BRONX PARTNERS FOR HEALTHY COMMUNITIES

SBH Health System BRONX

All-Member Webinar

January 18, 2017

Agenda

- Welcome
- BPHC Updates
- Mid-Point Assessment
  - New Programs Overview
    - Community Behavioral Health “Call to Action” Initiative
    - Community Health Literacy
    - Community Cultural Competency Training and Training Update
  - PCMH Update
  - Funds Distribution an Contracting Summary
  - Value-Based Payment (VBP)
  - Performance Reporting
- Care Coordination Management System (CCMS)
- Q&A
- Critical Time Intervention: Deep Dive
  - CTI Overview
  - CTI Partner: Visiting Nurse Services of New York (VNSNY)
  - CTI Partner: SCO Family Services
- Q&A

BPHC is happy to receive your questions in writing! Please email them to Luci deHaan (ldehaan@sbhny.org) and Shqipe Gjevukaj (sgjevukaj@sbhny.org)

Mid-Point Assessment and Audit

Covers DSRIP planning and implementation DY1-DY2Q2 (April 1, 2015 – June 30, 2016) period

- The Mid-Point Assessment included:
  - Overview of Domain 1 Work Streams and DSRIP Projects submitted to SDOH on June 30
  - BPHC Primary Care Strategic Plan submitted to SDOH on August 23
  - 360^{o} Partner Survey – distributed by SDOH through August 23
  - Site Visit by Independent Assessor Team on October 24
    - Representatives of BPHC Member Organizations participating in interview included:
      - David Menashy, Director Revenue Management. Montefiore Medical Center
      - Pam Mattel , COO, Acacia
      - Debbian Fletcher-Blake, COO, Morris Heights
      - Eileen Torres, ED, BronxWorks
      - Nicole Hollingsworth, AVP Community and Population Health, Montefiore Medical Center
      - Rosa Mejias, TEF
      - Kathy Miller, ED, RHIO
  - Contract and Financial Reporting Audit
  - PAOP Site Visit on November
    - PAOP Members:
      - Yvonne Graham, Associate Director, NYSDOH; Sherry Sutler, Consumer Representative
    - Representatives from BPHC Member Organizations:
      - Chris Norwood - HealthPeople
      - Shoshana Brown – a.i.r. Bronx
      - Mark Graham: CBC

Mid-Point Review and Assessment Report

- DOH Mid-Point Assessment reported by Independent Assessor Team consisted of:
  - Assessment of BPHC Partner Engagement
  - Assessment of 360º Partner Survey results
  - Comprehensive Mid-Point Assessment Analysis
- Summary of IA assessment and comments:
  - *BPHC performed well on DSRIP project implementation and PPS Operations*
    - *Received top scores (1s and 2s) on 7/8 projects*
    - *Scored 3 on At-Risk Health Home Project for slow patient engagement*
  - *BPHC ranked 12/24 on the 360º survey*
    - *30 providers randomly selected from 8,000 entries*
    - *14 (48%) responded – (higher than PPS average) with positive feedback but also pressing for continued engagement and fund distribution*

Mid-Point Assessment Summary

Mid-point Finance Review

- The efforts and investments of BPHC in its PPS resulted in the following analysis of Independent Assessor
  - In DY1, Q2 BPHC **earned all available Organizational Achievement Values (AVs) and earned 1/1 Patient Engagement Speed AVs**
  - In DY1, Q4, BPHC **earned all available Organizational AVs and earned 4/5 Patient Engagement Speed AVs**

Comment by Independent Assessor

"BPHC has demonstrated vigilance in their communication strategy and consistent partner interactions. This PPS employs an array of biweekly e-Bulletins, electronic newsletters, a BPHC website that includes a member resource directory, live meetings with onsite partner visits, and a variety of workgroups and tools, as means of communication and support to its partners. With a streamlined monitoring process, BPHC also fosters partner collaboration and compliance with policies and guidelines, which encourages effective process implementation".

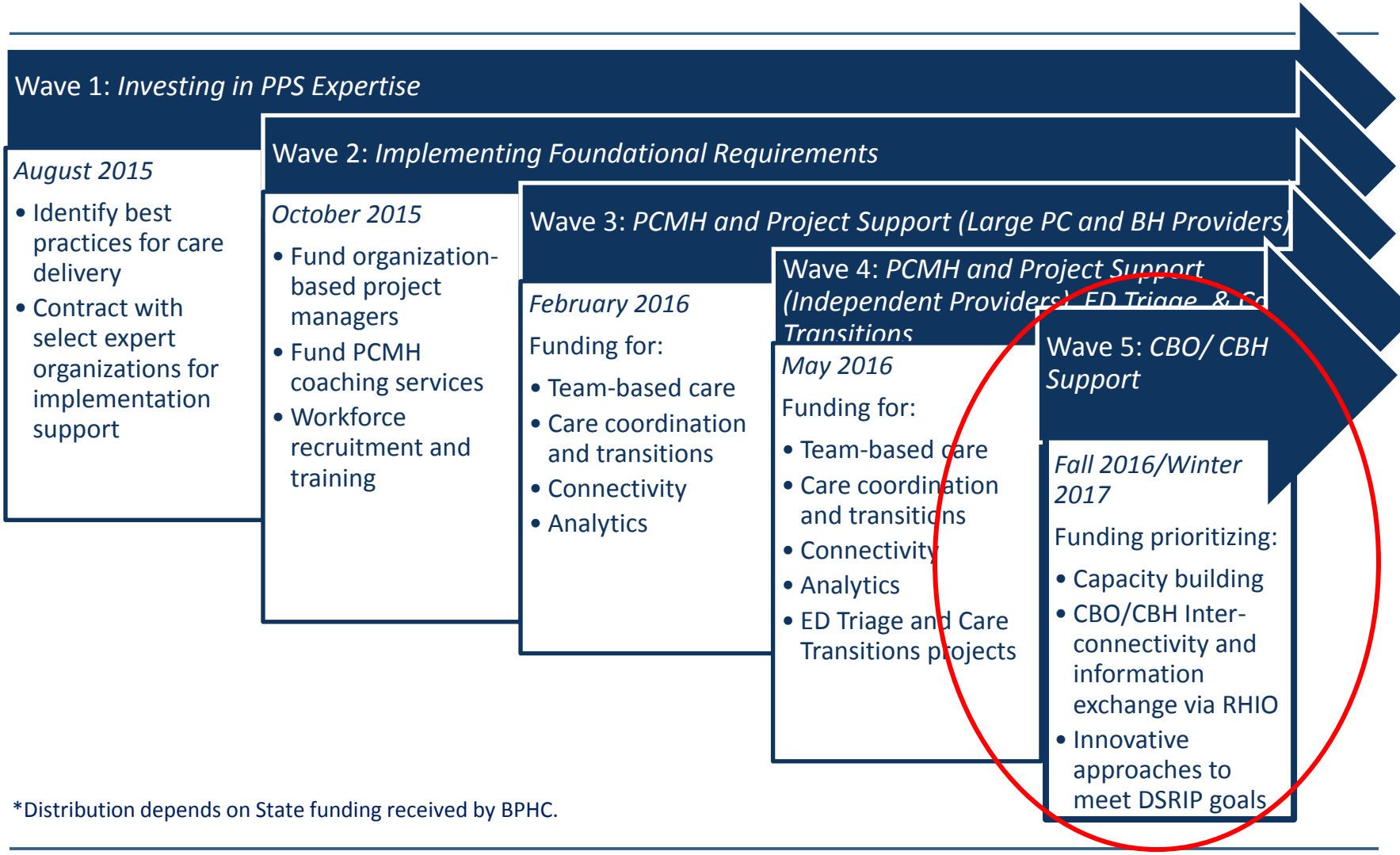
IA Mid-Point Assessment Recommendations

- **Recommendation 1:** The IA recommends the PPS create a plan to address the shortage of qualified and trained staff to engage in this project, thus improving the availability of proper care management and creating a foundation for appropriate referrals
- **Recommendation 2:** The IA recommends the PPS work with its partners in deciding on a vendor to provide IT solutions. The PPS will need to work with the vendor and network partners to address interoperability requirements that will enable the necessary data exchange for proper care management planning and documentation, as well as accurate patient engagement counts.
- **Recommendation 3:** The IA recommends that the PPS develop a strategy to increase partner engagement across all projects, with a specific emphasis on Mental Health partners for Domain 3a projects.

BPHC's response to the IA Mid-Point Assessment Recommendations will be made throughout today's Update and Deep Dive Presentation

COMMUNITY ENGAGEMENT

Funds Flow: Wave 5 Distribution



*Distribution depends on State funding received by BPHC.

Wave 5 Fund Distribution through RFP Process

- **Community-based Behavioral Health "Call to Action":** Adopt evidence-based practices to unify screening interventions and ensure that BPHC can meet its HEDIS metrics for PPS attribution with Behavioral Health conditions.
- **Community Health Literacy RFP:** Request for Letter of Interest was circulated to CBOs to provide community health literacy education on topics selected and vetted by both CBOs and providers
- **Cultural Competency Training:** BPHC issued a Letter of Intent (LOI) to 183 CBOs to announce an opportunity to contract with BPHC for the delivery of Cultural Competency training to its member organizations.
- **Critical Time Intervention (CTI) RFP: Today's Deep Dive Presentation:** Designed to prevent homelessness and other adverse outcomes in people with serious mental illness (SMI) following discharge from hospitals and shelters

Engaging Community Behavioral Health Providers

- BPHC has more than 60 community Behavioral Health member organizations with a combined attribution of approximately 60,000 patients
- The Community Behavioral Health Leadership Group was established to develop strategies for engaging the diverse CBH organizations in BPHC planning activities and operations
- The Community Behavioral Health leadership group recommended:
  - A "Call to Action" initiative for adopting best practices to be supported with Wave 5 funding for:
    - Implementation of PHQ2/9 and ESPRT screening
    - Linking clients to primary care and HH programs
  - Create a planning process for the CBH Initiative to be led by CBH agencies
  - Provide start-up funding to address resource needs critical to community Behavioral Health Providers including:
    - Technical support, implementation guidelines and tool kit and training opportunities
  - Establish funding methodology that incentivizes performance on key measures and provides rewards for meeting and surpassing targets

Behavioral Health "Call to Action"

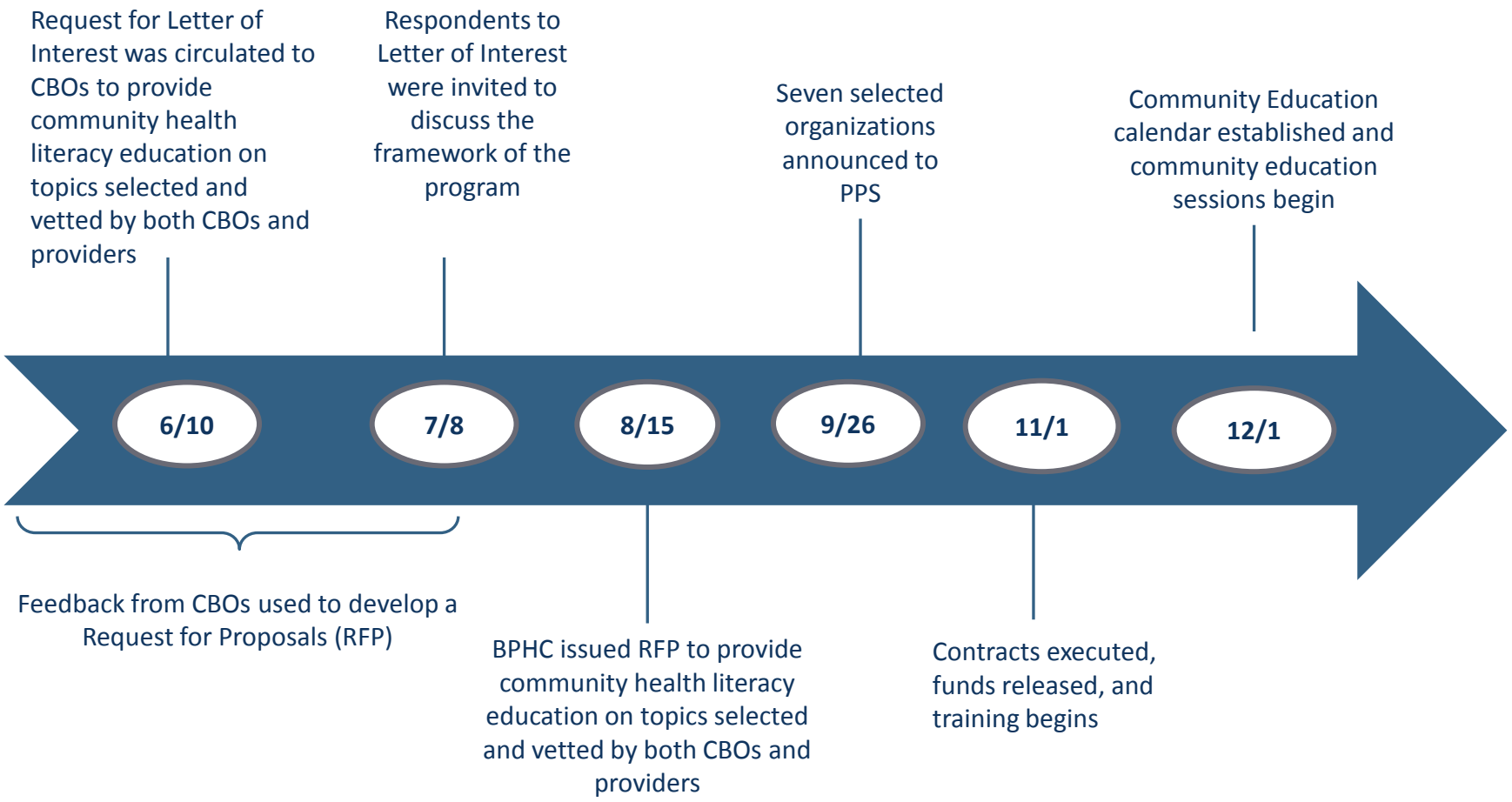
- 14 Community Behavioral Health Agencies were invited through an RFP to lead and participate in work groups to plan the "Call to Action" initiative for Behavioral Health
- The work groups developed and presented work plans for the Initiative to the CBH Leadership Group and the QCIS on:
    1. Standardizing practices for Mental Health and Substance Abuse Screenings
    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 with launch of the Initiative planned for March 2017.
- Look for our "Call to Action" LOI coming February 2017. We hope that you will join!

"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

Community Health Literacy

- BPHC Community Engagement Group recognized that health literacy and ability to navigate the healthcare system is essential to improving community's access to care and its health outcomes. Together we established a program that:
  - Target underserved individuals not well engaged in primary care and supportive Health Home Services
  - Employ peers and community health workers to provide education to learners in the community
  - Conduct educational sessions in various settings (community center, laundromat, churches, nail salon, the street) on the following topics:
    - Seeking and Using Health Insurance
    - Navigating the health care system
  - Provide a warm hand off to care coordinators and primary care providers

Community Health Literacy Plan Timeline



Community Health Literacy

- Curriculum development and trainers
  - 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
- First training for selected organizations on "*Seeking and Using Health Insurance*" conducted in November
- Education sessions for community learners began mid-November 2016
- First training for selected organizations on Care Navigation and Health Literacy to begin in February
- As of December 31
  - 48 education sessions held
  - 807 community learners reached

Cultural Competency Training

Eight Cultural Competency/Health Literacy training programs to be implemented in three phases:

First phase foundational programs provide basic knowledge to various segments of BPHC workforce, beginning in DY2Q4:

1. BPHC Cultural Competency for Leadership
2. Cultural Competency in the Bronx for Frontline Staff in the BPHC network
3. Cultural Competency and the Social Determinants of Health for Practitioners

The **second phase** programs based on the PPS's strategic needs, are also necessary to present by the end of DY2.

4. Community Health Literacy Program for community members via CBOs
5. Working with People with Behavioral Health Conditions for frontline staff in the BPHC network

The **third phase** of specialized programs in terms of the target trainees and depth of the subject, will be implemented beginning in DY3.

6. Patient-Centered Care for Immigrant Seniors in the Bronx
7. Cultural Competency for Home Care for home health workers
8. Poverty Simulation for frontline staff

BPHC Trainings to Date

Training Programs	Total Trained
Asthma Project Training	**73**
DOHMH Pest Management Workshop	11
JustFix Training	14
Motivational Interviewing (Dr. Pran Saha)	28
New Community Health Worker Training	6
New Director of QA and Evaluation Training	1
New Outreach Coordinator Training	1
Shelter Rights Training (The Legal Aid Society)	12
Care Coordination Training Series (HH@R, CVD Projects)	**105**
Care Coordinator Training Program	44
Essentials of Care Coordination	8
Medical Assistant Refresher Training	46
Nurse Care Management Training	7
Diabetes Project Training	**20**
Health People Peer Leader Training	20
ED Care Triage / Care Transitions Project Training	**81**
Critical Time Intervention Training	22
ED Care Triage and Care Transitions (CMO)	49
ED Care Triage and Care Transitions (CMO) Epic Training	10

Training Programs	Total Trained
PCBH Project Training	**159**
PCBH - Behavioral Activation	6
PCBH - Behavioral Health Collaborative Care for SBHCs	21
PCBH - Depression 101 for Non-Prescribers	2
PCBH - IMPACT School Based Health	49
PCBH - IMPACT Workflow	14
PCBH - Introduction to Collaborative Care	23
PCBH - Motivational Interviewing	11
PCBH - PHQ-9 Training	10
PCBH - Problem Solving Treatment	16
PCBH - SafeTALK	4
PCBH - Treatment to Target	3
Bronx RHIO Training	**34**
Spectrum Training	34
Community Health Literacy	**44**
Community Health Literacy (Seeking & Using Health Insurance)	44
Cultural Competency Training	**78**
Cultural Competency in the Bronx	78
Quality Improvement Training	**52**
Quality Improvement Training	52

Grand Total = 646

PCMH Engagement Progress To Date

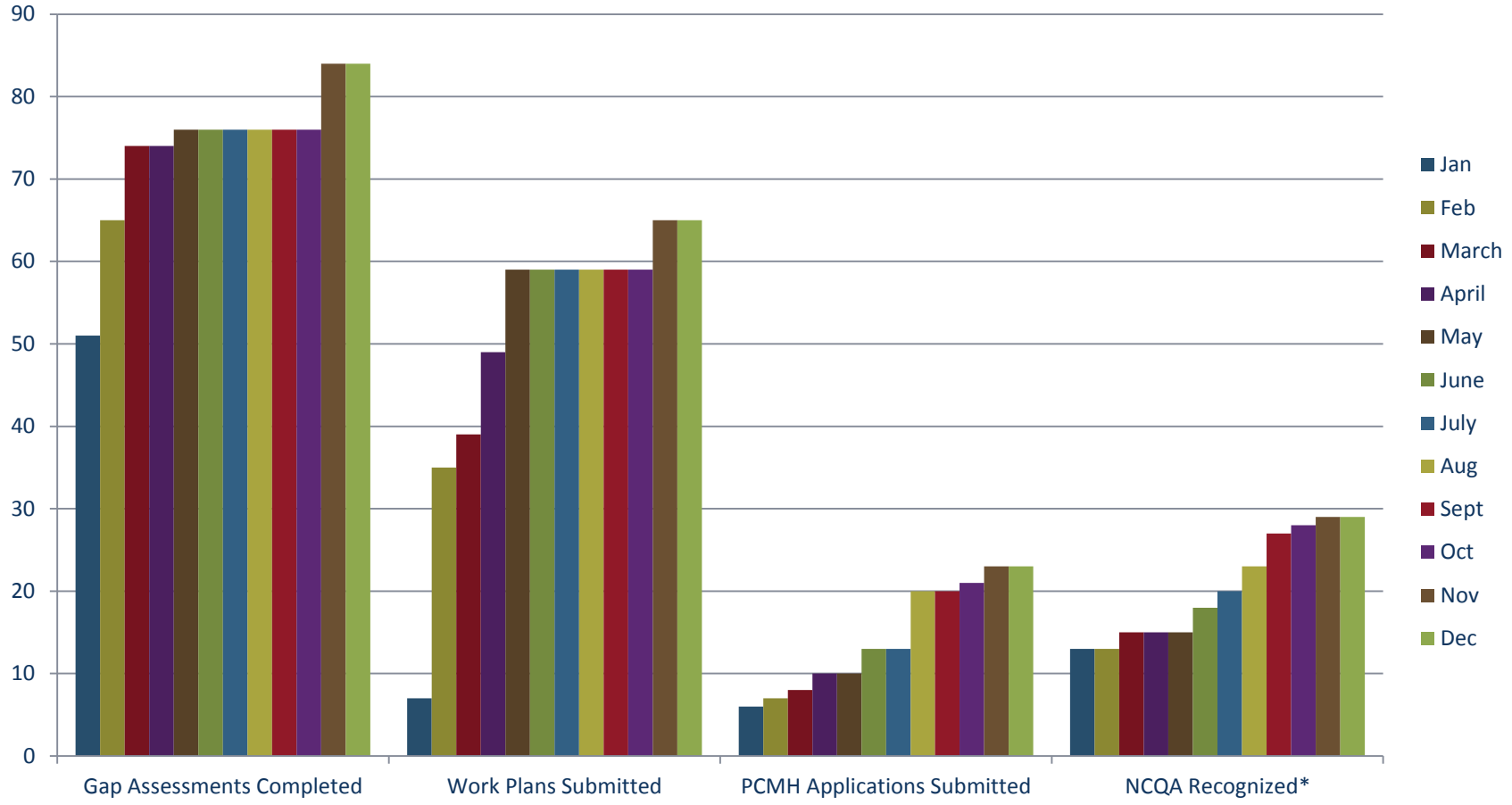
	PCP Count		
	SDOH PCP	Ineligible	PCMH 2014 Lvl 3
Montefiore Medical Center Employed	569	262	264
Montefiore Medical Center Voluntary	234	75	31
Institute for Family Health	88	37	52
SBH Health System	78	34	22
Morris Heights Health Center	50	17	29
Bronx United IPA	42	8	11
Union Community Health Center	39	15	3
Acacia Network	21	12	7
Independent	181	104	39
Grand Total (BPHC - Unduplicated)	1,145	510	406

Total SDOH PCPs in our PPS: 1,145
Total SDOH PCPs targeted for PCMH: 889
We have reached 46% of goal**
As of 01/07/2017

40 School-based health centers might be eligible for PCMH 2017 based on guidance expected in January

**PPSs will have the opportunity to identify and drop up to 10% of their total provider entries so that misclassified or inactive providers can be eliminated by January 15. As a result of the new provider count, BPHC will be able to meet its targeted PCMH goal before the end of 2017.

PCMH Monthly Engagement Progress*



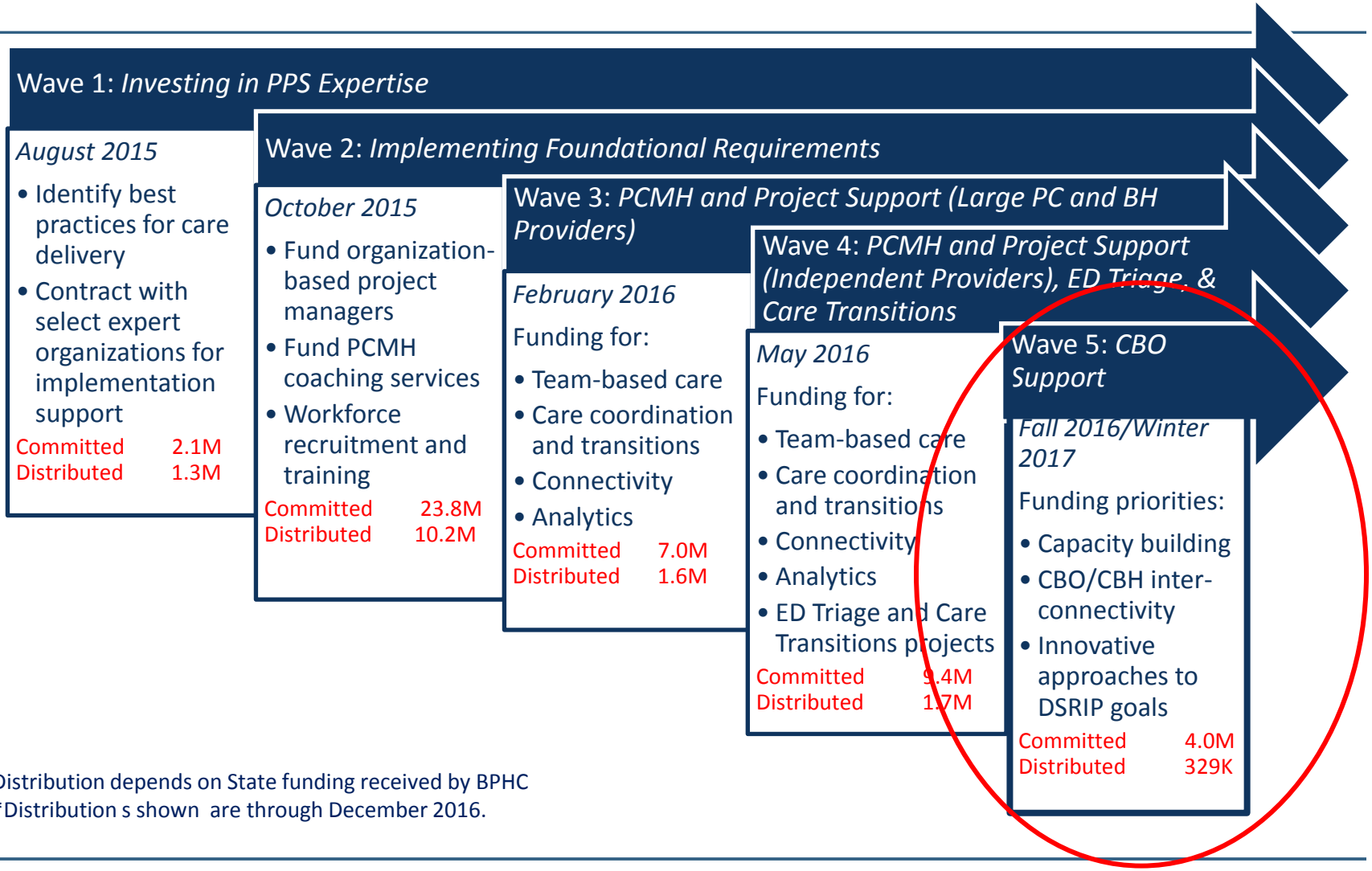
*Includes all recognized practices in BPHC

PCMH 2014 – Level 3 Recognized Practices

- Acacia: Clay Avenue Family Health Center
- Acacia: Park Avenue Family Health Center
- Acacia: Claremont Family Health Center
- BUIPA: Riverdale Family Practice
- BUIPA: Max Francois
- IFH: Walton Family Health Center & Center for Counseling
- IFH: Mt. Hope Family Practice
- IFH: Urban Horizons Family Health Center
- IFH: Stevenson Family Health Center
- Independent: Divino Nino Pediatrics
- Independent: Dr. Muhammad Sanni Adam – University Avenue
- Independent: Dr. Muhammad Sanni Adam – 174th Street
- MHHC: Burnside
- MHHC: St. Ann's
- MHHC: Walton
- Montefiore: Bronx East
- Montefiore: Center for Children's Health and Resiliency
- Montefiore: Co-Op Bartow
- Montefiore: Co-Op Dreiser
- Montefiore: Cross County
- Montefiore: Comprehensive Health Care Center
- Montefiore: Comprehensive Family Care Center
- Montefiore: Family Care Center
- Montefiore: Family Health Center
- Montefiore: Grand Concourse
- Montefiore: Medical Arts Pavilion
- Montefiore: Mount Vernon
- Montefiore: University Avenue Family Practice
- Montefiore: Wakefield Ambulatory Care Center
- Montefiore: West Farms Family Practice
- Montefiore: Williamsbridge Practice
- Montefiore: South Bronx Health Center
- SBH: Ambulatory Care

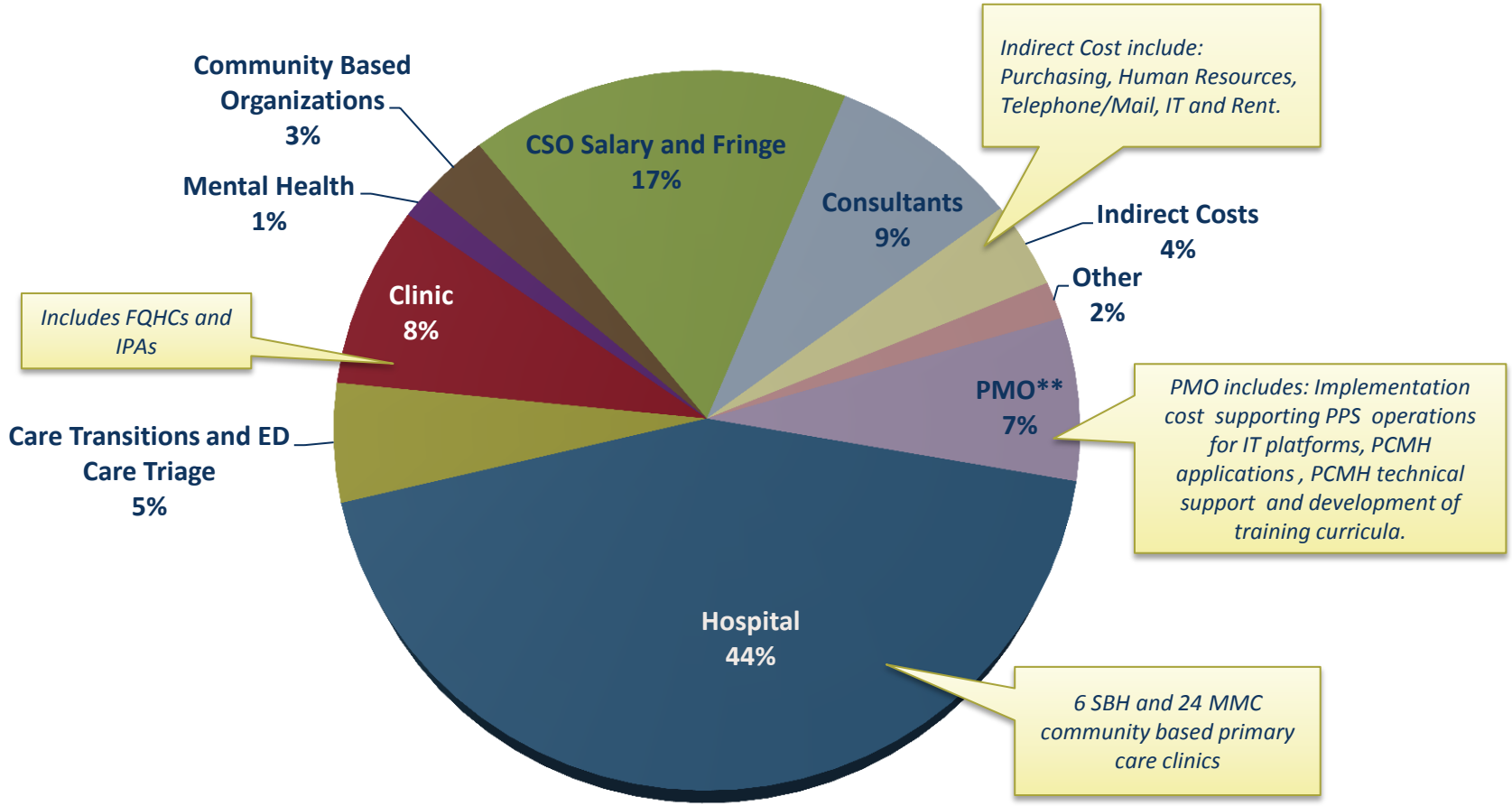
CONTRACTS AND FUNDS FLOW SUMMARY

Funds Flow: Wave 5



*Distribution depends on State funding received by BPHC
**Distribution s shown are through December 2016.

97% of Funding Distributed as of DY2Q1



Contracts with BPHC Member Organizations

Funding Commitments to Members by DSRIP Projects and Programs

Project/Program	# of Members Funded	Total Commitment
Start-Up Funding (Primary Care)	7	$ 13,986,193
Project 3.d.ii Asthma Home-Based Self-Mgmt	1	$ 1,303,916
Project 3.a.i Integrate BHPC	1	$ 543,929
Project 2.b.iii ED Care Triage & Project 2.b.iv Care Transitions	3	$ 3,909,400
Project 3.c.i. Diabetes	1	$ 368,732
Project 4.a.ii MHSA (50 Bronx Public Schools)	1	$ 2,566,956
Community Health Literacy Program	7	$ 1,050,000
Critical Time Intervention Program	4	$ 614,345
Community BH Call-to-Action Initiative*	2	$ 50,000
Patient-Centered Medical Home (PCMH)**	7	$ 3,530,000
DSRIP Project Directors (for 7 largest members)	7	$ 1,150,000
RHIO Services	1	$ 3,100,226
	Grand Total	**$ 32,173,697**

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 contracts are with vendors providing services to selected Members to assist them in achieving PCMH 2014 Level 3 recognition.

VALUE-BASED PAYMENT

Revised PPS VBP Responsibilities

Per new State guidance, PPSs VBP milestones are now focused on "surveying providers, identifying gaps, and implementing initiatives" to address those needs.

Milestone	Activity
Milestone 4	PPSs administer survey to members to identify opportunities to support transition to VBP.
Milestone 5	PPSs submit document to State detailing how VBP adoption will be supported as part of plan for ongoing sustainability.
Milestone 6	PPSs develop annual schedule of partner engagement sessions on VBP for different provider categories.
Milestone 7	Unique milestones based on VBP support implementation plan
Milestone 8	

Source: New York State Department of Health, December 2016

Changes to DSRIP VBP Milestones and Progress Reporting

Revised DSRIP VBP P4R Milestones shift PPS focus to partner engagement and education:

Current		Revised		
Milestone	*Date*	**Milestone**	**Date**	**Reporting Criteria @ Milestone Completion** ***[Developed with Independent Assessor]***
Baseline assessment of revenue linked to VBP	*DY2Q2*	Develop a Value Based Payments Needs Assessment ("VNA")	DY2Q4	Administer VBP activity survey to network
Finalize plan toward 90% VBP network	*TBD*	Develop implementation plan geared towards addressing the needs identified within your VNA.	DY3Q1	Submit VBP support implementation plan
Put Level 1 VBP arrangement in place	*TBD*	Develop partner engagement schedule for partners for VBP education and training	DY3Q1	*Initial Milestone Completion:* Submit VBP education/training schedule *Ongoing Reporting:* Submit documentation to support implementation of scheduled trainings, including training materials and attendance sheets through quarterly reports
50% of care cost level 1 VBPs; 30% cost level 2 VBPs	*TBD*	Unique milestone based upon implementation plan	TBD	TBD – Will be determined by PPS and IA once milestone is defined
90% VBPs in level 2 VBPs or higher	*TBD*	Unique milestone based upon implementation plan	TBD	TBD – Will be determined by PPS and IA once milestone is defined

Source: New York State Department of Health, December 2016

BPHC VBP Planning Objectives and Goals

1

Prepare Bronx Partners for Healthy Communities (BPHC) for early value-based purchasing (VBP) contracts with MCOs

- Document VBP models for Medicaid populations to inform VBP model development
- Analyze VBP Innovator Pilot program and potential impact on VBP planning

2

Define and inform BPHC stakeholders on current structures and capabilities of the Montefiore ACO

- Work to understand the current and future state of the Montefiore ACO
- Provide BPHC partners information about using the Montefiore ACO for Medicaid VBP contracts

3

Help BPHC explore the nature of potential contractual and other relationships with the Montefiore ACO

- Evaluate one or more options for contractual relationships with the Montefiore ACO
- Formulate plan to implement BPHC/Montefiore ACO VBP contracts and business functions

BPHC VBP Planning Efforts: Input from Partners

BPHC leadership and Manatt conducted interviews with BPHC partners to gain an understanding of their experiences and needs related to the transition to VBP:

- Acacia Network
- BronxWorks
- Bronx United IPA
- Essen Medical
- Institute for Family Health
- Montefiore
- The Jewish Board for Family and Children's Services
- Morris Heights Health Center
- Union Community Health Center
- VNSNY

BPHC leadership also consulted with the PPS Executive Committee and Finance and Sustainability Sub-Committee throughout the VBP planning efforts

BPHC and its Partners Face Key VBP Decisions

In developing VBP arrangements with Montefiore, BPHC and its partners will need to decide the following, subject to approval by the BPHC Executive Committee:

1. **What is the ideal MCO contracting structure for VBP implementation?**
2. **Which functions and capabilities will be performed by:**
   - **MCOs that enter into VBP contracts**
   - **Montefiore CMO**
   - **BPHC Central Services Organization (CSO)**
   - **BPHC partners**
3. **How should funds flow under VBP arrangements?**
4. **What is the best governance structure to oversee new arrangements?**

BPHC may want to take on increased responsibilities over time, or may want to develop agreements that leave open the option of taking on increased responsibilities over time.

Contracting Options Under Montefiore and BPHC Consideration

Potential contracting options:

A. **BPHC VBP Participants join existing Montefiore IPA (MIPA) as a BPHC VBP Participant Pod.**

B. **BPHC VBP Participants form a new BPHC VBP Participant IPA. The new IPA contracts with the Montefiore ACO IPA (an IPA to IPA "stacking" structure).**

C. **BPHC VBP Participants form a new BPHC VBP Participant IPA. The new IPA contracts directly with MCOs, separate from Montefiore contracts with those same MCOs. The new IPA contracts with the Montefiore CMO solely for services.**

Note: The selection of a contracting option is separate from selection of VBP risk method(s). Any VBP risk method(s) can fit with whichever contracting option is selected.

Proposed Workplan and Next Steps

December

- BPHC Partner VBP Webinar
- Executive Committee meeting:
  - Debrief from Webinar
  - Discuss contracting options (i.e., pod versus IPA)

January

- Executive Committee meeting:
  - Discuss BPHC VBP Participant participation in Montefiore governance.
- Initiate development of VBP implementation plan

February

- Finalize VBP implementation plan
- Executive Committee meeting:
  - Vote on and confirm VBP implementation plan

Next Steps for VBP Planning:

- ❑ Develop overall approach to contracting options and business functions.
- ❑ Identify broader BPHC VBP working group to lead implementation.
- ❑ Propose implementation steps.
- ❑ Present approach and implementation plan to Executive Committee.

PIVOTING TO PERFORMANCE IMPROVEMENT

BPHC Valuation Components

Funding Category	Net Valuation	Details
Net Project Valuation	$170,067,148*	P4P: 19 measures in DY2/3; 52 in DY4/5.
Equity Infrastructure Program	$105,642,873	Funds for activities vital to DSRIP success, not funded elsewhere.
Equity Performance Program	$70,428,582	7 metrics. Adds $70M for BPHC over 5 yrs. Must hit 10% gap to goal closure.
High Performance Program	$21,219,444	On 11 metrics. Must hit 20% gap to goal closure.
Additional High Performance	$16,913,314	Must hit 10% gap to goal closure on 5/9 metrics.
Total Valuation	**$384,271,362**	

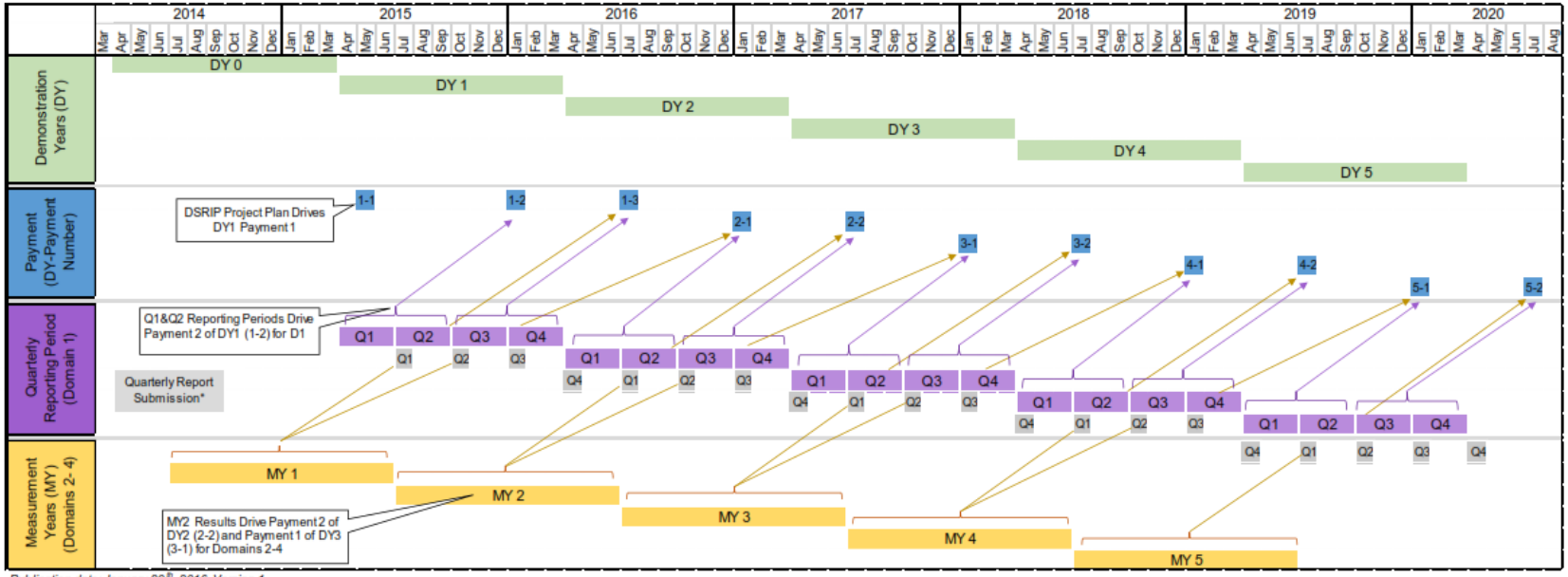
*Approximately $68M based on P4P and Patient Engagement

Payment Categories within NPV

Payment Category	Maximum Value	% of Total
Domain 2 Measures System Transformation	**$54,824,395**	**32%**
Domain 3 Measures Clinical Improvement	**$37,294,919**	**22%**
Organizational Components Governance, Workforce, Cultural Competency, Financial Sustainability	**$33,024,119**	**19%**
Implementation Plans Completed/Approved Summer 2015	**$16,157,743**	**10%**
Domain 4 Measures Population-Wide Health	**$12,400,325**	**7%**
Project Reporting Quarterly Reporting / Budget / Funds Flow	**$8,256,030**	**5%**
Patient Engagement Speed At Least 80% of Target	**$5,616,035**	**3%**
Project Implementation Speed Timely Milestone Completion in DY2, DY3, DY4	**$2,493,582**	**1%**
TOTAL NPV Does not include Safety Net Guarantee, Safety Net Equity Performance, Net High Performance, or Additional High Performance	**$170,067,148**	**100%**

DSRIP Timelines

Relating Demonstration Years, Payments, Quarterly Reporting Periods and Measurement Years



Publication date: January 29th, 2016. Version 1.

* Quarterly reports are generally due on the last day of the month following the close of the quarter

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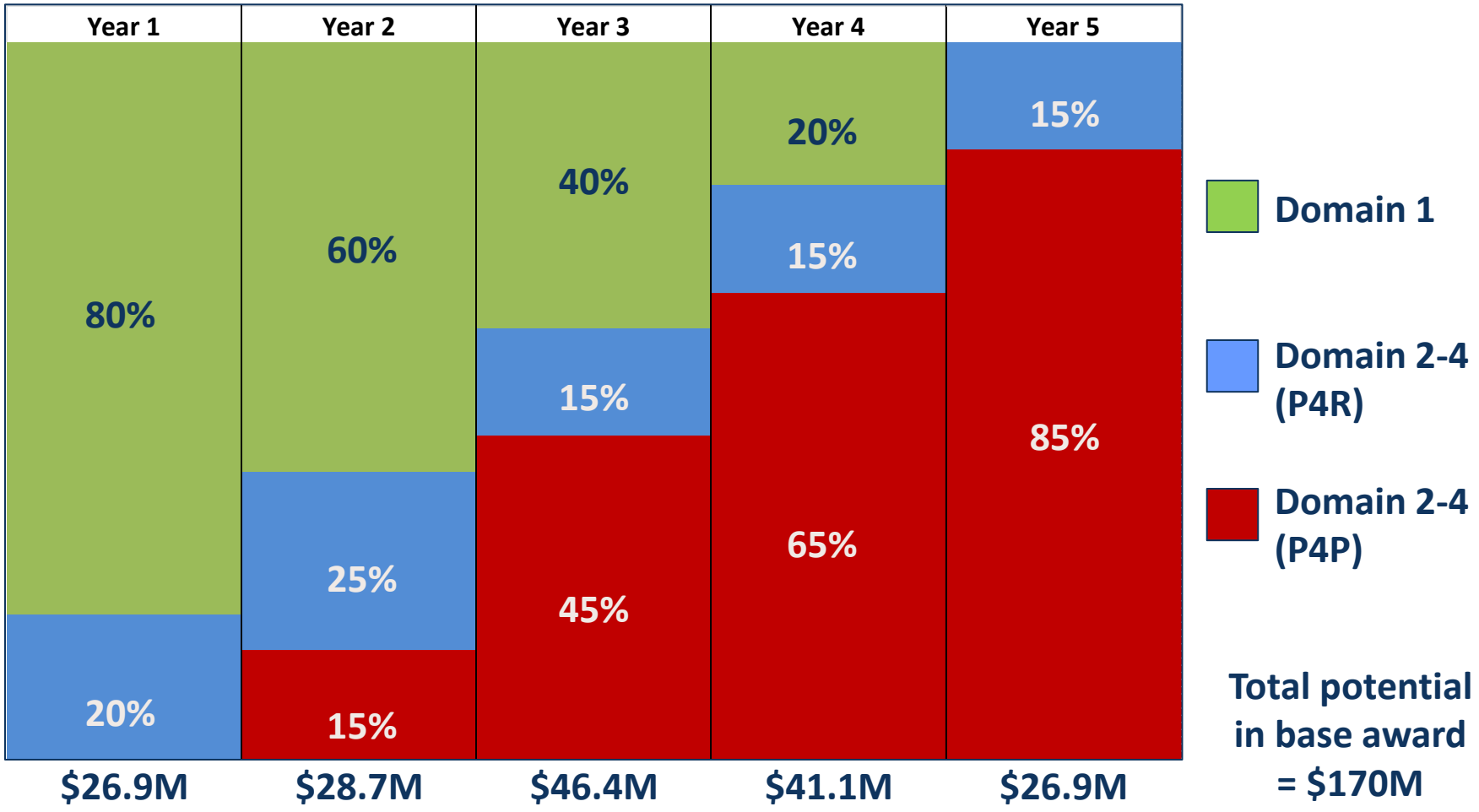
BRONX PARTNERS FOR HEALTHY COMMUNITIES

SBH Health System BRONX

DSRIP Funding Mix Evolution Over Time



* Note: $ amounts not reflective of SDOH changes received 2/9/16

BRONX PARTNERS FOR HEALTHY COMMUNITIES

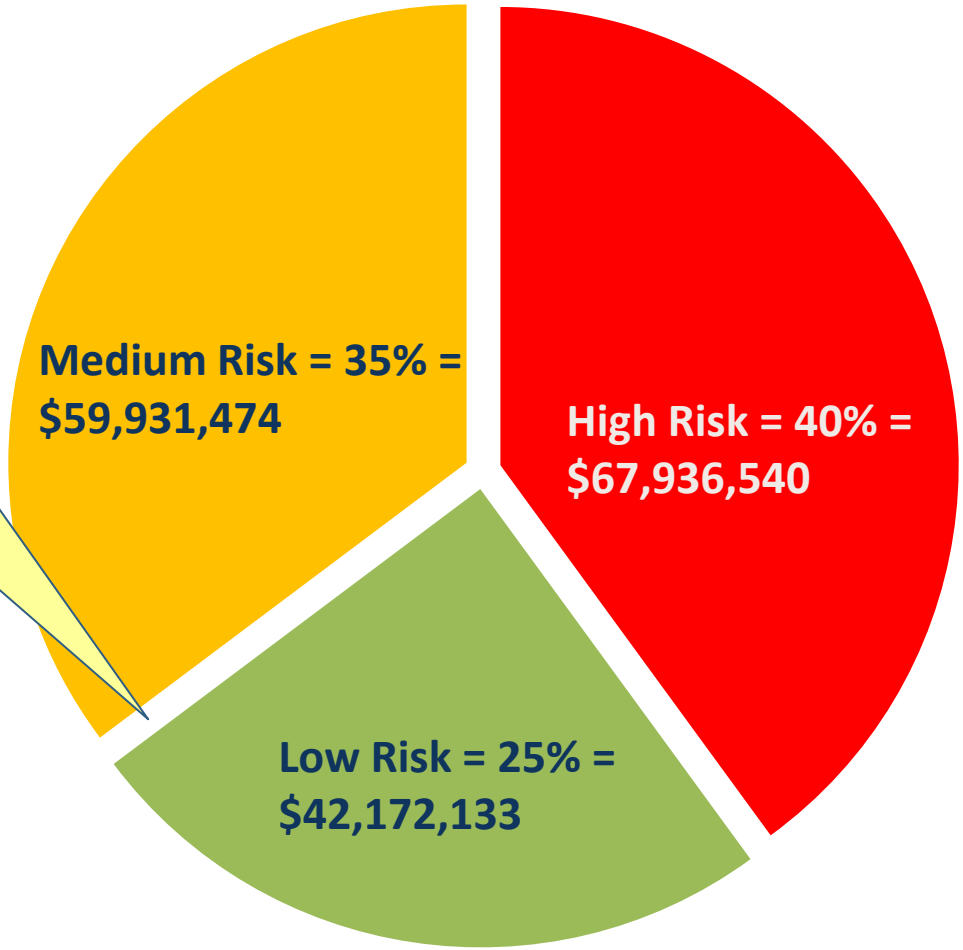
Source: *Attachment I – Program Funding and Mechanics*

****Note****: percentage of total funds based on hitting 100% of all milestones*

SBH Health System BRONX

Risk Level of AV-Related Funding in NPV

SANITY CHECK!
Low and High Risk Funds represent 60% of Net Project Value. If BPHC meets its reporting requirements it will receive $102,103,608



High Risk: Domain 2-4 P4P & Patient Engagement

Med. Risk: Domain 1 Project Reporting

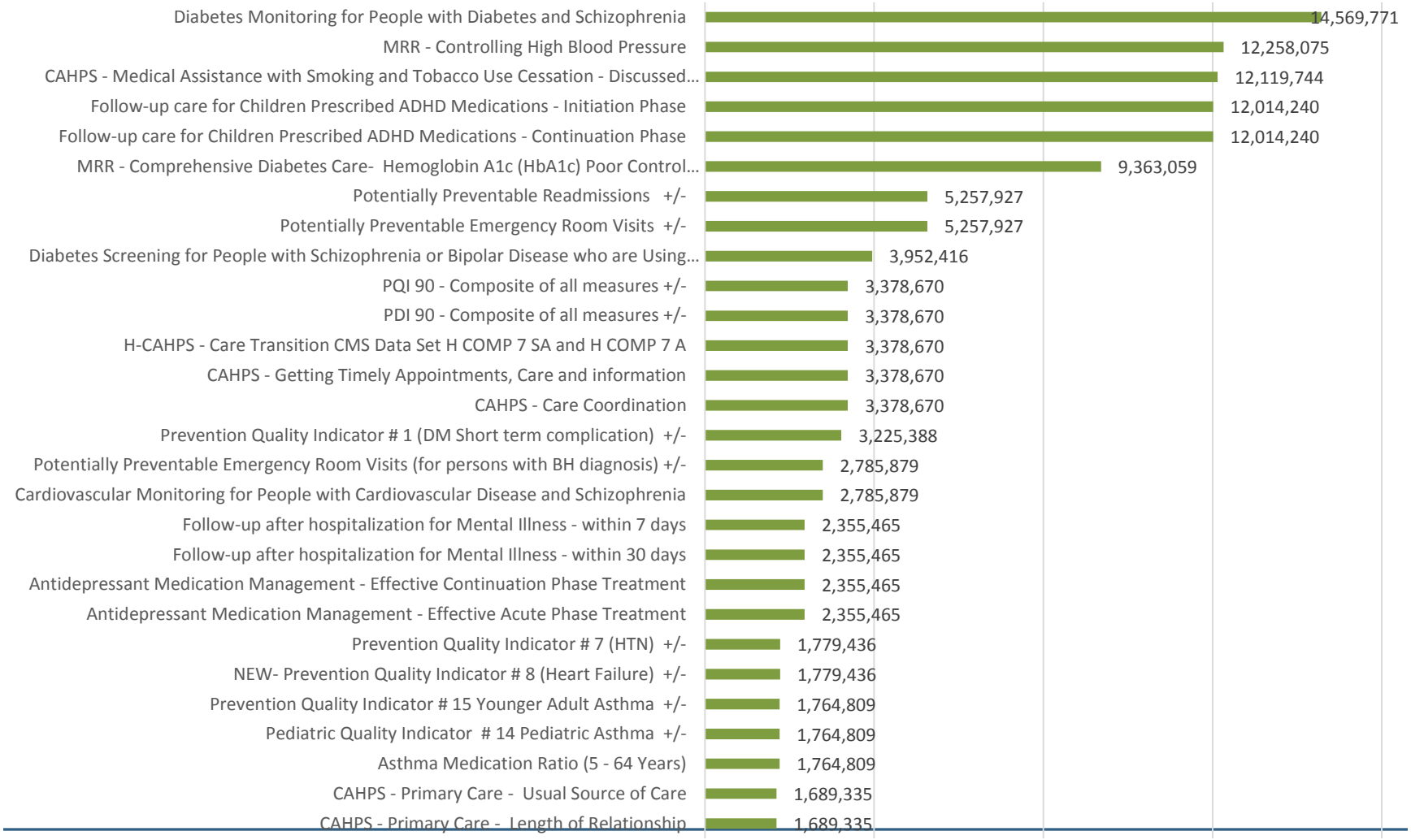
Low Risk: Domain 2-4 P4R (DOH)

Some Performance Measures Are Tied to Additional **Equity Performance** Funding

BPHC NY P4P Metrics with HPF, AHPP, & EPP

0	Project ID	Measure Result Name	Payment : DY 2 3	Payment : DY 4 5	rformance	At Risk Dollars v2016	P4P Pay For Performance	HPF High Performance Fund	AHPP Additional High Performance	EPP Equity Performance Program
19	2.a.i, 2.a.iii, 2.b.iii, 2.b.iv	Potentially Preventable Emergency Room Visits +/-	P4R	P4P	HPF AHPP	5,257,927	✓	✓	✓	
20	2.a.i, 2.a.iii, 2.b.iii, 2.b.iv	Potentially Preventable Readmissions +/-	P4R	P4P	HPF AHPP	5,257,927	✓	✓	✓	
90	3.a.i	Antidepressant Medication Management - Effective Acute Phase Treatment	P4P	P4P	HPF AHPP	2,355,465	✓	✓	✓	
91	3.a.i	Antidepressant Medication Management - Effective Continuation Phase Treatment	P4P	P4P	HPF AHPP	2,355,465	✓	✓	✓	
92	3.a.i	Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	P4P	P4P	HPF AHPP	2,785,879	✓	✓	✓	
93	3.a.i	Diabetes Monitoring for People with Diabetes and Schizophrenia	P4P	P4P	HPF AHPP EPP	14,569,770	✓	✓	✓	✓
94	3.a.i	Diabetes Screening for People with Schizophrenia or Bipolar Disease who are Using Antipsychotic Medication	P4P	P4P	EPP	3,850,028	✓			✓
96	3.a.i	Follow-up after hospitalization for Mental Illness - within 30 days	P4P	P4P	HPF AHPP	2,355,465	✓	✓	✓	
97	3.a.i	Follow-up after hospitalization for Mental Illness - within 7 days	P4P	P4P	HPF AHPP	2,355,465	✓	✓	✓	
98	3.a.i	Follow-up care for Children Prescribed ADHD Medications - Continuation Phase	P4R	P4P	EPP	12,014,240	✓			✓
99	3.a.i	Follow-up care for Children Prescribed ADHD Medications - Initiation Phase	P4R	P4P	EPP	12,014,240	✓			✓
101	3.a.i	Potentially Preventable Emergency Room Visits (for persons with BH diagnosis) +/-	P4P	P4P	HPF AHPP	2,785,879	✓	✓	✓	
106	3.b.i	MRR - Controlling High Blood Pressure	P4R	P4P	HPF EPP	12,258,075	✓	✓		✓
111	3.b.i, 3.c.i	CAHPS - Medical Assistance with Smoking and Tobacco Use Cessation - Discussed Cessation Medication	P4R	P4P	EPP	12,154,463	✓			✓
112	3.b.i, 3.c.i	CAHPS - Medical Assistance with Smoking and Tobacco Use Cessation - Discussed Cessation Strategies	P4R	P4P	HPF	416,366	✓	✓		
115	3.c.i	MRR - Comprehensive Diabetes Care- Hemoglobin A1c (HbA1c) Poor Control (>9.0%) +/-	P4R	P4P	EPP	9,569,606	✓			✓

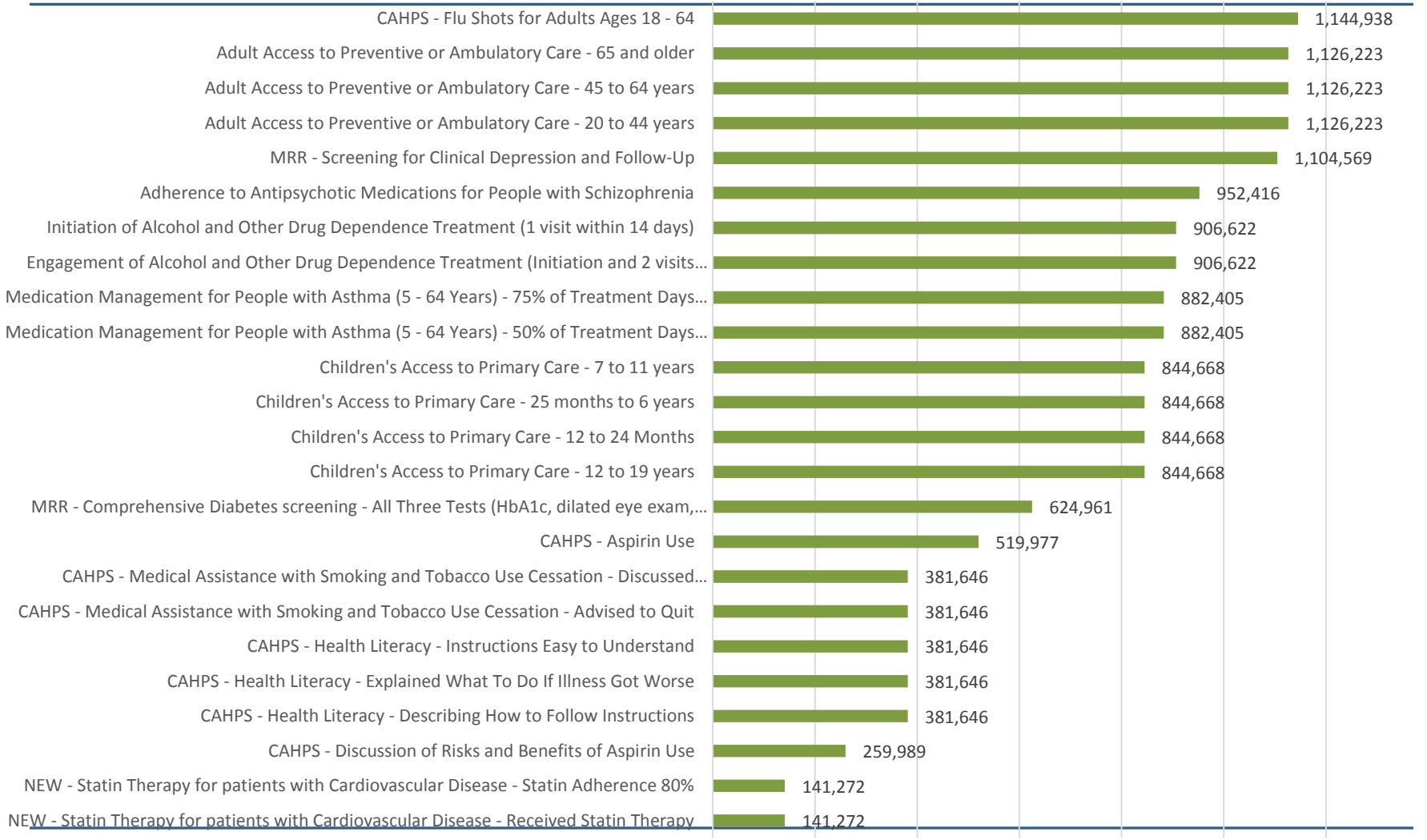
Equity Performance Program Metrics Dollars At-Risk (1)



BRONX PARTNERS FOR HEALTHY COMMUNITIES

SBH Health System BRONX

Equity Performance Program Metrics Dollars At-Risk (2)



CARE COORDINATION MANAGEMENT SYSTEM (CCMS)

CCMS and the Interoperability Strategy

- Leverage existing partner electronic medical record (EMR) systems for clinical documentation
- Utilize the Bronx RHIO for health information exchange, central data management and analytics
- **Provide a CCMS for members to use for care planning, clinical and social service navigation, care transition management, patient assessment, population stratification, and potentially for patient registries and patient engagement**
- Program management services for monitoring and assisting those partners requiring EMRs or EMR upgrades, EHR Meaningful Use attestation, PCMH 2014 recognition and RHIO/HIE adoption and integration

GSI Health is BPHC's Vendor for CCMS

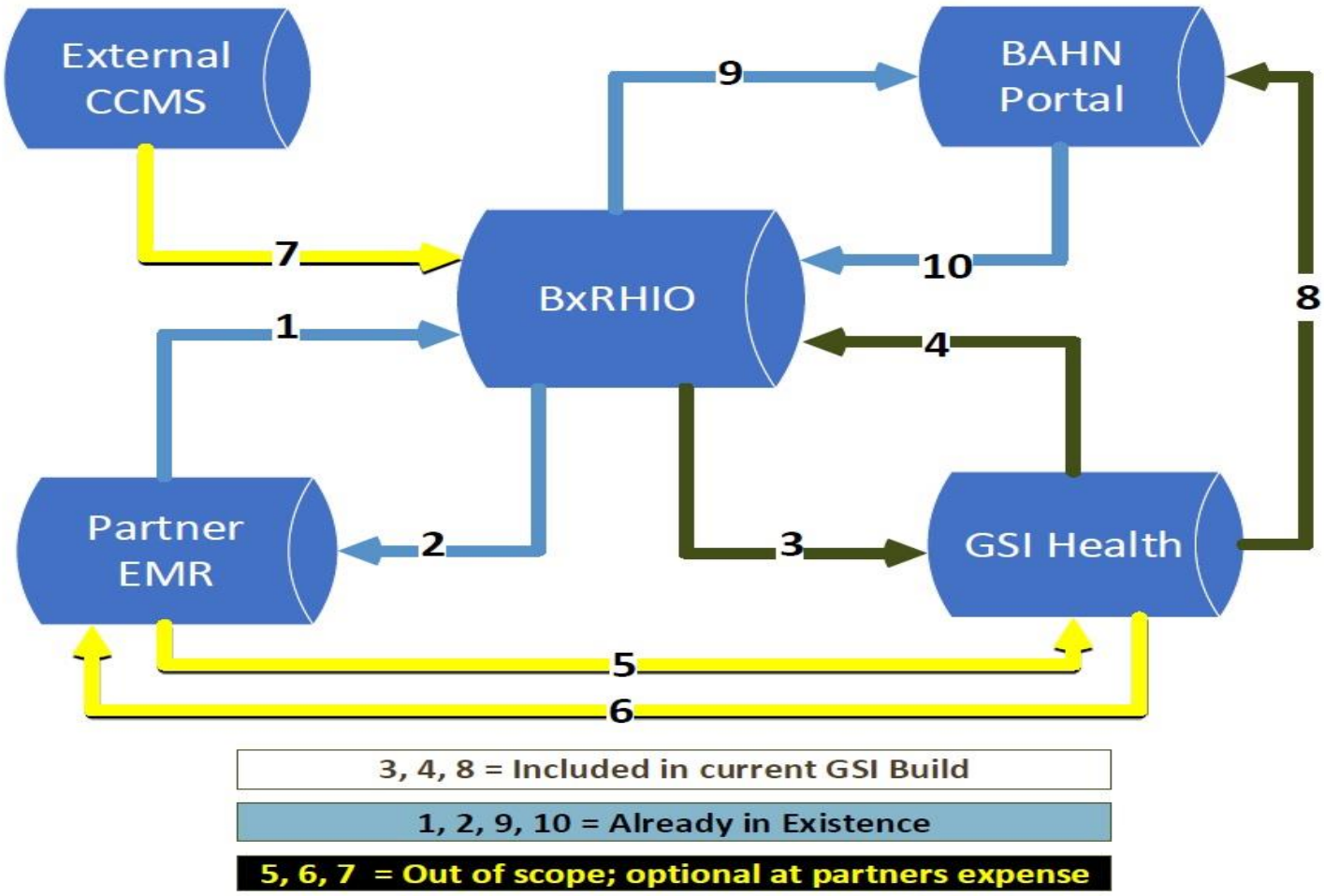
- Key Strengths of the GSI Health Platform:
  - Depth of DSRIP experience
    - Maimonides, HHC, SIPPS, CBC
    - Already built: HH, HH@R, Care Transitions, Asthma
  - Existing use among some BPHC partners
  - Strong customer service and ongoing TA
  - Accelerated speed to implementation
  - Mobile app allows providers to access secure messaging and RHIO alerts.
  - Strong operational analytic capabilities
    - Flag gaps in care and track quality metrics. Partners can run own reports.
    - Custom reports, dashboards.
  - Single sign on built with AllScripts. Experience integrating eCW, NextGen and EPIC.
  - Extensive experience with HIEs, SSO possible from RHIO
  - Dynamic consent capabilities
  - Experience with VBP

BPHC Care Coordination Platform

Assessments, Care Planning, Care Plan Management & Reporting will be available for care coordination in the following areas:

Primary Care-Based	• Health Home At-Risk Care Coordination • Connection to Asthma Home-Based Services
Hospital-Based	• ED Care Triage • 30-Day Care Transitions (CT)
Community-Based	• Critical Time Intervention (part of CT) • Health Home CMAs • Behavioral Health Care Coordination

Clinical and Care Coordination Data Flow



GSI Implementation

GSI Configuration

Work Group meetings are in progress.

- Steering Committee
- BPHC CSO Project Management
  - Timeline
  - Project Plan
- Implementation / Project Team
  - Configuration Decisions
  - Partner Update
- Technical Team
  - Interfaces
- Compliance Team
  - Consents

Project Management Timeline

- GSI currently reviewing and updating Project Planner to include configuration decisions
- Completion of configuration decisions will allow for environment creation
  - Approximately three (3) weeks to build new environment
- Environment availability will dictate timeline
  - User testing
  - Additional configuration requirements
  - User Training
  - Go live(s)
- Expected first go live in February
  - Health Home
  - Health Home @ Risk

Partner Update

Currently Participating	Area of Care Planning
SBH Health System	Primary Care, Hospital and Health Home
Union Community Health Center	Primary Care and Health Home
Bronx United IPA	Primary Care
Acacia Network	Primary Care and Health Home
a.i.r. bronx	Community-Based Care Coordination
Coordinated Behavioral Care / Project Renewal	Community-Based Care Coordination
Riverdale Mental Health Association	Community-Based Care Coordination
VNSNY	Community-Based Care Coordination
SCO Family Services	Community-Based Care Coordination
Bronx RHIO	N/A (IT/HIE Integration)
BAHN	N/A (IT/HH Integration)
Potential Future Participants	**Area of Care Planning**
Morris Heights Health Center -- TBD	Primary Care and Health Home
Montefiore COBRA	Community-Based Care Coordination
Community Behavioral Health Providers TBD	Community-Based Care Coordination
Village Care – TBD	Primary Care

Q&A

Overview and Updates

Visiting Nurse Service of New York

SCO Family Services

CRITICAL TIME INTERVENTION (CTI)

Overview: Critical Time Intervention (CTI)

- Patients with serious mental illness (SMI) are frequently excluded from care transitions programs.
- 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.
  - Effectiveness linked to focus on goal-setting and harm reduction in a time-limited setting.
  - Reach is achieved by utilizing nonclinical coordinators supervised by a licensed professional.

Overview: BPHC's Rationale Behind Selecting CTI

- 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 very available in their community.
  - CTI fills this gap by directly addressing behavioral health needs upon hospital discharge with targeted assistance.
- CTI can affect both DSRIP pay-for-performance (P4P) measures not otherwise addressed in the 2.b.iv Care Transitions project as well as stand to reduce overall Potentially Preventable Visits (PPV) to the ED and Potentially Preventable Readmissions (PPR).

DSRIP P4P Measures CTI Can Impact

Measure Result Name	Payment DY2 - 5	Maximum Dollar Value
Potentially Preventable Visits (PPV) to ED	P4P DY4,5	$5,257,927
Potentially Preventable Readmissions (PPR) to Hospital	P4P DY4,5	$5,257,927
Potentially Preventable Visits to the ED (for patients with a BH diagnosis)	P4P	$2,785,879
F/U visit after hosp. for Mental Illness – 30 days	P4P	$2,355,465
F/U visit after hosp. for Mental Illness - 7 days	P4P	$2,355,465
Initiation of Alcohol and Other Drug Dependence Treatment (1 visit within 14 days)	P4P	$453,311
Engagement of Alcohol and Other Drug Dependence Treatment (Initiation and 2 visits within 44 days)	P4P	$453,311
Total		**$18,919,285**

CTI Needs Assessment and Program Development

- 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.
- BPHC consulted a team of stakeholders including hospital staff, HH leadership, academics and organizations who previously implemented CTI to create a work-plan and define the population to be targeted by CTI.
- BPHC defined a CTI staffing model in collaboration with member organizations including behavioral health providers and HHs.
- Above informed our estimated costs to run an effective CTI program.

Overview: BPHC CTI Program Model

Phase	Fidelity Model	BPHC Program Model
1 (months 1-3)	**Intense "treatment" provide specialized support and implement transition plan** • Makes home visits. • Accompanies clients to community providers	Identical to Fidelity.
2 (months 4-6)	**Facilitate and test client's problem-solving skills** • Observes operation of support network • Helps to modify network as necessary	Identical to Fidelity. In last 6 weeks of this phase, identify Health Home Care Manager (HH CM) for hand-off and ensure that HH CM participates in 1-2 calls for warm hand-off.
3 (months 7-9)	**Complete CTI services with support network safely in place** • Develops and begins to set in motion plan for long-term goals (e.g., employment, education, family reunion, etc.)	Complete hand-off to traditional HH model of care.

CTI RFP and Provider Selection Process

- RFP issued to Articles 31/32 and Health Home CMAs to provide CTI services for BPHC.
  - Incorporated value-based arrangement with downside risk tied to failure to achieve a reduction in inpatient and ED visits.
  - Offered with two options: organizations with an existing CTI program and organizations with no existing CTI program.
  - Organizations were selected using a weighted scoring methodology.
- 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)
- Contracts were executed and funds released in November 2016.
- BPHC will distribute $600,000 to the four CTI providers for their first year of operation.
- CTI program is enrolling patients between January-December 2017.

CSO Activities Undertaken Since Partner Selection

- Hired BPHC- member Center for Urban Community Services (CUCS) to customize and provide training for CTI providers.
- Identified implementation teams for CTI at BPHC hospitals.
- Matched CTI providers with hospitals to ensure equitable distribution of referrals:

Hospital Site (s)	CTI Providers
SBH Health System	VNSNY – primary RMHA – back up
Montefiore Wakefield	Project Renewal (CBC) – primary VNSNY – back up
Montefiore Moses	RMHA – Primary SCO – back up
North Central Bronx, Jacobi and Bronx Lebanon (UBA patients only)	SCO

Referral Relationships Developed

- Social workers at hospitals/HH will identify and refer patients appropriate for intervention.
- CTI partners have met with hospital staff to establish referral process flows.
  - Efforts to connect patients to Health Home prior to discharge
  - CTI partners welcomed into hospital to do in-person visits
- CTI partners have developed marketing materials and are keeping records of patients enrolled in the program to submit to BPHC on a monthly basis.

VNSNY

Visiting Nurse Service of New York

- The **Visiting Nurse Service of New York** (VNSNY) was established in **1893** by Lillian D. Wald, the founder of public health nursing in the United States. VNSNY staff provide and coordinate the care of patients residing throughout New York City and in Westchester, Nassau and Suffolk counties.

- Established in 1986, VNSNY's division of **Community Mental Health Services (CMHS)** was the first of its kind to exist within a home health care agency.

- Today, CMHS administers **23 programs with a staff of 300** and an annual budget of more than $30 million dollars. Our programs **provide care to approximately 12,000 individuals** throughout New York City.

- CMHS delivers care to a spectrum of underserved individuals including those with acute and chronic mental illness, the geriatric population, children with emotional and psychiatric problems, the homeless and individuals with substance use disorders.

VNSNY Health Home Program

A Health Home is:

- a way to coordinate care for Medicaid patients who have complex chronic diseases and mental health disorders

- "…a care management service model whereby all of an individual's caregivers communicate with one another so that all of a patient's needs are addressed in a comprehensive manner."

- Our Health Home provider network is comprised of over 250 organizations including hospitals, primary and specialty medical care providers, outpatient psychiatric providers, substance abuse treatment programs, housing providers, and various community based social service networks.

- VNSNY serves the most vulnerable New Yorkers with severe behavioral health needs. Since its inception in January 2012, the HH has provided care coordination services to >**2,500 members.**

- VNSNY is a network partner/Care Management Agency (CMA) in 2 (soon to be 3) key NYC Health Homes:
  - Community Care Management Partners, which serves Manhattan and the Bronx
  - Brooklyn/Maimonides Health Home, which serves Brooklyn
  - Mount Sinai Health Home, which serves Manhattan, Brooklyn, the Bronx, and Queens

VNSNY Experience

- Our current **Health Home Care Coordination program** represents staff from two 'legacy' programs:
  - Intensive Case Management (**ICM**) which assisted the severe and mentally ill population, started in 1989 and reduced costly inpatient and emergency room utilization
  - Managed Addiction Treatment Services (**MATS**) which assisted the substance use population, started 2007 and reduced Medicaid expenditures on substance use treatment, by over 55% annually.

- **Mobile Crisis and Parachute Programs**
  - Mobile Crisis services provides in-home mental health assessment, crisis intervention and linkage services for adults in psychiatric crisis
  - Parachute is an innovative, recovery-based service for people to turn to in an emotional crisis rather than a hospital emergency room.

- **The Behavioral Health Community Transitions (BHCT) Program**, assists in the transition from inpatient psychiatric hospitalization to the community by providing in-home psychotherapy for patients who are unable or unwilling to go to psychiatric outpatient treatment within seven to 30 days of hospital discharge

- **Assertive Community Treatment (ACT)** is a comprehensive, community support and treatment program responsible for total outpatient psychiatric care and integration with medical care.

Vision of the VNSNY CTI Program

- CTI a well-researched; cost effective; evidence based model of care proven to assist with critical member transitions:
  - Recommends specialized interventions provided at a "critical time" and connects people with formal and informal community supports

- Given our tremendous expertise serving the mental health and homeless population by providing thoughtful community based services, we think this is a great opportunity to integrate all these services to provide meaningful care interventions to an underserved population.

- Allows our Care Coordination program to offer an intensive model of care in addition to Health Home services

VNSNY CTI Project Implementation

- Hired 2 dedicated CTI Care Managers; supervised by an LCSW Supervisor
- Attended the 2 day -CTI training offered by CUCS/ SBH

- Developed the referral process flow with primary Hospital site (SBH Health System)
  - Received our first 3 referrals on Tuesday Jan 10,2016
- Developing our work plan and our ideas of Pre-CTI workflows
  - The role of the Health Home/Care Coordinators (if the patient already has a Care Coordinator) and the continued collaboration up to complete handoff

- Participating in BPHC CTI learning collaborative with all 4 agencies to develop best practices for this program model.
- Developing our community resources and our program brochure

SCO FAMILY SERVICES

Who are we?

- We are part of SCO Family of Services which primarily specializes in services for children and vulnerable adults
- The mission of SCO Family of Services is “to get young children off to a good start, launch youth into adulthood, stabilize and strengthen families and unlock for potential for children and adults with special needs.”
- Our specific program, the Courtlandt Avenue Clinic specializes in mental health therapy and children’s case management.

SCO Family of Services

Extraordinary reach.
Unconditional care.
Life-changing results.

Why CTI?

- As community mental health providers we tend to be on the front line of what our clients need and witness to the struggles that they have.
- We often meet clients that come in express their frustrations with how ineffective they feel like their services are.
- We also see clients with the potential to be more independent than they are, struggling to utilize the services that they have.
- We often find ourselves as therapists, making phone calls and attempting to coordinate services in order to decrease the distress of our clients.
- This takes away from time that could be spent working on the client's therapeutic needs.
- CTI is a way for us to make the services that our client already have more effective and improve their overall ability to accomplish their goals.

First Steps

Our early process was as follows:

1. Motivational Interviewing training
2. Housing Application training
3. Visiting transitional housing programs
4. Community Walks
5. Coordinating with referral sources
6. Connecting with potential health homes for the handoff
7. Build a resource bank
8. Create a documentation schedule
9. Create a mock chart
10. Practice Cases

Our First Referral

Client is a 21 year African American male with learning difficulties, ADHD and Bi-Polar disorder. Client also struggles with obesity. Due to his learning difficulties and level of symptoms, his mother managed all of his care; even after he turned 18. The client and his mother have a highly conflicted relationship. As the client gained more control over his symptoms, the conflict increased. The client recently removed permission for his mother to participate in his health care which resulted in her refusing to give him his insurance cards and the funds from his recent SSI check. The client moved out and was sleeping on his grandmother's couch. On 12/30 he went to his mother's home demanding his documents and engaged in an altercation that resulted in her calling the police. Client was admitted to North Central on 12/30 and his mother agreed to sign his SSI back over to him. Client will need housing and services when he is released from in-patient.

Areas of focus for phase one:

1. ***Housing***
2. ***Medical***
3. ***Financial***

Q&A

Thank You!

BRONX PARTNERS FOR
HEALTHY COMMUNITIES

SBH
Health System
BRONX

Please visit our website: **www.bronxphc.org**
Contact **info@bronxphc.org** with DSRIP related questions.