



Partnerships Between New York City Health Care Institutions and Community-Based Organizations

A Qualitative Study on Processes, Outcomes, Facilitators, and Barriers to Effective Collaboration

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The Academy advances solutions that promote the health and wellbeing of people in cities worldwide. Established in 1847, The Academy continues to address the health challenges facing New York City and the world's rapidly growing urban populations. This is accomplished through the Institute for Urban Health, home of interdisciplinary research, evaluation, policy, and program initiatives; the world-class historical medical library and its public programming in history, the humanities, and the arts; and a Fellows program, a network of more than 2,000 experts elected by their peers from across the professions affecting health.

About Greater New York Hospital Association

GNYHA represents more than 160 member hospitals and health systems across New York State, as well as in New Jersey, Connecticut, and Rhode Island. GNYHA supports its member hospitals in the areas of clinical

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operations and quality improvement strategies, regulatory and legal compliance, effective financial operations and reimbursement, and cost-effective purchasing arrangements. GNYHA plays an active role in convening hospital administrative, clinical, and

educational leadership in identifying and developing new initiatives of interest to member hospitals, and effectively implementing them. The role has been extended to support PPSs in their DSRIP program efforts.

Executive Summary

While New York City-based health care organizations (HCOs) and community-based organizations (CBOs) share the mutual goal of serving the needs of their patients and clients, the extent to which they have effectively partnered to address social needs that impact health has varied. Now, partnerships between these organizations are gaining increased attention and support in the context of health care reform and addressing social determinants of health. This has been catalyzed by the New York State Department of Health's (DOH) Delivery System Reform Incentive Payment (DSRIP) program and Medicaid Roadmap to Value-Based Payment (VBP), both of which require CBO engagement as part of health care and population health improvements. As these programs evolve, policymakers, HCOs, and CBOs are seeking additional information on how to best partner to support the needs of their patients, clients, and communities. This report details partnering experiences, challenges, and facilitators as discussed in focus groups and key stakeholder interviews with representatives from New York City HCOs and CBOs. The report also details actionable information for HCOs and CBOs seeking to enter into or enhance existing partnerships.

For this project, HCOs include hospitals and Performing Provider Systems (PPSs) implementing DSRIP, while CBOs are organizations that primarily provide social services.

HCOs and CBOs recognize that partnerships are key to improving health within their communities, as well as reducing avoidable health care utilization and—ultimately—health care costs. HCOs and CBOs discussed their reasons for seeking and establishing partnerships with one another, including funder and/or regulatory requirements and organizational responsibility (e.g., hospital community benefit requirements, New York State Prevention Agenda goals, and organizational missions) for addressing

community needs. Many focus group participants discussed specific service gaps, disconnects, and unmet needs—identified through experience, public datasets, or community needs assessments—that could be best addressed through partnerships between HCOs and CBOs.

Generally, partnerships facilitated capacity building, staff professional development, networking opportunities, and increased access to funding. They also resulted in improved access to services and wellbeing through the use of home- and community-based services to improve care transitions, chronic disease self-management, and the provision of other social supports.

Participants discussed challenges, offered insights, and made recommendations for successful partnerships (see box, [page 5](#)).

Partnering under DSRIP

DSRIP brings additional opportunities and complexities to partnering. It has served as a prime motivator for accelerated and expanded collaboration, and has provided new resources, including the interest of DOH and the DSRIP Project Approval and Oversight Panel in partnerships that expedite linkages between previously unacquainted partners. For organizations with existing relationships, investments using DSRIP funding have offered opportunities to strengthen ties, increase capacity, and expand services.

Still, HCOs and CBOs participating in DSRIP detailed partnering complexities not previously encountered. While CBOs expected the program to release vast funds, PPSs were initially slow to share funds with CBOs—due partly to DSRIP program design. This strained some existing relationships and eroded trust. Also, major health systems' control of DSRIP funds exacerbated the perceived imbalance of resources,

Key Actions for Successful Partnerships

Take sufficient time to build trust. Developing trust is contingent on many factors, including sufficient time to build a relationship, an understanding of the value that partners add, transparency in expectations on both sides, a commitment to doing the necessary work to achieve partnership goals, and clear, effective communication processes.

Be strategic. Rather than contracting with several new partners at once, it is best to start with one partner and limit activities. CBOs in particular noted that starting small and building helped them better assess the financial and operational risks of partnering and develop effective processes over time.

Establish project or partnership champions at both organizations. Organizational champions catalyzed new relationships and were described as essential to implementation success, given the effort required to develop and sustain partnership activities.

Develop a formal process to ensure the alignment and feasibility of project goals. HCOs detailed how they used information sessions with groups of CBOs, written assessment tools, and site visits to assess the capabilities and expectations of potential partners. CBOs discussed the importance of finding the "right project" for their organization, meaning one that limited financial risk and aligned with their organization's stated mission.

Assess specific in-house skills and capacity such as information technology (IT) infrastructure, data capture, and reporting for health care-related measures. While HCOs are accustomed to data collection and reporting, they may not recognize the burdens such activities place on CBOs. Because HCOs use different reporting systems and processes, CBOs must likely implement multiple systems to contract with multiple HCOs. HCOs must be realistic about reporting requirements and CBOs' abilities to operate multiple data-collection systems and report health-related data. Partnerships that support capacity building as an element of collaboration result in a higher probability of success.

Maintain open lines of communication by identifying main points of contact for each organization, and systemize connections in preparation for potential organizational changes. Since individual staff can play key roles in the implementation of joint programming, relationships between CBOs and HCOs must survive inevitable organizational changes caused by staff turnover, among other things. This requires that information and systems be institutionalized.

Address imbalances in size and power between large health systems and (generally smaller) CBOs. Imbalances commonly permeate partnerships between HCOs and CBOs. Proactive steps such as a commitment to transparency and joint decision-making can mitigate the potentially detrimental impacts of such imbalances. Honest feedback on contracting and funding requirements—though it can be complicated by power imbalances between HCOs and CBOs—is necessary to foster productive partnerships that result in realistic outcomes.

CBOs should know their value, and HCOs should be prepared to acknowledge that value. During the contracting process, CBOs must be realistic and forthcoming about the costs of service delivery, administrative costs, and operating costs. When determining payment amounts, HCOs should consider the total cost of a CBO's services, including the added value the CBO brings in terms of community knowledge, relationships, and trust.

scale, and power between HCOs and CBOs. CBOs noted what they viewed as a lack of transparency in PPS processes, including outreach, partner selection, and budgeting. They also noted that the funds available to date have not adequately compensated them for the time their staff spent working on DSRIP requirements. Some CBOs opted out of DSRIP, believing costs would be greater than benefits. Others are participating but are wary of the financial risks.

Another challenge is that CBOs are held to the PPS's performance measures overall, though they have little control over them. Also, CBOs can't gauge progress because PPSs have not adequately shared outcomes data for the individuals receiving CBO services.

Looking Ahead: Partnership Sustainability and Potential for Growth

Health care reforms and the increasing recognition of factors that affect health outside the clinical encounter have accelerated HCO/CBO partnerships, and likely will continue to do so. DSRIP is currently in year three of five, with many lessons learned and meaningful partnerships with CBOs just reaching fruition. HCOs

and CBOs see significant potential for partnerships in the context of VBP and have noted that DSRIP and other partnering experiences provide useful knowledge, skills, and capacity that could be leveraged to sustain future partnership activities.

In focus groups and interviews, participants discussed the importance of payers, particularly Medicaid and Medicaid managed care organizations (MCOs), in sustaining programs developed through HCO/CBO partnerships. More information is needed on how to engage MCOs in payment models and VBP arrangements that can support and sustain HCO/CBO partnerships, a topic outside this project's scope.

HCO/CBO partnerships face many challenges, including being impacted by the requirements of funders, policymakers, or advisory bodies with insufficient appreciation of ground-level practices. Despite such challenges, partnering between HCOs and CBOs remains beneficial due to the potential of these relationships to improve health, reduce avoidable health care use, and better address key factors outside hospital walls that impact the wellbeing of communities.

Introduction

The Academy and GNYHA are pleased to release this joint report on partnerships between HCOs and CBOs in New York City. The report describes findings from focus groups and interviews with New York City-based HCOs and CBOs in which participants discussed partnering experiences and processes. For this project and report, HCOs include PPSs implementing DOH's DSRIP program, hospitals, and health systems. CBOs are broadly defined as organizations that primarily provide social services, including meals, case management, health education, and mental health and counseling services. Additional information on project scope and methods is in **Appendix B**.

While HCOs and CBOs share a mutual goal in serving the needs of their patients and clients, the extent to which they have effectively partnered has varied. Now, partnerships between these organizations are receiving increased attention in the context of health care reform, the shift to value-based payment (VBP) for health care services, and more general concerns about addressing social needs that impact health, such as housing and food insecurity, educational needs, job and financial assistance, and other social determinants.^{1,2} In New York State, HCO/CBO partnerships have addressed various issues, and many have lengthy histories. Still, health care institutions now have greater interest and motivation to partner with CBOs to address conditions outside hospital walls that impact health and health care utilization. This shift is partly due to DSRIP, which requires multi-

stakeholder PPSs, most of which are led by hospitals interested in engaging and funding partnerships with CBOs as part of their strategy to reduce avoidable hospital use. DSRIP also requires that all participating primary care providers become certified as patient-centered medical homes by the National Committee on Quality Assurance's 2014 standards or the New York State Advanced Primary Care model, both of which support collaboration with CBOs that provide non-

About DSRIP

New York's DSRIP program is a five-year initiative funded by an \$8 billion Medicaid waiver from the Centers for Medicare & Medicaid Services (CMS). DOH was awarded the funding because it achieved significant savings through its mandatory Medicaid managed care program and implementation of Governor Andrew Cuomo's Medicaid Redesign Team initiative to reduce Medicaid program costs and improve outcomes. DSRIP aims to reduce avoidable Medicaid hospital admissions, readmissions, and emergency department (ED) visits by 25% by March 2020. The program began in April 2015.

DSRIP is being implemented across New York State by 25 PPSs, most of which are led by a safety net hospital or health system. PPS partners include various health care stakeholders such as other hospitals, federally qualified health centers, large and small community-based practices, behavioral health providers, long-term care organizations, home health agencies, and CBOs. PPSs must implement between seven and 11 projects that build integrated delivery systems and improve chronic disease management and public health. PPSs are awarded incentive payments for achieving prescribed milestones and demonstrating improvement on more than 40 outcomes measures.

1 For more information on social determinants of health, visit www.healthypeople.gov.

2 GNYHA designed a curriculum on social determinants of health, available at <https://www.gnyha.org/tool/training-primary-care-residents-on-the-social-determinants-of-health/>.

clinical services. PPS implementation plans submitted to DOH in 2014 described various mechanisms for meeting partnership requirements, including contracts and referral relationships with CBOs. Still, despite DSRIP program requirements and PPSs' written intentions to engage with CBOs, DOH and the CBO community have expressed concerns that CBOs have not been meaningfully engaged or funded with DSRIP dollars. The DSRIP Project Approval and Oversight Panel (PAOP) has also focused on meaningful CBO engagement as a central concern and has encouraged PPSs to improve in this area. The PAOP is comprised of health care and community stakeholders and serves DOH and PPSs in an advisory and reviewer capacity. In reports to the PAOP, PPSs have publicly described their challenges and progress on CBO engagement and funding.

Significant work is being done nationally to examine and support the development of HCO/CBO partnerships. In a recent project, the Center for Health Care Strategies, the Nonprofit Finance Fund, and the Alliance for Strong Families and Communities analyzed lessons from existing cross-sector partnerships across the country and detailed success stories in a set of case studies. Key findings included the importance of complementary expertise and open communication, challenges of estimating resource needs and tracking outcomes, and securing sustainable funding.³ Several New York projects have examined the current state of HCO/CBO partnerships. The Citizens Budget Commission recently published a discussion paper on the specific challenges of integrating CBOs into PPS activities.⁴ Some challenges raised in that paper are well aligned with research findings in this report. Additionally, the Human Services Council (HSC), which represents social service organizations across

New York State, created a VBP commission that is developing a roadmap for identifying models and contracting pathways for human services organizations to contribute to health outcomes and participate in VBP. HSC expects to publish its recommendations in spring 2018.

This report complements ongoing efforts to assess and support HCO/CBO partnerships by emphasizing empirical data that describes partnerships at differing stages and with varying levels of success. The diversity of institutions and partnership focus also distinguishes this report from other efforts. HCOs, CBOs, and other stakeholders can benefit from guidance elicited from their peers as they undertake these activities in the context of changing policy mandates, payment reform, and the need to jointly address social needs to improve community and population health.

This report describes partnering experiences—including challenges and facilitators to effective partnerships, as reported by HCO and CBO representatives—and provides specific examples and tools to facilitate the development and sustainability of partnerships that best support public health. The report includes the following components, which summarize research findings and provide actionable information for developing partnerships.

- Key findings by major topic
- Key recommendations and actionable advice for organizations pursuing partnerships
- Spotlights on HCO/CBO partnership elements that reflect findings and recommendations
- Case studies that detail the experiences of HCO/CBO partners and other stakeholders

3 E. Miller, T. Nath, and L. Line, "Working Together Toward Better Health Outcomes," *Center for Health Care Strategies, Inc.* (July 2017). <https://www.chcs.org/resource/working-together-toward-better-health-outcomes/>.

4 "The Challenges of Enhancing Effective Engagement of Community-Based Organizations in Performing Provider Systems," *Citizens Budget Commission* (November 13, 2017).

Findings

Forming Partnerships

Key Findings:

- HCOs and CBOs agree that partnering has many benefits and is key to improved health for community members, reduced health care use, and—ultimately—reduced health care costs.
- Successful partnerships are built over time and include attributes such as clear and transparent communications that foster and instill trust.
- It is difficult for HCOs and CBOs to identify new partners, or even partnership opportunities, because they lack familiarity with one another's organizations and services, and in some cases, don't have the appropriate contacts.
- Though DSRIP has accelerated partnership formation, its scale, requirements, and overall funding have brought new challenges to the partnering process.

Key Recommendations:

- Whenever possible, build on long-term relationships and existing partnerships.
- Identify community needs and potential partners using available data, including public surveys and community needs assessments. See [Appendix C](#) for a list of potential data sources.
- Develop a formal review process to ensure that potential partners have aligned goals and the capabilities to achieve them within the partnership. Site visits by both parties can provide helpful context and a sense of the potential partnership benefits and challenges.
- Obtain leadership buy-in and support, and identify project or partnership champions at both organizations.

The Benefits of Partnering

Throughout this project, many specific partnership benefits were described. For CBOs, partnerships facilitated organizational capacity building, staff professional development, and networking opportunities, as well as increased access to funding. For HCOs, partnerships resulted in improved access to care and quality of services for at-risk populations. These services include community- or home-based care coordination and medication reconciliation following hospital discharge, reducing environmental triggers in the homes of children with asthma, or home delivery of meals. Both HCOs and CBOs benefited from educational and training opportunities, including mental health and substance use training for school personnel, health education for preschool parents, and cultural competency training for HCO staff. As focus group participants said:

We've been able to leverage a lot of training and professional development at a high level for our case management staff, for our senior center staff, for a multitude of our staffing. (CBO)

Our families get better services . . . That's what we really get out of it. We get a more comprehensive service for our kids . . . If we can bring those services to homes or closer to the home, then that will increase—my thinking—their school activity, school productivity, graduation, so on and so forth. (CBO)

I think we've been able to more appropriately place people in aftercare and aftercare housing⁵ than ever before and maintain people in the community better over the past maybe four years than we ever did in our history before that. (Hospital)

5 Housing and supportive services provided following hospital discharge for patients with complex social and health needs.

HCOs and CBOs discussed reasons for seeking and establishing partnerships with one another. Many partnerships were motivated by funder and/or regulatory requirements, including DSRIP. For others, the key motivator was organizational responsibility for addressing community needs (e.g., as related to hospital community benefits, New York State Prevention Agenda goals, HCO or CBO organizational missions). Many focus group participants discussed specific service gaps, disconnects, and unmet needs—identified through experience, public datasets, or community needs assessments—that could be best addressed through a partnership between HCOs and CBOs.

It really grew up just because of proximity and referrals. These are the patients that were, essentially, coming to us . . . from a particular agency. And the need to discharge back to [that agency] really required we work closely with them. (Hospital)

I started using a lot more public data, but then also doing some focus groups in our community . . . So I knew in [this area] there were really high rates of preventable hospitalizations, and I was trying to align this with where [we] had services, too . . . I also looked at the penalties for hospitals for readmissions. So, I knew who was hurting in

that capacity, and I thought this would be a good area to provide support. (CBO)

HCOs often identified particular community needs, but had difficulty finding a CBO partner. In general, HCOs reportedly lacked basic information about CBOs in their local communities and their relevant services. HCOs were sometimes impeded by lack of correct contact information. While CBOs knew about HCOs, they often did not know who the best contact person was, or how to contact them.

We have a spreadsheet, but a lot of the information might be outdated, or we're just finding that we call, and [the hospitals] don't really know who to put us through to, and we don't know who to ask for. (CBO)

Focus group participants discussed processes for assessing the needs, capabilities, and expectations of potential partners (and themselves). HCOs detailed information sessions with groups of CBOs, written assessment tools, and site visits—to determine current capacity and reach, which sometimes differed from what CBOs described. CBOs, in contrast, discussed the importance of finding the "right project" for their organization to limit financial risk and ensure alignment with their stated organizational mission.

Spotlight: Using Public Data to Develop a Partnership Proposition

Jewish Association Serving the Aging (JASA), a CBO that delivers a wide array of services to older adults, developed the capacity to address issues related to care transitions for high-risk patients recently discharged from the hospital. JASA ultimately aimed to create the service line and formally partner with hospitals whose patients could benefit from it. To determine hospital targets, the organization reviewed various public data sources, including readmissions data, CMS readmissions penalties, and a free data tool called Data2GO.NYC. JASA developed a business proposition based on relevant information and shared it with the chief executive officer at Wyckoff Heights Medical Center. Wyckoff ultimately contracted with JASA for their care transitions services, as described in more detail in Case Study One, [page 20](#).

FINDINGS – FORMING PARTNERSHIPS – CONTINUED

I was working with this partner in Brooklyn, and we had all these meetings, and it was so wonderful . . . but when we went into the community . . . the community that was once there was gone, and it was gentrified Brooklyn. And so the people . . . being described were no longer there. And so it wasn't relevant to our service area and our service goals . . . So we now have a set of questions when we do a visit, so there's some back and forth before we engage in a formal agreement. (Hospital)

I think it's just figuring out the right project. We're risking a lot by being in some of these relationships and contracts where we're not actually funded to do the work, and there's a lot of like, "We may get the money at the end of the year. We may not." We can only have so many of those. So we chose the ones where we know we have strong partnerships, and we trust that hopefully we can get there. (CBO)

Focus group participants discussed how the trust needed for partnership development was commonly absent. CBOs, in particular, noted that HCOs lacked appreciation for their capacity, work, and their potential role as liaisons to community members.

The hospitals have to learn what we have to offer . . . they have to be willing to give up a little of that control to be a real partner with the community, not walled off from the community. For them to do that, they really have to partner with CBOs who are out there . . . there's a lot of mistrust in the community of hospitals, either from your cultural background or experience. So, we are a valuable resource for them, and we have a reputation in the communities that is positive and can help bridge that gap. (CBO)

The development of trust was contingent on several factors, including sufficient time for relationship building; an understanding of the value added in partnering; transparency in expectations; a commitment to the necessary work to achieve

partnership goals; and clear and effective processes for communication, including a point person at each organization. Organizational champions were described as essential, given likely barriers.

Every community partnership that we pursue and we engage with, we come in with a strategic plan that really lines up to our roadmap for success for our hospital . . . And we find ways to engage partners in looking at the value that they add, not only to us but to the communities . . . So understanding and defining what the value added for both of us upfront has been a really wonderful experience and something that people could hold on to and say, "I'm invested in this partnership, because I can see the changes in outcomes." (Hospital)

For us, it's leadership driven. The leaders of the hospital value community-based organizations. I think that's what allows the partnership to function the way it does, because it definitely isn't driven by funding. It's driven by the leaders saying, "We need to do more for our constituents. How do we do that?" (CBO)

Establishing Partnerships in the Context of DSRIP

DSRIP has been a prime motivator for accelerated and expanded collaboration. DOH's and DSRIP PAOP's particular interest in engaging CBOs in PPS activities has expedited familiarity and linkages between previously unacquainted partners. For organizations with existing relationships, DSRIP offered an opportunity to strengthen ties, increase capacity, and expand services.

At our hospital, we started doing this before DSRIP. I think that time to cultivate and build is imperative. It translates to loyalty. It translates to long-lasting relationships, and so when something like DSRIP comes, we already had a core group that we can turn to and say, "Hey, we have this opportunity. Join us." (Hospital)

The hospitals didn't know what was going on in the community. Everything stopped at the hospital door when they discharged somebody. So, I think that's one of the values of DSRIP now. They're starting to realize what's out there. (CBO)

While PPSs generally perceive the value CBOs bring to their communities, they expressed concerns about the pressure to develop and formalize partnerships quickly, and to provide funding at levels they consider unrealistic.

Spotlight: Aligning System-Wide Efforts to Achieve DSRIP Goals and Engage CBO Partners

NYU Langone Brooklyn and its PPS are moving to leverage and align their system-wide efforts to increase the likelihood of meeting DSRIP goals and support sustainability beyond DSRIP. The hospital and PPS leveraged diabetes self-management education resources from the New York City Department of Health and Mental Hygiene (DOHMH) and plan to fund two of their longstanding CBO partners with DSRIP funding to educate the community, which bolstered their DSRIP diabetes project activities. They have also engaged their CBO partners to provide cultural competency guidance in asthma education brochures that are co-branded and distributed throughout the community. The hospital noted that one benefit of working with CBOs is that community members are “clients, they're our patients, and we need to understand from their perspective . . . to help guide a lot of the work that we're doing.”

[CBOs] still have this expectation and this feeling like, “DSRIP's got lots of money.” . . . So, there's this perception that DSRIP is the answer to everything. It's the cash cow—let's just say it—and it comes from everywhere, even within this organization. It's like, “We want to do this project. Well, let's just have DSRIP fund it.” (PPS)

I tell you what I do think complicates things: I think that the PAOP's pressure for the PPSs to contract with Tier 1s⁶ complicates things because we feel a ton of pressure—we're trying to figure out how to do this, how to implement these projects, and then, this immense pressure to bring these organizations in one at a time, and it's not fast enough, it's not enough money ever, but how do you do it in a meaningful way? (PPS)

Both HCOs and CBOs described partnering complexities not previously encountered, including the challenges of partnering within the context of a PPS, a large entity that may be disconnected from specific hospitals and neighborhoods. HCOs and CBOs also noted that although they had partnered for many years with little to no funding, the vast funds anticipated to be available through DSRIP—but initially slow to reach CBOs in substantial amounts—strained some existing relationships and eroded trust.

The thing that I didn't think about prior to this partnership is that the PPS itself is distinct from the hospitals. And that—I

just remember walking into one of the initial meetings and seeing that tension, which I felt was inner tension within the organization, and realized that the PPS is a layer that's separate from all these hospitals. (CBO)

But since DSRIP . . . in general, all the CBOs that we work with, it's changed the dynamic a little bit.

6 DOH defines a Tier 1 CBO as a CBO that is non-profit, non-Medicaid billing, community-based social and human service organizations (such as housing, social services, religious organizations, and food banks).

Because now, through these years, nobody had money, so we struggled. Everybody did things as you could. Now there's this pot of money that is out there, and it's just the feeling that now it's like, well, what's that effort worth? And everything has a dollar sign. So, to me at least, some of it has—the relationship's a little bit tainted, okay? They were great before. . . . But now, it's kind of like with the thought that how many millions of dollars is the hospital getting? (Hospital)

Maintaining HCO/CBO Partnerships: Logistics, Workflows, and Capabilities

Key Findings:

- CBO responsiveness is impacted by lean budget and staffing constraints.
- Collecting, managing, and reporting data can be challenging for CBOs, particularly if requirements focus on health outcomes, which CBOs may be unaccustomed to reporting.
- PPSs have provided resources to support and build CBO capacity.

Key Actions for Successful Partnerships:

- Maintain open lines of communication by identifying main contact people at both organizations.
- Put systems in place in the HCO and CBO to mitigate challenges related to staff turnover, and ensure that multiple staff members are aware of ongoing partnership initiatives and are trained in processes developed to maintain partnership activities.
- Facilitate CBO access to patients at the HCO site to ensure seamless handoffs between organizations.
- Honest feedback on contracting and funding requirements is necessary for productive partnerships with realistic outcomes.

Trust and clear communication processes remained themes in focus group descriptions of successful partnerships. HCOs and CBOs both emphasized that partnerships are commonly sustained by “champions” and personal relationships, and are negatively impacted by staff turnover.

When a hospital social worker or discharge planner or one of the nurses refers to us, [and] the results are good, they keep referring. And it is based on that personal relationship. But if that person leaves, or they retire, it's broken and there's no system to keep it going. (CBO)

There's a high rate of turnover in community-based organizations, and you'll have this momentum with a team of people or a few people and then you learn all of a sudden next week, they're not there. And you've spent weeks building this, or months, or four years, and this person just kind of disappears And they're the keeper of so much, and there's no one to replace that person immediately. (Hospital)

Participants also described the importance of knowledge and appreciation related to partner capacity, particularly regarding CBOs. CBOs reported operating on very lean budgets. Hiring new staff before contracts are in place and adequately funded creates levels of risk sometimes considered unacceptable. When current staff are already working at capacity, it is difficult to shift their responsibilities.

Inadequate IT and data systems within CBOs also impact partnership functioning, particularly when reporting requirements are new (e.g., health outcomes), extensive, and/or inconsistent with reporting requirements from other partners or funders. Many CBOs cannot easily generate the operational data that may be required in a partnership with an HCO.

IT and data are traditionally hard for social service organizations, and so to be totally blunt about this . . . we actually track everything in Excel, which is

hideous for us. It is hugely difficult for the amount of data we're collecting . . . it's a big burden. (CBO)

We would like to know the date and time of every pediatric asthma patient that's come in over the last six months from [this zip code]. And for us, that's several keystrokes. For them, if they're not on an electronic filing system, that is a massive activity. [A] routine question . . . could potentially be a multi-week effort. But I want that right now, and they still have an organization to run that does a range of other things. (Hospital)

While HCOs recognized CBO limitations, they also noted that reporting constraints presented challenges, particularly in the context of DSRIP and potentially for VBP. The amount of support PPSs provided CBOs to facilitate reporting varied significantly.

We want to also help with these types of skillsets: workflows, technology . . . [T]hey genuinely really care about the community and furthering the community they represent. So, the logistics then become what we can help them with, and we have a lot of resources here, so we put together this really huge training program here that we're rolling out right now, and I keep saying . . . from a training and development standpoint, what other resources can we offer to some of these community-based organizations to help move the needle? Some of them really are not sophisticated. They need some help in these areas. They don't have tons of resources. (PPS)

So, we have all of this work that we need to do, provide all these metrics to these [PPSs], and they

introduce these computer systems that are not user friendly, and it takes a full-time staff [person] just to understand the system, or there is not adequate training, or things like that. So, we haven't really been able to meet their demands. We had a bit of incentive money that was given to us, and yet when trying to meet those contractual obligations, it's just been extremely challenging. They haven't set up the system in an organized manner that helps community providers give them what they need. (CBO)

[This hospital] has a portal . . . that they opened up to all the partners . . . So all of our staff and the whole agency has been trained on it and has an access code to be able to use [the system] . . . So now you have this web-based referral system, which has been very useful. We're really happy. It has so many great features to it. (CBO)

Appendix D includes a list of resources for local CBOs to help them build their capacities and skills to partner with HCOs.

Spotlight: Learning Collaborative to Support Community Health Worker Asthma Interventions

OneCity Health, the NYC Health + Hospitals PPS, developed a learning collaborative for CBOs engaged in its asthma project. Comprised of community health worker (CHW) organizations, the collaborative reviewed elements of the PPS's asthma project implementation toolkit, which described project expectations and gave CHWs opportunities to roleplay various scenarios, including safety-related and clinical issues. Additional information, including the perspective of OneCity Health's CBO partner, Little Sisters of the Assumption Family Health Service, is in Case Study Two, [page 24](#).

Contracting and Financial Arrangements

Key Findings⁷:

- Many HCO/CBO partnerships have operated successfully without a contract or disbursement of funds, though the scope and expectations generally were relatively limited. Others, including grant-funded programs, have paid CBOs based on process measures such as units of service or number of staff dedicated to a project.
- Payments to CBOs based on unit of service do not regularly account for costs incurred for administration and the meeting of reporting requirements.
- Large differences in organizational size and scope have an impact on trust and the delineation of clear expectations.
- When partnering with large entities such as PPSs, CBOs have limited leverage to negotiate contract terms and pricing.

Key Actions:

- During the contracting process, CBOs should be realistic and forthcoming about the cost of service delivery and other expenses.
- When determining payment, HCOs must consider the total cost of CBO services, as well as differentiating factors such as the CBO's added value in community knowledge, relationships, and trust.

Several participants described successful partnering efforts that operated without contracts. Referral relationships and community health promotions (e.g., screening and other educational programs for community groups) are among the kinds of efforts typically implemented without a contract or exchange of funds. Projects with greater scope and

responsibilities generally require contracts, though with significant variability in the terms, ranging from simple to highly complex, the latter with a broad array of legal conditions that proved burdensome for CBOs during the contract review period. Many CBOs do not have legal departments, or even lawyers on staff, and reported struggling with lengthy contracts that included complex language that seemed “boilerplate” and irrelevant to the specific project.

It's a very diverse group. You have the big fancy [CBOs] who sometimes have in-house counsel, and then you have the smaller ones that don't have any, and they're all up against these big hospital legal departments, and it's a very difficult process, even if you want to change something or make it real and relevant to the grant. (Hospital)

I think CBOs traditionally think of a partnership as a pleasant negotiation [between] the person with the money and the person with the product, and it's not. It really is a negotiation, and you have to be firm. I'm not doing this work for you unless you give me money up front. And, a lot of people put themselves in a position where you get involved with something, and then you don't have the resources, and the hospital has the resources. (CBO)

I meet with [our partner CBOs] every other month . . . And we are experiencing some challenges with the smaller organizations, but working with them hands-on has become my main focus of the DSRIP work . . . [T]hey get monthly tracker tools, and it's an Excel file, and then they submit that to us every month . . . and every tracker tool looks different for the [xx] projects. (PPS)

Economics of Partnering under DSRIP

DSRIP contracts were commonly described as particularly problematic. In most cases, CBOs reported having little to no leverage, or opportunity

⁷ While similar questions were asked of HCOs and CBOs, challenges related to contracting and financial arrangements were more clearly evident to, and commonly reported by, CBOs. Thus, the CBO perspective is more strongly represented in this section.

Spotlight: Best Practice in Contract Negotiation

NewYork-Presbyterian Hospital (NYP) and the Northern Manhattan Perinatal Partnership (NMPP) have collaborated for several years on programs that provide self-management support to children and families in the surrounding community. Per the contract, NYP supports salaries and other expenses for CHWs employed by NMPP. This partly results from NMPP leadership’s directness about staffing costs of desired programs, and NYP leadership recognizing the importance of the CHWs’ community-based work for their patients. More information on the partnership between NYP and NMPP is in Case Study Three, [page 28](#).

to provide input or negotiate terms. Although some PPSs provided a comment period, CBOs felt that their recommended changes were not adequately addressed. PPSs agreed that CBOs had limited power to negotiate contract terms, and attributed this to the complexity of the program and the pace at which contracting needed to happen. PPSs described developing master contracts for use across their networks, with addenda for specific projects. According to both PPSs and CBOs, CBOs understood the advantages of involvement in delivery system and payment reform, so were eager to enter into DSRIP contracts. Some CBOs opted out of DSRIP, believing the costs would be greater than revenues. Others are participating but are wary of the financial risk.

I think within the DSRIP world, though, folks will . . . sometimes overpromise and under-deliver because they don’t want to be left out . . . But no one wants to say they won’t be able to do that for fear that they will miss out on the funding. So I think that sometimes that happens, that folks are concerned that they will be left out of the equation if they don’t say yes, or actually sign a [contract]. I’ve had CBOs sign a Schedule B and not be able to participate. I’m like, “Why did you sign that?” They’re like, “Well, you know, we were worried.” (PPS)

“I spend God knows how many hours going through this contract having many conversations with each of the PPSs trying to understand what we’re actually committing to. Small CBOs don’t have the time for that. They’ll just see it and be

like, “This is not for me,” whereas they have a lot of value and work that could really help the PPS and it would be great for them to partner with them, but they just can’t deal with these contracts.” (CBO)

The major health system control of DSRIP funds has exacerbated imbalances in resources, scale, and power between HCOs and CBOs. CBOs noted a lack of transparency in PPS processes, including outreach, selection of partners, and budgeting. CBOs recognize that they have little control over the contracting process. They feel that funds available to them to-date do not adequately cover staff time for the range of DSRIP requirements, including planning and governance activities, service delivery, and reporting.

It’s a very hospital-centric thing. They’ve got all the money, and power, and the decision-making capability. (CBO)

So, the money we’ve received from PPSs does not cover the amount of time that our workers have put in thus far. We think that it will, down the line with this contract, but we do need to have a greater volume of patients. But not too many, you know? In order to hit that sweet spot. So we’re still figuring that out. (CBO)

A few PPSs have begun to incorporate VBP concepts into their contracting, holding CBOs responsible for specific outcomes. While many CBOs felt that it was important to understand costs and outcomes, and that better data would help them eventually get to

more appropriate contract conditions, CBOs do not yet have the data on costs and outcomes that could support the business case for a VBP contract. Also, given their relative size and lean budgets, CBOs are not equipped to take on financial risk, particularly for outcomes over which they have little control. These constraints are exacerbated by a lack of reciprocity in data access: CBOs submit data to PPSs but do not receive information back about the outcomes that New York State uses to determine incentive payments for PPSs.

We have no idea and zero control (over whether) the PPS meets their large goals at the end of the year. We're risking. We're paying for this person. We're hoping, at the end of the year, we're getting reimbursed something based on the number of visits we're doing, but it's really hard. (CBO)

We can't do this for free. I think there's some trepidation that some people have about actually saying that. "Oh, I didn't know what I got into"... but we've got to correct it when we move forward. It's either we drop out or we change the reimbursement. (CBO)

Looking Ahead: Partnership Sustainability and Potential for Growth

As noted, health care reforms and the increasing recognition of non-clinical factors that affect health have accelerated HCO/CBO partnerships, and likely will continue to. DSRIP is currently in year three of five, with many lessons learned, meaningful CBO partnerships just reaching fruition, and others just beginning.

One of the interesting things is now that the rubber is hitting [the] road in the third [year] of DSRIP, and going forward, is that the hospitals at the beginning and the [PPSs]—they thought they could control it, that they could do everything within the bricks and mortars and maybe hire a couple of people. Now, they're realizing that, to be successful, they really have to establish

and maintain these relationships going forward. (CBO)

HCOs and CBOs perceived significant potential for partnership sustainability in the context of VBP, and noted that DSRIP and other partnering efforts are providing useful information for the transformation to VBP. They hope that knowledge, skills, and capacity are increasing and that VBP will offer the means for continued funding for partnership activities.

I think, too, the issue towards value-based rather than volume opens the door, really, for organizations like ours—so trying to get in line with as much as we can, whether it's using data or trying to find some of the pain points of our clinical partners with being fined for readmissions, or they need to help with chronic care management to reach certain goals. Trying to identify what those are, and using the best data we can, but also trying to just explain, to give us a shot to work together to deliver value. So that shift has opened a window for us. (CBO)

Where we really do see the sustainability, I think, is in the activities that we're trying to build now, and that is around—because you can put a value on this—buying performance . . . So if we have these value-based contracts, and these are the patients that we need to close gaps on, or that we need to engage because they're not engaged, these are the organizations that we want to build the expertise, and we want to gain that expertise. . . I think that's a lot of where the sustainability is going to come from, and we want to continue a lot of these relationships in the value-based world. (PPS)

CBOs also hope to leverage the knowledge and skills gained through DSRIP for potential negotiations with MCOs, which are considered another potential source of consistent funding for work CBOs now do. See the Payer Perspective on [page 31](#) for how Healthfirst, a New York City-based MCO, is partnering and contracting with CBOs.

Conclusions

Increased partnering between health care institutions and CBOs has the potential to better address factors outside hospital walls that affect health and health care use. HCO/CBO partnerships include many challenges that become more pronounced as HCOs are increasingly represented by entities like PPSs, the scale of which could reduce flexibility and the potential for negotiation with CBOs as equal partners. The challenges of partnering may also be impacted by the requirements of funders and/or regulators—including speed, scale, and somewhat extensive documentation—with insufficient appreciation of ground-level practices and capabilities.

According to CBOs and HCOs participating in this project, given these challenges, it is important that potential partners build from existing relationships, where knowledge and trust already exist. If not possible, the parties need to assess capacity, fit, and compatibility. Transparency is important for both HCOs and CBOs, and can mitigate the challenges associated with the imbalance of power in organization size, scope, and financial capacity. Information about costs and outcomes should be available to all parties, so decisions are informed and negotiations are fair and realistic. Partners must also recognize one another's limitations. For HCOs, this means recognizing the capacity needs and data collection constraints of CBOs. For CBOs, it means recognizing the complexities of large health care institutions and the regulatory aspects of their operations. In general, partners should be forthcoming about challenges, capabilities, and needs as part of a regular dialogue, ensuring that these discussions remain at the forefront so that issues can be addressed. Finally, CBO cash flow limitations and lack of funding for general operations must be underscored. Many CBOs operate primarily on grant funding and government contracts that often do not cover total operating costs. Performance-based contracts that do not include upfront payments are a difficult fit, and may hinder partnership and performance progress.

Many HCOs and CBOs have already engaged in practices that facilitate strong partnerships, including partner assessments and open dialogues for contracting. Learning and capacity-building opportunities for CBOs can be valuable, particularly when focused on areas that can benefit the CBO within the partnership, while aligning with the CBO's overall goals and mission. PPSs have begun to support CBOs with "innovation funds." Some PPSs have made grants available to CBO partners that allow them to draw down funding not tied specifically to a DSRIP project or metric. This has given CBOs flexibility to design projects or programs that demonstrate or build capabilities that decrease avoidable hospital utilization, a major DSRIP goal.

Significant challenges in HCO/CBO partnerships transcend what the organizations themselves can do. The financial value of CBO services within the context of health and health care savings has not been carefully calculated and can be difficult to ascertain. Despite efforts within DSRIP to address social needs, it has proven difficult to systematically link a social intervention with improvement on a health care measure. While some organizations have demonstrated links between, for example, stable housing and decreased health care costs, it can be difficult to do this across the spectrum of social needs (and CBOs that address them) that complex patients may require. Technical assistance or joint design around identifying appropriate measures would be beneficial to ensure that data can be appropriately collected and/or exchanged among partners.

New York City-based CBOs have actively worked to better understand how to calculate their value, current capabilities, and needs to prepare for HCO partnerships, particularly within the context of VBP. DOH's CBO Planning Grant provided awards to Tier 1 CBOs with budgets of less than \$5 million, which allowed the opportunity to identify capacity-building needs and support a higher probability of success working with HCOs. The Arthur Ashe Institute of Urban Health was awarded this grant for New York City, and is

FINDINGS – CONCLUSIONS – CONTINUED

convening Tier 1 CBOs across the region to determine their needs.

DOH is supporting CBO engagement in VBP through various avenues. The current version of the State’s VBP Roadmap, which guides VBP contracting for Medicaid managed care, requires VBP contracts at a certain level to include a Tier 1 CBO. DOH has also suggested social determinants of health interventions that could be included in VBP contracts, along with the types of CBOs that could be engaged. In addition, DOH’s new Bureau of Social Determinants of Health was developed, in part, to support improved CBO engagement as part of addressing social needs.

While this project made an effort to engage CBOs and HCOs of varying size, location, and mission within New York City—and with various partnering experiences—other perspectives may not have been captured, including those of organizations unable to partner to date. In addition, the sample was limited to New York City-based CBOs and HCOs. The extent to which their experiences are representative of other locations is unknown. Finally, the policy context and partnership activities continue to evolve, though the lessons and recommendations reported are expected to remain.

Case Study One

JASA & Wyckoff Heights Medical Center

Partnering for Care Transitions and Reduced Hospital Readmissions

The Partners

JASA serves approximately 40,000 older adults in the Bronx, Brooklyn, Manhattan, and Queens, and offers services including case management and counseling, health navigation, home care, legal assistance, adult protective services, home-delivered meals, mental health services, and low-income housing. In addition, JASA's 22 senior centers offer a variety of social, cultural, and wellness programs. JASA services are funded by multiple sources, including Medicaid, private insurance, City contracts, and philanthropy.

Wyckoff Heights Medical Center is a 350-bed teaching hospital in Bushwick, Brooklyn. It serves diverse populations in Brooklyn and Queens, including a large number of immigrants and patients with limited English proficiency.

Project Design & Development

JASA and Wyckoff partner on a home-based care transitions program for older adults. The goal is to reduce hospital readmissions that occur within 30 days of being discharged. Funded by Wyckoff, the program is offered to patients free of charge, independent of insurance status. The care transitions project was initially developed by JASA based on existing evidence-based models and previously implemented care transitions programs. JASA approached Wyckoff about the project, noting that it could help Wyckoff reduce its high 30-day readmission rates. Wyckoff staff do not do home visits, so the care transitions program fills an important gap for at-risk, medically complex patients. The project's care transitions services are available to individuals hospitalized at Wyckoff who speak English or Spanish, are over age 60, live in the

target zip codes, and have no serious mental illness or substance use disorder. JASA receives approximately 40 referrals per month.

The care transitions teams are comprised of care transitions specialists, discharge specialists, and peer health coaches. The care transitions specialists coordinate post-discharge services, including access to community-based self-management and other social services. The discharge specialists ensure patients understand discharge instructions; medication regimens, as provided on discharge; and other details on managing their conditions. The discharge specialists are typically international medical graduates who have not yet identified a residency or practice position in the US. While the team members do not provide clinical services, their medical education background allows them to recognize potential concerns, which they raise to either the inpatient care transitions team or the patient's primary care provider. The peer health coaches are older adults from the targeted community who are culturally similar to the clients. Because project staff meet clients in the hospital, they are screened, registered, and trained as volunteers through Wyckoff's human resources department.

After the Wyckoff team obtains the patient's verbal consent for a JASA visit, a JASA care team member meets the client in the hospital, providing opportunities for a "warm handoff" and the initial identification of post-discharge needs. Such access to the client while in the hospital is somewhat atypical, with some facilities prohibiting it. JASA staff feel that such early access demonstrates Wyckoff's commitment to a productive partnership. It also strengthens the program by facilitating patient engagement post-

CASE STUDY ONE – CONTINUED

discharge and promotes effective collaboration and trust between the staff of both organizations, who are in regular, in-person contact with one another.

JASA project staff visit clients in their homes within 48 hours of discharge to complete a follow-up assessment. During the visit, staff check whether the client understands his or her medical condition and its management, lives in a safe and clean environment, and has food and any needed durable medical equipment. In addition, project staff provide linkages to resources (e.g., Meals on Wheels), help with medications, and planning for follow-up physician visits. The peer health coaches serve as community health navigators and provide longer-term, targeted support, consistent with need. A licensed counselor also visits patients who have difficulty leaving their homes. Although the project is focused on reduced 30-day hospital readmissions, services are provided after the 30-day window, if needed.

JASA and Wyckoff staff communicate openly and frequently about individuals in the program. The partners have a standing biweekly call, but communicate between scheduled meetings to discuss issues and concerns that arise.

Contracting and Logistics

While JASA developed the specific contract conditions, including the scope of work and budget, Wyckoff developed the final contract, which is expense-based and does not require JASA to assume risk.

Although the goal of the program is reduced re-hospitalizations, there are no specific targets or detailed reporting requirements. The number of staff and patients is small enough that verbal and e-mail updates are the norm. JASA tracks referrals to, and engagement in, the program, care transitions services provided, service referrals, and readmissions for its own records and voluntarily gives the information to Wyckoff. Tracking services is difficult for JASA due to staffing constraints and a cumbersome information

system. Most of the tracking is in Excel, but efforts will be made this year to utilize an electronic medical record (EMR) to share information.

Challenges

While the partnering process has proceeded smoothly and the basic model is consistent with other programs implemented by JASA, the context and objectives have produced new challenges. For example, as a hospital discharge program, the clients are more medically complex than those previously served. Rather than focusing purely on social services, JASA staff must understand medical needs and complicated medication regimens—and be able to communicate issues to hospital staff. To do this effectively, early on, JASA incorporated international medical graduates into the project's staffing.

The client's home environment may pose challenges that are hard to identify without making an in-person visit, and these challenges frequently involve medication. A patient may have a shoebox of medications under the bed and not know which medications are current. So, being able to provide support and education to the patient and effectively communicate these challenges back to the hospital can be an important contribution. (JASA)

Further, a portion of the patients referred for—and needing—home-based services are so ill that re-hospitalization is likely, even with supportive services. According to JASA records, approximately 10% of program clients are readmitted.

Many patients referred to JASA are ill and have multiple comorbidities, some have end-stage disease, but all benefit from a JASA home visit. Although the goal is to decrease readmissions, some patients may need to return to the hospital within the 30-day period. Our joint concern is not the number of patients that are readmitted, but that the referred patients receive the care and support needed after the initial discharge. (Wyckoff)

CASE STUDY ONE – CONTINUED

For JASA, challenges in the current program are minimal, but would be more evident if the model was significantly expanded. As noted, a small number of staff are responsible for contracting and implementation. Personal relationships between them have facilitated trust, responsiveness, and an acceptance of flexibility that might be absent in a larger program.

Benefits

Since the start of the care transitions program, 30-day readmissions at Wyckoff have sharply declined. The project has not only assisted enrolled patients, but also has helped Wyckoff identify systemic issues associated with high readmission rates. For example, JASA project staff identified several post-discharge medication errors. Recognizing a pattern, Wyckoff developed a quality improvement project on medication prescribing at discharge; subsequent changes in practice have resulted in a significant reduction in errors. Language issues have also been linked to readmissions, and bilingual JASA project staff have provided translation services and helped Spanish-speaking patients understand their discharge instructions.

Lessons Learned and Future Directions

JASA and Wyckoff staff describe the care transitions partnership as an unqualified success, and underscored the importance of leadership support.

The success of the collaboration between JASA and Wyckoff hospital can be attributed, in part, to the commitment of the individual team members, as well as the support of leadership at both organizations. This program is a vital asset and, if possible, should be replicated at other hospitals. (Wyckoff)

Wyckoff, I believe, has a leader who sees the hospital as an important organization in the community, serving needs beyond acute care, and that's helpful for building this type of partnership.

Leadership commitment is essential to project success. (JASA)

Payment represents a future challenge if the program were to expand, given JASA's financial constraints. Organizational leadership at JASA is receptive to transitioning to a fee-for-service, then a VBP, contract, feeling that such arrangements will help them to better track costs and revenue—thereby facilitating higher levels of reimbursement than previous contracts, which were insufficient to cover expenses. Leadership also felt that a transition to VBP would encourage a focus on client outcomes rather than units of service.

You can say that's a good thing that we're not taking on any risk, per se, but it's something that we actually would like to think about differently, for a number of reasons. So, it would mean really doing things differently within the services side, which is really thinking about what is the cost per patient and offering a service package that way, versus how it is today. (JASA)

We have 50 years of experience with contracts that frequently don't cover the costs of our services—they don't meet the needs, really, of services . . . I think [the transition is] a way for us to not only recover costs, but to work toward being compensated for the value of the services we deliver—making sure our services are sustainable. (JASA)

Ultimately, JASA leadership is confident that the care transitions program will reduce health care costs and be a valuable service for hospitals. Documentation of outcomes and service costs will be necessary to ensure fair and appropriate contract conditions—and a financially viable program. Tracking is difficult, however, given the lack of experience and dedicated personnel focused on reporting.

We have a far way to go, but I'm really excited about it because when you talk about metrics, I think we can achieve metrics at a very low cost. I don't want

CASE STUDY ONE – CONTINUED

to get off-subject, but we go into patients' homes and they can't read their discharge orders or how to take their medicine. We have to do a home visit, of course, but it's very low cost to do that versus a readmission. I have great confidence that these

metrics actually will matter, and we'll be very well-positioned for value-based payment, if we can kind of figure out how to shape and design the programs accordingly. (JASA)

Case Study Two

Little Sisters of the Assumption Family Health Service & OneCity Health

Partnering for Improved Asthma Control in East Harlem

The Partners

Little Sisters of the Assumption Family Health Service (LSAFHS) is a neighborhood-based human services organization that has served East Harlem for more than 50 years with home visits, support groups, classes, and other services. In 1997, LSAFHS established its Environmental Health Services program to better address high rates of asthma among East Harlem children. Staffed and led by CHWs, the Environmental Health Services program has focused on mitigating the negative effects of unhealthy living conditions through hands-on remediation, caregiver education and skill building, and advocacy to promote systemic changes from housing management.

OneCity Health is a PPS formed by NYC Health + Hospitals, New York City's public hospital system. It operates in Brooklyn, the Bronx, Queens, and Manhattan in partnerships with hundreds of organizations, including Health + Hospitals acute care hospitals, community clinics, CBOs, and others.

Project Design & Development

OneCity Health and LSAFHS partner on a DSRIP project to reduce hospitalizations and ED visits for children with persistent, uncontrolled asthma. OneCity Health began its CHW asthma program in 2016, building from CHW programs that were operational at two NYC Health + Hospitals sites. The initiative partners clinical sites with local CBOs. The clinical sites identify patients appropriate for the program and refer them to CHWs employed by the CBOs. As per the child's asthma action plan, CHWs visit families at home,

provide asthma education, conduct assessments for home-based triggers, and make referrals for integrated pest management (IPM) services, which are provided through contracts with DOHMH.

Once we knew what issues were in the home, we didn't want to be a partner or PPS that just said, "Oh, great, we're identifying the issues," but we weren't doing anything about them. So, we added the IPM services, and we're the only PPS that has done that. Because without addressing that environment, we're not really impacting anything else. (OneCity Health)

At the project's start, OneCity Health issued a Project Participation Opportunity (PPO) to identify appropriate partnering CBOs. Those interested were asked to complete a brief questionnaire and participate in follow-up conversations to describe their catchment area, CHW experience and capacity, and motivation for partnering. LSAFHS responded to the PPO with:

Seeing the statistics for the neighborhood, we know that there are children who are very severe and uncontrolled that we weren't getting to—we weren't able to identify and get those referrals. So, we felt like being part of this would improve access to the patients who really need it. (LSAFHS)

CBOs selected for the project were gathered into a learning collaborative, and education and training was provided to facilitate standardization across sites regarding program delivery and workflow, patient assessment, use of asthma action plans, and

CASE STUDY TWO – CONTINUED

communication protocols. Tools were also created to provide a range of templates and an electronic platform with intervention prompts and platforms for data entry and submission.

While OneCity Health considered standardization essential, it presents challenges for LSAFHS, which uses an Environmental Health Program with a more comprehensive model. LSAFHS CHWs do home remediation and work closely with parents and other caregivers, so they have the knowledge and skills to address asthma triggers in the future. Providing a more limited set of services to families referred through the OneCity Health program would be problematic, so LSAFHS will offer the broader set of services where deemed necessary—and LSAFHS will absorb the costs of the extra services.

We will try to follow the model—have that fidelity—but if we feel like it's not enough, we're going to take the next step and help the family. (LSAFHS)

Contracting

OneCity Health has a centralized process and a standard contract for all CBOs working on the asthma project. From their perspective, use of a standard contract ensured transparency “that all partners are being held to the same standards and being paid the same way.” They note that the centralized process allows the clinical partners (i.e., hospitals and community health centers) to focus on project implementation.

Contract deliverables and indicators were developed and vetted through multiple parties, including the OneCity Health Executive Committee, which has multiple CBO members. The partnering CBOs were given the opportunity to meet with OneCity Health to discuss concerns. The contract for the project specifies that CBOs must comply with OneCity Health's efforts to provide supervision and ensure quality assurance.

In the early phase of the project, payment was for unit of service (e.g., case conference attendance,

home visits, outreach, and engagement). To focus more on quality and outcomes in the second phase, OneCity Health changed the payment methodology to be more consistent with a VBP approach. A signing bonus equal to 10% of the contract limit is provided at the start for upfront costs. Subsequent payments are based on the attainment of particular process and outcome thresholds. According to OneCity Health, the change caused concern among the CBOs:

So when we changed that methodology, they were very concerned. They weren't shy about letting us know. But we had lots of conversations with them, and we said to them, “This is VBP and being in a performance-based environment means that you will have some risk, some financial risk, that you have to absorb. You're not going to get all of your money upfront. And so this is the beginning of understanding how to manage what is expected of you contractually without clearly knowing all of the dollars that will be available to you.” (OneCity Health)

From LSAFHS's perspective, learning to work in a VBP context is essential and a benefit of the project.

We feel like we have to be in this to understand how [VBP] works, and so in that way, I think that that has also been beneficial . . . it has been sort of gradual learning and getting towards that. And so, I still probably should take a few webinars on value-based payment, and hopefully I'll have the time to do that soon. But you know, I think we'll—by the end—we should be able to learn how to play this game. (LSAFHS)

Challenges

Several challenges arose with implementation, in part due to the number of organizations and stakeholders, and minimal experience working together previously. In addition, OneCity Health's monitoring and oversight systems were still under development at the start of the project, leading to hurdles and delays for the CBOs, as

CASE STUDY TWO – CONTINUED

well as interruptions in payment and service delivery. For example, the clinical sites required the CHWs to have toxicology tests and submit a “chain of custody” form with the test results. Neither CHWs nor their providers were familiar with the form (or that it would be required), necessitating repeat tests that resulted in delays (onboarding took five months for one CHW), missed work, and out-of-pocket costs. Outside the startup challenges, OneCity Health emphasized the importance of careful monitoring:

I think in the beginning, they were surprised . . . But I think our concern was, again: [one], it's highly clinical, and two, the population is pediatric. So we had to be very sure that they really understood the expectations, they were meeting the requirements in order to go out and be in a patient's—a minor's— home, and engage with that minor and their guardian or parent. So we took it very, very seriously . . . We don't want parents or guardians or anyone on the clinical team to feel like we are sending unqualified staff in. (OneCity Health)

From OneCity Health's perspective, CBOs were not accustomed to the level of oversight considered necessary for the project to succeed.

[The CBOs] didn't realize that we actually would put parameters around what we expected and the quality that we expected from them. So that was surprising. I think many of them come from a grant background where they're just told, "You have a grant agreement," and you're pretty much left to figure out how you're going to deliver on that grant. They never expected that we would give the materials, the training, and then the [quality assurance] and support that we provided. So, there are lots of meetings that we convene with them around looking at their performance, the quality of their documentation, the quality of their engagement. (OneCity Health)

The financial arrangements also presented challenges—particularly at the project's start. CBO

staff had responsibilities early on, but invoicing to cover salaries could not begin until services were delivered. Throughout, adequate funding for staff time required that agreed-upon metrics be met. However, LSAFHS felt that expectations—to the extent they were clear—were reasonable.

The reporting requirements have also been problematic, given pre-existing data management systems for families enrolled in LSAFHS's Environmental Health Services program, but who are outside the OneCity Health initiative. To avoid the burden of double entry, LSAFHS now has client records in two different data entry and management systems. While the hope is to integrate results when reports are run, such functionality does not yet exist. The problem of multiple data systems is not unique to this project.

Benefits

OneCity Health and LSAFHS described the partnership's benefits as increased knowledge and trust, better care, and better health outcomes through improved coordination between the community and clinical services.

I think it kind of opens the eyes of the clinical team as well, because in the office, it's all about medication adherence, it's not really about environment. And opening these channels has really been an eye-opener for the clinical team, as well. So we're still following patients that have been participating in this program, seeing their ED trends, whether they go back or not, so it is ongoing, but I think it has made a difference so far. (OneCity Health)

And we feel like we have a lot to offer . . . a contract is another stream, but I think it also helps us to perform better, because we're closer to the rest of the health care team, and we case conference with physicians, and the nurses, and the social workers. And then we also are getting the infrastructure to actually communicate with them securely. Prior to

this project, that just didn't happen in a regular way. Some of the providers who would refer to us would ask for feedback, and we'd give it to them. But others would just send their patients to us, and they wouldn't ask—or we sometimes tried to reach out to doctors and, you know, and not hear back. (LSAFHS)

Lessons Learned and Future Directions

Some of the lessons learned are typical: for example, ensure that goals and objectives are clear and shared by both partners. The specifics of implementation are more informative: understanding the required levels of commitment and support, infrastructure needs, and clarity on reporting requirements and processes. Given the resource constraints CBOs typically face, sufficient financial support during the planning phase may have facilitated early recognition of potential problems—and solutions.

That said, LSAFHS and OneCity Health see significant benefits in the collaboration and intend to sustain it in the coming years.

We want these partnerships to sustain. Whether or not OneCity Health needs to be the coordinator is a question and whether or not there's a role or need for that beyond DSRIP, that's something that I think we're still trying to figure out. But outside of that, in general, this is a partnership that should continue for clinical sites, because it provides a valued service that they can't provide for themselves. It allows them to have eyes into the community and into a patient's home. And that's the only way that they can fully understand how to tailor their interventions to really address that patient's needs. (OneCity Health)

Case Study Three

Northern Manhattan Perinatal Partnership & NewYork-Presbyterian PPS

SKATE Program: A Community Health Worker-Led Program for Children with Special Health Care Needs

The Partners

The Northern Manhattan Perinatal Partnership (NMPP) provides health and social services to children and parents, with a primary focus on Harlem and other northern Manhattan communities. Founded to combat infant mortality in northern Manhattan, most NMPP programming is focused on case management and social support services for pregnant women and families with young children.

NewYork-Presbyterian's (NYP) PPS is a network of approximately 90 providers and community collaborators anchored by NewYork-Presbyterian Hospital. At NYP, the Special Kids Achieving Their Everything (SKATE) CHW program is based in the Ambulatory Care Network of the Weill Cornell Medical Center and the Columbia University Irving Medical Center.

Project Design & Development

The SKATE program supports children with special health care needs who are considered medically complex or socially unstable. SKATE is a DSRIP-funded initiative that sits within NYP's Center for Community Health Navigation (CCHN) and works to improve care and outcomes for high-risk and high-cost children with special health care needs. The initiative is led by CCHN and based on its more than a decade of CHW programming experience. Two CHWs—selected, credentialed, and supervised jointly by NYP and NMPP—are on NMPP's staff and serve patients and family members of NYP's Cornell pediatric ambulatory practice.

We actually worked probably about four to five months in that planning process identifying, "Well, what are the things we'd like our CHWs to work on with these families, in particular?" which was a new population. "What are the issues that those families face? What are the resources that they need to be linked to . . ." Things like connecting them to SSI, things like early intervention, the community of preschool education . . . And we really worked with NMPP in building that curriculum, not only to train our staff, but then to actually deliver that intervention to the families. (NYP)

The CHWs conduct home visits that include assessments of clients' needs and goals, which they share with the practice medical team during regularly scheduled interdisciplinary meetings. CHWs identify social determinants of health and provide support—including navigation, education, and social service referrals—to promote improved health and wellbeing.

. . . understanding their medication and how to use it, understanding the diagnosis and what it is that their child has. Sometimes it's like making sure they have all the medical equipment that they need in the home. It can be educational-based goals. A lot of the patients will need homeschooling or other [things], like PT, speech therapy, [or] all of those, so making sure that they're getting those connections and getting those referrals done. It can be making sure that their insurance is not cut off, so they don't miss appointments or can't see the doctors. (NMPP)

CASE STUDY THREE – CONTINUED

While CHWs do not have access to NYP’s EMR and scheduling system, they document in the hospital’s care management system. The CHWs are treated as equal and embedded members of the care teams, moving freely in the hospital and regularly participating in care management meetings. As mentioned, NMPP and NYP share supervision, supporting the CHWs in both the medical and community contexts.

For NMPP, the SKATE CHW program is unique in that it serves children up to age 21 in all five boroughs. In addition, the program has strict criteria for enrollment, limiting possibilities for cross-referrals, which is a common practice in other NMPP programs. NMPP describes it as “an experiment” consistent with its interest in expansion.

Contracting and Logistics

Contracting was described as unproblematic, benefiting from NYP’s decade of experience partnering to implement CHW programs and program champions identified by the institution. NYP vets potential partners, but requires only stable infrastructure to support the CHWs, the ability to invoice, and a point person for the collaboration. The contract covers direct service costs and the associated administrative expenses.

They were always willing to see our side of it and really make those numbers work for us. That’s not what we had within the other PPS. It never even got to the point where we could have this discussion, where they can hear why it doesn’t work for us. It was just like, “This is what we have. Take it or leave it.” (NMPP)

We don’t want this to come as an expense to the CBO in any way, and we want to make sure that we’re not only paying for the community health worker but all of the resources that would be needed to support that community health worker. So, the subcontract . . . pays for the CHW’s salary, pays for fringe, pays a stipend for our local supervisor; there are indirect, operational sort of overhead funds put

in there. Like, anything the CHW would [use] . . . the phone, the tablet, all of the resources. So, we want this to be capacity building. We don’t want it to be drawing resources from the community. We want to put the resources into the community and basically expand the portfolio and the resources that the CBOs have. (NYP)

NMPP is responsible for ensuring quality services are provided to the identified community members and agreed-upon performance requirements are included in the contract. While payments are not withheld for missing performance targets, there is an expectation that regular in-person interaction and close collaboration will resolve issues that arise. If requirements are not met, the team works together to support the CHW and develop a plan for improvement. Regular communication between NYP and NMPP ensures that both parties are engaged and better able to incorporate continued improvements into the program.

It’s not like we’re just, “Here’s money for a CHW. See you.” And it’s not, “Give us the person, and we’ll see you.” It doesn’t work that way. So, we’ve really set it up that the managers on our end are meeting monthly with people at the CBO level so that there’s information being exchanged, rather than, “Oh, we cut you the check for 12 months, and by the way, here’s the report.” (NYP)

Benefits

NYP and NMPP staff describe the CHW partnership as a success with notable positive outcomes.

It was a great balance, and again, that goes back to sort of the crux of how the model was developed. We bring the medical piece from the medical center expertise. They bring the real community and social piece. (NYP)

We get really positive feedback from the resident doctors and the doctors who are making the referrals—and just the value that they see in having

the CHWs at those team meetings, and giving them a really good vision of what's going on. And, just having them step back from themselves and seeing the patients and the families in a different way, and just having access to somebody to help that patient deal with all of the other stuff. (NMPP)

Benefits go beyond the SKATE program's direct services and the families impacted. NYP/Cornell pediatricians have learned about other NMPP services and make referrals for families outside the SKATE CHW program. NMPP staff also have had opportunities to learn more about health care issues and medical services.

I've gone to meet with all of the team at NYP/Cornell. They wanted to know what we do here, and, "How do we advertise what you guys do?" . . . "How do we make referrals to you guys outside of the SKATE program if we identify families that can use your services?" It's just been many opportunities that we've been able to increase our visibility with them and also just strengthen our relationship in a real way that we feel like they're true partners. (NMPP)

Lessons Learned and Future Directions

Although the SKATE program is new and was developed within the context of DSRIP, it builds on—and is facilitated by—years of experience and familiarity between stakeholders.

If we just came together for this project, and then we disbanded when the grant was over, it wouldn't work. We're really building upon years and years of relationships. So, like we said, before we started working with [the NMPP staff person] on this project, we already knew her, we'd already worked together, there's already an inherent trust there. So, I think that (the) longevity of that relationship and just building upon this foundation helps us with each new project. (NYP)

While time and familiarity are important, the duration of the relationship may be attributable to other factors, including appreciation of the relative resource base and contribution of the two institutions, and a partnership broader than the scope of services required for a specific project.

Payer Perspective

How Healthfirst Partners with CBOs

In focus groups and interviews, participants discussed the importance of payers, particularly Medicaid and MCOs, in sustaining programs developed through HCO/CBO partnerships to address social needs. Healthfirst is an MCO serving 1.2 million members in New York City and on Long Island. It provided information on the organization's history with CBOs and how they promote social services that impact health.

Healthfirst aims to build strong relationships with organizations that address health and social needs, including CBOs, faith-based organizations, public health agencies, and other types of organizations that serve Healthfirst members. Partnerships throughout New York City engage communities and facilitate outreach to members that the health system otherwise cannot engage via typical channels. Many partnerships stem from its Healthy Village Initiative (HVI), through which Healthfirst sponsors health programming and performs community-based activities—a number of which are grant funded—in partnership with local health care providers. HVI is also a testing ground for pilot projects to engage the community.

Healthfirst has been methodically testing models to determine payment for CBO services, and has begun contracting with CBOs that employ CHWs and/or peers who can engage patients in care. Healthfirst has found that these services fill important gaps between clinical care and community. Finding projects that meet the scale required for a payer has been a particular challenge. While the organization sees general value in assisting so called “high utilizers” who require the

most health care resources, Healthfirst must consider projects that can be scaled to reach the broader membership.

While Healthfirst does not conduct a formal assessment to identify and select CBO partners, it focuses on programs that fill particular gaps or address priority areas. Generally, Healthfirst works with CBOs with a long history, an appropriate mission, and a good reputation within the community. CBOs must have specific expertise that meets a need among Healthfirst members, and they must pass Healthfirst's privacy and compliance standards. This process helps ensure program integrity and that Medicaid dollars are appropriately spent. As an MCO, Healthfirst risks being denied payment by DOH if its use of funds is considered inappropriate. Healthfirst needs special permission from DOH to use funds for services outside the benefit scope.

Healthfirst has a few contracts with CBOs, which are paid a “case rate” for a set of services provided to Healthfirst members. Healthfirst discussed various challenges in partnering and contracting with CBOs. Many CBOs lack the infrastructure to bill payers for services, and others lack infrastructure to scale projects. As a payer, Healthfirst is typically unable to provide funding for capacity building. Healthfirst also discussed the challenges of measures and connecting CBO activities to health care outcomes. Because of these challenges, Healthfirst designs incentives for CBO partners around process measures related to finding Healthfirst members, connecting them to care, and navigating them to needed services.

Appendix A

Focus Group Participating Organizations

Health Care Organizations

Bronx Partners for Healthy Communities
BronxCare Hospital Center
Community Care of Brooklyn
Hospital for Special Surgery (2)
Interfaith Medical Center
Montefiore Health System (2)
Montefiore/BX Accountable Healthcare Network
Mount Sinai Health Home
Nassau Queens PPS
NewYork-Presbyterian (2)*
NewYork-Presbyterian/Weill Cornell Medical Center
NewYork-Presbyterian Health Home
NYC Health + Hospitals (2)
NYC Health + Hospitals/Bellevue
NYC Health + Hospitals/Jacobi
NYC Health + Hospitals/Lincoln
NYU Langone Hospital–Brooklyn*
NYU Langone–Brooklyn PPS (2)*
OneCity Health*
Staten Island PPS
Wyckoff Heights Medical Center†
Zucker Hillside Hospital

Community-Based Organizations

Arab-American Family Support Center
ArchCare
Brooklyn Community Services
Bedford Stuyvesant Restoration Corporation
BronxWorks
Carter Burden Network
CityMeals on Wheels
Directions for Our Youth
The Fortune Society
Fountain House
God's Love We Deliver
Jewish Association Serving the Aging (JASA)*
Jewish Community Center Staten Island
Jewish Board
Little Sisters of the Assumption Family Health Service*
Make the Road New York*
Northern Manhattan Perinatal Partnership*
Person Centered Care Services
Regional Aid for Interim Needs (2) (RAIN)
SCO Family of Services
SeedCo
LGBTQ Rights Center
City Harvest
START Treatment and Recovery Centers
Staten Island Partnership for Community Wellness (2)
Transportation Alternatives
Transitional Services for New York, Inc.
VISIONS

* Participated in interview.

† Participated in interview, but not in a focus group.

Appendix B

Methods

Project Scope and Definitions

This project focused on HCO/CBO partnerships in New York City. The HCO category included hospitals, health systems, DSRIP PPSs, and hospital-led Medicaid Health Homes. Federally qualified health centers (FQHCs), key providers in many communities, were not included because the project focused on larger health care institutions where partnering challenges are perceived to be the most significant. The CBO category included nonprofit organizations that primarily provide services related to social determinants of health, including but not limited to housing supports, food, education, and social support. Many, but not all, are neighborhood-based.

The term “partnership” was defined broadly for this project and includes the following:

- Referral relationships
- Contractual relationships
- Formal DSRIP engagement via a contract (with or without the flow of funds)
- Joint work (funded or unfunded) to meet a specific population’s needs

Data Collection

Data for this project were collected via a series of focus groups and key stakeholder interviews. Participants were recruited through existing Academy and GNYHA contacts, including umbrella and networking organizations that could do outreach to their members. Eligibility was limited to individuals from CBOs and HCOs with firsthand experience in a specific HCO/CBO partnership, either current or in the recent past. Although interviews and focus groups covered similar topics, the focus groups were

intended to elicit information on common issues and concerns. In contrast, the interviews focused on specific partnerships and were used to develop this report’s case studies.

Written guides were used for the focus groups and interviews, and included questions on partnership history; goals; the contributions of each partner; funding sources; contractual arrangements; and barriers, facilitators, and lessons learned. Focus groups and interviews were audio recorded and professionally transcribed. Focus group transcripts were coded to facilitate careful analysis. Focus group findings are reported without specific attribution to protect the confidentiality of participants. Case studies, in contrast, identified the partners to provide needed context.

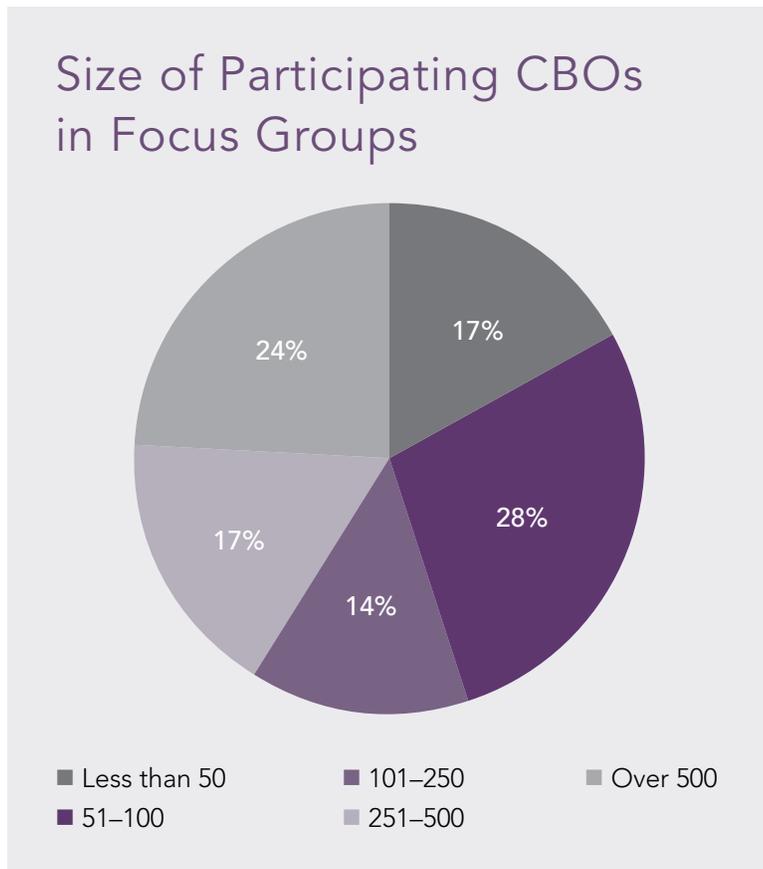
Focus Group Sample

Eleven focus groups were conducted, six with CBOs (30 participants) and five with HCOs (26 participants). Organizations from all five boroughs were represented.

HCO participants were from 14 hospitals, eight PPSs, and four hospital-led Health Homes. The hospital participants represented departments that included administration, ambulatory care, psychiatry, social work, community health, and grants administration. Most PPS participants were responsible for community engagement. Because the sample of hospital-led Health Homes was small, and because the organizations have a unique set of challenges and requirements, data collected from that focus group was excluded from this report.

Participating CBOs were of variable size (see figure on [page 34](#)). A majority reported serving low-income

populations, children and adolescents, older adults, and/or those with behavioral health needs. Fifty-five percent of the participating CBOs bill Medicaid for eligible services. Nearly half of the CBO representatives reported that they provided advocacy, case management, care coordination, and/or health education services as part of their partnerships with HCOs. Sixty percent of CBO representatives described their role as program management.



Interview Sample

Nine key stakeholder interviews were conducted. Interviewees were selected based on information gathered in the focus groups. The intention was to identify interviewees that could describe well-developed partnerships that were diverse in scope and configuration. The project team interviewed HCO and CBO representatives from one PPS/CBO partnership, one hospital/CBO partnership, and one partnership between a CBO and a hospital that also leads a PPS. The project team also conducted an interview with

one PPS about its general partnership experiences, one CBO about its VBP and sustainability strategy, and one MCO about its organizational perspective on CBOs and VBP.

Partnerships Described

In focus groups and interviews, partnerships focused on a wide variety of activities designed to keep people well. Most partnerships focused on improving quality of care for patients or providing additional community supports between health care visits. Several focused on care coordination, care transitions, or case management, including support focused on prevention or management of specific illnesses through education, assistance with medication, and/or health coaching. Other partnerships focused on populations with specific needs, such as older adults, LGBTQI, and individuals with disabilities. Partnerships focused on immigrant populations provided with language services and/or supports related to cultural competency. Finally, a number of partnerships addressed social determinants of health such as food security, housing quality and safety, and access to public benefits.

Many partnerships focused on a specific geographic community. In addition, several focused on particular populations, as described above, or on high utilizers of costly health care services, such as frequent users of inpatient and emergency department services, or those with certain conditions such as asthma. Staffing varied according to project scope and included community health workers, social workers, and counselors.

Partnership activities ranged from high-level transactional activities, such as completing surveys, to full service integration and collaboration, such as embedding CHWs in the hospital care team or having them do home visits.

Appendix C

Data Sources

Using Data to Identify Community Needs

Many publicly available data sources provide community-based information on disease prevalence, health care outcomes, health disparities, and CBOs. The below data sources may be useful.

National

Behavioral Risk Factor Surveillance System (BRFSS) data (<http://www.cdc.gov/brfss/>) are used to describe the population of New York State, New York City, and counties/boroughs in terms of health status (e.g., percentage of the population uninsured, percentage with diabetes or obese). The BRFSS is a telephone survey and the de-identified, individual-level data are publicly available for download from the Centers for Disease Control and Prevention.

County Health Rankings and Roadmaps, at <http://www.countyhealthrankings.org>, includes snapshots and comparisons of county-level health measures. Full datasets are also available for analysis.

The Center for Medicare & Medicaid Services has a **Mapping Medicare Disparities (MMD) Tool** with health outcome measures for disease prevalence, costs, and hospitalization for 18 specific chronic conditions, emergency department utilization, readmissions rates, mortality, and preventable hospitalizations. The tool allows the visualization of health outcome measures at a national, state, or county level. Outcome measures are available by age, race and ethnicity, and gender, and comparisons between geographic locations and racial and ethnic groups can be explored. The MMD Tool is available at <https://data.cms.gov/mapping-medicare-disparities>.

The United States Office of Disease Prevention and Health Promotion and Office of Minority Health support a publicly available tool called **DATA2020**, which can query health disparities information for measurable, population-based objectives. The tool is part of Healthy People 2020, a Federal public health initiative to improve the health of all Americans. DATA2020 and instructions on using it are at <https://www.healthypeople.gov/2020/data-search/health-disparities-data>.

New York State

Health Data NY collects data on myriad chronic diseases and can be accessed at <https://health.data.ny.gov>. The Community Health & Chronic Disease section of the site links to more than 150 reports, documents, and datasets that can identify ongoing and potential initiatives to improve health and impact health disparities. Local health departments also often offer data to the public to inform policy and evaluate public health programs. The datasets can also be used by residents to identify community health gaps and opportunities for improvement.

New York State Community Health Indicator Reports (CHIRS) include data on more than 300 health indicators. Accessible at <https://www.health.ny.gov/statistics/chac/indicators/>, the reports are organized by 15 health topics and include data tables, graphs, and maps.

The New York State Prevention Agenda 2013-2018 Tracking Indicators provide data for counties for a variety of health outcomes, including rates of preterm birth, unintended pregnancy, maternal mortality, new HIV cases, new STI cases, immunization rates, obesity, and smoking. The indicators can be found at <https://>

health.data.ny.gov/Health/Prevention-Agenda-2013-2017-Tracking-Indicators-Co/47s5-ehya.

New York City

DATA2GO.NYC is a free online mapping and data tool created by the nonprofit Measure of America of the Social Science Research Council, with funding from the Leona M. and Harry B. Helmsley Charitable Trust. It brings together Federal, State, and City data on a broad range of issues critical to the wellbeing of all New Yorkers.

EpiQuery: NYC Interactive Health Data provides City health data, including surveys, surveillance data, and vital records (births and deaths). Datasets that may be of interest through EpiQuery include the Community Health Survey, HIV/AIDS Surveillance Data, Infant Mortality Data, and NYC Census Data. EpiQuery modules are available at <https://a816-healthpsi.nyc.gov/epiquery/>.

GNHYHA's **Health Information Tool for Empowerment (HITE)**, at <http://www.hitesite.org>, is a public website that lists health and social service providers in New York City's five boroughs, as well as Nassau and Suffolk counties. HITE lists approximately 6,000 resources for low-income, uninsured, and underinsured individuals. Outside New York City, available resource directories

include 2-1-1, NY Connects, and other locally managed databases.

IMAGE: NYC, an Interactive Map of Aging, located at <http://www.imagenycmap.org>, was created by The New York Academy of Medicine in partnership with the Center for Urban Research at The Graduate Center/CUNY, with support from the Fan Fox & Leslie R. Samuels Foundation. IMAGE: NYC is an open-source map of New York City's current and projected population aged 65 and older, with overlays of age-friendly resources, services, and amenities.

New York City Community Health Profiles, available at <https://www1.nyc.gov/site/doh/data/data-publications/profiles.page>, contain information on the health of New York City's 59 community districts, including broader measures of health such as housing quality, air pollution, and food environment. Profiles are also available at the county level.

NYC Open Data, available at <https://opendata.cityofnewyork.us/>, is a user-friendly repository of all publicly available datasets managed by New York City. Datasets can be organized by category (e.g., environment, health), agency (e.g., DOHMH, Department of City Planning), or type of data (e.g., charts, maps).

Appendix D

Capacity-Building and Informational Resources for CBOs

Aging and Disability Business Institute

<https://www.aginganddisabilitybusinessinstitute.org/>

The website, sponsored by the Aging and Disability Business Institute (Business Institute), provides tools and resources to help CBOs successfully adapt to the changing health care environment, enhance organizational capacity, and capitalize on emerging opportunities to diversify funding. The Business Institute focuses on building skills and knowledge across business disciplines while looking ahead to the future of aging and disability services. The initiative's overarching vision is to improve the health and wellbeing of America's older adults and people with disabilities through improved and increased access to quality services and evidence-based programs.

Capacity Building & Oversight Trainings

<https://www1.nyc.gov/site/mocs/nonprofits/cbo-training.page>

The New York City Mayor's Office of Contract Services conducts free trainings for nonprofits to strengthen board governance and financial management, legal compliance, and contract management. Board members, officers, and staff members of nonprofit organizations with current contracts or grants with New York City may participate free of charge.

Communities Together for Health Equity (CTHE)

<https://www.arthurasheinstitute.org/aaiuh-dsrp>

A New York City coalition of CBOs across the city's five boroughs led by the Arthur Ashe Institute of Urban

Health, CTHE is funded by DOH's CBO planning grant. It has developed goals and strategies to improve CBO capacity and concretize a sustainable infrastructure and process to demonstrate CBO value, experience, and impact to inform DSRIP activities and ensure CBO engagement in a health care delivery system. CTHE also plans to develop capacity-building tools for the CBO community, including a platform for inter-organizational communication.

DOH Resources for CBOs

https://www.health.ny.gov/health_care/medicaid/redesign/dsrp/vbp_library/

DOH has compiled information to facilitate CBO involvement in VBP arrangements. Webinars, contracting documents, and information on CBOs across New York State are included in the DSRIP VBP Resource Library in the Social Determinants of Health and Community-Based Organizations section.

Linkage Lab Initiative

<http://www.thescanfoundation.org/linkage-lab-initiative>

This webpage, developed by the SCAN Foundation, contains materials from the organization's Linkage Lab initiative, which was developed to prepare California's CBOs to partner effectively with health care entities. The SCAN Foundation has published resources to help CBOs identify and develop specific capabilities. Tools include case studies, webinars, and a list of the contracts that participating CBOs entered into.

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