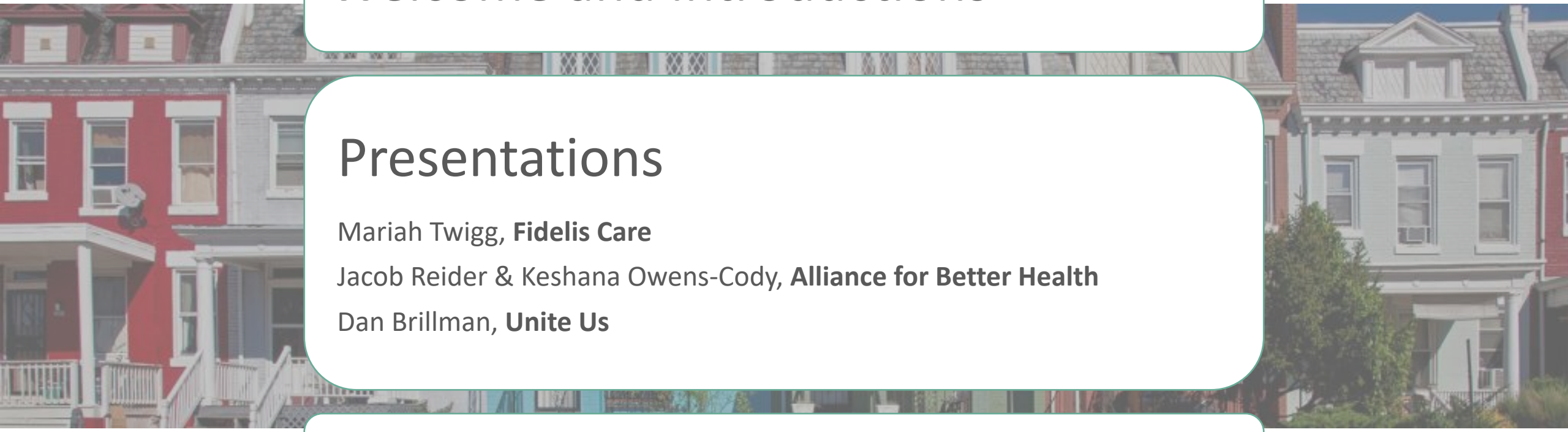
Aligning for HEALTH

Connecting Health and Social Needs in New York During COVID-19

25 June 2020

Agenda

Welcome and Introductions



Presentations

Mariah Twigg, **Fidelis Care**

Jacob Reider & Keshana Owens-Cody, **Alliance for Better Health**

Dan Brillman, **Unite Us**

Q&A & Discussion

Alliance FOR BETTER HEALTH

American Hospital Association
Advancing Health in America

AMIDA CARE
ABOVE AND BEYOND FOR YOU

BlueCross BlueShield of North Carolina

BlueCross BlueShield Association

CareSource

CENTENE Corporation

HCSC
Health Care Service Corporation

UNITE US

SOLERA
INTEGRATED HEALTH NETWORK

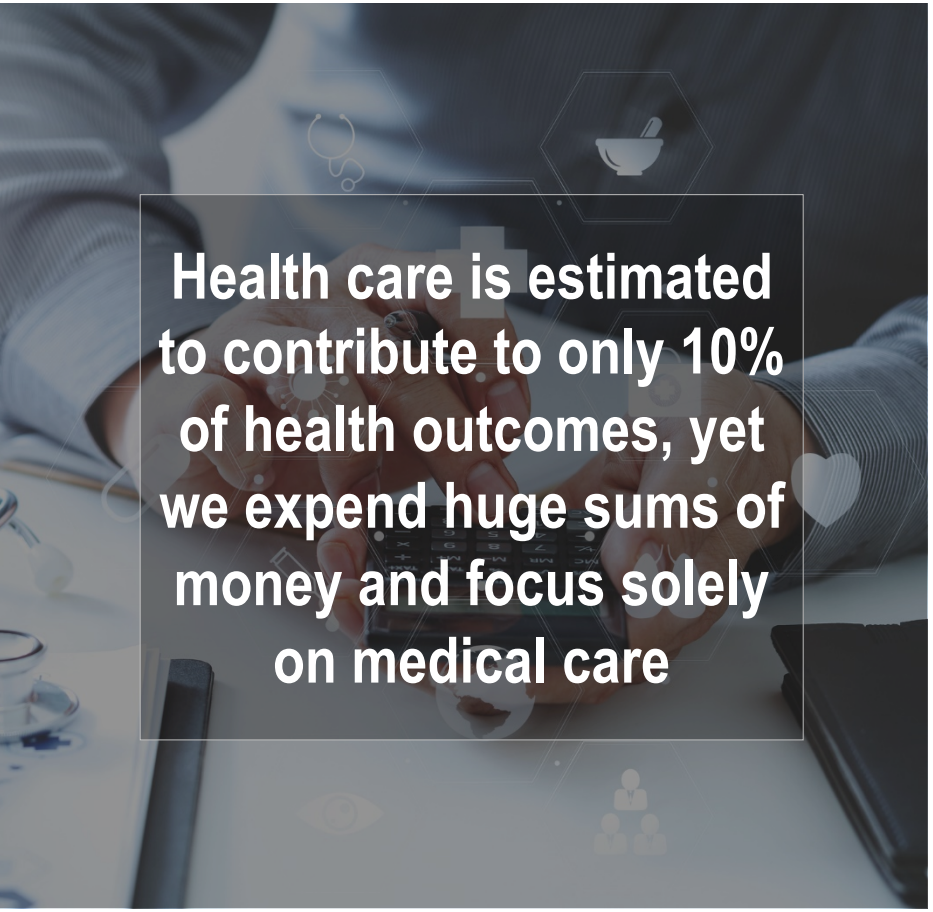
signifyhealth.

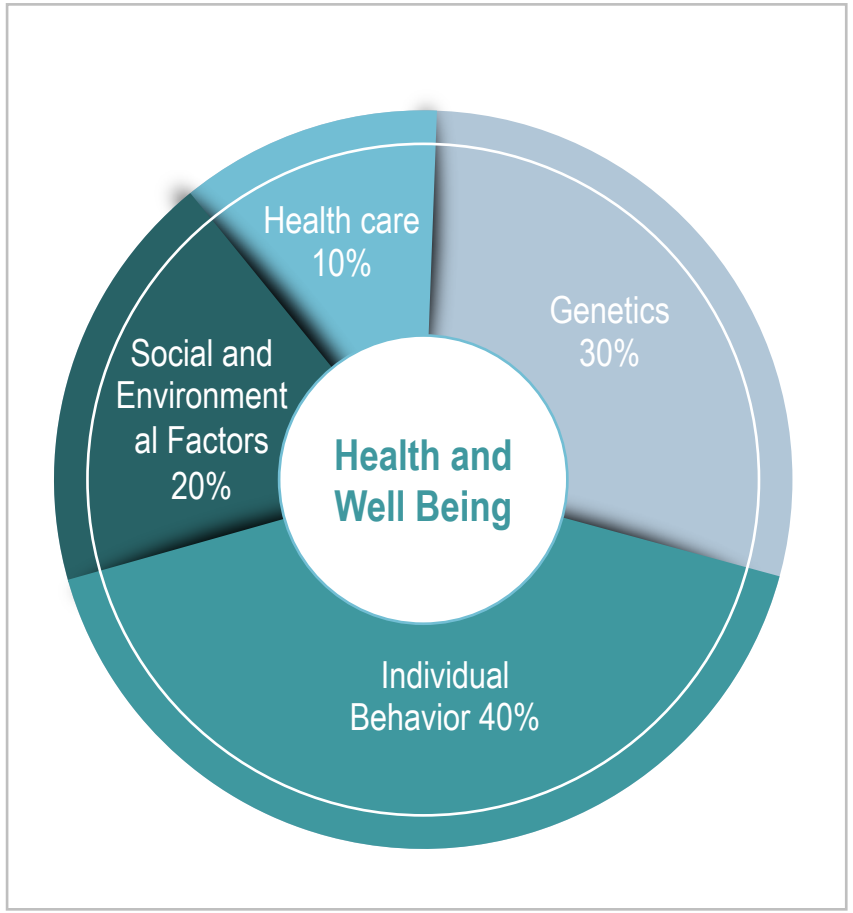
UPMC LIFE CHANGING MEDICINE

What are Social Determinants?

- Stable, affordable housing and supportive housing
- Access to quality nutrition
- Ability to meet basic needs, including transportation or childcare
- Healthy homes through energy subsidies, weatherization, etc.
- Access to health care services, including behavioral health services
- Workforce training, employment opportunities, mobility and independence.

How Social Determinants Impact Health





What we spend on being healthy

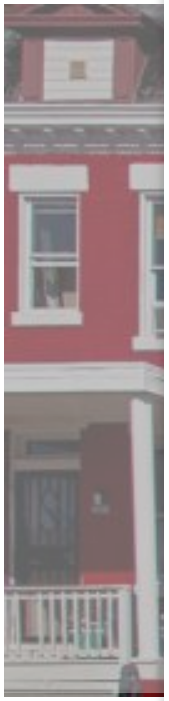
88% MEDICAL SERVICES

+

4% Healthy behaviors

8% Others

COVID-19 | Impact on New York and Health Disparities



Case Rates

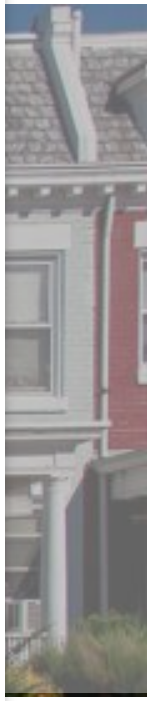
As of today, there have been 2,336,615 cases of COVID-19 in the U.S. and 121,117 deaths.

New York State and the New York region were hit particularly hard by the virus over April and May – New York has had almost 400,000 cases and 31,000 deaths.

Health Disparities

COVID-19 has had an outsized impact on racial and ethnic minority and vulnerable communities. Data released on Monday by the Centers for Medicare & Medicaid Services found much higher hospitalization rates for beneficiaries dually eligible for both Medicare & Medicaid and black and Hispanic Medicare beneficiaries, than other beneficiaries.

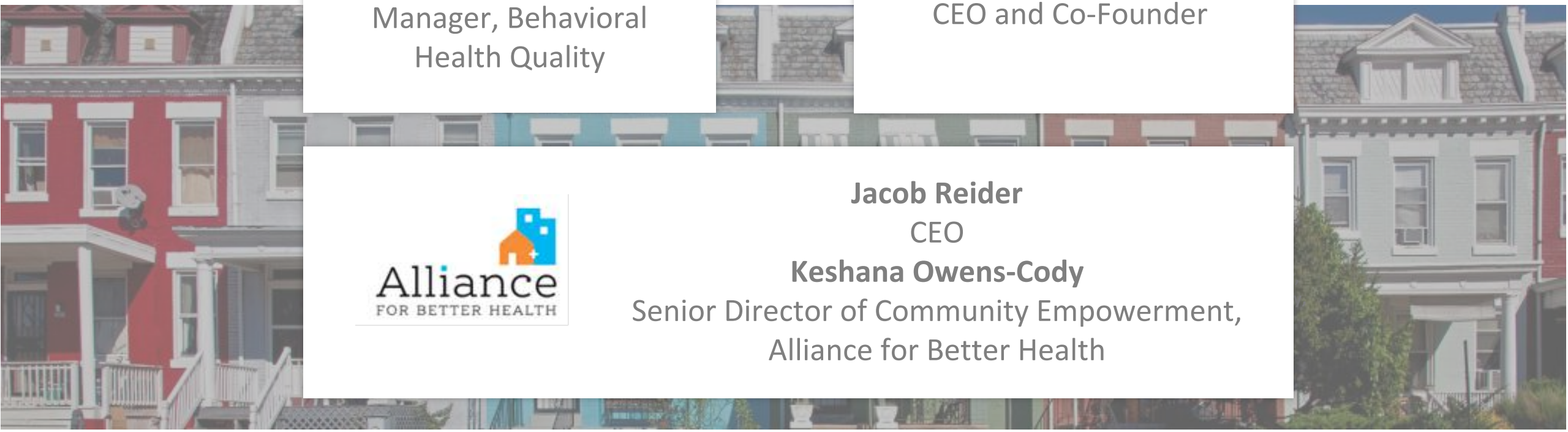
Deaths rates among Black and Hispanic/Latino in New York City are twice that of whites and Asians. Blacks died at a rate of 92.3 deaths per 100,000 and Hispanic/Latino persons at a rate of 74.3 compared to that of white (45.2) and Asian (34.5) persons.



Speakers

Mariah Twigg
Manager, Behavioral Health Quality

Daniel Brillman
CEO and Co-Founder



Jacob Reider
CEO
Keshana Owens-Cody
Senior Director of Community Empowerment, Alliance for Better Health

Connecting Health & Social Needs in NYC During COVID-19

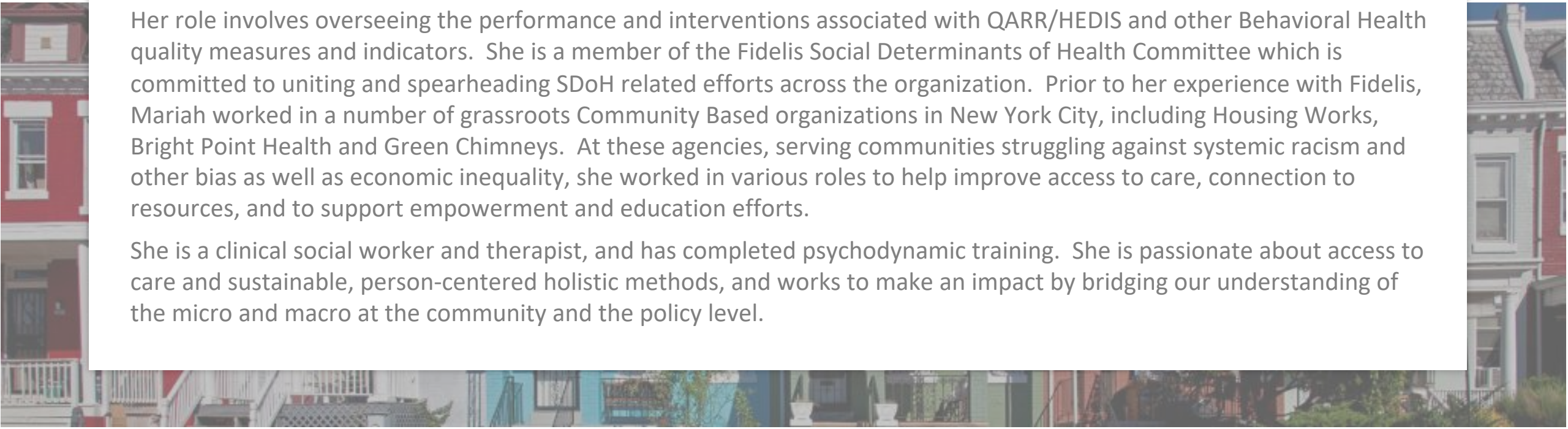
Speakers

Mariah Twigg, Manager, Behavioral Health Quality, Fidelis Care

Mariah Twigg is the Manager for Behavioral Health Quality at Fidelis Care.

Her role involves overseeing the performance and interventions associated with QARR/HEDIS and other Behavioral Health quality measures and indicators. She is a member of the Fidelis Social Determinants of Health Committee which is committed to uniting and spearheading SDoH related efforts across the organization. Prior to her experience with Fidelis, Mariah worked in a number of grassroots Community Based organizations in New York City, including Housing Works, Bright Point Health and Green Chimneys. At these agencies, serving communities struggling against systemic racism and other bias as well as economic inequality, she worked in various roles to help improve access to care, connection to resources, and to support empowerment and education efforts.

She is a clinical social worker and therapist, and has completed psychodynamic training. She is passionate about access to care and sustainable, person-centered holistic methods, and works to make an impact by bridging our understanding of the micro and macro at the community and the policy level.



FIDELIS CARE®

Quality health coverage. It's Our Mission.

Addressing Social Determinants of Health During The COVID 19 Crisis

06/25/2020






Fidelis SDoH Committee Champions

Stephanie Gillette, *Vice President Long Term Care and Product Development*

Mariah Twigg, *Clinical Manager, Behavioral Health*

Colleen Osborn, *Clinical Manager, Intake*

COMMUNITY PARTNERSHIPS

Challenge: Getting desperately needed resources out to the communities quickly in areas that need it most.

Solutions:

Using community partners as a conduit:

- Partnership with CIDNY- provided funding for programs to help LTSS members with disabilities experiencing adverse social impact due to or worsened by COVID-19
- 7,000 Walmart gift cards distributed to community organizations
- 30,000 surgical face masks distributed to provider partners, additional supplies (PPE) on the way

COMMUNITY OUTREACH: Adapting to COVID 19

Challenge: Social distancing requirements and office closures have limited our ability to service our members in our typical (face to face) manner.

Solution:

- Repurposed our mobile vans to provide mobile COVID-19 testing. Partnership with Chinese American IPA (NYC) and GBUAHN (Buffalo) to bring testing to high need community areas.
- While Community Offices are temporarily closed, the Fidelis Care team is sharing video resources in multiple languages to help answer questions about health insurance and provide resource information. https://www.fideliscare.org/Your-Online-Community-Office

FIDELIS CARE®

VIRTUAL FOOD BANK DONATION

Challenge: During the coronavirus (COVID-19) outbreak, the need for food in the communities we serve has never been greater.

Solution: As a way for us to come together in support of our friends and neighbors, the Giving and Community Committee of CODE, our Employee Engagement Committee, is working with a local food pantry in each region to set up a Fidelis Care virtual food drive. (NYC, Rochester, Central NY, The Capital Region and NYC)

- The food drive began accepting donations from Fidelis Care Employees on May 20, 2020 and will end June 15, 2020.
- Fidelis Care will match up to $50,000 of employee donations made statewide at the end of the campaign.

FIDELIS CARE MANAGEMENT: Challenges Across Discipline

Overarching Care Management Challenges:

- Inability or unwillingness to access many in person services like monitoring and routine blood draws, personal care services and Adult Day Care Services
- More members reporting loneliness, grief and loss, and mental health or substance use relapse
- Massive increase in food insecurity
- Confusion about how to access medical and mental health resources virtually or via phone
- COVID-19 related fear and anxiety about concessions and moratoriums being lifted (involuntary disenrollments, evictions, rent relief, etc).

SOLUTIONS: TELEHEALTH EXPANSION

Challenge: Members are having a more difficult time accessing services and care that they need due to the COVID 19 pandemic

Solution: expanded access to telehealth services

- Implemented Teladoc starting April 1, 2020, in response to the COVID-19 emergency
- Teladoc is App based and is offered as a new online option for all lines of business. Teladoc can also be accessed by phone.
- Clinical Services and Behavioral Health Care Managers were immediately educated on Teladoc and were able to assist members in using this tool to better access to care.

SOLUTIONS: Clinical Services Operational Efforts

The Clinical Services team quickly identified that a major barrier of members maintaining health and wellness during COVID-19 was a lack of knowledge around how to find resources the resources they need in their communities. In response to this, clinical services developed a special outreach initiative to inquire about and help link members to community resources during this time.

- Identified most vulnerable members and conducted outreach.
- Screening questions about loneliness and food security were incorporated into the outreach scripting for these members
- Utilized a team of in house social workers to specifically assist with processing referrals, such as those related to housing and SNAP/WIC applications.
- This team is also available to support member's social needs, including helping members set up apps on their phones to communicate with medical providers and family and caregivers.

SOLUTIONS: Behavioral Health Operational Efforts

- All staff resource page (Confluence) – Behavioral health shared various resources across our department including food pantry, transportation, virtual support groups, education support, benefit assistance etc. These resources are updated regularly along with a comprehensive list of COVID-19 talking points built from CDC and NY State guidance.
- High risk members were identified using medical and behavioral health identifiers. Members were outreached by clinicians who provided healthcare, SDOH and COVID-19 related support and resources.
- Outreach to HARP members was increased in frequency and all members had a check in regarding food security, home safety and COVID-19 status and access to testing and care.
- All members in behavioral health care management or in a transition of care from psychiatric hospitalization back into the community had explicit check in regarding social and emotional support, food security, home safety and access to COVID 19 testing and care.
- All behavioral health members in care management, including HARP and members in a transition of care from psychiatric hospitalization received explicit support in accessing telehealth resources, including identifying technology and assisting members with provider linkage. Care managers were provided with telehealth resources to use with their members.

SOLUTIONS: Long Term Care Operational Efforts

- All staff resource page (Wiki) - Similar to clinical services, this page compiled a regularly updated list of community resources for long term members. In addition this site contained the latest NYSDOH guidance with explicit instructions on how internal policies & procedures have been changed to comply with them.
- Using a red/yellow/green acuity stratification system, identified members with the most needs and more likely to be at risk from COVID-19. An outreach campaign was performed to speak to every member in acuity order to immediately assess exposure and identify needs.
- Developed a member log to track COVID-19 positive members. Increased contact with these members (weekly instead of monthly) to ensure needs were being met.
- Implemented daily huddle to quickly address time sensitive member issues (e.g. transportation home after discharge, members with no backup plans, SADC closures, etc)..
- Back-up Caregiver Agreement Outreach-mass mailing 19,000 letters, calls, and follow up to confirm back up plans during this time.
- Outreach to all home care agencies and fiscal intermediaries to request a single point of contact for COVID-19 and a copy of their COVID-19 preparedness plan. These plans used in conjunction with our own when member issues arose.

SOLUTIONS: Pharmacy Operational Efforts

Clozapine Blood Monitoring Outreaches

- Staff clinical pharmacists performed analysis to both identify members receiving clozapine therapy and to identify provider groups prescribing and monitoring this therapy
- Outreach to all identified provider groups to assess for issues relating to blood-draws that could adversely affect a member's ability to receive a clozapine prescription
- All information concerning blood monitoring barriers made available to interdisciplinary care management teams in order to provide holistic person-centered support to addressing barriers.
- Care management staff was provided with education regarding blood monitoring and clozapine to help inform their outreach

CONCLUSION AND NEXT STEPS

This has been a triage phase as our areas have moved to adapt to a quickly changing situation. Our efforts have been focused on outreach, and mobilizing resources.

The next steps will be more robust, complex and lasting. This includes:

- Increasing and enhancing VBP initiatives to reflect our changing environment and further partner with community based organizations (CBOs) in our network
- Development of an integrated housing committee to help members retain and obtain appropriate shelter
- Integrated efforts to link Fidelis Care management clinicians with CBO resources in our network.
- Identifying other resources that may continue to be helpful to members (e.g. analyzing ability to provide ipads to nursing homes for communication with loved ones)
- Ongoing efforts to provide education to our staff so that they can better serve our populations

FIDELIS CARE®

Quality health coverage. It's Our Mission.

For more information,
call **1-888-FIDELIS (1-888-343-3547)**
or visit **fideliscare.org**






Speakers

Jacob Reider, CEO, Alliance for Better Health

Dr. Reider joined Alliance because as a family physician, he wants the world to be more healthy. He has worked for decades to improve the health of our communities through the innovative use of technology, and the promotion of benevolence in business. He is currently CEO of Alliance For Better Health, a New York DSRIP care transformation initiative, Chief Health Officer of Health Coda, and co-founder of RS Partners, a health IT consulting and investing firm.

He previously served as the Deputy National Coordinator for Health Information Technology at the US Department of Health and Human Services. He also served as the CMIO of Allscripts, one of the nation's largest health IT developers, and was Associate Dean for Biomedical Informatics at Albany Medical College where he continues to teach on an adjunct basis. He co-founded four successful health IT start-up companies, and has held Directorships on boards of both non-profits and private companies. He has also held leadership roles in the American Medical Informatics Association and the New York State Academy of Family Physicians.

Keshana Owens-Cody, Senior Director of Community Empowerment, Alliance for Better Health

Keshana joined Alliance because she believes that it is important to serve those in need. As a former Community Health Worker and Transition Coordinator, Keshana saw firsthand the needs of not only of the community, but also the needs of the workforce. The importance of knowing the population served, the resources available in the community, and the ability to engage community members are critical skills needed to truly serve the community. Keshana has held various workforce development positions for the community health workforce, and currently teaches at both Hudson Valley and Schenectady County Community College. She holds a Bachelor's in Criminal Justice and is pursing a Master's in Human Resource Management at the University of Connecticut.

Secret to a healthy community?


Hospital

Social Care Network

Healthy Alliance IPA

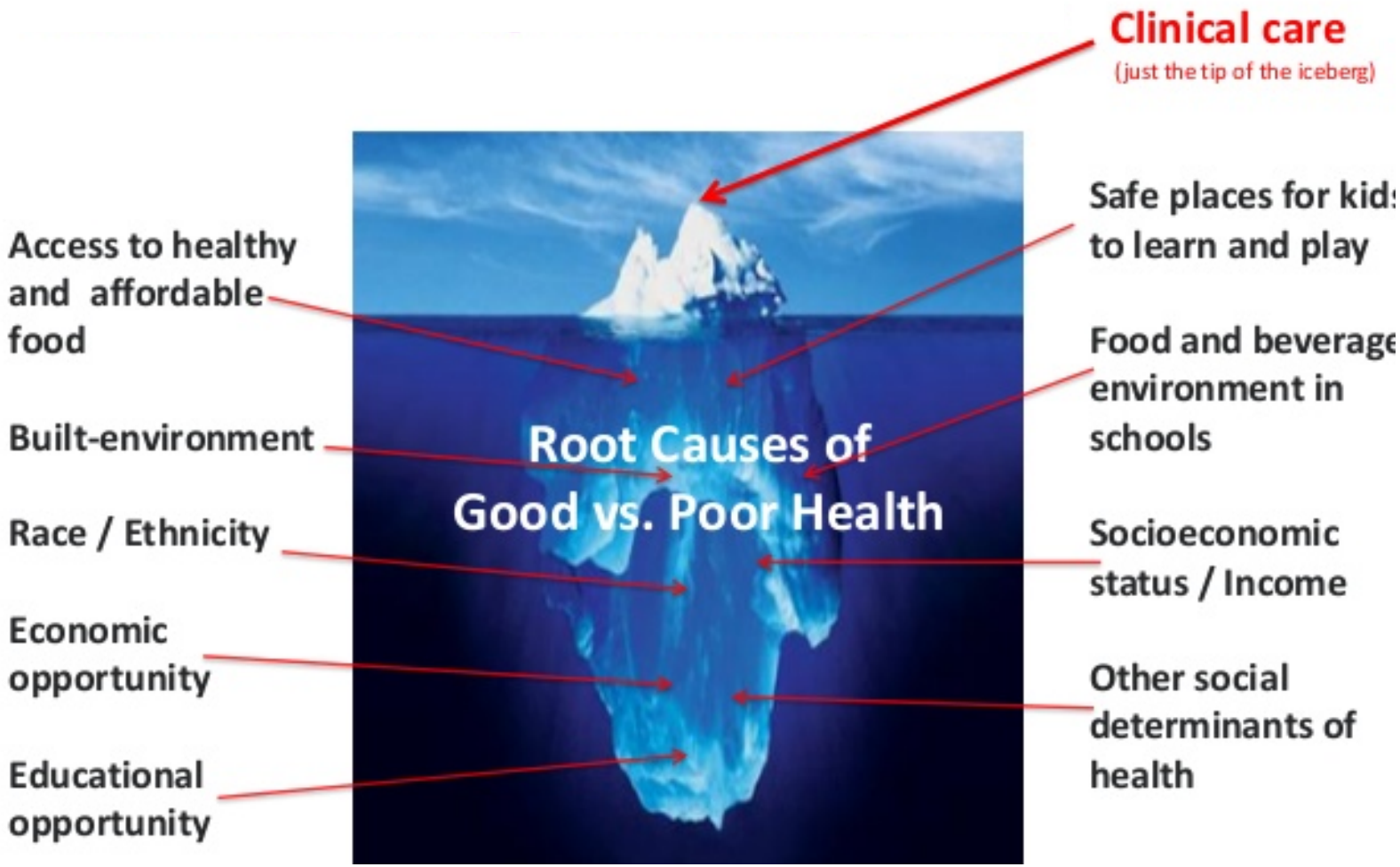
HEALTHY ALLIANCE IPA

Health < > Care

Health ?

"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

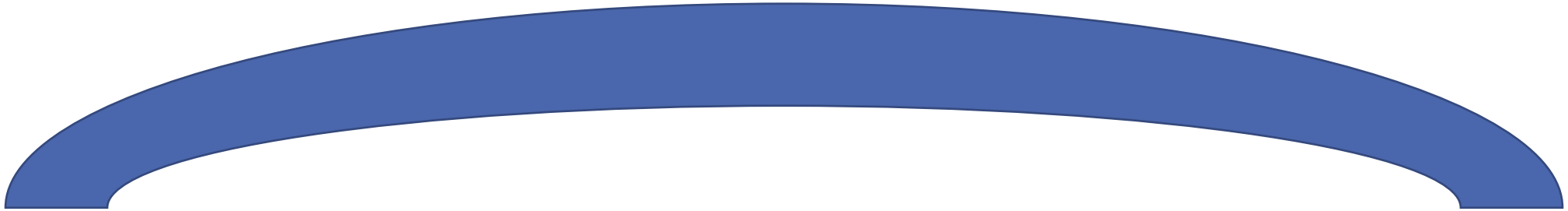
World Health Organization, 1946


Clinical care
(just the tip of the iceberg)
Access to healthy and affordable food
Built-environment
Race / Ethnicity
Economic opportunity
Educational opportunity
Root Causes of
Good vs. Poor Health
Safe places for kids to learn and play
Food and beverage environment in schools
Socioeconomic status / Income
Other social determinants of health

Health Care

Why is this two words?

Health Care



Social Services

Behavioral Health Services

Medical Services

NETWORKS empower social care providers

Connect social care providers

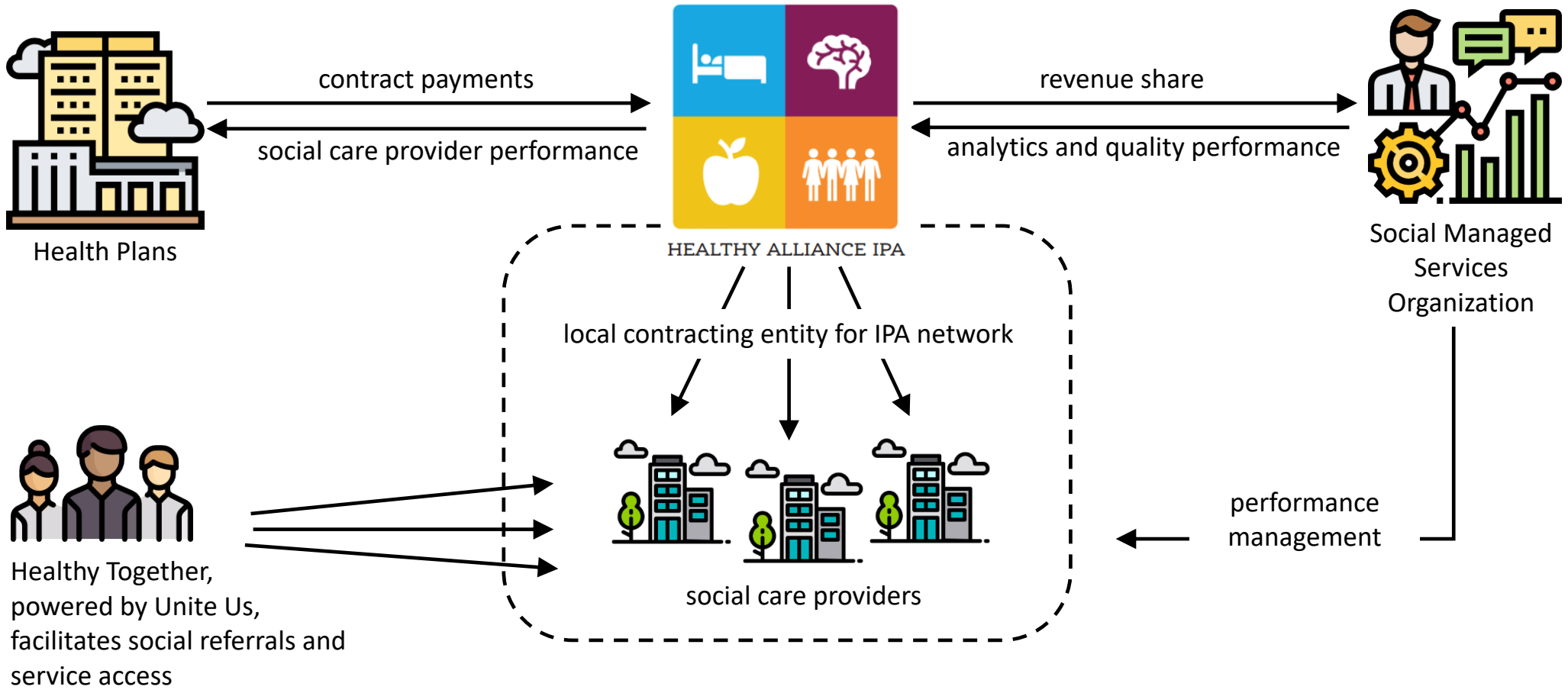
Create an organizational structure that ***supports everyone***

Define and execute services that ***managed care wants to pay for***

Grow funded programs to support social care programs through the IPA


Social Challenges
Behavioral Challenges
Physical Challenges

How it Works


contract payments
social care provider performance
Health Plans
HEALTHY ALLIANCE IPA
revenue share
analytics and quality performance
Social Managed Services Organization
local contracting entity for IPA network
social care providers
performance management
Healthy Together, powered by Unite Us, facilitates social referrals and service access

Current Healthy Alliance IPA Participants

	Housing (Temporary, Permanent)	Food	Case Manage-ment	Enrollment, Advocacy + Health Education	Job Training	Behavioral Health
Alliance for Positive Health	✓	✓	✓	✓		✓
Altamont Program	✓		✓	✓	✓	
Bethesda House of Schenectady, Inc.	✓	✓	✓	✓		✓
Capital District YMCA				✓		
CAPTAIN Community Human Services	✓	✓	✓	✓		✓
Catholic Charities of the Diocese of Albany	✓	✓	✓	✓		✓
Center for Disability Services			✓	✓		
Centro Civico, Inc.				✓		
Columbia County Community Healthcare Consortium, Inc.				✓	✓	
Commission of Economic Opportunity (CEO)		✓		✓	✓	
Community Caregivers Inc.				✓		
Community Health Center			✓			
Community Pharmacy Enhanced Service Network			✓	✓		
Conifer Park, Inc.						✓
Cornell Cooperative Extension		✓		✓		
Ellis Hospital		✓		✓		✓
Equinox	✓		✓			✓
Healthy Capital District Initiative				✓		
Green and Healthy Homes Initiative	✓					
Schenectady Family Health Services dba Hometown Health						✓
In Our Own Voices			✓	✓		✓
Independent Living Center of the Hudson Valley				✓	✓	
Interfaith Partnership for the Homeless	✓	✓	✓	✓		
Mechanicville Area Community Services		✓	✓	✓		
Planned Parenthood of Mohawk Hudson			✓	✓		✓
Promesa Inc Camino Nuevo						✓
Mom Starts Here			✓	✓		
New Choices Recovery Center			✓			✓
Northern Rivers			✓			✓
Rehabilitation Support Services, Inc.	✓		✓		✓	✓
Saratoga County Economic Opportunity Council		✓	✓	✓		
Schenectady City Mission	✓	✓	✓	✓	✓	
Schenectady Community Action Program	✓			✓	✓	
Second Chance Opportunities, Inc.	✓					✓
Senior Services of Albany (LifePath)		✓	✓	✓		
St. Catherine's Center for Children	✓		✓	✓		✓
St. Mary's Healthcare		✓	✓			✓
St. Paul's Center	✓			✓		
The Addictions Care Center of Albany		✓	✓	✓	✓	✓
The Albany Damien Center	✓	✓	✓	✓	✓	
The Family Counseling Center of Fulton County			✓			✓
The Food Pantries for the Capital District		✓				
The Prevention Council of Saratoga County			✓	✓		✓
The Salvation Army	✓	✓	✓			✓
Transitional Services Association	✓		✓			
Trinity Alliance of the Capital Region	✓	✓	✓	✓	✓	✓
Unity House of Troy	✓	✓	✓	✓		✓
Upper Hudson Planned Parenthood, Inc.			✓	✓		✓
U.S. Committee for Refugees and Immigrants (USCRI)			✓	✓		
Vanderheyden			✓			✓
YWCA Northeastern New York	✓		✓			

Total Participants: 51

Current Healthy Alliance IPA Participants

Benefits Navigation	Employment	Food Assistance	Health Care Coordination	Housing + Shelter	Legal	Mental + Behavioral Health	Social Care Coordination	Social Enrichment
								x
				x			x	
		x						
x		x			x	x	x	
						x	x	
				x				

STRONGER TOGETHER

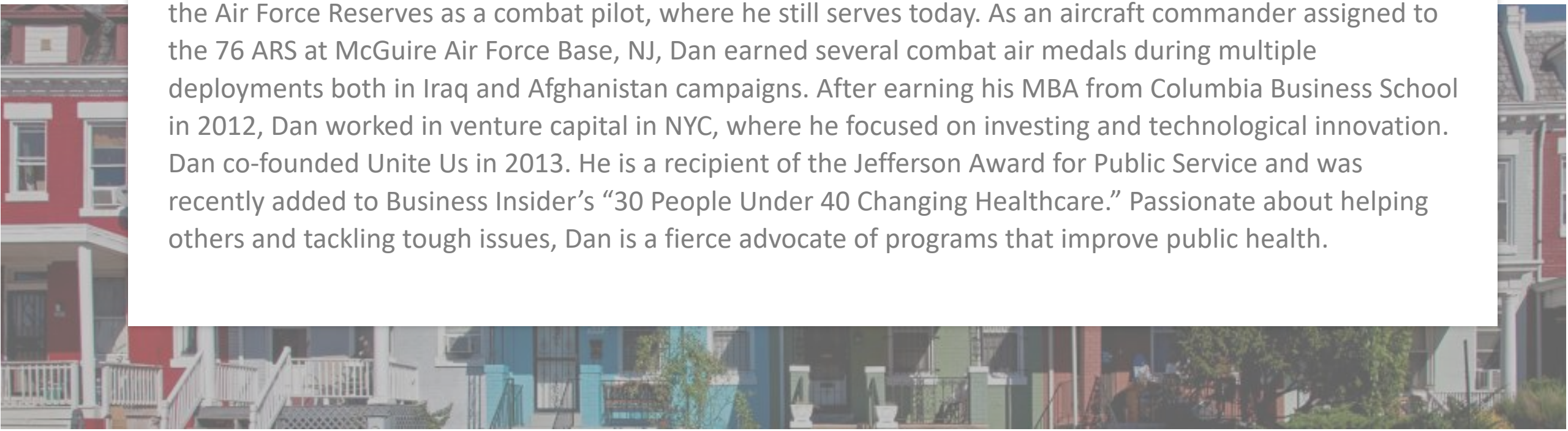
Lessons learned – the Network is necessary

- Siloes or regional efforts ***will fail:*** health plans need to interact with a state-wide organization
- Our model supports the creation of regional business units that retain autonomy, but use the power of shared resources
- Our model captures intervention data consistently and accurately across NYS to measure performance and maintain accountability
- We can demonstrate correlation of social interventions with improved health/reduced cost

Speakers

Daniel Brillman, CEO and Co-Founder, Unite Us

Dan Brillman graduated from Yale University in 2006 and worked in finance and consulting before joining the Air Force Reserves as a combat pilot, where he still serves today. As an aircraft commander assigned to the 76 ARS at McGuire Air Force Base, NJ, Dan earned several combat air medals during multiple deployments both in Iraq and Afghanistan campaigns. After earning his MBA from Columbia Business School in 2012, Dan worked in venture capital in NYC, where he focused on investing and technological innovation. Dan co-founded Unite Us in 2013. He is a recipient of the Jefferson Award for Public Service and was recently added to Business Insider's "30 People Under 40 Changing Healthcare." Passionate about helping others and tackling tough issues, Dan is a fierce advocate of programs that improve public health.




UNITE US
We connect health
and social care.

Public Health 2.0

What began as a solution for Military Veterans has grown into a national movement to **connect everyone to the care they need.**

Unite Us was founded in

2013

Today, we power health and social care in

35+ states

A solution at scale, our partners include:

and many more.

The Infrastructure

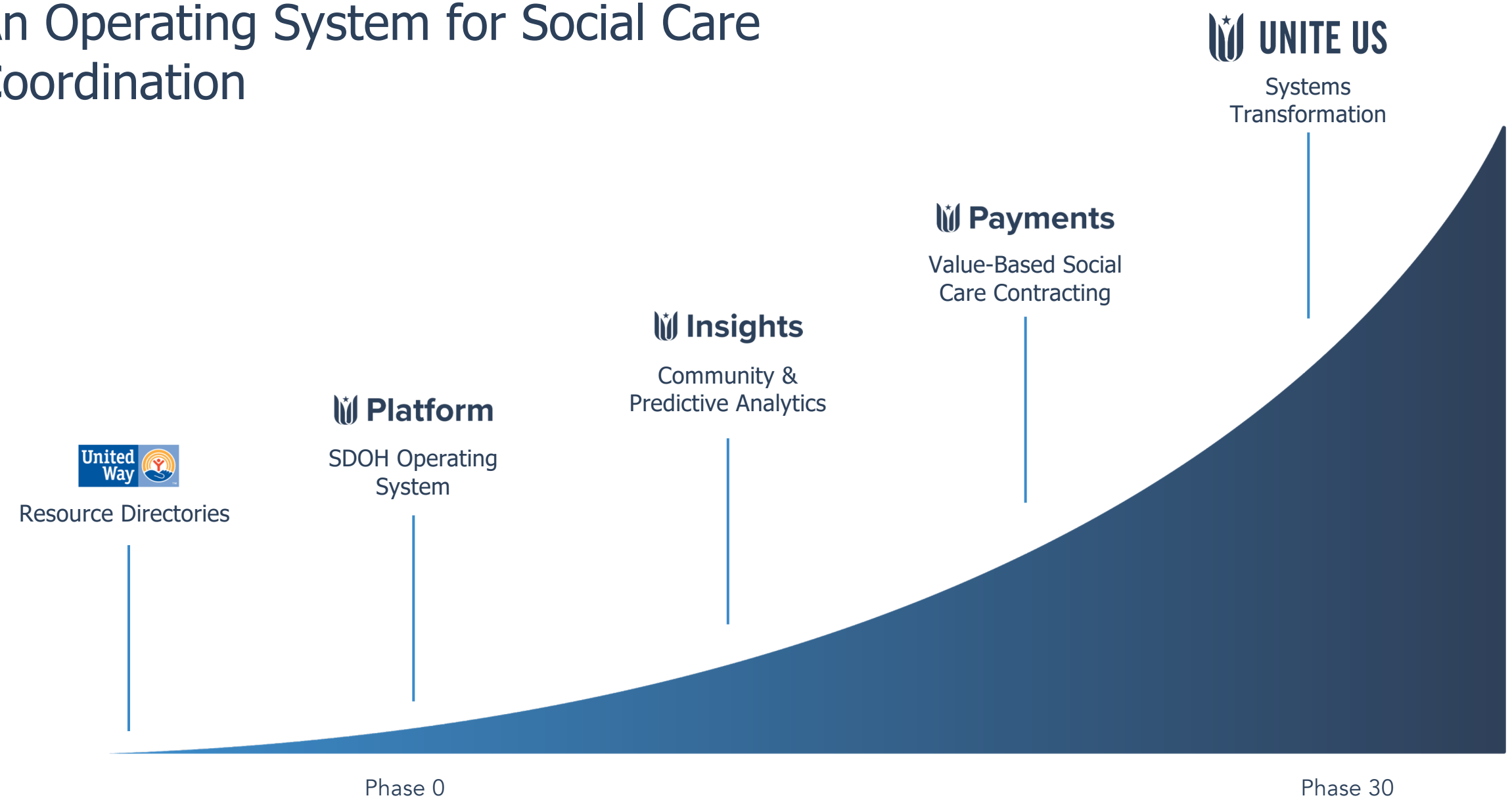
A person-centered, community-based system, where:

People are easily **connected to the *right* service, quickly and efficiently.**

Service providers can **view, coordinate, and collaborate** on their clients' care beyond the services they provide.

Outcomes data is tracked and leveraged to demonstrate impact, increase visibility of gaps in services, and improve access to services for all.

An Operating System for Social Care Coordination



Platform

Spanning a single continuum of care across healthcare and social services

On-the-ground Expertise

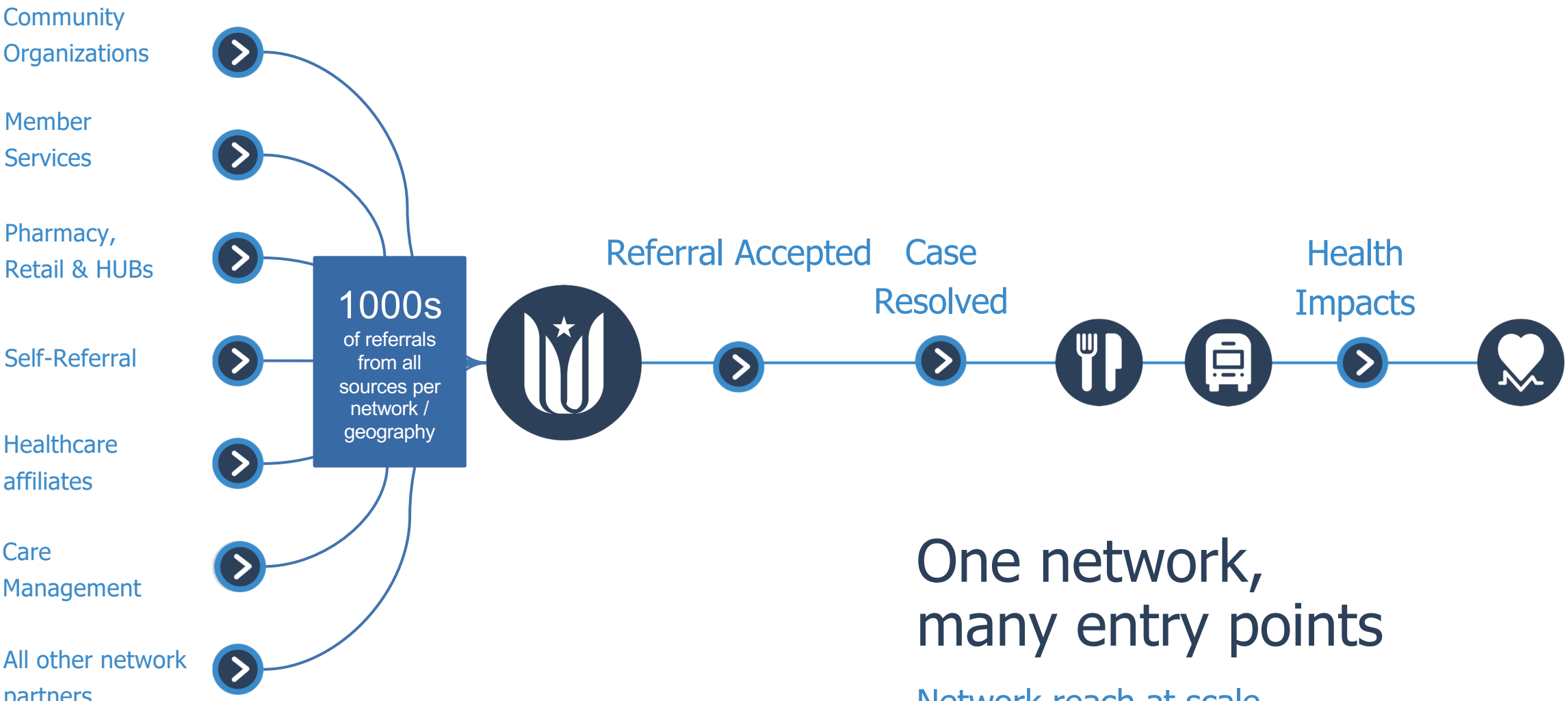
We deploy our implementation team to each community to build quality and accountable coordinated networks of health and community services.

Technology Platform

Our flexible and scalable platform helps all network partners track every step of each patient's total health journey inside and outside their four walls.

We do the heavy lifting so you don’t have to.

Challenge	Our Solution
Complex pre-existing community landscapes	Flexible network design
Building trust, community adoption and ownership	Change management and hands-on approach
Barriers to data-sharing	Consent & permissions driven platform



One network, many entry points

Network reach at scale

UNITE NEW YORK

Unite New York is a statewide network that connects health and social care providers. Unite New York brings together local community networks from across the state.

Including:

- Healthy Together
- ADK Wellness Connections
- Unite NYC
- CNYCares Referral Network
- 360 Collaborative Network

Healthy Together
Referral Network of Alliance for Better Health

ADK WELLNESS CONNECTIONS

360 COLLABORATIVE NETWORK

UNITE NYC

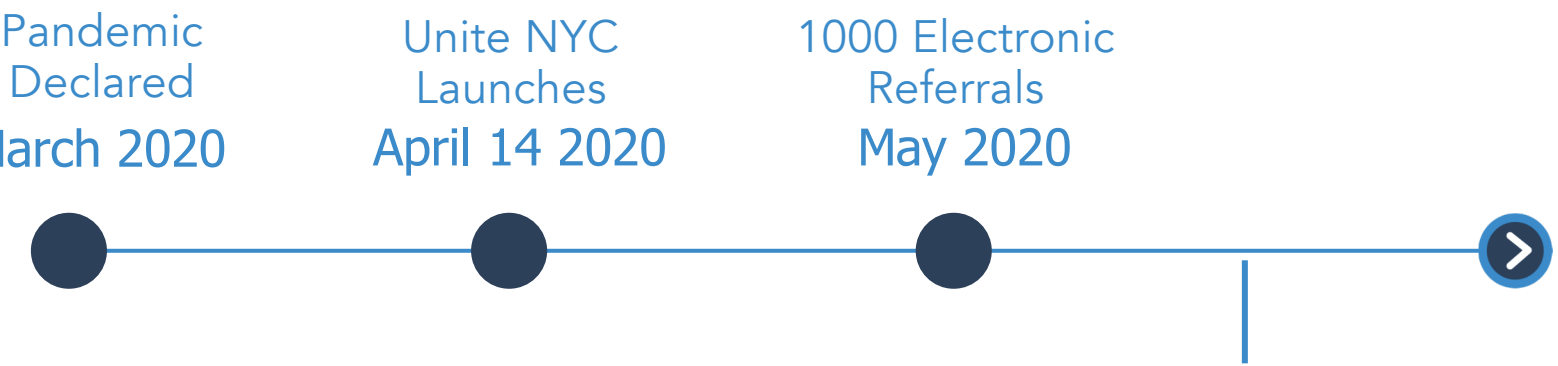
CNY CARE COLLABORATIVE

UNITE NYC

AIR nyc | Healthy has an address

Public Health Solutions

Unite NYC is a coordinated network of more than 100 organizations that launched in response to **COVID-19** to address emergency needs of New Yorkers.



93%

acceptance rate on all electronic referrals

Co-occurring Needs Analysis

What co-occurring needs and services are commonly being fulfilled in the network?

Service Type	Clothing & Household Goods	Employment	Wellness	Transportation	Substance Use	Mental/Behavioral Health	Legal	Income Support	Housing & Shelter	Benefits Navigation	Utilities	Individual & Family Support	Food Assistance	Social Enrichment	Physical Health	Money Management	Entrepreneurship	Education	Sports & Recreation	Health	Spiritual Enrichment
Clothing & Household Goods	826																				
Employment	90	1,376																			
Wellness	7	19	53																		
Transportation	68	66	7	419																	
Substance Use	8	8	4	6	31																
Mental/Behavioral Health	36	81	24	24	10	305															
Legal	39	73	14	22	8	47	624														
Income Support	93	225	14	63	11	73	75	1,399													
Housing & Shelter	173	314	17	121	9	87	119	267	2,600												
Benefits Navigation	98	202	12	69	10	74	79	236	332	1,651											
Utilities	44	59	11	33	5	23	24	72	119	55	422										
Individual & Family Support	54	98	12	36	5	45	41	88	127	105	34	516									
Food Assistance	190	118	9	85	5	38	39	125	212	113	78	62	573								
Social Enrichment	24	184	7	20	6	32	22	62	80	75	11	37	28	603							
Physical Health	30	43	12	28	9	36	28	50	77	97	29	30	39	20	354						
Money Management	25	49	6	12	2	25	25	55	65	47	21	29	21	27	15	233					
Entrepreneurship	2	13	0	2	1	5	2	12	6	9	1	6	3	5	4	2	56				
Education	16	129	10	17	5	21	21	43	59	59	18	37	24	34	22	14	5	281			
Sports & Recreation	5	21	8	4	2	14	5	10	14	11	3	20	9	20	11	7	0	13	66		
Health	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	3	
Spiritual Enrichment	3	1	2	0	1	4	2	1	2	3	2	1	1	3	2	1	0	1	2	0	5

NCCARE360

LIVE IN **100** COUNTIES

Implementation team formed
January 2019

Launched in three counties
March 2019

2000 electronic referrals
January 2020

1000 network partners
May 2020

Live statewide
June 2020

FOUNDATION FOR HEALTH LEADERSHIP & INNOVATION

Expound

NCDHHS

NORTH CAROLINA 211

United Way of North Carolina

One Medicaid Member's Journey

Due to COVID-19, a member was released from incarceration, Then he tested positive for COVID-19. He did not have stable housing, so his mother rented a home for him to quarantine.

Day 1

A health plan case manager identified that this member had several co-occurring needs.

That day, the case manager sent electronic referrals to network partners via Unite Us.

Day 3

Resolved

Within three days, the member was connected with an organization who was able to set him up with a new PCP as well as drop off basic housing supplies, medical equipment, and bikes for transportation.

Beyond

The member has successfully made an appointment with his new PCP. The same organization was also able to assist him with employment referrals and continues to provide ongoing support.

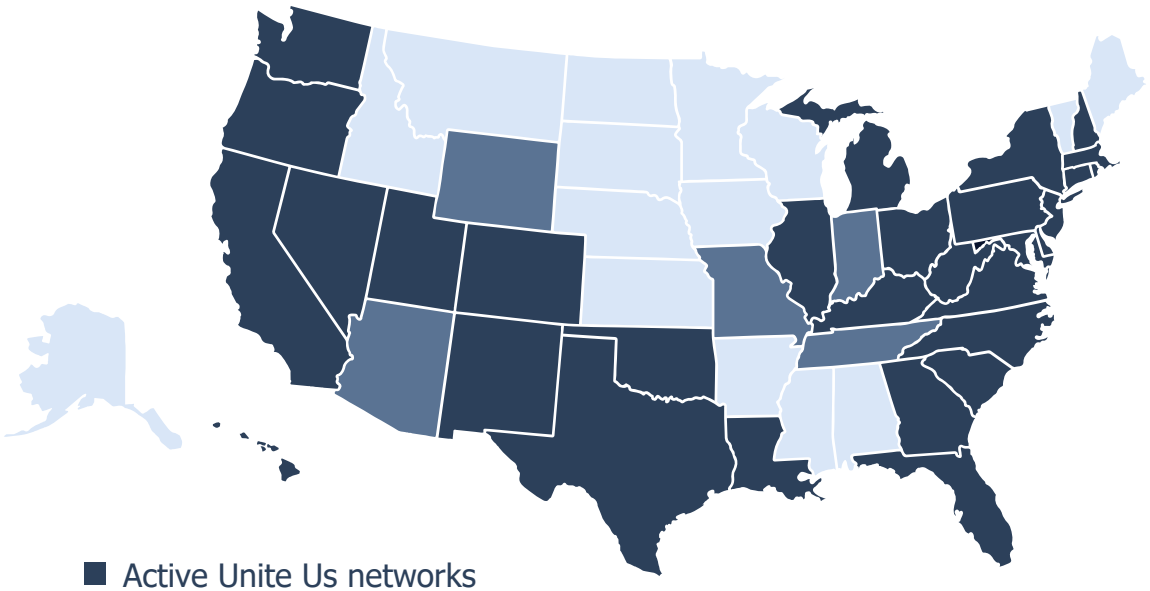
Insights

Gain actionable insights into:

- Network Partner Activity
- Service Demand and Delivery
- Co-occurring and Re-occurring Needs
- Network Efficiency and Impact
- Detailed Structured Outcomes

Our Connection to this Work

Our digital infrastructure supports individuals seeking services across the nation.



- Active Unite Us networks
- Unite Us networks in progress
- No active networks

UNITE US

Get in Touch

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Q&A

Aligning for HEALTH

Thank You!

Questions?

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