All-Member Webinar

Bronx Partners for Healthy Communities (BPHC)

October 31, 2014

11:00 am – 12:30 pm

BRONX PARTNERS FOR HEALTHY COMMUNITIES

Meeting Agenda & Goals

- General Updates
- Project Management Office Updates
- Application Overview
- Summary of CNA Findings
- Clinical Planning Updates
- Business Operations Updates
- Next Steps

General Updates

Member Participation in Planning Efforts

- From mid-July to today, BPHC has held:
  - 14 meetings of the committees composing the PAC, involving **37 individuals** across **19 member organizations**
  - 26 work group meetings across 7 work groups
  - 2 collaborative clinical planning meetings with HHC
- In total, the 7 work groups involve **118 individuals** across **54 member organizations**

Update on HHC Collaboration

Rationale for Collaboration: The needs of our communities and patients will be best met with a *consistent and coordinated approach* to improving the models of care *throughout the borough* and *across the care continuum*

BPHC and HHC have conducted joint planning on the following projects and will continue to work together during the implementation phase:

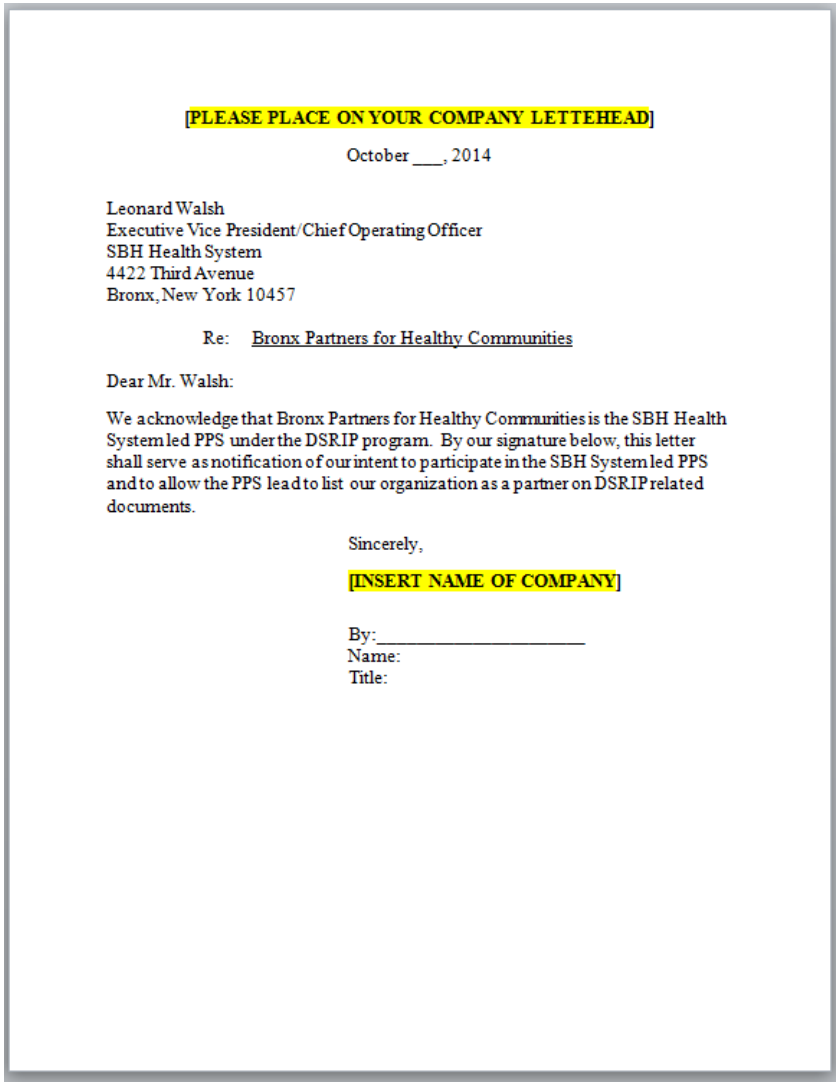
- Health Home At-Risk Intervention Program
- ED Care Triage
- Integration of Primary Care and Behavioral Health Services
- Expansion of Asthma Home-Based Self-Management Program
- Both Domain 4 Projects

BPHC Partner Consent Requirement

- The NYS Department of Health is requiring all PPS members to complete a letter of intent to participate in BPHC
- A request for these attestations was emailed to BPHC partners on Oct. 3rd
- If your organization has not already done so, **please mail completed letters of intent to:**

  SBH Health System
  Attn: Len Walsh, EVP & COO
  4422 Third Avenue
  Bronx, NY 10457

- Call 718-960-3987 with any questions



[PLEASE PLACE ON YOUR COMPANY LETTEHEAD]

October ___, 2014

Leonard Walsh
Executive Vice President/Chief Operating Officer
SBH Health System
4422 Third Avenue
Bronx, New York 10457

Re: Bronx Partners for Healthy Communities

Dear Mr. Walsh:

We acknowledge that Bronx Partners for Healthy Communities is the SBH Health System led PPS under the DSRIP program. By our signature below, this letter shall serve as notification of our intent to participate in the SBH System led PPS and to allow the PPS lead to list our organization as a partner on DSRIP related documents.

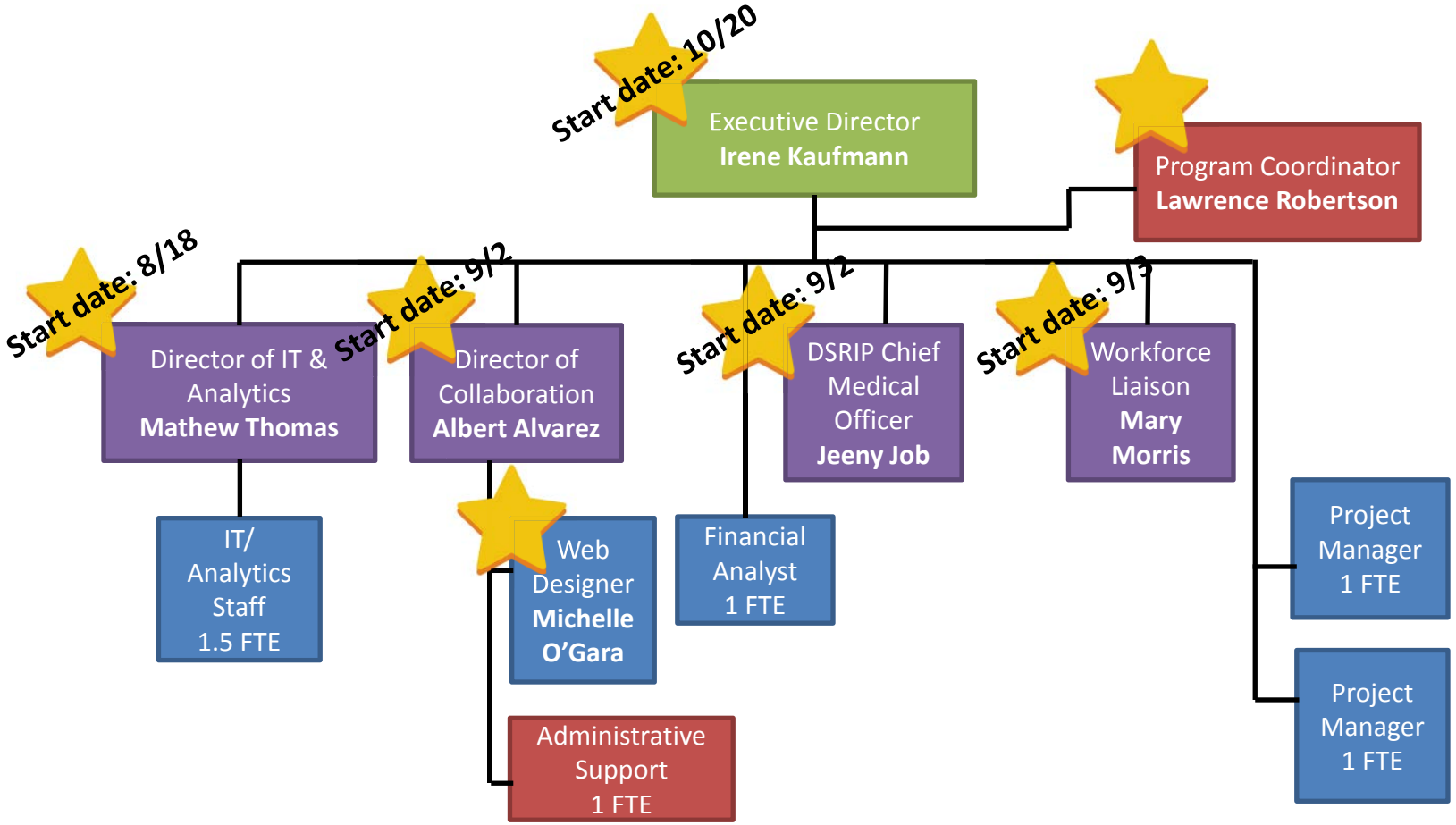
Sincerely,

[INSERT NAME OF COMPANY]

By:_____
Name:
Title:

Project Management Office Updates

Project Management Office Hiring Update



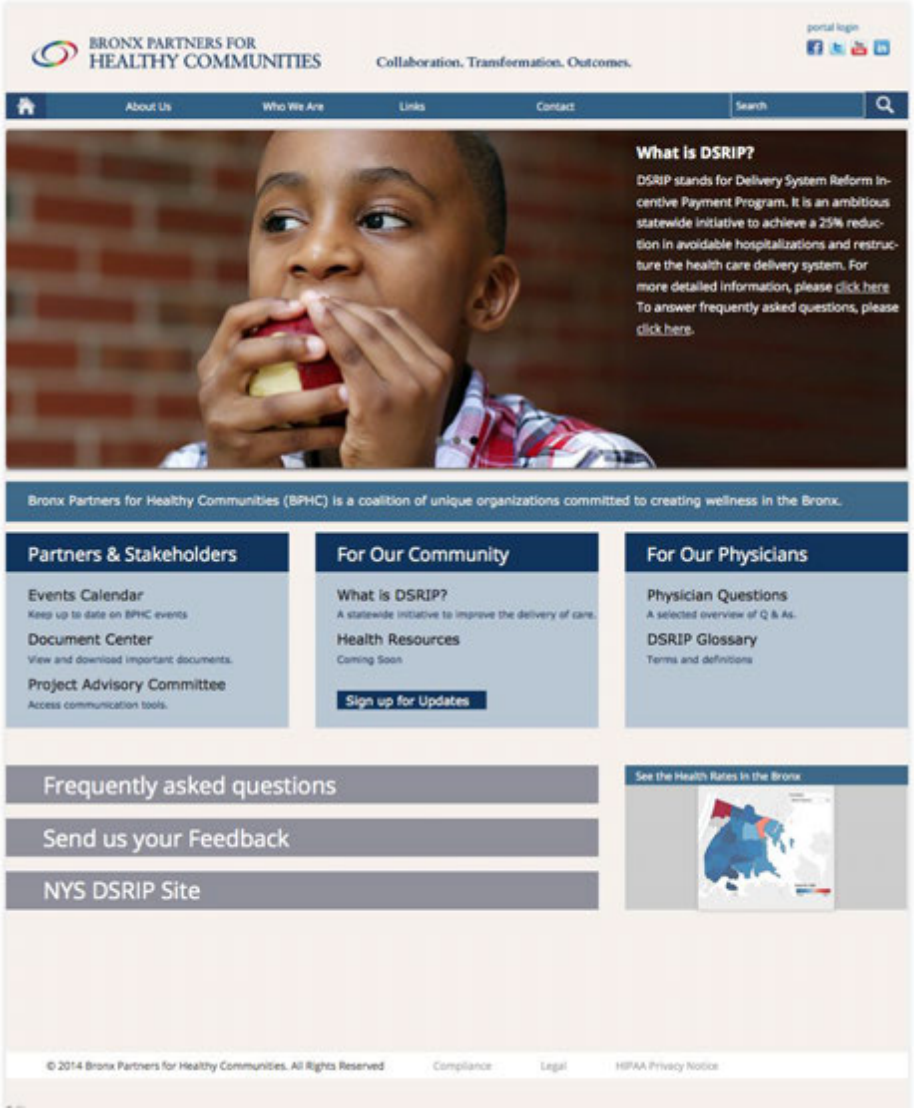
BPHC Logo Selection

On September 29th, the Steering Committee selected the official logo for the Bronx Partners for Healthy Communities PPS:

BRONX PARTNERS FOR
HEALTHY COMMUNITIES

BPHC Website Ready for Launch

Visit us at www.bronxphc.org!



Stakeholder Engagement Presentations

The PMO has developed presentations to educate and engage your staff. The following three presentations will be available on the BPHC website:

- General Presentation
  - What are the goals of DSRIP?
  - What is Bronx Partners for Healthy Communities (BPHC)?
  - What are the community health needs in the Bronx?
  - How will BPHC organizations work together to transform care delivery?

- Workforce Presentation
  - What is DSRIP?
  - How does DSRIP change care delivery?
  - How do the DSRIP projects focus on the health needs of patients?
  - What are the educational and training opportunities for your staff?

- Physician Presentation
  - What are the roles of physicians and BPHC in the DSRIP ecosystem?
  - Why should physicians participate in BPHC?
  - How will the pay for performance process work?

Application Overview

Draft DSRIP Project Plan Application

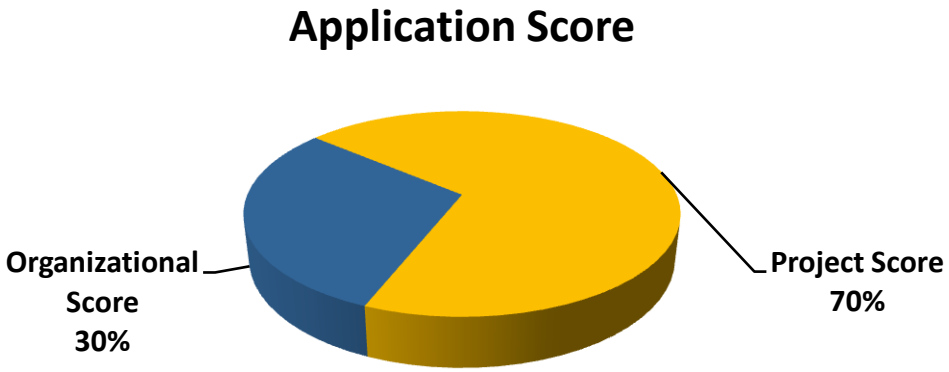
- The draft DSRIP Project Plan Application was released by the NYSDOH on September 29th and contains the following sections:

Table of Contents

- NYSDOH accepted comments on the draft through October 29th via dsripapp@health.ny.gov and is planning additional opportunities for review and discussion of the application (i.e., webinar, conference call, and public forum meeting with PPS leads)

The final application will be released on November 14th and is **due to the State on December 16.**

Application Score Overview



Organizational Scoring

- ❑ Executive Summary
- ❑ Governance
- ❑ Community Needs Assessment
- ❑ Workforce Strategy
- ❑ Data-Sharing, Confidentiality, and Rapid-Cycle Evaluation
- ❑ Cultural Competency/Health Literacy
- ❑ DSRIP Budget and Flow of Funds
- ❑ Financial Sustainability

Project Scoring

- ❑ Project Description and Justification
- ❑ Scale of Implementation
- ❑ Speed of Implementation/Patient Engagement
- ❑ Other Resource Needs and Other Initiatives

CNA Overview

CNA Highlights

NYAM completed the Bronx-wide CNA in early October. Key findings include…

Health in the Bronx

- *The Bronx is the **least healthy county in New York State** with high rates of chronic disease such as:*
  - *Diabetes*
  - *Cardiovascular disease*
  - *Respiratory disease including asthma/COPD*
  - *Cancer and high rates of obesity*
- *Among the Medicaid population, **the Bronx ranks highest among all boroughs in NYC in the rate of potentially preventable inpatient admissions**, including for chronic conditions overall.*
- *The costs incurred—in **both time and money—for medical care remain very problematic and act as a barrier** to effective use of prevention and disease management services from the perspective of community members.*

Socioeconomic Factors

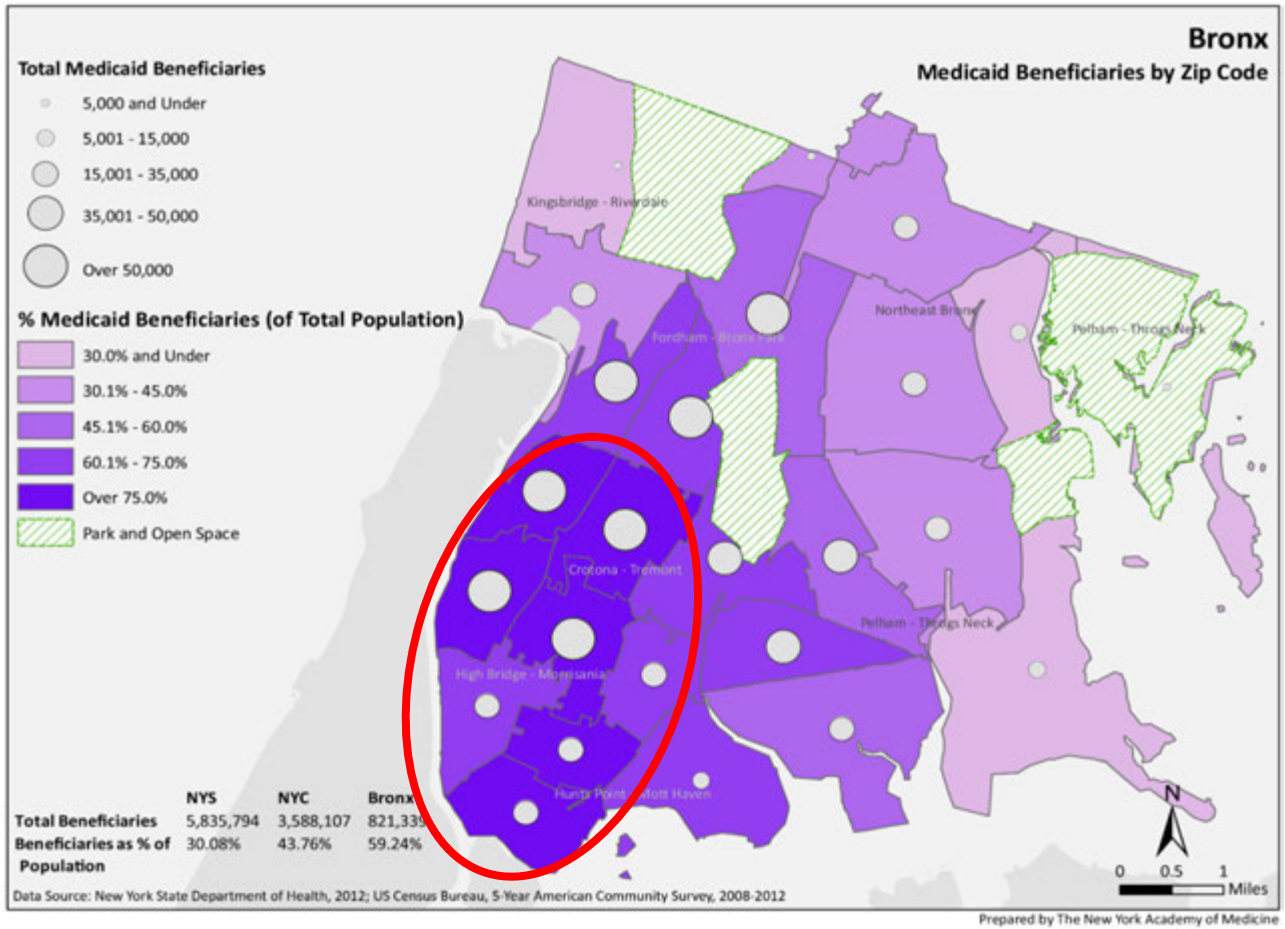
- *The Bronx outpaces NYC overall in **household poverty and low educational attainment.***
- ***More than half of the Bronx population speaks a language other than English** in the home.*
  - *Many of these people are immigrants, presenting possible additional cultural and legal challenges to health care access.*
- *The **link between depression and poverty** was also particularly obvious, as people worried about jobs, housing, entitlements, and the safety of their streets.*
- *A **dramatic indicator of poverty,** with obvious health implications **is food security**, which was described by multiple respondents.*

Medicaid Beneficiaries by Zip Code

Approximately 59% of Bronx residents are enrolled in Medicaid, with higher percentages of enrollees in many zip codes across the borough.

- In multiple zip codes in the Bronx, **over 75% of the total population** is enrolled in Medicaid.
- **Crotona-Tremont, High Bridge-Morrisania, and Hunts Point-Mott Haven** have the highest percentages of Medicaid beneficiaries.

1. Medicaid Beneficiaries by Zip Code

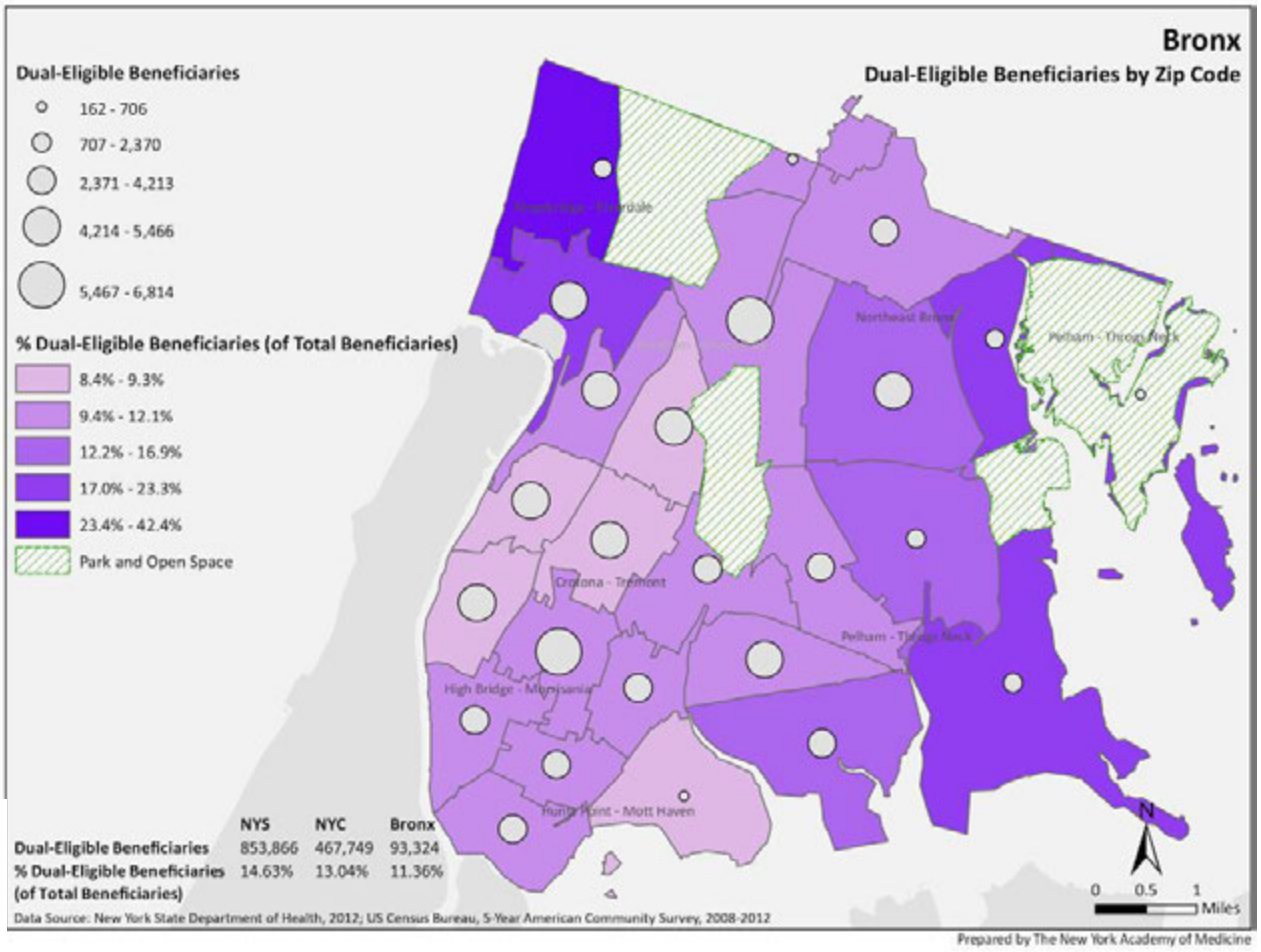


BRONX PARTNERS FOR HEALTHY COMMUNITIES

Dual-Eligible Beneficiaries by Zip Code

There are a high number of dual eligible individuals in the Bronx, indicating a high-need, costly population to serve.

2. Dual-Eligible Beneficiaries by Zip Code

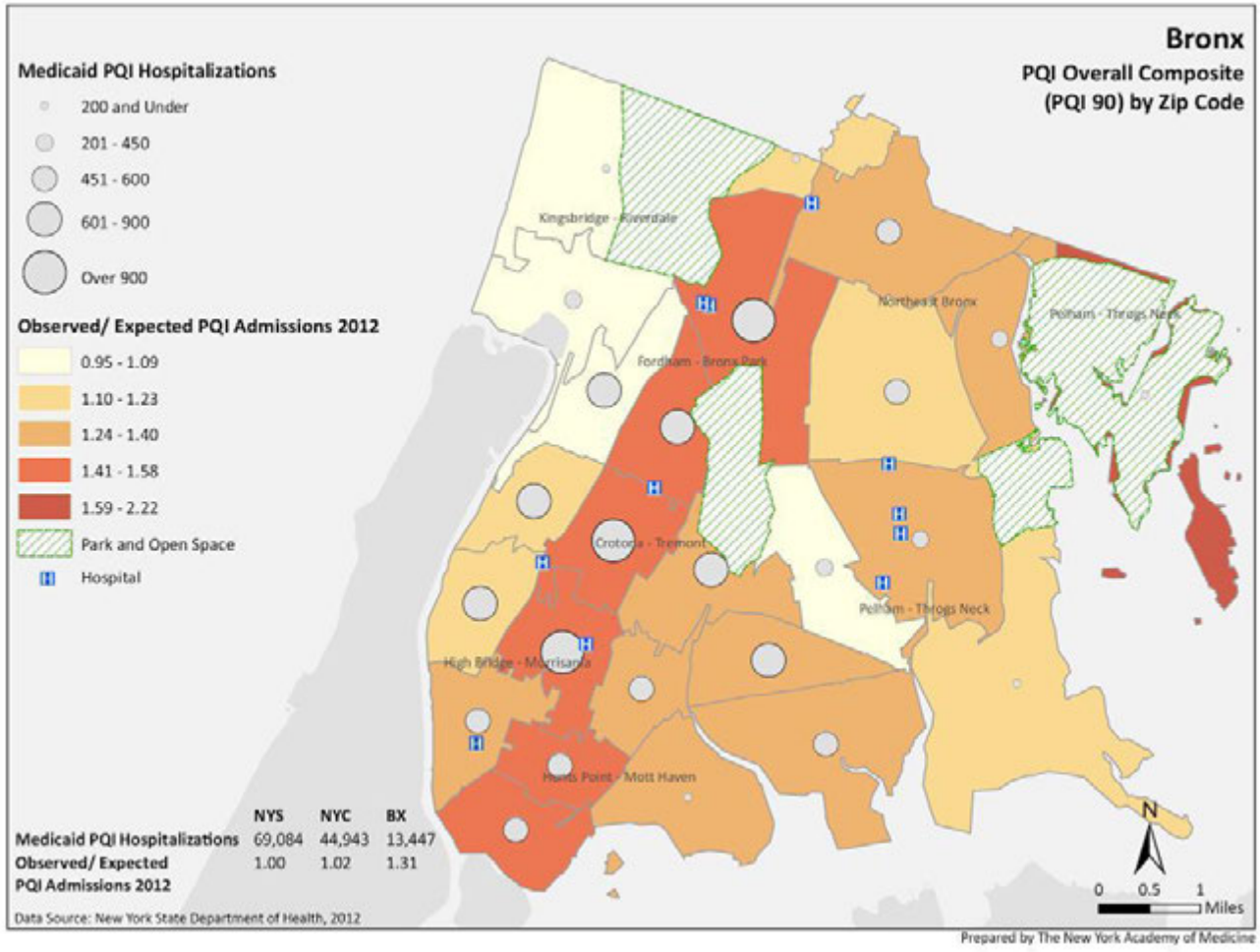


PQI Overall Composite (PQI 90) by Zip Code

Most Bronx neighborhoods have higher observed/expected ratios of PQI admissions than the city and state.

*The highest ratios of observed/expected PQI admissions are **concentrated in the areas of the Bronx in a wide corridor** from Fordham-Bronx Park in the north, south alongside the Grand Concourse to the South Bronx.*

35. PQI Overall Composite (PQI 90) by Zip Code



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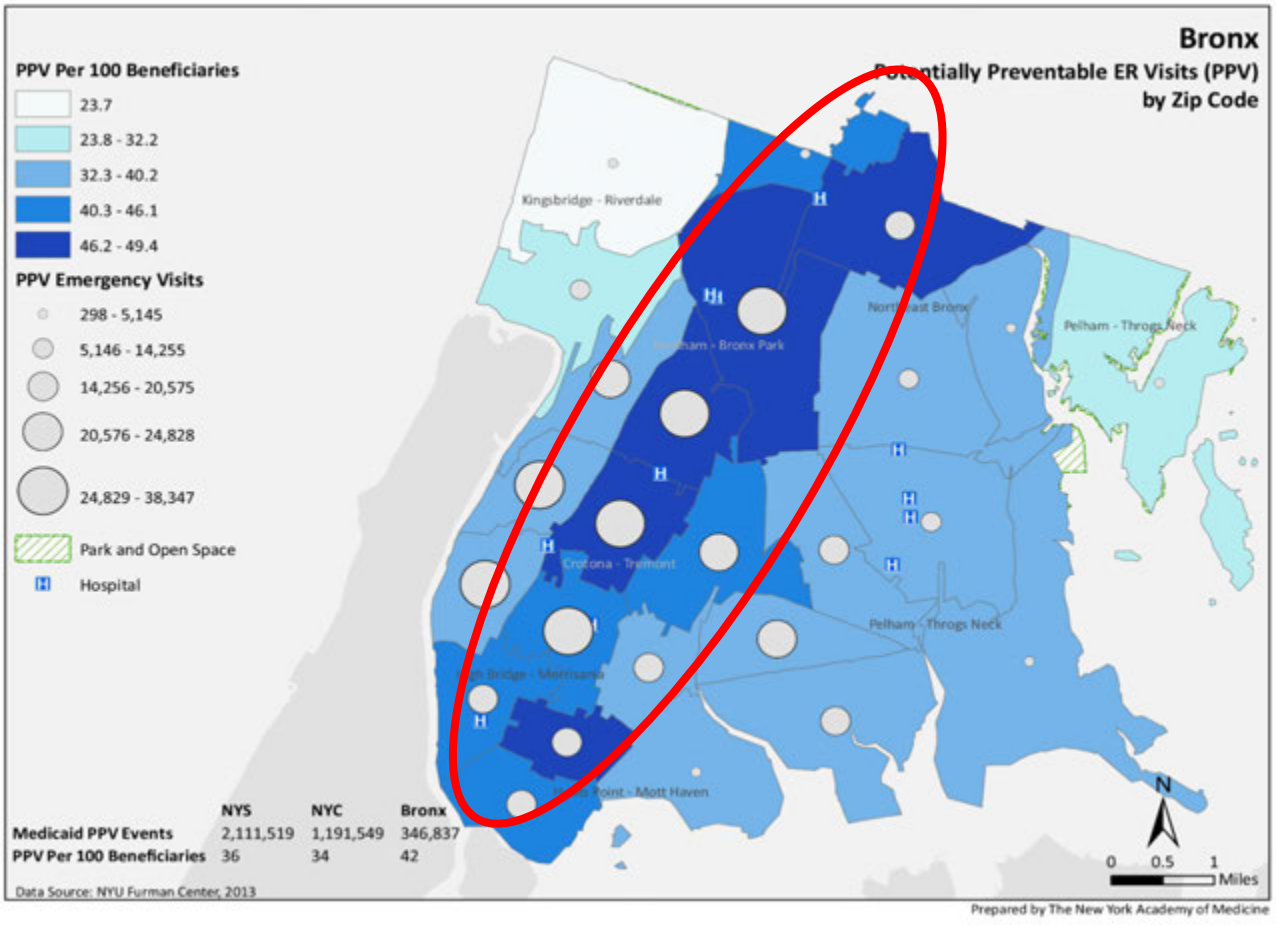
Potentially Preventable ER Visits by Zip Code

Long wait times for and at visits, as well as a need for multiple visits, make the emergency department a rational choice for "one stop shopping"

- Almost all of the neighborhoods in the Bronx are **at or above NYC and NYS rates for preventable ER visits per 100 beneficiaries.**
- The highest rates of preventable **emergency room visits per 100 beneficiaries are concentrated in the same corridor** where preventable admissions are prominent.

53. Potentially Preventable ER Visits (PPV) by Zip Code

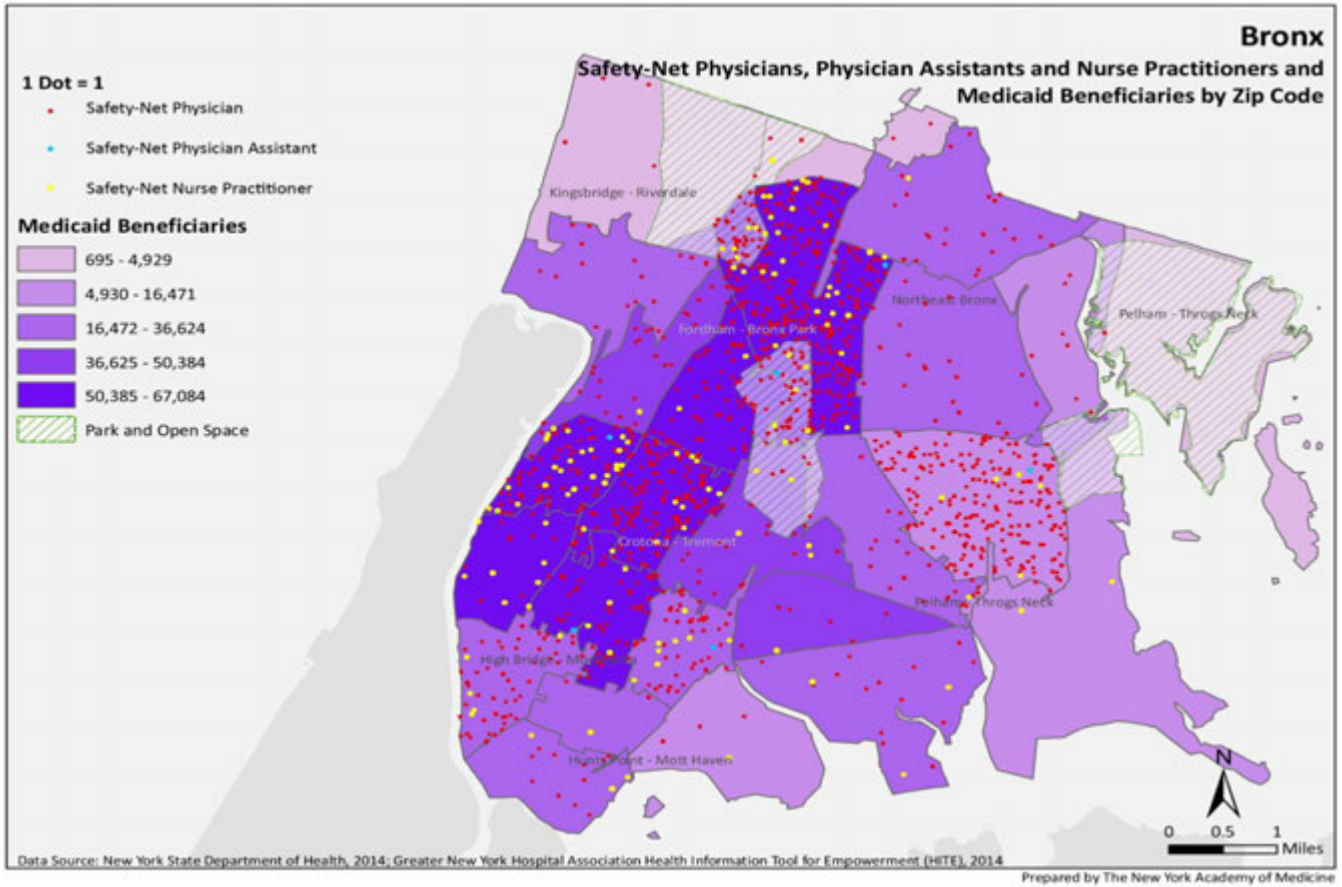


BRONX PARTNERS FOR HEALTHY COMMUNITIES

Alignment of Safety-Net Primary Care Providers and Medicaid Beneficiaries

In the Bronx, the distribution of safety net primary care providers is well aligned with where Medicaid beneficiaries reside.

82. Safety-Net Physicians, Physician Assistants, Nurse Practitioners and Medicaid Beneficiaries by Zip Code



Bronx CNA Project-Specific Highlights

- **Cardiovascular disease:** *Heart disease is the top cause of mortality among the white, black, and Hispanic populations of the Bronx. It is also the second leading cause of premature death in the borough.*
- **Diabetes:** *The rate of hospitalizations for short-term diabetes complications among Medicaid beneficiaries is higher in the Bronx (151.22 per 100,000) than in the city overall (105.03 per 100,000), and higher than the state overall (110.31 per 100,000).*
- **Asthma/COPD:** *While the observed rate of PQI respiratory admissions has declined in the Bronx since 2009, it remains at or above the expected rate.*
  - *There is a concentration of young adult asthma and respiratory hospitalizations in the southern part of the borough, extending across both sides of the Grand Concourse.*
- **Mental/behavioral health:** *Only 53.3% of respondents reported that the mental health services are "available" or "very available" in their community.*
- **Substance abuse:** *Substance abuse was the second most commonly cited health concern by survey respondents (47.2%)*
  - *Many (36.2%) also noted the need for education on the topic.*
- **HIV/AIDS:** *Four neighborhoods in the borough have a higher HIV/AIDS prevalence rate than the city as a whole: High Bridge/ Morrisania, Crotona/ Tremont, Fordham/ Bronx Park, and Hunts Point/ Mott Haven.*

Data from the CNA support our project selections

Clinical Planning Updates

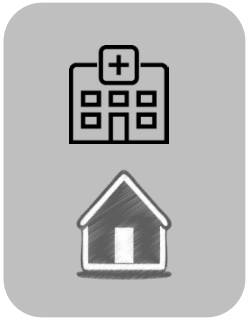
Final Project List

On October 29, the Steering Committee approved the clinical work groups' and CDPP Committee's recommendation that BPHC should move forward with implementing the following projects.

2.a.i	Create an Integrated Delivery System focused on Evidence-Based Medicine and Population Health Management
2.a.iii.	Health Home At-Risk Intervention Program
2.b.iii	ED Care Triage
2.b.iv	Care Transitions Intervention Model to Reduce 30 Day Readmissions
3.a.i	Integration of Primary Care and Behavioral Health Services
3.b.i	Evidence-based Strategies for Disease Management in High Risk/Affected Populations (adults only) - Cardiovascular Disease
3.c.i	Evidence-based Strategies for Disease Management in High Risk/Affected Populations (adult only) - Diabetes
3.d.ii	Expansion of Asthma Home-Based Self-Management Program
4.a.iii	Strengthen Mental Health and Substance Abuse Infrastructure Across Systems ★
4.c.ii	Increase Early Access to, and Retention in, HIV Care ★

★ = Indicates change from planning grant application submitted in June

Update: Care Management - Care Transitions



At a Glance

- **Meetings:** Held four Work Group meetings on 7/30, 8/11, 9/22, and 10/6
- **Small Group Meetings:** Held a series of small group meetings to conduct information gathering with community leaders who have experience implementing the interventions

Interventions

The Steering Committee approved the following interventions recommended by the CDPP Committee and the Clinical Work Groups:

30 Day Readmissions

- Bronx Collaborative
- Critical Time Intervention

ED Triage/Diversion

- Expansion of Montefiore CMO Clinical Navigator Program
- Parachute NYC

Health Homes

- Opportunities to strengthen current capabilities of Bronx Health Homes
- Opportunities to expand to individuals with a single chronic condition

Update: Primary Care and Behavioral Health Integration

At a Glance

- **Meetings:** Held four Work Group meetings on 7/30, 8/14, 8/27, 9/8

Interventions

The Steering Committee approved the following interventions recommended by the CDPP Committee and the Clinical Work Groups:

PCMH

Achieving 2014 NCQA Level 3 patient-centered medical homes (PCMHs) across BPHC primary care sites by December 2016

IMPACT / Collaborative Care Model

Utilizing the IMPACT/CCM for a subset of patients with mild/moderate depression. Work group members see potential to phase in treatment of anxiety, substance use and other disorders over time as providers gain experience

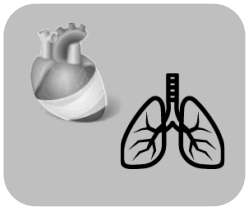
Co-location of Primary Care Providers into Article 31/32 Sites

- Pursuing physical co-location of services where logistically feasible and financially sustainable
- Instituting medical monitoring at locations where co-location is not feasible

Co-location of Behavioral Health Providers into Article 28 Sites

- Pursuing physical co-location of services where logistically feasible and financially sustainable
- These sites would also adopt the Collaborative Care model

Update: Cardiovascular Disease, Diabetes, and Asthma



At a Glance

- **Meetings:** Held five Work Group meetings on 7/30, 8/4, 8/18, 9/3, and 9/17

Interventions

The Steering Committee approved the following interventions recommended by the CDPP Committee and the Clinical Work Groups:

Cardiovascular Disease

- Implementing strategies recommended by the Million Hearts initiative for aggressive hypertension control
- Adopting a standard set of treatment and management standards, workflows, and protocols

Diabetes

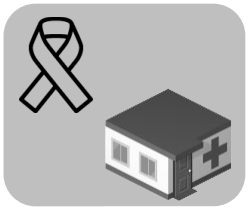
- Adapting the Million Hearts initiative disease management strategies to diabetes control
- Adopt evidence-based DM treatment guidelines
- Implementing the LEAP amputation prevention intervention as part of the broader patient engagement strategy

Asthma

- Contracting with a.i.r. bronx and other providers/community-based organizations to implement its home-based asthma intervention

For all assigned projects, the CVD/Asthma/Diabetes Work Group has noted that attainment of NCQA PCMH Level 3 recognition by primary care providers will be crucial.

Update: Population Health



At a Glance

- BPHC has met with the NYC Department of Health and Mental Hygiene (DOHMH) and the other Bronx PPSs to discuss collaboration on the population health projects
  - DOHMH has committed to providing its technical expertise and support on projects related to smoking cessation and HIV; the level of support provided will depend on each PPS's needs and resources
- Project 4.a.iii: Strengthen Mental Health and Substance Abuse Infrastructure Across Systems
  - BPHC is collaborating with HHC and Community Care Brooklyn (the Maimonides-led PPS) on this project
- Project 4.c.ii: Increase Early Access to, and Retention in, HIV Care
  - BPHC is participating in city-wide planning efforts for this project
- Project-specific meetings to identify interventions are in progress and will be completed by early November

Update: Patient Engagement

At a Glance

- All clinical work groups discussed strategies for patient engagement
- Strategies under discussion have spanned from assessment, risk stratification, and patient activation tools to specific patient engagement tactics that are built into projects. These strategies will target populations that can most benefit from each project.

Approach

The Work Groups recommend that BPHC...

General Approach

- Conduct patient engagement in a culturally competent manner that addresses the social determinants of health
- Seek to recruit and train community residents to work in patient engagement activities as patient navigators, peer coaches/educators
- Embed care managers & other workers in PCMHs
- Identify assessment tools that identify patients' behavioral health and unmet social needs so that physicians can connect their patients to necessary resources
- Work with community-based organizations to ensure they are integrally involved with the patient engagement strategy

Targeted Approaches

- Outstation Health Home care managers and patient navigators in EDs and discharge units to engage at risk patients at critical junctures in care
- Develop call-in lines for patients in crisis
- Deploy the Stanford Chronic Disease Self-Management Model for cardiovascular disease, diabetes, and asthma, and supplement this model with other interventions as needed (e.g., LEAP for amputation prevention)

Business Operations Updates

IT & Operations Planning: Progress to Date

The IT & Analytics Work Group has met four times:

- 8/19, 9/4, 9/15 and 9/30 to explore different topics and share experience and knowledge of IT solutions/assets already being used in the community

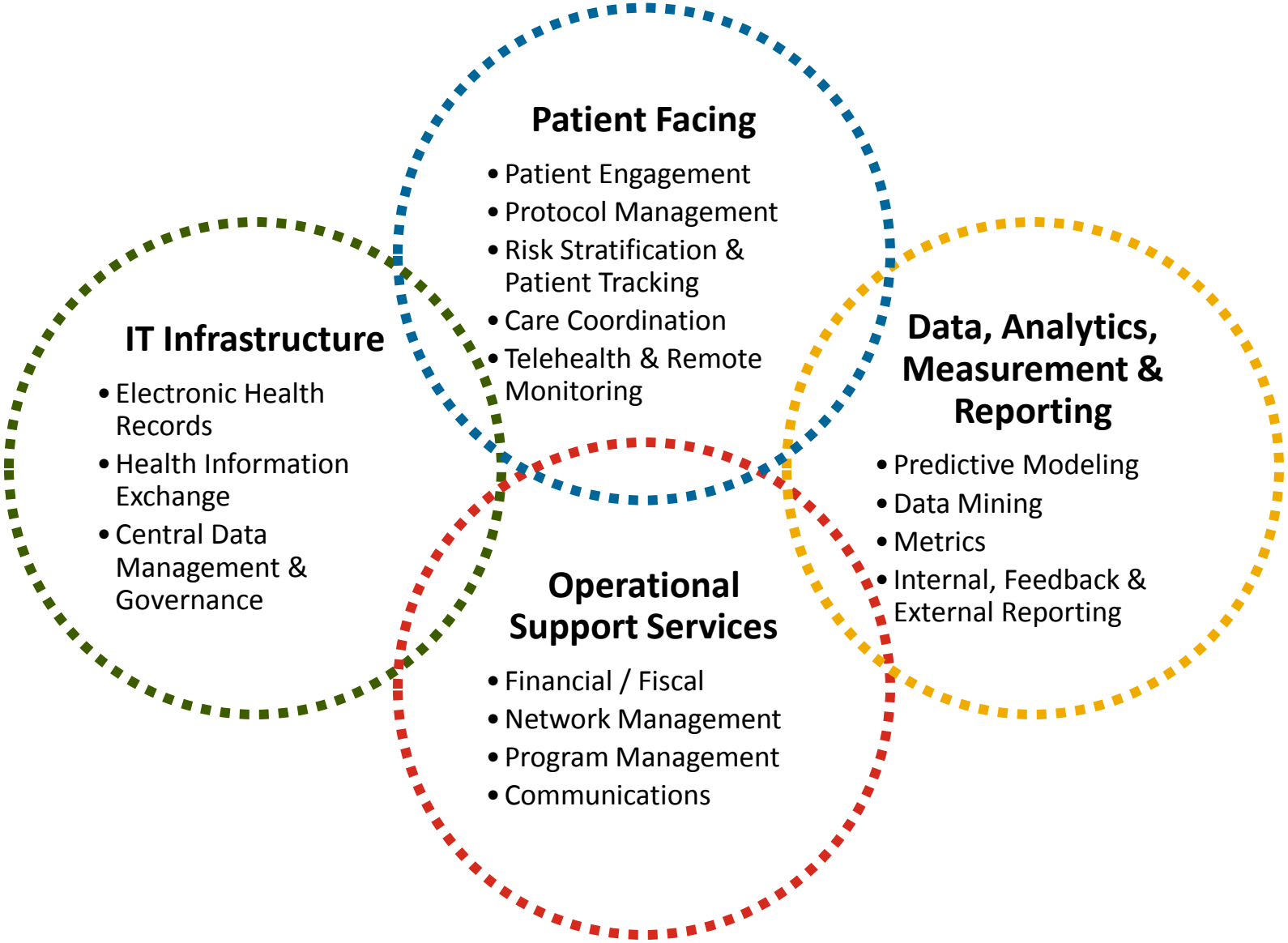
Planning direction has included:

- Target IT architecture development
- Partner IT survey and assessment
- Prioritization of IT requirements: HIE, analytics and care management solution
- Explore Bronx RHIO capabilities
- Explore synergy with health homes

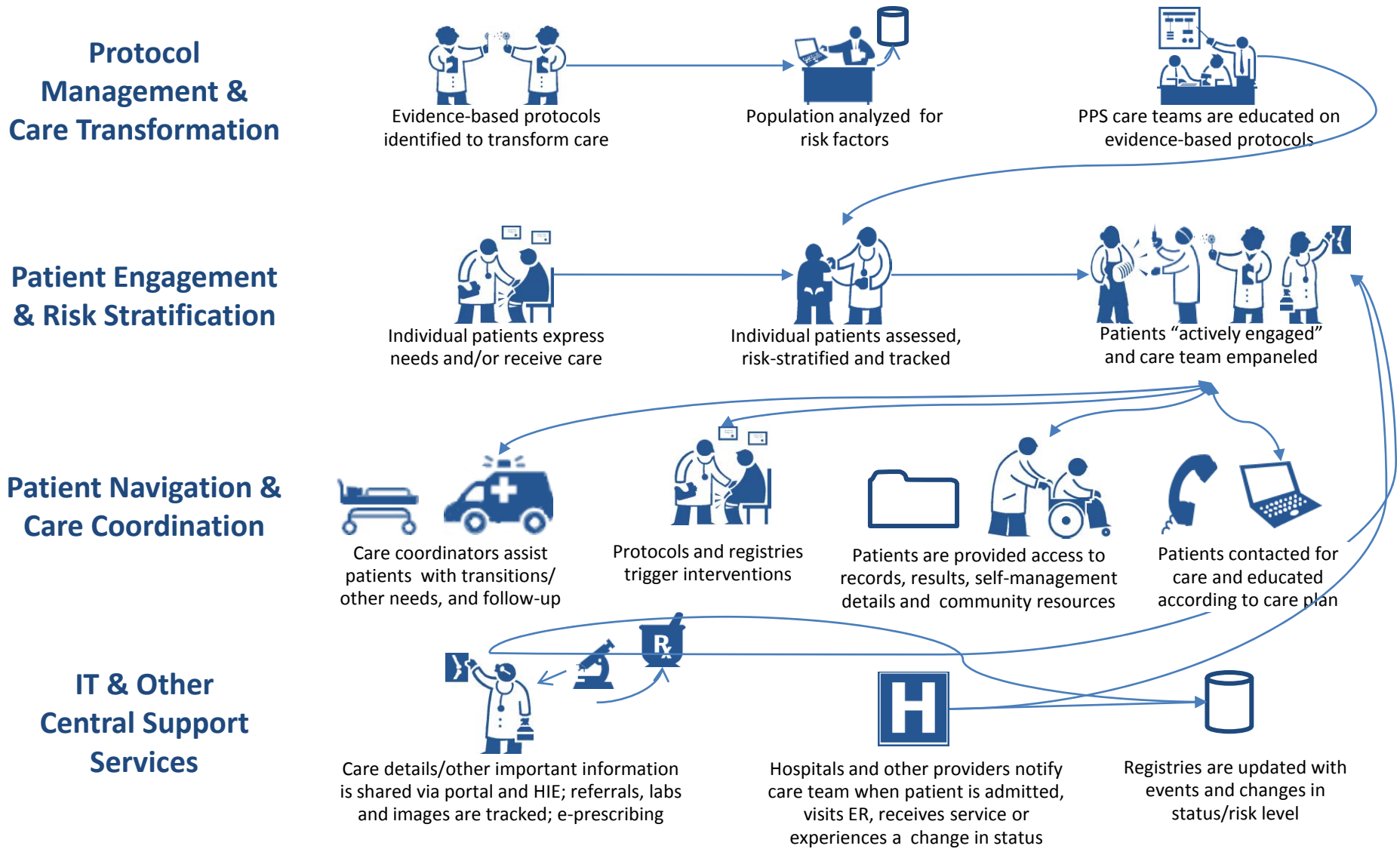
The Work Group will meet at least once more before application submission

- In addition, Work Group members will participate in joint IT & operational planning

IT & Operations Planning: Major Groupings of IT Functionality



IT & Operations Planning: Major Elements and Conceptual Flow Summary



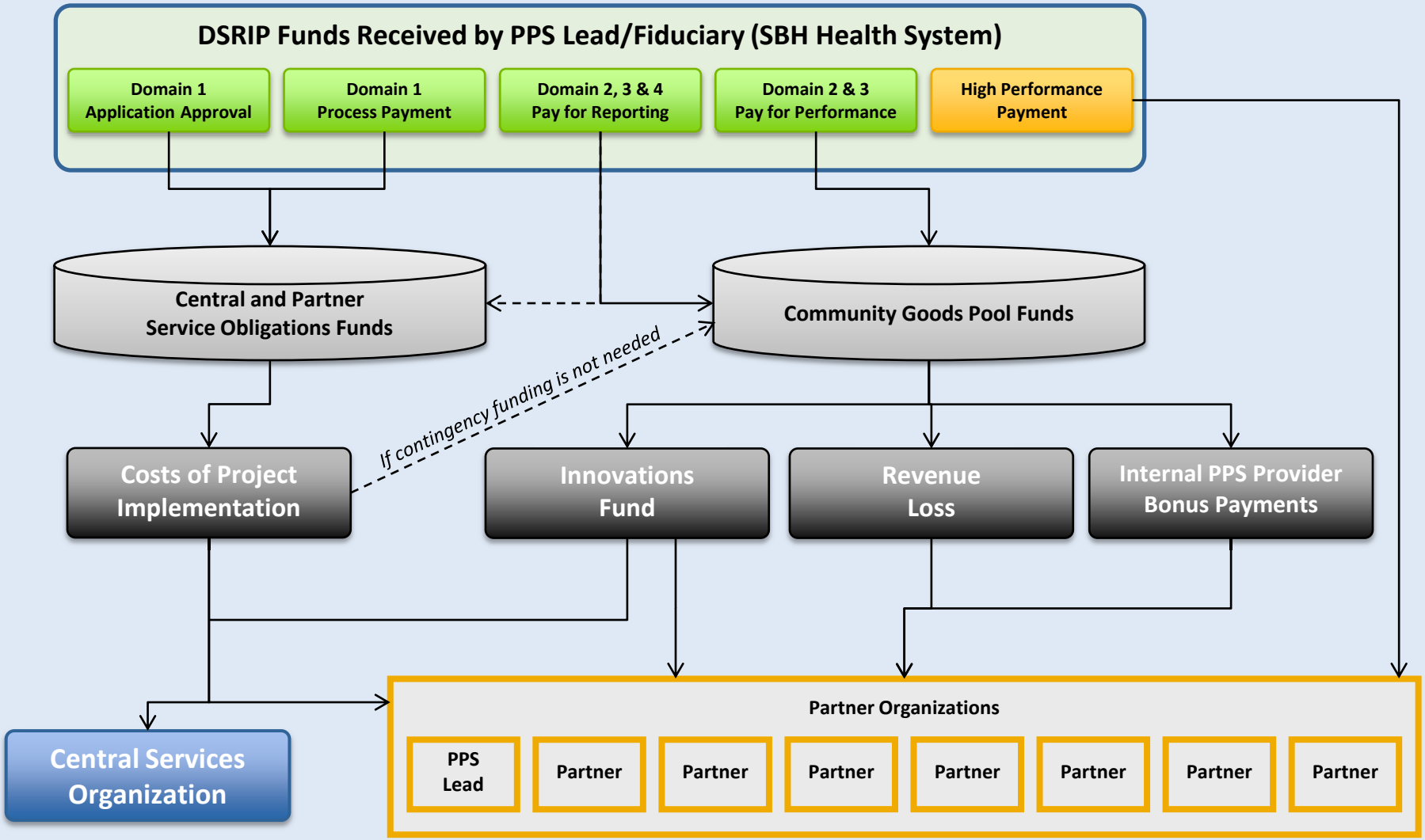
IT & Operations Planning: Preliminary IT Recommendations

- Pursue Bronx RHIO as a core solution, pending further due diligence on capabilities
  - Health information exchange
  - Centralized data storage, management & governance
  - Analytics, measurement & reporting
- Establish program management and acquire resources for monitoring or assisting partners with EHR Meaningful Use and PCMH 2014
  - Based on final attribution and partner inclusion
- Develop requirements for patient-facing solutions, based on the criticality to DSRIP and known gaps
  - Care coordination and management solution (CCMS) for care planning, clinical and social service navigation and transitions
  - Assessment and risk stratification
  - Patient registries

IT & Operations Planning: Next Steps

- Clinical planning teams and the IT & Analytics Workgroup have been working in parallel
- Joint planning at a more operational level is needed to inform IT and implementation decisions and to produce a coherent and consistent application
- Objective: Develop a high-level PPS "Concept of Operations" or operational vision with just enough detail for the application and as a step towards preparing for April 2015 implementation

Finance Update: Potential Model for Fund Distribution



Illustrative Example for Discussion Purposes Only

**This diagram demonstrates the funds flow of DSRIP dollars only and does not include capital funding.*

Finance Update: Distribution of DSRIP Funds

We have drafted a preliminary approach to distributing funds to partners, through three categories:

- ***Cost of Project Implementation:*** Distribution of payments for this category will be split between a central services organization and partner organizations to cover certain project implementation and maintenance costs. Partner organizations across the care delivery continuum will receive funding in two ways:
  - ***Upfront payments:*** provided so organizations, including the financially frail, have funding to initiate hiring and other project implementation tasks prior to reaching implementation milestones.
  - ***Milestone payment:*** Payments made upon completion of required milestones and actions identified for the participant.
- ***Revenue Loss***: Distributed to participating provider organizations as compensation for net revenue lost in implementing DSRIP projects, through significant changes in existing business models.
- ***Internal PPS Provider Bonus Payments***: Distributed to participating provider organizations to reflect contributions to DSRIP goals such as PPS performance on specified cost, quality and coordination measures. Funding amounts may vary based on performance as well as beneficiary attribution.

The BPHC Central Services Organization will further determine payment allocations.

Finance Update: Partner Financial Survey

Partner Financial Survey

- The purpose of the assessment is to inform the Financial Sustainability Plan portion of the DSRIP Application.
  - The results of the survey will not affect partner selection.
- Survey questions were translated into two forms – an online survey, and a writeable PDF form.
- The survey was distributed to partner organizations on Thursday, October 30th.
  - The survey was distributed to main contacts at partner organizations, with instructions to be forwarded to appropriate parties to complete the survey
  - Partner organizations **responses are due on Friday, November 14th.**

Workforce Development Work Group Update

Workforce Survey

- Distributed to all partner organizations on October 6
- Received 150 responses to date from 117 organizations
- Responses will largely be used for implementation planning efforts

Workforce Development Work Group last convened on October 16 to discuss DSRIP application requirements. Topics discussed included:

- How to define retraining and redeployment
- Implications of refusal to retrain/redeploy
- Redeployment supports and strategies
- How to communicate with workers about DSRIP planning and implications

Meetings Going Forward

The next all-member meeting will be in December.

Please send additional questions or feedback to:

Albert Alvarez, Director of Collaboration
Aalvarez3@sbhny.org
718-960-3783