Winning Trust for Productive Partner Engagement

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Irene Kaufmann, Donna Demetri Friedman, and J. Robin Moon today have no relevant financial or nonfinancial relationship(s) within the services described, reviewed, evaluated, or compared in this presentation.
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Today’s Objectives

1. Present proven strategies for engaging CBOs in a developing IDS

2. Provide concrete examples for how to maximize impact of collaboration

3. Explain how successful engagement readies CBOs to participate in value based environments
The Delivery System Redesign Incentive Program

NYS DRIVE TOWARD VALUE BASED PAYMENT
Delivery System Reform Incentive Payment

- DSRIP is a major collective effort to transform New York State’s Medicaid Healthcare Delivery System from a fragmented system, overly focused on inpatient care, to an integrated and community-based system focused on providing care in or close to the home.
- $6.42 billion allocated to this program with payouts to the PPS based on achievement of predefined targets in system transformation, clinical management and population-based health.
- 25 Performing Provider Systems (PPSs) were established in NYS to conduct this transformation.

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<thead>
<tr>
<th>FROM</th>
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<td>• Volume-based</td>
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<td>• Patient-based</td>
<td>• Population-based</td>
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<td>• Episodic</td>
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<td>• Acute Care</td>
<td>• Preventive Care</td>
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<td>• Sickness Care</td>
<td>• Wellness promotion</td>
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FROM

TO
DSRIP Goals

- **Reduce** unnecessary hospital use (inpatient and ED) **by 25%** over 5 years
- Create an **Integrated Delivery System (IDS)**
- Achieve **PCMH Recognition** for participating providers and expand access to **primary care**
- Support **integration** of **Behavioral Health** and **Primary Care**, and develop Care Management and Care Coordination capacity
- **Promote Information exchange and data integration** to support population health management and provide the “right level of care at right time”
- Shift the payment system from Volume-Based to **Value-Based**
Key Program Components

- **DSRIP projects** selected from a menu of state-defined interventions and designed around needs of the community
- Integration of **community-based organizations** to address the social determinants of health
- Training and strategic re-deployment to support a vibrant **workforce** operating throughout the continuum of care
- **Connectivity** to improve transitions of care across the PPS and facilitate population health approaches
- Ensure successful changes to the delivery system are **sustainable**
- Deliver patient-focused care and **empowering self-management**
One of Four Performing Provider Systems in the Bronx

BRONX PARTNERS FOR HEALTHY COMMUNITIES
BPHC: A Bronx Tale

The Community Needs Assessment (CNA) conducted by the New York Academy of Medicine in October 2014 highlighted the need for innovations in healthcare and improved collaboration between clinical and community resources.

Key Takeaways:
- **59% of Bronx residents enrolled in Medicaid**
- The Bronx is the **least healthy county in New York State** with high rates of preventable chronic disease.
  - The Bronx has the **highest rate of potentially preventable inpatient Medicaid admissions** of all five boroughs.
  - In 2012, the PQI* rate in the Bronx was 31% lower, compared to 2% lower for all of NYC, than all of NYS.
- The costs incurred for medical care are extremely high and act as a barrier to effective use of prevention and disease management services

*PQI: Preventive Quality Indicator, to identify quality of ambulatory care, such as preventable hospitalization*
Preventable Illness in the Bronx

**Cardiovascular Disease:** Heart disease is the top cause of mortality and the second leading cause of premature death in the borough, after cancer.

**Diabetes:** The rate of hospitalization for short-term diabetes complications among Medicaid beneficiaries is almost 50% higher in the Bronx than in the city and state overall (151/100,000 vs. 105/100,000 and 110/100,000, respectively).

**Asthma/COPD:** Young adult asthma and respiratory hospitalizations are concentrated in the southern part of the borough, extending across both sides of the Grand Concourse.

**Mental Health:** In the Bronx, 7.1% of all people report experiencing serious psychological distress, compared to 5.5% in NYC overall. Approximately half of CNA respondents reported that the mental health services are not very available in their community.

**Substance Abuse:** Substance abuse was the second most commonly cited health concern by survey respondents (47.2%).

**HIV/AIDS:** Four neighborhoods in the Bronx have higher HIV/AIDS prevalence rates than the city as a whole: High Bridge/Morrisania, Crotona/Tremont, Fordham/Bronx Park, and Hunts Point/Mott Haven.
Bronx Health Disparities Snapshot: Social Determinants of Health

**Language and Culture:** 50%+ of 1.5mil population speak a language other than English at home.

**Transportation:** Bronx residents have long commutes and higher rates of disruption to bus/subway service.

**Environment:** Poor air quality and other environmental pollutants from industrial activity and waste centers.

**Income:** ~30% of Bronx households live in poverty, and Bronx residents experience the greatest unemployment (~10%) when compared to other NYC boroughs.

**Food Insecurity:** ~22% of Bronx residents lack adequate access to food. Unhealthy food is more accessible than fresh fruits and vegetables.

**Education:** Fewer than 20% of Bronx residents [have] completed a degree beyond high school.

**Housing:** Over a third of the population has inadequate housing, and nearly 40% of households pay 50%+ of their income on rent. Bronx residents report higher rates of unsafe housing than other NYC boroughs.

**Healthcare Access:** 2,080 Bronx residents per primary care doctor, 2x the state average. ~16% of Bronx residents are uninsured.
# BPHC Profile

## Bronx Partners for Healthy Communities PPS

### SBH Health System (lead)
- 150 years of serving the Bronx
- Over 70% Medicaid patients

### Member organizations
- 240 organizations, 1,000+ sites
- ~70,000 employees

- Hospitals
- FQHCs
- D&TCs
- Health Homes
- Home Care
- Behavioral Health
- TCs
- IPAs
- CBOs
- Hospices

### Patient Population
- 170K attributed for valuation
- 370K attributed for performance*  

*B as of July 2016

## BPHC’s Charge and Challenge
Transform 240 siloed provider and community-based behavioral health and social service organizations into one Integrated Delivery System
Challenges to Partnership Development

• Compartmentalization and siloing of programs and services
  • Multiple payors separate what we get paid and who we get paid to care for
• Distrust between hospital and community organizations
• Resources concentrated in hospital systems and large agencies
• Mergers threatening autonomy and creating uncertainty
• Reimbursement doesn’t cover cost of clinical care
• Professional tribalism
Partnership Building

- We found that trust building was the essential ingredient for building productive partnerships with IDS partners especially community–based organizations that had limited partnering experience with large healthcare providers.
Partnership Building Goals

We found that building trust was the central ingredient for building productive partnerships with IDS partners especially community-based organizations that had limited partnering experience with large health care providers.
BUILD TRUST WITH INCLUSIVE GOVERNANCE

Stick to it rules
Provide guidance through Charters
Establish a structured organization
BPHC Governance Structure

Central Services Organization (CSO)
Staff supports the governing committees (PAC)

Committee reflect the diversity of BPHC’s member organizations
- 75 committee and subcommittee seats
- 150+ workgroup seats

Executive Committee Includes clinical and non-clinical stakeholders representing:
- Primary care and behavioral health providers in hospitals, FQHCs and IPAs;
- CBO (BronxWorks), MCO (HealthFirst), Workforce (1199), and the Bronx RHIO
- CBOs have seats on all committees, subcommittees and workgroups

Value transparency and collaboration
- Planning and implementation workgroups
- Frequent and targeted communications
- Monthly committee meetings
- Meetings with subcommittee co-chairs
BPHC Governance Structure (Cont’d)

**Participating Disciplines**

- CEO/ED/Sr. Admin 36%
- Finance 11%
- IT/QA 10%
- HR 8%
- Front Line 7%
- Physician 15%
- Other 6%
- Behavioral Health 7%

**Participating Organizations**

- Hospital 21%
- Non-Hospital Primary Care 26%
- Home Care 11%
- Labor Union 7%
- Long-Term Care 7%
- Community Behavioral Health 7%
- CBO 8%
- Other 10%
- RHIO 3%

**Makeup of Governance Committees**

* Includes Executive Committee, Nominating Committee and four Sub-committees: Finance & Sustainability, Workforce, IT and Quality & Care Innovation

** n = 72 total committee members as of January 2017
Operationalizing the Structure

• Run meetings regularly and consistently:
  – Incorporate reliable rituals
    • Prepare meeting materials and distribute at least 24 hours prior to meeting
    • Have a structured agenda
    • Review and approve minutes
    • Have a process for reaching consensus; vote
    • Use a drop box

• Invest time in preparation:
  – agenda, minutes and informational materials
  – Your distributed documents become the reference and historical backdrop for the relationships and positions taken by participating organizations

• Stick to the rules you establish and your organizing principles:
  – Use charters and agreements to define responsibilities and establish process
  – Use the rules to make decisions
  – Practice transparency by providing access to minutes, data, decisions and budgets
Mosaic’s Role in Governance:

- Mosaic Executive Director was nominated and selected to have a seat on the Finance and Sustainability Subcommittee in 2015
  - Her nomination was approved, like everyone else’s, based on the experience and expertise she brought to the group. She is an active member and continues to hold that seat.
  - Mosaic communicated BH providers’ need for: training for measurement of clinical outcomes using evidence-based screening tools; technological support for infrastructure; and opportunities to be paid through performance-based reimbursement.
  - Through ongoing feedback, Mosaic communicated what was working and where we needed additional support. There is an open dialogue between Mosaic and BPHC to maximize outcomes. There is a level of transparency from both sides that has been very important and has produced positive results.
  - BPHC ensured that Mosaic and the other BH providers had a role in setting fund-flow prioritization

- Mosaic Executive Director led one of three Behavioral Health Planning Workgroups:
  - Mosaic led the ADHD Planning Workgroup comprised of representatives from 6 community behavioral health agencies
  - Established expectations for attendance and participation
  - The Workgroups had to deliver presentation-ready work plans by specific due dates
  - This process helped to unify the providers in a way that was new and different: collaboration vs. competition
  - Set an expectation for the level and completeness of work required for the work plan and the accountability for producing it to those standards
BUILD TRUST BY PROMOTING PARTICIPATION AND ENGAGEMENT

Structure funding to promote equity
Encourage participants to lead
Intentional and unrelenting invitations to participate
Establishing a Central Role for BPHC CBOs

BPHC has 137 unique community-based organizations and each plays a vital role. How do we ensure that they each have a voice and play a role in helping BPHC become an effective integrated coalition of service providers?

- Convened over 40 CBOs to identify pain points and wish lists for improving care:
  - Meaningful involvement in planning and implementation activities
  - Improve communication between member organizations
  - Improve interconnectivity and access to IT support
  - Improve access to training to CBO frontline
  - Recognize and build on CBO competencies
  - Enhance understanding of available services
  - Offer networking opportunities
  - Advance behavioral health and CBO services
Community Engagement Plan

Integration with Community-Based Organizations (CBOs) is critical to our ability to fully address behavioral and social determinants of health

- Established a **Community Engagement Workgroup**
- Community Engagement Workgroup was linked to Governance
  - Represented on the Health Literacy Workgroup
  - Workforce Sub-Committee Co-Chair sits on the Community Engagement Workgroup
- Community Engagement Workgroup recommended 4 target programs:
  1. Create **directory of service resources** to improve coordination between BPHC healthcare providers and CBOs
  2. Provide **access to key training programs** for CBO frontline staff
  3. Build on CBO outreach and **cultural competencies**
  4. Facilitate **collaboration between community providers**
### Engaging Community Behavioral Health Providers

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<tr>
<th>1</th>
<th>A Community Behavioral Health (CBH) Leadership Group was established to develop strategies for engaging the diverse CBH organizations in BPHC planning activities</th>
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<td>2</td>
<td>CBH organizations established time-limited workgroups and developed action plans that defined the goals of the “Call to Action” Collaborative</td>
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<td>3</td>
<td>14 CBH agencies joined the “Call to Action” collaborative which was launched in March 2017.</td>
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<td>4</td>
<td>Funding to support information exchange, monitoring and patient tracking, as well as provide coaching for meeting specific performance targets was distributed to all applicants</td>
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**BPHC has 50+ community-based Behavioral Health member organizations**

“Call to Action” Kick-off breakfast at Mercy College, Bronx Campus, on Friday, November 4th. Keynote Speaker: Ann Sullivan, Commissioner, OMH, and Guest Speaker: NYS Senator Gustavo Rivera.

Acknowledgement and recognition by State officials reinforced goals of the Collaborative.
Implementing & Standardizing Screening
Measuring PHQ-9 Screening Rates
Mosaic’s Growing Participation

– Critical Time Intervention (CTI) Program
  • Helped to define and create the program design
  • Continued as CTI Provider

– Behavioral Health Collaborative
  • Workgroup Lead for planning the collaborative focus
  • BHI Collaborative Participant

– Innovations Programs
  • One of 7 evaluators to select top proposals of 88 submitted for a $2M funding opportunity
  • Invited to participate in VBP Innovations Program

– Mosaic independently developed a partnership with a BPHC FQHC and established an integrated BH/PC program whereby the FQHC’s mobile van delivered primary care services to Mosaic patients
Productive Partnership Cascade: HealthPeople

Joins BPHC Chronic Disease Management Planning Activity and advocates for its Peer Diabetes Self Management Model 2014

Selected to provide Peer led SM classes
Provided Peer Training
Peers lead DSM classes in clinics
Peers lead Adult Day Care Centers Classes
Peer led classes at NYCHA Housing
Expands classes to SOMOS IPA and Bronx Lebanon PPS

Joins BPHC Community Engagement Workgroup and collaborates on outreach and CBO engagement strategies

Selected to provide Health Literacy training for BPHC
Conducts CHL at community sites
Conducts CHL for Union
Provides CHL and outreach services for Union FQHC

Presented Peer SM classes at All PPS meeting

Selected by CBOs to be Hub for SDOH funded Communities Together for Health Equity

Established DSM classes in shelters with OneCity Innovations funding

Conducted HIV peer training in collaboration with BronxWorks

Participates in BPHC’s CBO Service Value and Evaluation training

OneCity PPS Community Strategy Group
Conducted to PM DMS Peer Training at One City CBOS
Contracted to PM Peer Training asthma case finding at One City CBOS

YEAR 1
YEAR 2
YEAR 3
YEAR 4
How Does Expanded Participation Build Trust?

- Growing the ranks overcomes resistance, skepticism, suspicion
- Generates momentum, excitement, enthusiasm, partnership
- New ideas, approaches and competencies energizes the groups
- Encourages collaboration and sharing
Promote Participation

• Create opportunities for each voice to count:
  – In engaging
  – In leading
  – In planning, designing and implementing
  – In outreaching

• Create funding opportunities that promote equity
  – Everybody who applies gets funded
  – Compensate for size and infrastructure vulnerability
  – Provide coaching and technical support to cover knowledge gaps

• Intentionally foster participation
  – Introduce new perspectives through focus groups and roundtable discussions
  – Design opportunities for feedback from prospective participants
  – Distribute invitations to participate broadly
Create Multiple Opportunities to Lead

• Community-based organizations are invited to shape the discourse on:
  – CBO engagement strategies
  – Behavioral health transformation agenda
  – Post-acute care transition gaps
  – Housing advocacy priorities

• Open up traditionally closed processes:
  – Invite CBOs to define and prioritize issues for action
  – Select and design programs
  – Invite all members in targeted sector to participate
  – Fund all who wish to participate
BUILD TRUST BY LEVELING THE PLAYING FIELD

Training and sharing tools and data
Press for performance and learning
Insist on accountability
Create communities of practice
Why Do You Need to Level the Playing Field?

Member organizations in a coalition or an IDS are hugely varied

- Size
- Available resources
- Expertise
- Organizational and IT infrastructure
- Advocacy vs vendors service provider orientation

In order to work effectively together, we needed to stand on common ground:
- Goals and values
- Measures
- Basic knowledge
- Competencies

Most of all, members have to overcome a sense of otherness and structural vulnerability and gain confidence in the emerging integrated delivery system
Training & Developing the Community Workforce

- BPHC has developed 29 courses delivered to more than 1,000 trainees
- 27 CBOs have registered staff to participate in these courses

Training Programs in Cultural Responsiveness: DY2Q4 – DY3

Programs for segments of BPHC workforce:
1. Leaders as change agents for cultural responsiveness
2. Cultural affirming care for frontline staff
3. Cultural competency & the social determinants of health for practitioners

Programs based on PPS community needs:
4. Train-the-trainer for CBOs to educate community members on obtaining health insurance & navigating health care system
5. Patient-centered care for immigrant seniors addresses behavioral & psychosocial issues

Raising cultural competency for the frontline:
6. Knowledge & skills for recovery-oriented care for people with behavioral health conditions
7. Understanding cultural values for home health workers
8. Poverty simulation to experience how living in poverty affects health behaviors and to influence policy changes

Celebrating Graduates
New York City Council Member Ritchie Torres and Ousman Laast, Office of U.S. Senator Kirsten Gillibrand, celebrating Peer Leaders & CHWs trained by Health People (Diabetes Self-Management) and a.i.r. bronx (Asthma Home-Based Self-Management)

Providing Cultural Responsiveness Training
- The Jewish Board
- NYC Human Resource Administration’s Office
- Immigrant Health and Cancer Disparities Service
- Healthlink NY
- People Care
- New York Association of Psychiatric Rehabilitation Services
- Regional Aid for Interim Needs (R.A.I.N)
- Selfhelp Community Services
Distribution of BPHC Training Resources

Total Spending per Type of Organization

- **FQHC**, $1,620,311, 33%
- **Community Primary Care**, $1,303,608, 26%
- **Community Behavioral Health**, $659,689, 13%
- **Social Services**, $796,357, 16%
- **Hospitals**, $176,092, 4%
- **Post-acute Care**, $377,153, 8%
## BPHC Training

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<tr>
<th>Type of Organization</th>
<th># Organizations</th>
<th>Participants in Training</th>
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<tr>
<td>Social Services</td>
<td>27</td>
<td>606</td>
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<tr>
<td>Community Behavioral Health</td>
<td>27</td>
<td>502</td>
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<tr>
<td>Community Primary Care</td>
<td>18</td>
<td>992</td>
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<tr>
<td>FQHC</td>
<td>2</td>
<td>1233</td>
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<tr>
<td>Hospitals</td>
<td>6</td>
<td>134</td>
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<tr>
<td>Post-acute Care</td>
<td>10</td>
<td>287</td>
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<td>Grand Total</td>
<td>86</td>
<td>3754</td>
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Community Health Literacy Program

Goal: Provide basic health literacy education to cultivate a more informed, activated community that acts as a partner in their healthcare.

- Builds on the expertise of CBOs to systemically improve the community’s ability to navigate the changing healthcare system and services provided by our PPS through community education
- Role of CBO Health Literacy educators
  - Conduct educational encounters in the community
  - Deliver community education curricula on:
    1. Seeking and using health insurance
    2. Navigating the health care system
  - Focus on underserved individuals not well engaged in primary care
  - Link learners participating in the educational sessions to primary care and health home services, as needed
  - Payment was linked to the number of individuals they outreached, the number of educational sessions they held and the number of individuals they connected to needed services
Boosting Health Literacy in the Community

- Peers and community health workers from the 7 participating CBOs were trained on the priority topics.
- They conducted outreach and provided educational sessions to learners in the community (i.e. community centers, laundromats, churches, nail salons, the street).
  - Met monthly to compare outreach strategies
  - Gave each other feedback on how the community reacted to the materials presented and the curriculum they used
  - Made suggestions on how to improve approach, referral priorities and incentive structure and methods for collecting data

Community educators trained: 44
Education sessions held: 219
Community learners: 2,916
CHL Program Reach Continues

Community educators trained: 48
Community learners: ~9,500

The frontline owned this program. They changed it and improved their performance because they knew we were behind them.
Create a Community of Practice

- Adhere to a shared vision and common goals
- Adopt selected best practices, develop standardized workflows that are vetted by the group and build an implementation plan
- Implement standardized performance monitoring and reporting strategies
- Establish a shared performance improvement methodology
- Issue continuous communications to keep participants informed and in the loop
- Hold social events and invite members to celebrate milestones
- Face time!
How Mosaic Benefitted from a More Level Playing Field

- Smaller agencies like ours have a voice in financial decisions

- BPHC support helped develop Mosaic’s IT Infrastructure
  - Implemented a care coordination system at no cost
  - Connected to HIE and achieved interconnectivity
  - Frontline trained on system

- Funds distributed provided needed support for VBP readiness
  - Supported work with Healthfirst on developing a pricing model for crisis respite

- Training provided by BPHC
  - SBIRT Training
  - GSI – care coordination system
  - Closed Loop Referrals
WHAT WE’VE LEARNED
Strategies for Building Productive Partnerships in our Emerging IDS

To create interoperability, integration and interdependence among diverse organizations that have historically competed for resources and clients in the same space

- **Establish inclusive, transparent governance**
  - Open nominations
  - Charters to define goals, roles and process
    - Stick to the rules – it’s not about compliance; it’s about reliability/predictability
  - Share and distribute communications widely

- **Promote participation**
  - Create opportunities to involve all in planning and decision making
    - Voice regardless of size; expertise trumps affiliation
  - Innovate and redesign together
  - Socialize, rejoice and celebrate

- **Level the playing field**
  - Fund and resource to promote equity
  - Press for performance, accountability and learning
  - Share tools, data and training
  - Create communities of practice
  - Insist on accountability
Partner Engagement Outcomes

Successful engagement has helped our CBOs develop skill sets and infrastructure that enable them to demonstrate their value to health plans and other providers.

- Shift from advocacy orientation to provider or vendor orientation
- Shift from counting encounter to measuring change or outcome
- Develop a process for valuing the services or support provided
  - Outcome improvement
  - Efficiency gain
  - Cost saving
- Develop the mechanisms to measure program outcomes
- Develop infrastructure for care coordination and data management
- Demonstrate the savings to the care delivery system
# Build Legitimacy and Win Trust

## Transparency & Empowerment
- Create a clear, collaborative structure
- Identify & foster community leadership
- Create opportunity for community leadership to actively participate
- Create opportunity for community to lead
- Require accountability for output, work products and performance outcomes

## Sustaining the Coalition
- Distinguish between participation and leading
- Put your dollars where your intent is (thoughtful and equitable distribution)
- Go beyond buy-in and create ownership
- Build a community of practice
THANK YOU!

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# Sharing the Funds Flow Strategy from the Start

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<td>Funding to independent</td>
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<td>Funding to post-acute care services and supportive housing providers for:</td>
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<td>- Contracts with select orgs with expertise identifying best practices to support DSRIP project implementation</td>
<td>- DSRIP Project Managers for BPHC partner organizations. - PCMH technical support and coaching services - Workforce recruitment and training programs.</td>
<td>and BH Providers for:</td>
<td>providers for:</td>
<td>- CBO/CBH capacity building</td>
<td>- Inter-connectivity and information exchange via RHIO</td>
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<td>- Team-based care</td>
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<td>- Care coordination</td>
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<td>advancing DSRIP goals</td>
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<td>- Inter-connectivity</td>
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