Collaboration
Transformation
Outcomes

BRONX PARTNERS FOR
HEALTHY COMMUNITIES

NEWSLETTER

Fall 2015

BPHC in Numbers

222
member organizations

$384,271,362
in maximum DSRIP funding across 5 years

356,863
Bronx residents attributed to our PPS

A Letter from the Executive Director

Dear BPHC Community,

An ambitious effort is underway to transform the way New Yorkers on Medicaid receive healthcare. It is an effort to make healthcare more effective for each patient, while at a lower cost to the system; to address both the medical and social determinants of health.

The (admittedly awkward) name of this program is DSRIP. While it may seem complex and even intimidating, DSRIP ultimately boils down to one thing: getting the care right.

Over a year ago, SBH Health System assumed a leading role in this transformation. It formed a Performing Provider System (PPS): a coalition of over 200 Bronx-based organizations that provide a variety of services to Bronx patients. This coalition is called Bronx Partners for Healthy Communities, or BPHC.

Through ten DSRIP projects, designed to meet our community's unique health needs, BPHC is building a coordinated, community-based healthcare system focused on the wellness of Bronx residents. This Newsletter will provide insight into what BPHC is, what we hope to achieve, and what we are doing to get there. We are glad to have you with us.

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

Connect with BPHC

You can visit us online:
www.bronxphc.org

E-mail us your feedback:
feedback@bronxphc.org

Our mailing address is:
4422 Third Avenue
Bronx, New York 10457

The BIG Picture

BPHC believes that getting the care right means integrating our healthcare delivery system: coordinating a range of healthcare and social services so that patients receive the right care when they need it.

Our strategy for realizing this vision relies on a strong foundation in primary care and well coordinated community-based services.

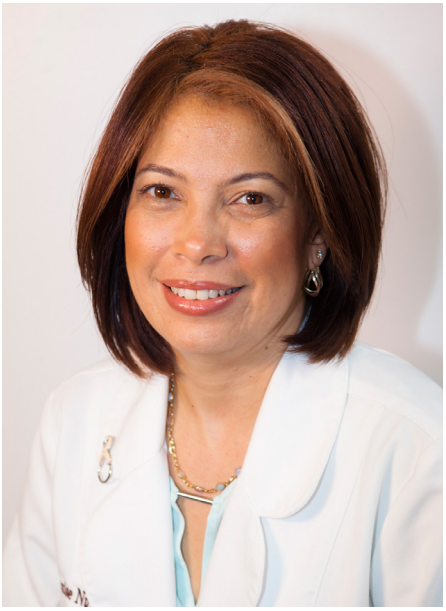
Transformation Rooted in Primary Care

Primary care is where patient wellness begins. It is where doctors identify health risks early and connect patients to the care they need; it is where patients learn to manage their own health; and it is the most powerful tool we have to manage chronic conditions and prevent unnecessary hospitalizations. For this reason, we are making sure that every primary care practice in our PPS has the opportunity to become a medical home at the highest level and achieves NCQA recognition as a Level 3 Patient Centered Medical Home (PCMH).

PCMH is a model of primary care delivery dedicated to the "Triple Aim": improved population health, better patient experience (which includes higher quality of care), and lower per capita cost of healthcare. But what does this look like in action?

The first step in achieving PCMH recognition is increasing patient access, often by scheduling same-day appointments and allowing 24/7 access to providers. Once the patient is in the door, they are seen by their care team. The care team treats and tracks a panel of patients, coordinates necessary services (including behavioral health and community services), and follows up with patients after every visit.

The journey to PCMH recognition is hard work. "Trying to do it from the beginning is tough," says Denise Nuñez, the Medical Director at Divino Niño, a small pediatric practice with PCMH Level 3 recognition. "You need people, you need resources, and you need money," But for her, it was worth the investment. "Quality, efficiency, and professionalism. PCMH has had a huge impact," she says.



Denise Nuñez is the Medical Director at Divino Niño Pediatrics and pediatrician specializing in critical care.

In other words PCMH works, and our PPS is working to achieve it at the highest level possible. We understand that establishing an NCQA-recognized medical home may require difficult changes in practice and workflow, which is why we have recruited PCMH coaches to provide guidance and support with the PCMH application and the practice transformation that will follow.

Integration of Community Services in Healthcare Delivery

Picture a child who puffs on an inhaler in a moldy bedroom; a woman for whom a hospital bed is the alternative to sleeping on the street; a man who cannot read the instructions for his diabetes medication. There are countless Bronx residents who must overcome social, economic, and cultural challenges simply to stay healthy.

Community-based organizations are vital members of our PPS because they address these challenges. They complement the work of healthcare providers, connecting patients to the care they need and helping patients stay healthy when they leave the doctor's office. BPHC will focus on coordinating and integrating community-based social services into the healthcare delivery system, so that they work in tandem with clinical care to treat the whole patient.

Looking Back

10 DSRIP Projects Tailored to Community Needs

In the early stages of DSRIP planning, BPHC conducted an in-depth analysis of the health challenges and the healthcare and community resources in the Bronx. We identified not only which health issues are most common, but also why they are so pervasive. Based on our findings, we customized ten projects to our community's specific healthcare issues, focusing on chronic disease management, hospital and emergency services, and behavioral health.

Plans for Every Project

After selecting our projects, we immediately began formulating plans to make them come to life. Healthcare experts from our member organizations helped us craft goals and set timelines for each project and for our PPS as a whole. Our entire PPS got involved, teaching us how to best incorporate each organization into each project.

This collective effort helped produce an Organizational Implementation Plan and ten Project Implementation Plans – one for each project. These plans outline BPHC's goals, and we will be awarded DSRIP funding based on whether or not we meet them.

Formation of the Project Advisory Committee

Our Project Advisory Committee, established in April, guides the work of the whole PPS. The Executive Committee is at the helm, overseeing overall DSRIP implementation. Four Sub-Committees supporting the Executive Committee develop strategies to implement projects, standardize best practices, oversee distribution of DSRIP funds, and deploy staff trained to deliver the highest quality of care.

Looking Ahead

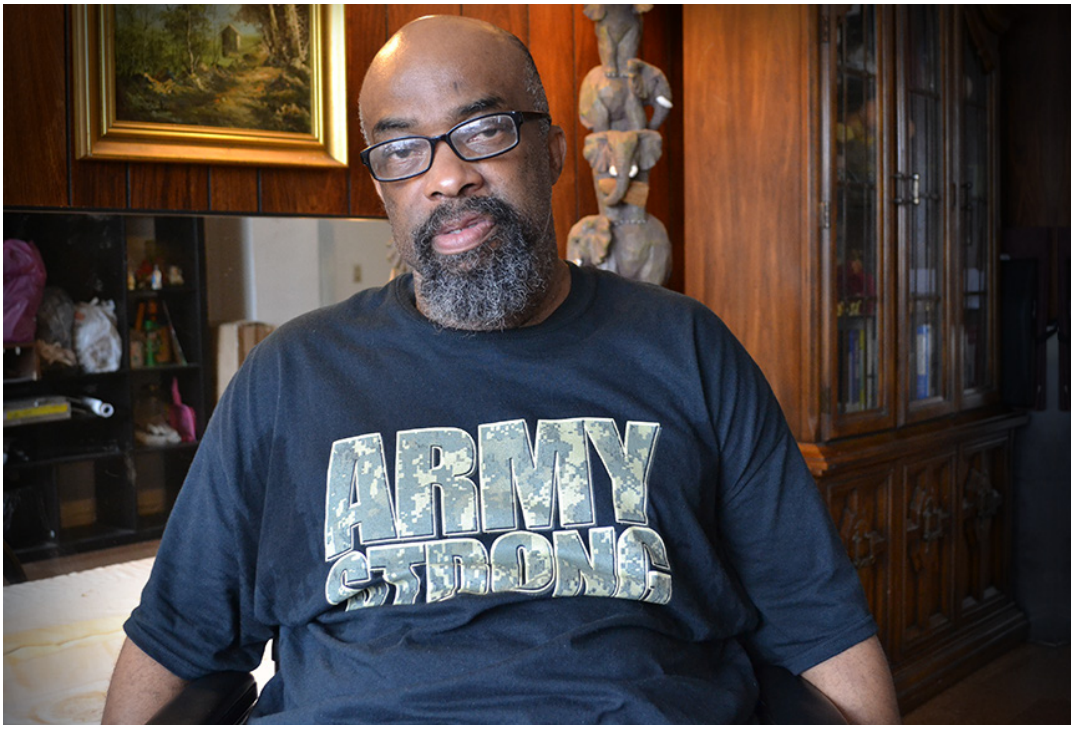
To date, much of the project planning and implementation has been coordinated by BPHC's Central Services Organization (CSO) and our Project Advisory Committee. But it is our partner organizations, and the staff that work directly with the community, that make healthcare transformation really happen. As we turn our attention to launching our DSRIP projects, we are supporting and preparing our partners to lead the DSRIP initiative on the organizational level.

Some healthcare providers, particularly those that are engaged in multiple projects and have a large number of primary care providers, will need support to coordinate, monitor, and report on their various projects. The CSO is recruiting DSRIP Program Managers to work for these PPS members and facilitate DSRIP implementation. In addition, primary care providers have been connected with experienced PCMH coaches who will help them achieve and sustain PCMH 2014 Level 3 recognition.

This summer nearly 40 BPHC members came together to discuss ways to improve the way organizations work with and support one another. These conversations emphasized the role that community services play in our projects and in the integrated healthcare system that we are working to build.

To continue these important discussions, work groups will meet throughout the DSRIP period to develop strategies for our PPS to engage our community, communicate and connect with one another, work with high-risk populations, and build capacity in supportive housing. This will make the services that our PPS members provide more effective and more sustainable during and beyond the DSRIP years.

There will be much more exciting news to come as we move further into the early stages of DSRIP implementation. To receive updates about our PPS's progress, please subscribe to our bi-weekly BPHC Bulletin.



Anthony "Malik" Wright is a certified Peer Leader at Health People, a community preventive health institute located in the heart of the South Bronx. Health People is a BPHC member with an integral role in our clinical projects.

Community Spotlight

Anthony "Malik" Wright struggled for years to manage his diabetes, but despite his attempts at improving his lifestyle, his leg was amputated two years ago. After training to become a certified Peer Leader with Health People, Mr. Wright now leads workshops to teach diabetics and pre-diabetics how to avoid his experience.

Health People is a community preventive organization that empowers and trains those affected by chronic disease to teach others how to manage their health. Health People plays an active role in BPHC's diabetes and cardiovascular disease projects.

> "I've learned to readjust my thinking, my eating, my everything."

What makes participants in his workshops so receptive to his message, Mr. Wright explains, is their shared understanding of living with diabetes. "To make someone learn, they gotta be like you…" he says. "I can tell them 'If you don't want to listen to the program, just look at me. I didn't listen, look at the outcome.'"

Mr. Wright also attends weekly support groups, which to him are a "blessing."

"I'm alive," he says. "I've learned to readjust my thinking, my eating, my everything."

Mr. Wright is now a certified Peer Leader of the acclaimed Stanford Diabetes Self-Management Program and leads workshops as part of Health People's LEAP (Lower Extremities Amputation Prevention) Program.