Delivery System Reform Incentive Payment (DSRIP) program
Updates for MMNY coalition
June 7, 2018

www.medicaidmattersny.org
@MedicaidMtrsNY
Advocates’ perspective on reform

- Medicaid consumer education and awareness
- Applaud the level of transparency and accountability built in, but must be attentive to overwhelming nature of info
- Must always include consumer and community perspectives in every aspect of reform
- Cultural competency; reaching people where they are (not just geography)
- Role and resources of CBOs and safety-net providers
- Social determinants of health
- Reform as a culture shift
Delivery System Reform Incentive Payment program

• The bulk of the MRT Waiver; $6.42 billion over five years to fund projects that will reduce avoidable hospitalizations and promote the Triple Aim

• Public hospitals and safety net providers formed Performing Provider Systems (PPS) to carry out DSRIP projects with large, broad networks of providers of all types

• Funding allocated based on project valuation and outcomes
Delivery System Reform Incentive Payment program (cont’d)

- All Medicaid members are attributed to PPS, based on where they typically use services
- Statewide performance must be demonstrated to CMS and funding will be reduced across the board if outcomes are not reached
- Intent is to promote permanent transformation of delivery system
DSRIP Key Themes

As presented by NYS Medicaid Director, Jason Helgerson:

FIVE KEY THEMES OF DSRIP

1. Collaboration, Collaboration, Collaboration!!!

2. Project Value drives
   a) Transformation and types of projects
   b) # of Medicaid members served (attribution)
   c) Application Quality

3. Performance Based Payments

4. Statewide Performance Matters

5. Lasting Change
   a) Long-Term Transformation
   b) Health System Sustainability
DSRIP Community Engagement

MMNY has aimed to capture what is happening across the state to inform statewide policy recommendations.

• How are the PPS doing at engaging the communities they aim to serve?
• Do CBOs feel they are being meaningfully engaged?
• What barriers do CBOs face in being able to more fully participate?
DSRIP Community Engagement (cont’d)

MMNY projects 2015-2017, funded by the NYS Health Foundation and the Health Foundation for Western and Central New York included:

• Statewide survey of community-based organizations
• Communication, facilitation, capacity building with CBOs across the state
• Local projects in Capital Region and the Southern Tier
• Statewide forum in October 2016
• All intended to inform policy
DSRIP community engagement: key themes

As reported by CBO representatives across NYS:

• Tremendous leeway = a double-edged sword
• DSRIP is hospital-centric
  – Lack of understanding of community (despite needs assessments)
  – Lack of understanding of the value of CBOs
  – Recreating the work of CBOs inside hospital walls
• CBO capacity to participate
  – Participation with little or no compensation
  – Lack of staff capacity
  – “Initiative fatigue”
  – Ability to articulate value varies
• DSRIP sustainability
  – Where is this all going?
  – What is going to stick?
DSRIP community engagement recommendations

- Continue to fund innovation
- Renew funding for statewide CBO strategic planning (perhaps with unearned DSRIP funds)
- Strive for better data and reporting on CBO engagement and social determinants of health
- Support community efforts to define priorities for delivery system transformation
- Continue to promote understanding and awareness about communities, true cultural competency, and the role CBOs can play
- “Engagement” should include other valuable assets CBOs bring to the table, like leadership and knowledge
Today’s guest speakers

Peggy Chan, MPH
DSRIP Program Director
NYS Department of Health
Office of Health Insurance Programs
Staff members: Shirley Belotte, Cherlyn Fay

Marilyn Fraser, MD
Chief Executive Officer
Arthur Ashe Institute for Urban Health

Lori Andrade
Chief Operating Officer
Health and Welfare Council of Long Island
PPS Progress on Mid-Point Action Plans – Funds Flow

• Through the DY3, Q2 PPS Quarterly Report, PPS have increased the amount of funding distributed to partners relative to the funding distributed at the time of the Mid-Point Assessment.
  • PPS distributed over $221M to partners in DY3, Q2.

<table>
<thead>
<tr>
<th>Cumulative Funds Flow at MPA (DY2, Q2)</th>
<th>Cumulative Funds Flow at DY3, Q2</th>
<th>Additional Funds Flow since MPA</th>
<th>% Change in Funds Flow</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Funds Flow</td>
<td>$414,267,236</td>
<td>$1,100,047,613</td>
<td>$685,7800,376</td>
</tr>
<tr>
<td>Non-Hospital / Non-PPS PMO Funds Flow</td>
<td>$113,408,240</td>
<td>$344,803,581</td>
<td>$231,395,341</td>
</tr>
</tbody>
</table>

• For the categories highlighted in the Mid-Point Assessment, PPS Funds Flow distributions increased by over 100%.

<table>
<thead>
<tr>
<th>Partner Category</th>
<th>Cumulative Funds Flow at MPA (DY2, Q2)</th>
<th>Cumulative Funds Flow at DY3, Q2</th>
<th>Additional Funds Flow since MPA</th>
<th>% Change in Funds Flow</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practitioner – Primary Care Provider (PCP)</td>
<td>$14,659,935</td>
<td>$63,754,315</td>
<td>$49,094,381</td>
<td>335%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>$9,741,485</td>
<td>$35,291,921</td>
<td>$25,550,436</td>
<td>262%</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>$4,319,963</td>
<td>$12,780,469</td>
<td>$8,460,506</td>
<td>196%</td>
</tr>
<tr>
<td>Community Based Organizations</td>
<td>$11,993,454</td>
<td>$33,990,664</td>
<td>$21,997,210</td>
<td>183%</td>
</tr>
</tbody>
</table>
## PPS Progress on Mid-Point Action Plans – Funds

<table>
<thead>
<tr>
<th></th>
<th>As of MPA (DY2, Q2)</th>
<th>As of DY3, Q2</th>
<th>Changes since MPA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Funds Distributed</td>
<td>% of Funds Distributed</td>
<td>Funds Distributed</td>
</tr>
<tr>
<td>Practitioner – Primary Care Provider (PCP)</td>
<td>$14,659,935</td>
<td>3.54%</td>
<td>$63,754,315</td>
</tr>
<tr>
<td>Practitioner – Non-Primary Care Provider (PCP)</td>
<td>$2,654,701</td>
<td>0.64%</td>
<td>$6,623,342</td>
</tr>
<tr>
<td>Hospital</td>
<td>$121,775,967</td>
<td>29.40%</td>
<td>$182,521,398</td>
</tr>
<tr>
<td>Hospital – IP/ED^</td>
<td>$0</td>
<td>0.00%</td>
<td>$147,358,192</td>
</tr>
<tr>
<td>Hospital – Ambulatory^</td>
<td>$0</td>
<td>0.00%</td>
<td>$29,612,421</td>
</tr>
<tr>
<td>Clinic</td>
<td>$29,687,182</td>
<td>7.17%</td>
<td>$87,904,817</td>
</tr>
<tr>
<td>Case Management / Health Home</td>
<td>$5,973,274</td>
<td>1.44%</td>
<td>$17,408,904</td>
</tr>
<tr>
<td>Case Management^</td>
<td>$0</td>
<td>0.00%</td>
<td>$4,670,951</td>
</tr>
<tr>
<td>Health Home^</td>
<td>$0</td>
<td>0.00%</td>
<td>$3,255,815</td>
</tr>
<tr>
<td>Mental Health</td>
<td>$9,741,485</td>
<td>2.35%</td>
<td>$35,291,921</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>$4,319,963</td>
<td>1.04%</td>
<td>$12,780,469</td>
</tr>
<tr>
<td>Nursing Home</td>
<td>$5,476,856</td>
<td>1.32%</td>
<td>$18,177,581</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>$305,708</td>
<td>0.07%</td>
<td>$1,461,616</td>
</tr>
<tr>
<td>Hospice</td>
<td>$739,659</td>
<td>0.18%</td>
<td>$3,279,031</td>
</tr>
<tr>
<td>Community Based Organization</td>
<td>$11,993,454</td>
<td>2.90%</td>
<td>$33,990,664</td>
</tr>
<tr>
<td>All Other</td>
<td>$23,297,909</td>
<td>5.62%</td>
<td>$39,802,885</td>
</tr>
<tr>
<td>Home Care^</td>
<td>$0</td>
<td>0.00%</td>
<td>$2,503,255</td>
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<tr>
<td>PPS PMO</td>
<td>$179,083,029</td>
<td>43.23%</td>
<td>$395,752,021</td>
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<tr>
<td>Other*</td>
<td>$4,558,116</td>
<td>1.10%</td>
<td>$14,298,017</td>
</tr>
<tr>
<td><strong>TOTAL – All Categories</strong></td>
<td><strong>$414,267,236</strong></td>
<td><strong>$1,100,047,613</strong></td>
<td><strong>$685,780,376</strong></td>
</tr>
</tbody>
</table>

* Other category includes Partner Type Categories for Uncategorized, Non-PPS Network, County Agency, CBO Tier 3.
^ Hospital – IP/ED, Hospital – Ambulatory, Case Management, Health Home, and Home Care categories are new following MPA.
# PPS Progress on Mid-Point Action Plans – Partner Engagement (adjusted for PPS outlier)

<table>
<thead>
<tr>
<th>Category</th>
<th>Committed (in DSRIP project Plan Application)</th>
<th>Partners Engaged</th>
<th>% of Committed Partners Engaged</th>
<th>As of MPA (DY2, Q2)</th>
<th>Partners Engaged</th>
<th>% of Committed Partners Engaged</th>
<th>As of DY3, Q2</th>
<th>Partners Engaged</th>
<th>% of Committed Partners Engaged</th>
<th>Changes since MPA</th>
<th>Additional Partners Engaged</th>
<th>% increase in Partners Engaged</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practitioner – Primary Care</td>
<td>53,417</td>
<td>37,424</td>
<td>70%</td>
<td>84,125</td>
<td>157%</td>
<td>46,701</td>
<td>125%</td>
<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Practitioner – Non-Primary Care</td>
<td>106,666</td>
<td>101,356</td>
<td>95%</td>
<td>256,892</td>
<td>241%</td>
<td>155,536</td>
<td>153%</td>
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<td></td>
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</tr>
<tr>
<td>Hospital</td>
<td>254</td>
<td>700</td>
<td>276%</td>
<td>1,150</td>
<td>453%</td>
<td>450</td>
<td>64%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinic</td>
<td>1,709</td>
<td>1,863</td>
<td>109%</td>
<td>3,105</td>
<td>182%</td>
<td>1,242</td>
<td>67%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case Management / Health Home</td>
<td>1,298</td>
<td>1,242</td>
<td>96%</td>
<td>2,199</td>
<td>169%</td>
<td>957</td>
<td>77%</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>9,750</td>
<td>9,273</td>
<td>95%</td>
<td>24,113</td>
<td>247%</td>
<td>14,840</td>
<td>160%</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>1,235</td>
<td>960</td>
<td>78%</td>
<td>1,781</td>
<td>144%</td>
<td>821</td>
<td>86%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Home</td>
<td>860</td>
<td>1,104</td>
<td>128%</td>
<td>1,329</td>
<td>155%</td>
<td>225</td>
<td>20%</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>979</td>
<td>324</td>
<td>33%</td>
<td>689</td>
<td>70%</td>
<td>365</td>
<td>113%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice</td>
<td>96</td>
<td>174</td>
<td>181%</td>
<td>225</td>
<td>234%</td>
<td>51</td>
<td>29%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Based Organization</td>
<td>2,771</td>
<td>2,064</td>
<td>74%</td>
<td>3,303</td>
<td>119%</td>
<td>1,239</td>
<td>60%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Other</td>
<td>65,942</td>
<td>72,117</td>
<td>109%</td>
<td>151,277</td>
<td>229%</td>
<td>79,160</td>
<td>110%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL – All Partners</strong></td>
<td><strong>244,977</strong></td>
<td><strong>228,601</strong></td>
<td><strong>93%</strong></td>
<td><strong>530,188</strong></td>
<td><strong>216%</strong></td>
<td><strong>301,587</strong></td>
<td><strong>132%</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

*Note: Count of committed and engaged partners does not reflect an unduplicated count. PPS could commit to and engage the same partner across multiple projects.
# PPS Progress on Mid-Point Action Plans – Partner Engagement (unadjusted for PPS outlier)

<table>
<thead>
<tr>
<th>Category</th>
<th>Committed (in DSRIP project Plan Application)</th>
<th>Partners Engaged</th>
<th>% of Committed Partners Engaged</th>
<th>As of MPA (DY2, Q2)</th>
<th>% of Committed Partners Engaged</th>
<th>Additional Partners Engaged</th>
<th>% increase in Partners Engaged</th>
<th>As of DY3, Q2</th>
<th>% of Committed Partners Engaged</th>
<th>Changes since MPA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practitioner – Primary Care</td>
<td>58,599</td>
<td>44,912</td>
<td>77%</td>
<td>90,572</td>
<td>155%</td>
<td>45,660</td>
<td>102%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practitioner – Non-Primary Care</td>
<td>113,253</td>
<td>111,924</td>
<td>99%</td>
<td>264,725</td>
<td>234%</td>
<td>152,801</td>
<td>137%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>268</td>
<td>788</td>
<td>294%</td>
<td>1,180</td>
<td>440%</td>
<td>392</td>
<td>50%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinic</td>
<td>1,823</td>
<td>2,095</td>
<td>115%</td>
<td>3,231</td>
<td>177%</td>
<td>1,136</td>
<td>54%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case Management / Health Home</td>
<td>1,346</td>
<td>1,402</td>
<td>104%</td>
<td>2,265</td>
<td>168%</td>
<td>863</td>
<td>62%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>10,365</td>
<td>10,841</td>
<td>105%</td>
<td>26,273</td>
<td>253%</td>
<td>15,432</td>
<td>142%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>1,395</td>
<td>1,312</td>
<td>94%</td>
<td>1,979</td>
<td>142%</td>
<td>667</td>
<td>51%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Home</td>
<td>887</td>
<td>1,448</td>
<td>163%</td>
<td>1,429</td>
<td>161%</td>
<td>(19)</td>
<td>-1%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>1,004</td>
<td>452</td>
<td>45%</td>
<td>809</td>
<td>81%</td>
<td>357</td>
<td>79%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice</td>
<td>99</td>
<td>222</td>
<td>224%</td>
<td>243</td>
<td>245%</td>
<td>21</td>
<td>9%</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Community Based Organization</td>
<td>2,876</td>
<td>2,592</td>
<td>90%</td>
<td>3,422</td>
<td>119%</td>
<td>830</td>
<td>32%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Other</td>
<td>75,371</td>
<td>88,437</td>
<td>117%</td>
<td>156,149</td>
<td>207%</td>
<td>67,712</td>
<td>77%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL – All Partners</strong></td>
<td><strong>326,927</strong></td>
<td><strong>315,942</strong></td>
<td><strong>96.64%</strong></td>
<td><strong>655,473</strong></td>
<td><strong>200%</strong></td>
<td><strong>339,531</strong></td>
<td><strong>107%</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note: Count of committed and engaged partners does not reflect an unduplicated count. PPS could commit to and engage the same partner across multiple projects.*
Data Sharing and Opt Out

- For the Performing Provider Systems (PPS) to provide the highest quality of care for the community they serve, and to evaluate their performance metrics, it is important for the PPS to receive Medicaid claims and encounters data.

- Within the Delivery System Reform Incentive Payment (DSRIP) Program, Medicaid members can restrict the sharing of their PHI Medicaid claims and encounters data, which is considered an “Opt Out”. If a member opts out, data will only be used in aggregate counts and calculations of PPS performance metrics.

- Mailings:
  - In February 2018, 1.9 million letters were sent to members deemed eligible and not opted out with an additional 22k members opting out
  - The first three mailings sent over 6.9m letters to newly eligible and recertified Medicaid members through August 2016. Of these, 177k members opted out
  - Of the total 199k opted out members, 123k have remained Medicaid eligible
  - MAXIMUS call center has received over 130k calls to date; 23k of these since February 2018
  - Monthly mailings to newly eligible and recertified members (approx. 150-200k each) began May 2018
  - Top translation requests are Spanish and Mandarin
Medicaid Marketing Research Project

**Program Goal:** Conduct focus groups and message testing to assess Medicaid members’ level of understanding of changes in the health care system; determine how to best communicate changes and benefits members may encounter; and effectively address concerns of Medicaid members and low-income uninsured individuals.

Project results will be used by the Department of Health to conduct an educational campaign about healthcare transformation.

- **Contractor:** New York Academy of Medicine
- **Contract Term:** February 2018 – August 2019
- Three stakeholder focus groups conducted during May/June 2018 in three regions: NYC/LI; Westchester north to border/west to Utica; and Utica west
- 25 focus groups to be conducted beginning Fall 2018 for Medicaid members and low-income uninsured in seven languages statewide
DSRIP Workforce
Emerging/Transformation Titles - New Hires

• The following slide shows the aggregate volumes of New Hires (combined full and partial placements) for all PPS for top transformation titles through DY3Q2.

• Emerging/Transformation titles are roles in which the scope of work and competencies are changing or have changed due to transformation efforts such as care transitions, integrating care delivery and improving access to care.

• All 25 PPS are implementing Project 3.a.i., Integration of primary care and behavioral health services. Drilling down into primary care and behavioral health titles, these New Hire findings appear to reflect PPS progress toward:
  • transitioning care away from institutions to community- and home-based care settings;
  • strengthening and expanding primary care and behavioral health; and
  • integrating these services.
Emerging/Transformation Title New Hires through DY3Q2

- Care Manager
- Personal Care Aides
- Licensed Masters Social Workers
- Social Worker Care Coordinators
- Case Managers
- Care Transition
- Licensed Clinical Social Workers
- Community Health Worker
- Patient or Care Navigator
- Peer Support Worker
- Social and Human Service Assistants
- Bachelors Social Work
PPS CBO VBP Trainings and Activities

PPS are required to complete VBP trainings for CBOs two times per year, along with other activities. Examples are:

- **Bronx Health Access** – Partnered with Columbia University to offer, upon request, one-on-one onsite TA in VBP Readiness to CBO partners
- **OneCity** – Offers TA to CBO partners through CSSNY
- **FLPPS** – Partnered with United Way to provide 14 CBOs with long-term training and TA
- **WMCHHealth** – Learning management system module on VBP for CBOs
- **NQP** – Will provide 5-6 Innovation Fund CBOs with paid consultant to advise on strategic planning, sustainability, growth, revenue and infrastructure

**Upcoming Trainings (currently scheduled):**
- **Capital Region:**
  - North Country Initiative – June 2018
- **Mid-Hudson:**
  - WMCHHealth – June, September, October and November 2018
- **Central NY:**
  - CNYCC – April 2019
  - Leatherstocking Collaborative Health Partners – June 2018
- **Long Island:**
  - Nassau Queens PPS – training facilitated by MCTAC in June 2018
  - SCC – CBO partner innovation networking event in June 2018
- **New York City:**
  - NYU Langone – September 2018
PPS Activities to Address SDH

- **Community Care of Brooklyn**
  - Identify four barriers to community health to make improvements
- **FLPPS**
  - Poverty reduction; regional technology platform development
- **Nassau Queens PPS**
  - Behavioral health initiative; CHW/Peer services
- **New York Presbyterian**
  - SDH Screening; CHW/Peer services; embedding SDH services on site
- **NYU Langone Brooklyn**
  - Support people with complex health and housing needs
- **Millennium Care Collaborative**
  - Healthy Corner Store Initiative

*PPS have engaged an average of 18 Tier 1 CBOs - January 2018 PPS CBO Survey*
CBO Planning Grant

Goal: Prepare Tier 1 CBOs, with a budget of less than $5M, for contracting with PPS/Providers/MCOs

- **New York City** – **Grantee:** Arthur Ashe Institute for Urban Health
  - Consortium Name: *Communities Together for Health Equity* (74 CBOs)
  - Contract Term: March 1, 2017 – February 28, 2018
  - 5 hubs (Bronx, Brooklyn, Manhattan, Queens, Staten Island)
  - Developed a central communications portal
  - Offered core trainings (e.g. Contracting 101, Role of CBO in Delivery System, Data Collection, Financing CBO Services, Purchasing Strategies and IT)
  - Offered learning collaboratives (Value Proposition, Business Planning, IT Capacity and Data)

- **Long Island/Hudson Valley** – **Grantee:** Health and Welfare Council of Long Island
  - Health and Welfare Council of Long Island - Long Island Consortium Hub (43 CBOs)
  - Collective for Community Wellness - Hudson Valley Consortium Hub (15 CBOs)
  - Contract Term: November 1, 2017 – October 31, 2018
  - Developed a central communications portal
  - Provide training and technical assistance for strategy and growth
  - Organized the Alliance Work Group (Tier 2 and 3 CBO, MCO, PPS)

- **Rest of State** – **Grantee:** TBD
  - Expected Contract Term: October 1, 2018 – September 30, 2019
  - RFA Applications due May 4, 2018
TRANSFORMATION IS THE GOAL

Marilyn Fraser, MD, CEO (Arthur Ashe Institute for Urban Health)
ARTHUR ASHE INSTITUTE FOR URBAN HEALTH (AAIUH)
• The Consortium

  – Sub-group of CBOs from the Coalition (and beyond) that fit grant mandated eligibility criteria (i.e. budget, consultant, non-medicaid billing, experience with SDH etc.).
Vision:
To establish a sustainable model for CBO collaboration, including the processes necessary to facilitate partnerships with payers (e.g. MCO, PPS) to support CBO-led community engagement, needs analysis, and service provision to address the social determinants of health post-DSRIP.

Mission:
To establish a diverse citywide network of small community based organizations to strategically plan and collectively develop and implement the infrastructure necessary to ensure robust CBO engagement within a transforming health care system and other payers.
CONSORTIUM GOALS

1. Form and sustain a CBO Consortium.

2. Support CBO capacity to meet their needs, as well as address identified community needs and DSRIP goals.

3. Monitor progress addressing project goals and conduct ongoing process improvement.

4. Ensure sustainable Consortium participation in addressing social determinants of health within VB service delivery for DSRIP and beyond.
FORMING A CONSORTIUM MEMBERSHIP

• **75 NYC-based agencies:**
  – 501(c)3
  – Non-Medicaid billing
  – Annual operating budgets ≤ $5 million
  – Experience providing community-based services that address SDH

• **Lead organization:** Arthur Ashe Institute for Urban Health

• **Recruitment & TA:** Commission on the Public’s Health System (CPHS)

• **Five Borough Hubs:**
  – Bronx Lead: Health People
  – Brooklyn Lead: Brooklyn Perinatal Network
  – Manhattan: African Services Committee
  – Queens: South Asian Council for Social Services
  – Staten Island: El Centro del Inmigrante
Steering Committee:
- Chair
- Arthur Ashe Institute for Urban Health (AAIUH)
- Commission for the Public Health System (CPHS)
- Borough (HUB) Leads
- CBOs representing populations
- CBOs representing SDOH

Workgroups:
- Evaluation
- IT
- Policy
- PPS/Payor Engagement
- Conference, Trainings & TA
- Strategic Planning
Partnerships are
- more than collaboration
- more than cooperation
Create a new way to:

- solve a problem
- provide healthcare services
Spend enough time to share in decision-making
ACCOMPLISHMENTS: VBP PREP TRAININGS & LEARNING COLLABORATIVES

CORE TRAINING WEBINARS

- DSRIP 101
- Collecting the Right Data
- Financing CBO Services
- Contracting 101
- Role of CBOs in Delivery System
- Strategies for Maximizing IT

LEARNING COLLABORATIVES

- Value Proposition and Service Planning
- Using Data to Improve Care, Guide Expansion & Enhance Services
- Improving IT Capacity
- Business Planning for Successful Service Delivery
The Path to Achieving Health Equity

What social and economic factors must be addressed on the continued path to achieving Health Equity?

- Discrimination/Minority Stressors
- Food Security and access to healthy foods
- Stable Income & Job Security
- Environmental Quality
- Educational Opportunities
- Quality Affordable Healthcare
- Neighborhood Conditions

Health Equity aims to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives.

The Health Equity Institute
http://healthequity.sfsu.edu
1600 Holloway Avenue, HSS 359
San Francisco, CA 94132
P: 415-405-2540
CTHE VALUE: POPULATIONS SERVED
CTHE VALUE: HIGHLIGHTS

• 95% of our CBO members have >5 years of experience working with NYC’s Medicaid and uninsured low income residents
  – 48% ≥ 25yrs of serving their target communities
  – 15% ≥ 40yrs of history serving NYC

• Geographically and linguistically diverse
  – HUBs represent and address the community needs of all 5 boroughs
  – Over 40 languages spoken

• CBOs within our network offer services across the Social Determinants of Health (SDH)
  – 78% Social, Family & Community
  – 75% Neighborhood & Environmental
  – 73% Economic Stability
  – 65% Education
  – 58% Health Literacy
  – 45% Access to Healthcare
  – 31% Access to Primary Care

• As a collective, we serve over 350 thousand of the city’s most disenfranchised residents
ACCOMPLISHMENTS: CTHE WEBSITE
ACCOMPLISHMENTS: CTHE PORTAL

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
<th>Email Address</th>
<th>Organization</th>
<th>Hub</th>
<th>Services</th>
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</thead>
<tbody>
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<td>CommonWise Education</td>
<td>Bronx</td>
<td>Civic Participation, Economic Stability, Neighborhood and Environment</td>
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ACCOMPLISHMENTS: CONFERENCES/SEMINARS

• CTHE Conference “Breaking Ground: Engaging CBO’s in Health Equity-Collective Action to Unify CBO’s for Healthcare Transformation”

• Queens Conference “The Transformative Power of CBO’s: Building a Healthy Community in Queens”

• Bronx Conference “Putting Community at the Center of Transforming our Bronx Health”
LESSONS LEARNED

• Prioritizing numerous community needs
• Strategic process
• Partner engagement
• Sustainability of partnerships
• Funding
ONGOING WORK

- Development of strategic sustainability plan
- Continued engagement of PPS
- 2\textsuperscript{nd} Conference
- Explore options for engagement (e.g. MCOs, PPS)
- Enhance IT infrastructure
- Innovation Funds for CBO projects
- Collaboration with other grantee (HWCLI)
HEALTHCARE: RIGHT NOT PRIVILEGE
“I know I could never forgive myself if I elected to live without humane purpose, without trying to help the poor and unfortunate, without recognizing that perhaps the purest joy in life comes with trying to help others”

-Arthur Ashe
THANK YOU!
CBO Engagement in VBP: An Opportunity to Meet Long Island’s Needs

Lori Andrade
Chief Operating Officer, HWCLII
Long Island’s regional nonprofit umbrella organization for health and human service providers.

ESTABLISHED IN 1947

MISSION

HWCLI serves the interests of poor and vulnerable people on Long Island by convening, representing, and supporting the organizations that serve them; and through:

- Illuminating the issues that critically impact them
- Organizing community and regional responses to their needs
  - Advocacy, research, policy analysis
  - Providing services, information and education
Why is this work critical?

“Fully addressing social determinants of health requires a shift in power that enables marginalized communities to co-design their own healthcare solutions. Unfortunately, health insurers, while willing to alter payment models and entertain some changes in what they will pay for, have yet to grasp the more fundamental nature of the need for system change and community empowerment inherent in the idea that health, ultimately, is about much, much more than health care.”

American Journal of Managed Care, 2/15/18
Why a health equity focus?

Value Based Payment Arrangement

Client Focused Service Delivery Model
Why a Health Equity Alliance?

By creating a system where one does not exist, we can better help underserved communities have equitable access to health & human services. Together, we can address inequities to build and sustain healthier Long Island communities.
Consider This

EQUALITY

COMMUNITY RESOURCES

EQUITY

COMMUNITY RESOURCES
Steering Committee Members

Health & Welfare Council of Long Island
CARECEN-NY
Child Care Council of Nassau
Choice for All
LI Against Domestic Violence
LI Coalition for the Homeless
HEALI Members

• 70 Long Island CBOs in the Alliance
• 46 Long Island CBOs
  – 501(c)3
  – Non-Medicaid billing
  – Annual operating budgets ≤ $5 million
  – Experience providing community-based services that address SDH
Geographic Diversity

HEALI serves clients from Elmont to Montauk
Wide Range of Service Areas

Social Determinants of Health Covered

- Housing
- Employment
- Transportation
- Education
- Immigration
- Child Care
- Re-Entry
- Elder Care
- Safety
- Community Engagement
- Youth
- Substance Abuse
- Health
- Mental Health
- Legal
- Faith Based
- Early Intervention

Social Determinants of Health Covered
Populations Served

- Hispanics
- Haitians
- Immigrants
- Undocumented
- Youth/At risk youth
- Children
- Families
- Child Care Providers
- Underemployed
- Low income citizens
- Health care providers
- Senior Citizens
- Homeless/Formerly homeless
- Active and illicit drug users
- LGBTQ
- People with Disabilities
- People with chronic illness
- People living with HIV/AIDS
- Formally incarcerated individuals
- Survivors of domestic violence, sex workers, women impacted by trauma
Work To Date

• Health Equity Summit
• Collaborative CBO Brainstorming Session
• 70 CBOs engaged
• Convened steering committee representing multiple SDH
• Engaged PPSs & MCOs in robust dialogue about this work and the potential for authentic partnerships
HEALI members asked to rate importance of (1-5 Likert Scale)

A centralized database of services provided by HEALI partners: 4.33

Clients to be a part of the development process of HEALI: 4.33

A unified system that tracks and refers clients as they move across the social determinants of health: 4.18

HEALI developing a clearing house or hub to coordinate services and to support clients: 4.12

HEALI partners having a standardized screening, intake, and referral process to serve clients: 3.67
Developing Work Groups

- Focused strategic planning to improve Long Island’s service delivery system
- Informative learning collaborative
- Educational webinars about VBP
- Innovative, state-of-the-art portal
Hudson Valley Partners

- Represents all 7 Hudson Valley Counties
- 28 CBOs engaged
- April 20th – Kickoff Event
- Designing a new self-assessment tool to assess CBO readiness
- CBO workgroups include
  - Communications
  - Advocacy
  - Data and evaluation
  - IT
  - Financing and contracting
Hudson Valley Steering Committee

TOUCH-NY
Yonkers CAP
Action Toward Independence
Lower Hudson Valley Perinatal Network
Maternal-Infant Services Network
Questions?

Lori Andrade
landrade@hwcli.com
516-364-2869
Q&A and discussion

Please enter your questions in the Q&A box on your screen.
Thank you!

As always, please contact Lara Kassel, MMNY Coordinator, with your questions, comments, concerns!

lkassel@medicaiddmattersny.org
518-463-1896 x124