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SHIP/DSRIP Workforce Workgroup Meeting

June 15, 2018

Timing	Topic	Slide	Lead
10:30 - 10:40	Welcome and Introductions	1-3	Wade Norwood and Jean Moore
10:40 - 11:05	New York State Patient-Centered Medical Home Update	4-24	Scott Rader and Lori Kicinski
11:05 - 11:15	Delivery System Reform Incentive Payment (DSRIP) Program Update	25-45	Lisa Ullman
11:15 - 12:30	Social Determinants of Health ▪ The Three Buckets of Prevention: The CDC Framework (New York State Department of Health, Office of Public Health) ▪ Improving Collaboration Between Primary Care Residency Programs and Community-Based Organizations (Greater New York Hospital Association) ▪ Value-Based Purchasing and the Social Determinants of Health (New York State Department of Health, Office of Health Insurance Programs, Bureau of Social Determinants of Health)	46 47-52 53-65 66-81	 ▪ Barbara Wallace ▪ Anu Ashok and Carla Nelson ▪ Emily Engel and Martina Ahadzi
12:30 - 12:40	Break		
12:40 - 1:15	Care Coordination and Integration ▪ Promoting Primary Care and Behavioral Health Integration ▪ Incorporating Care Coordination into Training ▪ Addressing Practice Barriers ▪ Enhancing Health Care Workforce Data	82 83 84 85 86	 ▪ Amy Jones-Renaud and Lisa Ullman ▪ Jean Moore and Tom Burke ▪ Wade Norwood and Lisa Ullman ▪ Jean Moore and Lisa Ullman
1:15 - 1:30	Adjournment		Wade Norwood and Jean Moore

Workforce Workgroup Charge

- Workforce is one of the underlying enablers for the State Health Innovation Plan (SHIP), supporting the five pillars and helping achieve the SHIP objective of moving towards the Advanced Primary Care model
- The Workforce Workgroup also serves the goals of the Delivery System Reform Incentive Payment (DSRIP) Program and the work of Performing Provider Systems (PPS), supporting efforts to reduce avoidable hospital use and achieve the sustainable transformation of the delivery system
- The charge of the Workforce Workgroup is to promote a health workforce that supports comprehensive, coordinated and timely access to care that will improve the health and well-being of New Yorkers, consistent with these transformational initiatives

New York State Patient-Centered Medical Home (PCMH) Update

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Why create a distinct “NYS PCMH”?

- A NYS PCMH program considers several state-specific components including investments in Health IT, Behavior Health integration, rigorous Care Coordination, Population Health, and the potential for multi-payer support
- Accelerating the transition toward value-based payment is a priority for NY

Why align with PCMH (NCQA PCMH 2017)?

- Accelerating the transition toward delivering value and succeeding in new payment models for all practices in NY State
- Opportunity to simplify a complicated landscape and reduce confusion
- Align Medicaid and SIM/APC around one common practice transformation program

Why transform to NYS PCMH?

- Prepare practices for value-based payment environment for NY State Medicaid and commercial VBP arrangements
- Participate successfully in Medicare, especially under MACRA/MIPS
- Take advantage of transformation fees paid by SIM grant

Medicaid/SIM Alignment Examples:

	DSRIP	SIM/APC
VBP approach:	Using Medicaid VBP Roadmap	Using developed commercial/ Medicare advantage programs
Primary Care focus:	Improve care + access to care	Improve care + access to care
Population Health approach:	NYS Prevention Agenda	NYS Prevention Agenda
Quality measurement:	Standardized measure set	Standardized measure set

NYS PCMH aligns largely with the NCQA program, with several targeted revisions

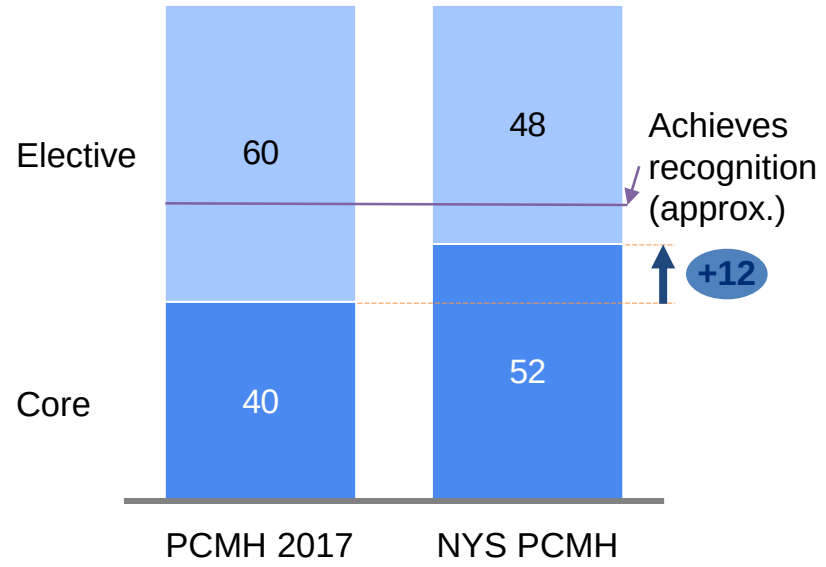
Key differences

	From: NCQA PCMH 2017	To: NYS PCMH
Phases of transformation	1. Commit 2. Transform 3. Succeed	▪ Same- in the spirit of simplification, the current NCQA PCMH phases and assessment model would fully replace APC Gates
Requirements	1. Commit, self-assess, plan 2. Develop and document PCMH capabilities 3. Re-certify on an annual basis	1. Same, **plus commitment to adopt VBP** 2. **Additionally require 12 NCQA-elective Behavioral Health, Care management, Population Health, and Health IT capabilities as "Core"**[1] 3. Same
Recognition	▪ Recognition by NCQA as a PCMH 2017 practice	▪ Recognition by NYS and NCQA as an **NYS PCMH 2017** practice
State-funded Technical Assistance (TA)	▪ None	▪ **State-funded TA** to achieve NYS PCMH recognition (with minimal to no need for changes in curriculum), contingent on continued participation for up to 2 years
Medicaid support	▪ Incentive payment upon achieving PMCH 2017 recognition	▪ PMPM payment upon reaching NYS PCMH recognition

1 NCQA PCMH 2017 electives that are required for NYS PCMH

NYS PCMH builds on APC/PCMH 2017 by converting 12 Electives into Core without asking the practices to do more

NYS PCMH criteria compared to PCMH 2017



Changes compared to NCQA PCMH 2017

- **12 Additional Core criteria** represent fundamental building blocks in the areas of:
  - Behavioral Health integration
  - More rigorous Care Coordination
  - Health IT capabilities
  - VBP arrangements
  - Population Health
- Providers would then complete **elective standards to earn 6-9 additional credits**
- **Continuation of TA vendor activities**

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What is ‘new’ to NYS PCMH as ‘Core’ criteria*:

	Code	Criteria
Behavioral health	CC9	Works with behavioral healthcare providers to whom the practice frequently refers to set expectations for information sharing and patient care
	KM4	Conducts BH screenings and/or assessments using a standardized tool. (implement two or more) A. Anxiety B. Alcohol Use Disorder C. Substance Use Disorder D. Pediatric Behavioral Health Screening E. PTSD F. ADHD G. Postpartum Depression
Care Mgt. Care Coord. & Pop Health	CM3	Applies a comprehensive risk - stratification process to entire patient panel in order to identify and direct resources appropriately
	CC8	Works with non-behavioral healthcare specialists to whom the practice frequently refers to set expectations for information sharing and patient care
	CM9	Care plan is integrated and accessible across settings of care
	CC19	Implements process to consistently obtain patient discharge summaries from the hospital and other facilities
	KM11	Identifies and addresses population-level needs based on the diversity of the practice and the community (Demonstrate at least 2) A. Target pop. health mgmt. on disparities in care B. Address health literacy of the practice C. Educate staff in cultural competence
Health IT	AC8	Has a secure electronic system for two-way communication to provide timely clinical advice
	AC12	Provides continuity of medical record information for care and advice when the office is closed
	CC21	Demonstrates electronic exchange of information with external entities, agencies and registries (may select 1 or more): RHIO, Immunization Registry, Summary of care record to other providers or care facilities for care transitions
	TC5	The practice uses an EHR system (or modules) that has been certified and issued an ONC Certification ID, conducts a security risk analysis, and implements security updates as necessary correcting identified security deficiencies
VBP	QI19	The practice is engaged in Value-Based Contract Agreement. (Maximum 2 credits) A. Practice engages in up-side risk contract

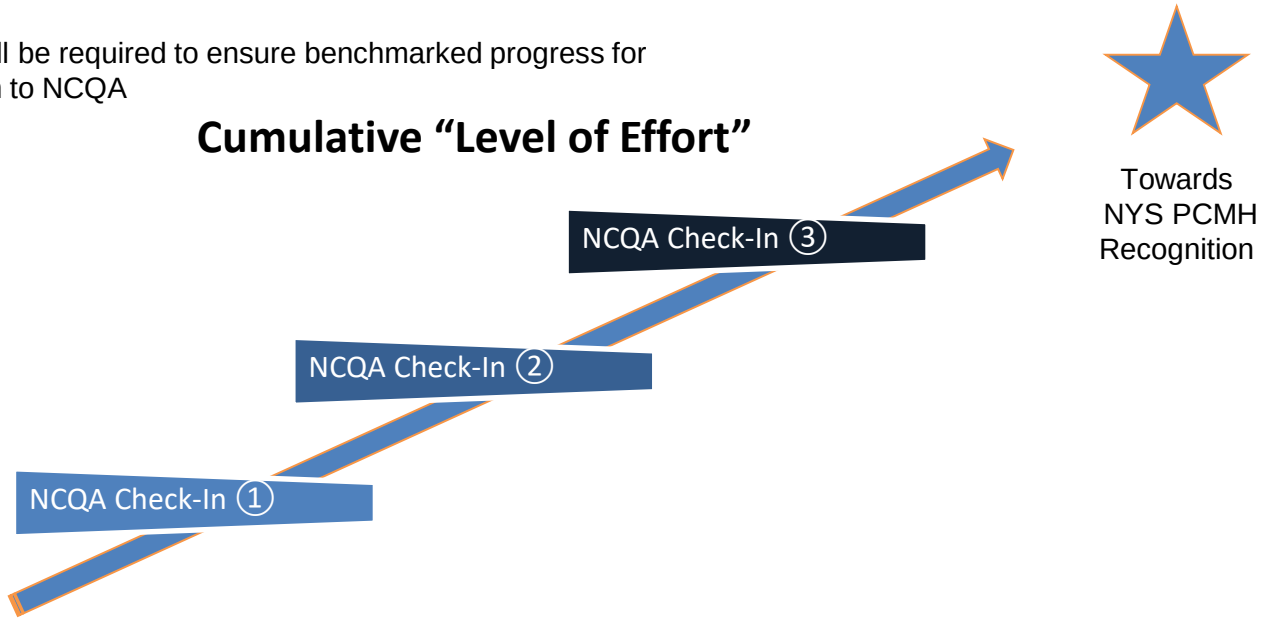
*Formerly NCQA 2017 elective criteria

Crosswalk between NCQA PCMH 2017 and APC (example):

NCQA PCMH 2017			APC					
Standard	Criteria	Criteria Level	Deliverable	Gate - Milestone	Aligned	Essential/ Questionable/ Non-Essential	Pre-CORE/ CORE/ ADVANCED	ALL/ MCAID/ MCARE/ PEDS
Team Based Care and Practice Organization (TC)	2.1 Has regular patient care team meetings or a structured communication process focused on individual patient care.	Core	> Conducts structured huddles/meetings to discuss cases with the care team.	3 - Care Management/ Care Coordination	Y	Essential	CORE	ALL
Team Based Care and Practice Organization (TC)	2.2 Involves care team staff in the practice's performance evaluation and quality improvement activities.	Core			N	Essential	CORE	ALL
Team Based Care and Practice Organization (TC)	E2.1 Has at least one care manager qualified to identify and coordinate behavioral health needs. (2 Credits)	Elective BH Distinct	> Has completed self-assessment for behavioral health integration and committed to meeting Gate 2 care management/care coordination milestones.	1 - Care Management/ Care Coordination	Y	Essential	CORE	ALL
Team Based Care and Practice Organization (TC)	E2.1 Has at least one care manager qualified to identify and coordinate behavioral health needs. (2 Credits)	Elective BH Distinct	> Completes training for behavioral health integration that broadens team-basd care and clinical treatment of depression.	2 - Care Management/ Care Coordination		Essential	CORE	ALL
Team Based Care and Practice Organization (TC)	3.1. Has a process for informing patients/ families/caregivers about the role of the medical home and provides patients/ families/caregivers materials that contain the information.	Core			N	Non-essential	CORE	ALL
Knowing and Managing Your Patients (KM)	1.1 Documents patient up-to-date problem list with current and active diagnoses	Core			N	Essential	Pre-CORE	ALL

Transformation Agents Assist in Transformation towards NYS PCMH

- NCQA will conduct up to 3 Virtual Check-Ins with each Practice*
- Transformation agents will partner through the entire Check-In and recognition process
- Transformation agents will be required to ensure benchmarked progress for submitting documentation to NCQA



*Practices with NCQA PCMH 2014 Level 3 status subject to renewal or an accelerated path may not require 3 Check-Ins; others subject to Annual Reporting will be required to meet NYS PCMH Core requirements in addition to NCQA's specifications.

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Costs of Transformation to NYS PCMH:

New Practices	Costs for NYS PCMH recognition will be paid for by SIM grant
NCQA PCMH 2014 Level 1+2	Costs for NYS PCMH recognition will be paid for by SIM grant
NCQA PCMH 2014 – Level 3	Costs for NYS PCMH recognition will be paid for by SIM grant
APC Practices	Costs for NYS PCMH recognition will be paid for by SIM grant

SIM grant funding will end February 2020

NYS PCMH Annual Reporting

- Submit documentation for annual check-in to sustain recognition
- Sustained recognition based on practice performance across six categories
- NCQA randomly select practices for audit

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Different Pathways to NYS PCMH:

	2018	2019	2020
New Practices	Enroll in NYS PCMH	Achieve NYS PCMH Recognition	NYS PCMH Annual Reporting
NCQA PCMH 2014 Level 1+2	Enroll in NYS PCMH Accelerated renewal	Achieve NYS PCMH Recognition/ NYS PCMH Annual Reporting	NYS PCMH Annual Reporting
NCQA PCMH 2014 – Level 3	**Practices expiring 2018:** Enroll in "First NYS PCMH Annual Report*" **Practices expiring 2019/ 2020:** "First NYS PCMH Annual Report*" optional.	**Practices expired in 2018:** NYS PCMH Annual Reporting. **Practices expiring 2019:** Enroll in "First NYS PCMH Annual Report*" **Practices expiring 2020:** "First NYS PCMH Annual Report*" optional	**Practices expired in 2018/2019:** NYS PCMH Annual Reporting. **Practices expiring 2020:** Enroll in "First NYS PCMH Annual Report*"
APC Practices	Enroll in NYS PCMH	Achieve NYS PCMH Recognition	NYS PCMH Annual Reporting

* For practices that are currently NCQA PCMH 2014 Level 3 recognized, the "First NYS PCMH annual report" will include evaluation of NCQA annual reporting requirements for the year and the 12 elective criteria required by New York State.

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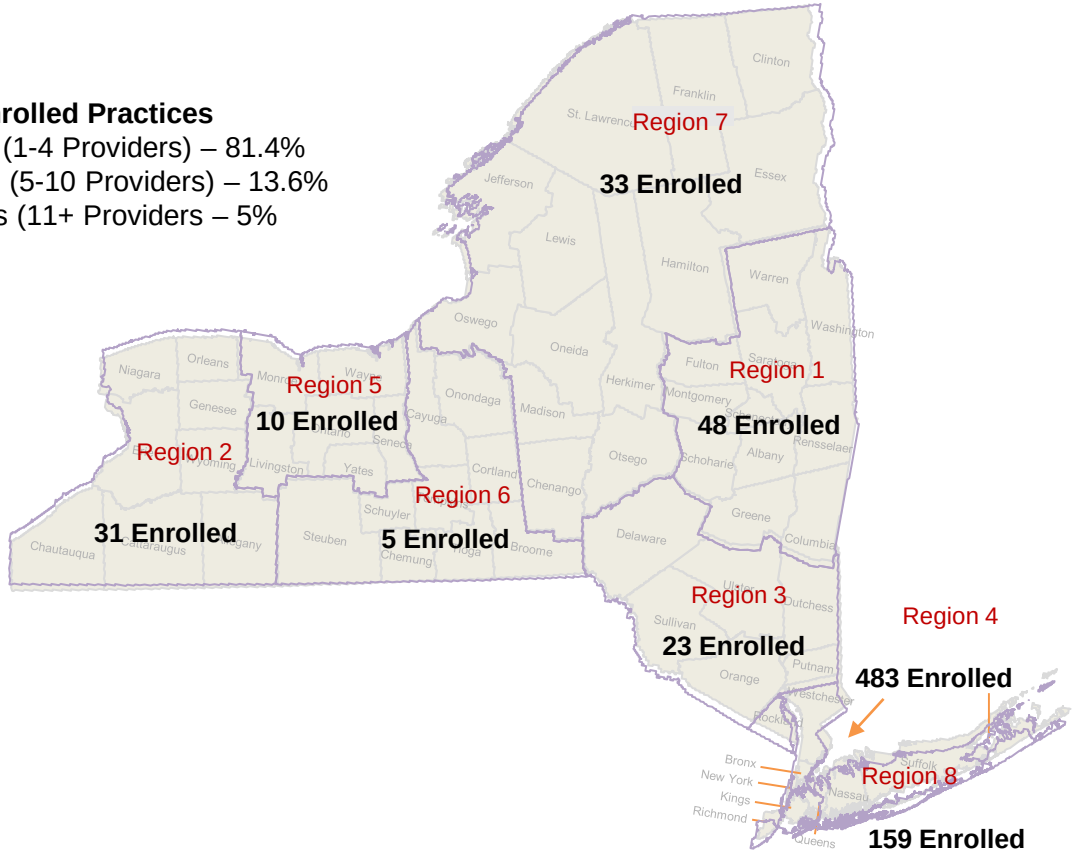
Current Program Participation (as of June 2017):

	PCMH	SIM/APC
Number of practices:	2,409	792
Number of physicians:	9,100	~3000
Level of recognition:	98.5% PCMH 2014	14.3% APC Gate 2

About 15% of APC providers were already PCMH 2014 level 3 certified

NYS PCMH Enrollment Status – 6/7/18

792 Total Enrolled Practices
643 Small Practices (1-4 Providers) – 81.4%
109 Medium Practices (5-10 Providers) – 13.6%
40 Large Practices (11+ Providers – 5%



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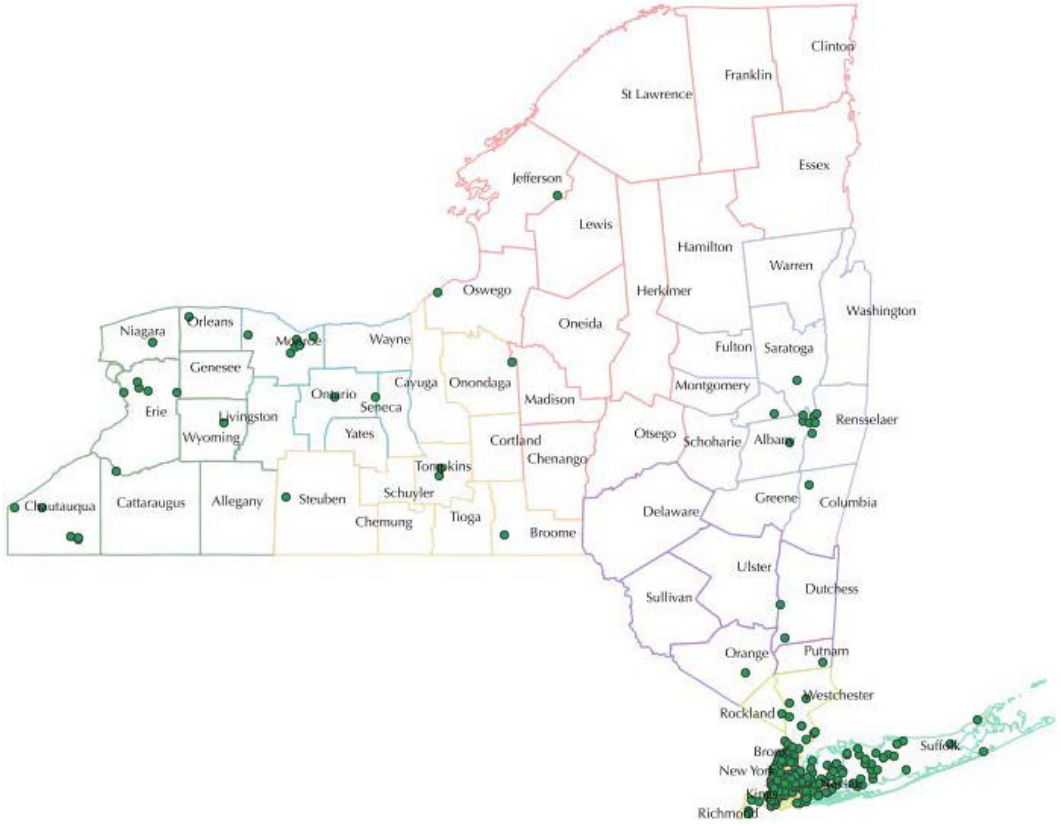
NYS PCMH Recruitment Status – 6/7/18



DFS Regions

- Region 1
- Region 2
- Region 3
- Region 4
- Region 5
- Region 6
- Region 7
- Region 8

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NYS PCMH Enrollment

- PTTS Enrollment – 792 (as of 6/7/18)
- This number includes both:
  - APC Transitioning Practices
  - PCMH Recognized Practices (any level)
- High volume of 2014 Level 3 practices already coming into NYS PCMH
- TA's are working to get all APC transitioning practices entered into the Q-PASS system by the June 2018
- Until NCQA builds reporting capacity and dashboards we will use both systems for tracking. An API is being developed to transmit data from Q-PASS into the PTTS system weekly

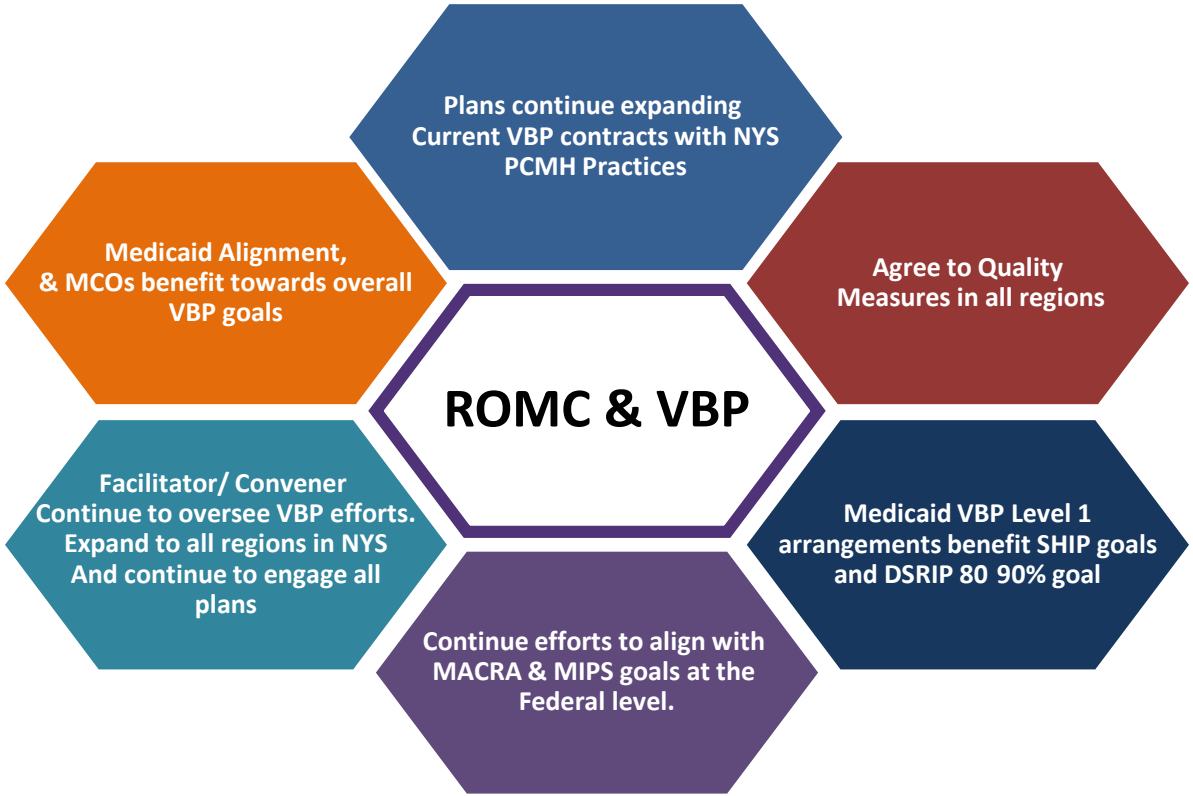
NYS PCMH Website

- Website dedicated to NYS PCMH was launched in the end of April
- https://www.health.ny.gov/technology/innovation_plan_initiative/nys_pcmh.htm
- Marketing & Communication materials available – links to NCQA website for enrollment
- NYS PCMH and the PCMH Medicaid incentive program materials were recently migrated to this one page

ROMC Goals & Approach

- One size may not fit all – Regional Approach makes sense in NYS
- Goal #1: Establish a regional consensus that implements a multi-payer, primary care initiative which may include providing financial support to practices as they transition from fee for service relationships to value based payment arrangements.
- Goal #2: Establish a regional agenda for supporting the APC model. Also supporting additional initiatives that we fund through the SIM grant

2018 ROMC VBP Goals



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Other NYS PCMH Updates:

- FQHC enrollment
- Conducted 2 Q&A webinars: PT TAs and PPS practices
- “Lunch & Learn” Series - Conducted 10 PT TA “peer-to-peer” webinars covering all NYS PCMH concepts, best practice strategies, and preparing practices for NCQA Check-In process
- OMH’s Behavioral Health Integration webinar series
- CPC+ and TCPI practices
- In-Person Summit: Fall 2018

NCQA NYS PCMH Marketing Campaign: 19 documents released

- Landing Page
- Press Release
- Webpage
- NYS PCMH Annual Reporting Webpage
- Standards & Guidelines
- NYS PCMH Annual Reporting (for NCQA PCMH 2014 Level 3 Practices)

For more information: ncqa.org/nyspcmh

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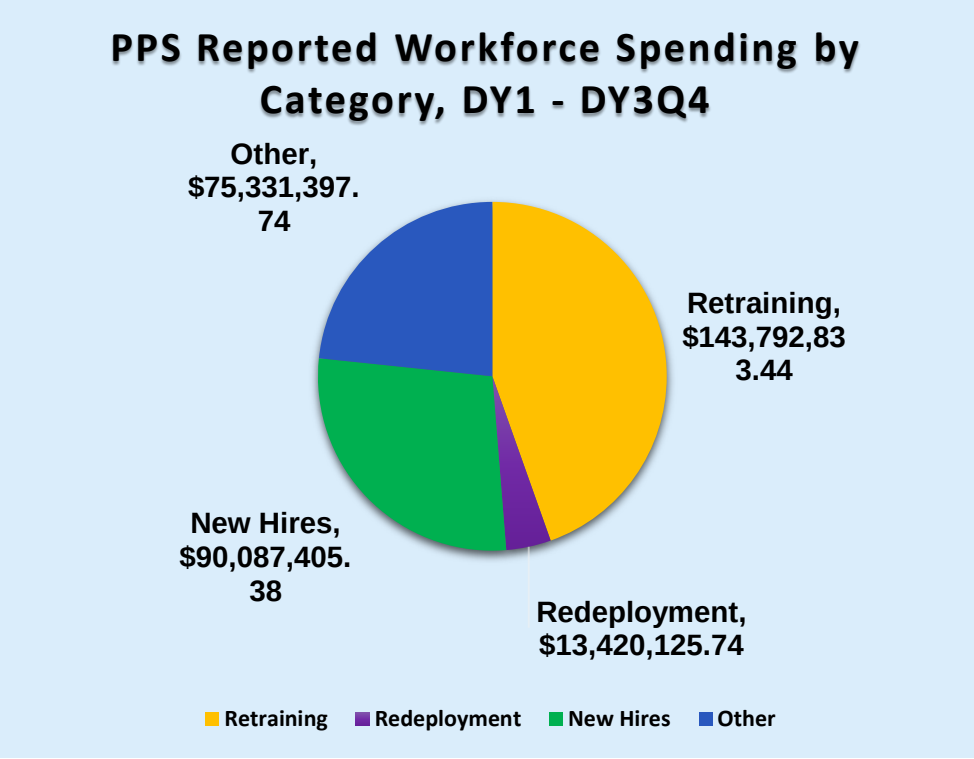
DSRIP Workforce Update

DSRIP Workforce Updates

DSRIP Workforce Spending DY1 – DY3Q4



Other includes:

- Workforce Vendor Subcontracting
- Compensation and Benefit Report Development
- Scholarships

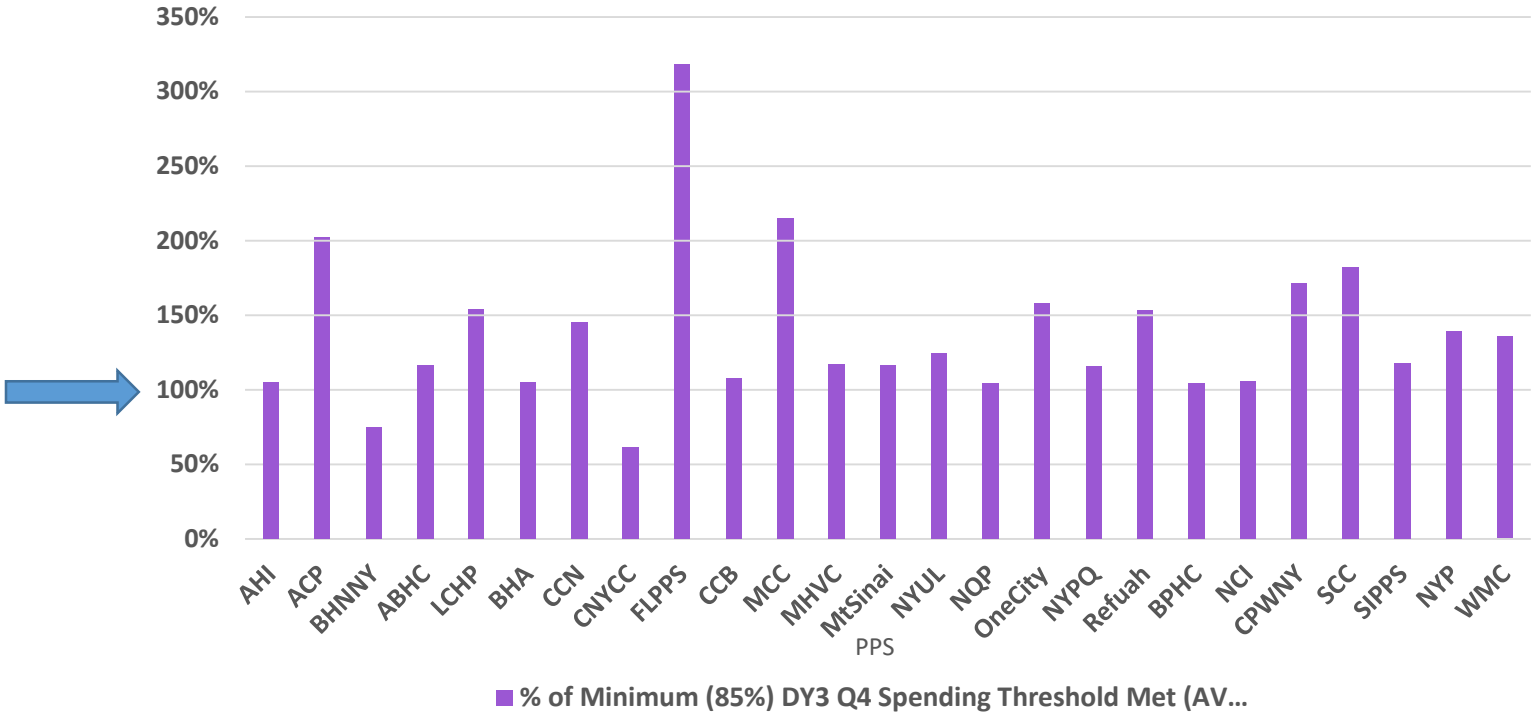
$322.6M

Total Spent

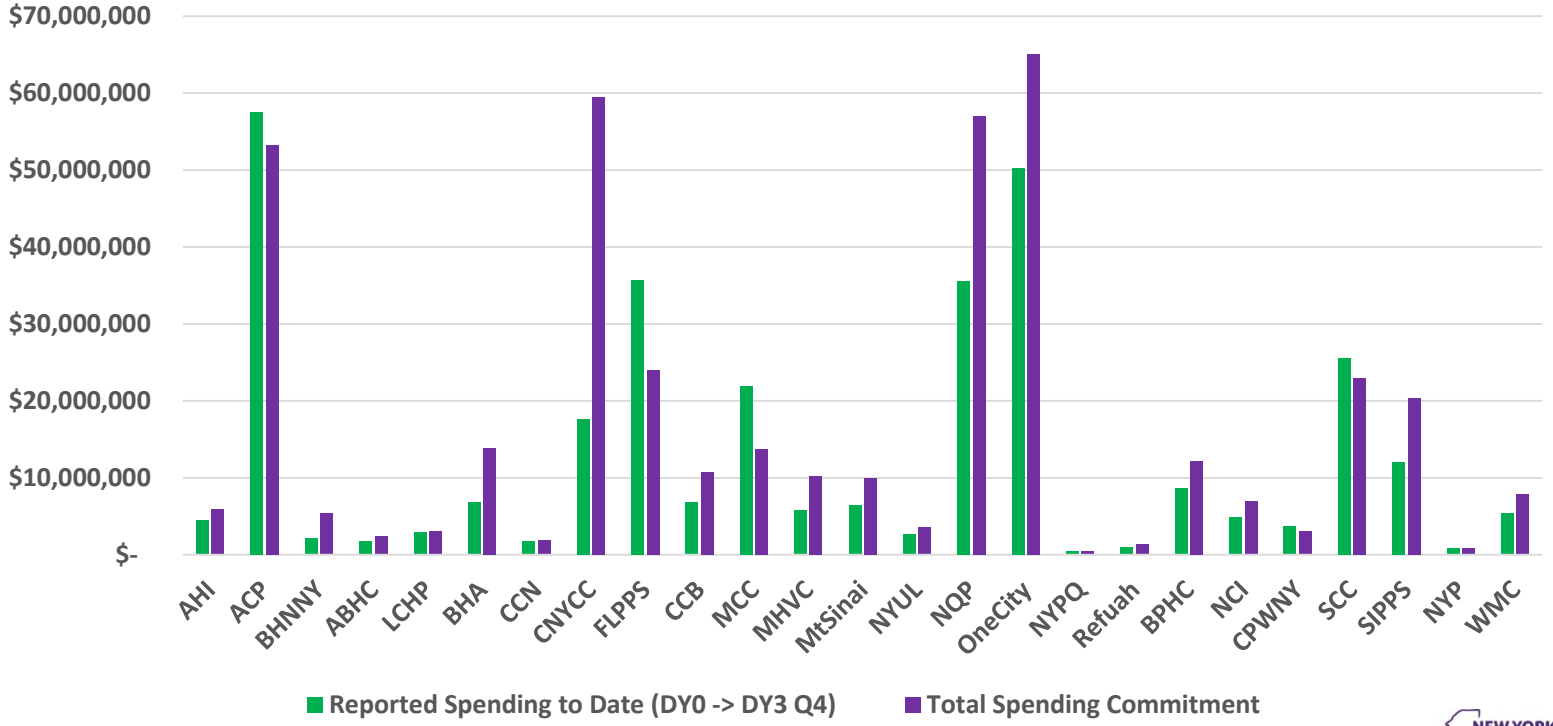
$266.5M

Spending commitment

PPS Progress Toward 85% AV DY3Q4 Commitment



Progress Toward Total Five Year PPS Workforce Spending Commitment as of DY3 Q4 – Dollars

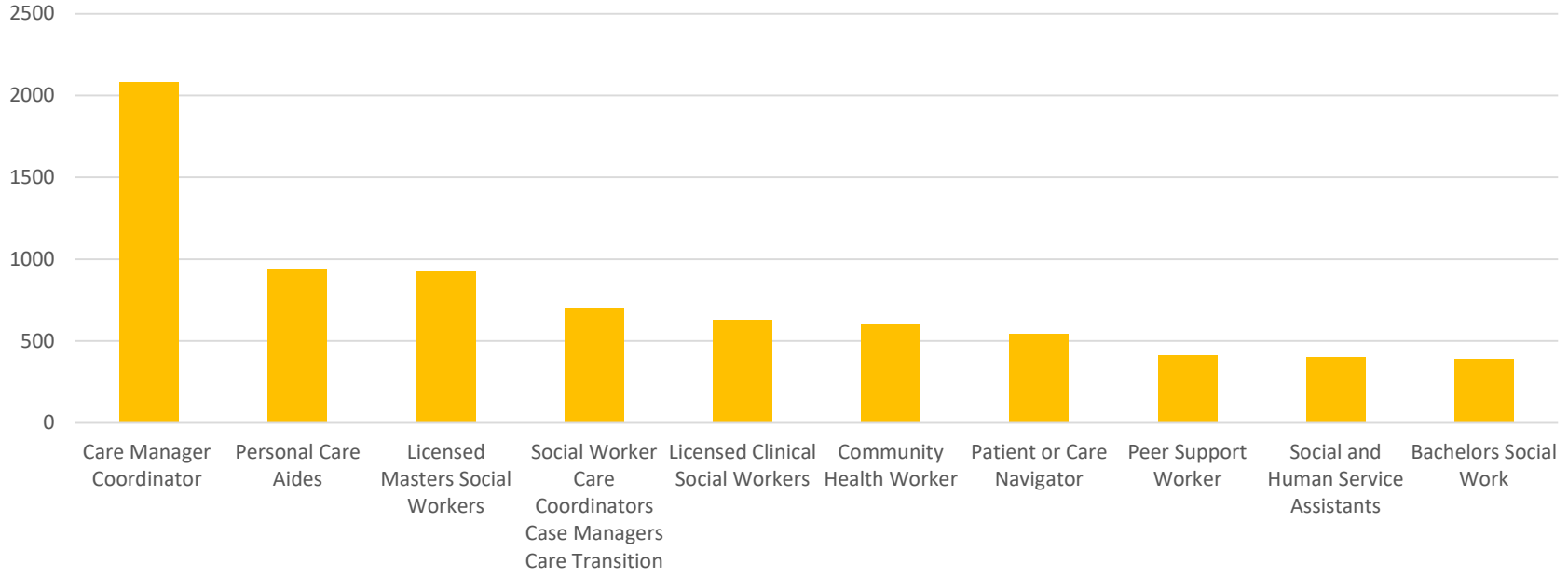


DSRIP Workforce Emerging/Transformation Titles - New Hires

- The following slide shows the aggregate volumes of New Hires (combined full and partial placements) for all PPS for top transformation titles through DY3Q2.
- Emerging/Transformation titles are roles in which the scope of work and competencies are changing or have changed due to transformation efforts such as care transitions, integrating care delivery and improving access to care.
- All 25 PPS are implementing Project 3.a.i., Integration of primary care and behavioral health services. Drilling down into primary care and behavioral health titles, these New Hire findings appear to reflect PPS progress toward:
  - transitioning care away from institutions to community- and home-based care settings;
  - strengthening and expanding primary care and behavioral health; and
  - integrating these services.

Full DSRIP Workforce Impact Analysis Report from February 2018 available at: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/workforce_docs/docs/2018-02_workforce_impact.pdf

Emerging/Transformation Title New Hires through DY3Q2



PPS Workforce Initiatives

Health Care Training and Education

A partnership has been established between SUNY Adirondack and the AHI PPS which supports education and training in health care occupations/career pathways that are experiencing labor shortages and/or are in high demand:

- Must be income eligible to participate
- Training in PPS priority areas (post-acute care, pre-nursing and CASAC)

Leverages SUNY Adirondack Health Professions Opportunity Grant (HPOG)

- Expands the number of individuals served who have expressed interest in health care training and education
- **54** served to date and more in the pipeline
  - Also includes wrap-around support to assist with retention and success in the program

Through this partnership, we are training individuals DSRIP is intended to target in high demand health care careers in our region.

BRONX HEALTH ACCESS

Achievements:

- Provided support to a grant-funded program that trained Community Health Workers as part of a US Department of Labor Office Apprenticeship program. Providing support for an additional 4th cohort of 16 which began 5/1/2018. Additional cohorts may be created with DSRIP funds.
- Presented PPS and partners Cultural Competency and Health Literacy lectures which covered the following topics: "What's going on?" Substance use outcomes and effective interventions for black and Latino youth and Impact of incarceration on individuals and families
- Partnered with Bronx Partners for Healthy Communities to create a RHIO Consent video to educate PPS and partners. Video is available at PPS website as well as HWapps.
- Delivered multiple Motivational Interviewing trainings attended by many PPS Partner employees
- Value Based Payment training video available on flash drives, at the PPS website as well as HWapps. 241staff trained up to date
- Partnered with Hostos Community College (CUNY) to deliver several Medical Assistant Refresher Courses. 57 staff have been trained as of May 2018. All 57 students are nationally certified medical assistants
- Partnered with VIP Community Services as training vendor to deliver a second CASAC training. 42 workers are participating in current training
- Continuous monitoring progress of Bachelor's degree program with Lehman College (CUNY) to train bilingual Spanish speaking workers to become Registered Nurses as a way to better serve the Bronx's patient population.

Workforce & Training Highlights

Network Engagement

As of the end of DY3

- More than **850 staff members** from across **77 organizations** have participated in stipend-eligible trainings
- Nearly **25,000 course-hours** completed by CCB Participants' staff
- Variety of topics and curricula for care managers, care navigators, health coaches, PCPs, ED Navigators, specialists, and RNs
- CCB Participants earned over **$330K in training stipends** to support participation in DSRIP-related training

Course Highlights

Social Determinants & The Law

CCB and 1199SEIU TEF in partnership with the New York Legal Assistance Group(NYLAG) offers two courses of Social Determinants & the Law. One focuses on legal matters pertaining to behavioral health and immigration rights and the other, housing, income and insurance coverage. LegalHealth, a division of NYLAG, trains healthcare professionals to understand the legal issues that their patients face and also provides free civil legal assistance to patients. To date, **156 staff members** have been trained.

Project ECHO Training

CCB launched its first ECHO training in Palliative Care in partnership with the MJHS Institute for Innovation in Palliative Care.

Project ECHO is a model of care to provide best-practice specialty care and reduce health disparities for community providers. Delivered by experts, the training takes place using virtual clinics, case conferences and CME credited didactic sessions.

Looking Ahead

Trainings to be Launched

Several new trainings are slated for launch in DY4:

- Interactive e-learning modules in Asthma and CVD
- Developing Registries
- Peer Training
- Navigating the Justice System

Sustainability

- Implementing Train-the-Trainer model for the following courses:
  - Cultural Competency/Health Literacy
  - De-escalation Training
  - Mental Health First Aid
- Development of e-learning modules accessible via CCB's Learning Management System

- PPS granted institutional training team at Catholic Health System, an important workforce training partner, funds to implement Mental Health First Aid training. Participation in this program is aligned with the community needs assessment of the hospital system

    - Training to be run by a non-Medicaid billing Tier 1 Community Based Organization, Compeer Buffalo.
    - Mental Health First Aid is an 8-hour course that teaches identification, understanding and responses to the signs of mental illnesses and substance use. The training provides skills for reaching out and providing initial help to patients and their care-givers. It help provide support to those who may be developing a mental health or substance use problem or experiencing a crisis.
    - Target for training is direct patient service staff. Trainings conducted once per month.

- PPS is funding SBIRT (screening and brief intervention and referral to treatment) training and program development resources, added to Catholic Health System substance abuse counseling and treatment program team.

Leatherstocking Collaborative Health Partners

Bassett Healthcare Network

DOH Success Stories- October 2017-April 2018

- **Disparities in Care Conference**-devoted to practitioner cultural competency focused on the importance of end of life care management and how it can affect the dual DSRIP goals of reducing avoidable ED visits and readmissions for this group of patients. CME credits were offered.
- **Community Action Poverty Simulation**- participants role-played the lives of low-income families as a way to understand the realities of poverty
- **April 3rd NARCAN education-** community and staff- 3 sessions
    - Through partner collaboration - planned and held a day of Narcan training sessions in an area identified as high need to reduce death from overdose. Also targeting recovery and reduction of ED transfers for substance abuse. Partners included O'Connor Hospital, Catholic Charities and Bassett Healthcare Network Care Management and Navigation services.
- **Sponsored the Healthier Living Expo- April 6-7th, 2018-** Hosted by Otsego County Department of Health- 1,500 community participants and informational booths by multiple LCHP Partners

NCI Incentive Programs

Approx. $4M

Success Story: Job Shadow Student from 2012 came back to region as PCP!

- **Provider Incentive Program** ($3.2M, 34 total: 12 PCP, 3 Psychiatrist, 2 Psychologist, 2 Dentist, 8 FNP, 4 Psych NP, 4 PA)
- **Certified Diabetes Educator Incentive Program** ($80k, 4 total)
- **Licensed Clinical Social Worker Incentive Program** ($265k, 8 total)
- **Medical Laboratory Technologist Incentive Program** ($130k, 10 total)
- **Nurse Education & Training Sustainment Program** ($100k, 3 awards)
- **Nurse Recruitment & Retention Incentive Program** (launched DY4)

Alignment with statewide initiatives (i.e. Doctors Across NY, National Health Service Corps, Nurse Corps, etc.)

STATE UNIVERSITY OF NEW YORK
JEFFERSON
There's more here.

Meeting Community Need: A Win-Win-Win

- Bryant & Stratton College: Health Services Administration, B.S.
- Greater Rochester Collaborative: Master's of Social Work
- Keuka College: Nursing, B.S. & Social Work, B.S.
- SUNY Upstate: Family Nurse Practitioner, M.S. & Family Psychiatric Mental Health Nurse Practitioner, M.S.

Past Programs: Respiratory Therapy, B.S. & Medical Technology, B.S.

Healthcare related Non-credit, Certificate & Associate Programs also offered through JCC (i.e. Care Coordination, Health Information Technology, RN (traditional & weekend), Phlebotomy, Pharmacy Technician, Billing & Coding, Certified Alcohol & Substance Abuse, etc.)

NQP WORKFORCE ACCOMPLISHMENTS May 2018

NQP Workforce Strategy

Fill Required Positions for Healthcare Delivery Transformation Success

Health Career Reception with NQP-CUNY York College on June 20 for employers to connect with skilled candidates

Produce Workforce to Meet Current and Future Needs

Data Analyst and CBO internships

Training Workforce in Required Competencies

Enhanced Smoking Cessation program to improve CAHPS scores

Motivational Interviewing classes

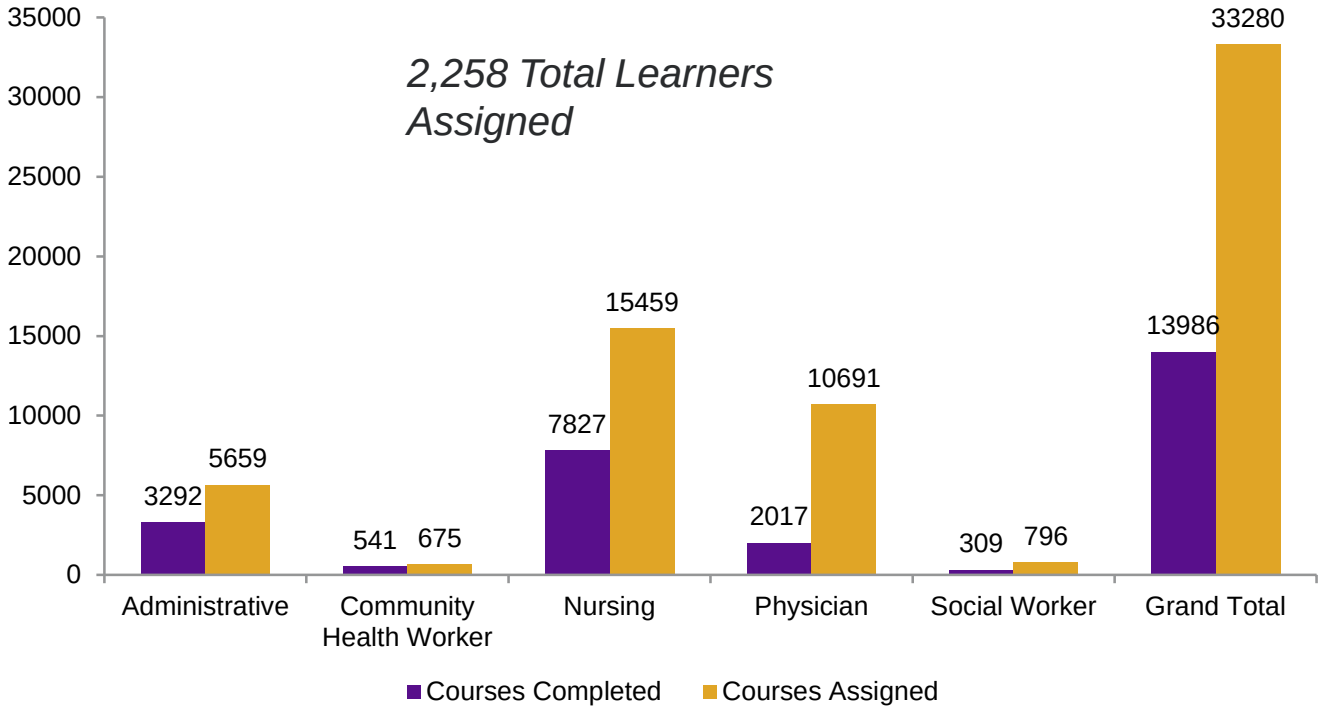
QAPI and VBP training program for SNFs

Chart Audit e-Learning

Sustainable Workforce so Education and Skill Development are ongoing

Train the Trainer programs under review in Mental Health First Aid and Patient Engagement

NYU Langone Brooklyn PPS*
Courses Assigned and Completed by Role as of 5/24/18



*Includes: NYU Langone Hospital Brooklyn, CBOs, and Primary Care Practices within PPS

Staten Island
Performing Provider System, LLC

CareerSTAT Recognition

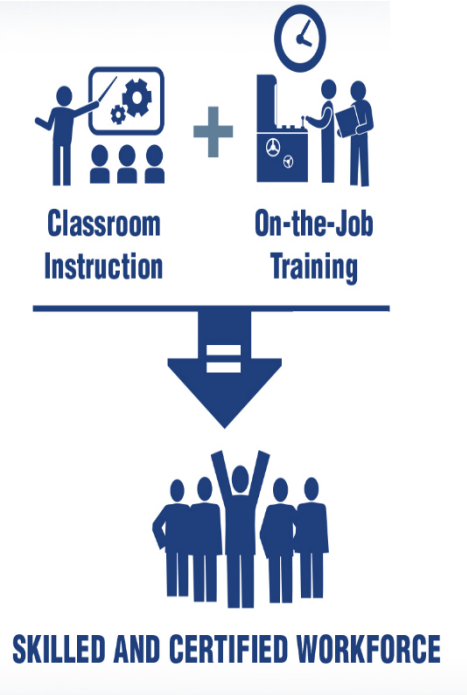
- SIPPS recognized as a 2018 Frontline Healthcare Worker Emerging Champion
- One of 36 organizations nationwide to receive recognition
- CareerSTAT to promote SIPPS' investments to generate support from healthcare leaders
  - Summer 2018 – Promotion Strategy
    - National Fund staff will assist SIPPS in developing an Emerging Champion profile highlighting frontline worker investments
    - Design and market Workforce Transformation Programs
    - National media announcements for recognized organizations - September
  - October 2018 - National Fund for Workforce Solution's Healthcare Connect Conference
    - Advances the conversation on key healthcare workforce and job issues nationwide
    - Awards given at National Event attended by more than 150 innovative healthcare and workforce leaders from around the country

WORKFORCE STRATEGY ALIGNMENT TO PROJECT IMPLEMENTATION & PERFORMANCE METRICS

Training strategy to support project implementation & performance

- Trained over 400 Community Health Workers and Associates in Patient Activation Measurement, Coaching for Activation and Community Navigation.
- Partnered with Nassau Queens PPS, the Long Island Health Collaborative and the Center for Suburban Studies at Hofstra University to deliver a Cultural Competency and Health Literacy (CC/HL) Training program. 150 Master Trainers and 222 workforce staff were trained.
- 172 Primary Care Practices (PCP) achieved NCQA 2014 PCMH Level 3 Recognition or APC Gate 2 approval.
- Facilitated 24 OASAS Certified SBIRT Training sessions, resulting in 327 staff (hospital, behavioral health and PCP sites) trained and received OASAS SBIRT Certifications.
- 25 nurse participants of the Transition of Care Project trained and certified in Coordination & Transition Management (CCTM).
- Learning Center supports 17 Learning Modules with 37 Topics available on-line – over 5,000 total trainings have been completed.

Program Overview – From the Community, For the Community



- 7-week training program that includes
  - **~50 hours of instructional classroom education**
  - **~ 190 hours of preceptor-supervised mentored apprenticeships**
  - **Participation stipend**
  - **Support with job placement & skills building**

- Graduates will have the skills to be able to:
  - ✓ **Navigate** the health system and social services
  - ✓ **Advocate** for individual and community needs
  - ✓ **Provide** Direct Services like
    - ❖ Care coordination
    - ❖ Patient navigation
    - ❖ Education/Empowerment for Self-care management

DSRIP Alignment

Community Engagement

- CHW Program engaged two Tier 1 CBOs: Glory House Recovery & Choice for All served as apprentice ship sites
- NQP Engagement Forum indicated community interest in/need of CHWs

Hotspot Engagement

- First cohort CHW recruitment focused on the communities of Roosevelt, Freeport, and Hempstead – all of which were identified by NQP as hotspot communities

Workforce Development

- NQP has interest in workforce development efforts – specifically investing in CHWS - in Far Rockaway
- St. John's Episcopal Hospital, part of the CHS Hub, has indicated interest in hiring CHWs

NYS VBP Menu

- The NYS VBP Menu includes CHW interventions in almost every category including Education; Social, Family and Community Context; Health & Healthcare; and Neighborhood Environment

Project Alignment

- DSRIP Projects/Workstreams include CHW interventions, including project 2ai.
- The CHW Program fostered Hub collaboration – LIFQHC (NUMC Hub) served as an apprenticeship site and Dr. Delmont (PPS Committee Member) provided input and was willing to serve as an apprenticeship site

Northwell Health™

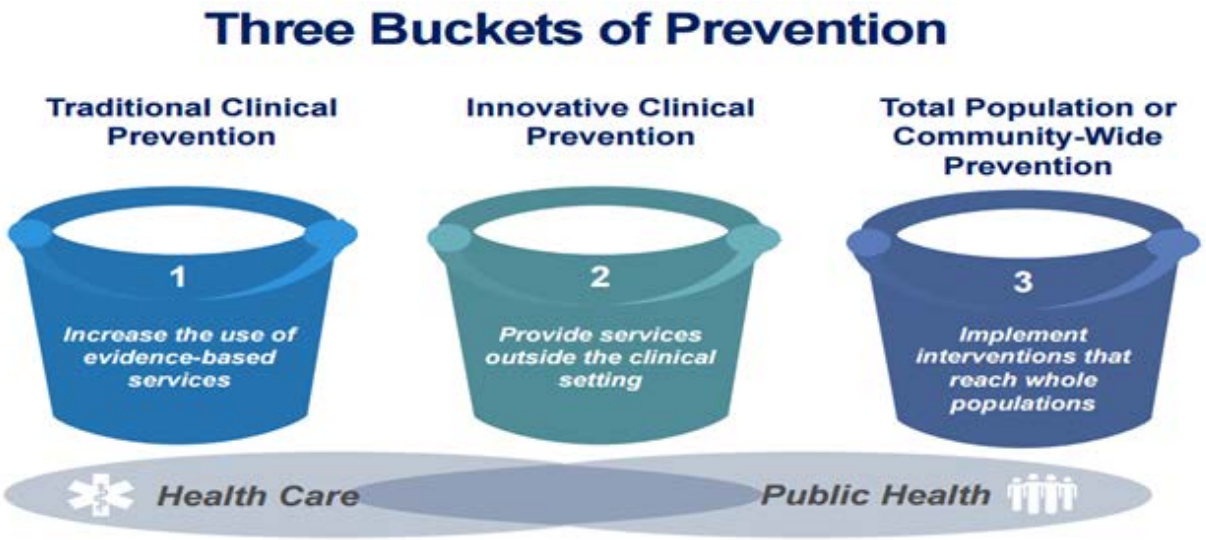
Social Determinants

Social Determinants

New York State Department of Health
Office of Public Health

NEW YORK STATE OF OPPORTUNITY. Department of Health

Population Health and SIM: CDC's Framework



Auerbach J., The 3 Buckets of Prevention. Journal of Public Health Management and Practice 2016.
http://journals.lww.com/jphmp/Citation/publishahead/The_3_Buckets_of_Prevention_.99695.aspx

CDC

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Example of the Three Buckets of Prevention

Ms. Jones

- 55 years old, married
- Smokes, overweight, little exercise
- Asthmatic, high blood pressure, depression
- Other factors contributing to her health:
  - Lives in a neighborhood with crime, few parks; no supermarket
  - Under stress; child with substance abuse problem
  - Sub-par housing with mold and ventilation problem

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Example of the Three Buckets of Prevention (continued)

Bucket 1: Ms. Jones receives **clinical preventive services:**

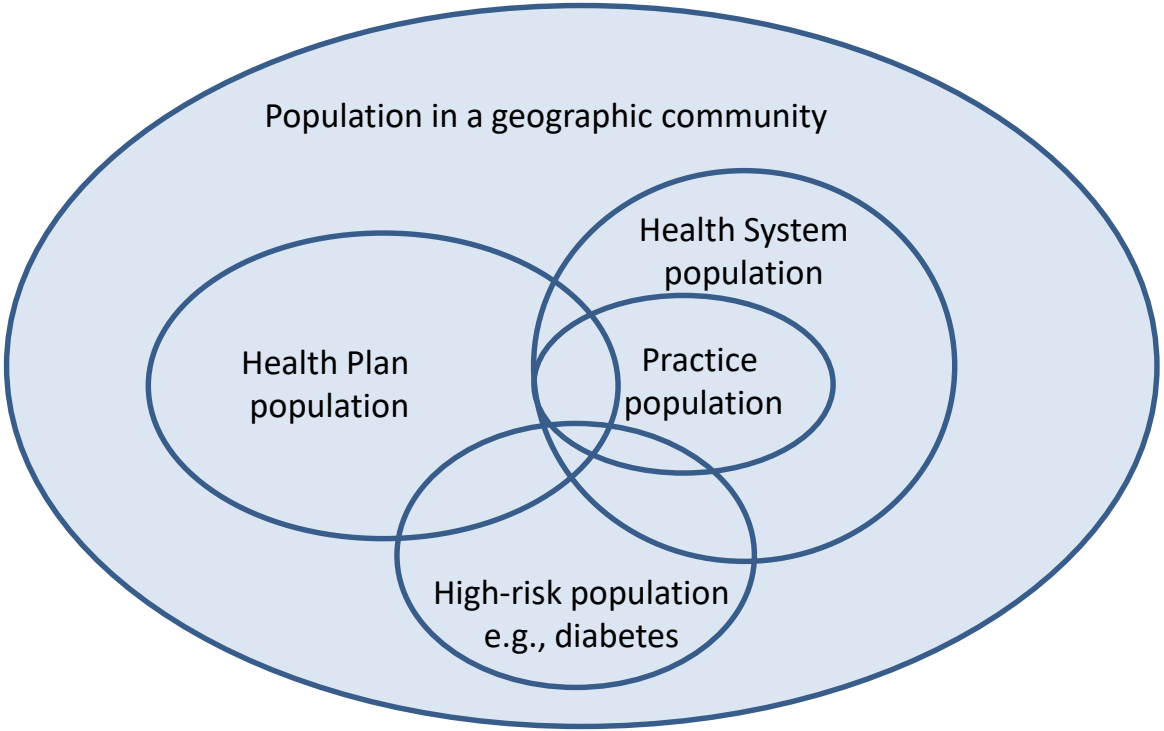
- Guideline-concordant care for asthma, tobacco dependency, HTN, obesity
- Recommended cancer screenings
- Screening and brief intervention for depression

Bucket 2: Ms. Jones receives **innovative patient-centered medical care** and is connected to **community services**:

- Home assessment by the local health department of asthma triggers
- Home blood pressure monitoring with follow up by a CHW
- Referral to a National Diabetes Prevention Program

Bucket 3: Ms. Jones lives in a **community that supports healthy lifestyles**:

- Smoke-free multi-unit housing
- Transportation systems that encourage mass transit, biking and walking
- Access to grocery stores with fresh vegetables and fruits



To achieve Population Health, strategies need to occur in all of these “populations,” including populations in communities.

Challenges to Implementing the Three Buckets of Prevention

- **Bucket 1: Services likely covered**
  Attention to lowering barriers, creating incentives, and promoting use
- **Bucket 2: Services potentially covered**
  Attention to adding coverage, creating incentives, ensuring capacity, promoting use, making linkages
- **Bucket 3: Activities likely not covered**
  Attention to building capacity and sustainability

Social Determinants

Greater New York Hospital Association

IMPROVING COLLABORATION BETWEEN PRIMARY CARE RESIDENCY PROGRAMS AND CBOS

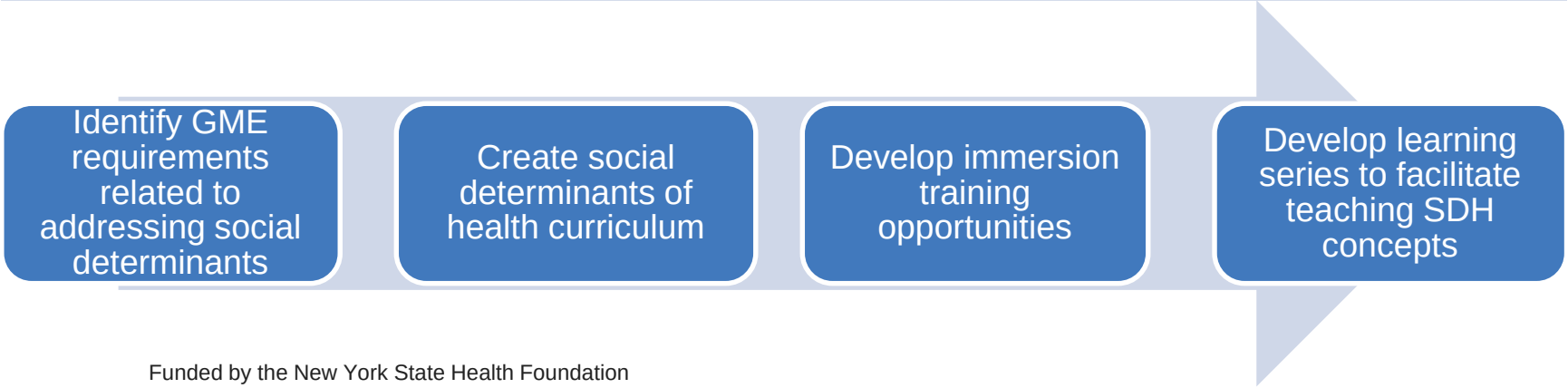
New York State Department of Health SHIP/DSRIP
Workforce Workgroup
June 15, 2018

GREATER NEW YORK HOSPITAL ASSOCIATION
Over 100 years of helping hospitals deliver the finest patient care in the most cost-effective way.

Improving Care Delivery through Integration of Residents with Community-Based Services

Project Goals

- Educate residents on social determinants of health
- Increase residents' awareness of community resources and activities of community-based organizations (CBOs); increase resident involvement in DSRIP, primary care transformation, value-based payment
- Create partnerships between teaching hospitals and CBOs



Funded by the New York State Health Foundation

Curriculum for Primary Care Residency Programs

Partnerships between CBOs and Residency Programs through Immersion Training

The goal of this collaboration is to create a sustainable, replicable model of training

- Immersion training consists of on-site education at the CBO
  - Orientation to the community served by the CBO
  - Opportunities for resident interaction with CBO clients
  - Hands-on learning activities for residents (tours, group meetings, direct observation)

GNYHA matched 15 primary care residency programs with 15 CBOs

- Trainings for took place throughout the 1st quarter of 2018
- Trainings ranged from one-day immersion experiences to 10 days of planned activities

Primary Care Residency Program and CBO Matches (cohort #1)

Hospital	Residency Program	CBO Match
The Brooklyn Hospital Center	Family Medicine	Arab-American Family Support Center
Cohen Children's Medical Center/ Northwell Health	Pediatrics	The Child Center of NY
Mount Sinai Hospital	Pediatrics	Little Sisters of the Assumption Family Health Service
Mount Sinai St. Luke's - Mount Sinai West	Internal Medicine	City Health Works
Northwell Health	Internal Medicine, Family Medicine	The Interfaith Nutrition Network
SBH Health System	Internal Medicine	a.i.r. nyc
South Nassau Communities Hospital	Family Medicine	AIDS Center of Queens County
Staten Island University Hospital	Pediatrics	Person Centered Care Services
SUNY Downstate Medical Center/ Kings County Hospital	Pediatrics	Young Adult Institute
	Internal Medicine	Institute for Community Living
	Family Medicine	God's Love We Deliver
Wyckoff Heights Medical Center	Internal Medicine	RiseBoro Community Partnership

Primary Care Residency Program and CBO Matches (cohort #2)

Hospital	Residency Program	CBO Match
Stony Brook University Hospital	Internal Medicine	WellLife Network
Brooklyn Methodist Hospital	Pediatrics	The Jewish Board
Rochester Regional Hospital	Internal Medicine	Foodlink

One Day Immersion Training Experience: South Nassau Communities Hospital and AIDS Center of Queens County

Morning

- Introductions to leadership in all care service areas and department overviews of each area
- Lectures on what a CBO is and why it helps to partner with one

Workshop

- Mock client intake with staff

Afternoon

- Tour transitional housing unit and meet with residents to discuss their experiences receiving medical care in the community
- Reflections by residents

Multiple, Half-Day Immersion Training Experience: Mount Sinai St. Luke's, Mount Sinai West and City Health Works

Day 1 (9:00 am – 1:00 pm)

- Orientation
- Meet & Greet luncheon

Day 2 (9:00 am – 1:00 pm)

- Shadow community health workers (CHW) with three CHW clients
- Sessions take place off-site at clients' homes or community settings

Day 3 (1:00 pm – 5:00 pm)

- Shadow CHW coaches with one CHW client (off-site)
- Return to CHW offices for reflection

10-Day Immersion Training Experience: Staten Island University Hospital and Person Centered Care Services

Days 1-3

- Full employee orientation

Days 4-7

- Shadow one department per day

Day 8

- Work with Program Development Department on collaboration and outreach plan

Day 9

- Outreach implementation

Day 10

- AM outreach implementation and PM reflection

Project Evaluation and Additional Deliverables

GNYHA is evaluating the overall project through focus groups of the program directors and CBO participants, and surveys of the residents who worked with the CBOs

GNYHA will develop guidance documents to inform additional partnerships

September 20 symposium will showcase resident experiences and discuss long-term partnership sustainability

Learning Series on Social Determinants of Health (materials are available on GNYHA website)

January 26, 2018	• Preparing Residents for Home Visits to Assess Social Needs (webinar)
March 6, 2018	• Addressing Social Needs and Health Disparities in Health Care Settings
May 18, 2018	• Social Needs for Vulnerable Populations in the Context of Health Care
June 15, 2018	• Addressing Social Needs of the Pediatric Population
September 20, 2018	• Improving Residency Program and CBO Collaboration Educational Symposium
Additional Programming	• Creating Medical-Legal Partnerships

Project Contacts

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Project documents and additional information is available on the GNYHA website (https://www.gnyha.org/program/resident-cbo-project/)

Social Determinants

New York State Department of Health
Office of Health Insurance Programs
Bureau of Social Determinants

NEW YORK STATE OF OPPORTUNITY. Department of Health

NEW YORK STATE | Department of Health | Medicaid Redesign Team

Workforce Workgroup Meeting

June 15, 2018

Emily Engel
Bureau of Social Determinants of Health
NYS DOH/OHIP/DPDM

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education			
Support	Walkability				

Health Outcomes

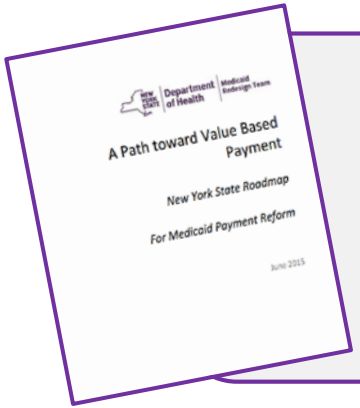
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Bureau of SDH: 2018 Goals

Implement the VBP Roadmap Requirements Related to SDH and CBOs	•Review VBP Level 2 and 3 Contracts and Amendments •Track SDH Interventions and CBO •Provide support and technical assistance
Stakeholder Engagement	•Learning collaboratives with MCOs, VBP contractors, CBOs, & health care providers •Maximize CBO and SDH interventions in the health care system.
Improve SDH Measures in Population Health and Payment Reform	•Increase data collection on SDHs (i.e. electronic health records) •Standardize SDH Quality Measures and incorporating into QARR
Prevention Agenda	•The State intends to introduce a value based payment arrangement pilot to focus specifically on achieving potentially trailing Prevention Agenda targets through CBO-led community-wide efforts
Create a New Housing Referral Process	•Integrate MRT SH with PPSs, VBP Contractors, and Health Systems •Create a plan to expand to families to align with the First 1K Days

Social Determinants of Health (SDH) VBP Roadmap Standards & Guidelines

Standard: Implementation of SDH Intervention



"To stimulate VBP contractors to venture into this crucial domain, VBP ***contractors in Level 2 or Level 3 agreements*** *will be* ***required****, as a statewide standard,* ***to implement*** *at least* ***one social determinant of health intervention****. Provider/provider networks in VBP Level 3 arrangements are expected to solely take on the responsibilities and risk." (VBP Roadmap, p. 41)*

Description:

VBP contractors in Level 2 or 3 arrangement must implement at least one social determinant of health intervention. Language fulfilling this standard must be included in the MCO contract submission to count as an "on-menu" VBP arrangement.

Guideline: SDH Intervention Selection

*"The **contractors will have the flexibility to decide on the type of intervention** (from size to level of investment) that they implement…The guidelines recommend that selection be based on information including (but not limited to): SDH screening of individual members, member health goals, impact of SDH on their health outcomes, as well as an assessment of community needs and resources." (VBP Roadmap, p. 42)*

Description:

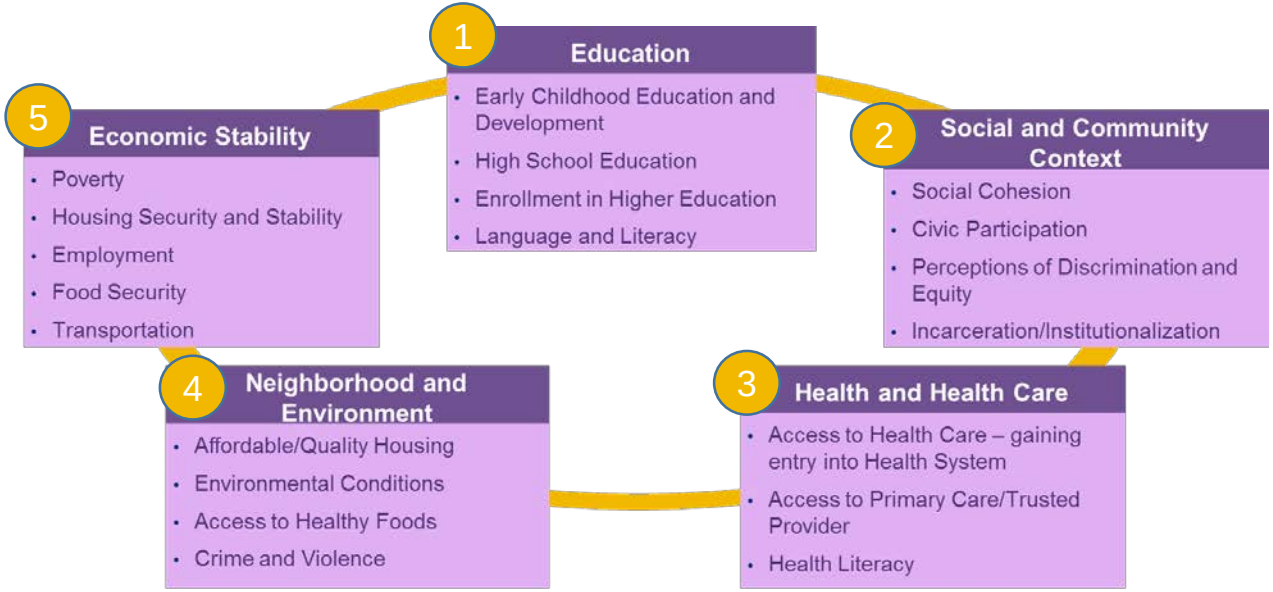
VBP contractors may decide on their own SDH intervention. Interventions should be measurable and able to be tracked and reported to the State. SDH Interventions must align with the five key areas of SDH outlined in the *SDH Intervention Menu Tool,* which includes:

1) Education, 2) Social, Family and Community Context, 3) Health and Healthcare 4) Neighborhood & Environment and 5) Economic Stability

The SDH Intervention Menu Tool was developed through the NYS VBP SDH Subcommittee and is available here: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/

The 5 Domains of Social Determinants of Health

VBP Contractors must select a social determinant of health intervention that aligns with at least one of the 5 key areas of social determinants of health, as outlined in the SDH Intervention Menu and SDH Recommendation Report.



The **VBP SDH** subcommittee created a **Intervention Menu Tool and recommendations** to supply providers with evidence-based interventions that aim to improve SDH: SDH Intervention Menu and Recommendations (Appendix C)

Community Based Organizations (CBOs) VBP Roadmap Standards & Guidelines

Tier 1, Tier 2, and Tier 3 CBO Definitions

01

Tier 1 CBO

- Non-profit, non-Medicaid billing, community based social and human service organizations
  - e.g. housing, social services, religious organizations, food banks
- *All or nothing*: All business units of a CBO must be non-Medicaid billing; an organization cannot have one component that bills Medicaid and one component that does not and still meet the Tier 1 definition

02

Tier 2 CBO

- Non-profit, Medicaid billing, non-clinical service providers
  - e.g. transportation provider, care coordination provider

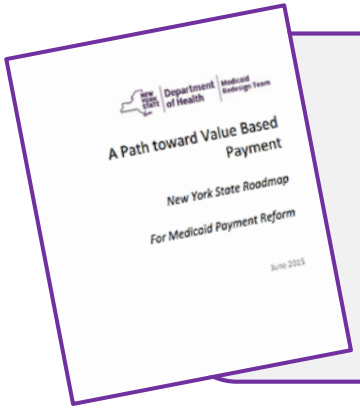
03

Tier 3 CBO

- Non-profit, Medicaid billing, clinical and clinical support service providers
- Licensed by the NYS Department of Health, NYS Office of Mental Health, NYS Office for Persons with Developmental Disabilities, or NYS Office of Alcoholism and Substance Abuse Services.

Use the **CBO list** on DOH's VBP website to find CBOs in your area

Standard: Inclusion of Tier 1 CBOs



"Though addressing SDH needs at a member and community level will have a significant impact on the success of VBP in New York State, it is also critical that community based organizations be supported and included in the transformation. It is therefore a ***requirement*** *that* ***starting January 2018, all Level 2 and 3 VBP arrangements include a minimum of one Tier 1 CBO****." (VBP Roadmap, p. 42)*

Description:

Starting January 2018, VBP contractors in a Level 2 or 3 arrangement **MUST contract with at least one Tier 1 CBO**. Language describing this standard must be included in the contract submission to count as an "on-menu" VBP arrangement.

This requirement **does not preclude VBP contractors from including Tier 2 and 3 CBOs in an arrangement** to address one or more social determinants of health. In fact, **VBP Contractors and Payers are encouraged to include Tier 2 and 3 CBOs in their arrangements.**

The Role of Tier 2 and 3 CBOs in VBP

Tier 2 and Tier 3 CBOs can and will play an important role in VBP!

The more the merrier

- While all Level 2 & 3 arrangements must include at minimum one Tier 1 CBO, a VBP Contractor can include more than one CBO (including Tier 2 & 3 CBOs) in an arrangement

Make a friend

- Tier 2 & 3 CBOs may partner with Tier 1 CBOs to help support the implementation of an SDH Intervention

VBP Contractors are incentivized to include multiple CBOs

- By addressing SDHs, CBOs (including Tier 2 and 3 CBOs) can have a large impact on the overall health of Medicaid members, which may result in more shared savings for a VBP Contractor

Align with a VBP arrangement

- Tier 2 and 3 CBOs may be the logical partners for specific types of arrangements if the services the CBO provides are aligned with the arrangement a lead VBP contractor is implementing

Cover a larger geographic area

- Tier 2 and 3 CBOs can cover regions/communities not already impacted by an SDH Intervention

Workforce and Social Determinants of Health

- Low Skill Direct Care Workforce
- Economic Barriers (Low Wages and Transportation Barriers)
- Client/Provider Trust Issues
- Provider Empathy Issues
- Lack of Functional Knowledge in Social Determinants of Health
- Cultural Sensitivity and Privacy Issues

SDH Workforce Challenges

- Cultural Competency Training
- Social Determinants of Health Education and Training for Workforce
- Community Engagement
- Community Driven Policy Development
- Social Determinants of Health Screening and Assessment Training

SDH Workforce Opportunities

Thank you!

For Additional Information:

Value Based Payment (VBP) Resource Library

Contact Us:

Bureau of Social Determinants of Health

SDH@health.ny.gov

Care Coordination and Integration

Promoting Physical and Behavioral Health Care Integration

- The Workgroup has recognized the need to support the integration of physical and behavioral health care, which is supported by recent legislative enactments

- See *Social Work/Mental Health Licensure* excerpt from 2019 Enacted Budget (Chapter 57 of the Laws of 2018, Part Y)

- See *Integrated Care* excerpt from 2019 Enacted Budget (Chapter 57 of the Laws of 2018, Part S, Subpart C)

- See *Telehealth* excerpt from 2019 Enacted Budget (Chapter 57 of the Laws of 2018, Part S, Subpart C)

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Incorporating Care Coordination into Training

- The Workgroup has recognized the need to identify consistent training guidelines for workers who carry out care coordination functions
- The Workgroup supported the issuance of care coordination guidelines for existing workers (*Core Curriculum to Train Care Coordination Workers)* https://www.health.ny.gov/technology/innovation_plan_initiative/docs/core_curriculum_train_ccw.pdf

- The Workgroup has discussed draft care coordination guidelines for students - see *Draft Care Coordination Curriculum Guidelines for Health Profession Students*

- A dissemination plan has been developed for the guidelines for students

NEW YORK STATE OF OPPORTUNITY. Department of Health

Addressing Practice Barriers

- The Workgroup has recognized the need to identify and address barriers to effective care coordination
- While the scope of practice for licensed professionals generally does not preclude them from carrying out tasks related to care coordination, there are potentially some actions that can be taken to maximize the ability of practitioners to provide patient-centered, team-based care
- One recommendation made by the Workgroup is to explore the expanded use of “standing orders” in specified situations

- See *Draft Discussion – Promoting Care Coordination through Standing Orders*

Enhancing Health Workforce Data

- The Workgroup has recommended that statutory changes be pursued to allow collection of more robust information about the health care workforce, particularly with respect to the distribution of practitioners

  - The Department of Health has proposed legislation to incorporate additional information into the Physician Profile (see *Physician Profile* legislation)

  - The Department of Health has also proposed legislation to require the provision of data by other health care practitioners upon registration and re-registration with the State Education Department (see *Practitioner Data* legislation)

Resources

Links

- New York State PCMH
  https://www.health.ny.gov/technology/innovation_plan_initiative/nys_pcmh.htm
- DSRIP Workforce Impact Analysis Report
  https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/workforce_docs/docs/2018-02_workforce_impact.pdf
- Greater New York Hospital Association Resident/CBO Project Information
  https://www.gnyha.org/program/resident-cbo-project
- NYS VBP Library
  https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library
- Core Curriculum to Train Care Coordination Workers
  https://www.health.ny.gov/technology/innovation_plan_initiative/docs/core_curriculum_train_ccw.pdf