BRONX PARTNERS FOR
HEALTHY COMMUNITIES

SBH
Health System
BRONX

DSRIP Project Approval and Oversight Panel Meeting

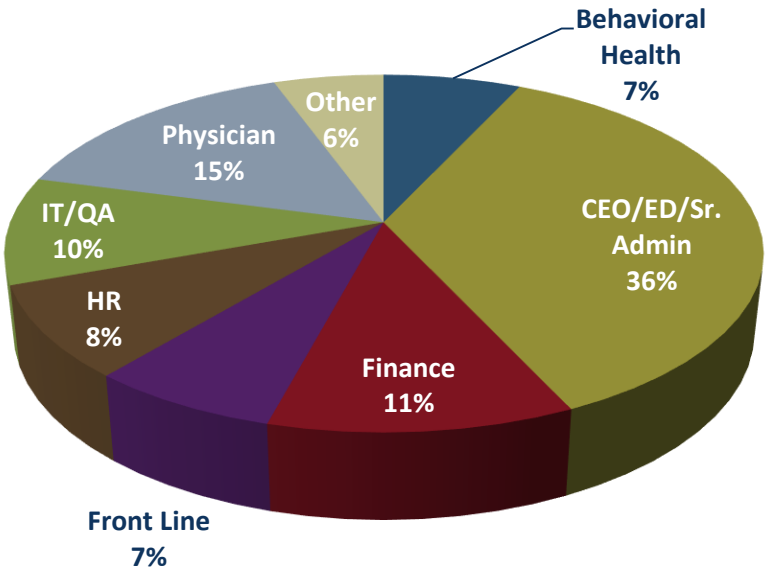
February 1, 2017

BPHC Governance Structure

Makeup of Governance Committees*

Participating Disciplines

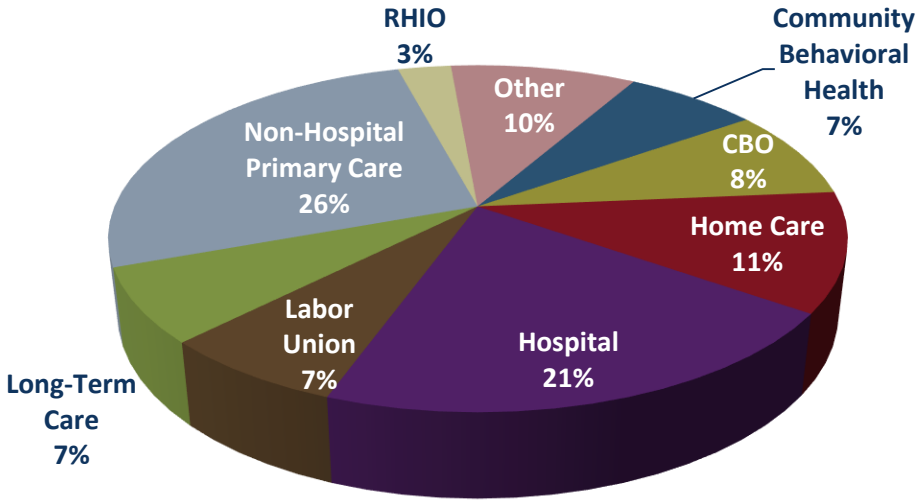
n=72**



Other: RN, Pharmacist, Care Management/Managed Care

Participating Organizations

n=72**

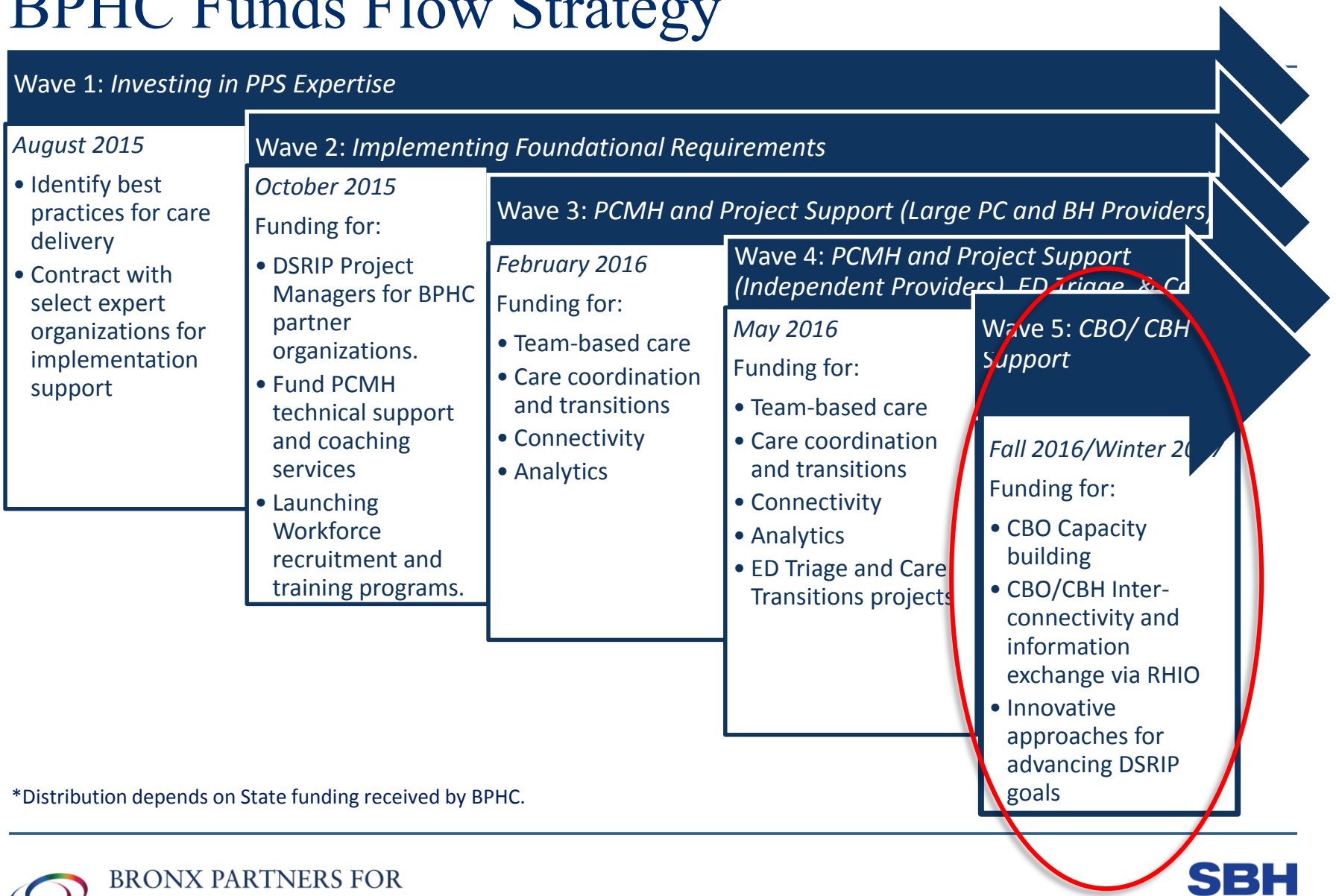


Other: Physician IPA, Payer, Pharmacy, Care Mgmt, NYCDOHMH, BPHC CSO

* 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

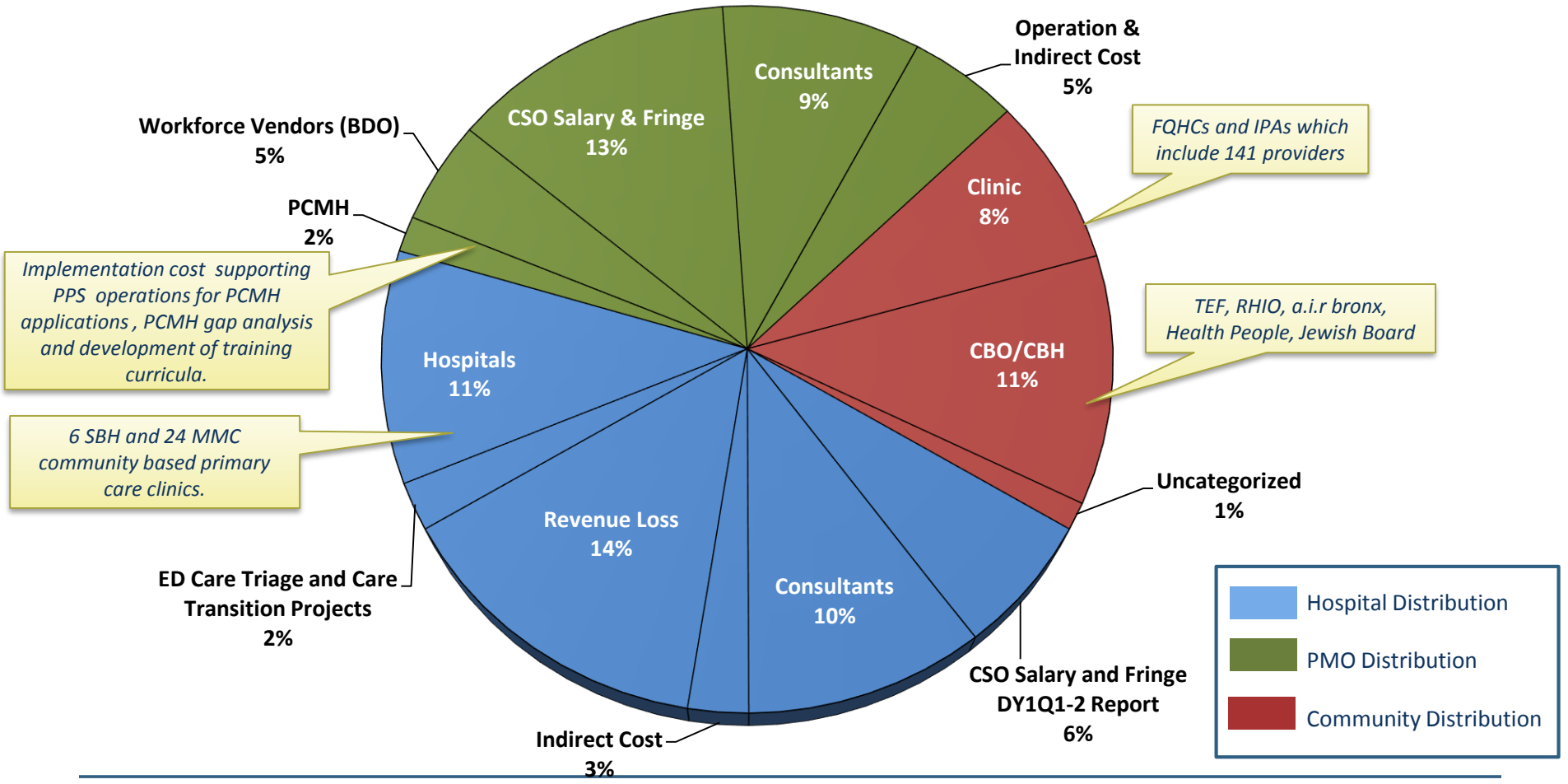
BPHC Funds Flow Strategy



*Distribution depends on State funding received by BPHC.

97% of NPV Distributed as of DY2Q2

$28.3M distributed from NPV and equity funds. ~40% of funds distributed for direct partner support.



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Contracts with BPHC Member Organizations

Funding Commitments to Members by DSRIP Projects and Programs

Project/Program	Total Commitment	Distributed as of DY2Q3
Start-Up Funding (Primary Care and Care Coordination)	$ 13,986,193	40%
a.i.r. nyc: Asthma Home-Based Self-Mgmt (Project 3.d.ii)***	$ 1,303,916	75%
Institute for Family Health: Integrate PCBH (Project 3.a.i)	$ 543,929	73%
Project 2.b.iii ED Care Triage & Project 2.b.iv Care Transitions (Montefiore Medical Center, SBH Health System and CMO)	$ 3,909,400	24%
Health People: Diabetes Self-Mgmt Program (Project 3.c.i)***	$ 368,732	34%
Project 4.a.ii MHSA (50 Bronx Public Schools, The Jewish Board)	$ 2,566,956	8%
Community Health Literacy Program (7 CBO Partners)***	$ 1,050,000	17%
Critical Time Intervention Program (4 CBO Partners)	$ 626,195	31%
Community BH Call-to-Action Initiative* (2 Lead CBO Partners)	$ 50,000	30%
Patient-Centered Medical Home (PCMH)**	$ 3,530,000	25%
DSRIP Project Directors (for 7 largest primary care Partners)	$ 2,700,000	60%
RHIO Services (Bronx RHIO)	$ 3,100,226	25%
Grand Total	**$ 33,735,547**	**37%**

Note: These contracts collectively fund the organizations that provide primary care and supportive service to the majority of our attributed patients. The Community BH Call-to-Action Initiative and subsequent funding waves for post acute care and best practice innovations will reach organizations that provide services to the balance of our attributed population.

* Two members currently have contracts for Community BH Call-to-Action Initiative; contracts with several more members to follow soon.
** PCMH vendor contracts assist selected members in achieving PCMH 2014 Level 3 recognition.
*** Tier 1 CBOs

Community Behavioral Health "Call to Action" Initiative

- 14 Community Behavioral Health (CBH) Agencies were invited through an RFP to lead and participate in planning the "Call to Action" initiative for Behavioral Health.
- The work plans for the initiative were presented to the CBH Leadership Group and the Quality and Care Innovation Subcommittee (QCIS) on:
    1. Standardizing screening for Depression and Substance Use
    2. Improving medication management for children with Attention Deficit and Hyperactivity Disorders (ADHD)
    3. Improving management of Diabetes in patients diagnosed with Schizophrenia
- These work plans will form the basis of the "Call to Action" RFP open to Community Behavioral Health and Supportive Housing Agencies in February 2017 with launch of the Initiative planned for March 2017.
- Base funding distributed to support information exchange, monitoring and patient tracking, as well as provide enhance findings for meeting specific performance targets.

"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.

Boosting Health Literacy in the Community

- Focuses on underserved individuals not well engaged in primary care and supportive Health Home Services.
- Selected CBOs employed peers and community health workers to provide educational sessions to learners in the community (i.e. community centers, laundromats, churches, nail salons, the street) on the following topics:
  - *Seeking and Using Health Insurance*
  - *Navigating the health care system.*

Curriculum development and training by:

- NYC Human Resource Administration's Office of Health Insurance Access - Seeking and Using Health Insurance
- Memorial Sloan Kettering Immigrant Health and Cancer Disparities Service - Care Navigation & Health Literacy

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Training & Developing the Community Workforce

Through DY2Q3…
- BPHC has developed 29 courses delivered to 781 trainees across the PPS
- 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: promotes behaviors & attitudes that enhance patient-provider communication & trust

Programs based on PPS community needs

4. Train-the-trainer for CBOs to educate community members on community health literacy topics (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 effects 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

Critical Time Intervention (CTI)

- A review of historical data from the behavioral health population BPHC serves showed an estimated 400 patients with probable homelessness and a pattern of four or more visits to the of the ED and inpatient setting in one year.
- According to the Bronx community needs assessment, 7.1% of Bronx residents report experiencing serious psychological distress, compared to 5.5% in NYC overall.
- Approximately half of the respondents reported that the mental health services are not readily available in their community.
  - CTI fills this gap by directly addressing behavioral health needs upon hospital discharge with targeted assistance.
- CTI is a nine-month, evidence-based, intensive care transitions model designed to prevent homelessness and other adverse health outcomes in people with SMI following discharge from hospitals and shelters.
- Four organizations selected to each enroll approximately 80 individuals in a nine-month* CTI program.
  - Coordinated Behavioral Care IPA (CBC),
  - Visiting Nurse Service of New York (VNSNY)
  - Riverdale Mental Health Association (RMHA)
  - SCO Family Services (SCO)
- Center for Urban Community Services (CUCS) customized and provided training for CTI providers.

Key Takeaways

- CBOs will extend and bridge care coordination in the community to reduce admissions.
- Promotes care to additional and previously excluded population.
- Promotes Value-Based Payment (VBP) methods that reward outcomes and reduce readmission cost.

**BPHC funding covers the first six months of program; last three months will be completed in the Health Home.*

Case Study: SCO Family Services

Client: 21 year African American male with learning difficulties, ADHD, Bi-Polar disorder, and Obesity

- Mother managed all of his care; even after he turned 18
  - Highly conflicted relationship
- As client gained more control over his symptoms, conflict with Mother increased
- Client recently removed permission for his mother to participate in his health care
  - Mother, in turn, refused to give him his insurance cards and the funds from his SSI check
- The client moved out and was sleeping on grandmother's couch
  - December 30th 2016 : Client went to his mother's home demanding his documents and an altercation ensued
  - NYPD called and responded.
  - Client admitted to North Central Bronx Hospital
- Mother agreed to sign his SSI back over to him.
- Client will need housing and services when he is released from in-patient.

Identified areas of focus for CTI phase one: Housing, Medical, and Financial

Implementation of a Care Coordination Management System across BPHC

- Contract with GSI Health executed November 2017.
- Work groups currently in progress:
  - Steering Committee
  - BPHC CSO Project Management
  - Implementation / Project Team
  - Technical Team
  - Compliance Team

- 100 GSI Health users will be trained in the initial phase (includes care coordination services for Health Home, Health Home At-Risk, CTI)
  - Additional users will be trained as the hospital-based and behavioral health-based care coordination programs go-live.
- Initial build to be completed by February 6th
- Go-live February 16th for Health Home and Health Home At-Risk

- In the first year, 10,000-15,000 at-risk patients will benefit from improved care planning and care coordination services.
- The GSI Health platform will be used by care coordination staff across organizations and care settings, working on a single care plan to promote clinical integration.
- This system facilitates enhanced communication and collaboration between providers, reduces duplication, and provides greater insight into the needs of patients as they navigate through the care delivery system

Clinical Integration, IT & Interconnectivity

Working with Bronx RHIO to:

- Expand number of practices connected
- Expand data points sent from those already connected (prescriptions, BPs).
- Collect care plans from GSI and other care management solutions across the PPS
- Expand the ability to share those care plans