NEW YORK STATE | Department of Health | Medicaid Redesign Team

Community Based Organization and Local Government Unit Engagement in DSRIP Implementation

Overview for Project Approval and Oversight Panel

January 4, 2017

January 2017

Agenda

- NYSDOH expectation/requirements for CBO and LGU engagement in DSRIP implementation and PPS progress across benchmarks to date
- Partner/provider categorization and CBO definition
- Scale of CBO and LGU engagement to date
- Examples of PPS approaches to engaging CBO and LGU partners

Goal of DSRIP is a fully transformed system with true systems alignment

- Addressing Social Determinants of Health through community partner engagement
- All systems that impact an individual's wellbeing are coordinated
- DSRIP and VBP break down silos within healthcare and build relationships with other sectors
- Working to create an environment that support the whole individual and the whole community

See August 2016, DSRIP – An Eye Toward the Future Whiteboard
https://www.youtube.com/watch?v=gAUqU7RSers

From the PPS application:

An effective governance model is key to building a well-integrated and high functioning DSRIP PPS network. The PPS must include a detailed description of how the PPS will be governed and how the PPS system will progressively advance from a group of affiliated providers to a high performing integrated delivery system, ***including contracts with community based organizations.***

Definitions of CBOs in DSRIP

Definition is determined by context:

- PPS provider networks:
  - Integrated delivery system requires linkages of hospitals with community-based providers and other community-based organizations.
- Speed and Scale:
  - Community-based providers with MMIS and NPIs fall into provider categories.
  - CBOs without MMIS or NPIs fall into CBO category.
- Quarterly reports - Contracting and engagement with CBOs
  - DOH is looking for contracts with **both** community providers and CBOs.

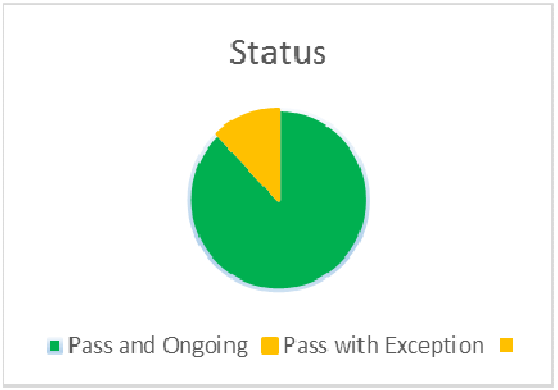
Value-based Payment Workgroup on Social Determinants and CBOs

Definitions in VBP Workgroup context:

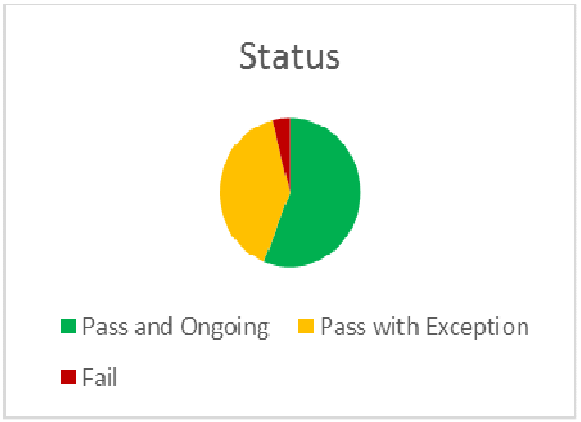
- **Tier 1 -** Non-profit, Non-Medicaid billing, community-based social and human service organizations
  - e.g. housing, social services, religious organizations, food banks
- **Tier 2 -** Non-profit, Medicaid billing, non-clinical service providers
  - e.g. transportation, care coordination
- **Tier 3 -** Non-profit, Medicaid billing, clinical and clinical support service providers licensed by the NYS Department of Health, NYS Office of Mental Health, NYS Office with Persons with Developmental Disabilities, or NYS Office of Alcoholism and Substance Abuse Services.

Organizational Milestones, Progress through DY2Q1

Governance Milestone 5: Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)



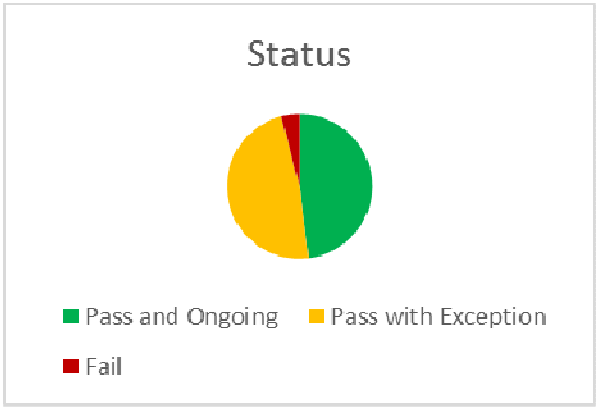
Governance Milestone 6: Finalize partnership agreements or contracts with CBOs



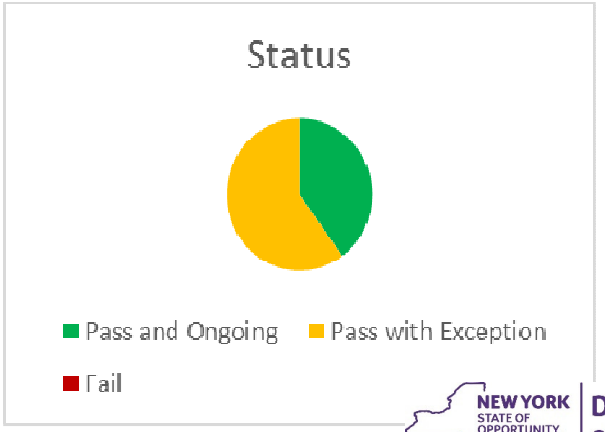
NEW YORK STATE OF OPPORTUNITY. Department of Health

Organizational Milestones, Progress through DY2Q1, cont'd

Governance Milestone 7: Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.)

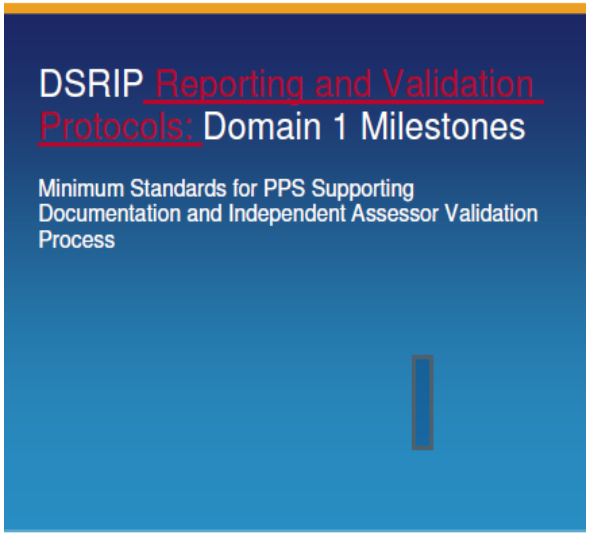


Governance Milestone 9: Inclusion of CBOs in PPS Implementation



NEW YORK STATE OF OPPORTUNITY. Department of Health

IA Reporting and Validation Protocols – Documenting Completion



Milestone #6: Finalize partnership agreements or contracts with CBOs.

Minimum Standards of Supporting Documentation to Substantiate Successful Completion of the Milestone: The PPS must demonstrate it has entered into partnership agreements/contracts with CBOs. Explain in detail how many CBOs you have or will be contracting with and by when; explain how they will be included in project delivery and in the development of your PPS network. The PPS must provide the IA:

- A list of CBOs with which the PPS has established a relationship.
  - A template, "***Community Based Organizations***" has been developed to capture activities completed to date. This template is mandatory and must be utilized to facilitate IA review.
- Copies of contracts should be available for review upon request.
  - A template, "***Community Based Organizations***" has been developed to capture activities completed to date. This template is mandatory and must be utilized to facilitate IA review.
- Evidence of meeting agendas, attendance/sign-in sheets, and meeting minutes.
  - A template, "***Meeting Schedule Template***" has been developed to capture meetings, which have occurred in the past quarter. This template is mandatory and must be utilized to facilitate IA review. In completing the template, the IA is only looking for a list of meetings, dates conducted, and whether there are meeting minutes or an attendees list available. As part of random sampling the IA MAY request a list of attendees or minutes after review of the meeting template.

Validation Process: As part of its oversight responsibilities, the IA will be validating the completion of Domain 1 milestones and measures. The IA will conduct a more extensive review to ensure the information submitted by the PPS is accurate and verifiable.

- The IA will review a random sample of the finalized agreements/contracts with CBOs to substantiate contracts have been fully executed and established.
- The IA will also request and review a random sample of meeting agendas, attendance/sign-in sheets, and meeting minutes of the meetings held with CBOs.

Minimum Standards of Supporting Documentation to Substantiate Ongoing Quarterly Report Updates: After the successful completion of the initial milestone, the PPS must provide the following information to the IA each quarter.

- The IA will request an updated list of CBOs with which the PPS has an agreement or contract.
  - The template, "***Community Based Organizations***" must be utilized to facilitate IA review when changes occur.

Validation Process: The IA will perform the validation process similar to the methodolog described above.

NEW YORK STATE OF OPPORTUNITY. Department of Health

Project Requirements, Progress through DY2Q1

Project 2.d.i: Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care

- Project Requirement 1: Contract or partner with community-based organizations (CBOs) to engage target populations using PAM® and other patient activation techniques.
  - ✓**12 out of 14 PPS on track for completion by due date, 2 out of 14 PPS Completed**

- Project Requirement 3: Identify "hot spot" areas. Contract or partner with CBOs to perform outreach within the identified areas.
  - ✓**12 out of 14 PPS on track for completion by due date, 2 out of 14 PPS Completed**

- Project Requirement 11: Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources and patient education
  - ✓**13 out of 14 PPS on track for completion by due date, 1 out of 14 PPS Completed**

Reporting and Validation Protocols - Documenting Project Requirement Completion

Project 2.d.i - Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care.

Project Requirement 1: Contract or partner with community-based organizations (CBOs) to engage target populations using PAM® and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.

Metric: Partnerships with CBOs to assist in patient "hot-spotting" and engagement efforts as evidenced by MOUs, contracts, letters of agreement or other partnership documentation.

Data Source	Documentation to be Provided Upon Requirement Completion by PPS	Documentation Validation Process
MOUs, contracts, letters of agreement or other partnership documentation.	List/inventory of MOUs, letters, contracts, agreements and other documentation between the PPS and CBOs as defined in milestone requirement.	The IA will request and review a random sample of agreements with partners participating in the project upon milestone completion as identified by the PPS within the Quarterly Report to ensure they sufficiently meet the project requirements.
Quarterly report narrative demonstrating successful implementation of project requirements.	Quarterly report narrative demonstrating successful implementation of project requirements.	The IA will review the documentation to ensure it sufficiently meets the project requirement.

Reporting and Validation Protocols - Documenting Project Requirement Completion

Project Requirement 3: Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.		
Metric: Analysis to identify "hot spot" areas completed and CBOs performing outreach engaged.		
Data Source	**Documentation to be Provided Upon Requirement Completion by PPS**	**Documentation Validation Process**
"Hot spot" map delineated by UI, NU, LU types.	"Hot spot" map delineated by UI, NU, LU types.	The IA will review the documentation to ensure it sufficiently meets the project requirement.
Evidence of CBO outreach within appropriate "hot spot" areas.	Documentation of CBO outreach within appropriate "hot spot" areas.	The IA will review the documentation to ensure it sufficiently meets the project requirement.

Project Requirement 11: Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.		
Metric: Community navigators identified and contracted.		
Data Source	**Documentation to be Provided Upon Requirement Completion by PPS**	**Documentation Validation Process**
Periodic list of community navigator credentials (by designated area) detailing navigator names, location, and contact information.	List/inventory of community navigator credentials (by designated area) detailing navigator names, location, and contact information.	The IA will request and review a random sample to ensure they sufficiently meet the project requirement.
Metric: Community navigators trained in connectivity to healthcare coverage and community healthcare resources, (including primary and preventive services), as well as patient education.		
Data Source	**Documentation to be Provided Upon Requirement Completion by PPS**	**Documentation Validation Process**
List of training dates along with number of staff trained.	Provide an inventory of trainings completed to date upon milestone completion. For each training provide: date of the training, the nature of the training (focus area or topic), format of the training (in person or online, etc.), as well as the number of staff trained.	The IA will potentially request and review a random sample of training events including requesting training materials, as well as sign in sheets to substantiate the number of staff trained.
Written training materials.	PPS must upload a document that articulates the inventory of training materials developed for this project.	The IA will potentially request and review a random sample of materials based upon the inventory of materials developed by the PPS and submitted upon milestone completion.

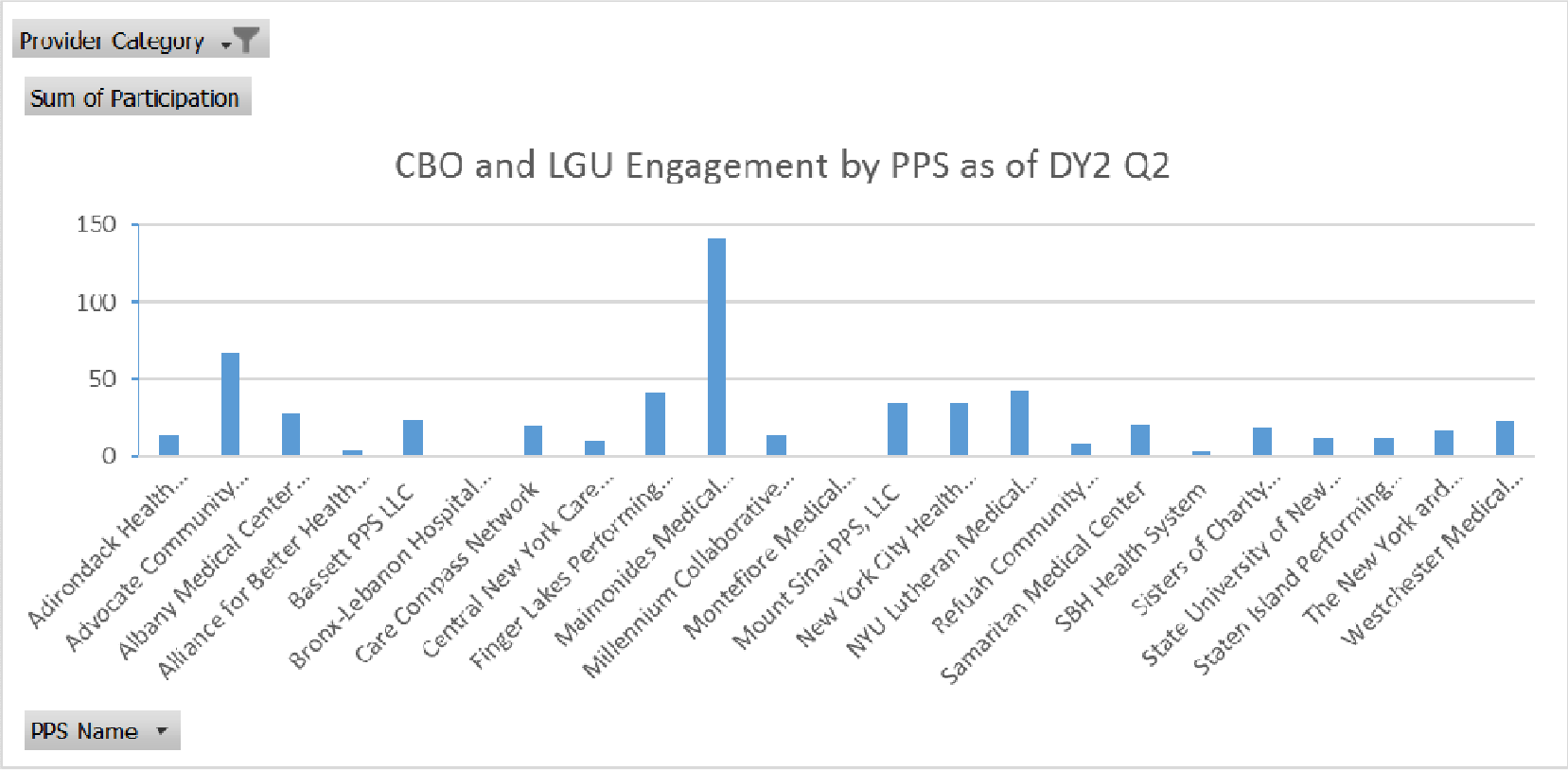
NEW YORK STATE OF OPPORTUNITY. Department of Health

Engagement and Funds Flow Reporting by Partner/Provider Types

Funds Flow Items
Waiver Revenue
Practitioner - Primary Care Provider (PCP)
Practitioner - Non-Primary Care Provider (PCP)
Hospital
Clinic
Case Management / Health Home
Mental Health
Substance Abuse
Nursing Home
Pharmacy
Hospice
Community Based Organizations
All Other
Total Funds Distributed
Undistributed Revenue

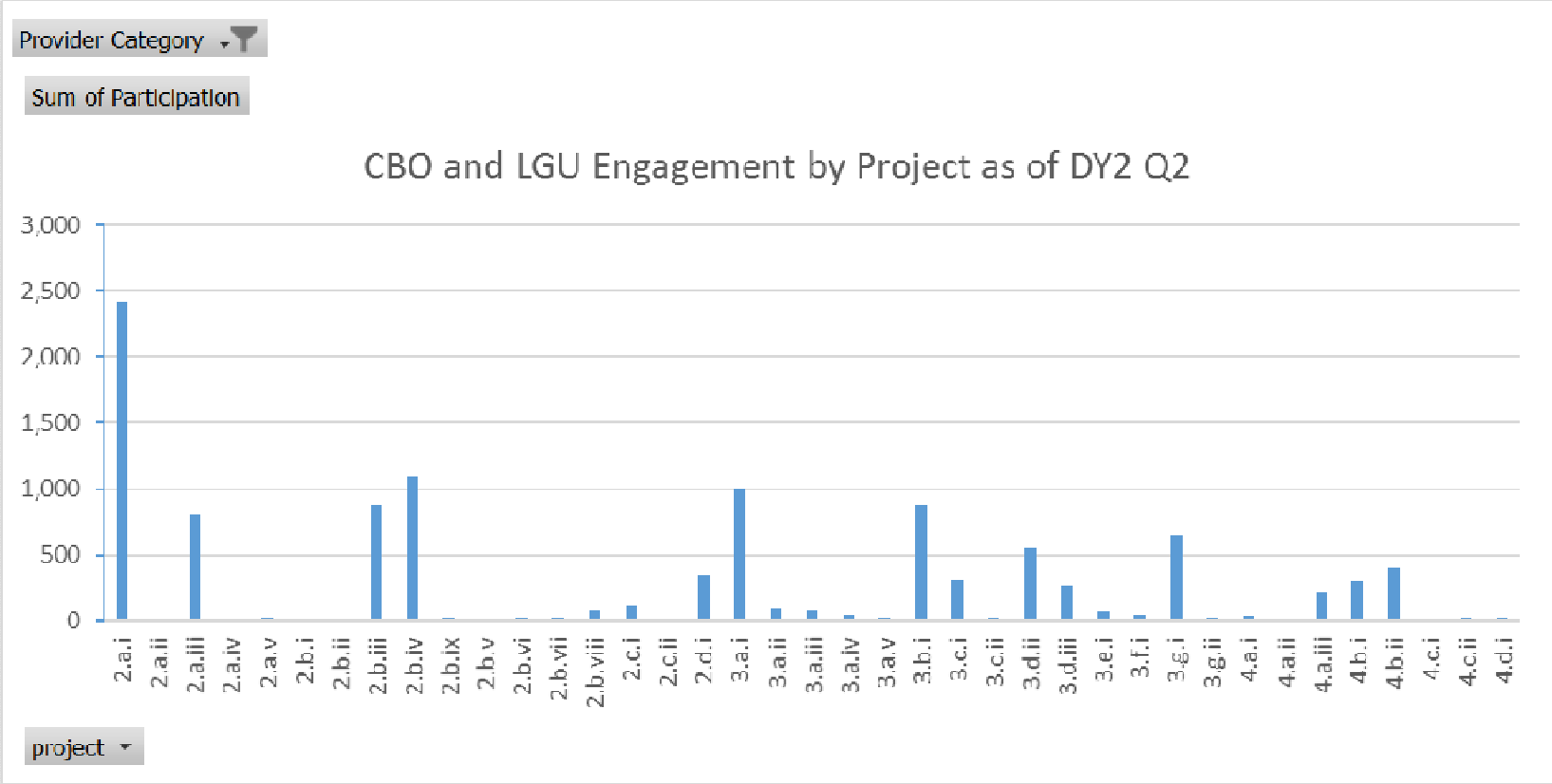
- All partner/provider types have specific definitions and align with the classifications of providers for PPS Speed & Scale commitments.
- Community Based Organizations are partners without a Medicaid Billing ID.
- The All Other provider type includes specific providers and is not an open category for reporting anything that does not fall in to one of the other provider type categories
- LGUs are contained within CBO, All Other, or specific provider types
- Standard Terms and Conditions: “DSRIP funding is available to Performing Provider Systems that consist of safety net providers…Non-qualifying providers can participate in Performing Providers Systems, however, non-qualifying providers are eligible to receive DSRIP payments totaling no more than 5% of …total valuation.”

of unique CBOs and LGUs Reported Engaged through DY2Q2 (de-duplicated across projects)



NEW YORK STATE OF OPPORTUNITY. Department of Health

of CBOs and LGUs Reported Engaged by Project



NEW YORK STATE OF OPPORTUNITY. Department of Health

NEW YORK STATE | Department of Health | Medicaid Redesign Team

PPS Examples of Engagement

January 2017

Igniting Change through… Community-Based Organizations

- Maternal & Child Health project
- Since November of 2015, we enrolled more than 650 mothers or expectant mothers into the Community Health Worker Home Visiting Program

Home Visiting Program

Community health workers working through CBOs visit mothers and expectant mothers at their homes to provide support, education, and connections to resources

Igniting Change through…
Funds Flow to the Community

- $3M in direct contracts to providers and CBOs
- Funded 78 community health workers

NIAGARA FALLS
Memorial Medical Center
Niagara's Premier Health Network

BPHC PPS - CBO Engagement

air nyc

Asthma home-based services

- 15 years experience
- Community health workers
- Know the Bronx
- Speak the languages
- Strong track record

HEALTH PEOPLE
Community Preventive Health Institute

- Diabetes Self-Management Program (Stanford model)
- Lower Extremity Amputation Prevention Program (LEAP)
- Paid training for 20 coaches = individuals recruited from community
- Classes for 600-800 students from community **hot spots**

request for proposal

CBO-driven

- Process & Criteria
- Content & Curriculum

Community-based BH and social services targeted for funding in DY2:

- **Cultural Competency Training**
- **Critical Time Intervention**
- **Behavioral Health "Call to Action"**
- **Community Health Literacy**

Community Health Literacy (CHL) Program

Community Health Literacy Partnering Organizations:

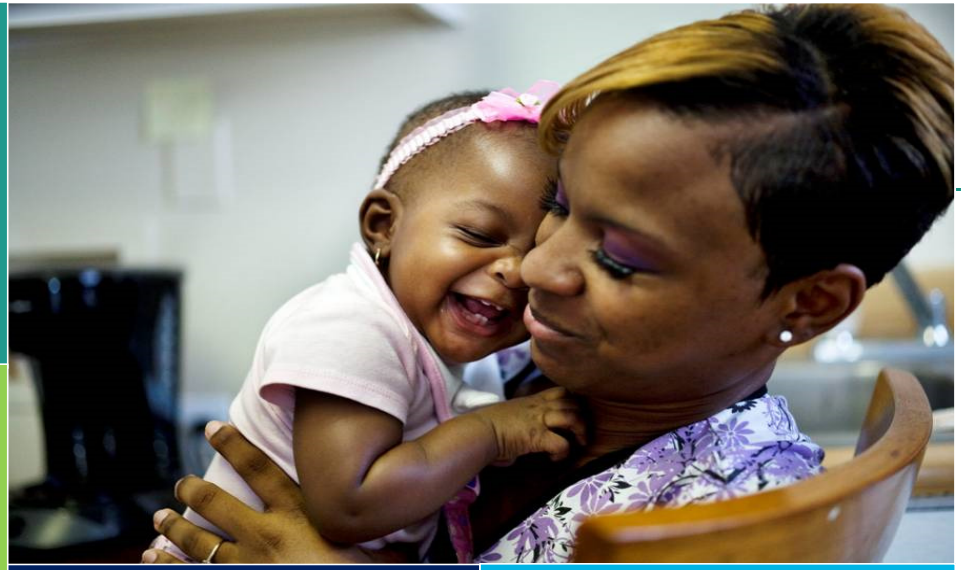
- ArchCare
- Bronx Community Health Network, Inc.
- Bronx Health Link
- BronxWorks, Inc.
- Health People
- Mary Mitchell Family & Youth Center, Inc.
- Regional Aid for Interim Needs (R.A.I.N)

- Will offer community education for groups or individuals on :
  - Health insurance access
  - How to navigate and access healthcare services
- Will target under-utilizers of healthcare services

CBO/Health System Partnership Impact on Avoidable Hospitalizations and Readmissions

DePaul Community Services **dedicates psychiatric and medical step-down beds** for Rochester Regional Health and UR Medicine.

An innovative partnership to address social determinants of health by providing a transitional housing solution.



80% Psychiatric Patients Transition to Permanent Housing

61% Medical Patients Transition to Permanent Housing

30x Cost Savings to Medicaid

Improved Quality of Life and Health Outcomes

FLPPS
FINGER LAKES PERFORMING PROVIDER SYSTEM

New York-Presbyterian Queens Pediatric Asthma Project- School Based Clinic Education Program

- Education program developed for school based clinic staff focused on:
  - Asthma basics
  - Environmental triggers
  - Home-based care opportunities, referrals and clinical providers

- Goals of the program:
  - Decrease school absenteeism
  - Reduce emergency department utilization & hospital admissions
  - Increase awareness & education
  - Link patients to programs for ongoing education or treatment

- CBO contract with the Asthma Coalition of Queens to build on existing programs

ADVOCATE COMMUNITY PROVIDERS PPS

Strong Community Engagement to Promote Primary Care and Health Literacy – as of September 2016

- Trained and deployed "boots on the ground": 21 **Community Health Workers (CHWs)** and 2 CHW Supervisors across Bronx, Brooklyn, Manhattan, Queens
- Conducted **"Hotspot" analysis** to inform community outreach and resource deployment
- Executed contracts with **CBOs** for a total of $250,000
- Conducted **Health Week:** 12 community events, ~1,000 participants in Morrisania in the Bronx, the state's "sickest" community district
- Partnership agreements with 9 **schools**:
  - 12 health, fitness and reading events at 11 schools
  - 1,385 children and families engaged

ACP
ADVOCATE COMMUNITY PROVIDERS

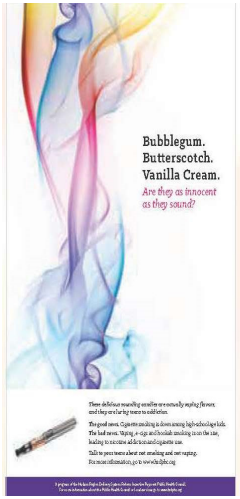
Cross-PPS Collaboration in the Hudson Valley

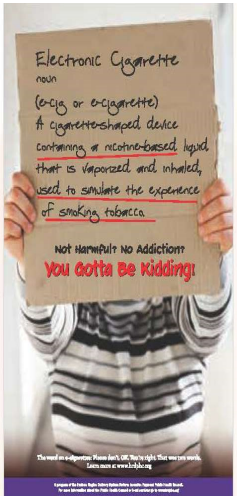
WMC Health | Performing Provider System (PPS)
Westchester Medical Center Health Network

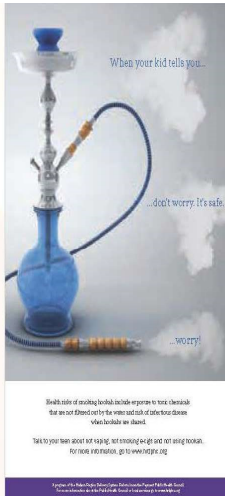
Montefiore HUDSON VALLEY COLLABORATIVE

RCHC Refuah Community Health Collaborative

The Hudson River DSRIP Public Health Council (HRD PHC), comprised of the three lower Hudson Valley PPS and a combination of over 45 government agencies and community organizations collaborating on Tobacco Cessation (4.b.i) and Cancer Screening (4.b.ii) public health projects.







Achievements:

- ✓ **Adopted NYS Prevention Agenda's cancer screen rates as benchmark and using the PDSA implementation process.**
- ✓ **Launched (timely) anti-vaping campaign aimed at high school students—way ahead of new FDA ban (8/8/2016) on e-cigarette and vaping sales to those under 18.**
- ✓ **Distributed over 5,000 posters in high schools throughout the Hudson Valley.**

Visit www.hrdphc.org to learn more.

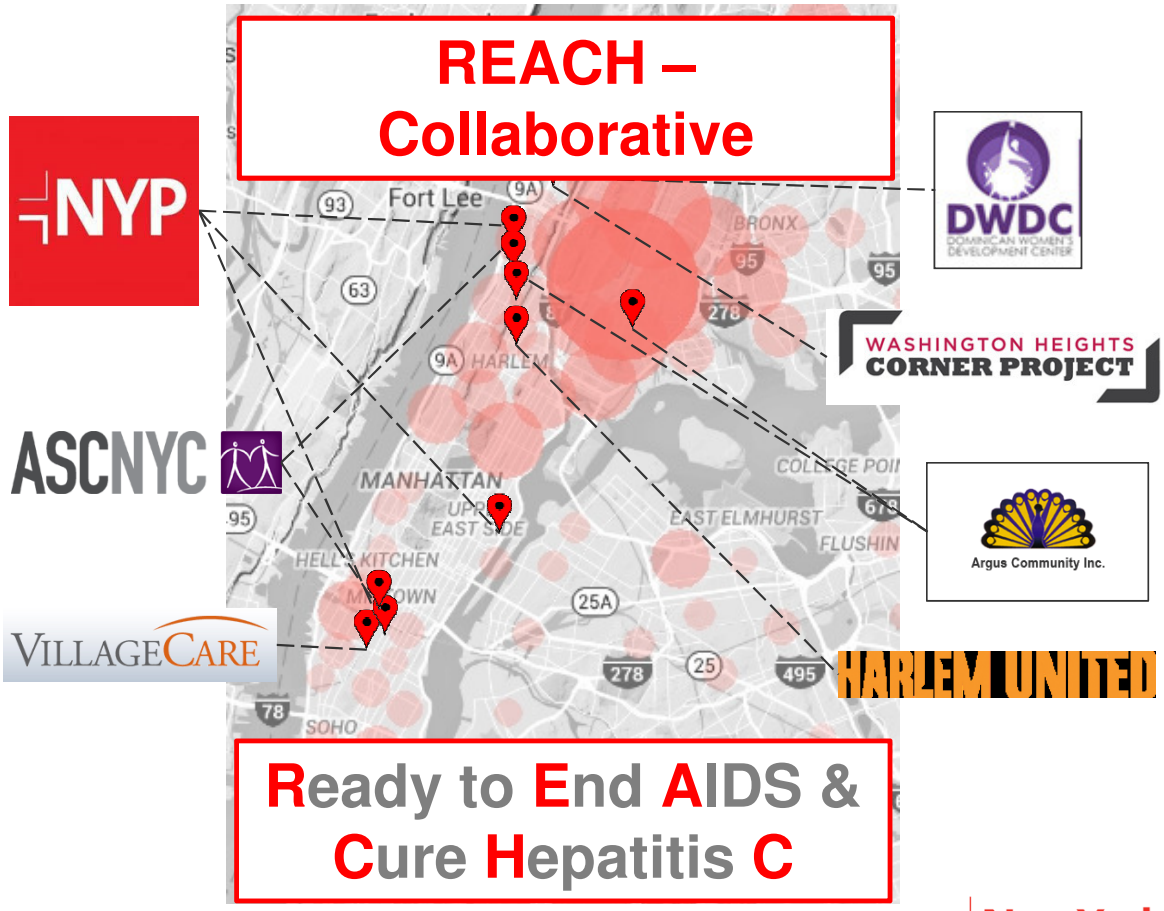
Maimonides PPS

Collaboration with CBOs to enhance the efficacy of community engagement:

- Established Community Engagement Committee as a part of CCB's governance structure
- Engaged CBO consortium to develop CCB's Cultural Competency / Health Literacy Strategy
- Formed a Cardiovascular Disease Workgroup to explore community-based approach to understanding the barriers to good health that may be contributing to the incidence and prevalence of cardiovascular disease
- Collaborated with faculty and graduate students from MIT, faculty and students from Medgar Evers College, FQHC leaders and area high school students to design and implement a 'Community Asset Mapping Project' in Central Brooklyn

COMMUNITY CARE OF BROOKLYN

NYP PPS: HIV Projects - CBO Engagement



NewYork-Presbyterian
Performing Provider System

CPWNY – Nurse Family Partnership Collaboration

- Partnership with Chautauqua County DOH
  - Mutual interest in NFP program
  - Collaboration - Health Foundation funds and DSRIP support
  - Well-established maternal-infant programs in the county and referral system
  - Expertise in place - supervisor with home visiting experience - Maternal and Infant Community Health Collaborative (MICHC Program)
  - Established, and active Maternal-Child Health Coalition (MICHC)

- Impact of NFP in the county
  - Improved outcomes for moms and babies
  - Positive impact in many divisions of Chautauqua County Department of Health & Human Services

Community Partners of Western NY

Cultural Competency and Health Literacy:

- Contracted with the Community Health Worker Network of Buffalo (CHWNB) to implement the CCHL training strategy.
- CHWNB is representative of people living in the "hot spot" communities in need, motto is:

  "Nothing without us, about us, is for us"

- Strategy focuses on biases, privilege, social justice and universal approach to literacy by bridging, mediating and facilitating understanding between and within communities and systems.

COMMUNITY PARTNERS OF WNY

Performing Provider System

Refuah CHC CBO contracted to address disparities

Contracted with Konbit Nèg Lakay Haitian Community Center to address the diabetic disparities experienced in their community by:

- Providing transportation, with linguistically accessible dispatch, to and from medical appointments
- Offering Zumba exercise classes at the community center
- Holding educational sessions on diabetes prevention and evidence-based Stanford Diabetes Self-Management Programs (DSMP) in Creole

Plans to replicate this model in Spanish, Hindi, and Chinese-speaking target communities

Questions and Comments

DSRIP e-mail:
dsrip@health.ny.gov