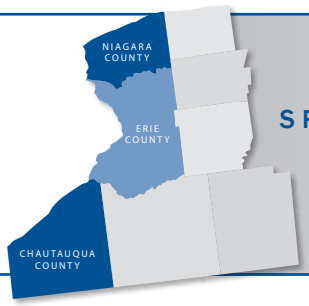
COMMUNITY PARTNERS OF WNY
Performing Provider System



SPRING/SUMMER 2017
NEWSLETTER

Community Health Workers: A Bridge Between Communities & Providers

Community Health Workers (CHWs) serve as a link between community health providers and patients. CHWs are a devoted group of people seeking to remove barriers created by social determinants of health. They advocate for people, even when those people don't advocate for themselves. They provide outreach. They connect communities and providers. They save lives.

As defined by Healthy People 2020, social determinants of health are "conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." With the overall goal of DSRIP to reduce avoidable hospital use by 25% over five years, population health and preventative medicine are natural focuses. However, personal conflicts, or adverse systematic conditions, can often prevent people from seeking or accessing the help they need. Circumstances such as job constraints, lack of transportation, substance abuse issues, and more can present significant obstacles. This is where CHWs come in.

Community Partners of Western New York (CPWNY) currently uses CHWs in two major areas: behavioral health and maternal/fetal health. After visiting a community health center, at-risk patients are identified in order to track their visits and support provider efforts to deliver the care necessary to maintain good health.

CHWs will introduce themselves to patients and establish a trusting relationship, either at the patient's first visit or a subsequent one. If a patient fails to present for their follow-up appointments, the CHWs have an established process for reaching out to the patient and encouraging them to return.

This protocol includes:

- Reaching out to patients via phone and try to connect with them to see what happened
- Following failed attempts to contact the patient by phone, attempting to make a home visit
- In the patient's absence, leaving behind information to let the patient know they stopped by.
- Follow-up attempts to connect with the patient via phone and in-person visits

Often times, it takes multiple phone calls and visits to achieve success in reconnecting the patient to the clinic, but in the end, the persistence usually pays off. CHWs are also instrumental in connecting these patients with further resources, such as community services, transportation assistance, and health insurance programs.

CPWNY works with two community sponsors of the Community Health Worker program, The Buffalo Urban League and Catholic Charities. Both organizations utilize the Community Health Worker Network of Buffalo to help train the workers on the best practices for working with the community. (Cont. on page 2)

Community health workers pose with the Buffalo Urban League Executive Vice President, Grace Tate.

From left to right: Christie Walker, Belinda Gaiter, Grace Tate, Maribel (Bella) Irizarry, and Mariana Cole-Rivera.

CHWs (Cont.)

Training topics include:

- communication
- privilege and power
- bias
- stages of behavior change
- ethics of care
- strengths/assets-based approaches
- the history of CHWs
- the history of Buffalo
- safety & self-care
- ethics of care
- learning theories

Renee Cadzow, PhD, serves on the Board of Directors for the Community Health Worker Network of Buffalo and is an active part of the training team. She says the training emphasizes the role of everyone as both learners and teachers, and has been extremely effective. “This approach is empowering to participants, particularly those who are from populations that have experienced oppression and pervasive disparities in resource access and health outcomes.”

For The Buffalo Urban League, partnering with CPWNY is ideally aligned with their goals as an organization. “It’s a natural partnership that serves many in our community who we can assist in improving their health outcomes,” says Grace Tate, executive vice president for the Buffalo Urban League.

For more information about how CHWs are impacting the DSRIP efforts of CPWNY, please contact Phyllis Gunning, Director of Clinical Programs, at 716-862-2482 or by emailing pgunning@chsbuffalo.org.

Independent Evaluator Named

UNIVERSITY AT ALBANY

State University of New York

New York State Department recently announced the University at Albany was selected to be the Independent Evaluator (IE) of the DSRIP program. The independent evaluation is a 5 year multi-method, comprehensive, statewide, independent evaluation. The University at Albany team will evaluate whether the DSRIP initiatives have achieved desired impact, effectiveness, cost savings and value improvements using a pre-post design. More information can be accessed online at: health.ny.gov/health_care/medicaid/redesign/dsrip/evaluation.htm

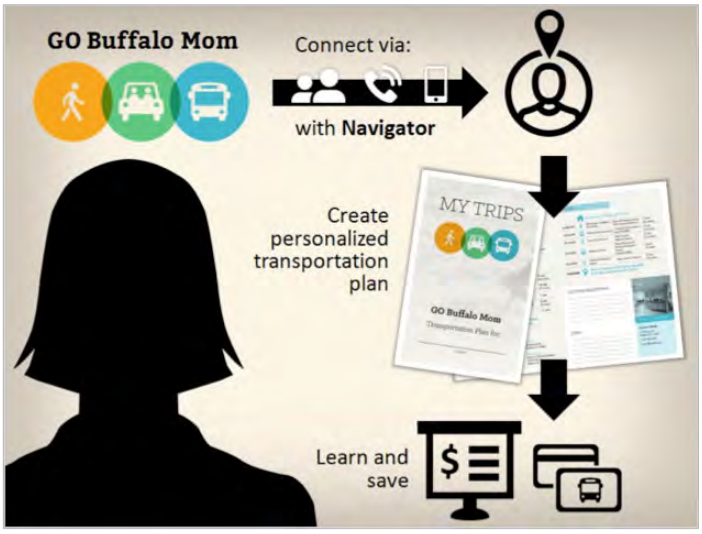
Project Advisory Committee Recap

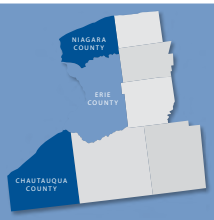
On March 29, 2017, Community Partners of Western New York’s Project Advisory Committee (PAC) held its quarterly meeting at the Millennium Hotel to update partners and the community on its progress. The meeting was well-attended and received excellent feedback!

For the full presentation slides, please visit our website at: wnycommunitypartners.org/wp-content/uploads/2017/03/3.29.17-PAC-Presentation.pdf

Topics covered at the meeting included:

- HEALTHeLINK updates, presented by Stephen Gates, Senior Manager of Provider Support Services, HEALTHeLINK
- A presentation from Kelly Dixon of the Greater Buffalo Regional Transportation Council, Go Buffalo Niagara
- Mary Comtois provided an overview of the United Way, Go Buffalo Mom program





Join our Project Advisory Committee!

Contact us at: wnycommunitypartners.org/contact-us/ and mention that you want to participate in our PAC!

Grant Provides Funding For Cardiovascular Health Program

Western New Yorkers in Buffalo's "Old First Ward" neighborhood are now able to get Heart Smart for Life thanks to a generous $165,770 grant from the AstraZeneca HealthCare Foundation. The Mercy Hospital Foundation is one of only ten nonprofit organizations across the country to receive funding as part of AstraZeneca HealthCare Foundation's Connections for Cardiovascular Health℠ program. The Mercy Comprehensive Care Center (MCCC) will utilize it to combat heart disease in one of Buffalo's most underserved neighborhoods.

This collaborative initiative is aimed at ensuring vulnerable populations have access to nutrition education, biometric health screenings, wellness programs, and other resources focused on preventing heart disease. Participants receive up to 20 sessions on cardiovascular health, healthy eating, exercise, behavioral health issues and medication usage. Weekly food demonstrations provide healthy, inexpensive, and easy to prepare meals. Weekly exercise sessions are available at the local community center that has committed to partnering in this effort. Classes are held in a "judgment-free zone" at the MCCC and in the community where small successes are celebrated and rewarded.

This initiative, unlike the traditional model of primary care, takes clinicians and care to potential participants/patients in the community. Recruitment begins via a mobile health screening van, presentations at community partner sites, clinic referrals and most importantly through "bring a friend" efforts.

Participants do not need to be current MCCC or Catholic Health patients. The program is open to the community and enrollment is offered on a rolling basis.

For more information about the program, please call 716-923-6152 or visit: wnycommunitypartners.org/wp-content/uploads/2017/05/Heart-Smart-Program.pdf.

Compliance Corner

Quality Assurance and Self-Auditing Process & Audits

The compliance team has implemented a three-step process to help ensure the information reported is accurate and conforms to appropriate DSRIP submission requirements. First, each Partner reporting patient engagement numbers must follow the CPWNY Quality Assurance and Self Auditing Process. Prior to submitting reports to CPWNY, each Partner must pull a random sample of 5% of the records to validate that they are true and accurate and consistent with the information required under the DSRIP program. If any errors are identified, the Partner shall work with CPWNY to identify the root cause and update the patient engagement reports accordingly, followed by a second audit of the revised report.

After the information is received by CPWNY, a second review of the information will be conducted, and any submissions that are not complete, or are duplicative, will be eliminated. Third, on no less than an annual basis, the compliance team will conduct an audit for each project to ensure proper and accurate reporting. This audit will include a random sample of the CIN numbers reported, and Partners will be contacted directly if additional information is necessary.

Any questions regarding the self-auditing process or audit policy can be directed to the CPWNY Compliance Officer, Kimberly Whistler, Esq., by calling 716-821-4471.

DSRIP On LinkedIn

Don't forget to check out our group!

A LinkedIn group has been established to bring together PPS members and community stakeholders from across the state, to learn from each other and to collaborate on effectively transforming New York's healthcare delivery system for Medicaid members.

Visit linkedin.com/groups/8466940 for discussions on popular topics, shared presentations and resources, and an opportunity to meet people involved both locally, and statewide in the DSRIP initiative.

Work Flow Updates

Workstreams provide structure in key areas of service delivery for the PPS. The workstream efforts are led by key staff of the PPS and members of the partner community, as required by the implementation plan submitted to the New York State Department of Health.

• **IT Systems and Processes Data Governance:** The Data IT Governance Committee (DIGC) continues to meet on a quarterly basis to oversee and report on CPWNY's IT processes and procedures. CPWNY, in support of the project management office, continues its work in carrying out its milestone completion, meeting the NYS security requirements, and collaborating with Millennium Collaborative Care and the local RHIO (HEALTHeLINK). These efforts are ongoing and are discussed through ad-hoc meetings, quarterly workgroups, and committees.

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HEALTHeLINK

Millennium
COLLABORATIVE CARE
Igniting Healthcare Change in WNY

• **Workforce:** CPWNY has successfully completed and submitted all five of the required milestones due for completion by the end of DSRIP year two (March 31, 2017). Moving forward, the PPS will monitor the staffing impact across its partners, pertaining to both the number of positions and job titles. CPWNY continues to collect and submit workforce budget spending across the four state-mandated categories on a bi-yearly basis to the state, due for submission on Q2 (10/31/2017) and Q4 (4/31/2018).

Workforce Compensation & Benefit Survey Coming Fall 2017

Starting in DSRIP year three, the partner members of CPWNY are required to complete a Compensation and Benefit review. This will be the second review completed and will follow the same process as the prior Compensation and Benefit survey completed in March 2016. The PPS and R-AHEC, our workforce partner, are seeking partner assistance in collaboratively completing the requirement. Planned start for this survey is September 2017. For more information about this survey, contact Rustam Ushurov at: rushurov@r-ahec.org or 585-786-6275, or Mark Gburek at: mgburek@chsbuffalo.org or 716-862-2484.

• **Performance Reporting:** CPWNY is analyzing state data with continuous updates on data use and confidentiality. Currently, the PPS provides practices with their performance from EMR (electronic medical record) data and intersect it with claims data through Crimson analytics software tools. Performance reporting efforts continue. Rapid Cycle improvement work is underway with PPS partners needing to improve patient engagement and quality metric results.

• **Cultural Competency and Health Literacy (CC/HL):** CPWNY and its partners continue to work within the community to reduce healthcare disparities, and focus on screenings for cancer and blood pressure. CPWNY is piloting incentives focusing on completion of preventive screenings at high volume Medicaid clinics. CPWNY continues to support self-management education through P2WNY in each county by focusing on blood pressure screenings and patient education materials (a Medicaid patient focus group evaluates the materials). In August, CPWNY will partner with Good for the Neighborhood to improve health monitoring in neighborhoods, with a goal of an increase in cancer and BP screenings.

Our CCHL Training Strategy Is On Course!

CPWNY offers a variety of methods for practices to attend training sessions, such as videos, on-site (minimum of at least 10 staff must attend) and large meetings, offered quarterly.
For more information, please contact Brittany Bolden at: bbolden1@chsbuffalo.org or Patti Podkulski at: ppodkuls@chsbuffalo.org.

Work Flow Updates (cont. from pg. 4)

• **Governance:** Governance committees continue to meet on a regular basis. These include the Executive Governing Committee, Clinical Governing Committee, the Data and IT Governing Committee, and the Financial Governing Committee. The community is regularly engaged in DSRIP updates, and is also solicited for two-way feedback, as part of the Project Advisory Committee (PAC), which met most recently on March 29. Topics from the PAC included transportation resources for partners and Medicaid Beneficiaries, including resources from GOBuffaloNiagara.com and its partner GO Buffalo Moms collaborative project. Partners also heard from HEALTHeLINK, health information exchange, about partner participation and patient consent to share data. CPWNY's submission for addressing recommendations of the Mid-Point Assessment were accepted by the Department of Health on May 15.

Kelly Dixon (pictured above) of the Greater Buffalo Regional Transportation Council, Go Buffalo Niagara, speaks about transportation resources at the March 29 PAC meeting.

• **Clinical Integration:** The 2016-2017 CI plan is in place and encompasses population health and performance reporting.

• **Population Health Management:** CPWNY continues to advance its population health endeavors through its 10 projects and related data reports, as well as through its Care Management tools and processes, its PCMH implementations, and community outreach. For example, population health focuses on steering Medicaid beneficiaries to physician offices, while reducing unnecessary emergency department and hospital use. Additionally, CPWNY's efforts seek to improve access to self-management, caregivers, and community support.

• **Financial Stability and Funds Flow:** The Finance Committee continues to report on and provide updates to Governance and the community workgroup on DSRIP financial milestones. The DY3 budget was presented to and approved by the CPWNY Finance Governance Committee (FGC) in March 2017 and the Executive Governance Board (EGB) in April 2017. Information regarding the DY3 budget was shared with the PAC committee in March 2017. The DY2 year-end financial statements were presented to and approved by the FGC, and will be presented to the EGB in July 2017. Work continues on the Value-Based Payment (VBP) planning and education efforts. A VBP subgroup of the Finance Committee is developing the overall VBP plan for the PPS, as well as a network education plan for VBP, which will be submitted to New York State for the June 30, 2017 quarterly milestone deliverable. Additionally, the FGC is preparing for the annual Financial Sustainability Assessment which will include a survey, as well as an analysis of financial information of network partners.

Continued Learning Opportunities for Value-Based Payment Reform!

The New York State Department of Health announced another video in its whiteboard series. In the video titled, "Value Based Payment (VBP) and The Year Ahead," New York State Medicaid Director, Jason Helgerson, gives an overview of VBP progress to-date, including an update on the percent of Medicaid payments that are currently value based. He also describes ways to move into VBP arrangements and what is next for VBP in the year ahead.

To view the video, click here: youtube.com/watch?v=jqFipBmg2Rs&feature=youtu.be

For additional status updates on the projects or workstreams, please contact the appropriate DSRIP project coordinator or staff member.

Brief Project Updates

2.a.i Create integrated delivery systems that are focused on evidence based medicine/population health management: CPWNY and Bertrand Chaffee Hospital have been engaged in project discussions specific to Care Transitions and the ED triage project. Other DSRIP projects are under review by the CPWNY team and the team at the hospital. Outreach efforts continue with Westfield Hospital to explore opportunities for Care Transitions and ED Triage projects. Progression of practices moving toward Patient Centered Medical Home level 3 continues across all three counties. Chautauqua County Health Network (CCHN) is an essential provider resource for this effort in the region. CCHN and their DSRIP practices are looking at Crimson quality reporting software tools for quality outcomes monitoring with EHR data.
Project Lead: Phyllis Gunning

BERTRAND CHAFFEE HOSPITAL

2.b.iii ED triage for at risk patients: Inside the partner hospital emergency departments (ED), Patient Navigators are successfully scheduling ED patients for a visit with a primary care physician. By utilizing the direct scheduling system implemented at primary care clinics, project teams have created greater access to follow-up appointments. The Health Connection outgoing call center team at Catholic Health continues to reach out to individuals who have presented to the ED when the patient navigators are not present. Also, the process for making the patient outreach calls was revised to allow for a greater number of contacts with patients. Health Connections continues to utilize the direct scheduling process with great success. The PPS is nearing a point where sufficient data can be reviewed, which will potentially allow for future expansion of the project. Areas considered for potential expansion and process improvement include supporting additional navigators, additional ED locations, and extending service hours. **Project Lead: Cheryl Freidman/Phyllis Gunning**

2.b.iv Care Transitions model to reduce 30-day readmission for chronic health conditions:
Care management tracking tools continue to be utilized for population management for clinical integration, such as documentation of follow-up phone calls, medication reconciliation, etc. Care Transition project reporting is ongoing with WCA hospital and Catholic Health.
Project Lead: Peggy Smering

2.c.ii Expand usage of telemedicine in underserved areas to provide access to otherwise scarce services:
The PPS has received proposals in response to its open request for proposals (RFP) and has reviewed each in detail. The PPS has notified partners of their funding status and is beginning the necessary steps for implementation. All organizations have been made aware of the decision of the PPS, as it pertains to their respective proposal. WCA Hospital in Chautauqua County acquired new telemedicine compliant ultrasound equipment, necessary for a Maternal Fetal Medicine imaging project. Training has begun with a newly hired ultrasound technician at WCA for the project. Communication among all parties has begun, and the project is currently on pace to provide patient engagement numbers starting in DY3Q2. **Project Lead: Carlos Santos, MD/Phyllis Gunning**

3.a.i. Integration of primary care and behavioral health services: Numerous partners are engaged and actively improving processes for this project. The Niagara County Department of Mental Health has begun to provide behavioral health services at a primary care practice in Niagara County, with the long-term plan to establish a satellite clinic. Mid-Erie Counseling and Treatment Services, in collaboration with a CPWNY primary care practice, is expected to go live with a fully integrated site in Southern Erie County by the end of the year. Horizon Health Services and Spectrum Behavioral Health Services continue to provide behavioral health services at designated primary care sites throughout Erie County. Additionally, Lakeshore Behavioral Health and Spectrum have both begun off-site mobile clinic services to clients who are unable to link to traditional, clinic-based services. Catholic Charities' community health worker program is underway with three CHWs dedicated to enhance care coordination, engagement, and linkages to primary care for clients with behavioral health conditions.
Project Lead: Bruce Nisbet

Brief Project Updates (cont. from pg. 6)

3.b.i Cardiovascular Health: Evidence-based strategies for disease management in high risk/affected populations (adult): CPWNY is currently supporting CCHN (Chautauqua County Health Network) as they collaborate with Millennium Collaborative Care with the regional Million Hearts campaign efforts. CPWNY has recently distributed a performance-based contract, which is inclusive of all of the required cardiac project outcomes. These performance-based contracts have been sent to partners across all three of the counties that we serve.
Project Lead: Peggy Smering

3.f.i Increase support programs for maternal & child health (including high risk pregnancies): Nurse-Family Partnership (NFP) successfully achieved full caseload in Chautauqua County in DSRIP year two, so the County Department of Health (DOH) is working to expand the program and hire two new nurses. With new nurses onboard, NFP will go from serving 60 families across the county, to 100. In Erie County, CPWNY is partnered with Buffalo Urban League to implement a Prenatal Community Health Worker pilot program to improve coordination of care in Catholic Health clinics. The pilot was a great success so the program was expanded to two additional OB/GYN clinic sites. The program is also in process of expanding further to assist two more primary care clinics with behavioral health and pediatrics.
Project Lead: Julie Lulek

3.g.i Integration of palliative care into the PCMH model: Hospice partners from Erie, Niagara, and Chautauqua counties continue to work with primary care practices to educate and facilitate referrals to their respective palliative care programs. CPWNY piloted a tool, within select primary care practices in Erie county, to assist in better identifying and capturing palliative care engagements with patients. Primary care practices in Chautauqua and Niagara counties are also piloting the tool.
Project Lead: Chris Kerr, MD

Nurse Family Partnership Chautauqua County is hiring!

Chautauqua County Department of Health is now accepting applications for NFP nurse home visitors.

For more information, please visit: chautauqua.ny.us/DocumentCenter/View/5113
or contact:
Julie Lulek at (716) 923-9784.

4.a.i Promote mental, emotional and behavioral (MEB) well-being in communities: The MEB project is underway for DSRIP year three. CPWNY continues to work with Millennium Collaborative Care (MCC), to extend the program to eight counties in Western New York. Our partner community-based organizations submitted April status reports, which are showing continued positive results. In addition, the public awareness campaign website, JustTellOne.org, continues to generate consistent traffic, and is being incorporated in multiple school districts' school handbooks. We are in the process of trying to expand the campaign even further to highlight our partners. Apart from its work with MCC, CPWNY will also be supporting the Workplace Wellness program, which will undoubtedly prove beneficial to the DSRIP program and the CPWNY partners. **Project Leads: Ken Houseknect**

4.b.i Promote tobacco use cessation, especially among low socio-economic (SES) populations and those with poor mental health: The Roswell Park Cancer Institute team continues outreach to interested community organizations to promote clean indoor and outdoor air policies, and to assist in implementing these policies. Roswell meets with DSRIP partners to promote and encourage participation in Opt-to-Quit. CPWNY meets monthly with Roswell to monitor progress of the project and to discuss any successes, issues, and/or risks. As part of the DSRIP year two report, CPWNY submitted three new milestones, and the project continues to have excellent results in the areas of smoking cessation and interventions. **Project Leads: Maansi Travers, PhD**

Meet CPWNY: Staff & Leadership

The core responsibility of the project management team within CPWNY is to help our organizations reach and educate the populations the DSRIP program is designed to bring together (patients, providers, and community-based organizations).

Meet the Team

Phyllis Gunning
Director, Clinical Programs, 716-862-2482

Amy L. White-Storfer
Director, Project Management Office, 716-862-2186

Mark Gburek
Project Administrator, 716-828-2484
Workforce workstream;
2.a.i: Integrated Delivery System;
2.c.ii: Telemedicine;
2.b.iii: ED triage;
2.b.iv: Care Transitions;
3.b.i: Cardiovascular.

Roxanne Cuebas
Project Administrator, 716-862-2458
3.a.i: Integration behavioral health/primary care;
3.g.i: Integration of palliative care into PCMH;

Michelle Johnson
Project Coordinator, 716-862-2449
4.b.i: Promote tobacco use cessation in populations with low socio-economic status and poor mental health;
Oversees project management tool and reporting.

Julie Lulek
Maternal Child Health, Project Lead and Project Coordinator, 716-923-9784
3.f.i: Maternal Child Health

Dapeng Cao, PhD
Manager of Health Analytics, 716-862-2167

Brittany Bolden
CPWNY Administrative Assistant, 716-862-2166
Supports all governing bodies and NYS reporting tool completion.

Patricia Podkulski
Director, Medical Policy and Accreditation, 716-862-2160
Workstreams: Cultural Competency and Health Literacy, Practitioner Engagement, Population Health, Clinical Integration, Performance Reporting.

Kimberly Whistler, Esq
DSRIP Compliance Officer, 716-821-4471
4.a.i: Promote mental, emotional, and behavioral well-being;

Michael Galang, DO, CIO, CHS
DSRIP Information Technology
(Barb Balk – Project Manager – IT – 716-862-2189)