BRONX PARTNERS FOR
HEALTHY COMMUNITIES

SBH
Health System
BRONX

Community Behavioral Health Call to Action Initiative

November 4, 2016 9:00am-12:00pm

Mercy College, Bronx Campus

Agenda

- Welcome
- Delivery System Reform Incentive Payment (DSRIP) Program Overview
- Guest Speaker: Gustavo Rivera, NYS Senator
- Key Note Speaker:
  - Ann Sullivan, MD, Commissioner, Office of Mental Health
- Bronx Partners for Health Communities Overview
- Performance Reporting
- The 'Call to Action'
  - Initiative Goals
  - Introduction of Workgroups and Workgroup Leads
- Breakout Sessions
- Report Out
- Next Steps

Irene Kaufmann, Executive Director, BPHC

WELCOME

What is DSRIP?

The Delivery System Reform Incentive Payment (DSRIP) program is a $6.42B program to transform the NYS safety net health care delivery system.

Reduce avoidable hospital use by 25% over 5 years

Pursue the Triple Aim

- Better Care
- Improve Health
- Reduce Costs

Ensure delivery system transformation continues beyond the waiver period through value-based payment reform

DSRIP and Transformation

Transforming the Delivery of Care: Four Arenas

- Payment Structure
- Workforce
- Technology
- Clinical Quality

Current State: Silos of Service

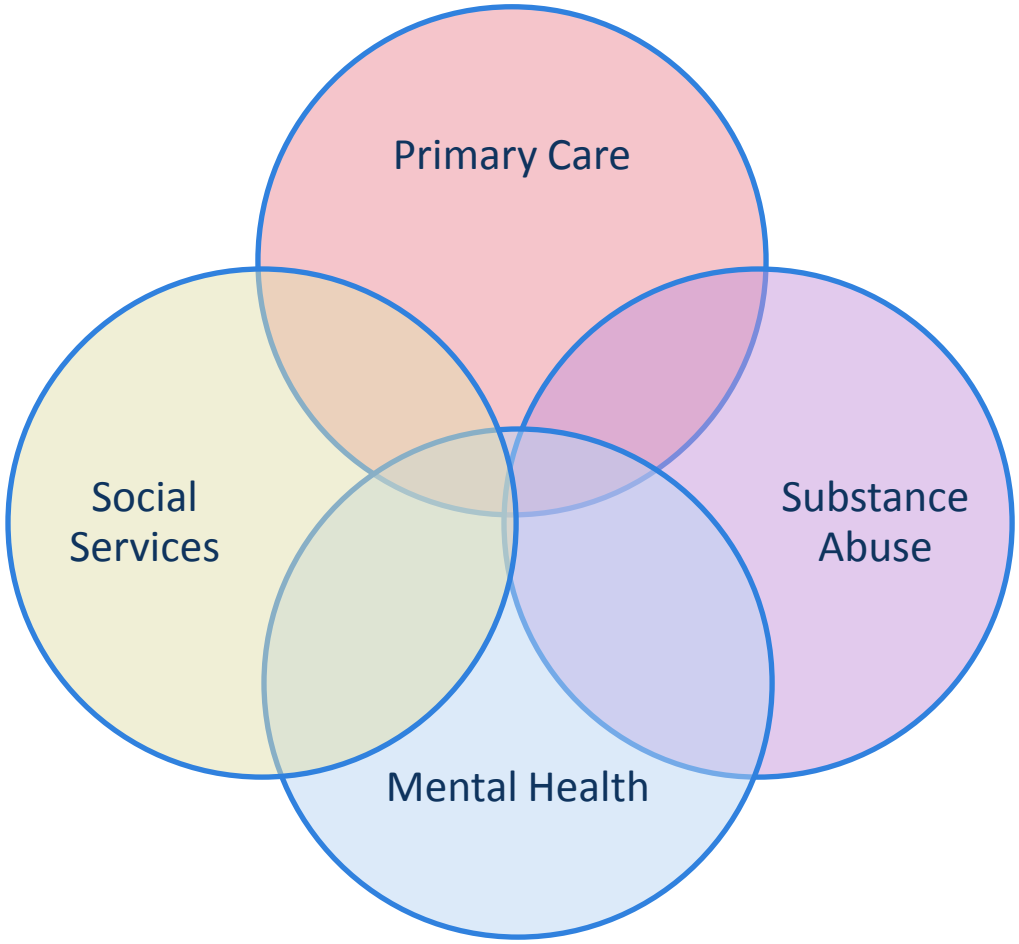
- Issues with a system of silos:
- No incentive for coordination or integration
- Much value is lost along the way:
  - Quality of patient care & experience
  - Avoidable costs & complications

- Journey toward value-based care delivery requires :
  - Coordination
  - Co-location
  - Integration

Journey Toward Value Based Care:

Coordinating with Community Based Services

Coordination between primary care and community based organizations that provide substance abuse, mental health and services that address the social determinants of health are critical for improving outcomes. Coordination is the most effective approach to caring for people with complex health care needs.



Guest Speaker

GUSTAVO RIVERA, NYS SENATOR

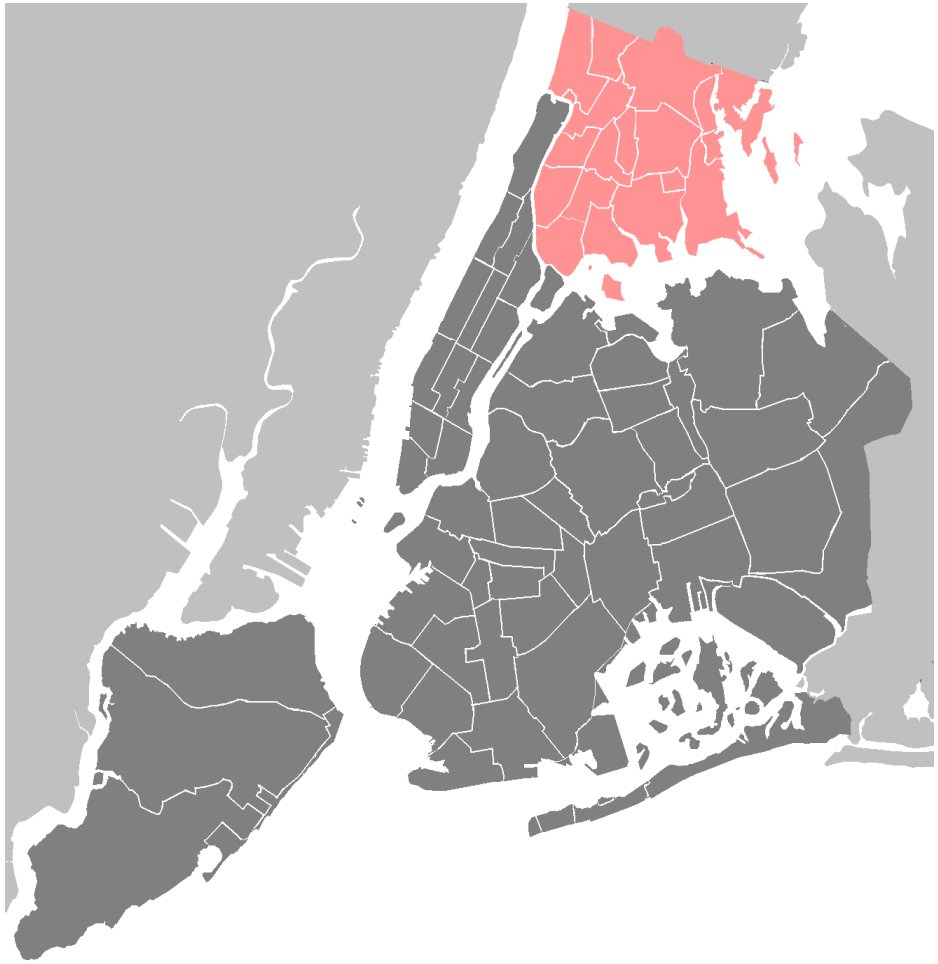
Key Note Speaker

ANN SULLIVAN, MD, COMMISSIONER, OMH

Amanda Ascher, MD, Chief Medical Officer, BPHC

BRONX PARTNERS FOR HEALTHY COMMUNITIES (BPHC)

BPHC Geographic Region



The Entire Bronx Borough

- **Population:** Culturally vibrant community with population of ~1.5 million
- **Medicaid Coverage:** Highest rates of Medicaid coverage in the State (59% of Bronx residents over the course of a year).
- **Population Health:** Though the Bronx represents only 7% of the State's population, it accounts for 22% of asthma hospitalizations and the diabetes mortality rate is 60% higher than the State's rate.
- **Social Factors:** Poorest county in New York State with approximately 30% of residents living in poverty, and a 12% unemployment rate. Over a third of the population has unaffordable or inadequate housing.

Community Needs Assessment 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.*

BPHC Profile

Bronx Partners for Healthy Communities PPS	
	**SBH Health System (lead)** • 150 years of serving the Bronx • Over 70% Medicaid patients
	**Member organizations** 240 organizations, 1,000+ sites ~70,000 employees ▪ Hospitals ▪ Behavioral Health ▪ FQHCs ▪ TCs ▪ D&TCs ▪ IPAs ▪ Health Homes ▪ CBOs ▪ Home Care ▪ Hospices
	**Patient Population** • 170K attributed for valuation • 370K attributed for performance*

* As of July 1016

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
- More than half of residents speak a language other than English at home

BPHC Governance Structure

Executive Committee

- Oversight of overall DSRIP Program implementation
- Satisfaction of key metrics to realize incentives
- 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 and Sustainability

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

Quality and 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 strategy

Bronx Partners for Healthy Communities (BPHC) CSO

BRONX PARTNERS FOR HEALTHY COMMUNITIES

SBH Health System BRONX

BPHC DSRIP Projects

Domain	DSRIP Project	Launch Dates
2.a.i	Integrated Delivery Service	
2.a.iii	Health Home At-Risk	January 11, 2016
2.b.iii 2.b.iv	ED Care Triage for At-Risk Populations Care Transitions to Reduce 30-Day Readmissions	November 23, 2015 November 11, 2015
3.a.i	Integration of Primary Care and Behavioral Health	September 30, 2015
3.b.i 3.c.i	Evidence-Based Strategies for Disease Management -CVD Evidence-Based Strategies for Disease Management - Diabetes	February 11, 2016
3.d.i	Expansion of Asthma Home-Based Self Management	March 10, 2016
4.a.iii	Mental Health and Substance Abuse Infrastructure	Fall 2016
4.c.ii	Early Access and Retention in HIV Care	June 30, 2016

Current Primary Care/Behavioral Health Integration (PCBH) Work

- **Three PCBH Models Implemented by BPHC**
  - Co-location of Behavioral Health into Primary Care
  - Co-location of Primary Care into Behavioral Health
  - Improving Mood – Promoting Access to Collaborative Treatment (IMPACT)
- Adopted to increase capacity in behavioral health settings for more severe behavioral health problems.
- BPHC is currently implementing PCBH in 53 unique sites
- Institute for Family Health (IFH) is providing training and technical assistance

IFH Training to Support PCBH Implementation:

- Introduction to Collaborative Care
- IMPACT 101
- Collaborative Care for Consulting Psychiatrists
- PHQ-2/9 screening tools
- Warm Hand-Off
- Workflow Development
- Motivational Interviewing
- Behavioral Activation
- Problem Solving Treatment
- safeTALK

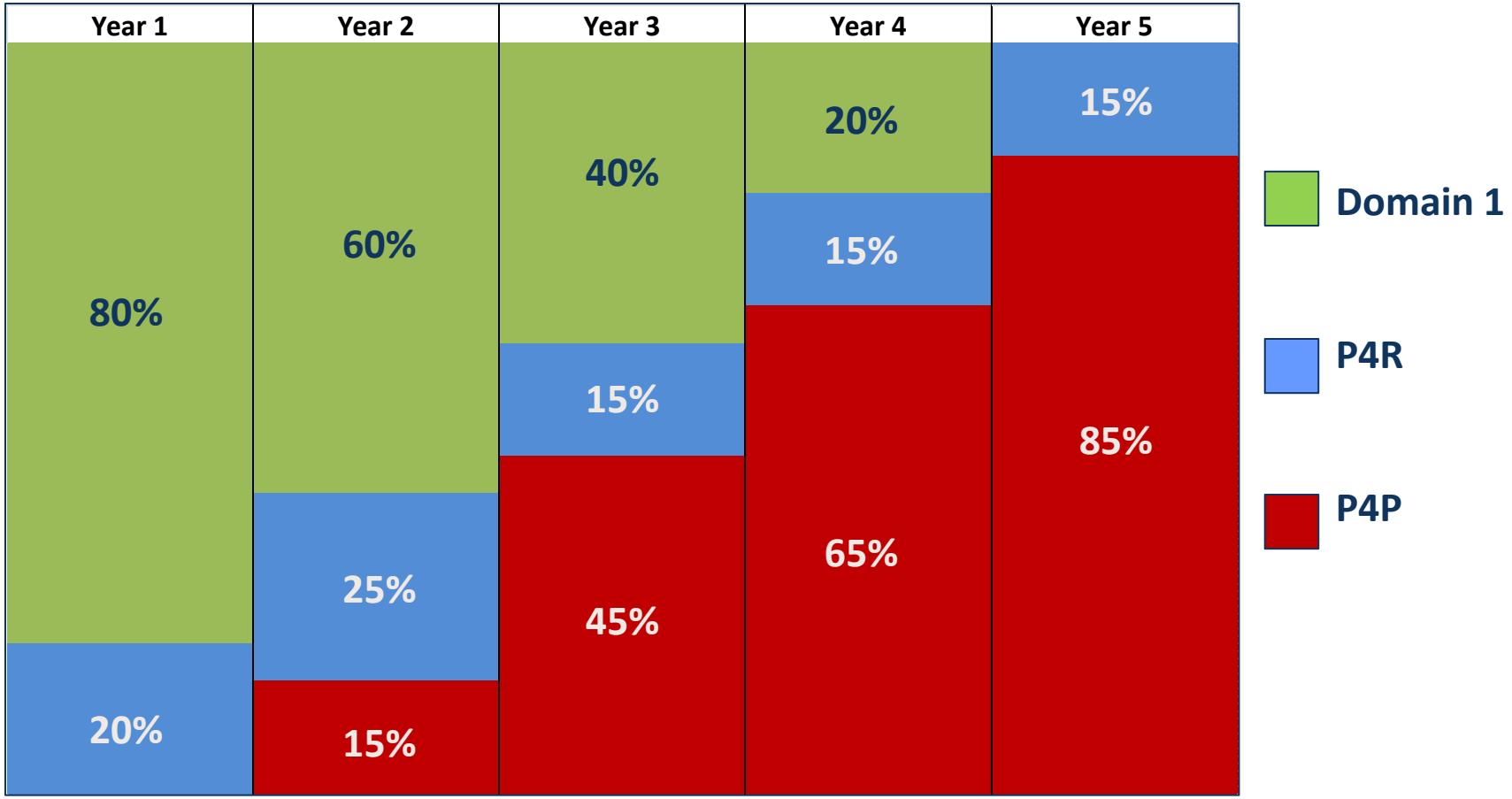
PCBH Integration Challenges

- Workflows
  - Re-engineering workflows to facilitate integration
- Training
  - New roles and skill set for care team members
  - Providers are busy seeing patients
- EMR Changes
  - Linkage and/or integration between behavioral and physical health
  - Ability to track screening and referrals
- Billing Issues
  - Limitations on same day services

Janine Dimitrakakis, Sr. Director, Analytics, BPHC

PERFORMANCE REPORTING

DSRIP Funding Methodology



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Source: *Attachment I – Program Funding and Mechanics*

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

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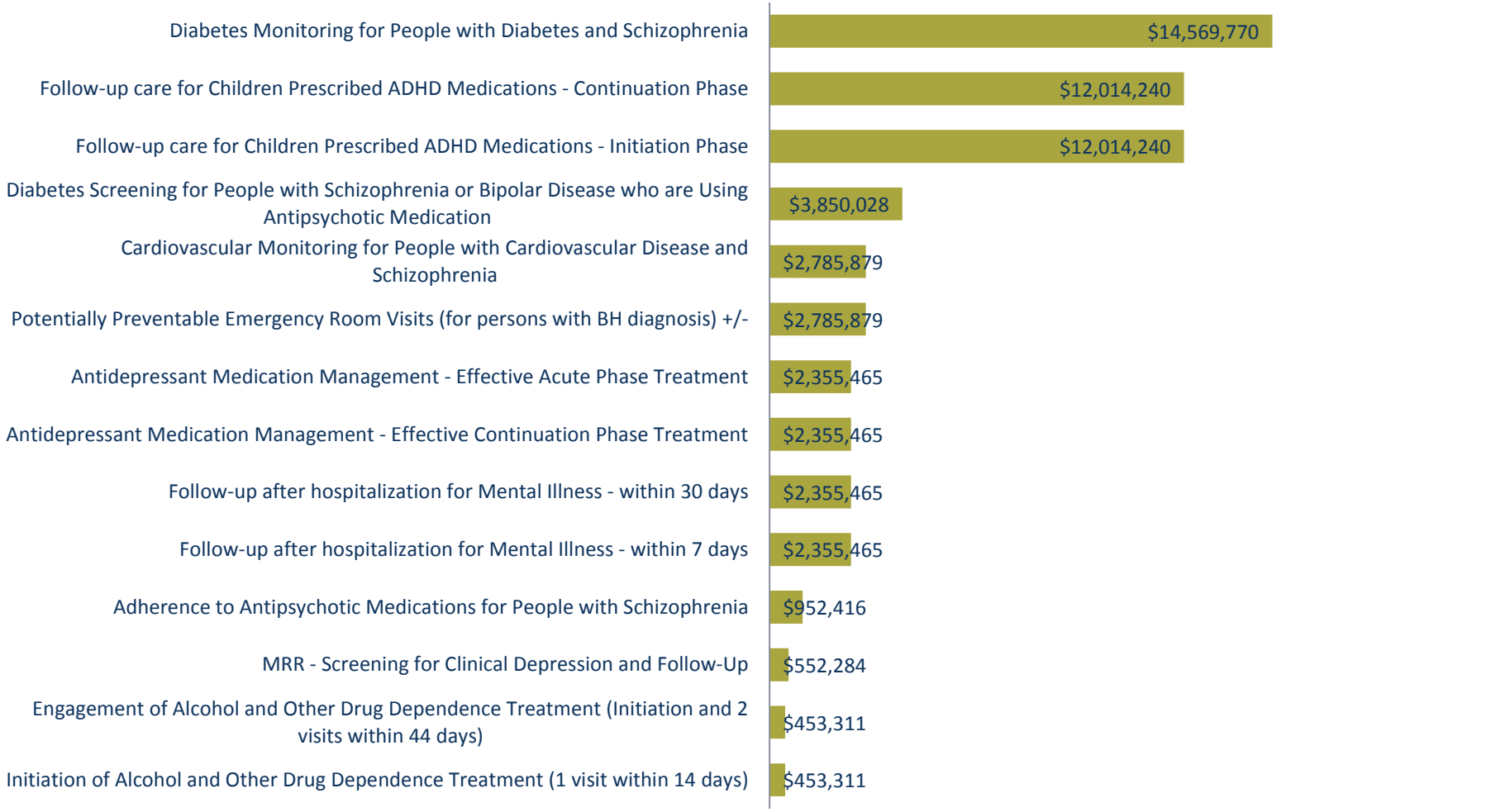
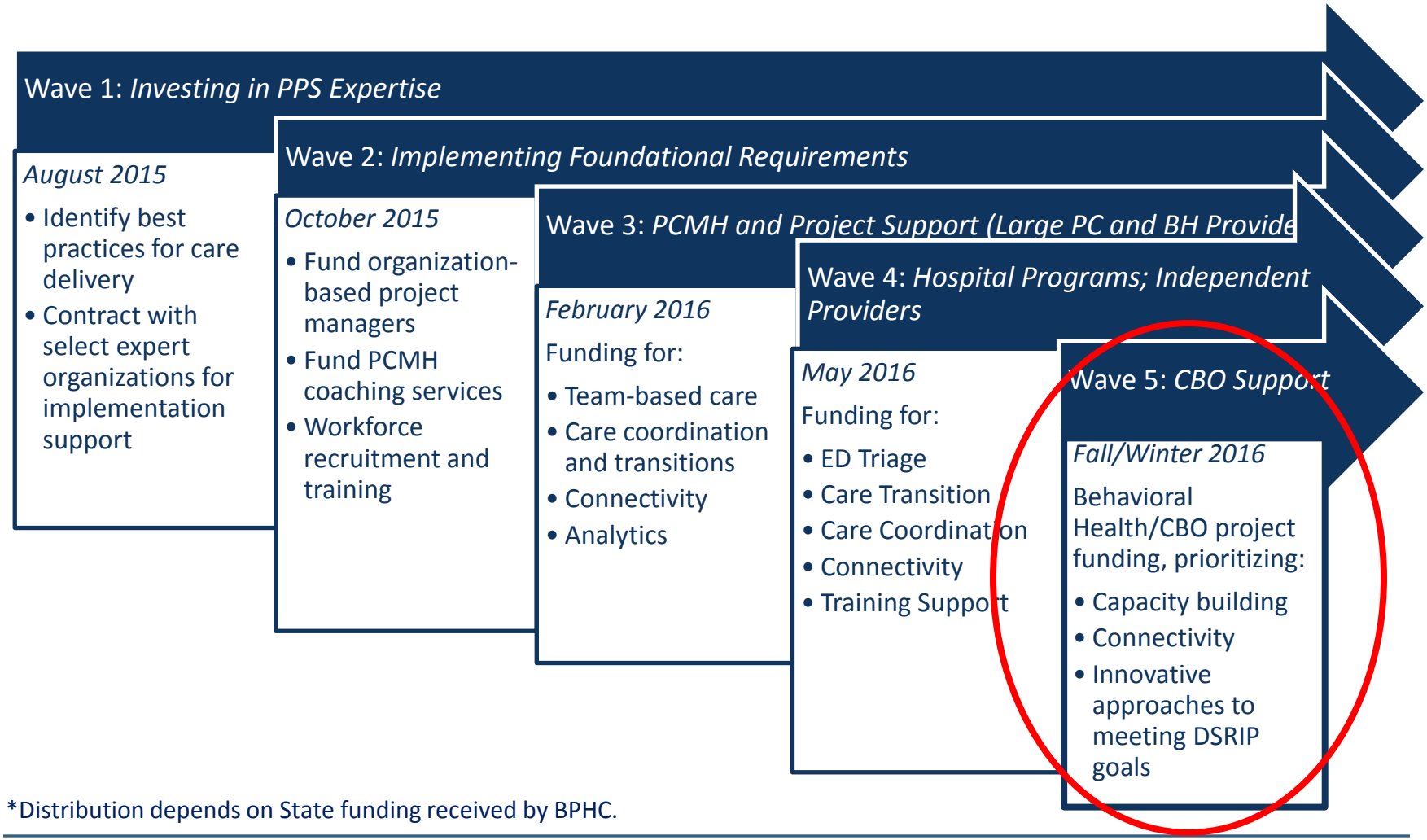
Behavioral Health At-Risk Dollars



The Initiative

A CALL TO ACTION

BPHC DY1-DY2 Funds Flow: Wave 5



*Distribution depends on State funding received by BPHC.

Behavioral Health Steering Committee

Role

- Guide the development of the engagement strategy for community based behavioral health providers
- Establish priorities for action
- Develop the 'Call to Action' Initiative
- Provide feedback and input on work plans as they are developed by the workgroups
- Review of the final work plan submitted by each workgroup to then begin implementation

Members

- **Doug Apple**, Executive Vice President & Chief Operating Officer, Samaritan Village, Inc.
- **Andrew Cleek**, Executive Officer & Senior Research Scientist, McSilver Institute for Poverty Policy & Research
- **John Kastan**, Chief Program Officer, The Jewish Board
- **Pam Mattel**, Chief Operating Officer, Acacia Network
- **Debbie Pantin**, Associate Executive Director, VIP Community Services
- **David Woodlock**, President & Chief Executive Officer, Institute for Community Living

BPHC Community Based Projects

PPS Community Based Project	Launch Dates
Community Health Literacy	October 2016
Critical Time Intervention	October 2016
Cultural Competency Training	November 2016
'Call to Action' Initiative ▪ ADHD in Children ▪ Schizophrenia and Diabetes ▪ Mental Health/Substance Use Screening and Referral	February 2017

Call to Action Initiative Goals

- Achieve DSRIP Performance Targets
- Achieve the Triple Aim:
  - Improve care
  - Improve services
  - Improve efficiency
- Improve Interconnectivity
  - Information Technology
  - Clinical linkages
  - Warm hand-offs and referral processes
- Establish a Foundation for VBP

ADHD in Children – Donna Demetri Friedman

Mental Health/Substance Use Screening and Referral – Marcia Holman

Schizophrenia and Diabetes – Amy Dorin

THE PROJECTS

ADHD in Children: Donna Demetri Friedman

Workgroup Charge: To ensure the use of best practices in the treatment of children, ages 4 to 17, with ADHD, and provide the social support and services to their families to further improve outcomes.

- In 2015, **over 800 children between the ages of 6 to 12 years**, attributed to BPHC, were **newly prescribed ADHD medication.** Of those, only 65% had a follow-up visit with a practitioner within 30 days after starting the medication.

- A 2015 report called "Redesigning Children's Behavioral Health Services in New York's Medicaid Program" by Medicaid Institute of United Hospital Fund, found that of children and adolescents receiving behavioral health services in New York State in 2013, **ADHD was the most prevalent diagnosis at 24.1%** (52,031 children)

Goal: To develop a model of care based on best practices including a focus on medication management for children with ADHD; with consideration given to models of collaborative and/or integrated care.

ADHD in Children

Lead: Donna Demetri Friedman, Deputy Executive Director, RMHA

- **Devon Bandison**, Director Children's Services, VNSNY
- **Mayra Estrada**, Director of Clinical and Information Systems, RMHA
- **June Helme**, Program Director of Tilden Street Clinic, Astor Services
- **Marilyn Jacob**, Senior Director, Behavioral Health in Schools, The Jewish Board
- **Carolann Slattery**, AVP Outpatient Services, Samaritan Daytop Village
- **Christina Soddano**, Director of Strategic Health Initiatives, Leake and Watts

Mental Health/Substance Use Screening and Referrals: Marcia Holman

Workgroup Charge: To implement screening standardization using the Personal Health Questionnaire (PHQ) – 2/9 and SBIRT across mental health and substance use treatment services

- According to SAMHSA's 2014 National Survey on Drug Use and Health, **7.9 million adults in the U.S. had co-occurring disorders.** SAMHSA states that the consequences of undiagnosed, untreated, or under treated co-occurring disorders can lead to a higher likelihood of experiencing homelessness, incarceration, medical illness, suicide, or early death.
- From April to September 2015, **5% of inpatient discharges of Bronx Medicaid patients were for Mental Disorders (all DSMIII C)**.

Goal: To standardize screening in the mental health and substance abuse treatment settings. To develop an integrated system for referring between mental health and substance abuse providers, and/or primary care providers when warranted, and to ensure communication and collaboration among the members of the care team.

Mental Health/Substance Abuse Screening and Referral

Lead: Marcia Holman, Representative, Coordinated Behavioral Care (CBC)

- **Pinny Brecher**, Coordinator of Co-Existing Disorder Programs, Astor Services
- **Christal Montague**, Chief Program Officer, VIP Community Services
- **Jacques Nir**, Director, Pelham Counseling Center, The Jewish Board
- **Tara Noto**, Director Program Operations, VNSNY
- **Yaberci Perez-Cubillan**, Acacia Network
- **Lourdes Sanchez**, Program Director, Samaritan Daytop Village
- **Joan Salmon**, Regional Director Treatment Services, Services for the UnderServed
- **Aneta Skrobacz**, Clinical Director, TRI Center
- **Monica Thomas**, Executive Vice President, The Osborne Association
- **Terri Udolf**, DSRIP Project Manager, St. Christopher's Inn

Schizophrenia and Diabetes: Amy Dorin

Workgroup Charge: To improve the care of persons with a diagnosis of schizophrenia by providing screening for diabetes and ongoing monitoring of people with schizophrenia and diabetes.

- The effects of psychotropic medications, used in the treatment of schizophrenia, can **cause or exacerbate diabetes**.
- Of the schizophrenics attributed to Bronx Partners for Healthy Communities (BPHC), **33%** are also diagnosed diabetics and of those **only 67% had an LDL-C and HbA1c during 2015**.

Goal: To develop a model in which people with schizophrenia are screened regularly for diabetes and are monitored routinely if they have diabetes. Included will be the ability to identify and share findings and develop referral processes and procedures for ongoing collaboration and communication among the members of the behavioral health and primary care teams.

Schizophrenia and Diabetes

Lead: Amy Dorin, BPHC Behavioral Health Advisor

- **Jason Cheng, MD,** Director of Integrated Care, ICL
- **Gabrielle Contreras**, Program Coordinator, Manhattan Mobile, VNSNY
- **Jessica Fonzi**, Director, Riverdale PROS, Riverdale Mental Health Association
- **Talanda Jackson**, Deputy Director Community Residences, Acacia-Promesa, Inc.
- **Daniel Johansson**, Executive Vice President/CEO, ACMH
- **Jacqueline Rosario-Perez**, Beacon of Hope

Workgroup Member Responsibilities

- Work together to identify and prioritize foundational components of the project
- Develop a timelined workplan for implementing the project
- Confer with Steering Committee about anticipated project challenges and report progress of the planning process
- Complete Project Workplan by December 15
- Present workplan to BPHC Executive Director, the Behavioral Health Steering Committee and the Quality and Care Innovation Subcommittee
- Incorporate feedback and recommendations from the Committees and finalize the workplan

BPHC Will Provide:

- Space for workgroup meetings
- Data, reference materials and consultation support
- Subject matter expertise in response to workgroup requests
- Facilitate and support coordination with city agencies and other PPSs in order to access resources
- Support development of presentations for Steering Committee and QCIS

Deliverables and Timeline

November 4, 2016: 'Call to Action' Initiative, Mercy College, Bronx Campus

- Development of Aim Statement
- Development of Workgroup Action Steps

November 7, 2016: Review of Project Aim Statements by BPHC

November 28, 2016: Workgroup Leads Report to Steering Committee

December 14, 2016: Workgroup Leads Report to QCIS

December 15, 2016: Workplan due to BPHC

January 6, 2017: BPHC Review and Approval of Workplans

BREAKOUT SESSIONS

Workgroup Breakout Sessions

Session I	Session II
Develop Project Aim Statement: ▪ What? ▪ For whom? ▪ By when? ▪ Process Measures ▪ Measurable outcome(s)?	**Work Plan Topics and Assignments:** ▪ Evidence Based Models ▪ Process and Work Flow ▪ Information Technology ▪ Measures ▪ Workforce Training ▪ Patient Education

Guests Breakout Sessions: Referrals

Current State	Future State

• How is your agency currently handling the referral process?
  – What problems have you experienced?
  – What has worked?
• Rate problems and successes from most (3) to least (1)
	• How would you define a successful referral?
	• What would be the elements of a successful referral process/system
	• Once your list is complete prioritize the elements you identify

Breakout Session Groups

REPORT OUT

NEXT STEPS

Next Steps

- Aim Statements reviewed, approved and returned to Workgroup Leads by November 8
- Next Workgroup Meetings
  - ADHD in Children Workgroup:
    - November 9, 10am-1pm, Riverdale Mental Health Association
  - Mental Health/Substance Abuse Screening and Referral Workgroup:
    - November 10, 2-4pm, VNSNY 148 West 125 Street, 4th Floor
  - Schizophrenia and Diabetes Workgroup:
    - November 8, 2:30-4:30pm, Auxiliary Conference Room, Braker Building, SBH
- Workgroup Leads report progress to Steering Committee
  - November 28, 2-3:30pm, Administrative Conference Room, Braker Building, SBH
- Workgroup Leads report to QCIS
  - December 14, 12-2pm, Administrative Conference Room, Braker Building, SBH

Contact

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repstein@sbhny.org

Thank You!

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