

HARM REDUCTION IS HEALTHCARE: SUSTAINABLE FUNDING FOR HARM REDUCTION PROGRAMS

*A Healthcare Financing Workbook for
Harm Reduction Organizations*





QVHD, New Haven, CT. Photo credit: Graham MacIndoe

Whether you're new to healthcare financing or have tried and didn't get anywhere, we know that being on the deliverable treadmill is tiring and the dollars aren't always reliable. This self-assessment tool is for leaders of harm reduction programs who are looking for guidance on how to internally and externally assess opportunities to pursue healthcare financing for their program.

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National Harm Reduction Coalition, Vital Strategies, Anka Consulting, and In The Works partnered to produce the “Harm Reduction is Healthcare: Sustainable Funding for Harm Reduction Programs” toolkit because we’re committed to seeing harm reduction grow and thrive--and there is a unique opportunity unlike ever before to pursue healthcare financing. We’ve been leaders of harm reduction programs and know how exhausting the deliverable treadmill and precarious public health dollars can be. Not only is it possible to pursue healthcare financing in a way that doesn’t burden your organization with administrative or billing logistics, but the healthcare systems *need* harm reduction programs to partner with to better close the gaps on the continuum of care. This toolkit was designed for leaders of harm reduction programs and was conceptualized with the input of harm reduction leaders across the country.

INTRODUCTION

SUSTAINABLE FUNDING FOR HARM REDUCTION PROGRAMS

Forward by Dr. Kimá Taylor, MD, MPH

The overdose crisis, COVID-19, budget cuts, racial justice, and the counter-protests have created opportunities for the inclusion of high-quality culturally relevant harm reduction services. The opioid overdose crisis opened the door to public health and healthcare systems to even consider harm reduction, but this was predominantly because the opioid overdose crisis was thought to reside within white communities; communities that were deemed unexpendable. COVID-19 made policymakers finally see longstanding racial and ethnic health and economic inequities within our systems, while the murders of George Floyd, Breonna Taylor, and Duante Wright and the subsequent protests have forced sustained attention towards rethinking the country's racist past and policing. Budget cuts following COVID-19 will place even more urgency on healthcare systems to find savings and/or contain costs, ultimately leading to expanded pay for value programming. This systemic churn offers a small window of opportunity for harm reduction providers to engage in partnerships with healthcare payers that would provide comprehensive sustainability funding.

While foundation and state block grant funding will always be an appreciated and important part of most Syringe Service Programs (SSPs) and other harm reduction



Dr. Kimá Taylor, MD, MPH

service provider budgets, SSPs are well suited to pursue a healthcare financing strategy as well. SSP's services benefit social, health, and public health system clients as well as those systems' bottom lines. Many physical healthcare payers and providers have little to no ability, or history, of effectively working with and engaging people who use drugs. Case management, care coordination, outreach, engagement, public health screening, physical health, and substance use services at SSPs offer connection and services to communities and people who health systems have refused to engage in the past. Prior to the

Affordable Care Act (ACA) their clients were uninsured and deemed costly and less valuable by the health, public health, and justice systems. Following the ACA, many clients have Medicaid or other insurance, and payers are now financially responsible for their health.

History has long demonstrated that merely having coverage is not the same as receiving respectful high-quality culturally and linguistically effective care that leads to equitable outcomes. The powerful healthcare system is rife with examples of inequities; most recently maternal child health mortality and morbidity is in the papers. This is just one example of inequitable outcomes based on race and ethnicity. Sustainable payment for harm reduction will require a deconstruction of healthcare system racism and bias towards people who use drugs. It will require diverse advocates of all types, including those who are currently using drugs, to hold the health and public health system to account to ensure equitable access to, and outcomes from services; lest this endeavor be yet another system where white people will benefit and others will not.

This work is complex and can seem exhausting, but is not impossible. This workbook and course are not meant to obscure the work needed to accomplish the goal, but to provide guidance to make that work a bit easier, effective, and inclusive of a racial justice lens. The goal of the brief is also to promote a new type of engagement, not the fee-for-services pathway which, while rewarding in some places, is not the current wave in healthcare financing. The new wave is focused on payment for equitable holistic outcomes with an eye (sometimes with a principal goal) of creating cost savings. It is with this lens the workbook and course provide guidance for engagement.

Pursuing a financial sustainability strategy with an outcomes-based lens requires SSPs to define their mission as it relates to healthcare relationships, define their work, cost the services out, and be able to articulate their value proposition in health care terms. Value proposition in hand, they must next identify which health care players offer the best reciprocal benefits and educate these potential partners about harm reduction services, ultimately seeking beneficial contracts. During the identification phase, SSPs need to carve out time to meet new players, understand their motivations and concerns, and build advocacy and content partners. So much of healthcare policy, practice, and programming is based on relationships.

At the same time, SSPs must remain somewhat cautious. The same events that have opened a window are also leading to unrealistic expectations or smaller organizations not fully benefiting. People want easy answers for complicated situations. SSPs must be sure not to overpromise in such an environment or they will lose their credibility and, ultimately, the funding. Harm reduction programs should exercise caution when promising returns on investment or changes in community health curves; they should likely start with cost containment and individual health engagement improvements. They must make sure they identify short, medium- and long-term process and health outcome measures so they are not judged solely on their ability to get people to enter treatment.

An equity lens means recognizing the strengths and shortfalls of your program in addressing the needs of BIPOC, undocumented, LGB/TGNC+, disabled, and otherwise marginalized participants. These groups are not monoliths, and promising to meet the needs of all

communities is unrealistic, sets your organization up for failure, and leaves communities without access to high-quality services. SSPs should lead with an equity lens but, should not pretend they can serve all populations with one model. If they have a history of providing culturally and linguistically effective services to diverse communities they should lead with this accomplishment. If not, they should take the time to learn how or recommend other service providers.

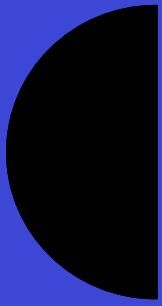
The past two years have been painful in so many ways, but opened the eyes of many to longstanding racism, inequities and injustices within our government funded systems. Patient centered and culturally effective harm reduction organizations must take this time of turmoil to create financially sustainable relationships with health care and other systems that will lead to improved outcomes and help individuals thrive.



Left: Quinnipiack Valley Health District, New Haven, CT. Right: Red Project, Grand Rapids, MI. Photo credit: Graham MacIndoe

The purpose of this tool is to...

- ▶ (Re)consider how building new or different types of relationships with healthcare entities is a worthwhile endeavor to create sustainable funding and partnerships for years to come
- ▶ Create a value-proposition that outlines the value of the services your organization offers using healthcare language
- ▶ Guide conversations with key community stakeholders in your organization to assess the opportunities, potential drawbacks, and roles people need to take to move forward
- ▶ Create an action plan to build relationships with potential healthcare partners that can lead to healthcare financing opportunities for your organization



STEP 1

LEARN & REVIEW THE BASICS OF HEALTHCARE FINANCING

We heard from the community that in order to understand pathways for healthcare financing, you need to better understand how healthcare financing actually works. We've gathered and created some additional tools as a way to orient yourself to the system and options before exploring which ones may work best for your program.

Harm Reduction is Healthcare E-Course (Free!)

Not sure how the healthcare system works? Busy running a program and haven't kept up with the many changes of the Affordable Care Act or Medicaid Expansion? Have team members who need a crash course so they can participate in conversations? We've got you covered. We recommend that you take our [90-minute e-course](#) to refresh your memory, and get inspired by some case studies from your peers.

Harm Reduction is Healthcare Overview

After you've reviewed the e-course, we created a [simple handout with some key explanations](#) for you to keep on hand for yourself or team members who are part of your assessment.

Harm Reduction is Healthcare Quick Reference Glossary

We created a [quick reference glossary of terms and processes](#) that are commonly referred to throughout the e-course and in conversations about healthcare financing.

Harm Reduction is Healthcare Templates

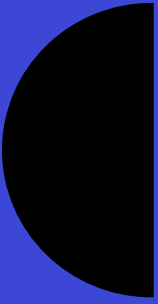
A [google drive with templates of the assessments and tools](#) included in this workbook.

Tool for Organizational Self-Assessment for Racial Equity

It's 2021 and if your organization hasn't taken a look at how you're centering racial equity in your mission, decision making, and organizational structures, you're late. We've included a [link to a tool](#) created by [Coalition of Communities of Color](#) to conduct your own self assessment so as you're navigating your value proposition, partnerships, and how to address inequity in access to health services, you're keeping that front and center.

Medicaid Expansion in Your State

Since every state is slightly different in their rules and regulations around Medicaid expansion. Bring yourself up to speed on details specific to your state using the [Kaiser Family Foundation Medicaid Expansion interactive map](#).



STEP 2

ORGANIZATIONAL READINESS ASSESSMENT

Who should fill this out:

The leader(s) of the organization who can see the 30,000 foot view across the organization in the areas of mission, programming, finance, community, partnerships, and governance.

For institutional memory, support, and leadership development, we encourage you to bring in mid-level managers early in the process to learn how these decisions get made and offer opportunities for input and buy-in upfront.

Directions:

Fill in the blanks with the numbers that best describe where your organization is in relation to the activities and structures listed below.

- 1- No and/or doesn't exist
- 2- Yes, we have done some work but it's very limited and/or no operationalized
- 3- Yes, we're working on it but it's not our strongest area
- 4- Yes, and it's one of our strongest areas of work

Before you jump into this, think about what you may need to do with your team to define some of the terms and what it looks like to operationalize some of these values.

Mission & Values	1	2	3	4	NA
1. Do you have a written mission statement that accurately reflects the work that your organization does today?					
2. Do you have articulated value statements for how your organization approaches its work?					
3. Do you have an articulated racial equity statement on how your organization centers racial equity?					
4. Do you aim to serve individuals who are uninsured or underinsured?					
5. Do you aim to serve individuals who may have co-occurring physical or mental health conditions?					
6. Do you offer your services in locations or venues where there are people who may be disconnected from social and healthcare services? (e.g. tent cities/encampments, single-resident-occupancy hotels)					
7. Are you the go-to organization in your geographic area that offers low-threshold services for people who use drugs?					
8. Do you have a mechanism in place like a participant advisory board or consumer advisory board to get ongoing feedback from people who receive services?					

Services	1	2	3	4	NA
1. Do you offer a space for people who use drugs to congregate?					
2. Do you offer a space for people who trade sex to congregate?					
3. Do you offer services specifically for people at other intersections of oppression? (e.g. LGBT, TGNC, people living with disabilities, non-English speakers, immigrants, pregnant or parenting people)					
4. Do you offer mobile-based services?					
5. Do you offer walkabout/street-based outreach-based services?					
6. Do you offer services-based outreach (e.g. outreach to emergency departments, re-entry programs, defenders offices, LEAD initiatives)?					
7. Do you have a community-level rapid response plan for overdose spikes?					
8. Do you offer preventative health services that can reduce negative health outcomes? (e.g. vaccines, syringes, naloxone, wound care supplies)					
9. Do you enroll folks in social service or healthcare benefits?					
10. Do you offer individual one-on-one services for case management?					
11. Do you offer one-on-one services for behavioral health counseling?					
12. Do you offer any one-on-one services for healthcare-specific health education? (e.g. not physical health services but discussion on how to reduce injection related infections, overdose prevention, etc)					
13. Do you offer any one-on-one services for healthcare-specific care coordination? (e.g. setting up medical appointments, locating specialists, going to provider appointments, coordinating prescription pick up or requests to external providers)					
14. Do you offer any one-on-one services for healthcare specific medical services? (e.g. HIV or hepatitis C testing, wound care and treatment of abscesses, PrEP)					
15. Do you offer any one-on-one services for medical treatment services? (e.g. general visits with an MD/PA/DO/NP, onsite hepatitis C treatment, buprenorphine treatment, prescriptions, vaccines, COVID-19 testing, reproductive health services including but not limited to contraception, pap spears, Plan B prescriptions)					
16. Do you offer any group-level services for healthcare specific topics? (e.g. hepatitis C support groups, diabetes management groups, sexual assault support groups, trauma-informed groups)					

Continued on the next page

Staffing	1	2	3	4	NA
1. Do you have adequate staff to serve the existing services during your current hours?					
2. Do you have existing medical or services billing staff? (e.g. billing and coding specialists)					
3. Do you have existing staff to manage data and reporting?					
4. Do you have existing staff to conduct QI and QA?					
5. Do you have existing staff to create and manage contracts with funders (healthcare payers, foundations, and government entities)?					
6. Do you have leader(s) in the organization who are familiar with and committed to building partnerships with healthcare entities?					
7. Do you have a leader(s) in the organization who have already or can map out potential healthcare entities to partner with to build relationships?					
8. Do you have a consultant or team member who can offer staff clinical supervision?					
9. Do you have any credentialed staff (e.g. peer credentialed staff like “certified recovery specialists”, LCSWs) to offer behavioral health services?					
10. Do you have any credentialed consultants (e.g. “certified recovery specialists”, LCSWs) to offer behavioral health services?					
11. Do you have any credentialed staff (e.g. MD, DO, NP, RN, PA, MA) to offer medical services?					
12. Do you have any credentialed consultants (e.g. MD, DO, NP, RN, PA, MA) to offer medical services?					

Systems	1	2	3	4	NA
1. Do you collect socio-demographic data (age, race, ethnicity, gender) for individuals who access care coordination or one-on-one services outlined above?					
2. Do you document services that you provide as outlined above? (e.g. written charts, outreach forms, electronic health records)					
3. Do you currently use an electronic health record system?					
4. Do you currently have a system in place for tracking referrals for people to external services for healthcare, housing, job training, or other services?					
5. Do you have a system for reporting on contract deliverables to funders and/or health departments?					

Continued on the next page

Relationships	1	2	3	4	NA
1. Are you already formally partnered (e.g. have an MOU and do bi-directional referrals with ongoing communication) with a healthcare clinic in your area?					
2. Are you already formally partnered (e.g. have an MOU and do bi-directional referrals with ongoing communication) with a hospital system in your area?					
3. Overall, are these partners mission-aligned, equity-focused, and effective?					
4. Does your organization sit on any existing community health committees (e.g. hospital community advisory board) with a local health system?					
5. Does your organization have any individuals on your board that are affiliated with a potential health system partner?					
6. Is your organization part of any coalitions or multi-organization grants with other healthcare providers or entities?					

Sustainability (thinking about the next 3-5 years...)	1	2	3	4	NA
1. Do you anticipate any funding gaps following COVID-19 emergency funding you may have received?					
2. Do you have sufficient funding for your program to operate its existing hours and services?					
3. Do you have a balance of funding between government, non-government foundation/private grants, individual donors/donations, and fundraising that if one was cut significantly you would still be able to operate without major disruption?					
4. Have you expanded your services to keep up with the growing volume of participants seeking your services?					
5. Have you expanded your services to keep up with the type of services that are needed to offer more comprehensive care?					
6. Have you been approached to be acquired or merged with a larger organization in your area?					



Reflection Questions:

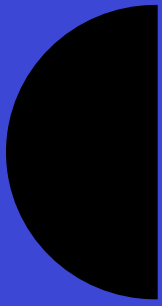
1. What were the three domains above that had overall higher numbers and may be your organization's strengths?
2. What were the three domains above that had overall lower numbers and may be your organization's limitations?
3. Do you think that working with a healthcare entity could help strengthen your organization's current limitations? How so?



**Looking for organizational support and technical assistance?
Stay updated with Vital Strategies and National Harm Reduction
Coalition by joining their email lists.**

Vital Strategies: www.vitalstrategies.org

National Harm Reduction Coalition: www.harmreduction.org



STEP 3

MAPPING OUT BILLABLE SERVICES

In the *Harm Reduction is Healthcare E-Course* (see Step 1) we described how many services that harm reduction programs offer that may be directly billable and/or valuable to healthcare systems in achieving their health outcome goals via value-based payments.

Directions:

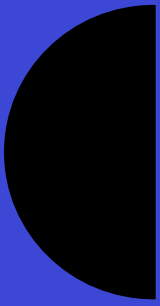
Using the chart on the next few pages, take a deeper dive in your services to clearly map out what you currently offer and what you could potentially offer with additional funding. Remember, this isn't about determining the maximum amount your team could accomplish! This is about figuring out what is doable so that your organization has an idea of what is realistic. At the end of the day, you do not want to over-promise for services that you will not be able to fulfill. If you prefer to type in your responses and share with others, [click here to download the accompanying Google Document template](#).

Services	Current Offer	Potential Offer	Estimated Services per Month	Estimated Clients Served per Month
<u>Preventative Services</u>				
Naloxone				
Vaccines - Hepatitis A/B				
Vaccines - COVID-19				
Vaccines - Flu				
Vaccines - Other				
Other				
<u>Home & Community Based Services (HCBS)</u>				
Enrollment in Benefits				
Adult Day Services				
Engagement Services				
Case Management-Support				
Case Management-Care Coordination				
Case Management-Care Navigator				
Other				
<u>Behavioral Health Services</u>				
Psychosocial Assessments				
Counseling - In-Person				
Counseling - Telehealth				
Support Groups				
Other				

MAPPING OUT BILLABLE SERVICES

Services	Current Offer	Potential Offer	Estimated Services per Month	Estimated Clients Served per Month
Medical Services				
Wound Care & Treatment				
PrEP/PEP				
HIV Testing				
HIV Treatment				
Hepatitis C Testing				
Hepatitis C Treatment				
STI Testing				
STI Treatment				
Reproductive Health Wellness Checks (e.g. birth control or Plan B Rx)				
Pap Smears				
General Well-care Visits				
General Labs				
Drug Treatment - Buprenorphine				
Other				
Other				
Other				
<i>Peer Support Services Provided by credentialed peer workers and may overlap with HCBS above, see your state guidelines</i>				
General Wellness & Coaching Specific to Recovery				
In-person Advocacy/Navigation to Appointments				
Support with Enrollment in Benefits				
Support with Housing Placement				
Support with Job Training				
Other				
Other				
Other				

MAPPING OUT BILLABLE SERVICES



STEP 4

MAPPING OUT WHAT IT TAKES TO GET PEOPLE TO SERVICES

You've mapped out the service categories you offer (or could potentially offer with additional funding/support) that fall into the billable services category. Whether or not you decide to pursue direct billing on your own, it's helpful to have these services mapped out when you partner with healthcare entities. But we know that it takes a lot to actually get to services. Harm reduction programs have the trust, rapport, and the experience to work with people who healthcare systems are trying to reach.

Who should be at the table for Step 4:

People on your team who are doing the day-to-day outreach, drop-in center management, linkage to care, and/or case management are the *second* best to talk about what it takes to successfully navigate someone to a service from start to finish. The best people to talk to are people receiving services themselves. In this step, we encourage you to meet with both people who consume harm reduction services, and people who support that process, to get in touch with what it takes.

Directions:

You will find facilitator guides for three different groups below: care coordination team members, people who receive services, and the leadership team who are making decisions about service expansion. We recommend that you carve out at least 90 minutes to have these conversations with each of the groups. Once you're all in the same room for a discussion, share the purpose of the discussion and how it is related to the organizational work and decisions that you're considering. *We've offered time guidance to keep you on track with your discussion.*

[Click here to download the accompanying Google Document for note-taking.](#)

▶ Discussion questions for care coordination team members

Have the facilitator read out these questions and offer paper/pencil for individuals to write their own notes (15 minutes with ~1 minute per question)

Think about a time in the last month where you successfully got a person to access a healthcare service offsite that they requested

- ▶ How long have they been receiving services from our organization?
- ▶ What documents did that person already have? Were they insured?
- ▶ What was the service they were looking for? Did they already have a culturally and linguistically effective provider, or did you need to find them a provider too? Do you know if they like their provider?
- ▶ Why were they looking for that healthcare service? Was it preventative/planned? Was it a follow-up or something new?
- ▶ Once you had all of the information needed, how long did it take you to set up an appointment? How long was the wait for the appointment?
- ▶ Did you provide information about how to get to the appointment?
- ▶ Did we offer any incentives (e.g. gift cards, mutual aid funding, cash, vouchers) for support?
- ▶ Did we provide transportation assistance?
- ▶ Did you accompany them to the appointment? Or arrange for someone to accompany?
- ▶ Did the provider offer translation services (if applicable)?
- ▶ How do you know they received the services they requested?
- ▶ Start to finish, how much time did it take you to do this entire process? How many people were involved?

Have each person share back their story - discuss the following together (20-30 minutes)

Post Referral Process (15 minutes)

- ▶ Why do you think that it was successful? What did you offer that felt related to the success of getting to the appointment?
- ▶ Do you know how the person you referred was treated by the provider?

Potential Partners (15 minutes)

- ▶ Are there providers or places you are reluctant to send people to care? Why?

Team Support (15 minutes)

- ▶ What do you think would make it easier for you, in your role, to successfully get people the health services they request in a timely manner?
- ▶ What do you think would make it easier for people who are requesting services to get the services in a timely manner?



Discussion questions for people who receive your services

Think about the last time you were trying to receive services for something related to your health (20 minutes)

- ▶ What type of place did you receive care? Primary care doctor? Urgent care? Emergency Room?
- ▶ [If applicable] How easy was it to get the appointment? Did you do it yourself or did someone here support you with it?
- ▶ Did you have the documents that you needed? What were they?
- ▶ (If insured) Did you have any issues with your insurance?
- ▶ (If insured) Did you have any unexpected costs from the insurance (like co-pays)?
- ▶ (If uninsured) Have you avoided going to get health services because you don't have insurance?

Access to Healthcare Services (20 minutes)

- ▶ What makes it easier to get to health services?
- ▶ What makes it more difficult to get to health services?
- ▶ What could we offer that would make it easier for you?
- ▶ What do kind, compassionate, healthcare services look like to you?
- ▶ What do you want to know about a provider before you see them?

Preferred Providers (20 minutes)

- ▶ Are there providers that you have found (outside of referrals with our organization) that you like?
- ▶ Do you have clinic sites that you go to that offer compassionate and accessible healthcare services?
- ▶ Do you have hospital-based sites that you go to that offer compassionate and accessible culturally and linguistically effective healthcare services?

Expanding Our Services (30 minutes)

- ▶ If we were to expand health services at our site, what would be your top five priorities for what we could offer (onsite or mobile-based)?
- ▶ [Alternative activity] Hand out notecards and ask individuals to rank their prioritized for what services they would like to see at your site.
- ▶ [Alternative activity] Hand out pre-printed pieces of paper that list services that your organization is considering and ask people to rank them in order of priority.
- ▶ How would you feel if we started to ask for insurance information for some types of services? Are there services you'd feel more comfortable sharing your information versus others?
- ▶ What else do you think we should consider as we think about expanding health services?



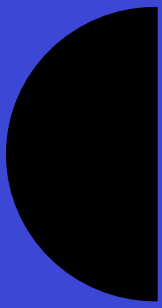
▶ **Review the themes from the responses from your care coordination/outreach teams and people who receive services. Answer the following questions:**

Review the themes from the responses from your care coordination/outreach teams and people who receive services in advance of the meeting. Then answer the following questions as a team:

- ▶ What are our care coordination/outreach teams offering to support people in receiving healthcare services? *(20 minutes)*
 - ▶ Care coordination/outreach teams said:
 - ▶ People who receive services said:
- ▶ What are people reporting as barriers to getting people into care? *(20 minutes)*
 - ▶ Care coordination/outreach teams said:
 - ▶ People who receive services said:
- ▶ What did people who received services share that they experienced as kind, compassionate, healthcare? *(20 minutes)*
- ▶ What did people who received services share that they wanted to know about a provider in advance? *(10 minutes)*
- ▶ What did people who received services say were their top priorities for services if we were to expand? *(10 minutes)*
- ▶ What are your high level takeaways from these two groups about how we should proceed with expanding health services or partnerships? *(10 minutes)*



Great! You've thought about your organizational readiness, the services you offer, and the experiences your team and consumers have with getting healthcare services. You're ready to start framing your value proposition.



STEP 5

CREATING YOUR ORGANIZATION'S VALUE POSITION

Overview of Value Propositions

Value propositions are basically your pitch about what your harm reduction program offers that benefits the health system and community health outcomes at large. Harm reduction programs offer a huge value to health systems that are looking to offer consistent preventative healthcare to avoid high-cost treatment down the road.

Harm reduction programs are very often serving people who may have one or more of the following:

- ▶ Substance use and related potential adverse health outcomes (e.g. overdose risk, injection-related viral and bacterial infections)
- ▶ Substance use and potential desire to access drug treatment (e.g. buprenorphine, methadone, contingency management, cognitive behavioral therapy, motivational interviewing)
- ▶ Co-occurring chronic health conditions (e.g. chronic hepatitis, HIV/AIDS, high blood pressure, diabetes)
- ▶ History of repeat use of emergency health services for preventable incidents (e.g. endocarditis due to an untreated injection-related infection, overdose)

What Does a Value Proposition Entail?

- ▶ Telling the story of what services you are offering, to whom, why they are needed, and what are the outcomes.
- ▶ This assessment is more than just having a demographic list, though that is important as well; it is a deep dive on who is effectively served and where there may be need for improvement.
- ▶ Harm reduction programs should also lead with an equity lens but should not pretend they can serve all populations with one model; be specific to what you already know about disparities and how your organization works to address them.

Value Propositions are...

your pitch about what your harm reduction program offers that benefits the health system and community health outcomes at large

Example Value Proposition

*Check out this [powerpoint](#) from **Washington Heights CORNER Project** and how they started to frame their value-proposition to New York Presbyterian Hospital, which resulted in co-located services, co-funded positions, and receiving payments directly from the healthcare system for wrap-around services*

Facilitated Guidance on Setting the Stage for Your Value Proposition

Themes for your Value Proposition

As the leader of a harm reduction program you probably already know a lot of the components of what will go into your value proposition, but you don't know everything. This is the stage of this process where including stakeholders will be an entry point for buy-in early on when considering healthcare financing.

We have included the following questions to ask community stakeholders as you begin to form your value proposition.

Who should be in this conversation:

Executive leadership, board members, senior staff, care coordination staff. This activity can be done as a series of meetings with the same group of people or as an iterative process with different groups reviewing different pieces best suited to their area of expertise and governance.

Directions:

Review the following section topics and look back on your notes from Step 4. This is a great opportunity as a leader of an organization to cross check your responses to the following questions with your team and community member's expertise.

[If you prefer to type in your responses and share with others, click here to download the accompanying Google Document template.](#)

What goes into a value proposition?

- ▶ Missions & Values
- ▶ Services
- ▶ Staffing
- ▶ Systems
- ▶ Culture
- ▶ Partnerships

Discussion Questions for Community Stakeholders: Themes for your Value Proposition

Mission & Values

- What does your organization aim to address in your community?
- What are your core strategic areas of work?
- What are your core organizational values?
- Who does your organization serve directly?
- How does your organization center racial justice & equity?

Services

- What services do we offer to the community that nobody else offers?
- What wrap-around services do we offer that are related to improving community health?
- What services do we link to other providers in the community?
- What partnerships do we already have with other providers in the community?

Staffing

- What does our team look like in terms of capacity and strengths to offer care coordination and linkage to services?
- What skills do we already have onsite to offer health promotion, behavioral health, and medical services?
- How do we conduct outreach and engagement with people we serve?
- How much time do we spend navigating insurance enrollment/"turning insurance back on" in our existing care coordination services?
- How much time do we spend working with people to enroll or re-enroll in other services? E.g. SNAP, WIC, disability insurance, unemployment, housing-related programs
- What other support or capacity do we need to offer care coordination?

Systems

- What data do we already collect from people who receive services?
- Are there services for which we don't collect any data?
- Are there services for which we collect some data? What data?
- Are there services for which we need to collect data? What data?
- Can we disaggregate data? What do we know about everyone we serve vs. other specific people we serve because of what services they access?
- What services do we feel are crucial to continue to not collect identifying information?
- What systems do we already have in place to document and coordinate care services?
- What insurance or identification information are we already asking?
- What gaps do we already know exist in how we offer care coordination?

Discussion Questions for Community Stakeholders: Themes for your Value Proposition (cont.)

Culture

How would you feel if we were sharing your/participant identifying information with a potential health provider? Clinic? Hospital system?

What kinds of information feels okay to share?

Are there times where you would feel more comfortable sharing information depending on what the situation was? For example, if you had an abscess vs. experienced an overdose?

What would it mean to ask for people who receive services to share their insurance information with us?

How does asking for identification or insurance information impact our approach to offering low threshold services? When is it appropriate to ask for this information?

What would you want to know to be sure that your/clients' privacy is protected?

Partnerships

Do you have providers that we work with that you trust?

Who do you trust?

Who do you not trust?

What values feel important to you/the organization in building partnerships with healthcare entities?

Framing Specifically for Healthcare Entities

If your local health system (e.g. hospital, FQHC) were in a room with you and wanted you to describe what your organization specifically can offer to...

- ▶ Improve the health of the community at large
- ▶ Reduce hospital admissions or acute care episodes
- ▶ Improve care coordination and linkage
- ▶ Improve management of chronic conditions

... what would you say?

Reflection Notes:

What did you learn?

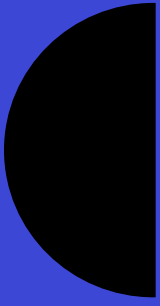
Writing Out Your Value Proposition

You've spent time talking to community stakeholders and collecting a lot of data. Now that you're immersed in the experience and values of your community stakeholders, let's start to write out your value proposition.

[Click here](#) to download a Powerpoint template for creating your own value proposition presentation

Get a full refresher of this course:

There's a lot of information here. From the Affordable Care Act to value propositions, we've got you! Go to bit.ly/HCFtoolkit for access to our full *Harm Reduction is Health Care: Sustainable Funding for Harm Reduction Programs* E-Course.



STEP 6

CHOOSE YOUR OWN HEALTHCARE FINANCING ADVENTURE

You've been deep in data collection, service mapping, and creating a value proposition. The next step is to map out and build partnerships with potential partners - but let's check that you've taken the steps to choose your healthcare financing adventure.

Go to the next page and choose your own healthcare financing adventure!

Are you pursuing direct billing of insurance?

yes

no

Have you discussed with your team about the culture and staffing capacity shifts that would be necessary to pursue direct billing?

Are you interested in pursuing partnerships with healthcare entities to receiving funding and ready to do work?

yes

no

yes

no

Do you know the breakdown of how people you serve are insured?

Go back and discuss with your team about the cultural, staffing capacity, and systems implications to pursue this option (page 21)

Have you had conversations with key community stakeholders and feel clear about your values around potential partnerships?

Sounds like you're not ready for this or it isn't a top priority - come back when you're ready or reach out for a consultation at [training@harmreduction.org](mailto:harmreduction.org)

yes

no

yes

no

Have you conducted a cost-benefit analysis with the information you have about existing and potential people to receive services by service type and rate of reimbursement?

Review your data and consider doing a short survey to assess type of insurance and basic demographics to better inform feasibility of direct billing

Have you created your value proposition document and/or presentation and shared with staff?

Go back to your notes and write out what would need to be in place for stakeholders to feel comfortable and in alignment with your organizational values; check in with members of those conversations for validation

yes

no

yes

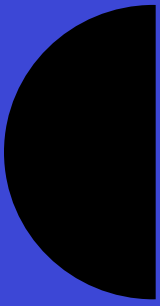
no

Direct billing is a feasible pathway for your organization! Move on to contracting

Write out the types of insurance and corresponding estimates of people you serve x the projected number of services and reimbursement rates to budget out the cost benefit

Great! You're ready to map out potential partners and set up meetings for further discussion

Go back to Writing Your Organization's Value Proposition (page 24)



STEP 7

MAPPING OUT POTENTIAL PARTNERS

High-Level Mapping

You've collected a lot of data and created a value proposition so look back to your earlier notes from conversations with your team and community.

Let's map them out to include the type of entity, name of the organization/entity, details of any existing relationship, overlap and areas for potential relationships, and next steps with contact information. We recommend doing this work with team members who offer care coordination services.

For an online google document version of this chart, [v](#)

Federally Qualified Health Centers (FQHCs)/Health Care for the Homeless Centers/Health Homes				
Name	Location(s)	Existing Relationship	Potential Relationship	Next Steps & Contact Info

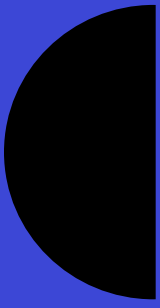
Hospital Systems				
Name	Location(s)	Existing Relationship	Potential Relationship	Next Steps & Contact Info

Do your research:

After you’ve mapped out your potential partnership options, start doing some research. Here are some tips we have for you regarding what to learn about each partner before you’re in the same room. In preparation for reaching out or connecting with individuals from healthcare entities, we recommend you do some of your own research.

Here are a few things to review to feel confident going into that meeting:

1. Review the healthcare entities website: note the language, types of programs that they feature on the front pages, and read their blog or news section to be up to speed on the kinds of work that is emerging, and any health needs assessments they have (or haven’t!) done
2. Review the healthcare entities partnerships: on their website or via a google search, note where the healthcare entity is partnering or sponsoring other community groups or causes in your neighborhood
3. Review the potential partner’s provider list for services that overlap or touch folks who receive your services: get familiar with any of the providers who offer infectious disease, adult medicine, addiction medicine, and HIV and hepatitis C treatment
4. Review how easy (or hard) it would be to make an appointment as a consumer: test it out as someone who has resources and make note of what was easy or difficult for you and how people you serve may experience the process. Note what you can bring to the table to make it easier.
5. Review the organization’s statement or work related to racial equity: what is the organization doing to reduce disparities and address racial equity in their services? If this is missing, ask about it. If it’s not, dig in deeper to ask about how they’re addressing these inequities intersecting with stigma related to substance use specifically for people of color.



STEP 8

SETTING AN AGENDA

You're almost there!

You've done your research. You've talked with community stakeholders. You have your value proposition ready. And you have some partners you're going to connect with next. But what do you talk about?

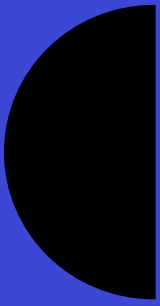
Here are some suggestions for an agenda.

Preparation & Setup

- If you have space, bring them to your site.** Don't shut down your drop-in center because you want to impress your potential partner. Keep it real. This is an opportunity to connect the dots of what your program actually does since it's possible they've never been to a harm reduction program.
- Give them a tour (in person or in photos) of where you offer services and where you conduct engagement.** You want potential partners to be able to imagine where your (potential) overlapping services and clients are as a way to see how you're already working in partnership, but just not in coordination. If you envision them coming and working in your site, show them where they would be and how it would work.
- Introduce them to your team!** Prep any of your team members who will be part of the meeting and give them specific areas of the agenda that they can be the content expert and play a role in the meeting. Potential partners are looking at longevity and institutional memory - building these relationships and visibility of people doing the work is great leadership development and gives a nod to commitment.

Suggested Items for Discussion

- Introductions of all team members** of your organization & the potential partner organization - names, pronouns, roles, how long they've been at the organization, and how familiar people are with each others work
- Orientation to a (brief) history of your organization** - when it was founded, how it has grown, the values that you center including racial justice and equity - and why you reached out to the potential partner
- Ask the potential partners to share why they were open to meeting** - what have they known about to date of your organization? Do they know any colleagues or people who have received services?
- What is the healthcare entity seeing in terms of people who may be accessing harm reduction services?** Are they seeing a lot of injection related infections? Overdoses? What are they offering already?
- Share more about your approach** to care coordination, case management, and general services here
- Share your **value proposition**
- What opportunities are there for collaboration?** Do they have any specific initiatives related to overdose prevention or other areas of overlap? Need for additional linkage to care and wrap-around services?
- What are the next steps to formalize our partnership?** What opportunities are there for participating in initiatives and being funded for coordinated wrap-around services? Who are the decision makers?
- Are there other forums, meetings, or people that your organization should be in contact with?**



STEP 9

ORGANIZE & ADVOCATE

We're calling this Step 9 but it's really a necessary and parallel process.

Every state is so different in terms of what is available, how regulations work, and available funds. And it's people at the state or local government level that dictate how and if regulations are adopted for what services are valued. There is power in numbers so get a seat at the table.

Here are a few tips to get started.

Read Up On Your State

- Do your research to understand what Medicaid expansion has looked like in your state - warm up your fingers and look up keywords like 'Medicaid Expansion' and 'value-based payments' + your state name
- Look up the departments of health and substance use authorities to understand the bigger structures (if you don't know this already)
- Read up on the carve ins / carve out structures for behavioral health services, pharmacy programs, and other benefits offered in your state
- Map out the major managed care organizations and see if you recognize them as insurance that your participants have
- Talk to your contacts at the municipal/local, county, and state health departments to understand where funds are flowing since they may have higher-level insight -and take the opportunity to remind them that they should be on top of this for opportunities for harm reduction programs!

Organize Harm Reduction Programs

- Connect with other harm reduction programs (if you aren't already) about healthcare financing opportunities and learn what others in your state are already doing
- Consider going through a process to map out your collective impact and services if you want to negotiate as a larger coalition/group/consortium
- Create a strategy together to map out the largest healthcare entities/organizations to organize meetings as a starting point of building a collaborative relationship that could lead to contracting and funding opportunities

Get a Seat at the Table

- Identify other places where you can take a seat at the table for harm reduction -including opportunities to be on task forces, working groups, offering public comment, and other places where there are decision makers in the room
- Talk about the value of harm reduction loud and proud at...
 - ▶ Webinars organized by public health departments on general public health topics
 - ▶ Community board meetings where there are usually representatives from health clinics and hospitals
 - ▶ Conferences or meetings on general community health, healthcare, public health, health equity, addiction, or anything labeled "community engagement" "reaching hard to reach groups" etc
 - ▶ Public testimony at city hall or capitol hill on legislation specific to insurance or treatment for people who are unhoused, using substances, etc

To learn more information about healthcare financing and support, you can visit:

[Vital Strategies](#)

[National Harm Reduction Coalition](#)

[In The Works](#)

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Photos provided by Vital Strategies' Overdose Prevention Program and photographer Graham MacIndoe. These photos are part of the photo documentary series highlighting harm reduction titled "*Love & Dignity: Portraits From the Front Lines of the Overdose Crisis.*"

GLOSSARY

Affordable Care Act (ACA): the comprehensive healthcare reform law enacted in 2010 that expanded the number of people who could get insurance, expanded Medicaid in some states to make more people are eligible, and shifted the value to prioritize quality, access, and cost containment.

BIPOC: Black, Indigenous, and People of Color

Federal Poverty Level (FPL): measure of income issues every year by the Department of Health and Human Services (HHS) and determine eligibility for certain programs and benefits such as Medicaid: see [here](#).

Medicaid: a federal-state insurance program that services low-income individuals of all ages with zero to low co-payments.

Medicaid expansion: expanding the eligibility of people who are eligible for Medicaid widening the income qualifications so that more low-income individuals and families are eligible to receive coverage under Medicaid.

Medicare: a federal insurance program that serves people over the age of 65, as well as some younger people living with disabilities.

Dual-eligible: people who are eligible for Medicaid (because of their income) and Medicare (because they are 65 or older and/or disabled).

Healthcare entity: a provider, clinic, insurance company “payer,” or hospital system that offers healthcare services.

Federally Qualified Healthcare Clinics (FQHCs): Federally funded to provide primary health care, social, and some specialty services to uninsured and underinsured populations, regardless of documentation. These clinics are required to serve folks, regardless of documentation, though historically they have not always been held accountable to this mandate. who are undocumented, but historically they have not honored this mandate.

Behavioral health: the promotion of mental health, resilience and wellbeing; behavioral health services may include the treatment of mental and substance use disorders and supportive services for people who are receiving services and their caregivers. Read more about behavioral health services [here](#).

Accountable Care Organizations (ACO's): a highly integrated system of providers who share patients as a way to better offer comprehensive, coordinated care for each patient.

Managed Care Organizations (MCO's): a healthcare company or a “health plan” that is focused on managing the overall healthcare of individuals as a model to limit costs, while keeping quality of care high.

- ▶ Some examples of MCOs you may have heard of health maintenance organizations (HMO's), preferred provider organizations (PPO), and exclusive provider organization (EPO). Each of these plans have different rules for who you can access services from, how you can get referrals for speciality care, and rates for payment.

GLOSSARY

Direct billing (or fee-for-service): collecting insurance information from someone to bill their insurance company for services that are provided, receiving payments from the insurance company based on rates that are set by type of service (varies depending on insurance).

Capitated payment: a fixed amount of money per patient per unit of time paid in advance to the healthcare service provided.

Value-based payments: reimbursement that focuses on how to prevent chronic diseases and hospital visits, aiming for high quality health coordination instead of fee-for-service; this is a value over volume model.

- ▶ **Pay for Performance:** Working with an insurer to receive a “capitation payment” (i.e. a fixed amount of money per patient per unit of time paid in advance to the healthcare service provider) for a desired outcome.
- ▶ **Bundled Payment:** Capitation payments where insurers pay both a set fee for a patient and pay you the amount needed for the provider to achieve documented improved outcomes for your patient population at a lower cost.
- ▶ **Shared Savings:** Partnering with a Health Home or other entity that has a specific list of people with two or more chronic conditions and agreeing to offer wrap-around services (e.g. care coordination, referrals, health education) as part of a “team approach” to support that individual stay in care and prevent adverse health outcomes.

Carve-ins/Carve-outs: Terms used to describe how behavioral health and substance use services were included in healthcare plans (“carve-ins”) or how they are excluded from a healthcare plan (“carve-outs”) and paid instead via fee for service by the state and managed by an MCO. Learn more [here](#) about Medicaid carve-outs for behavioral health since they vary state-to-state, and [here](#) for implementation stories and lessons learned.

Peer support services: also referred to as recovery support services are designed to offer peer-to-peer support by credentialed workers with lived experience. Services may include coaching, system/care navigators, and assertive community treatment (“ACT teams”) services. Learn more about peer support services [here](#) and check out your specific state peer support services [here](#).