Care Compass Network
Community-Based Navigation Transformation Model Grant Program
DSRIP Year 3 & 4 (April, 1 2017- March 31, 2019)

Request for Application

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Introduction

Care Compass Network (CCN) is participating in a five-year Delivery System Reform Incentive Payment (DSRIP) program to shift healthcare from a fee-for-service model to a value based payment program. CCN is accountable to work collaboratively with the community to implement eleven projects/initiatives to help transform healthcare. One of the initiatives is known as "Community-Based Navigation". The goal of the Community-Based Navigation project is to provide support and remove barriers for residents to reduce avoidable use of hospital services. Community-Based Navigation services target addressing social determinants of health such as health literacy, language barriers, transportation, and access to food, as well as helping to provide meaningful ways for Medicaid Members to engage with community health care services that can result in unnecessary use of hospital services and improved health status. Community members who do not understand how to access and use the health care system cannot be expected to use it effectively.

Since 2015, CCN staff and the Community-Based Navigation Project team have met to discuss how to help Medicaid beneficiaries efficiently access health and community services. With the many conversations and additional forums to engage a diverse array of community based organizations and health care systems, the Community-Based Navigation Transformation Model was formed.

Community-Based Organizations (CBOs) can apply for funding for outreach and engagement assistance to assist in the implementation of the Community-Based Navigation Transformation Model. The following pages include details on the Community-Based Navigation Transformation model as well as details on eligibility and application requirements.

Community-Based Navigation Transformation Model Grant Program

GOAL

25% reduction in avoidable Emergency Department visits and hospital readmissions in the Medicaid population by 2020 (within the PPS).

WHY IT MATTERS

Care Compass Network and our partners agree that Community Based Organizations (CBOs) are a critical element of an integrated delivery system designed to reduce avoidable Emergency Department visits and hospital readmissions and potentially avoidable admissions by 25% in the Medicaid population. CBOs are trusted partners with Medicaid beneficiaries and as such can remove barriers to health care by engaging beneficiaries at various touchpoints across the integrated delivery system through outreach and navigation.

THE GRANT PROGRAM

CBOs located within the Care Compass Network nine county region will be able to apply for a dedicated outreach and engagement resource to assist the Medicaid Non-and Low Utilizers with health literacy, community values, language barriers, education on the availability of services, and ultimately re-engage them with their Primary Care Provider (PCP) and community health care services to reduce avoidable Emergency Department visits and hospital readmissions. A Medicaid Low Utilizer, as defined by New York State Department of Health, is a Medicaid Member without continuous enrollment in the previous 12 months, and has received services from his/her primary care physician two or fewer times in the previous 24 months. The outreach and engagement resource would be a person who has been trained and resourced to understand and access the community care system and, support the PCP relationship as appropriate, e.g., assisting patients with appointments and obtaining community services. The outreach and engagement resource would:

1. Follow the Medicaid Member longitudinally to ensure the Medicaid Member is able to access health care and other needed services.

2. Educate beneficiaries on the importance of patient-provider communication so that the most appropriate care setting can be accessed.
3. Ensure the Medicaid Member is gaining self- confidence in management of his/her health.
4. Use funding to support strategies to increase engagement for Low and Non-Utilizer Medicaid Members in the PPS.

CCN will provide funding to selected organizations to support outreach and engagement resources in each of the following nine counties:

- Broome: 2
- Chemung: 1
- Chenango: 1
- Cortland: 1
- Delaware: 1
- Schuyler: 1
- Steuben: 1
- Tioga: 1
- Tompkins: 2

Target Population:
Medicaid Members who are Low and Non-Utilizers. Uninsured persons do not count.

County	**Number of Low-Utilizers**	**Number of Non-Utilizers**
Broome	23,680	10,123
Chemung	2,448	1,162
Chenango	4,623	2,070
Cortland	5,244	2,050
Delaware	2,003	774
Schuyler	1,718	756
Steuben	1,843	901
Tioga	4,138	1,978
Tompkins	7,822	3,645

Note: Data from Salient as of 7/14/2017. Low-Utilizers was defined as having 0-2 PCP visits in the last 24 months or less.

Eligibility

- Organization must be a Tier 1 Community Based Organization (Non-profit, non-Medicaid billing, community based social and human service organization (i.e. housing, social services, religious organizations, food banks)), or Tier 2 Community Based Organization

(Non-profit, Medicaid billing, non-clinical service providers (i.e. transportation, care coordination)).

- Must have a BAA and a Partner Agreement in place with CCN
- CCN recommends CBOs have a relationship as a downstream provider with primary care and/or a health system for outreach and engagement services.
- Outreach and Engagement Resource must be an employee of the awarded organization
- If your approach is to use the Outreach and Engagement Resource to be embedded at a third party location, please provide a letter of support from that location
- Be able to meet the project objective effectively and efficiently
- The outreach and engagement resource will be used exclusively to serve Medicaid Members, with the initial focus to be Medicaid Low and Non-Utilizers in the PPS.
- Organization must have office space readily available for staff and be located in the county the resource will be used to support.
- Organization must have an intake process and have the ability to store/share data from it.
- The outreach and engagement resource will need the technology tools necessary to educate each Medicaid member they work with on the availability and features of the Community Resource Guide.
- Must be willing to use data provided by CCN as well as report progress and results back to CCN. CBO will be required to report monthly to CCN, all services provided to Medicaid Members.
    - Note: The services provided to Medicaid Members by the outreach and engagement resource would need to be reported to CCN but would not be eligible for additional fee for service payment by CCN.
- Organization to ensure the outreach and engagement resource(s) shall follow the Medicaid member longitudinally to ensure member is able to access healthcare and other needed services

Request for Application Instructions

If organization is interested in applying to receive funding to support an outreach and engagement resource as described above, applicants must submit a Request for Application (RFA) stating the following requirements:

- Clearly states funding through the Community-Based Navigation Transformation Model will be used to only serve Medicaid members who are Low and Non-Utilizers residing in the county supported by the outreach and engagement resource. Organizations who

serve a larger geographic area outside the PPS may apply but must ensure the resource will only support activity in the PPS counties.

- Provide data on the targeted population for each county this resource will cover
- State how the organization is actively engaged with the local health systems on new and innovative ways to engage and perform.
- Clearly states the total number of outreach and engagement resources requested and state the specific county or counties the resource(s) will support.
- Clearly state if the organization would transition an existing resource or would hire and provide training for the outreach and engagement resource.
- The outreach and engagement resource would need to perform the following with the targeted population:
    - Administer PAM survey and then re-PAM in six months (not to super utilizers or Level 4's)
    - Navigation Intake Process and Storage of Data
    - Medicaid Health Home Referral (when appropriate)
    - Warm-Handoff to Insurance Navigator (for re-enrollment)
    - Re-connect to their PCP or Warm Hand-Off to a new PCP
    - CCN Community Resource Guide Education and Distribution of Materials
    - Education on Urgent Care or Walk-In Clinics
    - As needed, provide overview of CDSMP Living Healthy Workshops and refer member to attend the Workshop
    - Community Resources/Needs knowledge

- Complete the table below and include in the RFA to assist CCN in understanding the readiness of the organization in supporting the outreach and engagement resource.

Training	Organization **has** processes in place to train.	Organization **does not have** processes in place to train.
Trained to administer PAM survey and Coaching for Activation		
Navigation Intake Process		
Process to refer Medicaid Member to Medicaid Health Home		
Process for Warm-Handoff to Insurance Navigator		
Process to re-connect Medicaid Member to their PCP or Warm Hand-Off to a new PCP		

CCN Community Resource Guide education		
Education on Urgent Care or Walk-In Clinics		
Education on available community services and how to use them		
Trained to understand the community care system and how to access the system		
CDSMP Living Health Workshops (Requires 1 workshop each week for 6 weeks)		

EVALUATION & SELECTION PROCESS

Care Compass Network will award funding through a competitive review process led by COPE Health. COPE Health is responsible for reviewing and ranking all applications. CCN will work closely with COPE Health to determine the most appropriate CBOs to be awarded. Funding to be awarded to applicants based on completion of specific deliverables and shall be available on a yearly basis for a maximum of two years. Selected applicants will receive $60,000 each year for an outreach and engagement resource supporting one of the nine counties located in the PPS. Deliverables for each year will be provided by CCN.

INVESTMENT TIMELINE

July 19, 2017:	RFA Released
Week of July 31, 2017:	Webinar Q&A Session
August 16, 2017 11:59pm:	RFA applications due to Care Compass Network for consideration
September 1, 2017:	Care Compass Network notifies applicants of funding decisions
September 16, 2017:	Funding for the Navigation Transformation Model 2017-2018 cycle begins

Q&A WEBINAR

Care Compass Network will hold an informational webinar to offer organizations and community members any opportunities to ask questions and learn more about this funding opportunity.

DEADLINE TO SUBMIT RFA

Interested applicants should email their RFA as a PDF attachment to EBalmer@carecompassnetwork.org no later than 11:59 PM on Wednesday, August 16, 2017. **Hard copy paper applications will not be accepted, and late applications will not be reviewed.**

QUESTIONS?

Please email or call Emily Balmer, the Community-Based Navigation Project Manager, with any questions you have regarding this. Emily's email address is EBalmer@carecompassnetwork.org and her phone number is (607)240-2576.