BRONX PARTNERS FOR HEALTHY COMMUNITIES

SBH Health System BRONX

All-Member Webinar

September 20, 2017

Agenda

- Welcome: Irene Kaufmann
- BPHC 2017 Innovations Fund: J. Robin Moon
- Performance Payment Program: Amanda Ascher
- MAX Series: Substance Use – Acacia/SBH
  - Meredith Stanford
  - Pam Mattel, Acacia Network
  - Pat Belair, SBH Health System
- Workforce Update – Course Delivery
  - Cultural Competency in the Bronx: Lisa Martin, Ph. D., The Jewish Board
  - Social Determinants and the Law: Charles Daitz, Esq., Legal Health, NYLAG
- BPHC Communications Update: Luci DeHaan
  - Know Your Primary Care Provider Campaign
- BPHC Resource Directory: Albert Alvarez
- Q&A

BPHC is happy to receive your questions in writing! Please email them to Luci deHaan (ldehaan@sbhny.org) and Aayesha Vichare (avichare@sbhny.org)

BPHC 2017 INNOVATIONS FUND

BPHC 2017 Innovations Fund: $5.7 Million

Submission Domains

- IT Innovations in Care Delivery
- Transformation and Performance Improvement
- Partnerships and Communications
- Finance and Payment Innovations
- Social Determinants of Healthcare Access and Utilization

Submission and Vetting

• Invitation to Participate	*June 21*
• Informational Calls	*June 26 & 28*
• Follow-up Q&A Call	*July 10*
• Proposals Due	*July 21*
• Review Work Group* Vetting	*8/14 – 8/26*
• Finalist Revision	*8/28 – 9/8*
• Recommendations to EC & Announce	*9/11-9/15*
• Contracts Issued	*Sept 28*
• Contracts Executed / Pilots Begin	*Oct 16*

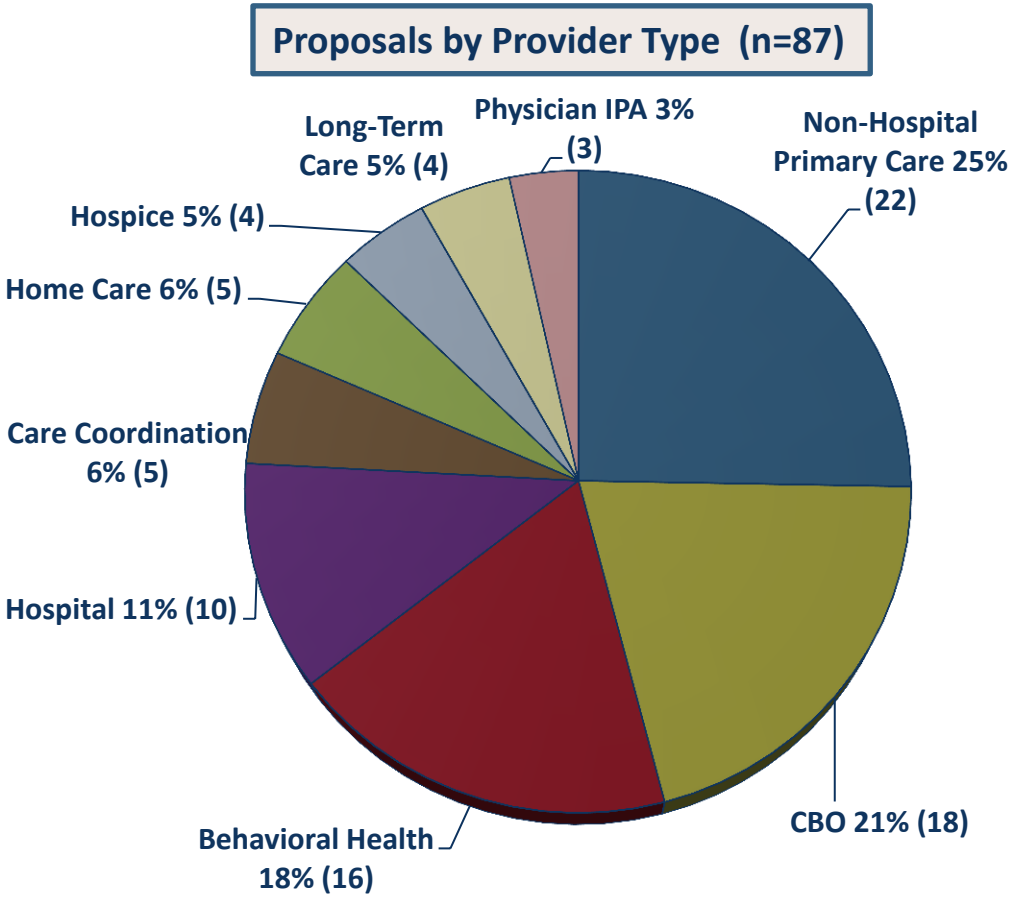
Proposals must demonstrate:

- Which measure(s) for what population to which the project will be dedicated
- How work will accelerate VBP readiness
- How work will drive performance improvement and help PPS achieve 5-year targets
- How program will sustain the gains post DY5
- How the project will achieve financial sustainability post DY5
- Budgeting for the pilot work, with sustainability in mind

**Review Work Group was comprised of CSO leads and selected members from the BPHC Project Advisory Committee.*

BPHC Received 87 Eligible Proposals*

Total number of all proposals received	**94**
Total number of eligible Proposals	87
Total number of unique organizations	34
Total number proposals by Tier 1 CBOs	12
Total number of Tier 1 CBOs	7
Total $ requested	**$19,497,591.22**



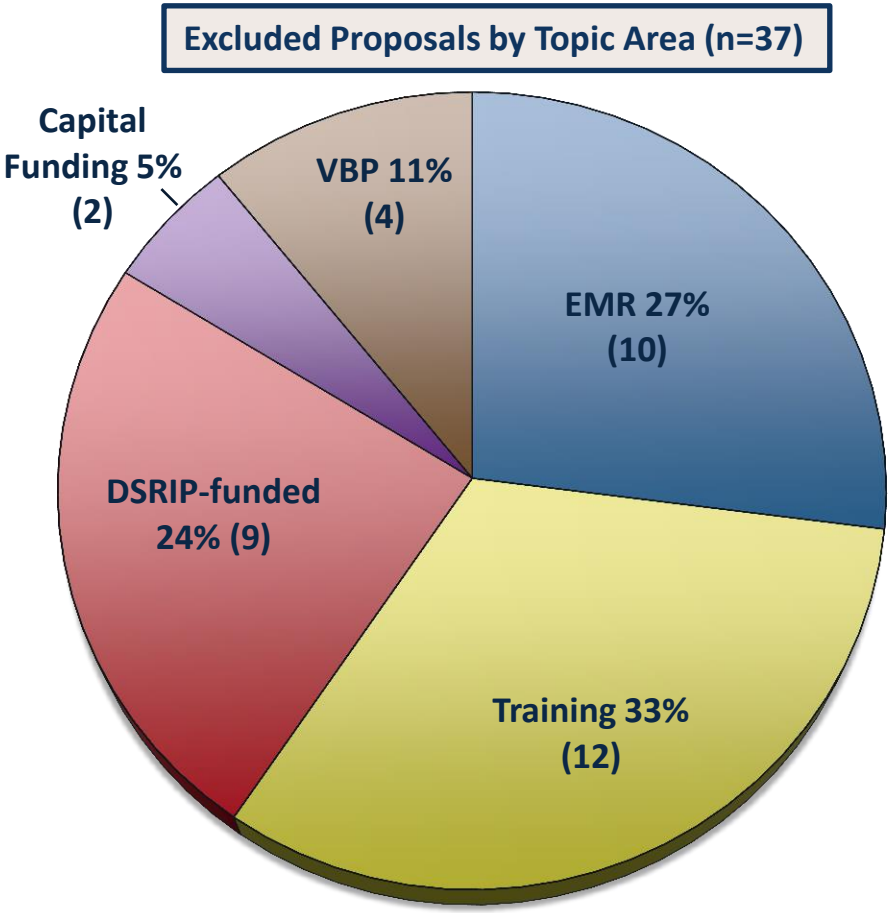
*Ineligible proposals included non-BPHC members and proposals over the five (5) proposals limit from any one organization.

BRONX PARTNERS FOR HEALTHY COMMUNITIES

SBH Health System BRONX

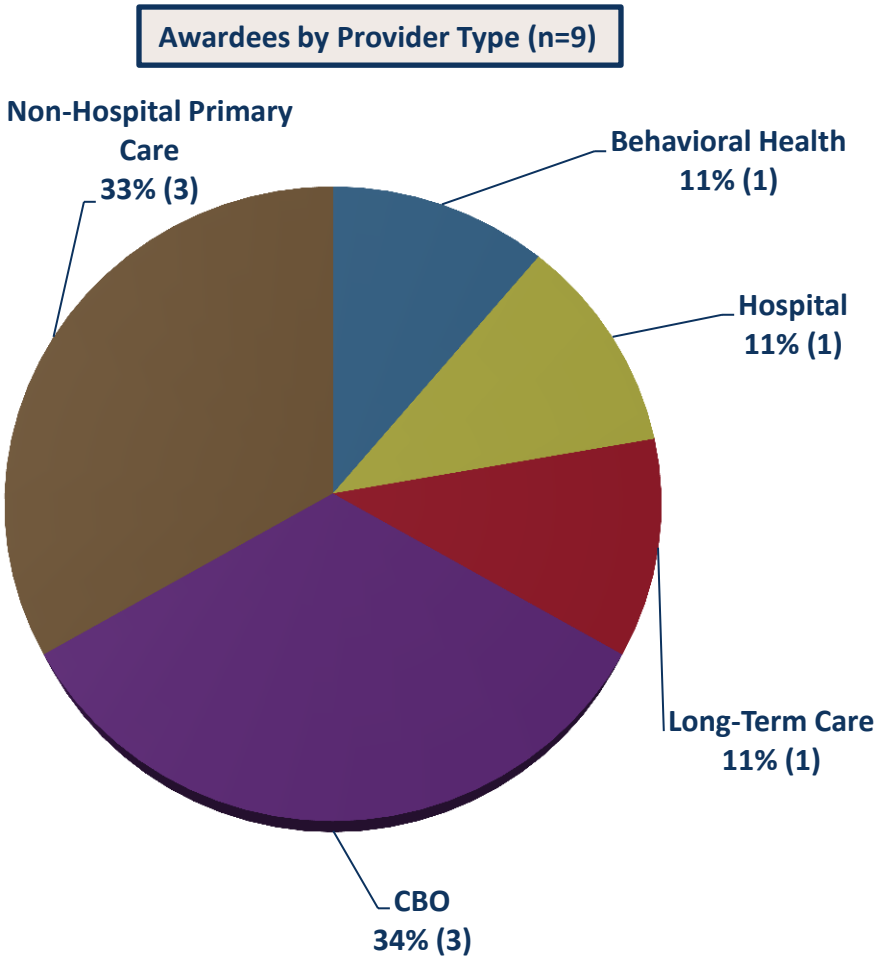
Excluded from the Innovation Fund

- **37 proposals** were removed from the Innovation Fund pool and were classified as programs that already have funding sources, specific to the organization or not relevant as innovation
  - Already DSRIP Program
  - Workforce Innovation
  - Wave 6 (post-acute care)
  - EMR-implementation
- The CSO is re-reviewing these proposals to strategize opportunities through other funding streams for current/emerging DSRIP programs

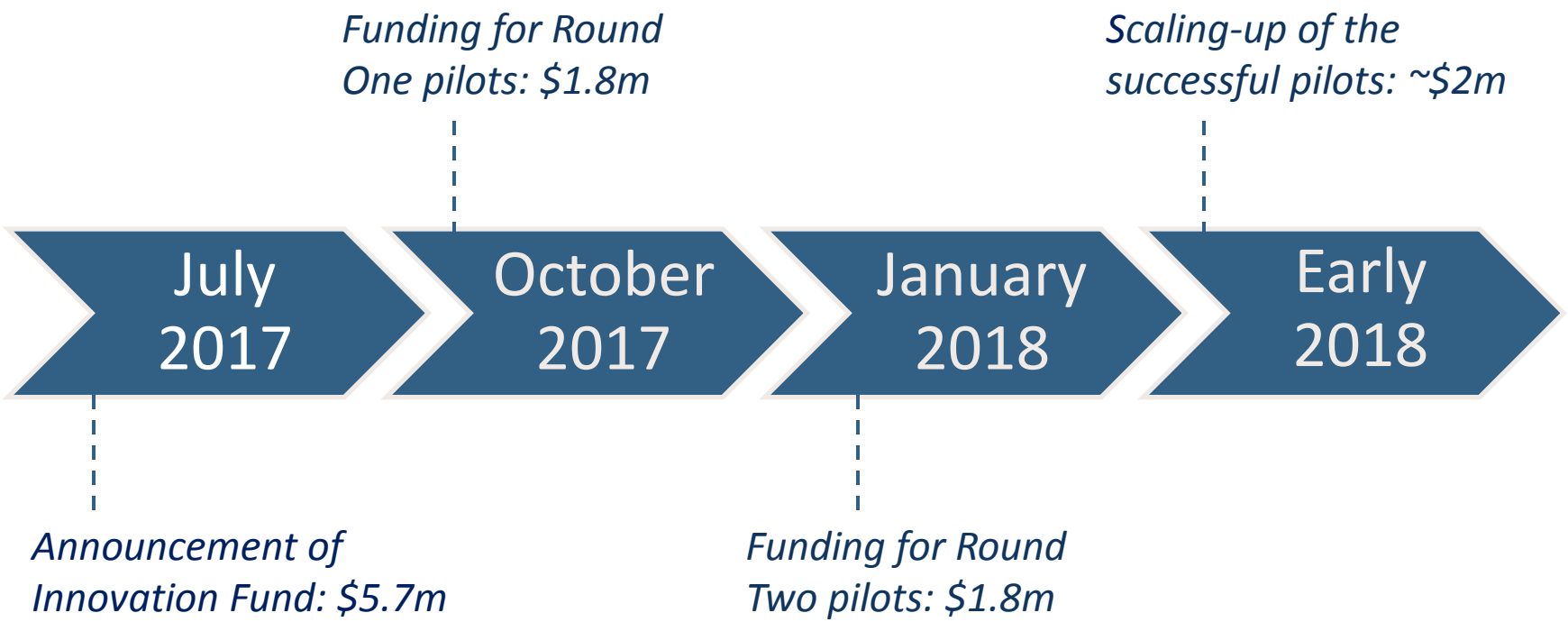


Awarded Organizations & Funding

	Organization	Award Amount
1	Acacia Network	$249,728.00
2	ArchCare	$136,000.00
3	BronxWorks	$250,000.00
4	The Institute for Family Health	$181,492.60
5	Mary Mitchell Family & Youth Center	$190,842.00
6	Northwest Bronx Community & Clergy Coalition	$250,000.00
7	Riverdale Family Practice	$143,703.00
8	Services for the Underserved	$231,790.00
9	SBH Health System	$211,575.00
	Total Funding	$1,845,130.60



Timeline for $ Distribution



The Finalists

Social Determinants of Healthcare Access and Utilization				
	Organization	**Proposal Summary**	**Targeted Metrics/Outcomes**	**Target Population/#**
1	**Acacia Network**	Utilize EarnBenefits Online to increase **enrollment in public benefits** for their clients, including Medicaid, SNAP, tax credits, heating/energy assistance and prescription drug coverage.	1. Keep families out of the emergency room 2. Med adherence 3. Home stability	Bronx Residents / 1,300
2	**ArchCare**	Expand TimeBank, a unique service exchange model that **reduces isolation of at-risk seniors**, in the Bronx with a special focus on **frail and/or homebound** Bronx residence.	1. Isolation 2. MH and physical health	225 homebound frail and elderly in Bx.
3	**BronxWorks**	Research, design, and provide start-up funds for a **medical respite** program in the Bronx that will fill the current gap in care for **homeless persons** who are medically appropriate for discharge from the hospital but **too ill or frail to recover** from a physical illness or injury on the streets or in the traditional shelter system.	1. Lower hospital lengths of stay 2. Decreased avoidable emergency department and inpatient use, 3. Improved health status	Homeless and Medically frail / 56

The Finalists *cont'd*

IT Innovations in Care Delivery, Patient Engagement and Education				
	Organization	**Proposal Summary**	**Targeted Metrics/Outcomes**	**Target Population/#**
4	**The Institute for Family Health**	Use an electronic, **web-based consultation** (eConsults) platform to obtain evidence-based recommendations from **specialists** for patients within the **primary care setting**.	1. CAHPS – Care Coordination 2. CAHPS – Getting Timely Appointments, Care and Information; 3. Reduction of ED visits and re-admissions	Primary Care Patients / 40,000
5	**Services for the Underserved**	**Telepsychiatry** to connect low income individuals, who are **currently homeless** and living in shelters, to medication prescribing and management and mental health counseling.	1. MH patient engagement 2. Depression 3. Medication adherence 4. PPR, PPV	3,000 Bronx BH patients, including DV shelter residents
6	**SBH Health System**	Incorporate **RxUniverse**, the prescription and **patient-engagement** platform, into provider **workflows**.	1. Reduction in ambulatory care 2. Patient self-monitoring 3. Patient education and self-management 4. Medication adherence	SBH asthma patients

The Finalists *cont'd*

Change Management and Performance Improvement				
	Organization	**Proposal Summary**	**Targeted Metrics / Outcomes**	**Target Population/#**
7	**Mary Mitchell Family and Youth Center**	Build off the food buying club, La Canasta, to utilize the "**food as medicine**" model to prevent and manage **Diabetes**.	1. Change the culture of health 2. Education on how to use food as medicine 3. Improve HTN, DM, and A1c	Patients with DM / 96 patients
8	**Northwest Bronx Community and Clergy Coalition**	**Asthma hot-spotting**, building-wide **integrated pest management** (IPM) and deepen resident **engagement**/ leadership **training**.	1. Asthma-related PPV, PPR 2. Improved behavior and self-agency of residents 3. Reduce healthcare costs for patient/system 4. Increase number of symptom-free days for asthma patient 5. Local jobs and business development	NW/Central Bronx residents living in hot spot (highest asthma-related ED and hospital admissions) buildings
9	**Riverdale Family Practice**	Comprehensive diabetes care by investing in retinal Imager to **screen diabetes** patients for retinopathy, iPRO2 Continuous Glucose Monitoring to **monitor glucose** levels over time and **diabetes education** classes in primary care setting.	1. PPV 2. A1c>9 3. BP	High-risk DM2 population

PERFORMANCE PAYMENT PROGRAM

Multiple methods to drive improvement

BPHC plans to drive Continuous Quality Improvement (CQI) efforts through several different channels.

Direct financial support

SPRINT
(Concluded summer 2017)

Pay for ProXy Provider Incentives (P4X)

Implementation Renewals*: Pay for Reporting (P4R)

Pay for Performance (P4P)

Non-financial support

MAX Series

Improvement Workgroup (IWG) Initiatives

* Renewals of contracts for Implementation Funds for Ambulatory Care and Hospital Programs

Performance Payment Opportunities

Measures for all programs approved by QCIS and Executive Committee.

The Marathon

Component	Performance Period	Objective	Participants
SPRINT	April-June 2017 (MY3)	Close as many care gaps as possible in 11 Priority Measures for MY3; pilot continuous quality improvement program	Select Primary Care Orgs, CMAs and Community Pharmacies
Implementation Renewal: Pay for Reporting (P4R)	Fall 2017- Summer 2018 (MY 4)	Continuation of DY2 Start-up funding in DY3; collect data on priority measures, establish P4X baseline	Eligible Partner Orgs
Pay for ProXy Provider Incentives (P4X)	Fall/Winter 2017- Summer 2018 (MY4)	Single stakeholder continuous quality improvement	Eligible Partner Orgs
Pay for Performance (P4P)	Ongoing (MY2-MY5)	Pass through funding from NYS earned by BPHC on to contributing stakeholders	Stakeholders determined by IWG/QCIS

Sprint Gaps Closed to Date

Results of the Sprint for Seven MY3 Priority Measures (March – June 2017)

BPHC allocated up to $775,000 to support MY3 performance improvement work

	Controlling High Blood Pressure	Follow-up care for Children Prescribed ADHD Meds - Initiation Phase	Follow-up care for Children Prescribed ADHD Meds - Continuation Phase	Diabetes Screening for People with Schizophrenia or Bipolar Disease Using Antipsychotics	Diabetes Monitoring for People with Diabetes and Schizophrenia	Cardiovascular Monitoring for People with CVD and Schizophrenia	Comp. Diabetes Care - HbA1c Poor Control
Maximum Allowed	1253	70	52	238	164	52	1253
Submitted	1610	84	142	427	142	124	1113
Approved*	1275	71	113	335	112	80	953
Funded	846	39	27	158	86	26	807

- Goal: Close as many care gaps as possible in 11 Priority Measures (Antidepressant adherence and Follow-up after Mental Health Hospitalization not shown) for MY3, our highest valued, most readily impacted measures worth $13.2M for MY3
- This data only includes final gaps closed by SBH Health System, Montefiore Medical Center, Union Community Health Center, Bronx United IPA and Acacia Network. The remaining numbers of preliminary.

* “Approved” includes gaps closed by some partners who did work in excess of contracted maximum amounts.

The Marathon

BPHC CSO has chosen to divide P4X funding ($5.7M) between three rounds:

Rounds 1 and 2:

- Rounds 1 and 2 distribute funds to BPHC partner organizations based on their primary care attribution and their performance on sets of key primary care proxy measures.
- Round 1 will run for six months and Round 2 will immediately follow Round 1.
- New or additional proxy measures may be added to Round 2 based on Round 1 performance or MY3 performance data.

Round A:

- Distributes funds to BPHC partner organizations based on their behavioral health claims (a proxy attribution) and performance on behavioral health proxy measures.
- Additional partner organizations and proxy measures may be added.
- Note: Round A timing is still being determined and will likely overlap with Rounds 1 and 2.

Proxy Measures Round 1
Improve % of patients (broken down by age group) with Well visit in past year
Improve % of patients with essential HTN who are controlled
Improve % of patients with diabetes and A1C>9
Improve number of health home at risk care plans developed per month
Improve % of diabetics with Retinal Exams in past month
Improve % of patients with RHIO Consents

The Marathon *cont'd*

- IWGs are working to improve multi-stakeholder measures (e.g. PPV) and this work will improve our performance for MY4
- Pay for Performance payments from state reflect PPSs work on these measures
- Funds flow for P4P will take into account member participation, attribution or proxy attribution, and stakeholder type
  - Primary Care (Adult & Peds
  - Specialty Care (Outpatient)
  - Care Management (Health Home)
  - Pharmacy Services (Outpatient)
  - Home Health Services
  - Emergency Services
  - Hospital Services (Inpatient)
  - Mental Health Services (Inpatient & Outpatient)
  - Substance Abuse (Outpatient, Nonresidential, Inpatient, Residential, Detox & Rehab)
  - Skilled Nursing Facilities
  - Urgent care
  - Short Term Housing (Shelter)
  - Transportation Needs
- MY2 P4P funds released to PPS in winter and spring and then will be distributed.

MAX SERIES

Evolution of the MAX series at BPHC

- First BPHC MAX series at SBH Health System
  - Revealed means of reducing **ED** utilization by addressing needs of patients with Substance Use Disorder and Mental Illness
  - Due to highly regulated environment of data exchange for these populations it is difficult to gain and share historical utilization among institutions without patient consent, so those patients were not a focus
- MY2 performance in DSRIP measures show that the substance use/behavioral health population has uncharacteristically high utilization in potentially preventable ED visits and readmissions
- Current MAX series focuses on reducing **inpatient** utilization amongst high utilizers with a behavioral health focus to determine interventions to reduce such utilization

First Max Series for High Utilizers

September 2015 – March 2016

Our Baseline

(Data reflects Nov '14 – Oct. '15)

Our initial cohort was defined as the top 50 ED treat and release patients

50 Patients
(0.06% of total)

=

3195 ED Visits
(2.74% of total)

270 IP Admissions
(1.1% of total)

Our Actions (Workshop 2 Action Plans)

1 Classify Homeless Status

47 patients *classified as homeless and* ***15 identified*** *as Safe Haven eligible*

2 Implement ED Flag

ED Flag includes all 50 SU patients *and alerts counselors when SU patients enter the ED, or are admitted*

3 Formulate Workflow

Trained security guards and counselors to help ***connect 7 patients to housing, or the Living Room***

ED-Living Room Shuttle

Partnered with Bronxworks to shuttle patients from ED to 24-hour-drop-in center; have transported 81 patients since 3/22/16 and monitoring their connections to services and subsequent utilization

Max Series for High Utilizers *cont'd*

Our Impact

(Data reflects Nov. '15 – Apr. '16)

50
Cohort patients

15 (30%)
Identified as eligible for Safe Haven beds

4 (27%)
Eligible patients have presented in the ED

3 (75%)
Patients that presented connected to a Safe Haven bed

Connected patients have 10.33 fewer ED visits/month since Safe Haven engagement (90.7% reduction)

Total Cohort (All 50 Patients)

	Before (May '15-Oct. '15)	After (Nov '15.-Mar. '16)	%Δ
ED Visits	248 /month	159 /month	-36%

- On an annual basis, connecting these 3 patients to services is projected to **prevent 124 ED visits**

Our Story

EB is a 50 year old homeless male who has been chronically homeless for 13 years and chronically uses alcohol; he has had 103 ED visits between May 2015 to March 2016. As a Super Utilizer, when the patient presented on 3/15/2016, his **need for housing** was identified, he was **engaged by the Homeless Outreach Team,** transported to the Living Room and **assigned a Safe Haven bed.** His assigned **care manager** continues to work with the patient, connecting him with a **psychiatrist** and a **day program** for substance abuse and intellectual disabilities. He has presented to the ED only once since being engaged.

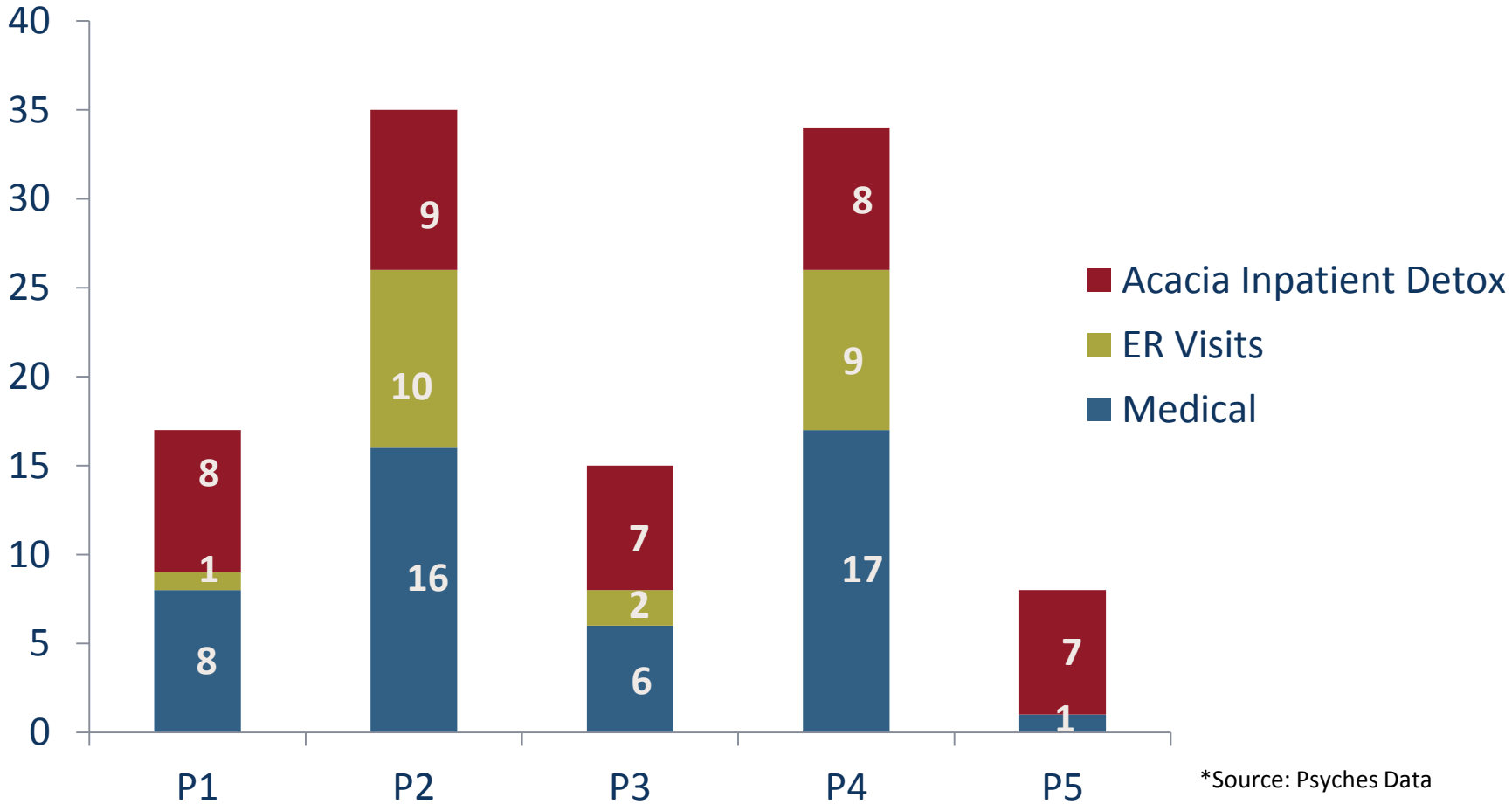
BPHC MAXny series have kicked off

- BPHC is participating in three MAXny projects:
  - Reducing readmissions among patients on SBH detox (facilitated by Rebekah Epstein)
  - A partnership between Acacia Network and SBH Health System to reduce readmissions for patients known to Acacia (facilitated by Meredith Stanford)
    - **UPDATE: Program kicked off with completion of site visit. Historical data collection will require patient consent. Identification and intervention workflows being considered. Drivers of Utilization interviews underway! First workshop occurred on September 18th.**
  - Reducing readmissions among patients on SBH Mental Health units (facilitated by Caitlin Verrilli)
    - **UPDATE: Program in planning stages with site visit scheduled for September 20 and first workshop scheduled for late September/early October.**

Review of Detox High Utilizers

- **TABLE OF CONTENTS**
  - Historical Hospital Admission Trends
  - Clinical Findings
  - Recommendations/MAXny Series Future Plans

Integrated View of Last 12 Months*



*Source: Psyches Data

Clinical Findings

- **Medical Conditions**: Most hospitalizations were for a mental or physical illness, not additional substance abuse treatment. The most frequent medical diagnoses were: Hypertension and Hepatitis with other chronic conditions of asthma and acute kidney failure.
- **Substance Abuse Diagnosis**: Opioid Dependence was the common substance abuse diagnosis.
- **Mental Health Conditions**: The most common mental health diagnosis is Unspecified Depressive Disorder. Additionally 3 patients presented with a secondary diagnosis of Unspecified Bipolar.
- **Social Determinants of Health:** There was striking trend of homelessness, unemployment, and lack of family/social support system.

MAXny Series Future Plans

- **Identify and address risk factors**:

  Assess for health and social determinants risk factors and implement policy and procedure to reduce readmissions.

  Implement team based care

  Provide improved patient education and self management support during and post discharge.

- **Optimize Discharge process**

  Implement protocol checklist to ensure best practices in risk stratified discharge planning, including procedures for health home care management , and bridging time between discharge and admission to next level of care.

  Design post discharge continued engagement for high risk patients through peer advocates, hotline, telephone/text or other practices.

Review of Detox High Utilizers

- **TABLE OF CONTENTS**

Summary of Current MAX Work

Workshop #1 Strategies:

1. In-Patient Unit Focus Group: conversations with patients to identify their drivers of utilization using the Social Determinants Questionnaire
2. Whiteboard Rounds: using the psychiatry department's model; MDs, PAs, nursing, counselors, and social work all involved
3. Referral to Critical Time Intervention (CTI): identifying patients who meet the requirements of CTI using an appropriateness screen with social work

- **The Action Team has weekly check-in calls and Workshop #2 is scheduled for September 22nd**

Detailed Case Study

HISTORY

- 21-year old male
- Medical hx of mental illness and metabolic disorder
- Homeless for approximately 2-3 years since his aunt (with whom he was living) died
- Riding the trains and comes to SBH Health System because he does “not have anywhere else to stay”
- 2015 – 82 ED Visits
- Costs/charges associated with those ED visits - $68,553 (1.3% of charges for the hospital for this period of time)

ACTIONS

- Bronxworks contacted and A Safe Haven Bed assigned
- HRA/housing application initiated
- SSI benefits assistance to reinstate service
- Medications filled by SBH
- Health home enrollment
- Critical Time Intervention referral

Future Plans

- Continue to learn through engaging individual patients referrals and resources that will address drivers of utilizations and improve care transitions
- Refer patients appropriate for Critical Time Intervention (CTI) services to this service
- Workshop #2 focus: Development of three more strategies to work with this population
  - BronxWorks will be in attendance to guide strategy development around housing referrals
  - Riverdale Mental Health Association and Visiting Nurse Service of New York will also be present to help develop a CTI appropriateness screening tool

WORKFORCE DEVELOPMENT

CULTURAL COMPETENCY

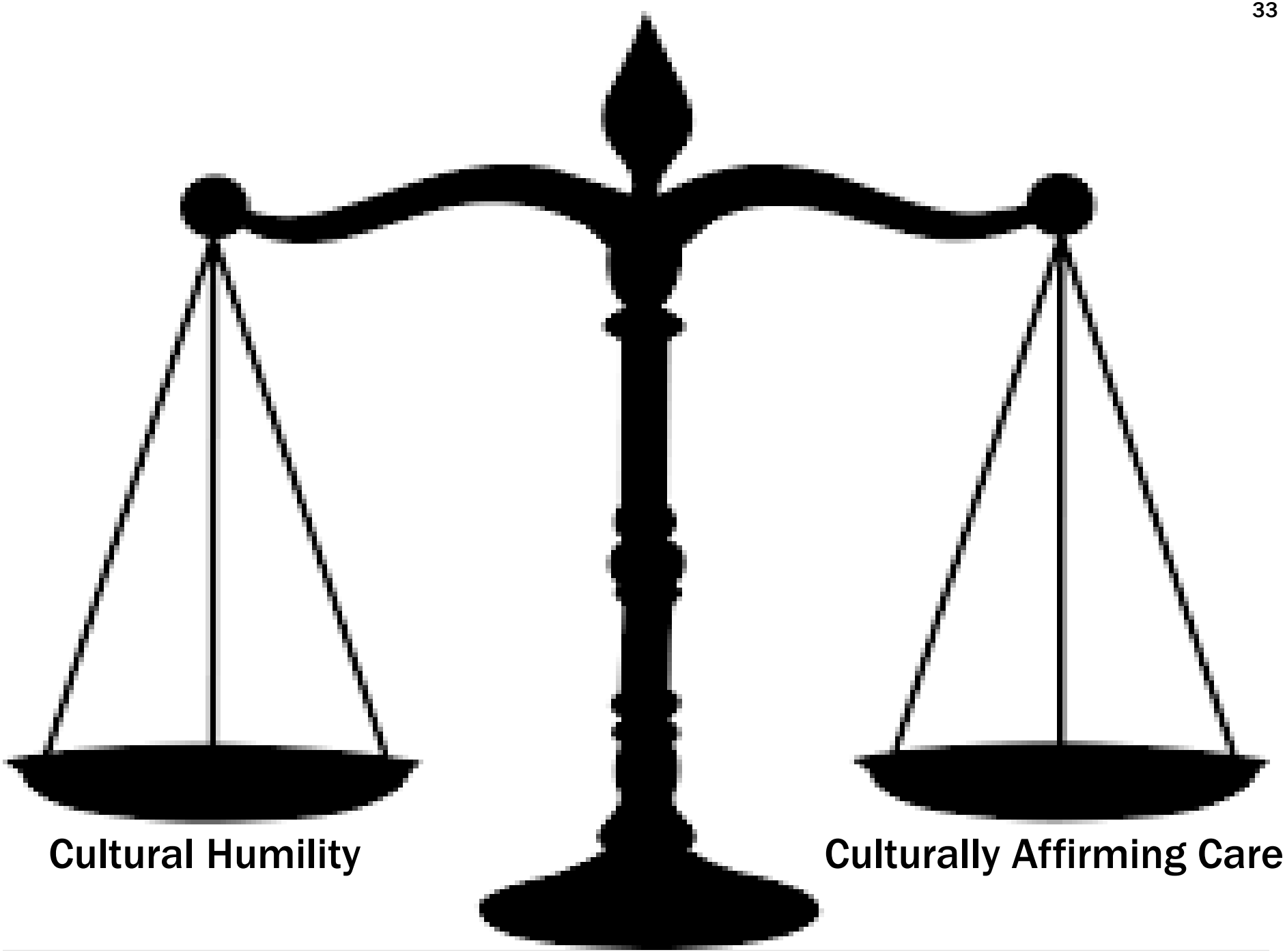
FOR BRONX PARTNERS FOR HEALTHY COMMUNITIES

Lisa Martin, Ph.D.

2017

Martha K. Selig Educational Institute

The Jewish Board
Health and Human Services for All New Yorkers


Cultural Humility
Culturally Affirming Care

PROGRAM

COMMUNITY

SELF


NORTHWEST BRONX
OMUNITY AND CLERGY
COALITION


PS 23
FEB 1949
CLASS 2-2


Muslims
are not all
terrorists


I can
actually
SEE you


MY HAIR
IS REAL


Ill MARRY
whoever
I WANT.


I AM NOT
A
COLOR


I will
NOT CUT
YOUR GRASS


We're
NOT
All MEXICAN

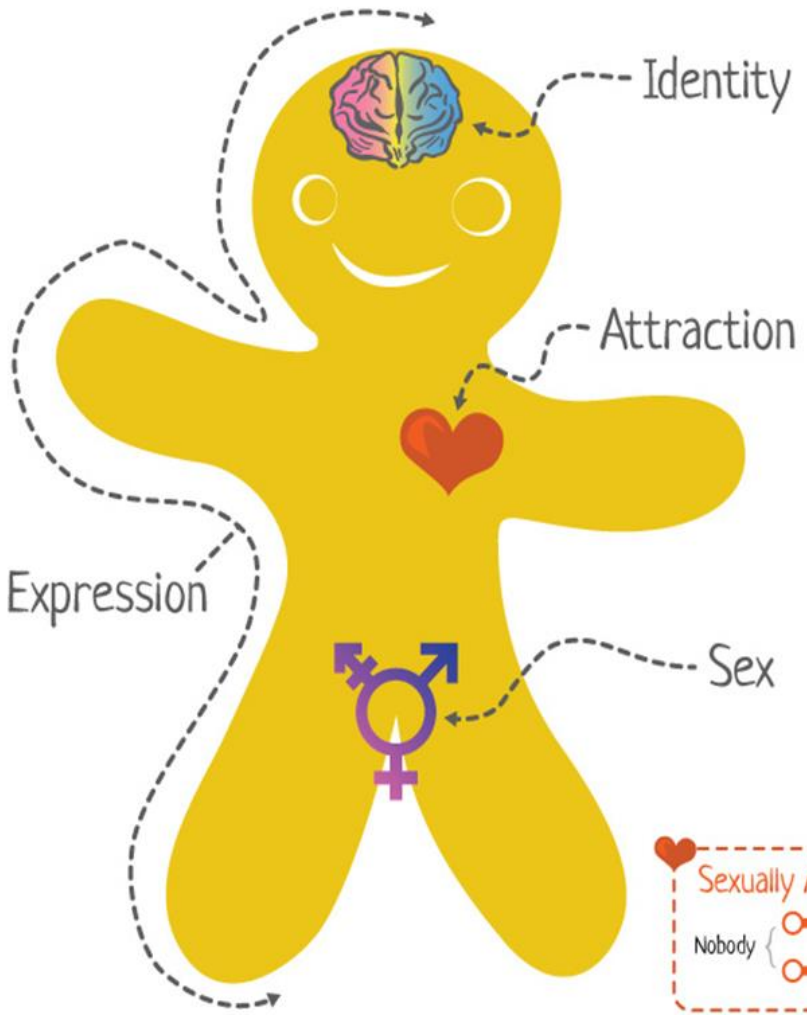

Not all Asians are
studious, have squinty
eyes, and speak the
same language.


I AM NOT
WHITE TRASH

The Genderbread Person v3.3

by it's pronounced METROsexual .com

Gender is one of those things everyone thinks they understand, but most people don't. Like *Inception*. Gender isn't binary. It's not either/or. In many cases it's both/and. A bit of this, a dash of that. This tasty little guide is meant to be an appetizer for gender understanding. It's okay if you're hungry for more. In fact, that's the idea.



Plot a point on both continua in each category to represent your identity; combine all ingredients to form your Genderbread

4 (of infinite) possible plot and label combos

Gender Identity

⊘ Indicates a lack of what's on the right.

- Woman-ness
- Man-ness

"woman" "man" "two-spirit" "gender-queer"

How you, in your head, define your gender, based on how much you align (or don't align) with what you understand to be the options for gender.

Gender Expression

- Feminine
- Masculine

"butch" "femme" "androgynous" "gender neutral"

The ways you present gender, through your actions, dress, and demeanor, and how those presentations are interpreted based on gender norms.

Biological Sex

- Female-ness
- Male-ness

"male" "female" "intersex" "MtF Female"

The physical sex characteristics you're born with and develop, including genitalia, body shape, voice pitch, body hair, hormones, chromosomes, etc.

Sexually Attracted to

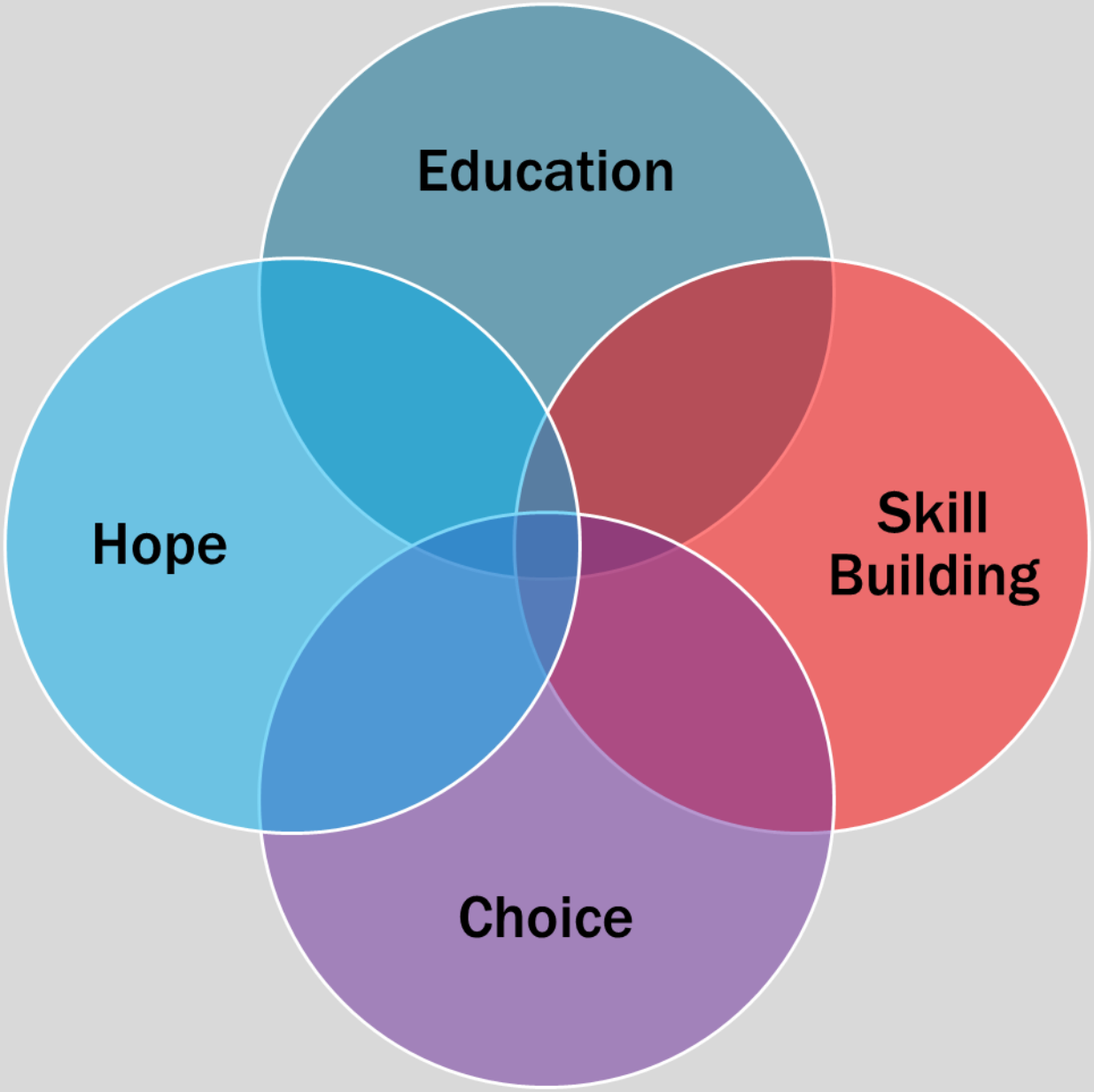
Nobody
- (Women/Females/Femininity)
- (Men/Males/Masculinity)

Romantically Attracted to

Nobody
- (Women/Females/Femininity)
- (Men/Males/Masculinity)

In each grouping, circle all that apply to you and plot a point, depicting the aspects of gender toward which you experience attraction.

For a bigger bite, read more at http://bit.ly/genderbread


Education
Hope
Skill Building
Choice

A Division of the New York Legal Assistance Group
LegalHealth

Social Determinants of Health and the Law

How Patient Advocates Can Identify Legal Needs and Refer Patients for Services

Training by LegalHealth

(a division of the New York Legal Assistance Group)

New York Legal Assistance Group & LegalHealth

- **New York Legal Assistance Group** (NYLAG): each year, provides free civil legal services to over 76,000 low-income New Yorkers who cannot afford attorneys.
- A division of NYLAG since 2001, **LegalHealth**:
  - serves individuals with ***serious and chronic illness*** in the ***healthcare*** setting, with clinics on-site at hospitals;
  - ***trains healthcare professionals*** to understand the legal issues their patients face; and
  - sets off a chain reaction resulting in ***better patient health***, unnecessary hospital readmissions, and a decrease in healthcare spending.

Many Socioeconomic and Healthcare Disparities Have Legal Solutions

Substandard Housing	• Legal right to housing repair
Housing Instability	• Eviction prevention
Lack of Insurance	• Insurance access, appeals & other remedies
Food Insecurity	• Appeals of benefit reduction/denial
Lack of immigration status	• Immigration remedies
Employment uncertainties	• Legal rights of employees
Lack of family/caregiver support	• Homecare eligibility
Patients' and families' inability to manage environment	• Advance directives

Why Collaboration between Patient Advocates and Lawyers is So Important

Patient advocates (Case Managers, Community Health Workers, Care Managers, Social Workers, etc.):

- Are in a position to identify legal (and social, financial, or other) problems that a patient is experiencing
- Have special knowledge and trust-based relationship with patients, therefore patients will open up about legal issues
- Are a voice of authority
- Have expertise to take action on behalf of patients and prevent crisis, such as making legal referrals
- Can meet the patient where they are emotionally.

LegalHealth Training for BPHC Partners

- Recognizing the significance of social and legal determinants on health outcomes, LegalHealth and BPHC have developed a one-day training program to help patient advocates spot legal issues, take steps to help patients, and make legal referrals.
- Program topics:
  - Housing
  - Immigration
  - Domestic Violence
- Offered on October 23rd, October 30th, November 3rd, November 13th.
- Contact Maria D. Galafá (at mgalafa@sbhny.org or 646-773-2314) to register and with questions.
- Available to all PPS partners and staff.

Training, Section 1: Housing

- Housing and Health
  - Poor quality housing contributes to health problems such as infectious and chronic diseases, injuries and poor childhood development.
  - People who have difficulty maintaining stable housing are less likely to have regular medical care and are more likely to postpone treatment and to use the emergency room for treatment.
- Housing Training Objectives
  - Provide an understanding of the types of housing your patients live in and types of housing assistance that is available to your patients. Review the rights patients have with respect to their housing.
  - Provide tools you can use as an advocate to improve or stabilize your patients' housing, including legal referrals.

Training, Section 2: Immigration

- Immigration and Health
  - A person's citizenship status (e.g., citizen, legal immigrant, or undocumented alien) affects eligibility for benefits like Medicaid and the likelihood of having a job that offers benefits like insurance coverage.
  - Undocumented immigrants are more likely to be uninsured and less likely to see a doctor or receive other health care services than citizens.
- Immigration Training Objectives
  - Provide an understanding of the types of immigration statuses your patients may have, a brief overview their eligibility for benefits, and discuss the current immigration climate.
  - Provide tools you can use as an advocate to help immigrant patients and discuss when a legal referral is appropriate.

Training, Section 3: Domestic Violence

- Domestic Violence and Health
  - Domestic violence contributes to health problems such as depression, anxiety, sleep disturbances, as well as the physical injuries from physical abuse.
  - People who are experiencing domestic violence are less likely to seek out assistance from the police and others, and may be unable to get medical care regularly. They are more likely to postpone treatment and to use the emergency room for treatment.
- Domestic Violence Training Objectives
  - Provide an understanding of what constitutes domestic violence, the ways in which it can manifest in your patients, and the remedies that may be available to your patients.
  - Provide tools you can use as an advocate to increase your patients' safety, including legal referrals.

Legal Referral Resources Tool

- For the purposes of this training, BPHC and LegalHealth have composed a comprehensive list of Legal Referral Resources for patients in the Bronx.
  - Trainees will be provided with a copy of the tool.
  - The organizations listed provide direct legal services, helpful legal information and/or referrals in the following categories:
    - Advance Planning, Bankruptcy, Consumer Law, Criminal, Economic Justice, Employment Law, Family, General Civil Legal Services, Government Benefits, Guardianship, Housing, and Immigration.
  - BPHC will update this list of legal resources periodically and post it on our website: www.bronxphc.org/workforceresources.

Bronx PPS Collaboration

Know Your Primary Care Physician Campaign

BPHC COMMUNICATIONS UPDATE

Bronx PPS Collaboration

- Bronx PPSs:
  - Advocate Community Providers
  - Bronx Health Access (Bronx-Lebanon)
  - Bronx Partners for Healthy Communities
  - OneCity Health (NYC Health + Hospitals)
- Previous Collaborations:
  - Workforce Survey and Analysis
  - 100 Schools Project
- Current Initiatives – Communications:
  - Maximize resources and align messages around shared communications priorities that focus on patient health and wellness
    - Know Your Primary Care Physician Campaign

Know Your Primary Care Physician Campaign

Awareness campaign to educate community, under-utilizers and patients who rely on ED for their medical care on the benefits of visiting their primary care physicians (PCPs) for their health care

Message themes

- Get to know your PCP
- Five reasons to visit your PCP
- What are urgent care centers

Toolkits for BPHC members

- Handout
- Web articles
- Social posts
- Video

BPHC RESOURCE DIRECTORY

Bronx Resource Directory

BronxResourceDirectory.org

or

visit bronxphc.org

- Online, searchable tool featuring our PPS member organizations and range of services they offer to Bronx community.
- Users can conduct searches by name of organization, location, services offered, and more.
- Organizations can update their information at any time to ensure that their Resource Directory page is timely and accurate.

Bronx Resource Directory

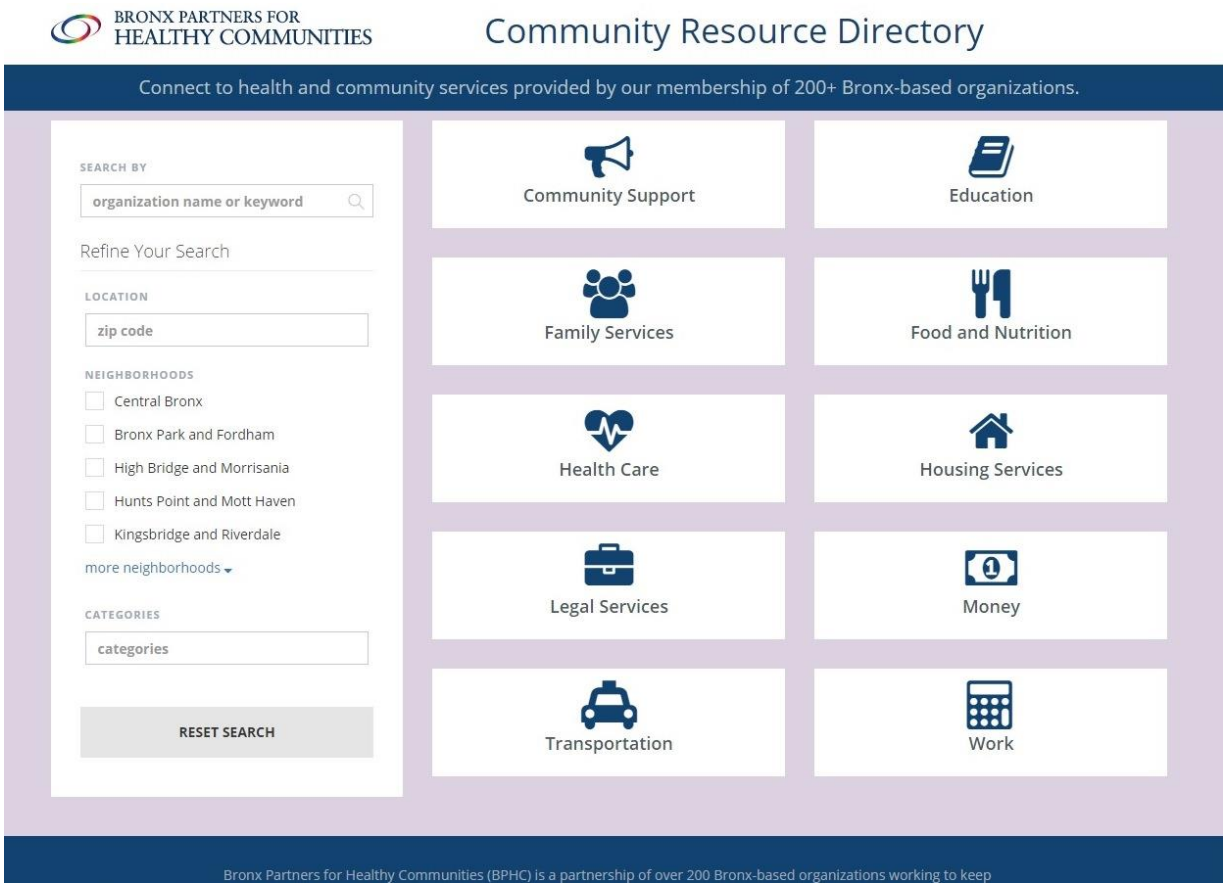
Project of BPHC Community Engagement Workgroup

- Engage community-based organizations
- Feature vast array of programs and services provided through our PPS membership

Developed for all users:

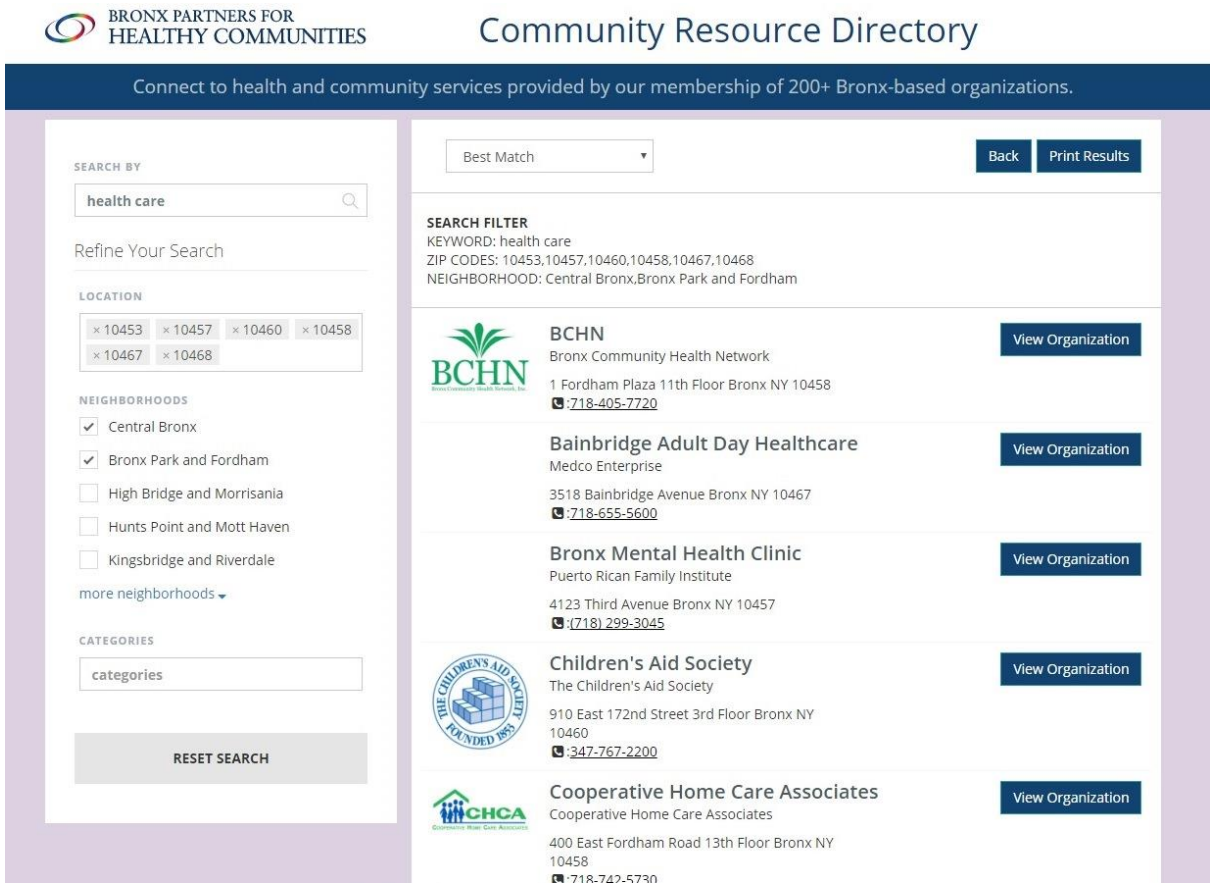
- PPS member organizations
- Non-PPS member organizations
- Public

Bronx Resource Directory



Main Page

Bronx Resource Directory

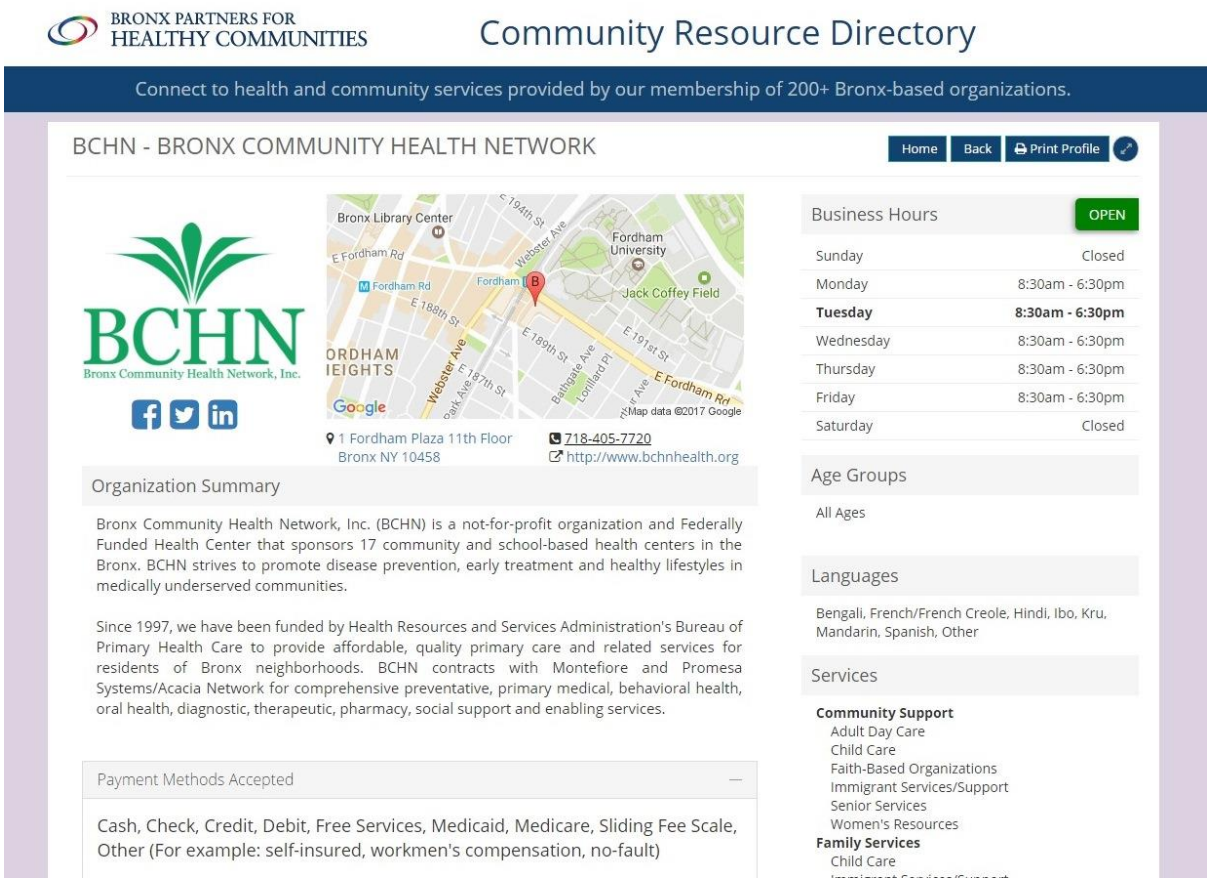


Sample Search Results

BRONX PARTNERS FOR HEALTHY COMMUNITIES

SBH Health System BRONX

Bronx Resource Directory



Sample organization profile

Bronx Resource Directory

BronxResourceDirectory.org

To include your organization in the Resource Directory,
e-mail: Albert Alvarez at AAlvarez3@sbhny.org.

Contact Information for BPHC Leadership

Irene Kaufmann: ikaufmann@sbhny.org

Amanda Ascher: aascher@sbhny.org

J. Robin Moon: jrmoon@sbhny.org

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.