SOMOS COMMUNITY CARE

From the desk of the CEO
Mario J. Paredes

In New York State, focus remains on reforming publicly funded healthcare.

IN NEW YORK STATE's health-care universe, all eyes are on the results of the Delivery System Reform Incentive (DSRIP) program. Now in its fifth year—the final year of DSRIP'S current mandate—the program was designed to provide Medicaid patients in the state with superior, comprehensive care at a manageable cost. The program was funded by the investment of $8B in federal savings produced by Medicaid Redesign Team reforms; DSRIP was designed to deliver significant savings to New York State taxpayers by reducing unnecessary hospitalizations by 25 percent at the end of five years.

That goal is on track of being met by all the 25 so-called Performing Provider Systems (PPSs). These are health-care networks mandated by DSRIP to implement a range of highly innovative clinical and organizational practices that in the past four years have shown great promise. DSRIP is driven by the Value-Based Payment (VBP) formula by which physicians, clinics and hospitals are compensated according to the longer-term health outcomes of their patients; the healthier the patient, the greater the compensation. And patients who are better taken care off are less likely to let a medical or mental condition get out of hand to the point at which they have go to an emergency room.

SOMOS Community Care is the only doctor-led PPS, with the other PPSs being hospital system-based. The SOMOS network of 3,500 providers—including 2,500 primary care physicians—serves close to a million of New York City's poorest Medicaid patients in Chinese American, African American and Latino communities. In four years, SOMOS was able to reduce preventable hospital readmissions by 36 percent, unnecessary visits to the ER by 34 percent, and preventable behavioral health emergency visits by 47 percent.

The incentive for providers to invest themselves in the well-being of the patients they serve holds up a potent alternative to the traditional Medicaid model that pays doctors according to services rendered—tests, office visits, etc.—discrete transactions that by and large fail to provide holistic, comprehensive care. Moreover, Medicaid as we know it is prone to waste and fraud—and it largely fails to keep patients out of the ER.

With DSRIP showing significant positive results, the looming question concerns the future of this approach to Medicaid reform past March 30, 2020, when the DSRIP mandate is slated to end at the five-year mark. The United Hospital Fund (UHF)—a non-profit dedicated to working for better and more affordable health care for all New Yorkers—just published a report that analyzes various DSRIP practices with an idea on the programs longer-term

SOMOS COMMUNITY CARE

From the desk of the CEO
Mario J. Paredes

prospects. The findings hold out the promise that—"with additional time and support to bridge the gap to VBP," the linchpin of the reform effort—there could well be a future for DSRIP beyond 2020.

The UHF report salutes DSRIP and the achievements of the PPSs under the rubric of: "new infrastructure and workforce investments," with, in the case of SOMOS, Community Health Workers deployed to assist medical practices in keeping track of patients' appointments and making home visits; SOMOS CHWs also run numerous community education projects.

The research applauds the PPSs' deployment of "clinical information systems, such as electronic medical records and regional health information exchanges that support direct care delivery, identify and follow high-risk patients, and alert providers when their patients are admitted to hospitals or discharged from them;" then there is emphasis on DSRIP's reliance on "data analytics that use clinical and claims data to target and better manage the care of complex patients and populations, as well as measure performance and support continuous quality improvement." DSRIP, indeed, is highly data-driven, wedding sophisticated technology to the authentically personal touch of doctors.

The report lauds DSRIP's emphasis on "provider and community relationships" to address the social determinants of health, meaning "partnerships between health care providers [and] community-based social service organizations," etc., to ensure patients' social needs, are being met—social needs that impact the individual's overall well-being. On this score the report acknowledges the SOMOS effort to build "stronger relations between clinical and community partners," which the report calls a "foundational element of high-performing delivery systems."

SOMOS primary care physicians teaming up with Community-Based Organizations helps, says the report, to "more effectively address patients' economic insecurity and implement a broad spectrum of social needs interventions: case management and entitlement assistance, legal services to prevent eviction, other housing-related services and home-delivered meals to address food insecurity."

The UHF report also acknowledges the premium the DSRIP program puts on bolstering "care management capacities," through, for example, SOMOS' deployment of practice-transformation teams to enable primary-care practices to function as Patient Centered Medical Homes (PCMHs) that coordinate all of the patients' medical and behavioral treatment needs. More than 600 medical practices in the SOMOS network have achieved

SOMOS COMMUNITY CARE

From the desk of the CEO
Mario J. Paredes

PCHM status—a unique achievement in that small medical practices, notes the report, have "historically been underrepresented in the PCMH program."

SOMOS is particularly proud in that the organization has been able to restore the position of the primary care doctor as a trusted figure in the community. Many SOMOS doctors live and work in the same communities they serve and, in many cases, share the same cultural background and speak the same language as their patients. With the physician invested in really getting to know his or her patient, the doctor-patient relationship is based on trust.

With a medical practice certified as a PCMH, the doctor and his staff are committed and able to ensure that patients receive all the medical and behavioral care they need; the primary care doctor is also encouraged to engage other community leaders—experts on housing, education, employment, etc.—and launch community task forces to create local cultures of health and overall well-being. Such is the high calling of the primary care physician.

This new iteration of the family doctor of old—a trusted figure in the community who embraces the Value-Based Payment or Pay-for-Performance formula—is at the heart of SOMOS Founder and Chairman Dr. Ramon Tallaj's vision of the Neighborhood-Based Primary Care model: a patient-centered, comprehensive, integrated, single-stop health care model that addresses the patient's full spectrum of clinical and social needs.

The UHF report has amply demonstrated the great potential of holistic, comprehensive and cost-effective healthcare DSRIP offers the most vulnerable patients. Given more time and study of the scalability and long-term viability of its innovations, DSRIP could spawn, concludes the UHF report, "broader-scale adoption" of its practices at the state level. And why not consider the prospect of the Value-Based Payment formula being replicated at the federal level?

Surely, it would be a shame if DSRIP would come to a screeching halt come March 2020. Let us hope that the New York State Department of Health will be successful, come later this year, in petitioning the federal government for an extension of DSRIP.