SOMOS COMMUNITY CARE

From the desk of the CEO
Mario J. Paredes

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A program that is transforming health care for the poor must be extended

A BROAD COALITION of health-care entities that serve the poor across New York State, including the New York State Department of Health (NYSDOH), have urgently petitioned the federal government for an extension of an experimental Medicaid program that has been transforming health care for the most vulnerable New Yorkers for the past four years. It is up to the Centers for Medicare and Medicaid Services (CMS) to authorize a four-year extension of the Delivery System Reform Incentive Payment (DSRIP) program.

It is vitally important that DSRIP be renewed to ensure a lasting foundation for a sharp improvement in the quality of health care for Medicaid recipients.

Technical jargon aside, DSRIP stands for a model of health-care delivery that compensates physicians according to the longer-term health and well-being of patients. It is a formula called Value-Based Payment (VBP) or Pay-for-Performance. The greater the flourishing and well-being of the patient, the greater the renumeration for the health-care provider. In sharp contrast with the traditional Medicaid fee-for-service model, under DSRIP doctors are incentivized to take better care of their patients. And healthier patients translate into fewer costly hospitalizations.

The program, which launched April 1, 2014, aimed to reduce unnecessary hospitalizations by 25 percent during its initial five-year run, with a target of some $12B in savings for New York State taxpayers. Unless the program is renewed, DSRIP is scheduled to end March 31, 2020.

DSRIP contracted with 25 so-called Performing Provider Systems (PPS) to execute the strategy of providing Medicaid recipients with comprehensive, holistic and preventive care. The NYSDOH has reported that, in four years, 11 PPS have reduced potentially preventable admissions (PPA) and potentially preventable readmissions (PPR) by more than 25 percent; five PPS have achieved a reduction in PPA by 38 percent. SOMOS Community Care—the only physician-led PPS, the others being hospital-based—has achieved a reduction in PPA of 20.4 percent and reduction in PPR of 25.7 percent. This has produced a savings of $300M.

The figures tell only part of the story that makes the DSRIP program—the new face of Medicaid—so unique. A four-year renewal of DSRIP—DSRIP 2.0—holds the promise of

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impacting the future of Medicaid reform at the national level. The program's lessons so far are immensely valuable. At the core is the VBP formula, which dictates that the needs of the whole person of the patient must be considered, meaning not only strictly medical conditions, but also behavioral and social factors.

Guided by a new, comprehensive understanding of overall health and well-being, DSRIP humanizes care even as it saves significant public monies. DSRIP 2.0 will help make permanent gains that demonstrate that it is eminently affordable to provide vulnerable patients with superior health care. Quality care should not be only accessible for more fortunate members of society. DSRIP 2.0 will bring about a much-needed shake-up of Medicaid as we know it.

There is an urgent need for smarter spending on public health care. DSRIP has produced strong evidence that many pathways to good health are non-medical. What constitutes being truly well goes well beyond the realm of prescriptions, medical procedures and insurance matters, important as these are. As it stands, the National Institutes of Health spends only 3 percent of its budget on research of the impact of behavioral and social factors on a person's overall health and well-being. Clearly, a course correction is in order as 50 percent of premature deaths in the US are linked to precisely such non-medical factors.

Tackling the Social Determinants of Health (SDH) form a major part of the plans of NYSDOH for DSRIP 2.0. These call for the development and strengthening of a network of Community-Based Organizations (CBOs) that tackle social, psychosocial and cultural factors that impact people's health. These include patients' toxic housing, lack of access to fresh and healthy foods, lack of access to transportation, cultural barriers and domestic violence.

In the vision of Jason Helgerson—the former New York State Director of Medicaid who played a key role in the development of DSRIP—the medical provider works in tandem with CBOs in addressing patients' overall needs. In this scenario, the doctor becomes a community leader who enlists various experts in social issues to make contributions to patients' overall well-being.

For SOMOS this enrichment of health care for the poor is evident in the bond established between doctor and patient. It is a relationship of trust; it is evident to patients that their physician truly cares for them and is aware of all their various needs, medical and otherwise.

Serving largely African American, Chinese American and Latino patients in New York City, the more than 2500 doctors in the SOMOS network—most of them primary care physicians—live

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and work in the same communities as their patients. In most cases, these doctors have the same cultural and ethnic background as the people they care for. Cultural competence is a key ingredient of DSRIP.

SOMOS Community-Health Workers, who visit patients' homes to check on domestic conditions and send patients reminders to keep medical appointments, are the eyes and ears of the doctors. SOMOS practice transformation teams help train and equip physicians and staff so that practices become Patient-Centered Medical Homes, access points for all the carefully coordinated, comprehensive care patients require.

By comparison, the traditional Medicaid model leaves little room for the development of a genuine patient-doctor relationship and there is no mechanism to integrate and coordinate the various treatments, tests, and office visits in a manner that the patient can readily understand. Plus, traditional Medicaid health-care delivery largely ignores the effect of social factors on a patient's physical and mental health.

SOMOS Founder and Chairman Dr. Ramon Tallaj believes the future of inner-city public health care for the poor will be driven by the Neighborhood-Based Primary Care model. Through its work under DSRIP, SOMOS has reiterated the role of the primary care physician as the family doctor of old, as the trusted community leader. In a letter to NYSDOH advocating for the renewal of DSRIP, Dr. Tallaj stated that "the relationship between the family doctor and the patient is the strongest infrastructure tool in achieving the primary goal of the DSRIP program, to reduce the cost and frequency of hospitalizations."

DSRIP 2.0 will allow for establishing a critical mass of providers and managed care organizations willing and capable of embracing the Value-Based Payment formula. An extra four years will help make sure that the lessons and achievements of DSRIP will help inform the reform of public health care. Common sense would suggest that a program which improves care for the poor at tremendous savings should get the nod for a second chapter.