BRONX PARTNERS FOR HEALTHY COMMUNITIES

SBH Health System BRONX

All-Member Webinar

March 20, 2018

Agenda

- Welcome
- BPHC Program Update
  - Wave 6 (Post-Acute Care)
    - Home Care Training
    - Nursing Homes
    - Critical Time Intervention
  - Community Behavioral Health Initiative
- MY2 P4P Distribution
- BPHC Innovation Fund
  - Acacia's Benefits Identification Program
- RHIO Consent Training
- Q&A
- Concluding Remarks

WAVE 6 (POST-ACUTE CARE) UPDATE

Home Care Training

BPHC Pilot Program: Home Care Aides' identification of worsening chronic conditions to avoid potentially preventable ED visits (PPV) and hospital readmissions (PPR)

Purpose of Project

- Develop pilot for home care aides to methodically identify (using tools) and report worsening conditions for patients with CVD, diabetes and COPD resulting in reduced PPV, PPR

Priorities for Home Care Training

- Training to enhance competencies of Home Health Aides to increase awareness of chronic conditions and utilize tools to help evaluate the worsening of these conditions
- Training design includes day-long classes for 20 participants at each agency and training sessions for supervisors
- Training provided by 1199 Home Care Industry Fund

BPHC CQI Team Working with Agencies

- Data collection and analysis: use of Bronx RHIO for pre and post data
- Develop and implement improved work flows and information exchange between home care agency and care team
- Regular check-ins and support for Home Care Agencies as needed

Home Care Training *cont'd*

BPHC Pilot Program: Home Care Aides' identification of worsening chronic conditions to avoid potentially preventable ED visits (PPV) and hospital readmissions (PPR)

Participating Agencies

- Participating agencies include Self-Help, Best Care, Best Choice (CenterLight), RAIN, Accent Care, People Care, Cooperative Home Care Associates and All Metro Home Care in cooperation with 1199 SEIU
- Each agency has representatives for decision making, coordination of training, data collection, and monthly data reporting during trial
- Twenty patients and aides will be identified from each agency meeting certain criteria

Timeline

March - Kick off
- Identify patients meeting criteria
- Identify home health aides for training
- Support work flows and data collection

April
- Training for staff and supervisors

May - October
- Trial tool implementation and data collection

November
- Data analysis
- Final report
- Decisions about expanding training

Nursing Homes

- Nursing Homes/Long-term Care/Rehab
- Post-acute care focus groups conducted with CenterLight, Rebekah Rehab, Providence Rest, Centers Health Care, Daughters of Jacob, Archcare, and Bainbridge
- Identified priorities:
  - Reduce re-hospitalization
  - Expand resources for behavioral health
  - Improve care transitions (from hospital to nursing home, nursing home to community)
  - Improve care coordination between settings
  - Interconnectivity (RHIO)
- Invitations to participate issued and proposals were submitted to select 6-month pilot projects to begin in January 2018

Nursing Homes *cont'd*

$300,000 Awarded for Nursing Home Pilots

- Three six-month pilots selected from five proposals for implementation as below to reduce re-hospitalization rates, unnecessary emergency room visits and transitions for medically frail patients, and expand resources for providing quality care

Selected Organization	Project Type	Pilot Objective
Providence Rest Nursing Home	Emergency telemedicine	Prevent re-hospitalization during hours when a physician is not on call at nursing home
Grand Manor Nursing and Rehabilitation Center	Combined telemedicine/ telepsychiatry	Enable consultations with emergency, primary care, and specialists (including psychiatrists) to prevent re-hospitalization and reduce transitions for medically fragile patients
Centers Health Care	"Direct Admit"	Engage Centers' five Bronx-based nursing homes in tracking patients at-risk of re-hospitalization and work with their community-based health care providers to refer the patient directly back into the nursing home if additional care is needed to reduce re-hospitalization rates

Critical Time Intervention (CTI) Year 1 Complete

Program Review

Goal: provide a time-limited intervention to support patients with SMI and homelessness during periods of transition and reduce avoidable hospital use

- Role of CTI Case Managers
  - Support homeless or precariously housed SMI high utilizers in building community ties and ensuring continuity of care
  - Implement the evidence-based model over the course of a 9-month period
    - Phase 1: Transition
    - Phase 2: Try-Out
    - Phase 3: Transfer of Care
- Four BPHC partner organizations were selected to enroll ~80 individuals each in 2017 (RMHA, CBC, VNSNY, SCO)
- Early results show reduced utilization, increased use of PC/BH services and access to housing and employment services

Year 1 Outcomes

- Enrollment:
  - Goal: ~300 enrollees, based on needs assessment and limited historical data
  - Result: 298 referrals were made into CTI from 19 unique referral sources (primarily hospitals and shelters)
    - **159 clients successfully engaged**
      - 53% of referrals successful
    - 55 clients transitioned into Phase 3 (Health Home handoff)
    - 93 clients were engaged for less than 30 days and lost to follow up
- Hospital utilization:
  - Goal: Reduce days in a hospital setting* by 25%
  - Result: **55% reduction in days spent in a hospital setting among the 80-patient cohort engaged from January – June 2017**

	6-months Pre-CTI Start Date		6-months Post-CTI Start Date	
	Inpatient Days	ED Visits	Inpatient Days	ED Visits
Total Days	1409	236	492	254
Total Utilization*	1645		746	
% Change	55%			

BRONX PARTNERS FOR HEALTHY COMMUNITIES

** Days in hospital setting defined as ED visits + IP days:*
- *ED visit = 1*
- *Inpatient days = total length of stay*

SBH Health System BRONX

COMMUNITY BEHAVIORAL HEALTH INITIATIVE

CBH Collaborative

Aim

- Thirteen partner organizations participating in the CBH Collaborative aim to implement universal depression and substance use screening to:
  - Improve outcomes for clients with serious behavioral health disorders
  - Strengthen the healthcare delivery system
  - Prepare CBH organizations for value-based payment arrangements

CBH Collaborative Activities

Collaborative Learning Sessions

- June 14, 2017: Depression Screening Workflows and Best Practice Referrals
  - Keynote Address – Greg Allen, Director, OHIP, NYS DOH
  - Best Practices for Depression Screening - Dr. Virna Little, CUNY
  - Best Practice Referrals – Alvin Lin, Senior Managing Director, Strategy and Innovation, PCIP/NYC REACH
- October 17, 2017: Performance Improvement for Data, Screening and Referrals
  - Keynote Address – Pat Lincourt, Director, Division of Practice Innovation and Care Management, NYS OASAS
  - Performance Improvement Basics – Jane Taylor, Ed. D., Joslyn Levy and Associates
- March 2, 2018: Improving Performance and Outcomes to Achieve Clinical Integration
  - Building Effective Integration in the Bronx Using Nominal Group Technique - Mathew Roosa, ACSW, LCSW-R
  - Storyboard Rounds: Using Data for a Small Test of Change – Jane Taylor, Ed. D., Joslyn Levy and Associates

CBH Collaborative Update

Year 1 Accomplishments

Ability to Report on Rates of Screening, Brief Intervention and Referrals Across CBH Partners						
PHQ-2/9 Screening	SUD Screening	SUD Brief Intervention	SUD Referral	Tobacco Screening	Tobacco Brief Intervention	Tobacco Referral
84.6%	87.5%	87.5%	87.5%	92.3%	92.3%	61.5%

- Screening rate data is monitored to identify needed support, including areas where a PDSA cycle may be needed
  - Learning is accelerated through joint review of screening rates, best practices and resources across CBH Partners within and across workgroups
- Workforce training plans developed based on identified needs: Screening: PHQ-2, PHQ-9, Tobacco, SBIRT; Cultural Competency; Data Collection and Reporting; Quality Assurance, Quality Improvement, Performance Improvement; Privacy; and Value-based Payment
- Three organizations connected to the Bronx RHIO; others are in process with completion targeted by June 2018

CBH Collaborative Year 2

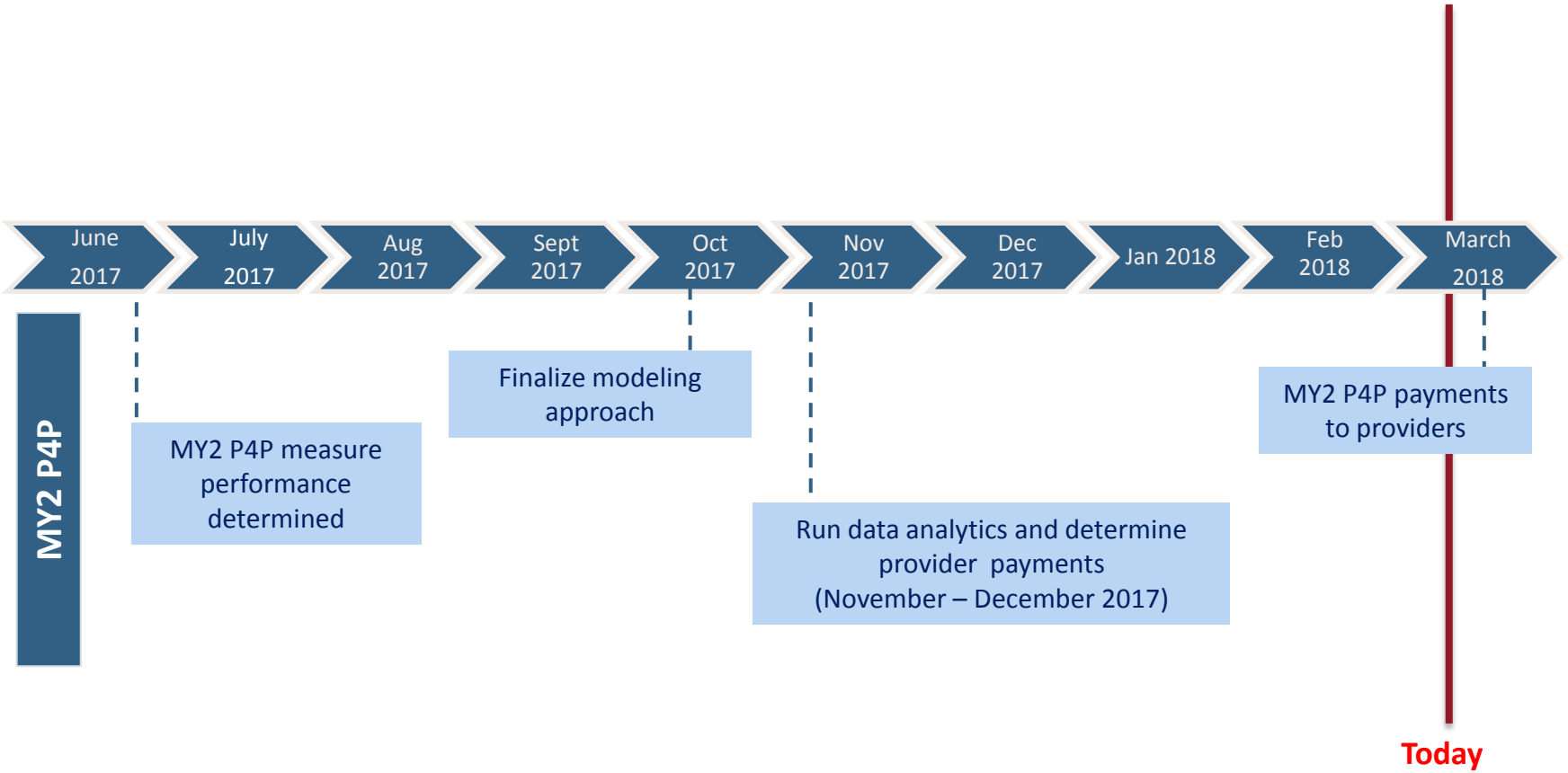
- CBH teams identified three areas of intent for Year 2:
  - Continue screening improvement work
  - Interconnectivity and effective, sustainable referral pathways between behavioral health, substance use and primary care providers
  - Establish operations around RHIO alerts for Behavioral Health Patient ED visits and discharges

BPHC P4P FUNDS DISTRIBUTION METHODOLOGY

BRONX PARTNERS FOR HEALTHY COMMUNITIES

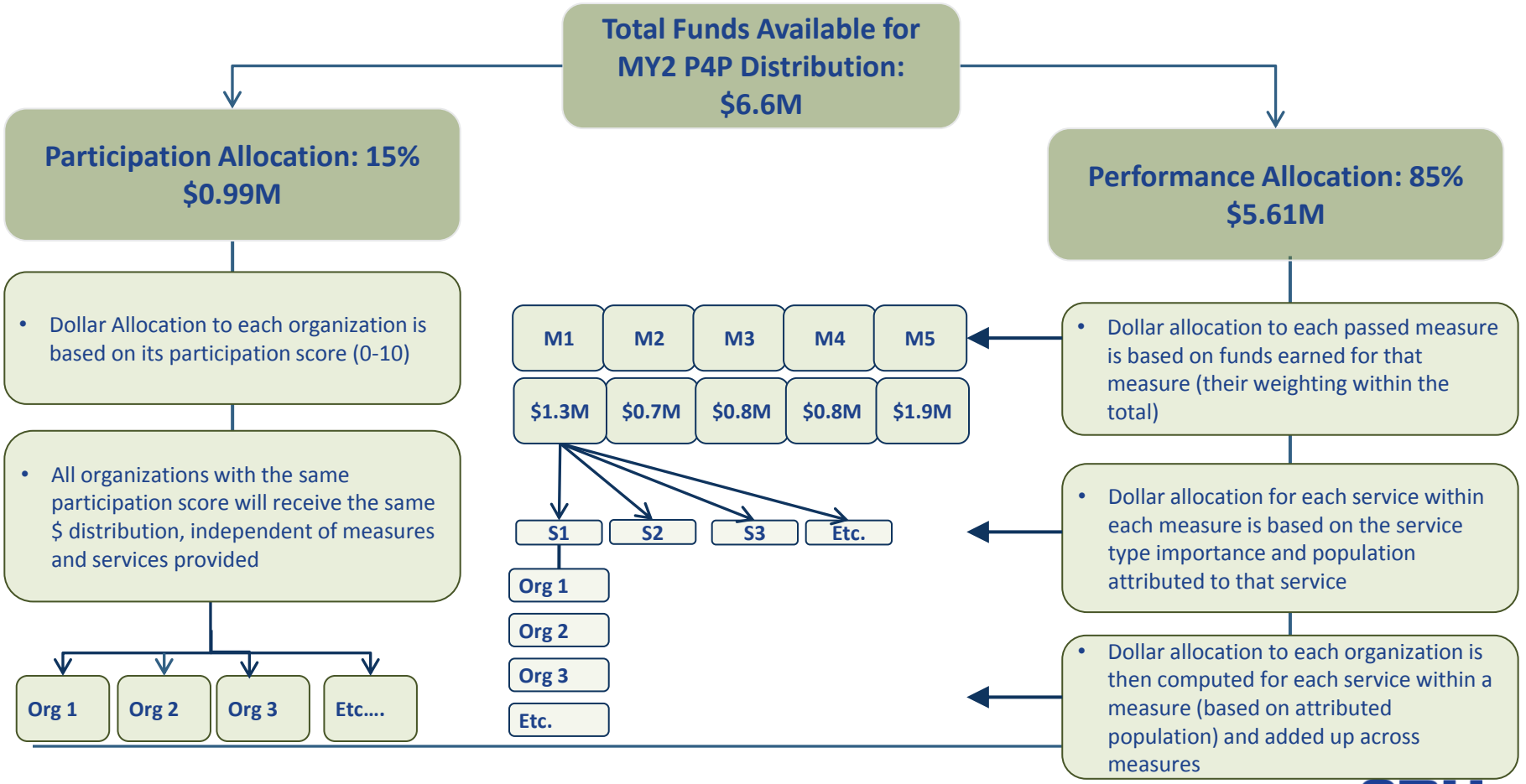
SBH Health System BRONX

MY2 P4P Analysis and Funds Distribution Timeline



Distribution Calculation: Example

Funds Allocation was computed for all organizations eligible for participation and performance dollar distribution.



BRONX PARTNERS FOR HEALTHY COMMUNITIES

SBH Health System BRONX

MY2 P4P Measures BPHC Passed

Measure	MY2 Results (6/2016)	MY2 Target	Weighting based on MY2 Dollars Earned	MY2 P4P Dollars flowing to BPHC members for performance by measure*
Diabetes Screening (Antipsychotic Med)	82.52	80.71	14.7%	$ 824,670
PDI 14 – Pediatric Asthma	361.48	781.85	23.7%	$ 1,329,570
Antipsychotic Medication Adherence	60	59.47	14.7%	$ 824,670
Medication Mgmt for Asthma (50%)	60.83	59.95	11.9%	$ 667,590
Diabetes Monitoring (DM & Schizophrenia)*	68.43	70.03	35%	$1,936,500
			100%	**$5,610,000**

* 0.99M of funds for P4P are based on participation not performance

Participation-Based Distributions

Factors Driving Participation-Based Distribution:

- All attested partnering provider organizations are eligible for a participation-based distribution if they:
  - Bill Medicaid for services; or
  - Do not bill Medicaid but provide services to patients and do not already have a specific contract with BPHC for those services.
- Participation-based distributions are calculated based on an organization's participation score of 0-10, which is static for MY2, and based on the following criteria:
  - Signed MSA;
  - Workgroup participation;
  - Governance participation (Executive Committee/Subcommittees);
  - RHIO connectivity;
  - PCMH certification; and
  - DSRIP reporting.
- Participation-based allocation is calculated for each organization in total and is independent of measures.

Performance-Based Distributions

Performance-Based Distribution allocations are based on measure-specific and service-specific population attribution for each organization:

- **Metrics passed:** The dollars available for each measure is based on the actual dollars earned for that measure as a percentage of total P4P dollars earned. Example: $1M earned for P4P. Out of 3 measures one earned $500K. That measure would get 50% of the performance-based distribution pool.
- **Service-Type Importance:** Within each measure, calculate the dollars allocated to each service type based on the service-type importance weighting assigned by QCIS and that service's attributed population.
- **Unique Patient Volume:** For each service-type within each measure, calculate dollar allocation for each organization based on the population attributed to that measure and service type and the total dollar allocation for that service type (from previous step). Total payment is calculated by summing the dollars earned by an organization across all service-types performed by that organization for that metric.

Salient claims data is used to calculate unique patient counts for each metric by organization and service-type

INNOVATION FUND UPDATE

Innovation Fund Winter Round 2018 ($2M)

- BPHC issued an invitation for participation in the second round of the Innovation Fund, created to:
  - Encourage innovative strategies, new interventions and programs
  - Support programs that will make a transformative difference in patient care and outcomes and that do not currently have a funding stream
- Proposals required to show how the intervention has value – by improving quality and performance or reducing cost – and is sustainable
- Total allocation of $5.7M was made available for the Innovation Fund
  - Funding for Round I pilots: $1.8M (9 finalists)
  - Funding for Round II pilots: $2M
  - Scaling-up for the successful pilots: ~$2M
- Implementation will start in April 2018, ending by the end of DY4 (March 2019)

Innovation Fund Round II Focus

Populations

a. **Behavioral Health**
   - Serious Mental Health (SMI)
   - Substance Use Disorder (SUD)

b. **Medically homeless**, including supportive housing, transitional housing, respite, shelters

c. **Justice-involved**
   - Re-entry population
   - Recidivist population

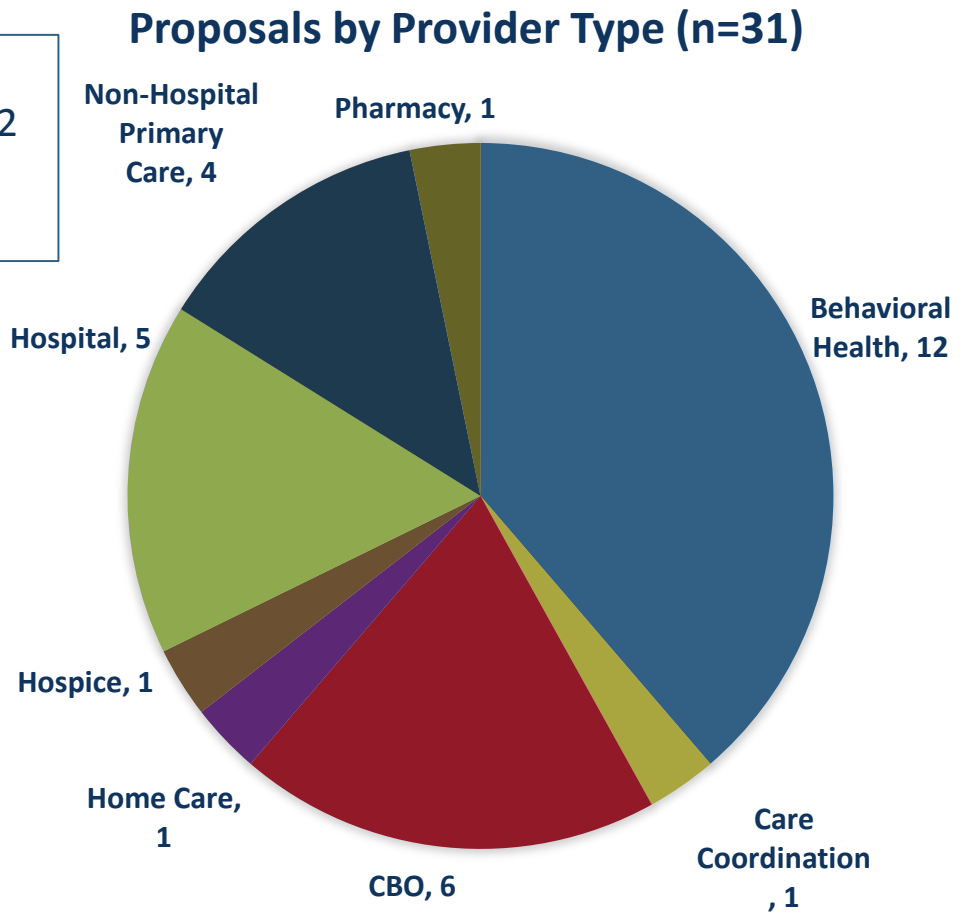
Program Areas

a. **Care transition** program that creates alternatives to readmission, hospitalization and incarceration; examples include detox, opioid treatment, harm reduction, SUD care coordination/integration, collaboration between transitions and social services

b. **(Re-)connecting** patients to care; examples include (re-)enrollment into Medicaid, Health Home transition for re-entry population, stabilization and improved access to housing (avoidable ED visits, connection to food, housing and employment services)

Innovation Fund Round II ($2M): 31 Proposals

- Total number of proposals received: 31
- Total number of unique organizations: 22
- Total number of Tier 1 CBOs*: 5
- Total $ requested: $6,629,802



*Each Tier 1 CBO submitted one proposal in this round.

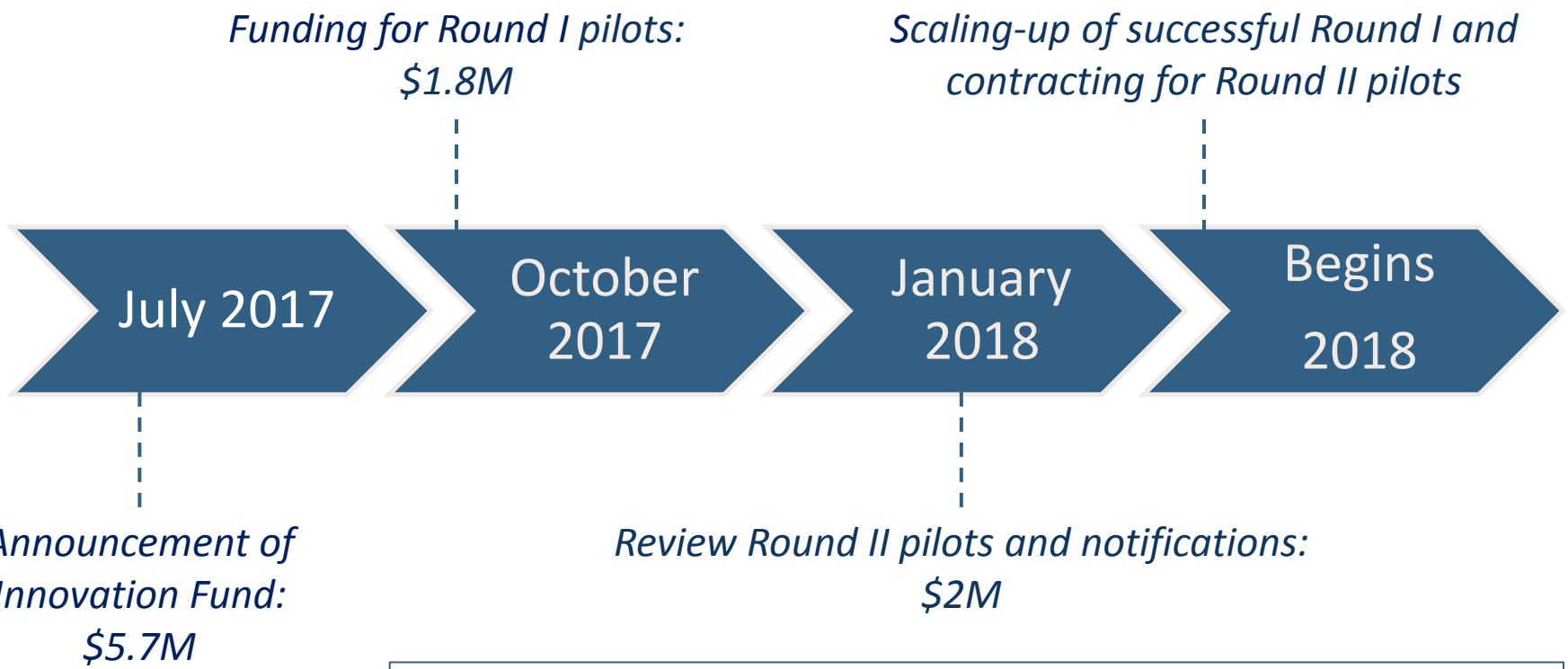
Innovation Fund Review Workgroup

- Consists of 10 members: 1 from EC, 6 from Subcommittees, and 3 from CSO.
- Assigned proposals for review and scoring. Each proposal was reviewed by at least 5 reviewers.

Seven of the 31 proposals selected by the Innovation Fund Review Workgroup to be submitted to the Executive Committee for approval on March 29, 2018.

Name	Affiliation	Organization
Nicholas Youngstrom	EC	HealthFirst
Carol Cassell	F&S SC	ArchCare
Donna Friedman	F&S SC	Mosaic
John Kastan	QCI SC	Jewish Board
Ed Telzak	QCI SC	SBH Health System
Susan Rabinowitz	QCI SC	VNSNY
Rosa Mejias	WF SC	1199 SEIU
Irene Kaufmann	CSO	BPHC
J. Robin Moon	CSO	BPHC
Amanda Ascher	CSO	BPHC

Timeline for $ Distribution through DY3



We plan to announce Innovation Fund Round III in April. Our focus in Round III will be on pilots advancing VBP readiness.

Acacia Network
ROOTED IN THE COMMUNITY SINCE 1969

Seedco | improving lives growing communities

Earn Benefits®

Bronx Health and Benefits Initiative:

Fostering Economic Self-Sufficiency and Addressing Social Determinants of Health

Presentation to Bronx Partners for Healthy Communities
Tara Colton, Executive Director, Seedco

March 2018

Introduction to Seedco

- Seedco is a **national non-profit organization founded in 1987** dedicated to advancing economic opportunity for people, businesses, and communities in need
- Seedco serves many different communities, from rural farmland to urban centers, across five states: **Tennessee, Maryland, New York, Georgia and Connecticut**.
- Seedco operates as both a **direct services provider and an intermediary organization**, helping community-based organizations expand outreach and secure funding.
- We achieve our mission through two primary lines of work:
  - **Workforce development**: Using our long-term career case management model, we help individuals with barriers to employment obtain, retain and advance in jobs.
  - **Work and family supports**: Seedco's helps low-income families successfully enroll in benefits and assistance programs and move towards self-sufficiency.
- Seedco's **Earnbenefits Online (EBO) software** is central to our work helping low-income families successfully enroll in benefits/assistance programs and move towards self-sufficiency
- Seedco became an affiliate of the Acacia Network in 2017

Seedco Program Portfolio: March 2018

NEW YORK

- BPHC-Bronx Health and Benefits Initiative
- Building Bridges and Bonds
- EarnBenefits Online
- Start by Asking
- Strong Fathers, Stronger Families
- The Self Sufficiency Project
- Wage Subsidy Program
- Youth Advancing in the Workplace

MARYLAND

- Connecting Maryland Kids to Coverage
- EarnBenefits Online
- Maryland Health Connection
- Maryland Tech Connection
- SNAP (food stamps) Outreach
- West Baltimore Career Pathways Collaborative

TENNESSEE

- EarnBenefits Online
- Memphis Bioworks Ready to Work
- Memphis Workforce Investment Network Out-of-School Youth Program
- Mid-South Career Pathways Collaborative
- Turning Point

CONNECTICUT

- EarnBenefits Online

GEORGIA

- EarnBenefits Online

Seedco | improving lives growing communities

Acacia Network
ROOTED IN THE COMMUNITY SINCE 1969

EarnBenefits®

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education			
Support	Walkability				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Source: Kaiser Family Foundation

EarnBenefits Online

- Seedco's EarnBenefits Online (EBO) is a web-based software tool which includes rapid and accurate benefit eligibility determination, application assistance, case management and reporting functionality

- EBO is a caseworker-facing technology which allows the worker to:
  - Discuss multiple benefits with a client in one sitting
  - Input the client's information
  - Determine their eligibility for multiple benefits
  - Populate application forms
  - Help clients submit them to the relevant government agency

- For more information about EBO, visit www.earnbenefits.org

Nationally, since 2005, more than 219,000 households have accessed over $307 million in income-enhancing benefits via EBO.

EarnBenefits Online

Key Characteristics of EBO:

Accurate • Easy to Use • Convenient • Educational • Streamlined

Secure and Confidential • Comprehensive • Customizable

- EBO serves as a "one stop shop" for clients, and quickly and accurately screens them for a range of critical public and private benefits and resources such as health insurance, food assistance, tax credits and energy assistance
- On average, EBO screens clients for 20 benefits at one time
- EBO generates monthly reports on metrics including:
  - Number of households:
    - Screened
    - Eligible for benefits
    - Referred to local providers
    - Enrolled in benefits
  - Dollar value of benefits
  - Breakdown of benefits received
- Customized reports and additional technical assistance available

Examples of Benefits Available in EBO

- Advanced Premium Tax Credit (APTC)
- Child Care Subsidy Benefits
- Child Support Payment Incentive
- Child Tax Credit
- Children's Health Insurance Program (CHIP)
- Disability Rent Increase Exemption (DRIE)
- Earned Income Tax Credit (EITC)
- Emergency Home Energy Assistance Program (HEAP)
- Family Eviction Prevention Supplement (FEPS)
- Free and Reduced Price School Meals
- Free Tax Prep
- Habitat for Humanity
- Head Start/Early Head Start
- Homeowners' Tax Credit
- Lifeline/Link Up
- Low Income Home Energy Assistance Program (LIHEAP)
- Medicaid for Children and Parents/Adults
- Medicaid for Disabled Adults
- Medicaid for Pregnant Women
- Medicare Extra Help
- Medicare Savings Programs
- NeedyMeds Drug Discount Card
- Planning for Healthy Babies (Medicaid Family Planning Benefit)
- Renter's Tax Credit
- Senior Citizen Rent Increase Exemption (SCRIE)
- Supplemental Nutrition Assistance Program (SNAP)
- Temporary Assistance for Needy Families
- Temporary Disability Assistance (TDAP)
- Water Assistance
- Women and Infant Children (WIC)

EBO Users

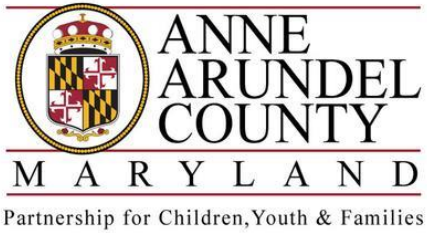
- EBO is currently used in urban, suburban and rural communities across the country

- EBO users include:
  - Hospitals
  - Federally-qualified health centers
  - Social service providers
  - Community-based organizations
  - Affordable housing organizations
  - Government agencies

Job Titles of Current EBO Users:

- Family Benefits Eligibility Specialist
- EarnBenefits Counselor
- Community Health Worker
- Community Support Specialist
- Family Support Services Coach
- Case Worker
- Financial Counselor
- Outreach and Eligibility Community Health Worker
- Outreach Specialist

Examples of Current EBO Users



MARYLAND CONSUMER RIGHTS COALITION

EBO and Health Care Providers

For health care providers, EBO is a critical resource to help them:

- Improve health outcomes by addressing clients' complex needs and broader challenges
- Integrate health care and social services
- Promote health equity
- Demonstrate impact on social determinants of health, at both the client- and community-level
- Address population health
- Spread their reach beyond the walls of the hospital or health provider
- Reduce readmissions

Case Study: EBO's Impact in a Hospital Setting

The Brookings Institution released "Hospitals as Hubs to Create Health Communities: Lessons from Washington Adventist Hospital." This report highlights the partnership between Seedco and Washington Adventist Hospital (WAH), in Takoma Park, Maryland, which uses EBO to help patients enroll in benefits. Report excerpts include:

- "**Many WAH patients are not aware of the benefit programs they are eligible for** — benefits and services that might stabilize them financially and address other problems that reduce their quality of life and add to their health risks."
- "**The partnership with Seedco is an important new dimension to WAH's ability to address the full needs of patients after discharge**. Partnering with Seedco through their Earn Benefits program allows the hospital to gain access to a data system for social service benefits without having to design its own."
- The partnership involves the hospital's Population Health Team, its volunteer office, and staff of Community Clinics Incorporated (CCI). EBO streamlines access to the benefits enrollment process and **WAH follows the patients' application processes through their stay at the hospital**."

Full study available at http://www.brookings.edu/~/media/research/files/papers/2015/09/health-neighborhood/hospitals-as-hubs-to-create-health-communities.pdf

Seedco | improving lives growing communities

Acacia Network
ROOTED IN THE COMMUNITY SINCE 1969

Earn Benefits®

Bronx Partners For Healthy Communities Innovation Fund Grant

BRONX PARTNERS FOR HEALTHY COMMUNITIES

The Bronx Partners For Healthy Communities (BPHC) Innovation Fund program was "established to encourage and promote BPHC member organizations to take on innovative and new interventions and programs to address certain gaps in care and missing links in the care support structure in and among member organizations."

The Innovation Fund will support programs and interventions that will make a transformative difference in patient care and outcomes and do not currently have a funding stream."

In October 2017, Seedco and our partners at the Acacia Network were funded to launch the Bronx Health and Benefits Initiative:

- Acacia will use Seedco's EarnBenefits Online (EBO) tool to help Bronx residents enroll in public benefits, including Medicaid, SNAP (food stamps), tax credits, heating/energy assistance and prescription drug coverage.
- Program sites will include Acacia's primary and behavioral health clinics, substance abuse programs, homeless shelters, and Health Homes. The goal is to ultimately integrate EBO into Acacia's existing care teams.
- Outcomes will be connected to targets of reducing ER visits and unnecessary hospitalizations while increasing preventive care and medication adherence.

Seedco improving lives growing communities

Acacia Network ROOTED IN THE COMMUNITY SINCE 1969

EarnBenefits®

BPHC Innovation Fund Grant: Bronx Health and Benefits Initiative (BHBI)

Need for Services

- An informal survey of Acacia's Health Home Care Managers found that many individuals on their caseloads solely receive Medicaid and do not receive other public benefits like SNAP (food stamps), heating assistance or child tax credits.
- Clients are often frustrated trying to navigate the public benefits system, citing the time spent waiting in various offices and a perception that they "get the run around" from government staff.
- Most Acacia clients that reside in homeless shelters are eligible for benefits but many are unable or unwilling to travel from the Bronx to Queens, where the designated benefits center for shelter clients is located.

Program Design

- BHBI will screen 1,300 individuals at Acacia's Bronx sites for benefits, generating an estimated benefits value of $3 million.
- Spanish-speaking EarnBenefits Screeners will conduct outreach, screen clients, assist with applications, follow up with clients to document receipt of benefits, and troubleshoot problems clients encounter while applying for benefits, such as gathering documentation.
- BHBI will also provide EBO licenses and training for Acacia staff (e.g. Care Coordinators, Entitlement Specialists, Health Home Care Managers) to use EBO in their programs, drawing on their experience, trust, and cultural competency.
- The goal is to ultimately integrate EBO into Acacia's existing care teams.

Seedco | improving lives growing communities

Acacia Network
ROOTED IN THE COMMUNITY SINCE 1969

EarnBenefits®

A Client's Story

- Anita*, a mother of two young girls, had been told by friends that she would need to pay to apply for public assistance.
- She couldn't afford transportation to nearby government agencies to enroll in benefits.
- Anita was at a local church that was hosting an *Earn*Benefits event, where Seedco's counselor corrected her misconception about application fees and worked with her to complete the eligibility application.
- In just a few minutes, they learned that Anita qualified for Medicaid, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), food stamps (SNAP), and Head Start benefits for her two girls.
- Within a few weeks, Anita called the counselor to report that she had all the approval paperwork in hand.

*Name has been changed

An EBO Screener's Story

"As an *Earn*Benefits specialist for the nonprofit Seedco, Carlos Bolanos helps to screen low-income residents for benefits including food stamps, health insurance programs, tax credits, housing and utility assistance.

Along the way, he debunks a lot of rumors and dispels a lot of myths…Some think their children will have to pay the benefits back when they turn 18. Others believe accepting benefits mean their children will someday be enrolled in the military automatically.

'So a lot of my day is just diffusing those rumors,' Bolanos said." –ABC-2 News Baltimore

abc 2
WMAR BALTIMORE

Bilingual man educates low-income Maryland residents, immigrants about benefits for the needy

April 17, 2015

By: Allison Bourg
http://www.abc2news.com/news/region/baltimore-city/bilingual-man-educates-low-income-maryland-residents-about-benefits

BALTIMORE - When Carlos Bolanos arrives at the Esperanza Center in Fells Point twice a week, the line is often 15 people deep, even on a slow day.

Full story at http://www.seedco.org/wp-content/uploads/2015/04/ABC2-Bilingual-man-educates-low-income.pdf

Seedco | improving lives growing communities
Acacia Network ROOTED IN THE COMMUNITY SINCE 1969
Earn Benefits®

Thank You!

For more information, contact:

Tara Colton
Executive Director, Seedco
tcolton@seedco.org
(646) 688-7270

www.seedco.org

www.earnbenefits.org

BRONX RHIO CONSENT TRAINING

RHIO Consent Rate Needs Improvement

- PPS-wide RHIO consent target: 90%
  - Without RHIO consent from patients we cannot access data
  - Currently only the Institute for Family Health has achieved 90% or better

- BPHC support to improve RHIO consent rate
  - Created incentives to improve performance on collection of RHIO consents
  - Through P4X program, providers are incentivized to improve consent rates by 10%
  - Developed training resources to provide front-line staff strategies for improving how consents are obtained

RHIO Consent Training

- Goal: Improve consent rates for organizations currently and those that will be connected to the RHIO (related to a P4X measure)
- RHIO consent training materials including a Video, PowerPoint and Tip Sheet developed for registrars and other front-line staff seeking RHIO consent from their patients
  - Development participants: Bronx RHIO, Bronx Health Access PPS, Sarah Nosal, MD and other staff from the Institute's Urban Horizon Family Health Center, focus group of SBH patient access registrars along with Luci de Hann and Mary Morris from the CSO
  - Vetted by BPHC and Bronx Health Access Workforce Subcommittees

RHIO Consent Training Distribution Plan

- A total of 37 organizations (and their sites) that are currently or will be connected to RHIO will receive the training and materials
- Outreach and engagement is already underway, BPHC staff are actively reaching out to organizations to work with those who plan staff trainings at the targeted organizations in the PPS. These organizations include:
  - 18 primary care
  - 12 behavioral health
  - 6 post-acute care
- BPHC staff will work closely with contacts at each organization to assist with planning trainings for front line staff – we look forward to speaking with you and your teams

View the RHIO Consent Training Video here:

https://www.youtube.com/watch?v=ehdXb-BDEg4

TRAININGS

Trainings

VBP Training for Behavioral Health Providers

Part 1: Tuesday, March 27 9:00 AM – 12:00 PM

Presented by the NYU McSilver Institute for Poverty Policy and Research

- This three-part training module was developed for behavioral health providers who are members of BPHC and Bronx Health Access. (The second and third parts will be offered later in the year.)

- St. Barnabas Hospital
  Auditorium – 1st Floor
  4422 Third Avenue
  Bronx, NY 10457
  (Parking available)

- RSVP to Rebekah Epstein at (REpstein@sbhny.org) or 718.618.8238.

Trainings *cont'd*

Protecting Patient Privacy While Building an Integrated Delivery System

April 10 and 17 (two-part webinar)

(1.0 Continuing Medical Education credit available for each webinar)

The collection and sharing of patient health information is highly regulated by federal and state privacy laws that affect the flow of information that is so critical to our success in DSRIP. Join us for a discussion to explore:

- Key privacy laws that apply to organizations and what they mean
- How federal and state laws interact with each other and affect on information sharing
- Key questions BPHC should members raise with their legal/compliance teams to support information sharing?

Calendar invite will be sent following this webinar. For questions, contact Suzette Gordon, BPHC Compliance Officer at SGordon2@sbhny.org.

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.