Creating and Managing a New Coalition Across the Health Care Continuum

New York State Public Health Association Annual Meeting
April 27, 2017

BRONX PARTNERS FOR HEALTHY COMMUNITIES

Today’s Objectives

1. How to identify and generate buy-in from disparate partners
2. How to create and sustain communities of practice
3. How to create and sustain structures to support program implementation across a large system
Topics Covered

1. What is DSRIP?
2. BPHC and its Governance Framework
3. Building the Clinical Network
4. Community Engagement Strategies
5. Lessons Learned
## Delivery System Reform Incentive Payment

- **DSRIP** is a major collective effort to transform New York State’s Medicaid Healthcare Delivery System from a fragmented system, overly focused on inpatient care, to an integrated and community-based system focused on providing care in or close to the home.
- NYS ranked 50\textsuperscript{th} for potentially avoidable hospital use and cost of care
- 25 **Performing Provider Systems** (PPSs) were established in NYS to conduct this transformation
- Up to $6.42 billion allocated to this program with payouts to the PPS based upon achieving predefined results in *system transformation, clinical management* and *population-based health*

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<thead>
<tr>
<th>FROM</th>
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<tr>
<td>• Volume-based</td>
<td>• Value-based</td>
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<td>• Patient-based</td>
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<td>• Episodic</td>
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<td>• Acute Care</td>
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<td>• Sickness Care</td>
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DSRIP Goals

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

![Diagram showing balance between Projects and Outcomes](attachment:image.png)
Key Program Components

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

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

**Key Takeaways:**

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

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* PQI: Preventive Quality Indicator, to identify quality of ambulatory care, such as preventable hospitalization.
Bronx Health Disparities Snapshot: Social Determinants of Health

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

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

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

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

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

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

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

**Healthcare Access:** 2,080 Bronx residents per primary care doctor, 2xthe state average. ~16% of Bronx residents are uninsured.
Preventable Illness in the Bronx

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

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

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

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

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

**HIV/AIDS:** Four neighborhoods in the Bronx have higher HIV/AIDS prevalence rates than the city as a whole: High Bridge/ Morristania, Crotona/ Tremont, Fordham/ Bronx Park, and Hunts Point/ Mott Haven.
ESTABLISHING THE BPHC PERFORMING PROVIDER SYSTEM
## BPHC Profile

### Bronx Partners for Healthy Communities PPS

<table>
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<th>SBH Health System (lead)</th>
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<tr>
<td>• 150 years of serving the Bronx</td>
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<td>• Over 70% Medicaid patients</td>
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<th>Member organizations</th>
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<td>240 organizations, 1,000+ sites</td>
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<td>~70,000 employees</td>
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<td>• Hospitals</td>
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<td>• TCs</td>
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<td>• IPAs</td>
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<td>• CBOs</td>
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<td>• Hospices</td>
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<th>Patient Population</th>
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<td>• 170K attributed for valuation</td>
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<td>• 370K attributed for performance*</td>
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* As of July 2016

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The Bronx is ready for DSRIP:
- Least healthy county in NYS
- Poorest urban county in the US
- <70% adults have attained a high school diploma or equivalent
- Over half of residents speak a language other than English at home
BPHC’s Charge

Transform 240 siloed provider and community based behavioral health and social service organizations into one Integrated Delivery System
## BPHC Engagement & Funds Flow Strategy

### Wave 1: Investing in PPS Expertise

**August 2015**
- Contracts with select orgs with expertise identifying best practices to support DSRIP project implementation

### Wave 2: Implementing Foundational Requirements

**October 2015**
- Funding to large PC and BH Providers for:
  - DSRIP Project Managers for BPHC partner organizations.
  - PCMH technical support and coaching services
  - Workforce recruitment and training programs.

### Wave 3: PCMH and Project Support

**February 2016**
- Funding to independent providers for:
  - Team-based care
  - Care coordination
  - Inter-connectivity
  - Population health

### Wave 4: PCMH and Project Support

**May 2016**
- Funding to hospitals for:
  - ED Triage and Care Transitions

### Wave 5: CBO/ CBH Support

**Fall 2016/Winter 2017**
- CBO/CBH capacity building
- Inter-connectivity via RHIO & CCMS
- Health Literacy and community engagement
- Innovative approaches to advance DSRIP goals
- Depression/substance abuse screening, PC connection

### Wave 6: Post-acute and Housing Support

**Summer/Fall 2017**
- Funding to post-acute care services and supportive housing providers for:
  - Inter-connectivity and information exchange via RHIO
  - Innovative approaches for advancing DSRIP goals
Executive Committee
- Oversight of overall DSRIP Program implementation
- Satisfaction of key metrics to realize incentives payments
- Development of Program vision and implementation of “rules of the road”
- Representative of the PPS (though some partners may not have a direct representative)
- Involvement of executives with ability to commit their organizations to decisions and provide leadership
- Oversight of PPS financial management

Subcommittees

Finance & Sustainability
Make recommendations on distribution of Project Partner Implementation Funds and Community Good Pool (approved by Exec Committee and SBH)

Quality & Care Innovation
Create and update clinical processes and protocols applicable to all Partners

Information Technology
Create and update IT processes and protocols applicable to all Partners

Workforce
Develop and implement a comprehensive workforce development strategy

BPHC Central Services Organization
BPHC Governance Structure (Cont’d)

**Executive Committee**

- **Finance & Sustainability**
  - 7 Clinical Workgroups
  - 3 Workforce Workgroups
  - Health Home Workgroup

- **Quality & Care Innovations**
  - Cultural Responsiveness Workgroup
  - Pharmacy Workgroup
  - Behavioral Health Steering Committee

- **Information Technology**
  - Collaborative with 14 BH Agencies

- **Workforce**
  - 3 Workforce Workgroups

**Subcommittees**

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

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

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

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

Makeup of Governance Committees*

Participating Disciplines

n=72**

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

Participating Organizations

n=72**

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

Other: RN, Pharmacist, Care Management/Managed Care

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’s Central Services Organization (CSO)

Operational Functionalities

**Patient & Provider Engagement**
- Care management support
- Patient registries support
- Provider engagement

**Clinical Support**
- Clinical operation plans
- Target population identification
- Protocol compliance
- Performance monitoring

**Workforce, Staffing & Training**
- Workforce development
- Recruiting / deployment
- Training

**Data & Analytics**
- Population health management
- Data / trend reporting
- Partner performance feedback

**Information Technology**
- IT infrastructure strategy
- HIT, HIE, and telehealth
- Central data management

**Financial / Program Management**
- Fiscal agent / funds distribution
- Contracting
- Compliance
- Sustainability and VBP planning
Establishing a Primary Care Network
Creating a Community Practice
Unifying Program Implementation Across BPHC
Embedding Local Resources of Accountability

BUILDING THE CLINICAL NETWORK
Establishing a Unified Primary Care Network

**One Standard of Care**

- Engage all PCPs in PCMH Recognition Program
- Support PCP engagement with consultant to provide technical assistance with application and transformation processes
- Establish standardized tools for measuring baseline, operational gaps and project planning
- Quarterly meetings with practice leadership regarding hurdles and achievements toward PCMH journey

**Challenges**

- Achieve PCMH 2014 Level 3 by March 2018
- Varied settings, preparation & experience
- Commitment to 889 practice sites
- PCMH PCPs recognized by NCQA: 503

**Best Practices**

**Funding for PCMH Coaches**

- CSO recruited pool of coaches
- Practices selected coaches from the pool

**Funding Startup for PCMH Infrastructure**

- Care Team and Care Coordination
- Regular meetings to exchange learnings and best practices
Unifying Program Implementation Across BPHC

Quality & Care Innovation Subcommittee (QCIS)

Improvement* Work Groups

CSO Clinical / Ops Team

DSRIP Program Directors (DPDs)

Site-specific Implementation Teams (SSITs)

Larger Organizations

* IWG evolved from Planning Work Groups to Transitional Work Groups, Implementation Work Groups, and eventually into Improvement Work Groups.
DSRIP Program Directors (DPDs)

- Embedded liaisons and implementation facilitators at the seven largest primary care organization partners.
- Play the management, coordination and liaison role between the Site-Specific Implementation Teams (SSIT) and the CSO.
- Support and advocate for the partner organizations in every possible way to enable them to accomplish their DSRIP goals and objectives.
- Serve as the voice back at their organizations and help accomplish BPHC’s DSRIP requirements:
  - Coordinate and monitor the progress of the clinical projects.
  - Ensure the success of project implementation, monitoring, reporting, communication and coordination.
- Responsible for submitting a wide range of reports representing the implementation and performance progress on behalf of the partner organizations they represent.
Quality & Care Innovation Sub-Committee

- Comprised of members from hospitals, FQHCs, IPAs, CBOs and Pharmacies.
- Charged with establishing evidence-based practice and quality standards, and measurements, overseeing clinical care management processes, and, together with the Executive Committee, holding providers and the PPS accountable for achieving targeted metrics and clinical outcomes.
- QCIS reports to the Executive Committee.

Practitioner Communication and Education
Advise BPHC's Implementation Work Groups (IWGs)
Evidence-Based Practice Guidelines/Clinical Processes & Protocols.
Monitor Performance
Oversee Clinical Project Implementation.
Collaborate with Other Sub-Committees.
Support Development of Cultural Competency and Health Literacy Strategy
Regional Information System
Care Coordination and Management System
Referral Management Systems

SYSTEMS SUPPORTING NETWORK COMMUNICATION AND INFORMATION SHARING
BPHC Interoperability Framework

- **Data**
- **HIE / VHR**
- **Data Storage**
- **Analytics**
- **CCMS**
- **RMS**

**VHR**: Virtual health record  
**HIE**: Health Information Exchange  
**CCMS**: Care Coordination Management System  
**RMS**: Referral Management System
Care Coordination Management System

A key element in BPHC’s interoperability and population health management (PHM) strategies.

- Supports self-management for higher-risk patients
- Tracks assessments and care planning, mainly for social determinants of health
- Identifies social service needs
- Enhances communication and collaboration between providers
- Reduces duplication
- Provides greater insight into the needs of patients as they navigate through the care delivery system
Population health management
Goal: reduce costs by preventing illness, improving quality of life and enhancing health outcomes for those suffering from chronic conditions.

Integrated referral management
Goal: optimize referral processes, drive accountability and minimize disruptions.

Referral management system would complete the missing link in the framework for managing patient’s medical and social needs across the IDS

EXPANDING PARTICIPATION THROUGH COMMUNITY ENGAGEMENT STRATEGIES

Establishing Designated Resources
Representation
Engagement Strategy and Plan
Reinforcing a Central Role for BPHC CBOs

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

- Convened over 40 CBOs to identify common pain points and wish lists for improving care delivery across PPS organizations:
  - Meaningful Involvement in Planning and Implementation Activities
  - Improve Communication between Member Organizations
  - Improve interconnectivity and Access to IT Support
  - Improve Access to Training to CBO Frontline
  - Recognize and Build on CBO Competencies
  - Enhance Understanding of Array of Available Services
  - Offer Networking Opportunities
  - Advance BH and CBO services
Community Engagement Plan

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

- Established a **Community Engagement Work Group**
- Community Engagement Group is linked to the Governance
  - Represented on the Workforce Health Literacy Work Group
  - Workforce Sub-Committee Co-Chair sits on the Community Engagement Work Group
- Community Engagement Work Group developed a **Strategy and Work Plan** recommending four targeted programs:
  1. Create **directory of service resources** to improve coordination between BPHC healthcare providers and CBOs
  2. Provide **access to key training programs** for CBO frontline staff
  3. Build on CBO outreach and **cultural competencies**
  4. Facilitate **collaboration between community providers**
TRANSLATING PLANS INTO ACTION

Community Resource Directory
Community Engagement Programs
Community Health Literacy Program
Training Programs
Community Behavioral Health Initiative
BPHC Resource Directory

- Identify the vast array of programs and services provided through our PPS membership
- Develop information and tools to better navigate community resources

110 Member Organizations already represented in the Directory
Boosting Health Literacy in the Community

- Focuses on underserved individuals not well engaged in primary care and supportive Health Home Services.
- 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:
  - *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*
Training & Developing the Community Workforce

- BPHC has developed 29 courses delivered to more than 1000 trainees
- 27 CBOs have registered staff to participate in these courses

Training Programs in Cultural Responsiveness: DY2Q4 – DY3

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

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

Raising cultural competency for the frontline:
6. Knowledge & skills for recovery-oriented care for people with behavioral health conditions
7. Understanding cultural values for home health workers
8. Poverty simulation to experience how living in poverty 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
Engaging Community Behavioral Health Providers

- BPHC has 60+ community-based Behavioral Health member organizations with ~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
- 14 CBH agencies invited through an RFP to lead and participate in planning the “Call to Action” initiative in 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.
WHAT WE’VE LEARNED
Engage Stakeholders

- Include stakeholders in the Governance structure and decision making
- Work within a framework to achieve specific goals
- Clear, timely, frequent, and transparent communication
- Incorporate Collaborative Design principles
- Maintain flexibility to change course when needed
- Provide timely and relevant Technical Assistance and support
- Use data to drive engagement
- Focus on developing infrastructure for sustainability
  - Population Health Management
  - Train the Trainer
  - Develop downstream P4P strategies
## Build Legitimacy and Trust

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<tr>
<th>Transparency &amp; Empowerment</th>
<th>Sustaining the Coalition</th>
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<tr>
<td>▪ Create a clear, collaborative structure</td>
<td>▪ Distinguish between participation and leading</td>
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<tr>
<td>▪ Identify &amp; foster community leadership</td>
<td>▪ Put your dollars where your intent is (thoughtful and equitable distribution)</td>
</tr>
<tr>
<td>▪ Create opportunity for community leadership to actively participate</td>
<td>▪ Go beyond buy-in and create ownership</td>
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<td>▪ Create opportunity for community to lead</td>
<td>▪ Build a community of practice</td>
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<td>▪ Require accountability for output, work products and performance outcomes</td>
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Create a Community of Practice

- Adhere to a shared vision and common goals
- Adopt selected best practices, and Clinical Operations Plans
- Implement standardized performance monitoring and reporting strategies
- Establish a shared performance improvement methodology
- Issue continuous communications to keep participants informed and in the loop
- Hold social events and invite members to celebrate milestones
- Face time!
The Challenges

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<tr>
<th>Anticipated</th>
<th>Challenges Unforeseen</th>
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<td>▪ Aligning hospitals, community-based FQHC and independent practice providers</td>
<td>▪ Continuously changing role of the CSO</td>
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<td>▪ Integrating physical and behavioral health services</td>
<td>▪ Limited access to current data and analytics</td>
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<td>▪ Creating a common ground for (competitive) vendors</td>
<td>▪ Bridging the gap between institutional and community-based organizations</td>
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<td>▪ Getting the buy-in for network-wide system integration</td>
<td>▪ Thinking about future VBP with partners who are still building trust in a world that’s still fee for service</td>
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<td>▪ Aligning clinical and non-clinical agendas</td>
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THANK YOU!

- Irene Kaufmann, ikaufmann@sbhny.org
- J. Robin Moon, jrmoon@sbhny.org
- Amanda Ascher, aascher@sbhny.org