A Glimpse Into Partnership Between a Managed Care Organization and a Community Based Organization

Louisa Marra, St. Catherine's Center for Children

Kathy Leyden, CDPHP

Charlene Schlude, CDPHP

About St. Catherine's Center for Children

- Provides a comprehensive range of human services that:
  - Offer hope
  - Foster growth
  - Improve the lives of children, families, and individuals

- Publicly-funded

ST. CATHERINE'S
CENTER FOR CHILDREN

- Offer services, treatment, and education for the community's most at-risk children and families

St. Catherine’s – Services

- Community-based Comprehensive homeless services for families and adults
- Residential services for children ages 5 to 13
- Foster care services
- Day treatment/special education elementary school
- Prevention services

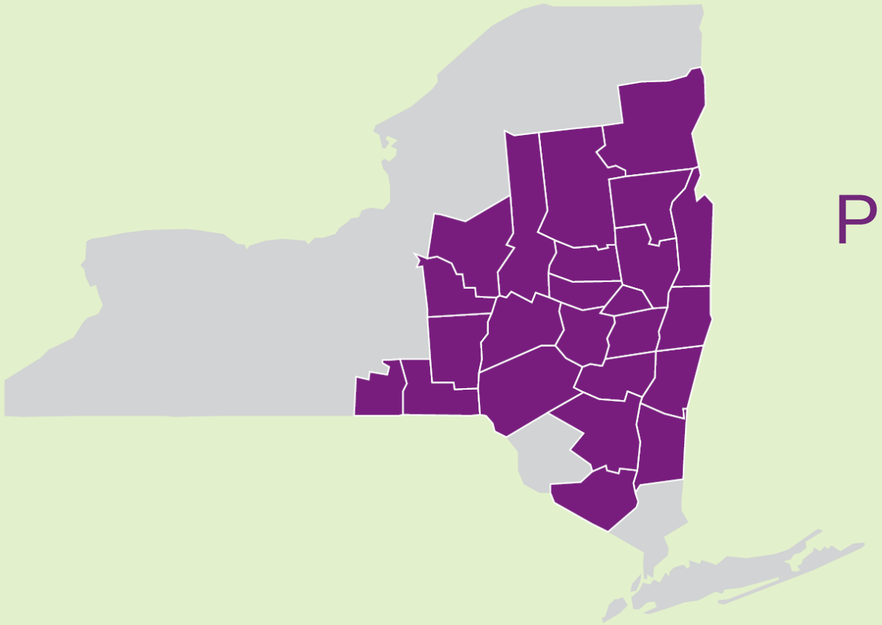
ST. CATHERINE'S
CENTER FOR CHILDREN

Marillac Homeless Family Program

- Funneled through the Office of Temporary Assistance and Albany County Department of Social Services
- Emergency shelter for 24 families
- Case management
- Supported employment
- On-site childcare/transportation/ recreation

ST. CATHERINE'S
CENTER FOR CHILDREN

About CDPHP



Physician-founded, not-for-profit, mission-driven

26
COUNTIES
in Upstate NY

365,000+
MEMBERS
across all lines of business

825,000+
PROVIDERS
throughout the country

CDPHP Awards and Recognitions

NCQA's Private Health Insurance Plan Ratings 2019-2020

- CDPHP HMO: 5 out of 5 (top-rated in New York state)
- CDPHN HMO/POS: 5 out of 5

NCQA's Medicaid Health Insurance Plan Ratings 2019-2020

- CDPHP HMO: 4.5 out of 5 (among the highest-rated in New York state)

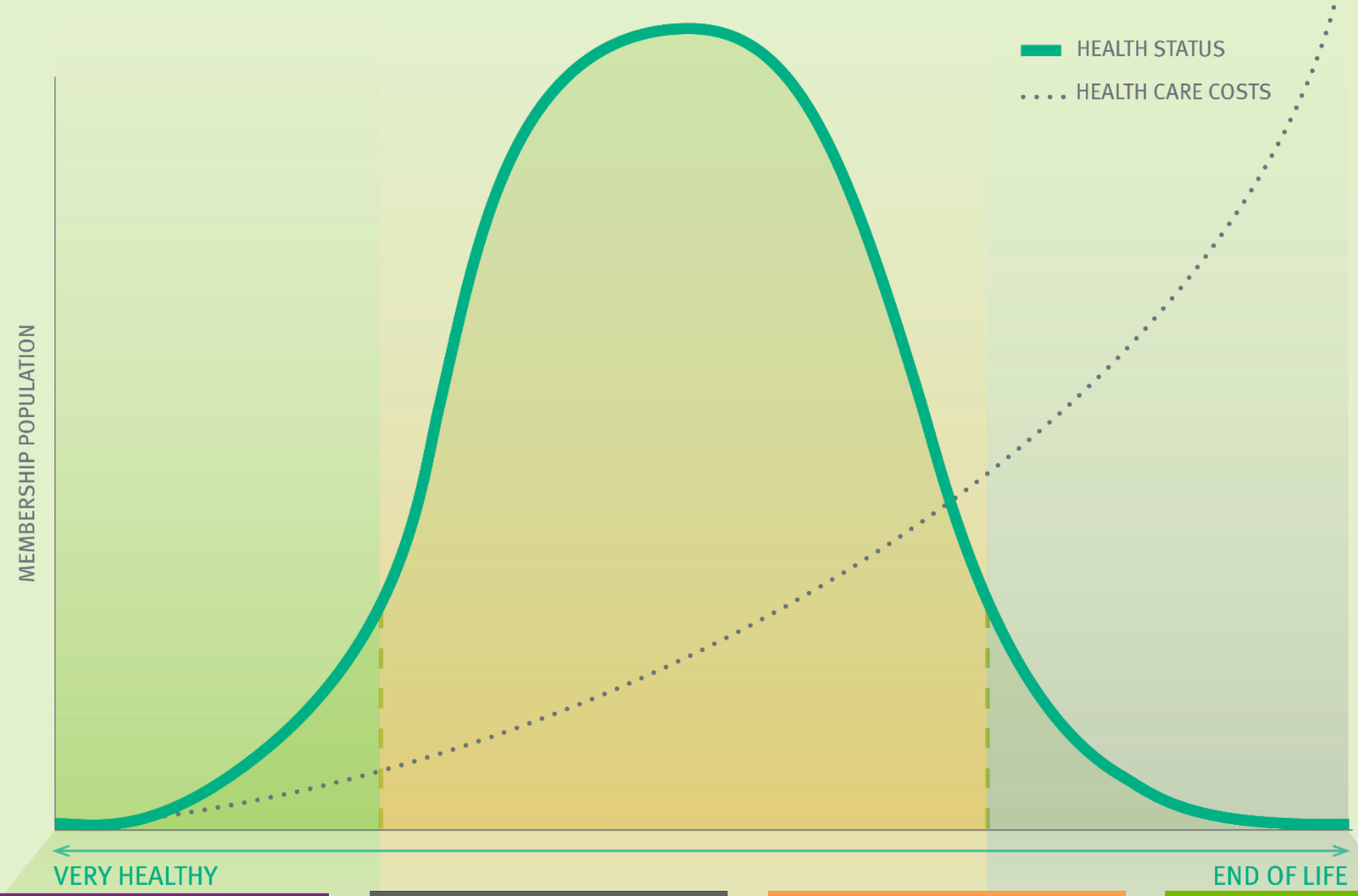
NCQA's Medicare Health Insurance Plan Ratings 2019-2020

- CDPHP HMO: 4.5 out of 5 (among the highest-rated in New York state)

Population Health

- Population health is the focus of nearly every stakeholder in health care
- To achieve improved health outcomes for the most vulnerable populations, Managed Care organizations (MCOs) rely on support from community based organizations (CBOs) to help access and manage care
- MCOs are partnering with organizations within the community to effectively address social determinants of health, a key factor in health decline
- Homelessness is a key driver of poor health

Continuum of Health



Homeless individuals often fall within the chronic or complex segments

Keeping Members Healthy | **Emerging Risk** | **Chronic Conditions** | **Complex Case Management**

Multidisciplinary Care Team Approach

- The CDPHP Care Team recognizes that 20% of an individual's health is based on care they receive. 80% is determined by genetics, lifestyle choices, and social determinants of health
- Our care teams provide face-to-face and telephonic interactions in a variety of settings
  - Hospitals, emergency rooms (ERs), behavioral health clinics, community agencies
- Face-to-face engagement offers the best chance for success with high-risk individuals

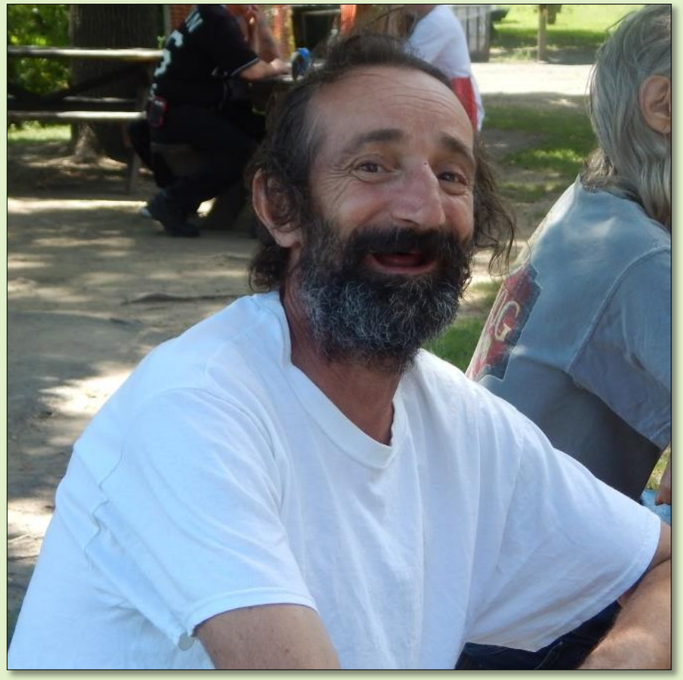
CDPHP Care Team members:

- Registered nurse case managers
- Licensed behavioral health case managers
- Social work case managers
- Asthma educators
- Certified Diabetes educators/registered dieticians

Background: Project HOST

Louisa Marra, St. Catherine’s Center for Children

Project HOST



- Healthy Outcomes through Supportive Transitions (HOST)
- New York State Department of Health (NYSDOH) funded since 2015 (MRT)
- Houses and provides case management for 36 homeless/unstably housed individuals at scattered sites
- Primary focus: decrease Medicaid costs and improve health outcomes
- Serves high users of crisis services, including those who struggle with severe mental health, substance abuse, and/or chronic illness

Project HOST – Outreach and Engagement

- Based on evidence-based practices
- Client-driven service delivery
- Street outreach
- Engaging community resources and contacts
  - Medicaid Managed Care/Health Homes
  - Shelters
  - Emergency rooms and police
  - Mental health units
  - Detox

Addressing Social Determinants of Health

- Economic stability
- Health literacy challenges & barriers to accessing appropriate care
- Social needs
- Housing
- Transportation
- Safety

Economic Stability

- Case managers offer employment assistance
- Staff are trained in the SSI/SSDI Outreach, Access, and Recovery (SOAR) model
- Albany, Columbia, and Rensselaer County departments of social services secure mainstream benefits (housing allowance, food stamps, and Medicaid)

Health and Healthcare

- Health Homes/care coordination
- MCOs
- Hospitals
- Albany County Department of Mental Health Program Services Coordinating Committee (PSCC)

Social and Community Context

- Peer support services connecting clients to support groups, drop-in centers
- Clients participate in focus groups to help educate and raise awareness of homelessness, mental illness, and addiction
- Client engagement activities
  - Annual summer cookout
  - Thanksgiving
  - Coat drive
  - Client participation in event panels

Neighborhood and Environment

- Secure safe, affordable, and stable housing
- Encourage healthy foods and eating (i.e. Price Chopper partnership)
- Address crime and violence
  - Albany Police Law Enforcement Assisted Diversion (LEAD)
  - Albany Police Neighborhood Engagement Unit

Project HOST Outcomes

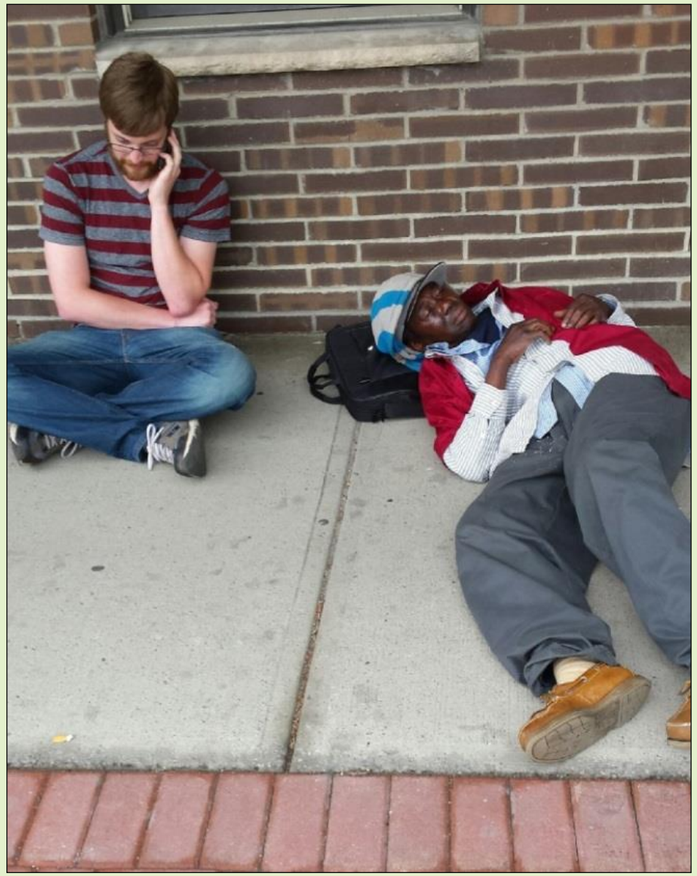
- October 1, 2017 – September 11, 2019
- Housed 63 CDPHP members
- Currently serving 36 individuals in three counties (Albany, Columbia, and Rensselaer)
- Decrease in emergency department visits, as well as a decrease in inpatient days
- 23 individuals once housed with Project HOST have moved on:
  - 14 have accessed a permanent housing voucher
  - 2 have accessed a higher level of care

Client Profile: Meet Doug

- Emergency room visits in the year prior to housing: **160**
- Lived and slept on the streets
- Active warrant and constant police contact
- Medical issues: Vision and gastro
- Cognitive limitations
- Little to no informal support structures in place
- History of substance abuse/alcoholism
- Emergency room visits in the year after housing placement: **20**

A story of hope…

Doug's Story



Doug and case manager on South Pearl Street in Albany

Doug in his Albany apartment with Christmas presents donated by CDPHP

Doug visiting with case manager, Shannon, at the rehabilitation and nursing center

Relationship Building & Contracting

Kathy Leyden, LMSW

Director, Community Engagement

CDPHP

Background of CDPHP Interest in Housing Initiatives

- Strong working knowledge of the bi-directional link between housing and health
- Organized and hosted the Housing is Healthcare training initiative in 2017
- Member of local Continuums of Care since 2013
- Embedded care team at local shelter and housing sites
- Strong referral relationships with housing entities

Relationship Building

- Served as a referral source for Project HOST cases
- With St. Catherine’s launch of Project HOST, we quickly realized the opportunity for impact with some early wins among the most challenging cases
- Developed an effective rhythm of communication & co-management of cases
- Utilized a tag team approach to support members in achieving and maintaining greater stability, managing crises, and staying connected to care
- The relationship between our teams “clicked”

Contracting

- CDPHP approached St. Catherine's with an opportunity to expand the great work already being done, with customizations specific to serving CDPHP Medicaid members
- Spent time going over the ABC's of contracting
- Made a conscious effort to keep first year of contract simple
- Weathered the "not so fun" details of contracting together
- Resulted in a mutually agreeable service & reimbursement model

Contract: Year 1

Housing placement & support services for 15 - 25 CDPHP Medicaid members

A minimum of 6 rental subsidies will be administered

Emphasis placed on identifying person-centered, long-term housing solutions

Flexible program model

Delivery Model and Housing Supports Offered to Homeless or At-Risk Individuals

Charlene Schlude BSN, MPA, CCM

Director, Care Management

CDPHP

How Do We Identify People in Need of Housing Support?

Referral Sources

- CDPHP Hospital Experience Program
  - » Care Team staff in three tertiary care facilities (ER and medical units)
- Homeless Management Information System (HMIS) through CARES INC.
- Community based settings
- St. Catherine’s and other CBOs
- Physicians (medical and behavioral health providers)

Eligibility

- Single adult, 18+
- Residing in Albany, Columbia, Greene, and Rensselaer counties
- Multiple chronic conditions, including medical or behavioral health
- Significant utilization of ER and/or inpatient services
- Homeless or at-risk

Referrals are reviewed and discussed by the CDPHP Care Team, in conjunction with St. Catherine’s.

Guiding Principles

- Co-management is the hallmark of this program
  - » Has provided framework, including formation of unique relationship between an MCO and a CBO
- Engaging with feet-to-the-street resources who are deeply rooted in the community
- Essential to start with each person where they are at
- Include the individual in each step of the process
- Include a holistic plan for ongoing supports

The goal is to offer housing as early as possible and to offer wrap around services.

Evidence-Based Approaches to Service Delivery

Housing-First Approach

- Provides quick access to housing with few or no barriers

Motivational Interviewing

- Client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence

Critical Time Intervention

- A time-limited, evidence-based practice that mobilizes support for society's most vulnerable individuals during transition periods

ST. CATHERINE'S
CENTER FOR CHILDREN

Case Vignette

MEET JOHN

Diagnosed with Schizophrenia, poorly-controlled Diabetes, and Asthma

- John used cocaine and alcohol regularly resulting in homelessness
- His only way of utilizing health care was the ER
  - » 11 ER visits and three (3) admissions in 2019 related to alcohol and drug use, elevated blood sugars, and psychotic episodes
- $98k in medical spend over a 22-month period, largely related to ER and inpatient expenses
- John was identified by a CDPHP HARP case manager during a weekly visit at a local homeless shelter. Case management assisted him with a referral to St Catherine's

Case Vignette: Collaborative Interventions = Positive Outcomes

- St. Catherine's housing team and CDPHP Care Team worked collaboratively to address all of John's health care needs
- John completed an inpatient rehab stay while awaiting available housing. John was housed in his own apartment in August of 2019
- He is currently maintaining sobriety, has established primary care, and is taking all of his medications regularly
- John checks his blood sugars daily and has not had an ER or admission since he was housed

St. Catherine's and CDPHP teams maintain contact to provide advocacy and support to help John maintain his success

Project Measurement

Kathy Leyden, LMSW

Director, Community Engagement

CDPHP

Performance Targets: Year One

80%

of program participants will be successfully placed into stable, suitable housing

70%

of program participants will remain in stable housing for a minimum of 6 months

100%

of program participants that remain in program for at least 6 months will show improvement in their social determinants of health status via screening at time of program enrollment and post enrollment screening after 6 months

Project Measurement

- Total cost of care
- ER & inpatient utilization
- Primary & specialty care utilization
- Medication adherence
- Housing retention & stability
- Criminal justice involvement
- Social supports
- Social determinants of health
- HEDIS gap closures

Sustainability

- Total cost of care will be measured longitudinally
- Savings will be calculated on a PM/PM basis
- Other areas of impact will be monitored and included in a holistic analysis of the project during defined measurement periods
- Ultimately, the project must demonstrate both a traditional return on investment (ROI) in addition to value of impact (VOI)

Lessons Learned for Effective Collaboration

- Philosophy on service & mission must be fully aligned
- Value the skill set each other brings to the table
- Trust takes time and must be proven through action
- Keep it simple - resist the urge to overcomplicate contracts
- Regular communication is key to healthy program operation
- Both partners must be “in it to win it”

In Conclusion…

"Coming together is a beginning, staying together is progress, and working together is success."

- Henry Ford

Project Contacts

CDPHP

Kathy Leyden, Director, Community Engagement

kathy.Leyden@cdphp.com

Charlene Schlude, Director, Care Management

charlene.Schlude@cdphp.com

St. Catherine's Center for Children

Louisa Marra, Associate Executive Director of Homeless Services

lmarra@st-cath.org

Questions?