BRONX PARTNERS FOR
HEALTHY COMMUNITIES
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COMMUNITY HEALTH LITERACY
RFP Questions & Answers

August 25, 2016

1. What is the recommended or approximate length and number of a workshop session? What is the structure of the curriculum?
   We don't know yet, as the curriculum is still under development. Recognizing that community-based organizations will be called to present information in short and long formats depending on the locations and organizations that they serve, the curriculum developer will provide community-based organizations with a presentation templates that can be used and adapted for a variety of venues and audiences.

   The curriculum for the Community Health Literacy Program is being developed by groups with deep experience training trainers and training the community. The curriculum developers are aware and remain cognizant of potential situations where a program participant is invited to train at a faith-based organization, for example, and provided 15 minutes within which to provide training. Program participants will have the opportunity during the Train the Trainer phase to provide feedback and tweak the format or content of the curriculum or delivery method based on their experiences with the community.

2. May we choose topics most relevant for our audience or are they provided/assigned by BPHC? Can an organization be both a vendor and trainer or only trainer?
   BPHC is interested in feedback from program participants and community learners regarding current and additional relevant topics. The first topic will be on seeking and using health insurance and the second on navigating the healthcare system. Launching the Community Health Literacy Program in this way provides common language within the community and a common base from which to measure progress and impact of the program. There will be opportunity as the program progresses to include additional topics and for community-based organizations with deep experience in particular topic areas to provide training for those topics in the coming year.

3. Please define "under-utilizers"
   Under-utilizers are individuals in the community not currently connected to primary care or health homes (if eligible), or are connected to a physician but have not had a visit in the last 12-month period. These individuals are most at risk for not receiving care for needed services and seeking care in emergency departments.

4. Is there a specific geographical area(s) that BPHC would like to target?
   BPHC's geographical area is the Bronx, but BPHC recognizes that the Bronx Community Needs Assessment Maps can be a valuable tool for identifying zip codes and neighborhoods to target for addressing specific community health problems. We would like the Partner organizations to focus on engaging under-utilizers as defined above.

5. Should the 10 page proposal be double-spaced or is single-spaced okay?
   The proposal should be no more than 10 pages long, and the format of the proposal (whether double-spaced or single-spaced) is at the discretion of the community-based organization.

6. Can you please provide a detailed breakdown of funding? ex. How can each organization maximize the total amount of funding?
   A program participant will be paid $15,000 on contract signing, and $15,000 at the end of each of the first two quarters. In the third and fourth quarter, this $15,000 payment will be pro-rated should the number of community learners per month fall below 120 per quarter. This base allocation will allow the program participant to build infrastructure and put processes in place to implement the program. Organizations may work with existing staff or on board new staff. Based on community best practices, BPHC promotes the use of community health workers or peers for this work, but staff hires of health educators, social worker, or part-time staff are also permitted and at the discretion of the organization. The funding model with the incentive structure that we are using for this program is designed to transition our contracting with CBOs towards the value-based payment model that will be implementing as part of the DSRIP program.

   An organization can maximize funding by significantly exceeding the expected minimum of training 120 community learners per quarter to trigger considerable amounts of incentive payments. Achieving but not exceeding the expected minimum throughout the 12-month program period will result in a Partner organization receiving the maximum base allocation of $75,000 for the whole project. The following scenario is an example of how an organization can maximize its total funding to approximately $150,000:

   > *Train an average of 285 community learners per month and refer an average of 86 community learners per month through the BPHC centralized intake line. A community-based organization would be reimbursed a total of $75,036 for this work over the course of the 12-month program. The total funding realized would $75,000 in base allocation funding <u>plus</u> $75,036 in incentive payments. (Note: This is only one example of how to maximize funding; it is possible for an organization to maximize the total amount of funding via many different permutations of training encounters and referrals.)*

7. Please explain program framework diagram in detail? Who are the vendors? Workflow? etc.
   BPHC is in contracting discussions with two curriculum development groups: NYC Human Resources Administration/Department of Social Services Office of Citywide Health Insurance Access and Immigrant Health and Cancer Disparities (Memorial Sloan Kettering Cancer Center), both with deep experience in their respective fields to develop curriculum and provide training materials on topics covering essential areas of health literacy knowledge and healthcare system navigation skills identified by the BPHC Community Engagement Work Group. BPHC will provide essential materials and program tools such as attendance tracking sheet [Exhibit C], program evaluation forms and self-assessment forms for learners to help identify programs for which they may be eligible.

   The Community Health Literacy Program will have oversight from two work groups: the Community Engagement Workgroup and the Cultural Responsiveness Workgroup. The Community Engagement Workgroup will be

responsible for providing recommendations for collaborations with key stakeholders to broaden the reach of community education being delivered by the Community Health Literacy Program. Examples of key stakeholders may include primary care providers, Health Home programs, faith-based organizations, police precincts and community boards. The Cultural Responsiveness Workgroup reports to the Quality & Care Innovation Subcommittee, and will participate in quarterly meetings with selected organizations to review trainer and learner feedback about the program curriculum, training materials and educational topics. The Cultural Responsiveness Workgroup will ensure that this feedback will be used to continuously improve the Community Health Literacy curriculum and training materials, to keep it current and responsive to the community's immediate health literacy needs.

Learners will be asked to evaluate the educational sessions they attend, provide feedback about the sessions and suggest new topics. This feedback will be shared with BPHC, the Community Engagement Workgroup and the Cultural Responsiveness Workgroup. In addition to providing education, the Community Health Literacy Program is also designed to help individuals take action based on the information they receive. We will therefore ask selected organizations to have their learners complete self-assessment forms to help determine if they need better access to health insurance, primary care and Health Home services. Self-assessments by community learners will be used by BPHC as an outcome of education provided to measure the program's impact on community. Selected organizations will be incented to help their learners connect to these services through a centralized service operated by BPHC. However, the community health literacy education piece is primary and necessarily prior to routing of patients to needed programs and services.

Community-based organizations will initially meet with BPHC monthly, along with the curriculum vendors, and BPHC staff to continue to develop the program based on feedback from program participants and the community. In these sessions, the group will collectively review course feedback forms and suggestions for new topics.

The ways in which workflows will change internally are individual to community-based organizations participating in this program. As program participants develop their internal processes, BPHC recommends reaching out to stakeholders to expand their reach into the community. In the RFP, we do ask that these workflows be shared with BPHC while encouraging use of an approach that integrates well with your existing workflows and services.

8. Can there be an extension on the due date?
   Yes, we are extending the due date for proposals to Monday, September 12.

9. Do patients referred need to be trained in order to be counted? Or can any patients be counted if some type of education is given informally by a trainer?
   This is a community health literacy training program, so community learners referred must be trained in order to be counted for the referral incentive; referrals must be made through BPHC's centralized intake line. Training encounters will only be counted if training is completed per the curricula.

10. Is there a restart every month with the number of people trained? Or do we add on from the previous month?
    The count of community learners trained restarts every month and the count from each following month may include unique training encounters only. A unique training encounter is defined as a unique community learner being trained on a single training module. Unique community learners can be trained on multiple topics, and each training module will be counted as a unique training encounter. Note: To meet the expected minimum of 40 community learners per month, we will use the average of unique training encounters over a quarter (120). Payments will be made to program participants quarterly.

11. Are referrals only for primary care or do they include referrals for socioeconomic needs as well?
    BPHC aims to address primary care and health home needs first. Through these linkages, community learners will be able to access needed services from other social service agencies.

12. How are under-utilizers identified? Will BPHC provide guidance on how to target under-utilizers?
    Self-assessments forms will be provided to community learners, which they can use as a tool to self-identify needs for primary care and health home services. BPHC is responsible for 355,000 Medicaid patients, and ~70,000 of them are not linked to primary care. We hope through this program to connect these individuals to primary care and health homes to meet their care needs.