KPMG

(Re) defining the healthcare delivery system: The role of social services

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Introduction

The U.S. health system is in the midst of an extraordinary transformation. One element of the shift is an effort by public officials to include "social" interventions into health delivery systems. Medicaid and Medicare, for example, increasingly are using financial incentives to encourage healthcare providers to address the social needs of their patients and, more generally, the social conditions in the communities in which they work. This trend is prompted by a broader recognition that disease often arises from unhealthy housing conditions, poverty, crime, poorly designed urban landscapes, and psychosocial stressors. The policy assumption is that improving social conditions will lower health system costs by preventing disease before it has a chance to take hold.[1]

Perhaps the most widely watched such initiative is taking place in New York, in the so-called Delivery System Reform Incentive Payment ("DSRIP") program, in which Medicaid is offering more than $7 billion in supplemental funds to provide financial incentives to groups of providers that can create (at least partly through the expanded use of community-based social services) a system transformation big enough to achieve a 25 percent reduction in avoidable hospitalization use over five years. There now are 25 groups of providers that have created so-called "Performing Provider Systems" (PPSs), each of which aims to not only meet the avoidable hospitalization metric, but also to meet a series of other metrics around health system transformation and improved health outcomes.

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[1] Deborah Bachrach, et. al, "Addressing Patients' Social Needs: An Emerging Business Case for Provider Investment," (Manatt Health Solutions, May 2014).

In this context, in May 2015, the Mailman School of Public Health, through its Department of Health Policy and Management (HPM), and KPMG LLP (KPMG) jointly hosted a conference to consider key questions raised by DSRIP and similar initiatives that seek to bridge the gap between social services and health. The conference included a panel that examined where social services fit in a re-defined health delivery system, another that asked whether and when health insurers should pay for such services, and a third that considered whether DSRIP represented a new approach or old wine in new bottles. To answer these questions, the conference brought together health policy leaders, academic researchers, healthcare consultants, and health and social services providers, all of whom provided a different perspective, a different expertise and a different set of expectations.[2] Following the conference, Mailman

faculty conducted site visits to two groups of DSRIP providers to make an even deeper dive into these efforts at population health management.

This white paper seeks to integrate the expertise of conference participants with the lessons suggested from the academic literature and also the DSRIP site visits. We focus on four questions. First, why is the effort to integrate social and medical services so hard? Second, what are some examples of promising efforts at such integration? Third, does the evidence so far support the hopeful proposition that a higher priority for social services will improve health outcomes (and lower overall costs)? Fourth, and finally, what are the key takeaways for policymakers and academics alike?

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[2] The Conference Agenda is attached as Appendix A and a list of Participants is attached as Appendix B.

Health insurance and social services: The potential fit

The power of medical care to prolong, restore, and improve health has been recognized since Hippocrates, and the expansion of that power is one of the scientific and social triumphs of the last 100 years. Competing with this notion historically, however, is the idea that disease arises from, and can be prevented by social conditions-also an idea that arose in the time of Hippocrates.[3] Otherwise put, what if health status and outcomes are produced in part by factors (such as education, housing, and income) that lie outside the spheres of traditional medical care and clinical services? What, indeed, if these external factors—"social determinants"—are, in some or most cases, more important to health than is medical care per se? What if social policies addressed to such social determinants are at least as powerful a dose of prevention as medical care.[4] What if, Kenneth Davis, the President and CEO of the Mount Sinai Health System in New York, argued, social service investments are the best path to both lower costs and better outcomes?[5]

This issue is of more than academic interest, because public and private institutions in the United States pay handsomely for medical ("healthcare") services and have long bemoaned their rising cost. As part of the effort to lower costs, therefore, perhaps health insurers (both public and private) should be paying more attention to, and more money for, social programs and social services that tackle the "real" (social) determinants of health. And because doing so should produce better outcomes and (hence) lower spending on medical care, the sums needed to augment social interventions might arguably be reclaimed from expensive healthcare budgets.

There are, however, historical, political, cultural, and economic barriers to using health insurance premiums to pay for social (rather than medical) services. For starters, for nearly a century, we have had a coverage model under which health insurers pay for the provision of those "covered services" deemed to be "medically necessary" to either treat or prevent disease. Until recently, most such services had a clear and compelling grounding in traditional medical care: physician visits, prescription drugs, in-patient hospital stays, and other services delivered within healthcare settings, by medically-trained and licensed personnel. Non-clinical services, delivered outside of healthcare institutions, were deemed insufficiently medical and generally were not covered.

The longstanding focus on coverage for medical care services is not a historical accident. Back in the early 1930s, hospitals and physicians formed the nation's very first health insurance companies, doing so as part of an effort to survive financially during a catastrophic economic depression. Their goal was to maximize provider income in an era in which ordinary citizens no longer had the money to themselves pay for care. These provider-sponsored insurers (such as Blue Cross and Blue Shield) thus put in place a reimbursement model that paid a separate fee for every medical service provided. As the insurance system evolved and expanded, nearly all insurers (including the commercial and public insurers that eventually came to dominate) adopted the same fee-for-medical service reimbursement model, prioritizing coverage for curative and acute care services (over primary or preventive services). Nearly a century later, this same fee-for-medical service model is still dominant.

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[3] Krieger N. Theories for social epidemiology in the 21st century: an ecosocial perspective. Int J Epidemiol 2001;30:668-77.

[4] Virchow, R. (1849). Notes on the typhoid epidemic prevailing in Upper Silesia. Arch Pathologische Anatomic Physiologic Klinische Medizin, 2, 143-322.

[5] Kenneth Davis, "To Lower the Cost of Healthcare, Invest in Social Services," *Health Affairs*, July 14, 2015.

In this context, policies or programs explicitly designed to address social conditions such as poverty, poor schools, unsafe neighborhoods, or pollution were considered well outside of the medical (and thus health insurance) sphere. Indeed, even in the heyday of the Great Society movement in the 1960s, only one federally-qualified community health center was providing extensive social services with federal dollars.[6] Other community-based social services organizations that work to address such social conditions have struggled to attract sufficient grant and/or philanthropic funding to remain in business.

To be sure, even under this traditional medical coverage model, health insurers occasionally covered services that blurred the line between health and social services. State Medicaid programs, for example, have always had the discretion to pay for "personal attendants" and other "home and community-based" services for elderly and disabled beneficiaries. These personal attendants are hired to help their clients with a range of "non-clinical" services, including dressing, shopping and cooking. Moreover, Medicaid funding for nursing home care *de facto* pays facilities for the cost of housing beneficiaries (along with whatever more traditional medical services are provided within the facility).

Similarly, public and private insurers alike have long covered the work done by hospital discharge planners (typically social workers) and care managers more generally. The movement in the mid-1990s toward "managed care" in Medicaid was designed to do more than simply manage disease; the focus presumably would be on prevention, and care managers in at least some of the health plans counseled beneficiaries on how best to navigate and coordinate with various social services programs. There was, of course, variation in the tasks assigned to these care managers, and first priority typically was to coordinate (and review for pre-authorization) the various medical services provided to patients. But while encouraging connections with social services agencies tended to be a second-tier agenda, the precedent for at least referral to non-medical social services was reinforced, albeit generally with limited payment for the cost of such social services.

Rather remarkably, however, there now are changes afoot in the healthcare industry (on both the provider and payer side) that make it far more likely that health insurers will pay more than lip service to the social needs that impact health, and to the community-based organizations that can help in that effort. Four market-based trends seem especially important.

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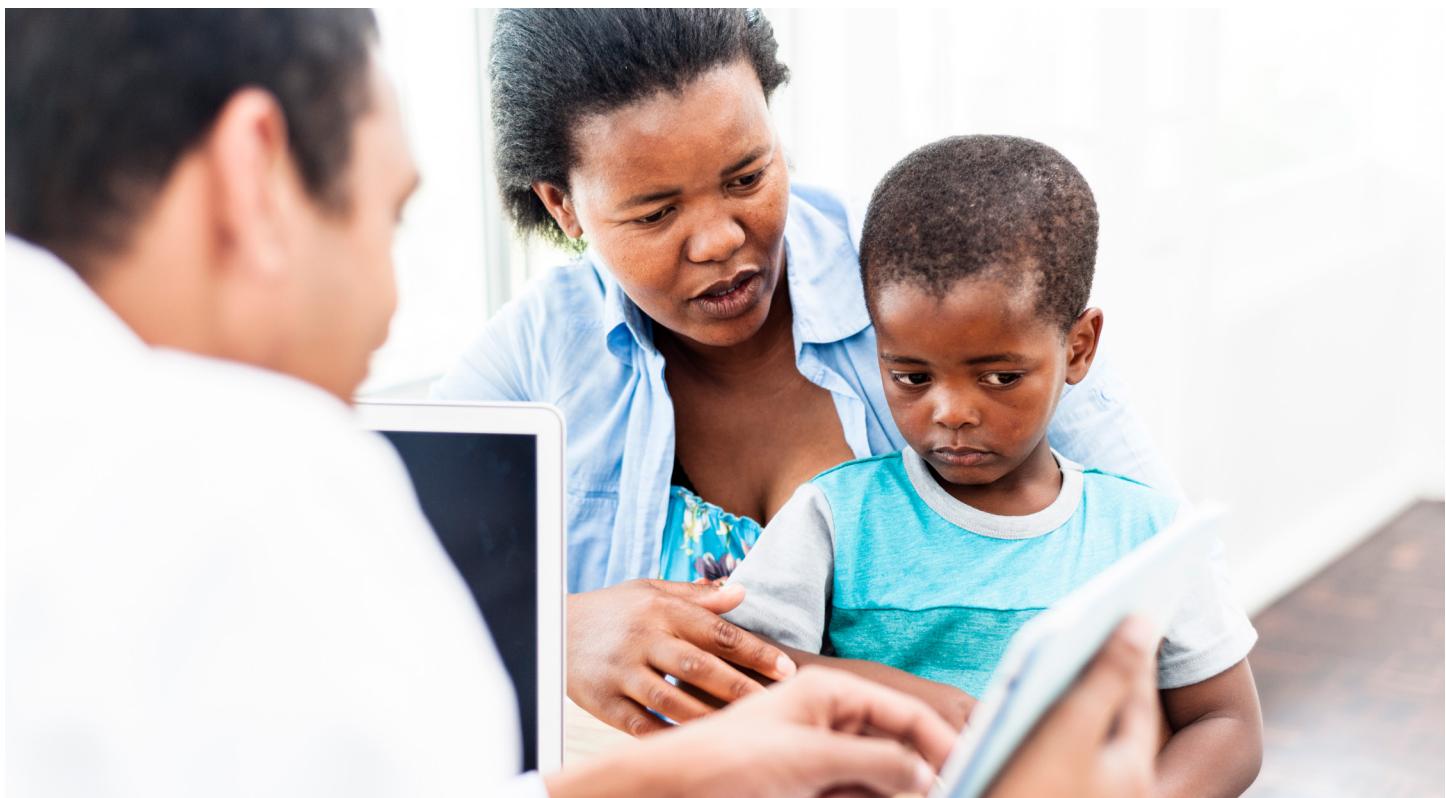
[6] H. Jack Geiger, "Community-Oriented Primary Care: A Path to Community Development," *American Journal of Public Health* (November 2002).

- The health system is consolidating as the industry undergoes an unprecedented wave of mergers and acquisitions.

- The consolidation is both horizontal and vertical, as the effort to get bigger is accompanied by the attempt to create "integrated delivery systems," in which previously siloed sectors (such as the hospital, the community clinic, and the office-based physician) all become part of a single organization.

- These new integrated delivery systems have access to data about their patients' utilization patterns and costs that far exceed what has long been available.

- Most important, health insurers are seeking to move away from fee-for-service reimbursement models and toward so-called "value-based purchasing," and in so doing are experimenting with efforts to put groups of providers at financial risk for the cost and quality of care received by a defined community or population.

These market-based trends are encouraged as well by federal and state policy. The Affordable Care Act, for example, relies largely on value-based payment policies both to contain healthcare costs and to improve quality and outcomes. For example, hospitals now face financial penalties if federal officials find that too many of their patients with a diagnosis of heart failure or pneumonia are readmitted within 30 days of discharge. No longer do such readmissions guarantee increased reimbursements: the payment for the additional service must now be balanced against the potential for fiscal penalties. Federal officials hope the new rules encourage hospitals to increase their post-discharge care management activities. Such care managers, for example, might assess the home and social environment of the discharged patient, and offer advice, encouragement and perhaps even some tangible resources that could minimize the likelihood of a preventable readmission. The hospital might even use community health workers from the local area who have connections with, and the trust of, the at-risk populations.

The ACA also encourages insurers to create so-called Accountable Care Organizations (ACOs). There are, for example, nearly 400 ACOs that participate in the Medicare Shared Savings Program. Each of these ACOs is at financial risk for the cost and quality of at least 5000 Medicare "fee-for service" beneficiaries; the federal government tells the ACO what the group of beneficiaries will likely cost over the course of a year. If the costs turn out to be lower, and the beneficiaries as a group meet various health quality metrics, then the ACO gets to share in the savings presumably generated by its successful population health management. While only a quarter of the participating ACOs are so far sharing in savings, and while federal officials tinker with program rules to encourage improved performance, the model itself is gaining increased traction across all payers; indeed private health plans have themselves moved quickly to adopt the ACO model for their commercial markets, and there now are more ACO enrollees in that market than in Medicare.

The impact of these various market and policy trends is that health systems are being asked to manage the health of large groups of individuals instead of focusing narrowly on the health of one individual at a time. This focus on "population health management" encourages novel strategies (such as paying for social services with health dollars) to improve population-based health metrics (while also reducing overall costs). It also represents a strange and unfamiliar world for hospital officials (among others) who have training and experience in filling hospital beds, but who are now asked to reduce in-patient occupancy (and the revenue that accompanies such admissions) and to instead focus on prevention and population health.

There even has emerged a new industry (with companies such as Healthify and Health Leads) that works with providers and payers to connect their patients and members to needed social services. The assumption is that these groups (and others) can use new technologies and modeling techniques to identify policies and strategies targeted to the needs of particular communities (or even individuals), and then use equally new technologies and techniques to screen for needed services, refer to culturally appropriate and competent service providers, and evaluate compliance, performance and the overall impact of these new strategies on health outcomes.

The connection between social and medical services seems especially promising in low-income communities where there is clearly a range of non-medical factors that particularly harm the health of the poor. For example, it is intuitive that a homeless person is less likely to be readmitted for dehydration and exposure to the elements if he or she had a home. Historically, many such cases seemed to lead to extended hospital stays, because it was not permissible or desirable to discharge a person "to the street" rather than "to home".[7] Therefore, why not refer the patient to a short-term housing assistance program, if one is available? And why not have hospitals collaborate with public housing agencies as well as community-based housing assistance programs to both increase the stock of such housing and also create linkage and referral systems to ensure appropriate placements, and reduction in care utilization?[8].

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7 Larimer ME, Malone DK, Garner MD, et al. Health care and public service use and costs before and after provision of housing for chronically homeless persons with severe alcohol problems. JAMA 2009;301:1349-57.

8 Martinez TE, Burt MR. Impact of permanent supportive housing on the use of acute care health services by homeless adults. Psychiatr Serv 2006.

To be sure, there are clear limits to what payers will cover. For example, while Jim Knickman, formerly President of the NYS Health Foundation, called the $15 minimum wage for fast food workers the most important public health policy implemented in New York State in 2015,[9] neither Knickman nor anyone else suggests that Medicaid or any health insurer contribute to the wages of such workers. Similarly, few if any Medicaid officials (or provider organizations) suggest that Medicaid should pay for school vouchers or pollution remediation or new inner city parks (even though each of these has potential to reduce Medicaid expenditures).

The current effort to link the health and social services arenas instead focuses on several more incremental approaches. For example, instead of waiting for non-English speaking immigrants to contact and perhaps enroll in a care management initiative, why not hire a community-based and highly trusted social services organization to do outreach, screening, referral and non-clinical follow-up? That same community-based organization also could be hired to help their clients navigate the various health-related social service benefits to which they are legally entitled (such as cash assistance or a low-cost energy subsidy). The "community health worker" could even assess the beneficiary's home environment and recommend that an insurer pay for a low-cost non-traditional service (such as an air conditioner or a cell phone) that could lead to a safer and healthier home, while also lowering overall costs. This has been done in a variety of ways over time, and forms one leg of a model called "community-oriented primary care."[10] This model—addressing the biology, individual, family, community, and society in the generation of health—has its origins in the revolutions of 1848.[11] One modern example is the federally-funded community health center in Bolivar County, Mississippi. In the 1970s, "prescriptions" included counseling parents on childcare, installed screens on windows, upgraded water and sanitation systems, and repairs to damages to the home.[12]

Medicaid coverage for supportive housing illustrates the complicated rules, blurring lines, and innovative efforts. For example, federal law prohibits states from using federal Medicaid dollars to pay "room and board" unless such payments are pursuant to a "section 1915(c) waiver" for short-term home respite services or for "unrelated live-in caregivers."[13] But state Medicaid directors can also use

such waivers to cover the cost of a host of "housing-related services," including communicating with landlords, completing housing applications, paying security deposits, buying furniture, financing moving expenses, and paying for modifications to the rental space to accommodate particular physical needs.[14] Medicaid officials are using such waiver authority to develop housing assistance programs for homeless (and other) beneficiaries in numerous communities around the nation.[15] In fact, while the Centers for Medicare and Medicaid Services (CMS) has traditionally funded many social services (e.g., transportation), it now funds not only housing, but community-based parenting programs, substance abuse programs, and even bicycle helmet distribution programs.[16] It is far too early to tell whether such programs are working, and, indeed, few efforts are being made to conduct the research that is needed to know whether they are working.

There is, of course, no template for a successful Medicaid-funded housing assistance program. Nor is there clear guidance for Medicaid directors on what is permissible (and what could prompt a federal audit). But there are many qualities that such a program presumably should have:

– Medical clinics close to the housing units, patient/client-friendly hours of service (perhaps 24/7)

– Teamwork (multidisciplinary coordinated care teams)

– Careful anticipation of problems that renters may face when they enter and/or are discharged from a hospital

– Close attention to handoffs and transitions (in the course of discharge planning and otherwise)

– A dedicated resource to ensure integrative arrangements work[17]

The personnel drawn upon to perform these tasks can include housing experts, mental health professionals, counselors, case managers, client navigators, lawyers, clinicians, job training experts, nutritionists (and cooking instructors), exercise therapists, weight control advisors, and transitional nurses/discharge planners. In all of these tasks partnership, dialogue, and a "client-centered" ethos are invaluable.

9 James Knickman, "The Most Important Public Health Advance of the Year: A $15 Minimum Wage," *NYS Health Foundation*, July 23, 2015.

10 Mullan F. Community-oriented primary care. N Engl J Med 1982;307:1076-8.

11 Krieger N, Birn A-E. A vision of social justice as the foundation of public health: commemorating 150 years of the spirit of 1848. Am J Public Health 1998;88:1603-6.

12 Geiger HJ. Community-oriented primary care: a path to community development. Am J Public Health 2002;92:1713-6.

13 Victoria Wachino, "Coverage of Housing-Related Activities and Services for Individuals with Disabilities," CMS Informational Bulletin, June 26, 2015.

14 Ibid.

15 Kathy Moses and Rachel Davis, "Housing is a Prescription for Better Health," *Health Affairs Blog*, July 22, 2015.

16 Kassler WJ, Tomoyasu N, Conway PH. Beyond a traditional payer—CMS's role in improving population health. N Engl J Med 2015;372:109-11.

17 Nutting PA, United States. Health Resources and Services Administration. Office of Primary Care Studies. Community-oriented primary care: from principle to practice. [Rockville, Md.]: U.S. Dept. of Health and Human Services, Public Health Service, Health Resources and Services Administration, Office of Primary Care Studies, 1987.

Along with new efforts to incorporate social needs into health insurance comes increased interest in evaluating their success. The federal government, for example, just announced a $157 million initiative (called the Accountable Health Communities model) to evaluate whether awareness and access to health-related social needs will lower health system costs and positively impact "quality," as defined under relevant metrics, such as readmission rates. Applicants for funding of this sort could include dozens if not hundreds of pilot initiatives around the country, all designed to enable safety net health providers to collaborate with partners new to the healthcare arena. There is extraordinary variation in these policy laboratories. New York City is training teachers and job placement specialists to identify and treat mental health issues.[18] Connecticut is offering supplemental Medicaid payments to community health centers that contract with social services providers.[19] Vermont is using Medicaid funds to pay for day care services for a group of substance-abusing mothers.[20] Similar programs pay for bicycle helmets, car seats, employment initiatives, and literacy programs.[21]

Despite the promise of such partnerships, there also is concern about the many obstacles that still need to be overcome. Many of the targeted community-based groups have few connections or collaborations with the hospital-based medical safety net that has long looked after the healthcare needs of the poor. The two sectors also have long had different missions, different funding sources, and different regulatory oversight.

Consider, for example, the laudable effort to integrate the (health) world of treatment for maternal depression and the (social services) world of child abuse. Progress is slow, at least in part because each sector is comprised of a complex set of highly stressed programs, which vary significantly by state and community, with different cultures, languages, funding sources, and regulatory oversight. Integrated efforts, however, such as Nurse Family Partnership, have had experimentally-proven success at improving both maternal and child outcomes.[22]

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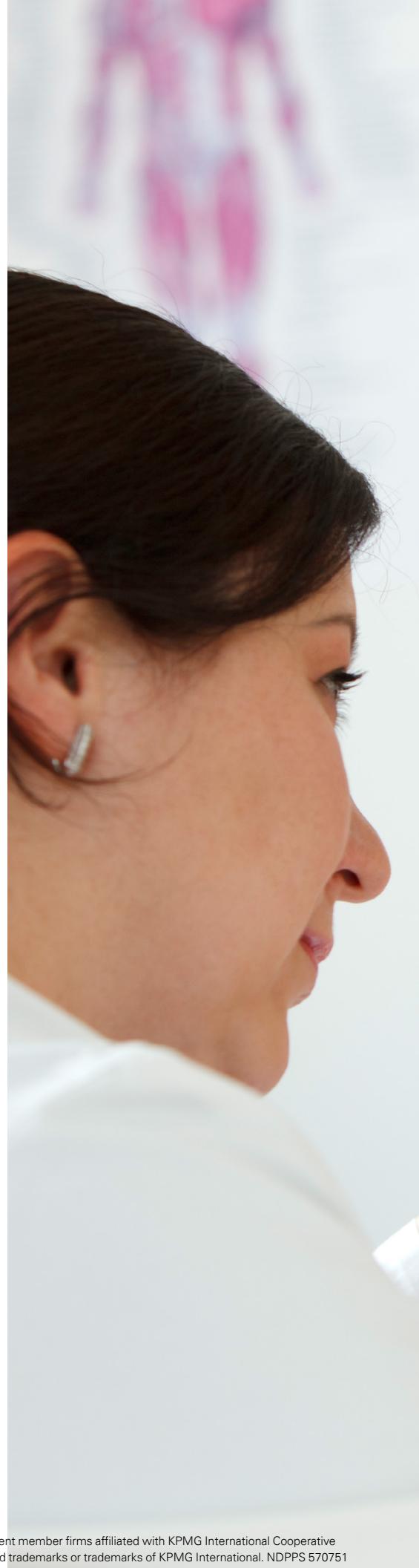
[18] NY Times, July 30, 2015

[19] Kate McEvoy, conference transcript

[20] William J. Kassler, Naomi Tomoyasu, and Patrick H. Conway, "Beyond a Traditional Payer – CMS's Role in Improving Population Health," *New England Journal of Medicine* (January 8, 2015)

[21] Ibid.

[22] Olds DL. The nurse-family partnership: An evidence-based preventive intervention. Infant Mental Health Journal 2006;27:5-25.

Health insurance and social services: Who does what?

Enabling healthcare providers to address the social needs of both patients and populations entails four tasks:

– Screening individual patients for health-related social needs

– Referring them to the best agency to treat those social needs

– Ensuring that they receive such services

– Paying for some-or even all-tasks within this chain of events.

The mix and match of who does which task is limitless. Hospitals facing penalties for excessive readmissions can rely on their own discharge planners and care managers to address the problem, hire a firm to do so, contract with community health workers from a community-based organization to do so, or to do some mix of the above. The same pattern holds true for Medicaid managed care plans, Accountable Care Organizations, or provider organizations created pursuant to Medicaid DSRIP initiatives. Under any scenario, however, the services (whether care management or housing support) must be allowed and authorized by the insurer that is ultimately paying the bill, whether that is Medicare, Medicaid, or a commercial health plan.

While there is no single answer to the "who does what" question, there are important organizational and financial implications at stake. Consider the role of the care manager. Should s/he be a hospital employee, perhaps a nurse, or a social worker, or a community health worker? Or should the hospital hire a community-based organization that has a long history of education, advocacy and social services to work with the newly discharged patient? Or what about a newly formed "care management" organization? How might the organizational culture of the employer impact likely performance? (For instance, newer, data-driven providers might do a better job of finding a mix of optimal and tailored service providers than traditional hospital chains.) Should hospitals that remain "medical" at their core go into this new line of business? Similarly, should collaborations with community-based organizations go beyond efforts to refer and/or link, and involve actual care delivery services? How far can or should a provider go in using personal information about a patient to ensure that the patient receives care that is highly tailored to his or her case?

There are, of course, challenges with any strategy: health systems are, by definition, deeply rooted in a healthcare perspective, are governed by healthcare bureaucracies, are paid to perform healthcare services, and have experience and expertise in healthcare. Asking the traditional medical care system to take on the task of integrating social services into their portfolio will require a significant change in mission, culture, and funding, a challenge that may be necessary but will certainly be difficult to meet.

At the same time, asking community-based social services organizations to form collaborations and alliances with healthcare providers and payers raises another set of challenges and concerns. Bradley and Taylor[23] note, for example, an important difference in the orientation of the health and social services sectors toward those they serve: in the health realm, there is the "patient" ready to be "treated" whereas social service providers have "clients," to whom they listen closely and from whom they take cues, and whose "life plans" they seek to develop and advance. Proponents of integration on the medical side speak from within complex organizational hierarchies of prestigious professionals, led by highly-paid physicians; those on the social services side may work in small, loosely structured, organizations (under) staffed by lower-paid social service professionals.

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[23] Elizabeth Bradley and Lauren Taylor, "The American Healthcare Paradox: Why Spending More Is Getting Us Less, (Public Affairs Press, 2013).

Health and social service entities also are accountable to different licensing boards, regulators, and legislative authorities (and some social services entities may not function within a regulatory or licensing framework at all), with very different rules on eligibility for services, among other things. Their information systems may not be compatible, and HIPAA and other rules and norms may inhibit sharing of information on patients between medical providers and "lay" agencies. Community-based organizations may have a small infrastructure, a limited budget, heavy dependence on timely payments, and weak capacity to monitor, document, and report their work.

Additionally, it is probably safe to say that the medical providers who are supposed to launch and lead all this integration have limited experience with, and insight into, the operations of, and constraints on, social service organizations. This also comes in an era in which government funding for social services is at risk. Nor are health officials likely to be adept at choosing among social agencies with which to work. If social service organizations are abundant in a given community, how does one decide among them? If there are few (or one), how does one leverage performance?

These challenges raise valid questions about the capacity required to make integration of medical and social services work. Four implications seem to emerge.

– Policymakers should expect and tolerate considerable trial and error as links are (or fail to be) forged.

– Putting providers at financial risk as a means of motivating these links may invite a heavy handed issuing of "doctor's orders" that social service organizations may not know how (and may resent being asked) to obey. "Medicalization" of social service agencies may be a victory for rationalization and standardization in an often inefficient sector—or maybe not.

– Medical leaders who have protested that they cannot properly be held "accountable" by "Accountable Care Organizations" for health outcomes they do not control may have a point that applies in this case too; asking medical professionals to contrive complex organizational arrangements at the other end of which emerge better health outcomes for troubled people with multiple morbidities, and to save money in the process, may be unrealistic.

– Although integration is supposed to be "comprehensive," covering the continuum of needs, trying to integrate too many services too fast may invite trouble. Good working relations between providers and (say) housing authorities and organizations may be hard to arrange. Even former Mayor Michael Bloomberg of New York City found that integrating his own city agencies with his own appointees at the helm was a work in progress at the end of three terms in office.[24] The Bloomberg Administration had great success in interagency efforts aimed at better health outcomes – such as improving nutritional standards in food provided by multiple City agencies. It also had great success integrating agencies working across the health and human services spectrum – for example, through its HHS-Connect initiative that created more accessible City services for needy families and a more holistic picture of those families for the agencies serving them. But none of these efforts was without significant challenges, and all required persistence and strong leadership. Trying simultaneously to do likewise with service providers in several other domains may overtax all concerned, treating as wholesale inter-organizational connections that must be sold and bought "retail."

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[24] Tom Farley, "Saving Gotham: A Billionaire Mayor, Activist Doctors, and the Fight for Eight Million Lives," *(W.W. Norton and Company, 2015).*

Connecting health and social services: Two DSRIP case studies

Perhaps the nation's most ambitious (and well-funded) effort to use financial incentives to transform the safety net health delivery system is taking place in New York State, through the so-called "Delivery System Reform Incentive Payment" (DSRIP) program. There were four key components to the DSRIP initiative.

– In late 2014, New York created a "toolkit" of 44 "intervention projects" designed to encourage system transformation, clinical improvement, or population health.

– Performing Provider Systems (typically collaborations between hospitals and a host of community based providers) then conducted community needs assessments to determine which projects were most appropriate to serve the Medicaid population needs in their catchment area.

– The Performing Provider Systems then selected anywhere from five to eleven such projects as the core of their DSRIP initiative; each such project had to have a role for a range of community-based organizations.

– In April 2015, 25 Performing Provider Initiatives began to implement their projects; long-term funding will depend on their ability to achieve a 25 percent reduction in avoidable hospitalization use over five years while also meeting a host of other metrics connected to their particular projects.

There are many early examples of how PPSs are partnering with social service and community-based organization to support the design and implementation of their DSRIP Projects. Two such cases are explored below.

The Staten Island PPS

Shortly after the DSRIP initiative was announced, Staten Island University Hospital (which is part of the larger Northwell Health System) and Richmond Hill Hospital applied for, and received, a $1.5 million PPS planning grant. The planning process required a community needs assessment and the development of proposed health transformation projects. From the beginning, the PPS leadership included the borough's community based social services organizations (such as food banks, homeless shelters, and immigrant aid organizations), as well as the community health centers, and physicians groups that served large numbers of the community's Medicaid and uninsured populations. Local political leaders and various health advocacy organizations were also brought in to participate.

In late June 2015, the State announced that the Staten Island PPS would be eligible to receive $217 million over the next five years so long as it met the program's metrics; namely, the 25 percent reduction in avoidable hospitalizations and several additional metrics related to the various PPS projects. The PPS's eleven "projects" include initiatives to reduce youth substance abuse, improve health literacy, and better coordinate the care of people with serious medical, behavioral, and social conditions.

When developing these (and similar) projects, the PPS leadership sought partnerships with community-based organizations that were "actively engaged" with target populations. The PPS also created two funding pools specifically designed to support novel (and previously uncovered) services and/or organizations. First is the so-

called "Infrastructure" funding pool, which includes 5% of the overall funding (or roughly $10.8 million), and is designed to finance partnerships with community based social services organizations that are not licensed healthcare providers and that would not typically be eligible to receive any Medicaid funding. Second is the so-called "Innovation" funding pool, that also includes just under $11 million, and is designed to pay community-based healthcare providers for services that typically are not covered by Medicaid (from Tele-medicine programs to enhanced translational services).

Using the infrastructure fund, the PPS now has a contract with Island Voice, a community-based group that works with the local African immigrant communities to provide peer navigation services to the large Liberian community on the Island, and to (presumably) steer individuals to relevant parts of the PPS network (such as its "health homes" program). The PPS also is hiring El Centro Del Immigrante and Make the Road New York, two immigrant aid organizations, to conduct health screenings, and it is paying these two groups a separate fee for each screening submitted. In addition, they are providing a more general grant to each group for providing a peer navigator and referral services.

These contracts are part of the PPS' broader strategy to 1) use data to target key health and social needs in particular neighborhoods, 2) work with trusted community-based organizations to screen, educate, and refer at risk individuals within those communities, and 3) ensure that those individuals receive the needed services (from nutritional counseling to housing support to coordinated care management). It is too soon to tell, of course, whether the overall strategy will work, whether the partnerships with the community-based groups will pay off, or whether the PPS will meet the metrics around avoidable hospitalization. Moreover, even if the community-based partnerships work well, and if the services they provide actually produce the desired health outcomes, the PPS will need to figure out a long-term strategy to shift them from a grant (or even fee-for-service) funding model. Specifically, they will need to move toward the value-based payment model that the PPS and the healthcare system more generally are moving toward. This shift that will be necessary if the partnerships are to continue after the five-year DSRIP funding is gone.

The Westchester Medical Center PPS
Given its longstanding focus on high tech tertiary care, and its relatively limited engagement with nearby community-based organizations, the Westchester Medical Center moved slowly and cautiously toward the DSRIP initiative. At the same time, however the hospital leadership was growing concerned about their readiness for reimbursement systems focused increasingly on value-based payment and population health management, and DSRIP offered

one path toward creating the community-based network they needed. The Medical Center therefore created the Center for Regional Healthcare Innovation and tasked it with conducting a community needs assessment and the other PPS planning activities. In June 2015 the New York State announced that the Westchester Medical Center PPS would be eligible to receive $274 million dollars over the next five years.

Like the other PPSs, Westchester Medical Center has developed an array of initiatives designed to reduce avoidable hospitalizations and improve overall health system performance. Two of its strategies are especially noteworthy: the first is an effort to provide community-based organizations new to the health arena with the knowledge and skills needed to transition into this new and changing market, and the second is its decision to hire Healthify, a software company that works with providers and health plans to screen and refer for health related social needs.

The training program, called the "Learning Labs," will be administered by a strategy consulting firm that ran a previous initiative for several AIDS treatment organizations that had to adapt as AIDS funding shifted from categorical grant dollars to chronic disease treatment dollars. The assumption is that the community-based DSRIP groups will undergo a similar transition, moving from their grant-funded social services arena into a fee-for-service (and eventually value-based payment) healthcare world. Participating community groups need to send at least two organizational leaders to all (or nearly all) of the five half-day sessions that take place over a two-month period. The curriculum includes a combination of information exchange (how the health arena is changing, what is a PPS, a health home, and so on), and strategic planning (what value do community based groups bring to the health arena, and how can they leverage that value over time).

The contract between the PPS and Healthify also has the potential to create much closer and better connections between the hospital, outpatient health providers, and community-based social services organizations. Healthify, which has contracts in 24 states, provides software that screens for health-related social needs, refers to the nearest and most appropriate social services organizations, and tracks utilization. The PPS plans to pilot the software in partnership with a federally-qualified community health organization, and will roll out the software to other care managers over time.

Connecting health and social services: What does the evidence suggest?

The Staten Island PPS and its counterpart at Westchester Medical Center are using DSRIP funding to create new and innovative efforts to address the social determinants of health. The initiatives have emerged from a combination of generous (though short term) Medicaid funding, a movement to value-based reimbursement, and a policy consensus that connecting health and social services is both feasible and desirable. Those factors are prompting similar (if less expansive) efforts in other state Medicaid programs. The creation of Accountable Care Organizations rests on the same set of assumptions, as does the movement toward population health management more generally.

That social determinants impact health seems undeniable. From exposure to cigarette smoke in the womb to lead and abuse in childhood and crime and pollution in adulthood, poverty probably has a huge influence on health. Indeed, in America, poverty is associated with a greater burden of disease than smoking and obesity combined.[25] That connecting health and social services networks should lead to lower costs and better quality is intuitively appealing. But is there good evidence that connecting health and social services achieves that potential? As it turns out, the literature on the question is surprisingly thin.

Before discussing the evidence, it is important to note that the concepts of "social determinants of health" and "social services" have become somewhat conflated. The observation that disease lies in the social realm was (like the very idea of medicine) first introduced in Hippocrates' time. Various Enlightenment era thinkers revived it. For example, Rudolf Virchow, sent to investigate a Typhus outbreak, recommended housing, education, and democracy as the only true means of preventing future spread of the illness.[26] However, these preventive measures upon which the notion of social prevention were based are quite "upstream" from providing coordinated social services to patients who are already ill from having fewer social opportunities.

In the realm of the possible—actually providing coordinated social services—it is difficult to find clear evidence on the best way forward. There are several reasons for the paucity of good evidence. For starters, the financial emphasis on social services provision to patients is quite new. (It has always existed, but was usually a task delegated to an overworked social worker on a hospital floor.) A second explanation is that the gold standard for such evaluations, the randomized controlled trial, is expensive, logistically complex, and particularly problematic when considering traditional social service providers who rarely if ever have "control" clients that are experimentally assigned. Third, traditional science funders are often reluctant to provide grants for qualitative studies, which are often essential for such evaluations. Fourth, regardless of the research methodology, figuring out the right metrics for evaluation is complicated. It is difficult to tease out the impact of a single intervention targeted toward a single social determinant given the multitude of social determinants and social programs in play. Given that the most expensive patients often suffer from a combination of problems—mental illness, homelessness, substance abuse, HIV, and various physical problems—and given that they often reside, and will continue to reside, in harsh and violent environments, how much improvement in health status can one reasonably expect? (That is, without turning to upstream interventions in childhood, such as pre-K or parenting programs.) Fifth, such interventions, even if properly

25 Muennig P, Fiscella K, Tancredi D, Franks P. The relative health burden of selected social and behavioral risk factors in the United States: implications for policy. Am J Public Health 2010;100:1758-64.

26 Virchow, R. (1849). Notes on the typhoid epidemic prevailing in Upper Silesia. Arch Pathologische Anatomic Physiologic Klinische Medizin, 2, 143-322.

studied and measured, may take years to produce useful results. Sixth, and finally, even if successful, collaborations between the health and social services sector may be extraordinarily hard to replicate given the importance of leadership, commitment, and management expertise in executing any one given program. Significant investments in franchise management that might standardize the roll-out of such services, coupled with funding contingent on proven local success, could solve this problem.[27] In the world of social service programs, this problem is referred to as "scaling up." But it is perhaps better thought of as a management challenge, handled more like commercial retail chains. One example is the Head Start program, which recently responded to evaluation data showing significant quality variation among sites by establishing more prescriptive Performance Standards, which include health-related requirements.[28]

Despite these obstacles, there is a small but useful literature to examine. Perhaps the most robust set of relevant research examines "care management" initiatives. Most of these are largely medical in nature, but some also include home visitation components that blur the health and social services divide. The consensus seems to be that such programs can improve quality but they rarely contain costs.

In 2009, for example, Bodenheimer and colleagues synthesized studies looking at care management of patients with complex health needs, and found that even when such efforts improved quality and outcomes, there typically was little evidence of cost savings.[29] Similarly, though Mandelblatt and colleagues demonstrated that "patient navigators" could increase breast cancer screening among low-income women, they also found that both patient navigation services and breast cancer screening increase, rather than reduce, overall costs.[30] In fact, when clinical preventive services have been evaluated for cost-effectiveness in the realm of medical care provision, most tend to be quite costly.[31] Moreover,

in some of these cases, the possibility that the program produced no net quality benefit loomed large. For example, a study by Mandelblatt and colleagues suggested that patient navigation, and in fact breast cancer screening as a whole, might produce more overall harm than good. That is because false positive tests can lead to unnecessary psychological stress, surgical procedures (which are associated with bleeding and infection), and do not actually prevent mortality from breast cancer in most cases. (In the case of prostate cancer, it is quite clear that screening and treatment produce more harm than good for all of these reasons.)[32]

Importantly, however, the care management programs most likely to both improve outcomes and lower costs were post-discharge hospital-to-home programs that relied on home visitation, that is, the care management programs that *de facto* blurred the lines between health and social services.[33] This suggests that an increased focus on post-discharge hospital planning is wise, and that payer initiatives to encourage such efforts (ranging from the Medicare readmission penalties to DSRIP) are smart strategies.

Another important effort to synthesize the literature is *The Guide to Community Preventive Services,* which presents the findings from a large government task force charged with evaluating such programs.[34] This guide rates hundreds of such evaluations based upon the rigor and consistency in the literature. The interventions recommended to leverage the social determinants of health, to improve the health of communities, can be quite nuanced and quite numerous. However, the *Guide* does have many useful and empirically based recommendations for providers both in medical institutions and community-based organizations. For instance, diabetes readmissions could be reduced both by patient education programs within a hospital and by community-based interventions to promote diet and exercise (both of which were rated as having good evidence).

[27] Olds DL, Hill PL, O'Brien R, Racine D, Moritz P. Taking preventive intervention to scale: The nurse-family partnership. Cogn Behav Pract 2003;10:278-90.

[28] See 80 CFR 35429 (June 19, 2015).

[29] Thomas Bodenheimer and Rachel Berry-Millett, "Care Management of Patients with Complex Healthcare Needs," *RWJ Synthesis Project*, December 2009

[30] Mandelblatt, et. al, "Benefits and Costs of Interventions to Improve Breast Cancer Outcomes in African American Women," *Journal of Clinical Oncology*, (July 2004)

[31] "Agency for Health Research and Quality. United States Preventive Services Task Force. Available online at: http://www.ahrq.gov/clinic/uspstfix.htm Accessed 9/19/2010."; "Tufts Medical Center. The CEA Registry. Available online at: https://research.tufts-nemc.org/cear4/Resources/LeagueTable.aspx Accessed 10/22/2013."

[32] Moyer VA. Screening for prostate cancer: US Preventive Services Task Force recommendation statement. Ann Intern Med 2012;157:120-34.

[33] Bodenheimer, RWJ Synthesis, 2009; Michael Sparer, "Medicaid Managed Care: Costs, Access and Quality of Care," *RWJ Synthesis Project*, September 2012; see also Monica Sweet and Mark Appelbaum, "Is Home Visiting An Effective Strategy? A Meta-Analytic Review of Home Visiting Programs for Families with Young Children," *Child Development* (September/October 2004).

[34] Centers for Disease Control and Prevention. Guide to Community Preventive Services. Available online at: http://www.thecommunityguide.org/index.html. Accessed 2/5/2016.

Still, the policy strategy that should follow, given the thin evidentiary base and the difficulties that organizations face in replicating successful interventions cited in the literature, is far from clear. The extensive "Evidence Gaps" section in the *Guide* could adapt to the new realities created by ACA and DSRIP-like initiatives to suggest economic analyses of all programs from the institutional perspective.

As we mention at the start of this section, the rigorous evidence (in the form of experimental studies) that does show both health and economic benefits, typically are interventions too removed from anything that a health insurer could or should pay for. For example, while there is good evidence that improved educational systems will lead to better health and longevity[35] no DSRIP PPSs are funding pre-kindergarten programs. This is partly because it is very clear that such an effort would not actually save the PPSs dollars. Instead, the most impressive returns happen decades later as children grow and pass through the education system, possibly long after the insurer and hospital have shut their doors. It is also partly because the nexus between Medicaid and pre-K programs seems to be too distant to warrant direct collaboration. It should be kept in mind that the Department of Health and Human Services is an agency that administers both programs that explicitly fund medical care and those that fund non-medical services that might improve health. Coordination of intra-agency services—much the way that Mayor Bloomberg attempted to coordinate services across agencies in New York City—might produce unrecognized synergies that reduce the overall taxpayer burden. For instance, modifications to Temporary Assistance for Needy Families (TANF) could improve population health and reduce mortality among single mothers. The early experiments on the time limits to welfare showed that TANF saves money, but comes at the cost of lives lost.[36]

While it is clear that PPSs would not wish to fund pre-K programs, the question of whether a DSRIP-funded community-based organization could or should provide parental coaching is less clear. Parental coaching has been tested using experimental protocols, has proven to be highly effective and cost-effective, involves people who have had contact with the medical system (mothers who deliver babies in the hospital) and produces outcomes over a somewhat shorter (e.g., 5-year) time frame.[37] But does

it cross the line defining the limits of what health dollars (even DSRIP dollars) should pay for? After all, such services are provided to healthy members of the community in the name of preventing future illness. This objective is very far from the financial incentives provided to reduce readmission rates.

Similarly, despite the host of pilot programs providing various forms of housing assistance (including, on occasion, room and board), there is remarkably little data on the impact of such programs on costs and health outcomes. To be sure, there is a literature that suggests that neighborhoods and/or housing are important components of long-term health.[38] One longitudinal study, for example, looked at the impact of housing vouchers on health and well-being: participants were randomized to stay in housing projects, to receive a voucher that would allow them to move into private housing, or to receive an even higher-value voucher that required them to move into a wealthier neighborhood. Decades after the experiment began, those that received the vouchers showed moderate but significant improvements on measures of physical health.[39] Such findings do not, however, provide an evidence base for the Medicaid-funded housing assistance programs now underway, nor do they provide policymakers with the information they need to choose between different versions of such programs. Not only is there little experimental evidence to support them, it is far too early to assess what they look like in real-world implementation.[40] What they do offer, however, is a safer place to send patients on discharge. In this sense, they are at least conceptually closer to what a medical provider or payer might be willing to finance.

These problems are hardly deterring policymakers, insurers, and health systems from moving ahead with efforts to integrate social services into health delivery systems. Fortunately however, funds are now becoming available to evaluate the impact of such efforts over time, most notably the recently announced $157 million federal initiative to fund up to 44 "Accountable Health Communities" and to rigorously evaluate the results. Perhaps over the next several years we will have a better sense of what works and what does not, and why.

[35] Muennig, P. (2015). Can universal pre-kindergarten programs improve population health and longevity? Mechanisms, evidence, and policy implications. Soc Sci Med, 127, 116-123. doi:10.1016/j.socscimed.2014.08.033

[36] Muennig P, Caleyachetty R, Rosen Z, Korotzer A. More money, fewer lives: the cost effectiveness of welfare reform in the United States. Am J Public Health 2015;105:324-8.

[37] Olds, D. L. (2006). The nurse-family partnership: An evidence-based preventive intervention. *Infant Mental Health Journal, 27*(1), 5-25.

[38] Evans, Wells, and Moch, "Housing and Mental Health: A Review of the Evidence and a Methodological and Conceptual Critique," *Journal of Social Issues* (2003); Thomson, Petticrew, and Morrison, "Health Impact Assessment of Housing Improvements: Incorporating Research Evidence," *Journal of Epidemiol Community Health* (2003).

[39] Ludwig, et. al, "Neighborhoods, Obesity and Diabetes: A Randomized Social Experiment," New England Journal of Medicine (October 2011)

[40] Kassler WJ, Tomoyasu N, Conway PH. Beyond a traditional payer—CMS's role in improving population health. N Engl J Med 2015;372:109-11.

What are the key takeaways for policymakers?

The current emphasis on integrating the social services into the health delivery system is accompanied by a hope and even expectation that such initiatives should be "evidence-based," and that researchers can and should provide clear guidance about what the evidence does and does not support. At this point, however, the data for a set of such conclusions simply does not exist: the initiatives are typically too new and too variable, and developing the right evaluation methodology is complicated, expensive, and perhaps incapable of generating useful findings for many years (if at all). That said, several takeaways follow from the relevant literature that does exist, takeaways that are consistent with the comments and suggestions of those that participated in the HPM-KPMG conference.

– There is a clear consensus among policymakers and health system leaders that better integrating the health and social services systems is an important component of the effort to improve the health of low-income populations.

– There are significant financial incentives now in place to encourage such system integration

– There also are new information technologies that can help facilitate such efforts, making them more efficient and less costly.

– Health and social service leaders should focus on incremental initiatives that break down silos and encourage more coordinated care:

  » Creating "connections" between health and social services programs

  » Encouraging health system "referrals" to social services programs

  » Creating "collaborations" between health systems (providers and payers) and community-based social services programs

  » Focusing on post-hospital discharge care management programs that include a home visitation component

  » Expanding health-funded housing assistance programs

– Health and social services leaders should be cautious and conservative in their estimates of the likely benefits of using health system dollars to fund social services initiatives. There is a particular need to take into account potential trade-offs between costs, access, and quality, since initiatives that improve access and/or quality could lead to higher costs. Put simply, better integrating the health and social services systems is a wise strategy, but it is not a magical solution to an expensive and inadequate health delivery system for low-income populations.

– Complicating the integration of the health and social services sectors is the reality that the two systems have different histories, cultures, infrastructures, sources of revenue, and regulatory oversight.

– Efforts to shift financial risk to community–based social services organizations should be limited and capped: most community-based social services agencies have even less experience with risk-contracts than do health systems, are less familiar with performance-based metrics, and have less capacity to absorb financial losses.

– Replicating successful initiatives will be hard, given the role that leadership and management play in program implementation.

– Both the health and the social services systems are under significant fiscal pressure, and open-ended Medicaid funding should not be used to compensate for cuts in grant funding to social services organizations.

– There is a clear need for more and better mixed methods research on the impact of health system funding of social service programs.

  » States should act as policy laboratories, trying and testing different strategies, looking and learning from each other, but recognizing that different models will work differently in different communities.

  » It may take years for an initiative to demonstrate an evidence-based impact on costs or quality.

Acknowledgements and contacts

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Appendix A

(Re) defining the Healthcare Delivery System: The Role of Social Services
Columbia University Faculty House, 64 Morningside Drive, New York, NY

May 11, 2015

Agenda

Welcome and Opening Remarks

Michael Sparer, *Chair, Health Policy & Management, Mailman School of Public Health, Columbia University*
Mark Britnell, *Chairman, Global Health Practice, KPMG International*

Panel one: (Re) defining the Healthcare Delivery System: Where Do Social Services Fit?

Moderator: David Hansell, JD
Global Head, Human & Social Services Center of Excellence, KPMG LLP

Panelists: Peter Muennig, MD, MPH
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Panel two: Paying for Social Services: Where Do Health Insurers Fit?

Moderator: Lawrence D. Brown, PhD
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Panel three: Is DSRIP Different?

Moderator: Michael Sparer, JD, PhD
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Bruce Vladeck, PhD
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Small Group Session

Plenary Discussion: How Can States Best Integrate Social Services into Health Delivery?
Michael Sparer, *Chair, Health Policy & Management, Mailman School of Public Health, Columbia University*

Closing Remarks

Appendix B

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