Focus on Social Determinants of Health May Hold Key to Healthcare Reform

By Mario J. Paredes

STRIKINGLY, the topic has somewhat receded from the headlines, but the battle for health- care reform continues as legislators on both sides of the aisle continue the painstaking and still hotly-contested process of deciding the ultimate fate of the Affordable Care Act.

Uncertainty persists, as the country's poorest and most vulnerable citizens are awaiting an answer from their country's leaders who are charged with plotting out a course for publicly- funded healthcare that of superior quality and also affordable for taxpayers.

The two, of course, go hand-in-hand: quality care—with an emphasis on preventive intervention—makes for better longer-term health outcomes, which in turn makes for savings as it keeps people out of emergency rooms and hospital beds. New York State has taken a leading role in Medicaid reform precisely in pursuit of this 'magic' formula: better healthcare and at lower costs.

Simply put, to incentivize and inspire doctors—Primary Care Physicians (PCPs), in particular—to do a better job taking care of their patients, the New York State Department of Health (NYSDOH) has engineered a major shift toward a Value-Based Care, or Value-Based- Payment model governing Medicaid-provided healthcare. This formula takes the place of the traditional fee-for-service model—a model prone to waste and fraud—and rewards the doctors according to the longer-term health outcomes of their patients.

The healthier the patient over the longer term, the higher the fee for the provider. Naturally, the doctors take a risk; the old system—with fixed fees for office visits, exams, tests—was reliable; value-based care requires a learning curve; a willingness to get to know the patients better; better put, it requires a genuine relationship between doctor and patient—and that takes work and willingness.

Success in providing their patients with superior care implies getting to know their patients more fully, more intimately. That means that the doctor must not only knows their patient's medical history and present medical condition, but also a range of

non-medical conditions that have a significant impact on a person's health. These factors are known as the Social Determinants of Health (SDHs), and they are increasingly taking center-stage in Medicaid reform.

The NYSDOH estimates that SDHs—the level of access to healthy foods, safe housing, and reliable transformation, for example—account for some 80 percent of factors impinging on a person's health. Under the old regimen, with the doctor simply administering tests, for example, the role of SDHs in the patient's life would never come into the picture. The minimal interaction between physician and patient simply does not allow for any meaningful discussion about critical conditions in the patient's social environment that may seriously impact his or her health.

Taking SDHs into account in treating a patient—and accompanying him or her on a more or less ongoing basis—holds the key to truly comprehensive, holistic healthcare as the product of Value-Based Care and Value-Based-payment. That approach is at the heart of a New York State Medicaid experiment now in the fourth year of its five-year mandate. Spearheaded by Jason Helgerson, the former NYS Medicaid director, NYSDOH in 2015 launched the Delivery System Reform Incentive Payment program, DSRIP.

In New York State, 25 so-called Performing Provider Systems (PPSs) operate under the DSRIP mandate. Their primary goal, from the onset, was to reduce unnecessary hospitalizations by 25 percent at the end of five-years—a goal that will likely be exceeded and save New York State taxpayers more than $12B. And almost from the start, Jason stressed the importance of taking SDHs into account.

Among the 25 PPSs, SOMOS Community Care is the only PPS that is led by physicians. The other PPSs are managed by large, corporate-style hospital systems. SOMOS providers—the bulk of them Primary-Care Physicians running their own small businesses—are in a unique position to really get to know their patients; in many cases, they live and work in the same community as their patients, often speaking the same language and hailing from the same cultural background—all key factors that make for fertile ground for establishing meaningful relationships between doctor and patient.

Such a relationship embraces all dimensions of a patient's life, the medical as well those dimensions determined by the Social Determinants of Health. Establishing that intimacy is simply not feasible for even the best hospitals, employing the best specialists, working with the latest equipment. The logistics and 'efficiencies' of large hospital systems simply do not allow for the forging of that personal bond between

doctor and patient, who simply does not have a chance to explain the social circumstances of life at home or in the neighborhood.

Again, with SDHs having such a large impact on patients' health, not taking their impact into SOMOS deploys a growing cadre of Community Health Care workers who save doctors time, hence create time for the building of relationships—for example, by assisting PCPs and their staff with very time-consuming electronic record-keeping; and by getting to know a practice's patients personal, social circumstances—and informing the doctor and his staff about those social determinants of health and their impact on their patients' medical conditions.

In this manner, the Primary Care Physician becomes a leader in the community, just like the family doctor of old; in Jason Helgerson's vision, it is precisely the neighborhood doctor who calls together other community leaders, who are dealing with a range of SDHs. These include: the state of housing, with vermin and mildew playing a potential harmful role; discovering that a household's income may fall short and deprives the family of basic healthy foods that can help combat of prevent diabetes and obesity; family members smoking and impacting the health of those with lung conditions; unwholesome diets, etc.

In the DSRIP model—and beyond, as part of New York State's overall Value-Based Roadmap—the doctor's practice becomes a Patient-Centered Medical Home, a nexus of knowledge about all aspects of a patient's life and a resource for patients to seek help on any number of fronts. Ryan Ashe, Director of Medicaid Payment Reform for the NYSDOH, identifies five key SDHs: economic stability, education, health and healthcare, neighborhood environment, and social, family, and community context.

Ashe cites such practical examples as providing seriously ill Medicaid patients with medically-tailored meals; nutritional counseling; rental assistance; legal aid for patients confronting housing instability; ride-sharing arrangements to ensure patients make it to appointments. These measures and others make for healthier patients and for reduced costs by avoiding the need for catastrophic care—and ultimately those very expensive hospitalizations.

SOMOS Community Care, operating at the vanguard of Value-Based Care in the urban setting of New York City, is delivering proof concept: demonstrating the vital importance of tackling Social Determinants of Health in providing patient with holistic, comprehensive care. All parties gain: the patient is healthier, longer; the doctor earns incentive pay for that achievement; the state saves money in reduced need for hospitalization and other forms of catastrophic care.

SOMOS COMMUNITY CARE

SOMOS Community Care, convinced of the solidity of its approach to Medicaid-provided healthcare, intends to continue operations beyond the end of the DSRIP mandate in 2020— both as a non-profit and a for-profit entity. It is to be hoped that our political leaders will take note and make Value-Based Payment and the integration of addressing the Social Determinants of Health two major pillars of publicly-funded healthcare reform across the land.