Collaboration
Transformation
Outcomes

BRONX PARTNERS FOR
HEALTHY COMMUNITIES

NEWSLETTER

Winter 2016

BPHC in Numbers

Over 150,000
Bronx hospitalizations are potentially avoidable

That's more than
50% of all
hospital admissions.

BPHC is working to reduce avoidable hospital use
by 25% over 5 years.

A Letter from the Executive Director

Dear BPHC Community,

After months of planning and preparation, BPHC has launched seven of our ten DSRIP projects. Right now, nearly 230 Bronx-based providers are adopting new practices and protocols to address the most prevalent health issues in the Bronx.

Being a member of the BPHC Performing Provider System (PPS) is about more than practices, protocols, and projects, however. It is about being part of an Integrated Delivery System - a network of healthcare and social service providers, working seamlessly together to support Bronx residents across the continuum of care.

This Integrated Delivery System will be necessary for successful projects, for effective patient care, and for a healthy community. It is a fundamental part of what BPHC is trying to accomplish in the Bronx, and our work towards building it has already begun.

We are identifying technological innovations which make it easier to share information and coordinate care within teams and across providers. A diverse group of community-based organizations is helping us to identify gaps in care and learn how to improve care coordination and cultural competency.

In this Newsletter you will learn about BPHC's approach to our projects and to reaching the urgent goal of integrating our healthcare delivery system.

Sincerely,
Irene Kaufmann
Executive Director, Bronx Partners for Healthy Communities

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The BIG Picture

Care Coordination: the Backbone of the Integrated Delivery System

There are thousands of healthcare and social service providers in the Bronx, and each one is committed to giving Bronx residents the best care possible. Yet no person or organization alone can satisfy every need of every patient. Whether it is accessing the results of a diabetic patient's most recent A1C test, connecting a woman suffering from severe depression to a psychiatrist, or stabilizing housing for an elderly man with heart disease, providers must work together constantly to coordinate care.

Getting coordinated care right means learning what each patient needs to be healthy, connecting them to the right services, and making sure they are following through with their treatment. It means helping providers reach the patients who need them most.

However, coordinating care is not always easy; it takes time to manage a patient's many needs, and may require new IT infrastructure to share information more efficiently. Not every provider can overcome these hurdles, and when there is a hole in the care coordination process – when any one provider is excluded from this system - every provider and every patient suffers. BPHC's strategy for healthcare reform involves standardizing systems of care coordination across our PPS and across the Bronx.

Our providers will gain access to care coordination staff, some of whom will support the highest risk populations, for whom care coordination is not a matter of convenience but of necessity. Care coordination staff will utilize new technologies to share information about their patients. Community-based organizations (CBOs), which play an indispensable role in addressing the social determinants of health, will be included in this care coordination process and in the broader Integrated Delivery System.

Building the Bridge Between Projects

A year from now, a man will visit the emergency room because he is having an asthma attack. He will speak with a patient navigator in the ED, who will reach out to an a.i.r. bronx community health worker, who will meet him at home to help him manage his asthma symptoms, medication, and triggers, and even hire an exterminator because roaches at home make his asthma worse. A care coordinator, embedded within the man's primary care team, will guide him to the healthcare and community services that he needs to stay healthy. Care coordination is what ties BPHC's projects together.

Each BPHC project is targeted, focusing on improving services that are heavily utilized in our community, like hospitals, primary care practices, behavioral health, and social services. These projects have also been carefully designed to intersect with and reinforce one another, because there are multiple social and medical factors at play in every person's health. BPHC will need to seamlessly guide patients from one project to the next – to coordinate their care across projects – to fully manage their health and everything affecting it.

Looking Back

Nearly All BPHC Projects Have Launched

In the beginning stages of DSRIP planning, we developed ten projects targeting the specific health needs of Bronx residents. To date, nearly all of these projects have launched. Participating member organizations will begin adopting new clinical protocols, information-sharing technologies, reporting systems, and possibly new staff. This will not happen all at once, of course. Our projects are complex and multifaceted, and will be implemented in phases throughout the DSRIP period.

Transformation Driven by Partner Expertise

DSRIP is not about reinventing the wheel – it is about making the most of the abundant resources already available in our community. Our PPS members have already developed their own unique and impactful service models, and we aim to spread them throughout our PPS.

This work has already begun. Innovative care models pioneered by the Institute for Family Health, a.i.r. NYC, and Montefiore's Care Management Organization have become the centerpieces of several BPHC projects and will be soon widely adopted by BPHC member organizations. Throughout the DSRIP period, our work will be driven and inspired by the expertise of our PPS members.

Supporting the Success of Our Partners

With DSRIP projects now underway, the landscape for Bronx healthcare will begin to shift, and the Central Services Organization (CSO) is here to help our PPS members in this transition. The CSO has connected primary care providers with experts in NCQA's Patient-Centered Medical Home (PCMH) recognition program, who will help providers apply for and sustain the highest level of PCMH recognition.

Several BPHC member organizations are involved heavily in nearly every project, and have dedicated DSRIP Program Directors (DPDs) to manage the DSRIP effort. The CSO is supporting DPDs with the training and tools necessary to successfully implement BPHC's projects. In particular, DPDs are guided by a clinical operations plan – a step-by-step roadmap to every project – which the CSO crafted in collaboration with clinical experts from a diverse group of PPS members.

Looking Ahead

Investing in Innovation

Coordinating care, building a robust foundation in primary care, integrating community-based and medical services into healthcare – these are expansive and systemic reforms designed to affect the Bronx as a whole. But each community within the Bronx has its own unique set of needs, which our PPS members understand best.

Many community based organizations and healthcare providers have developed innovative, targeted, and effective ways to help their clients and patients – innovations which could benefit the entire PPS. BPHC will learn about the innovations in our PPS, and make it possible for member organizations to develop, pilot, and spread them throughout the Bronx.

Targeted Support for Small and Independent Practices

Nearly half of BPHC's primary care providers – over 450 in total – are based out of small and independent practices. These providers are vital members of our PPS, and will benefit from shared resources like care coordination technologies and PCMH coaches. However, they will require additional supports more tailored to their unique care models. They will attend project launch events designed specifically for their needs and expertise, and will gain access to shared care coordination resources.

Engaging Community-Based Organizations in Healthcare Integration

One of the most exciting implications of the Integrated Delivery System is that it incorporates a wide range of services that promote health and wellness into healthcare delivery. Leaders of several Bronx-based CBOs meet monthly to discuss ways to best accomplish this through improved care coordination between social and healthcare services. They will work together to help make providers aware of which social services are available to their patients and how to access them.

With their roots in diverse communities and cultures, CBOs are also valuable resources for our PPS when it comes to cultural competency and health literacy. They will train providers to ensure that care is delivered in a manner that is responsive to patients' cultural backgrounds, and that Bronx residents are better prepared to make informed decisions about their health.

Community Spotlight

Ursula Soler is a Patient Navigator with Union Community Health Center. Union Community Health Center has achieved PCMH 2011 Level 3 recognition, and provides comprehensive, quality healthcare services in a patient-friendly environment. Union plays an integral role in many of BPHC's clinical projects and its governance.

"We have huddles every morning," says Ursula Soler, Patient Navigator with the Health Home Program at Union Community Health Center. "It's really a quick meeting, a good way to communicate with doctors. If doctors have any complicated patients, they'll connect them to us."

When Ms. Soler first reaches out to new patients, they can be wary - what she offers sounds almost too good to be true. Soon, however, the skepticism wears off.

"I start mentioning that I can help them navigate through benefits, social services, any medical services that might be giving them a hard time, anything that would help them lead a healthier lifestyle," Ms. Soler says. "That's when the light pops on and they say, 'ok, this is what I need.'"

Health Home patients in particular are in need of this extra support. They suffer from chronic and complex medical conditions, usually more than one at the same time, not to mention the many challenges associated with poverty that make it difficult to stay healthy.

"It's having someone there, who's able to support patients in dealing with a condition that they may not understand."

Once she learns about each patient's unique situation, Ms. Soler works with them to set health goals, develop a care plan, coordinate healthcare and social services, and more. "There are so many little things that can improve someone's health," Ms. Soler has learned, "like just making a phone call or reminding them of their appointments."

Ms. Soler is not only a valuable asset to her patients, but also to her care team. "Doctors see that with us, there is someone they can depend on," she explains. "Doctors will call us into the consultation to explain something to the patient or help them follow through with a medication or a treatment."

Ms. Soler's ultimate goal is for patients to learn to manage their own health and to "graduate" from the Health Homes Program. The key to this, she has found, is trust. "It's having someone there, who's able to support them in dealing with a condition that they may not understand," she says. "It helps them to be more self-sufficient."