IPA, MSO, and ACO Social Determinants of Health

Background

This customer is an IPA, MSO, and ACO that was founded and is owned by over 2500 NYC community physicians serving a government programs population of over 1 million patients. The customer is comprised of multiple payer contracts in various risk models with delegated administration. With a mission to serve independent community doctors with the support necessary to drive high-quality, patient-centric care in NYC's most valuable communities comes the dependency on proactive - not reactive - population health innovations and technological solutions.

Situation

New York State Department of Health designed the customer's Innovator Program to support provider organizations committed to charting the path to the highest level of value-based payments for the Medicaid population. The NYSDOH has approved the customer as a VBP Innovator and, as part of the successful execution and operationalization of Innovator contracts, is responsible for implementing SDOH programs for approximately 80,000 lives. As stated in the New York State VBP Roadmap, all Level 2 and 3 VBP contractors are required to show a commitment to addressing Social Determinants of Health (SDH) and working with Community Based Organizations (CBOs), the customer is responsible for outline and delivering the proposed intervention(s). To accomplish this, the customer partnered with Regional Aid for Interim Needs, Inc. (R.A.I.N CBO) to tackle food insecurity and housing instability interventions.

Problem

The customer's network must identify members' needs for social determinants of health interventions, track referral outcomes, the status of interventions, success rates of closed cases, and ultimately, MCO performance impact on all patients that qualified for interventions. The complexity and barrier to accomplishing this is the multiple parties lacking a central data aggregate tool. The trigger referral for SDOH interventions come from the customer via spreadsheets to R.A.I.N. and there was no effective way for R.A.I.N community healthcare workers to report on outcome status easily. In addition, an aggregate reporting tool was needed to track ED/IP utilization, cost, and patient chronic condition trends over time with clinical and payer data that is standardized and centralized.

Solution

Garage worked closely with the customer and R.A.I.N to develop a custom referral intake tool and a smart form to monitor all referrals and applications using the GRID application. Housing Security and Food Security/Access to Healthy Foods are the two interventions managed by the customer, with 9 and 7, respectively, program applications and closures tracked in Garage. Staff from R.A.I.N can mark outreach attempts and the status of submitted applications to identify what programs the patient is enrolled in and the closure date of cases. Differentiation on short- and long-term

interventions can also be monitored. The customer can access this data at any time to understand the success of the program and performance outcomes with R.A.I.N, and ultimately assess the impact of this SDOH program. Applications tracked through GRID include: NYCHA Housing, SNAP Food Benefits, WIC Food Benefits, Food Pantry, and FHEPS Applications.

Outcome

From go-live in July 2021 to June 2022, R.A.I.N. received 772 referrals in Bridge. Nieve Berrido, the primary community healthcare worker at R.A.I.N overseeing the customer's initiatives, uses the tool in Garage as her daily reference point to receive new requests, track the status of all programs and call interactions, and close cases for the customer's reporting. Below are the success points achieved during that time frame:

- 379 for Food - 341 cases closed; 27 deferred; 11 in progress
- 427 for Home - 392 cases closed; 28 deferred; 7 in progress
- 102 Uncategorized Support Requests

"The development of this innovative collaborative approach to managing social determinant of health interventions has resulted in our Innovation ability to respond to the requirement of the contracted plans and the NYS Department of Health. This collaboration has simplified the process and has allowed us to meet the needs of those most in need for interventions on food and housing insecurity."

– Vice President, Clinical Quality