect your benefits and services and should not be completed if you filled one out in the last 6 months.

First Name: _____	Birthdate: ___/___/___		
Last Name: _____	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male		
Address: _____	OR Uninsured: <input type="checkbox"/>		
City: _____ State: _____ Zip Code: _____	Medicaid CIN: _____		
	Primary Phone #: _____		
Screening and Targeted Health Questions	Yes, client plans to self-resolve	Yes, client agreeable to referral	No
1. In the last 12 months, did you ever eat less than you felt you should because there was not enough money for food?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. In the last 12 months, has your utility company shut off your service for not paying your bills?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you worried that in the next 2 months you may not have stable housing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do problems getting childcare make it difficult for you to work or study? (If No children, please select N/A)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> N/A
5. In the last 12 months, have you needed to see a doctor, but could not because of cost?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. In the last 12 months, have you ever had to go without health care because you did not have a way to get there?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you ever need help reading hospital materials?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Are you afraid you might be hurt in your apartment building or house?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you seen a primary care provider in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Are you currently enrolled in a Medicaid Managed Care Plan with an "active" status?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you require assistance accessing your prescriptions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Completed by CHW/Worker Name: _____ Screening Date: _____
Organization Name: _____

What Goes Into Your Health?





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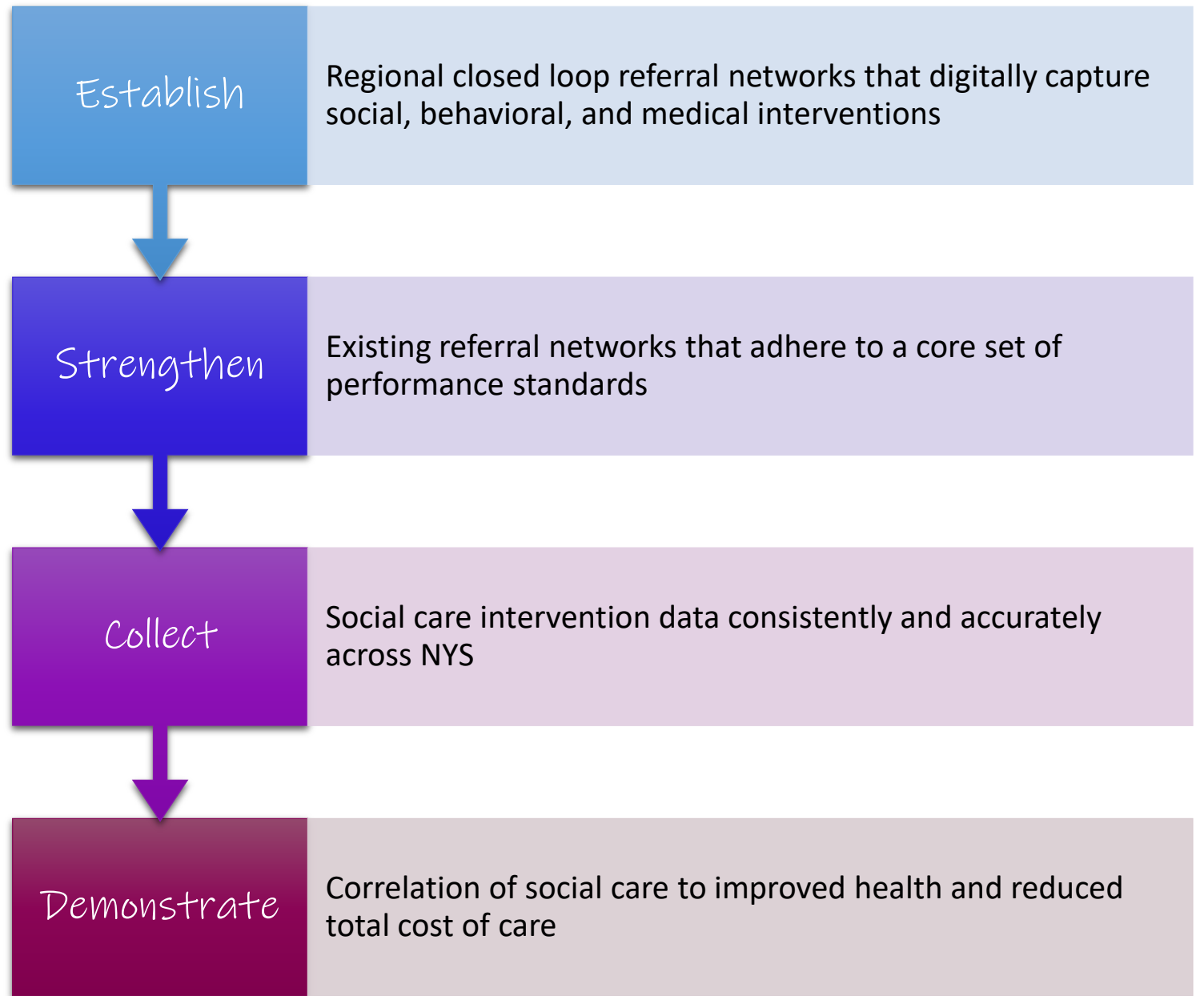
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Social Determinants of Health Screening Tool

Poll Question:
How many of your organizations
currently screen for social
determinants of health?

Leveraging Lessons Learned



Networks empower social care providers



HEALTHY ALLIANCE IPA
COMMUNITY SOLUTIONS FOR BETTER HEALTH



Complete SDOH screenings, refer individuals to social care providers



Connect social care providers



Create an organizational structure that *supports everyone*












Define and execute services that *managed care wants to pay for*



Grow funded programs to support social care programs through the IPA.

Snapshot of Healthy Alliance IPA Participants

									
	Benefits Navigation	Employment	Food Assistance	Health Care Coordination	Housing + Shelter	Legal	Mental + Behavioral Health	Social Care Coordination	Social Enrichment
<u>Alliance for Positive Health</u>	✓		✓	✓	✓		✓	✓	
<u>Altamont Program</u>	✓	✓			✓			✓	
<u>Bethesda House of Schenectady, Inc.</u>	✓		✓	✓	✓		✓	✓	
<u>Beyond Living</u>							✓		✓
<u>Capital District YMCA</u>									✓
<u>CAPTAIN Community Human Services</u>	✓		✓		✓		✓	✓	✓
<u>Catholic Charities of the Diocese of Albany</u>	✓		✓		✓		✓	✓	✓
<u>Center for Disability Services</u>	✓			✓					✓
<u>CEK RN Consulting, Inc.</u>				✓					
<u>Centro Civico, Inc.</u>	✓								
<u>Church of St. Vincent de Paul</u>			✓						
<u>Columbia County Community Healthcare Consortium, Inc.</u>	✓	✓		✓					
<u>Commission of Economic Opportunity (CEO)</u>	✓	✓	✓						
<u>Community Caregivers Inc.</u>	✓								✓
<u>Community Health Center</u>				✓					
<u>Conifer Park, Inc.</u>				✓			✓		✓
<u>Cornell Cooperative Extension</u>	✓		✓						
<u>Eleanor Young Clinic</u>							✓		
<u>Ellis Hospital</u>	✓		✓	✓			✓		
<u>Equinox</u>				✓	✓		✓		
<u>Franklin Community Center</u>			✓						
<u>Healthy Capital District Initiative</u>	✓			✓					

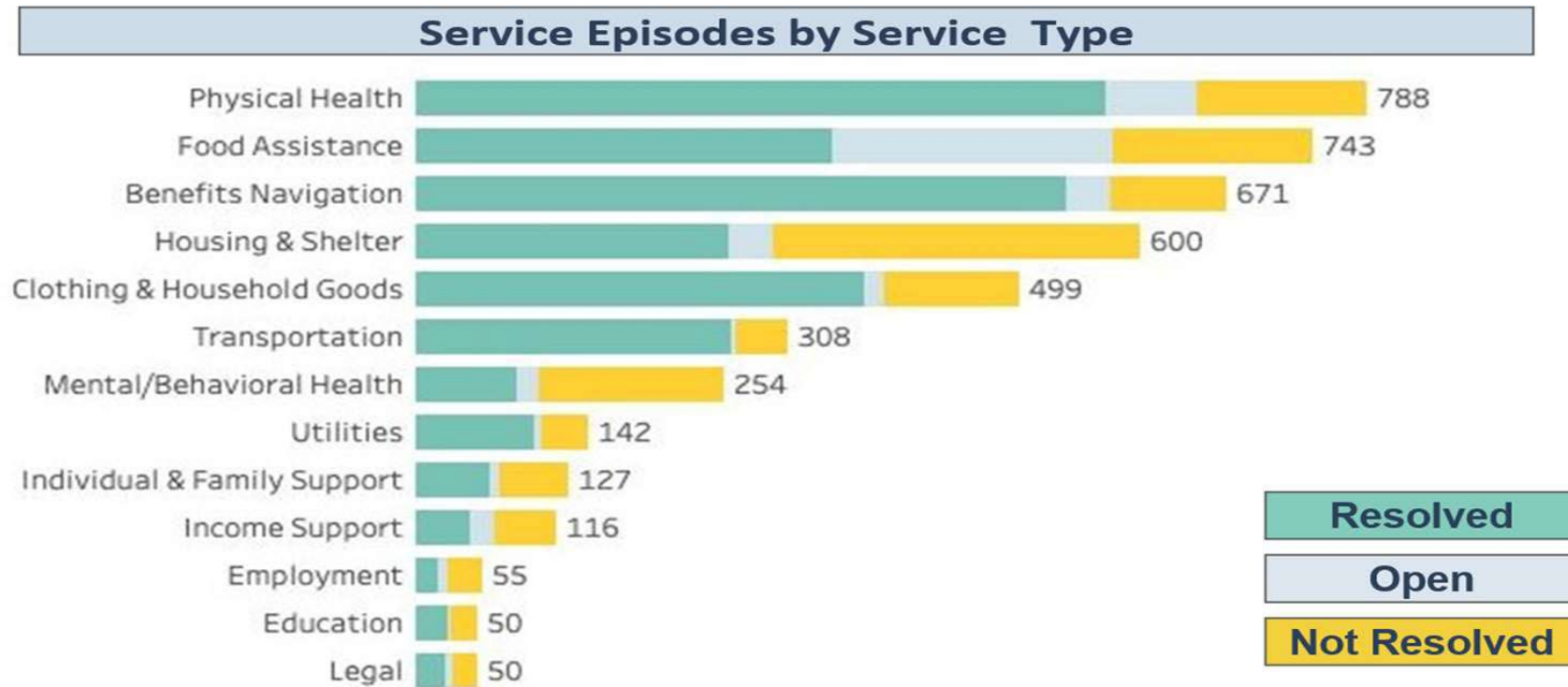
Network Impact Through April 2021

April 2018 - April 2021



Community Impact

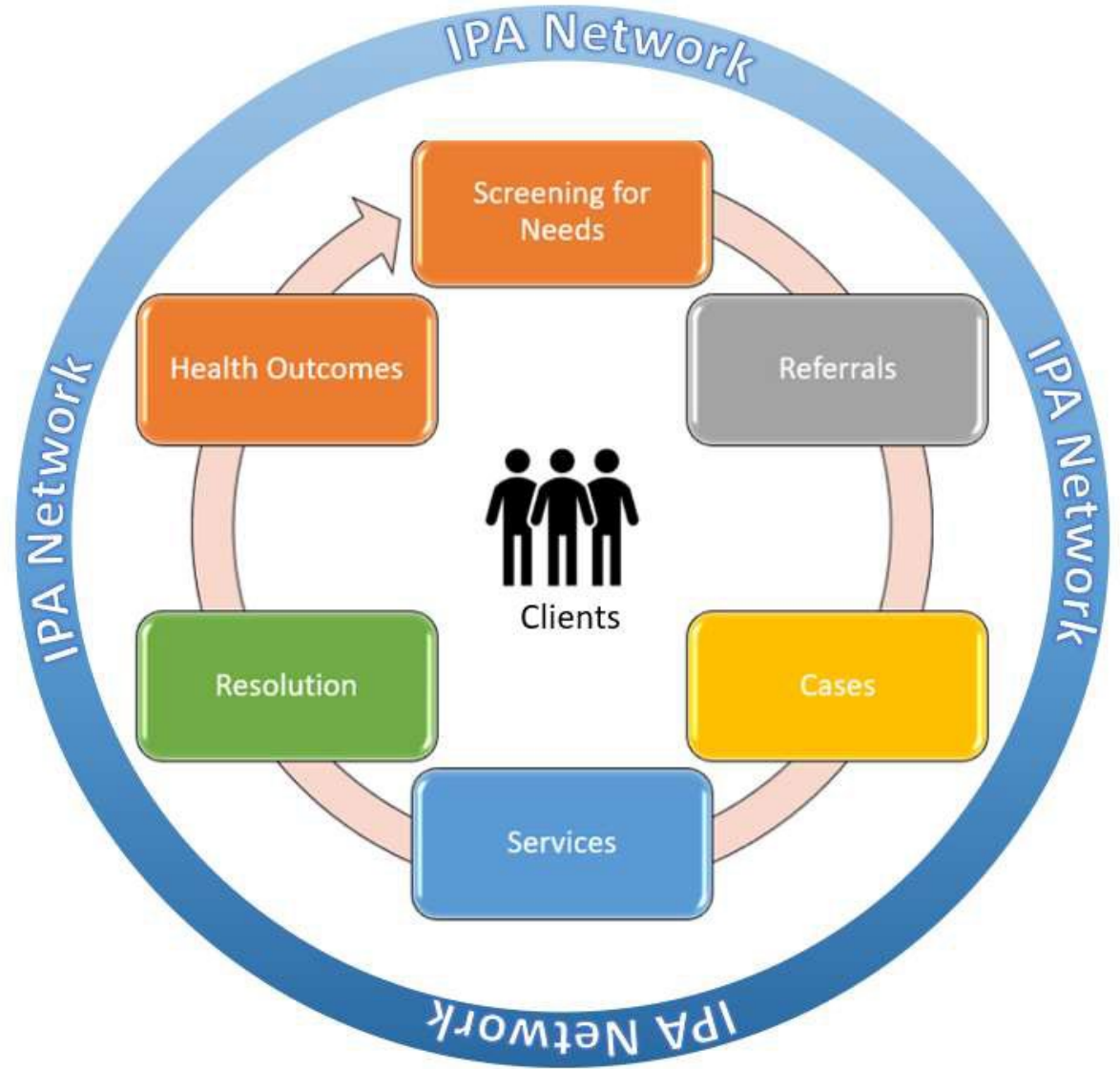
Jan - March 2021



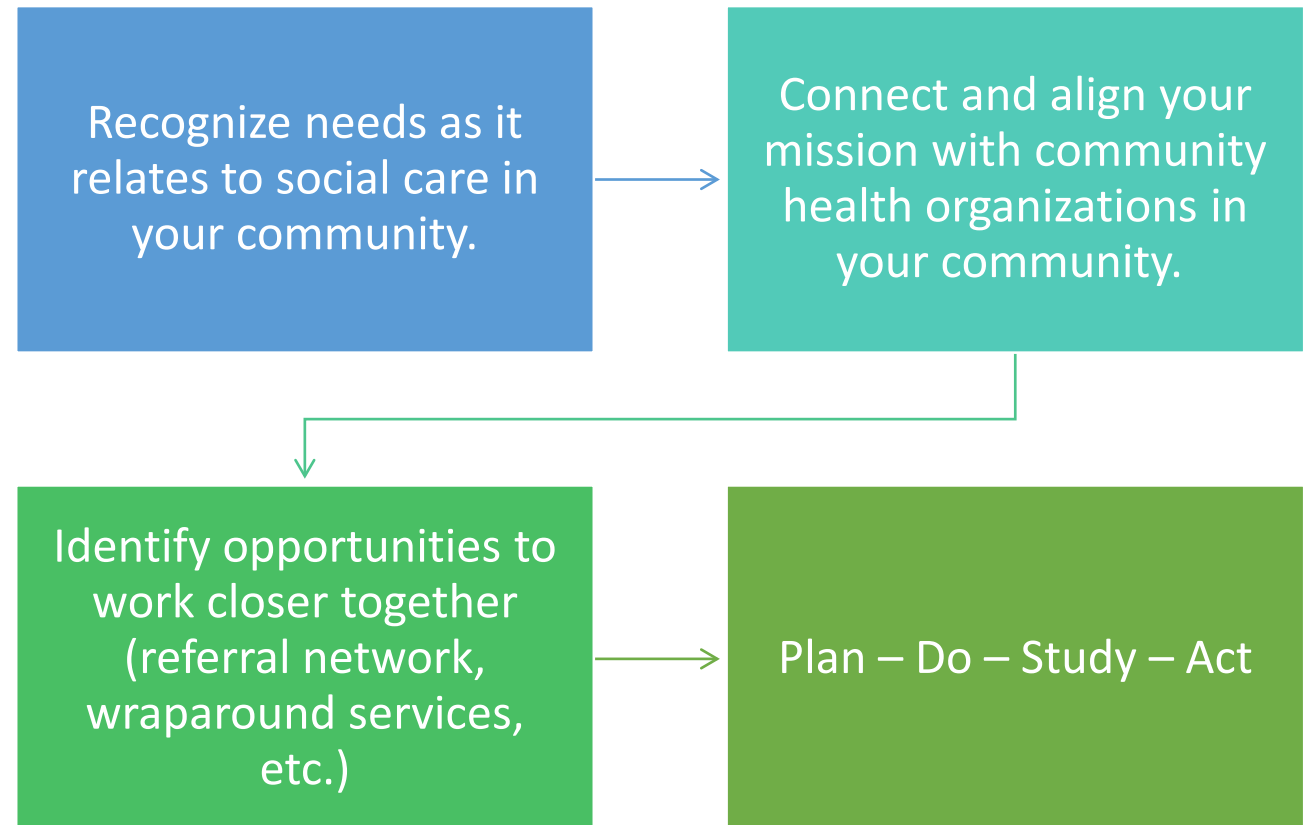
Healthy Alliance IPA Contracts

Health Plan	Term	Details
Capital District Physicians Health Plan (CDPHP)	3 years	(1) Food insecurity program with three-levels of service including food pantry plus, medically tailored food pantry, and healthy prepared meals (2) transportation for social isolation
Capital District Physicians Health Plan (CDPHP)	6 months	CDPHP contribution to Alliance vaccine work using Collaborative Approach to Public Goods Investment (CAPGI) methodology
Eddy SeniorCare PACE	1 year auto-renew	3 levels of food service available to PACE participants identified as food insecure (Traditional food pantry, medically tailored meals, home delivered prepared meals)
Innovative Health Alliance of NY (sub-contract to Fidelis VBP contract)	6 months	Connect members with chronic conditions who have not had an office visit in \geq 6 months to primary care appointments through outreach by social care organizations.
MVP Health Plan	2 years	7 social care organizations funded to optimize the use of Healthy Together referral platform and implement social care programs that improve community health.
MVP Health Plan	1 year auto-renew	Cooking classes - healthy cooking classes for MVP Staff and MVP Medicare Advantage members and community

Building a High Performing Network



Building a Social Care Network



Network Health

Goal Setting

- Set targets together to make an impact on your community
- S-M-A-R-T (Specific, Measurable, Attainable, Realistic, Time-Based)

Use

- Use your data to demonstrate your effectiveness

Convene

- Work with your partners on an individual level and learn how they are succeeding and where they are stuck

Share

- Share best practices

Challenge

- Challenge yourself to move the needle higher than your initial goals

Network Relevance



Review out of network referrals



Community Engagement



Seek out new partners



Close the funding gap for CBOs to expand services

Reporting and Analytics

Establish a technical infrastructure that captures social, behavioral, and medical interventions.



Collect consistent data elements across the entire network.



Safely submit data to Healthy Alliance IPA to fulfill contract obligations.

Benefits of Staying Connected

Interconnectivity

- Support interconnectivity between clinic and community
- Implement closed loop referral system, powered by Unite Us
- Digitally bundle social care providers

Organizational Structure

- Ensure volume and quality of referral goals are met
- Data analysis
- Leverage resources to meet Value Based Program requirements

Ongoing Support

- Leverage experience of Healthy Alliance IPA team
- Access to social care navigators
- Access to performance management team

What is the Value to my Organization?

Improved Health

- Fewer social care admissions, a reduction in total cost of care, and an increase in quality scores – some of which will be realized 2-4 years postintervention

Social Care Data

- Visibility to member specific, standardized social care needs and services data

Social Care Tools

- Access to screening tools for social needs and then referring appropriately using a closed-loop referral system, making sure members don't fall through the cracks

Member-Centric

- Improve HEDIS/QARR scores
- Member satisfaction

Questions and Next Steps

We'd love to hear from you!



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