BRONX PARTNERS FOR
HEALTHY COMMUNITIES

SBH
Health System
BRONX

Implementation Guidelines

The DSRIP Challenge

DSRIP (Delivery System Reform Incentive Payment) Program is a major collective effort to transform New York's Medicaid Healthcare Delivery System from a fragmented system, overly focused on inpatient care, to an integrated and community-based system focused on providing care in or close to the home.

Where the current delivery system is predominantly re-active and provider-focused, DSRIP aims to create a more pro-active and patient-focused system, with a vibrant workforce throughout the continuum of care, emphasizing population health and closely involving social services.

As a coalition of medical and social service providers, we at **Bronx Partners for Healthy Communities** are forging an integrated care delivery network (or Performing Provider System, PPS) that offers high-quality primary care and care coordination, with increased attention to the social determinants of health.

We are glad to have you as part of our coalition as we embark on this challenging but exciting journey to improve health and wellness across the Bronx!

The BPHC CSO Team

October 2015

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DSRIP: A BRONX TALE

DSRIP: A Bronx Tale

BPHC's 2014 Community Needs Assessment highlighted the need for innovations in healthcare and improved collaboration between clinical and community resources.

- 59% of residents enrolled in Medicaid
- Least healthy county in New York State
- High rates of preventable chronic disease.
- Highest rate of potentially preventable inpatient Medicaid admissions in NYC
- Costs incurred for medical care are extremely high and act as a barrier to effective use of prevention and disease management services.

** PQI: Preventive Quality Indicator, to identify quality of ambulatory care, such as preventable hospitalization*

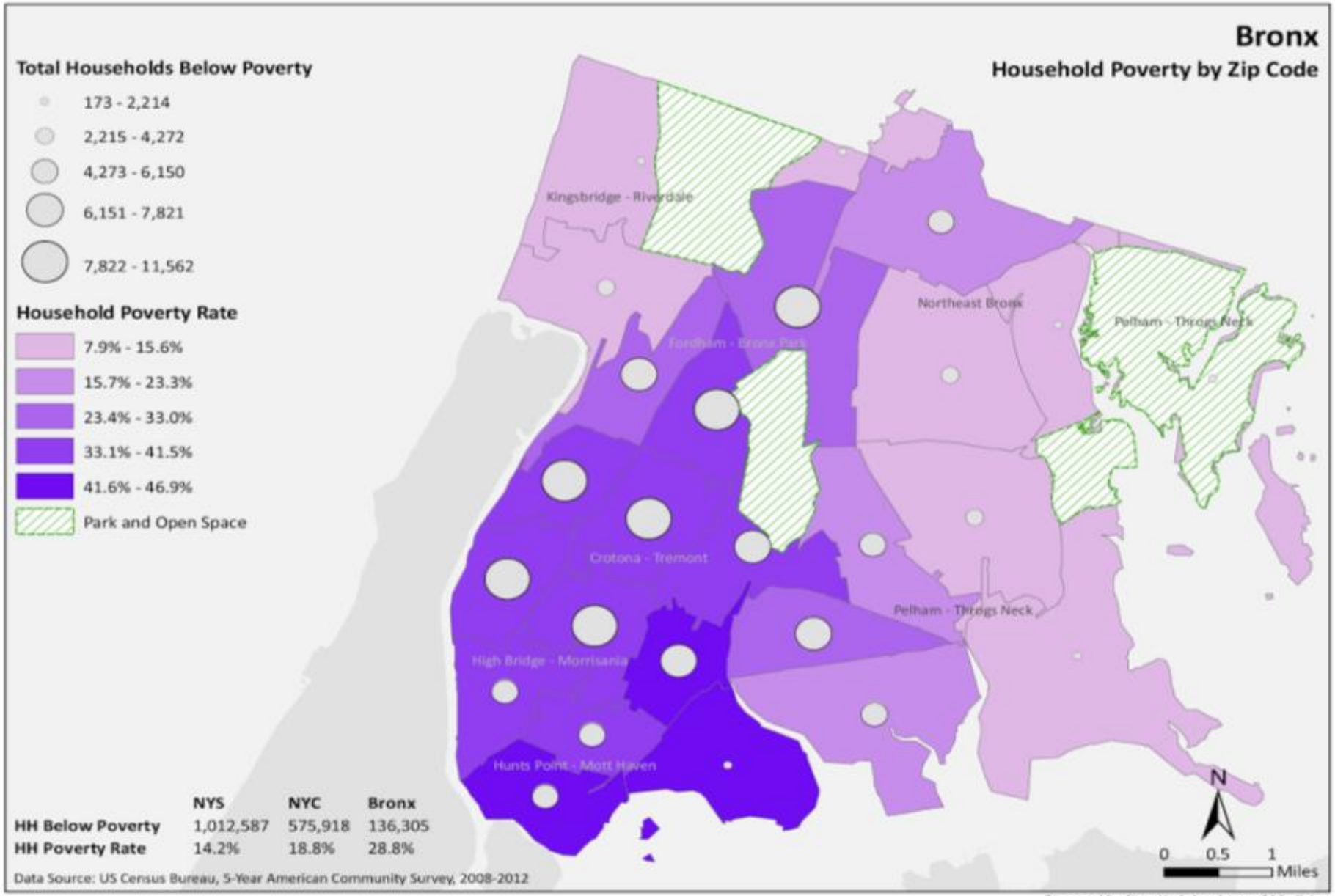
Bronx Health Disparities Snapshot:
These Conditions Contribute to Poor Health Outcomes

Language and Culture: Over 50% of the population of ~1.5 million speak a language other than English at home.

Transportation: Bronx residents have long commutes and higher rates of disruption to bus/subway service.

Environment: Poor air quality and other environmental pollutants from industrial activity and waste centers.

Income: ~ 30% of Bronx households live in poverty, and Bronx residents experience the greatest unemployment (~10%) when compared to other NYC boroughs.



	NYS	NYC	Bronx
HH Below Poverty	1,012,587	575,918	136,305
HH Poverty Rate	14.2%	18.8%	28.8%

Data Source: US Census Bureau, 5-Year American Community Survey, 2008-2012

Prepared by New York Academy of Medicine

Bronx Health Disparities Snapshot:
These Conditions Contribute to Poor Health Outcomes

Food Insecurity: ~22% of Bronx residents lack adequate access to food. Unhealthy food is more accessible than fresh fruits and vegetables.

Education: Fewer than 20% of Bronx residents [have] completed a degree beyond high school.

Housing: Over a third of the population has inadequate housing, and nearly 40% of households pay 50%+ of their income on rent. Bronx residents report higher rates of unsafe housing than other NYC boroughs**.**

Healthcare Access: There are 2,080 Bronx residents per primary care doctor, twice the state average. ~16% of Bronx residents are uninsured.

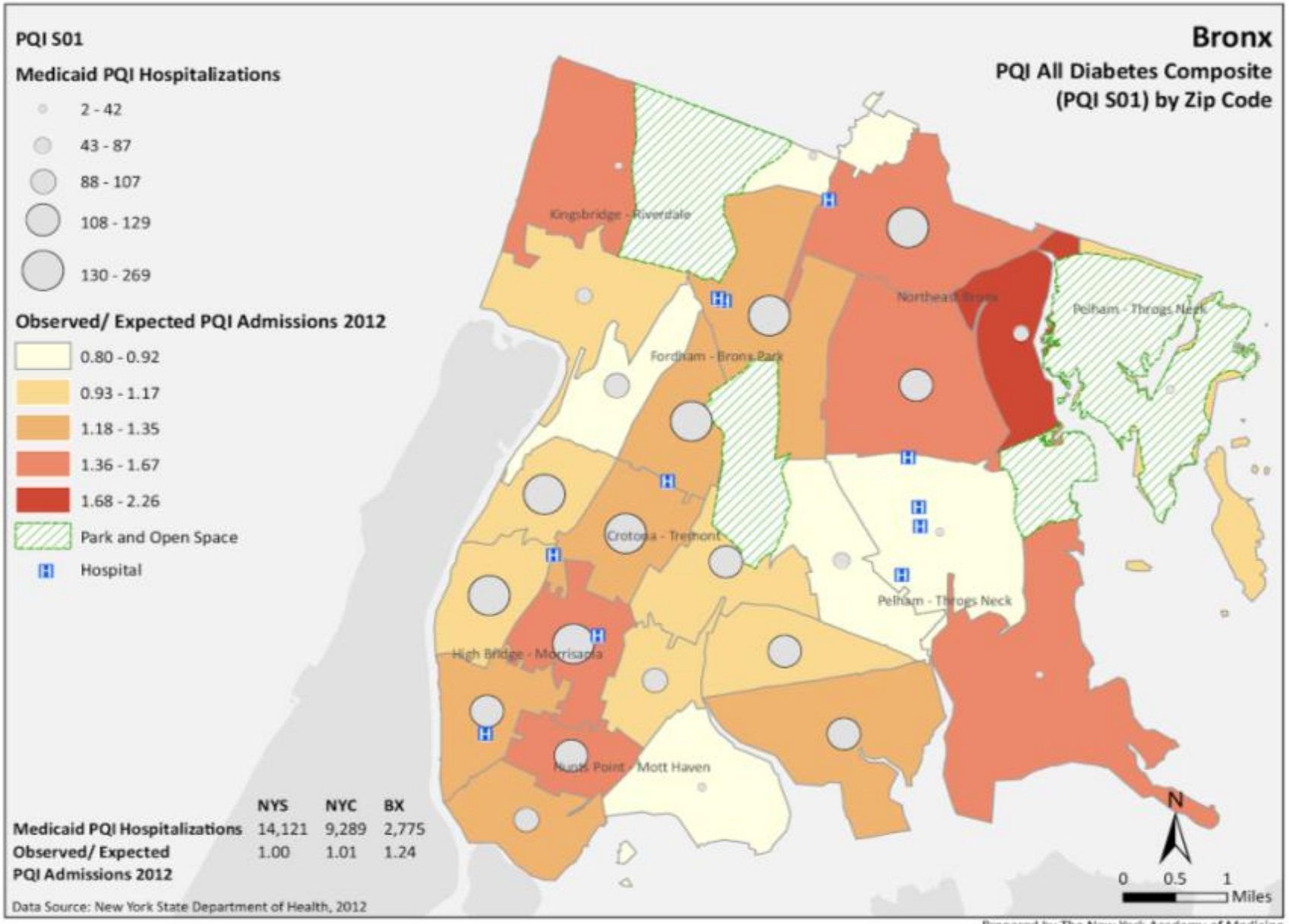
Unfortunately, none of this is new….

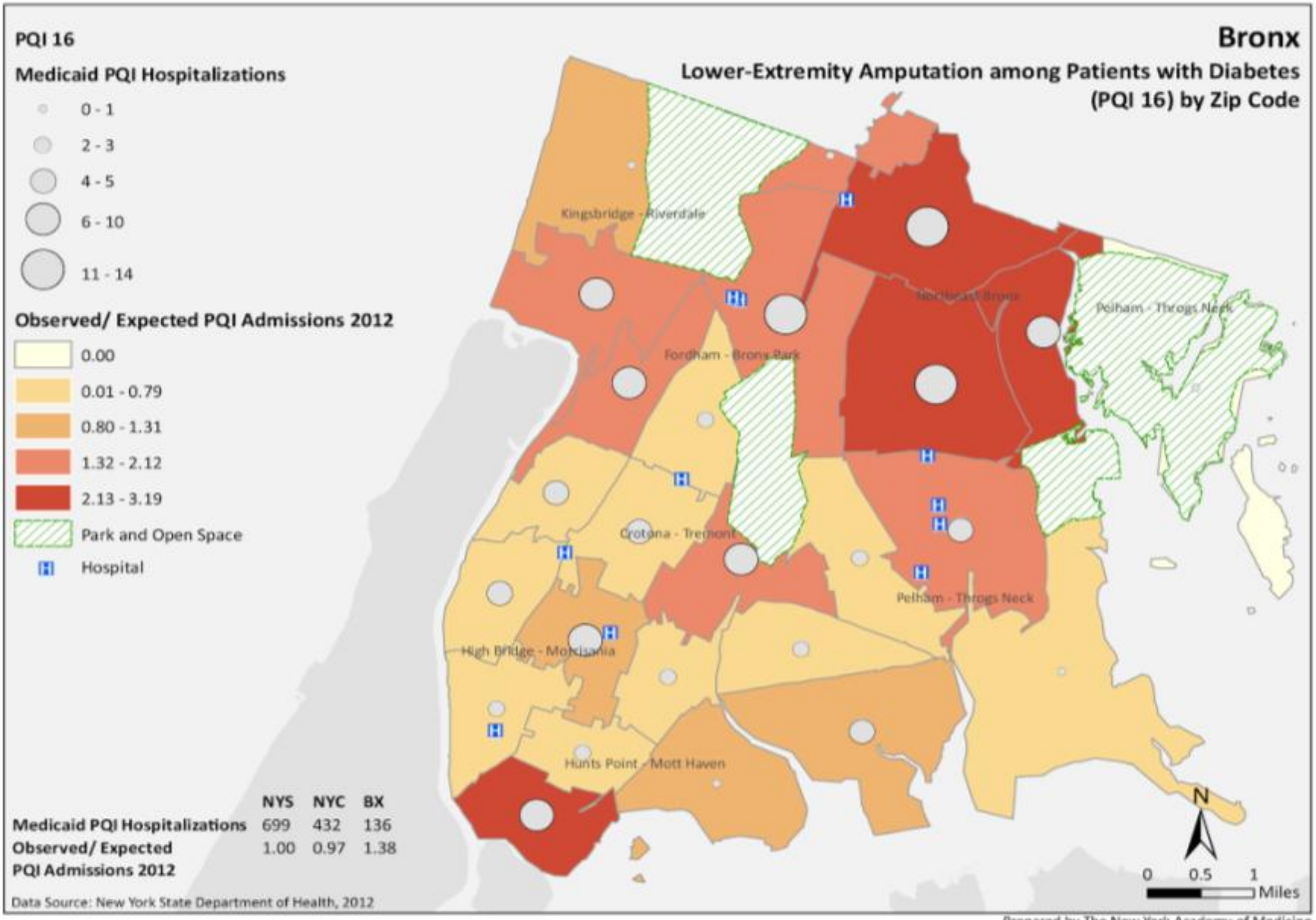
Preventable Illness in the Bronx

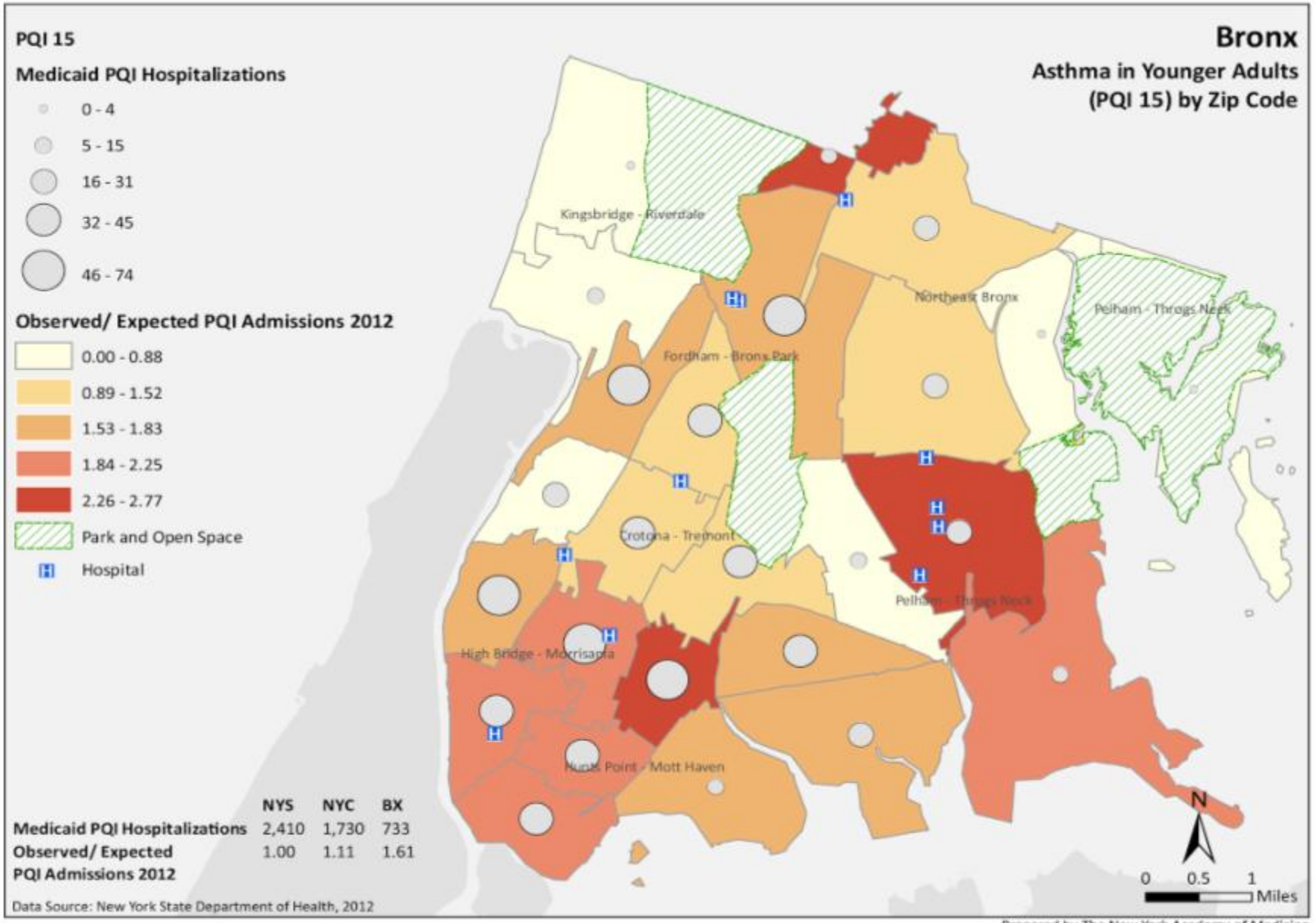
Cardiovascular Disease: Heart disease is the top cause of mortality and the second leading cause of premature death in the borough, after cancer.

Diabetes: The rate of hospitalization for short-term diabetes complications among Medicaid beneficiaries is almost 50 % higher in the Bronx than in the city and state overall (151/100,000 vs. 105/100,000 and 110/100,000, respectively).

Asthma/COPD: Young adult asthma and respiratory hospitalizations are concentrated in the southern part of the borough, extending across both sides of the Grand Concourse.


PQI S01
Medicaid PQI Hospitalizations
2 - 42
43 - 87
88 - 107
108 - 129
130 - 269
Observed/ Expected PQI Admissions 2012
0.80 - 0.92
0.93 - 1.17
1.18 - 1.35
1.36 - 1.67
1.68 - 2.26
Park and Open Space
Hospital
Bronx
PQI All Diabetes Composite
(PQI S01) by Zip Code
Kingsbridge - Riverdale
Northeast Bronx
Pelham - Throgs Neck
Fordham - Bronx Park
Crotona - Tremont
Pelham - Throgs Neck
High Bridge - Morrisania
Hunts Point - Mott Haven
N
0 0.5 1
Miles
NYS NYC BX
Medicaid PQI Hospitalizations 14,121 9,289 2,775
Observed/ Expected PQI Admissions 2012 1.00 1.01 1.24
Data Source: New York State Department of Health, 2012
Prepared by The New York Academy of Medicine


PQI 16
Bronx
Lower-Extremity Amputation among Patients with Diabetes (PQI 16) by Zip Code
Medicaid PQI Hospitalizations
0 - 1
2 - 3
4 - 5
6 - 10
11 - 14
Observed/ Expected PQI Admissions 2012
0.00
0.01 - 0.79
0.80 - 1.31
1.32 - 2.12
2.13 - 3.19
Park and Open Space
Hospital
Kingsbridge - Riverdale
Fordham - Bronx Park
Crotona - Tremont
High Bridge - Morrisania
Hunts Point - Mott Haven
Pelham - Throgs Neck
NYS NYC BX
Medicaid PQI Hospitalizations 699 432 136
Observed/ Expected PQI Admissions 2012 1.00 0.97 1.38
Data Source: New York State Department of Health, 2012
N
0 0.5 1
Miles
Prepared by The New York Academy of Medicine

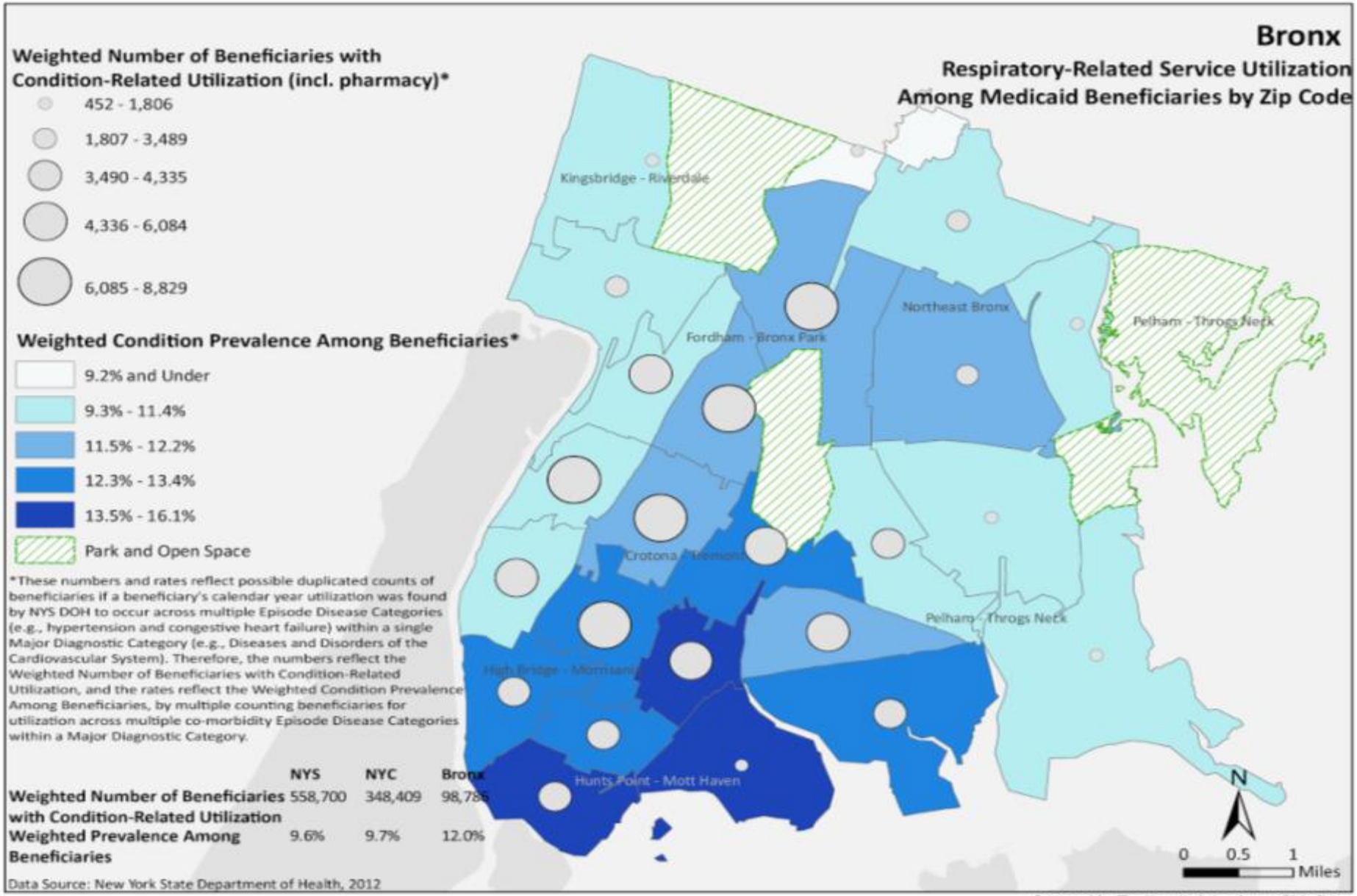


	NYS	NYC	BX
Medicaid PQI Hospitalizations	2,410	1,730	733
Observed/ Expected PQI Admissions 2012	1.00	1.11	1.61

Prepared by The New York Academy of Medicine

Bronx

Respiratory-Related Service Utilization Among Medicaid Beneficiaries by Zip Code



*These numbers and rates reflect possible duplicated counts of beneficiaries if a beneficiary's calendar year utilization was found by NYS DOH to occur across multiple Episode Disease Categories (e.g., hypertension and congestive heart failure) within a single Major Diagnostic Category (e.g., Diseases and Disorders of the Cardiovascular System). Therefore, the numbers reflect the Weighted Number of Beneficiaries with Condition-Related Utilization, and the rates reflect the Weighted Condition Prevalence Among Beneficiaries, by multiple counting beneficiaries for utilization across multiple co-morbidity Episode Disease Categories within a Major Diagnostic Category.

	NYS	NYC	Bronx
Weighted Number of Beneficiaries with Condition-Related Utilization	558,700	348,409	98,785
Weighted Prevalence Among Beneficiaries	9.6%	9.7%	12.0%

Data Source: New York State Department of Health, 2012

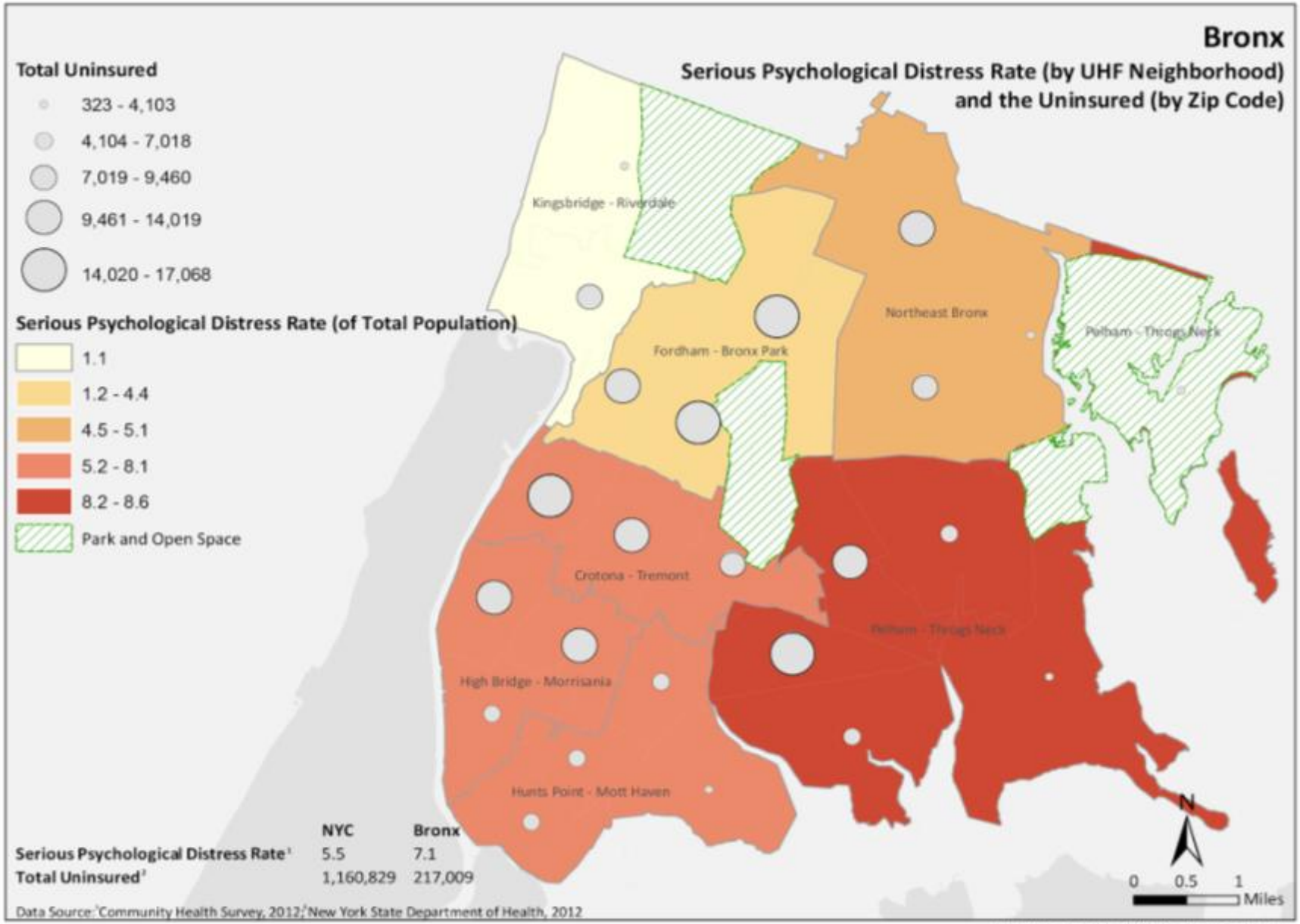
Prepared by The New York Academy of Medicine

Preventable Illness in the Bronx

Mental/behavioral health: In the Bronx, 7.1% of all people report experiencing serious psychological distress, compared to 5.5% in NYC overall. Approximately half of CNA respondents reported that the mental health services are not very available in their community.

Substance abuse: Substance abuse was the second most commonly cited health concern by survey respondents (47.2%).

HIV/AIDS: Four neighborhoods in the Bronx have higher HIV/AIDS prevalence rates than the city as a whole: High Bridge/ Morrisania, Crotona/ Tremont, Fordham/ Bronx Park, and Hunts Point/ Mott Haven.



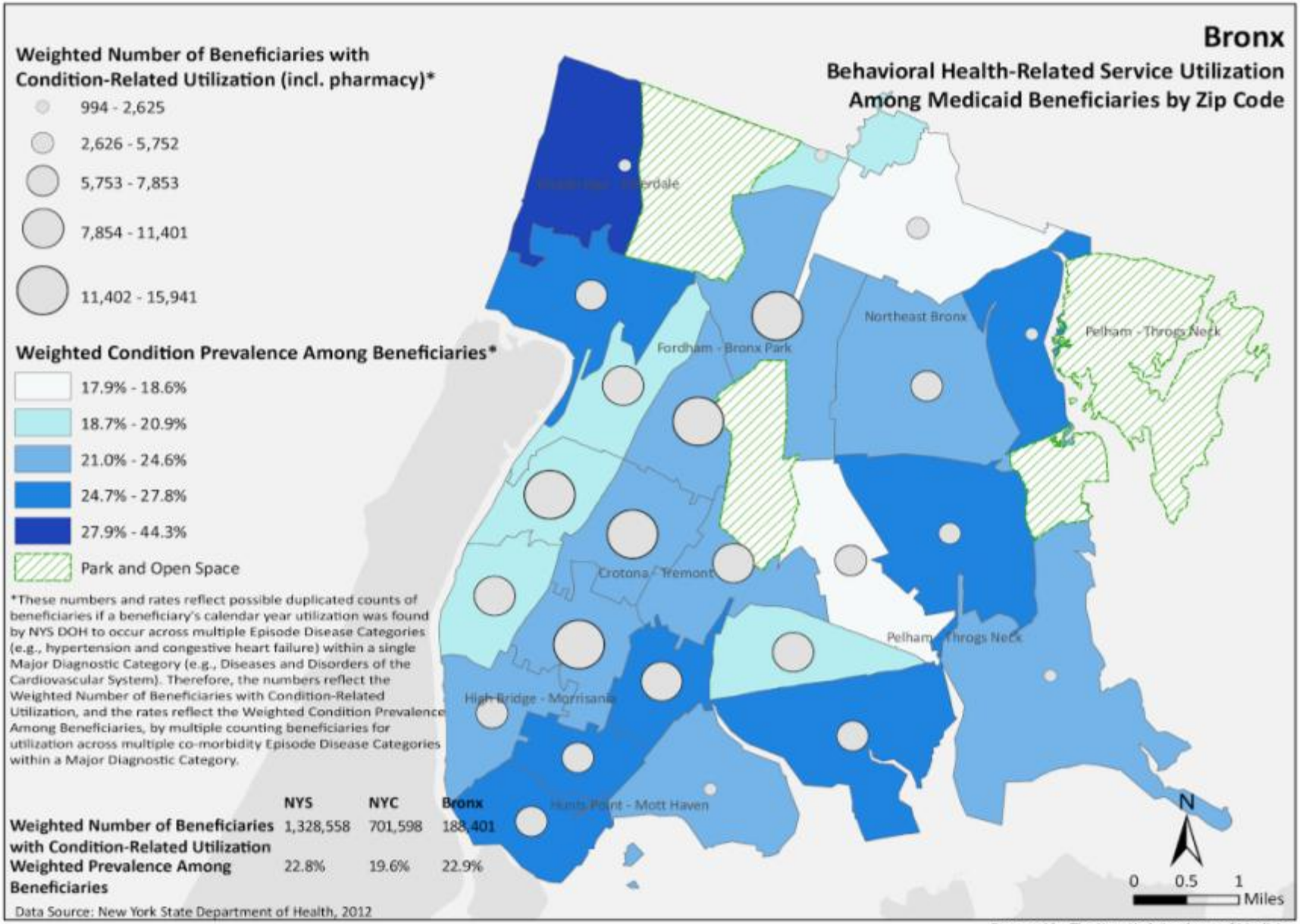
	NYC	Bronx
Serious Psychological Distress Rate[1]	5.5	7.1
Total Uninsured[2]	1,160,829	217,009

Data Source: [1]Community Health Survey, 2012; [2]New York State Department of Health, 2012

Prepared by The New York Academy of Medicine

Bronx

Behavioral Health-Related Service Utilization Among Medicaid Beneficiaries by Zip Code

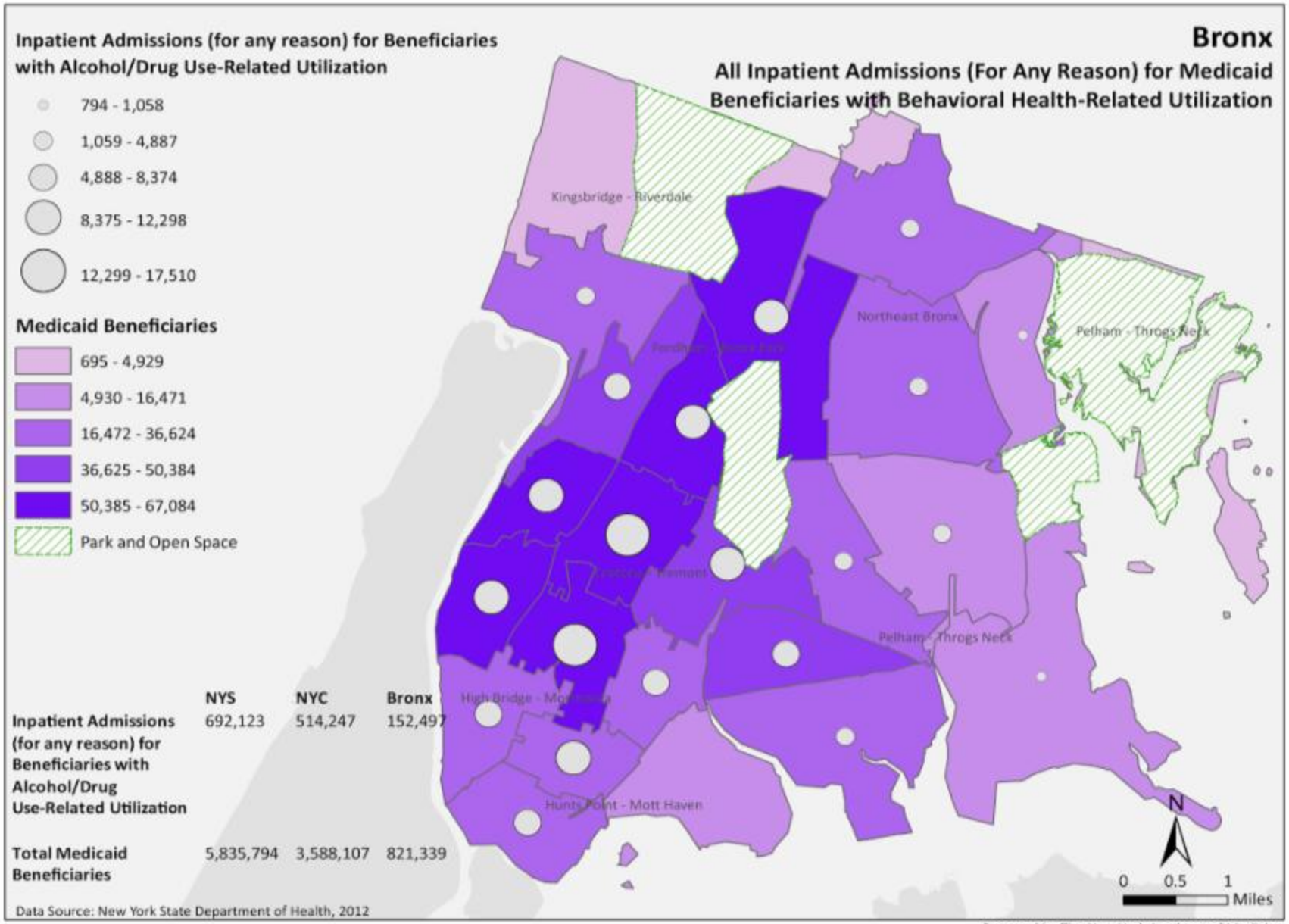


*These numbers and rates reflect possible duplicated counts of beneficiaries if a beneficiary's calendar year utilization was found by NYS DOH to occur across multiple Episode Disease Categories (e.g., hypertension and congestive heart failure) within a single Major Diagnostic Category (e.g., Diseases and Disorders of the Cardiovascular System). Therefore, the numbers reflect the Weighted Number of Beneficiaries with Condition-Related Utilization, and the rates reflect the Weighted Condition Prevalence Among Beneficiaries, by multiple counting beneficiaries for utilization across multiple co-morbidity Episode Disease Categories within a Major Diagnostic Category.

	NYS	NYC	Bronx
Weighted Number of Beneficiaries with Condition-Related Utilization	1,328,558	701,598	188,401
Weighted Prevalence Among Beneficiaries	22.8%	19.6%	22.9%

Data Source: New York State Department of Health, 2012

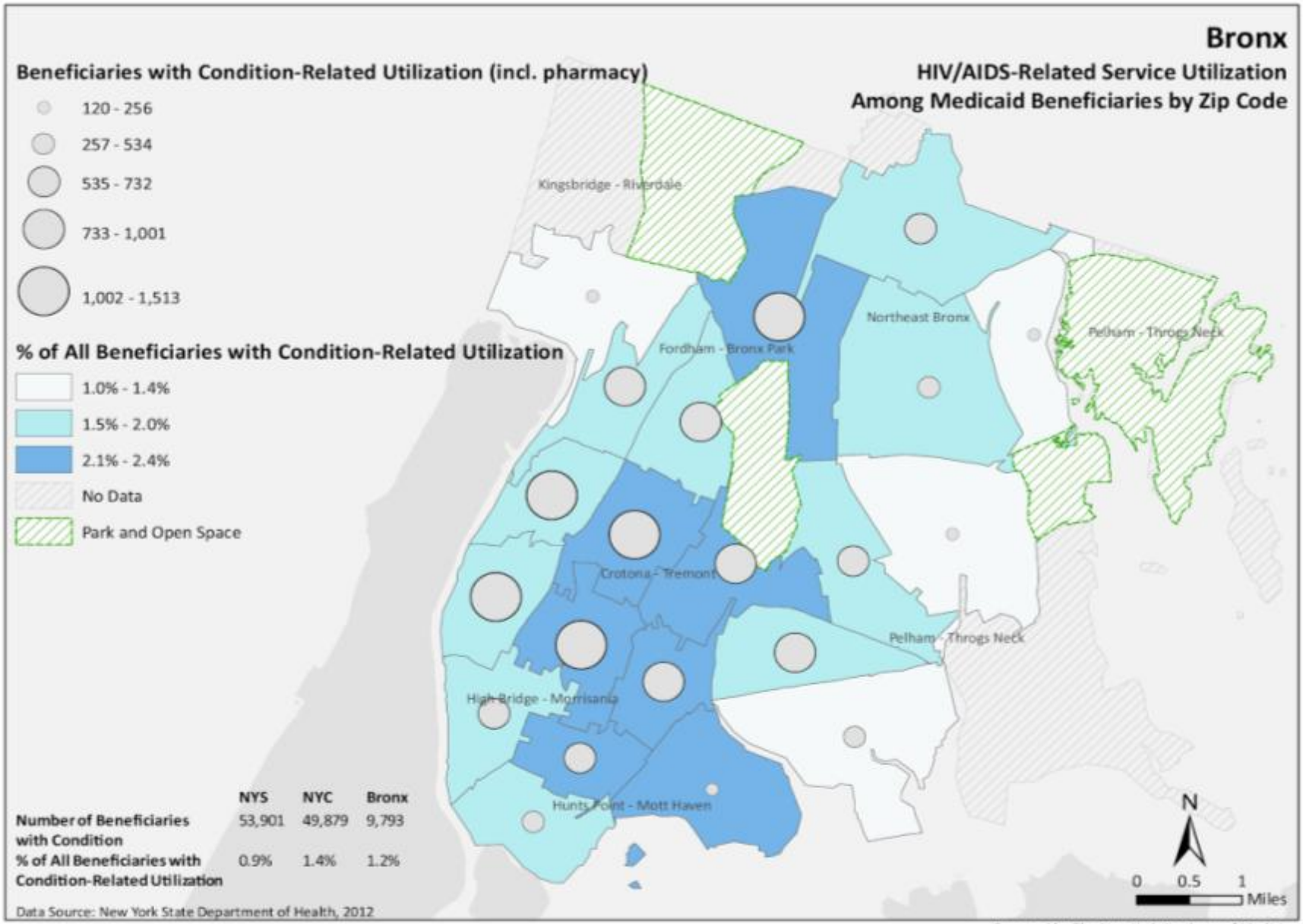
Prepared by The New York Academy of Medicine



	NYS	NYC	Bronx
Inpatient Admissions (for any reason) for Beneficiaries with Alcohol/Drug Use-Related Utilization	692,123	514,247	152,497
Total Medicaid Beneficiaries	5,835,794	3,588,107	821,339

Data Source: New York State Department of Health, 2012

Prepared by The New York Academy of Medicine



Prepared by The New York Academy of Medicine

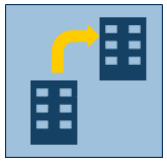
What Sets DSRIP Apart from Past Initiatives?

Upfront Funding. Previous programs expected participants to implement change first, then patiently wait for reimbursement, DSRIP supports transformation through immediate funding, regulatory relief, capital funding and other resources. It's not a grant program: it is an incentive program based on performance.

A marathon: Five years is much longer than preceding programs; it gives time for change to occur, there are processes in place to tweak along the way, and sustainability is at the core of the value-based payment reform. We are seeking long-term transformation.

Unprecedented amount of funding and accountability: $6.42B in funding linked to benchmarks and outcomes.

Learned from past mistakes: The complexity of DSRIP is reflective of the complexity of the problems it aims to address. A lot of thought has gone into building a program that takes into account the competing incentives, regulatory barriers and cultural factors that act as barriers to change.



Builds on past initiatives but takes it to the next level: Previous work (ACO, HMH, Health Home, PCMH, RHIO) has mostly been limited to single healthcare systems and the clinical setting. DSRIP links healthcare providers from different networks and disciplines. DSRIP brings in community-based partners for healthcare reform unlike ever before, in a real effort to address social determinants of health.

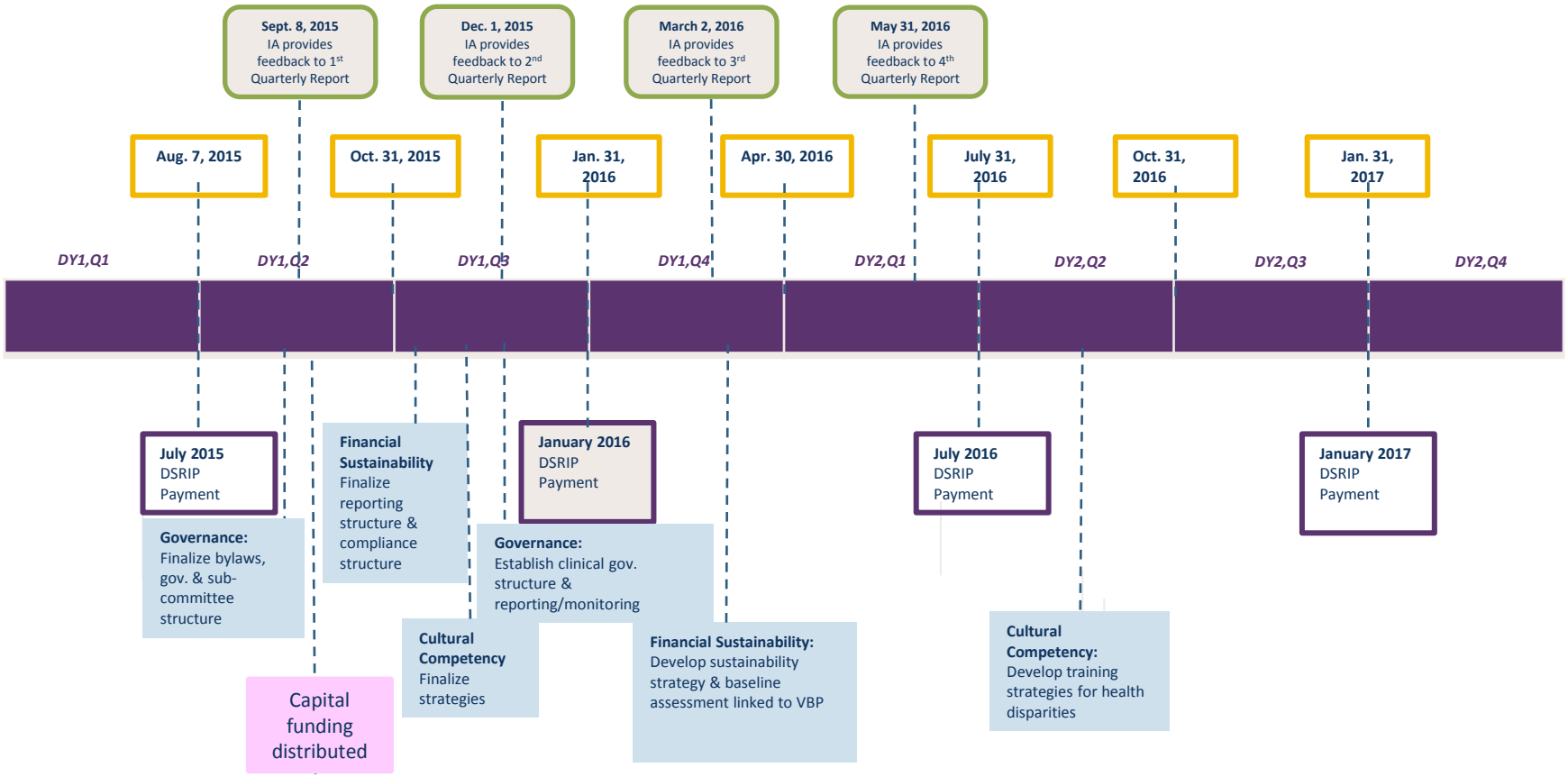
DSRIP OVERVIEW

Implementation Timeline

Legend:

** DY3 – DY5 have the same schedules for payments and quarterly reports*

- **DSRIP Payments Schedule**
  - Q1: April1- June 30
  - Q2: July 1-September 30
  - Q3: October 1- December 30
  - Q4: January 1- March 31
- **Quarterly Report Deadline**
- **Organizational Milestone Deadlines**
  - Workforce measures are ongoing
  - Financial sustainability VBP measures are TBD
- **Capital Funding Distributed**
- **Independent Assessor distributes feedback to PPSs**



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 admissions 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 managed care payment reform

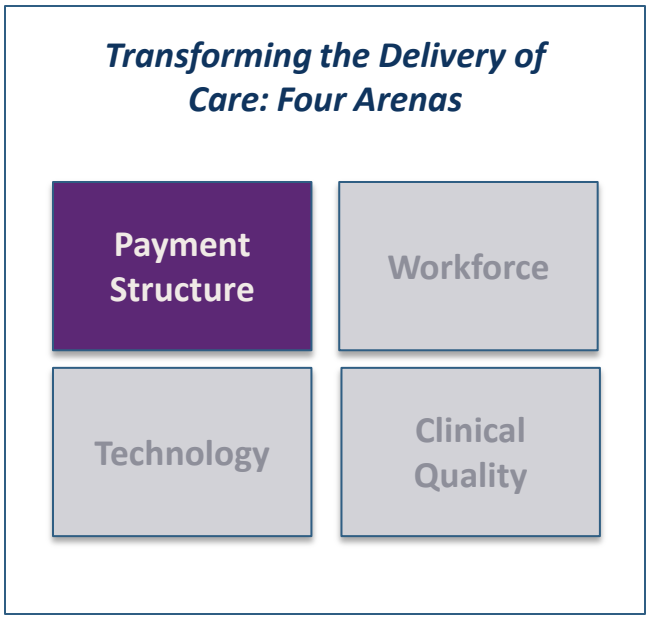
What is DSRIP?

What is DSRIP? – Strategy

Transforming the Delivery of Care: Four Arenas

- Payment Structure
- Workforce
- Technology
- Clinical Quality

Payment Structure Transformation

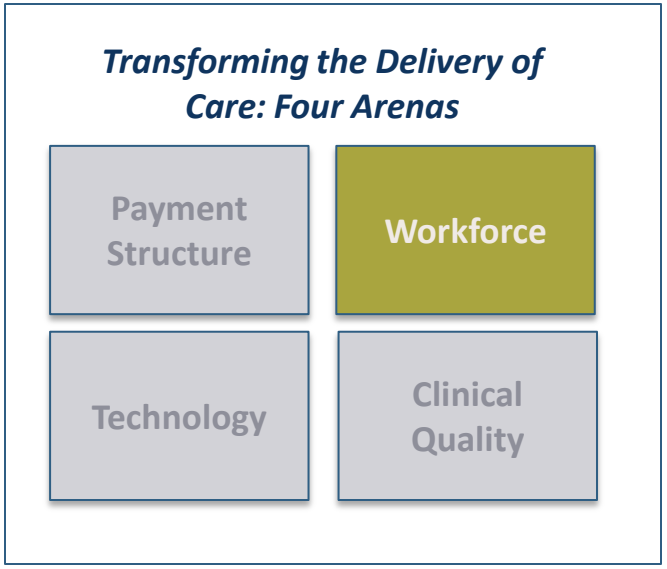


- The Volume-Based Payment system provides disproportionately more funding for "more" care rather than focusing on preventive care, health outcomes, coordination and integration
- The Value-Based Payment system of the future
  - Links funding to performance, based on the health outcomes of providers' entire patient panels and changes the focus to population health management
  - Emphasizes prevention, outpatient and community-based care.

Payment Structure Transformation

- By DSRIP Year 5, all Managed Care Organizations (MCOs) must employ non-fee-for-service payment systems (i.e., alternative payment system such as capitation or quality contracts) that reward value over volume for at least 90% of their provider payments.
- Patient stratification and risk management – focus on total population, with specific integrated interventions for relevant sub-populations.
- Shared savings arrangements to be negotiated between MCOs and PPS.

Workforce Transformation

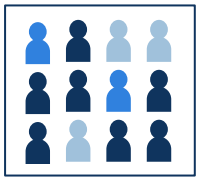


- The shift in focus from inpatient hospital care to primary care and community-based services has implications for the health workforce
  - Anticipated reduction in hospital admissions and beds → fewer hospital staff required
  - Increased demand for primary care providers, care managers, community health workers → more outpatient staff required
- Create an integrated delivery system with interdisciplinary coordination
- Retrain existing workforce to meet the needs of the future
- Create jobs and recruit new health workers to fill gaps
- Ensure cultural competence and understanding of social determinants of health

Workforce Transformation Aims

- Create an integrated delivery system with interdisciplinary coordination

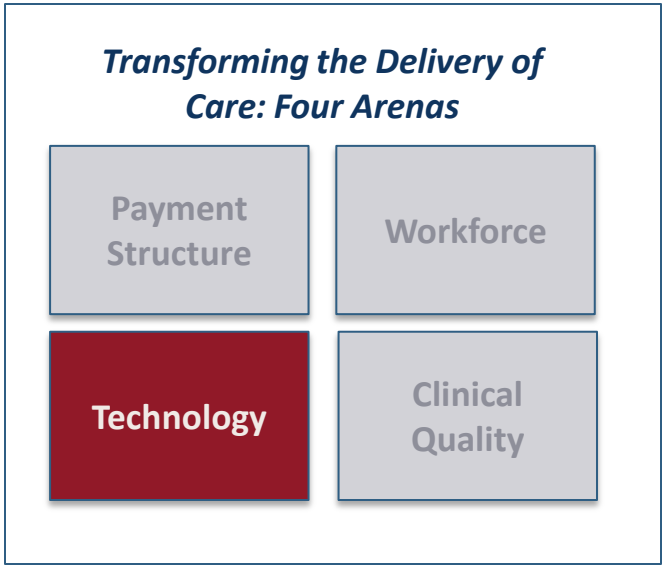
- Retrain existing workforce to meet the needs of the future



- Create jobs and recruit health workers to fill gaps

- Ensure cultural competency and understanding of social determinants of health

Technology Transformation



Currently….

- EHRs operate in isolation
- Data not shared across the continuum of care
- Patients engaged on a reactive basis
- Patient data used only when care is administered
- Hospital systems rely on internal data sources

Must evolve to meet the needs of an integrated delivery system that actively shares information and employs population health management techniques

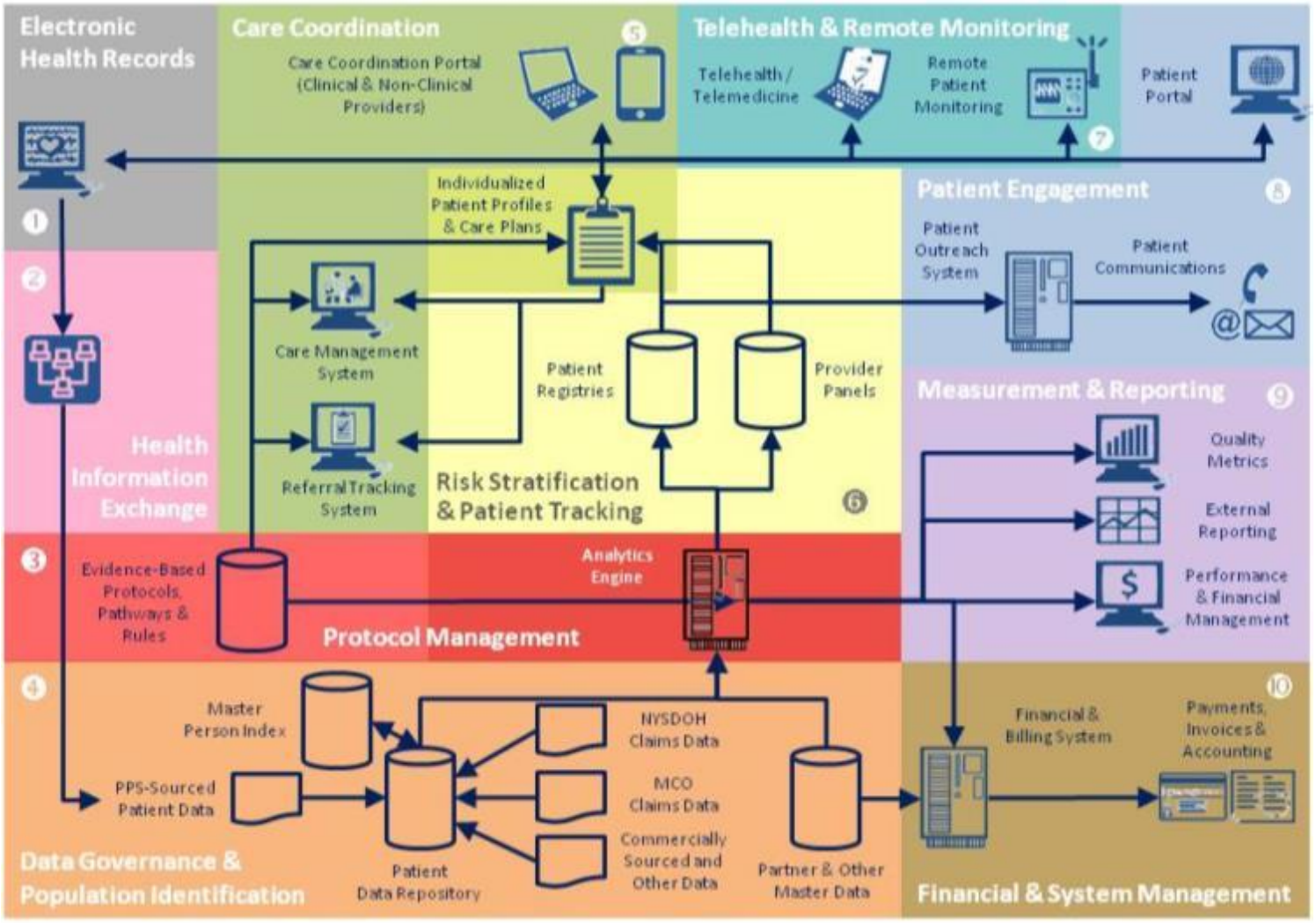
IDS: Technology Components

Via Bronx RHIO HIE

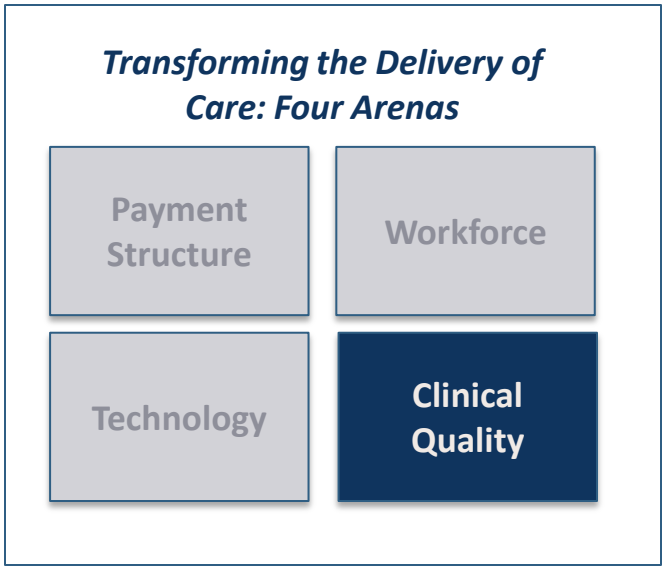
Component	Purpose
PCMH-Related IT Requirements	EMR Requirements, MU2 Certification
Care Coordination Management System (CCMS) -Acupera	Assessments, Care Plans, Referral Tracking, Patient Outreach/Portal
Analytics & Population Health	Stratification, Registries, Predictive Modeling
Reporting	RCEs and External Reporting, Support of VBP
Connections to Partner Systems / Other RHIOs/PPSs	Partner and non-partner's systems: EHRs, ADT Systems, CCMS
CRM/Member Management System (Salesforce)	Communicate with participating organizations and serve as knowledge repository
Data Governance/Security	Management of data availability, usability, integrity, and security, including PHI

Note: *Summarized for presentation, subject to change*

Relationship of IT Components to Requirements

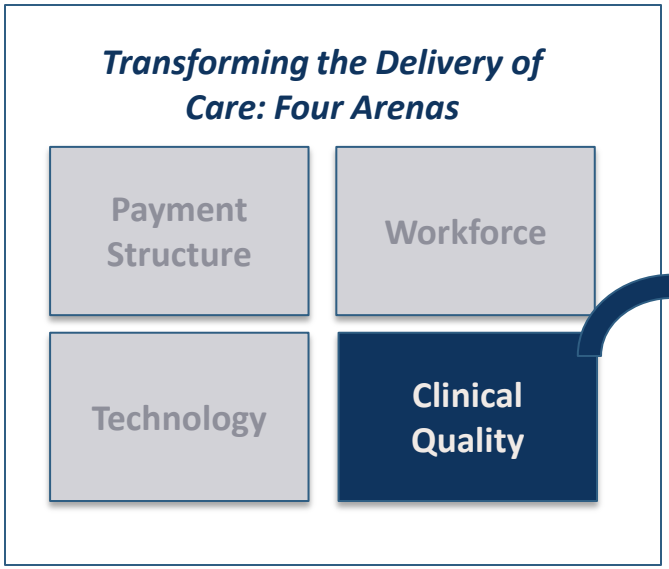


Clinical Quality Transformation



- Provide care at the right level, time, and place
  - Transition to high-quality, integrated primary, specialty and behavioral health care in the community setting
  - Hospitals used primarily for emergency and tertiary level of services
- Standardize clinical quality
  - Use of evidence-based guidelines
  - Coordinated, culturally competent care

Clinical Quality Transformation



BPHC's clinical quality transformation work falls into four categories

- Support the Primary Care Team
- Support Care Transitions & Care Connections
- Engage Patients in their Own Care
- Provide Care Beyond the Clinical Setting

Support the Primary Care Team

Clinical Quality: Care Categories

- **Support the Primary Care Team**
- Support Care Transitions & Care Connections
- Engage Patients in their Own Care
- Provide Care Beyond the Clinical Setting

- Primary care is fundamental to improving health for patients and communities
- The patient-centered medical home (PCMH) organizes primary care to emphasizes care coordination and communication
- Population health management (PHM) helps practices improve health outcomes for their entire patient panel
- Patients with uncontrolled chronic diseases and conditions not eligible for Health Homes may require care management that goes beyond the scope of the PCMH care team

Objectives:	Enhance primary care teams and standardize the delivery of high-quality, accessible and patient-centered primary care that effectively provides for patients with complex needs.

Support the Primary Care Team

Activities and resources:	• Support achievement of PCMH 2014 Level-3 recognition • Facilitate inter-connectivity with the Bronx RHIO • Create a BPHC-wide Care Coordination Management System, referral management system, and community resource directory • Promote a standardized quality of care through clinical operations plans that include evidence-based guidelines • Embed care management and behavioral health providers in primary care teams • Support population health management and patient outreach • Assist providers in negotiations with MCOs on transition to Value Based Payments

Support the Primary Care Team

CSO support:	• Convening thought leaders and subject matter experts to develop standard evidence-based guidelines and protocols for consistent and coordinated patient-entered care focused on strengthening services in primary care settings for patients with uncontrolled chronic disease and those at-risk of developing more complex healthcare needs • Providing technical assistance for primary care practice sites to become NCQA 2014 Level-3 Patient-Centered Medical Homes (PCMHs) • Providing data and IT systems to support efforts to strengthen primary care (including updating / implementing EHR systems, RHIO connectivity, Care Coordination Management Systems, closed-loop referral tracking, and population health management)

Support Care Transitions & Connections

- Care fragmentation results in failed referrals, lack of follow-up, and increased hospital admissions and readmissions
- Targeted care coordination for high-risk patients can improve the quality of a patient's care, health, and experience with the medical system
- "Closed-loop" systems ensure the flow of information between providers and the success of referrals, preventing patients from getting "lost in the system"

Objective:	Create a closed loop environment to improve patient safety by facilitating successful patient transitions between care settings and providers across the Bronx.

Support Care Transitions & Connections

Activities and resources:	• Reduce barriers to care and enhance patient support through care coordination • Build relationships and connectivity between PCPs, hospitals (EDs and in-patient), specialists, health homes, CBOs, and other providers • Integrate behavioral health and specialty care into care delivery through co-location or referral arrangements. • Increase referrals to health homes • Close the loop through referral tracking

Support Care Transitions & Connections

CSO support:	• Facilitating the creation of an integrated delivery system • Leveraging the State's existing health homes for patients with more complex needs • Integrating behavioral health (BH) into primary care • Managing patient transitions among various healthcare providers and settings • Creating a BPHC-wide referral tracking system, establishing policies and procedures, and ensuring members' connectivity

Engage Patients in their Own Care

Clinical Quality: Care Categories

- Support the Primary Care Team
- Support Care Transitions & Care Connections
- **Engage Patients in their Own Care**
- Provide Care Beyond the Clinical Setting

- Research shows that patients who lack the skills and confidence to manage their own health care often require more of it and incur higher health care costs.
- Initiatives to provide patients with the knowledge and confidence necessary to take control of their own health can help them to improve their health and better manage their conditions.

Objectives:	Create processes that encourage patients to be more involved in decisions about their care and in the management of their health.

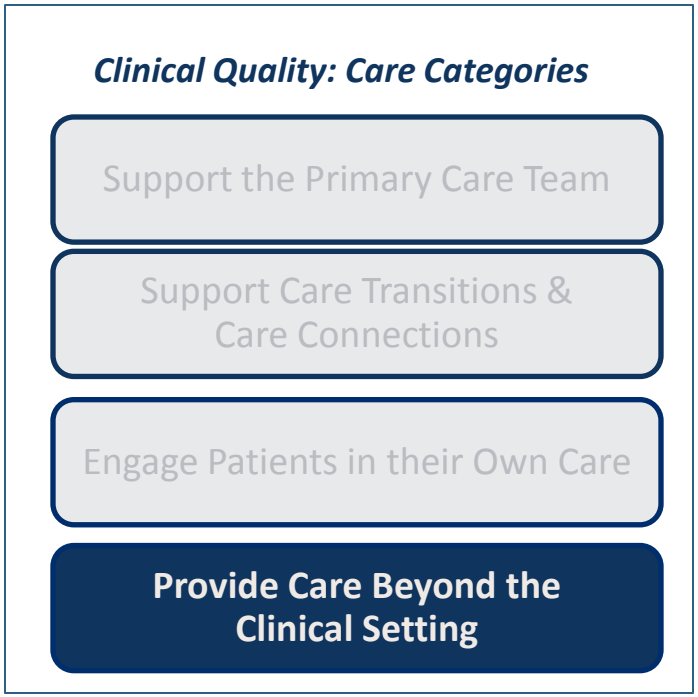
Engage Patients in their Own Care

Activities and resources:	• Document patient self-management goals in the medical record and review with patients at subsequent visits • Develop and distribute culturally competent educational materials • Develop and implement protocols for home blood pressure monitoring • Refer patients to chronic disease self-management programs • Refer patients to smoking cessation classes and resources • Implement training and asthma self-management education services

Engage Patients in their Own Care

CSO support:	• Supporting the development of care teams to support patients' achievement of self-management goals. • Providing training resources on screening and assessing patients to establish self-management goals in individualized patient care plans • Providing referrals and access to self-care resources • Developing and distributing culturally competent educational materials

Provide Care Beyond the Clinical Setting



- Patients cannot achieve their health goals and effectively follow medical advice without support in their neighborhoods, workplaces and schools.
- Connecting healthcare inside the doctor's office with home and community-based health and social service programs can provide ongoing opportunities for patients to manage their health where most health decisions happen—outside of the examination room.

Objectives:	Support the health of individuals and communities in the Bronx by addressing the social determinants of health and extending care beyond the doctor's office.

Provide Care Beyond the Clinical Setting

Activities and resources:	• Expand asthma home-based self-management program to include home environmental trigger reduction • Referrals to community based programs • Community Health Workers, Health Coaches, and Home Visiting • Home blood pressure monitoring • Implement Mental Health and Substance Use (MHSA) project for young adults in schools • Supporting facilities in developing alternative visit workflows for Blood Pressure checks • 24/7 access to clinical advice and providing alternative types of clinical encounters

Provide Care Beyond the Clinical Setting

CSO support:	• Enlisting and engaging community-based housing, social service, and advocacy organizations in addressing the social determinants of health and patients' non-medical health and wellness needs, including home-based asthma education and diabetes and cardiovascular disease management interventions • Employing community health workers, health coaches and facilitating home visits • Participating in city- and state-wide population health initiatives

BPHC Projects

Based on a list of 44 potential projects developed by NYS DOH, BPHC chose 10 projects based on priorities identified in the Community Needs Assessment

Domain 2 System Transformation	**2.a.i**	Create Integrated Delivery Systems
	2.a.iii	Health Home At-Risk Intervention Program
	2.b.iii	Emergency Department Care Triage
	2.b.iv	Care Transitions to Reduce 30-Day Readmissions
Domain 3 Clinical Improvement	**3.a.i**	Integration of Primary Care Services and Behavioral Health
	3.b.i	Evidence-Based Strategies for Managing Adult Population with Cardiovascular Disease
	3.c.i	Evidence-Based Diabetes Management
	3.d.ii	Expansion of Asthma Home-Based Self-Management Program
Domain 4 Population-wide	**4.a.iii**	Strengthen Mental Health and Substance Use Infrastructure Across Systems
	4.c.ii	Increase Early Access to, and Retention in, HIV Care

BPHC OVERVIEW

BPHC Is a Performing Provider Systems (PPS)

To participate in DSRIP, providers were required to form geographic-based, voluntary partnerships with other providers with whom they shared patients.

PERFORMING PROVIDER SYSTEMS (PPS): LOCAL PARTNERSHIPS TO TRANSFORM THE DELIVERY SYSTEM

Partners should include:

- *Hospitals*
- *Health Homes*
- *Skilled Nursing Facilities*
- *Clinics & FQHCs*
- *Behavioral Health Providers*
- *Home Care Agencies*
- *Other Key Stakeholders*

Responsibilities must include:

- Community health care needs assessment based on multi-stakeholder input and objective data.
- Building and implementing a DSRIP Project Plan based upon the needs assessment in alignment with DSRIP strategies.
- Meeting and reporting on DSRIP Project Plan process and outcome milestones.

Each PPS has a **lead organization**. SBH Health System is the lead organization for BPHC.

BPHC overview

BPHC represents a diverse network of over 200 member organizations, including

Hospitals

FQHCs

Health Homes

Home Care Agencies

Behavioral Health Facilities

Long Term Care Facilities

IPAs and Independent Providers

Community Based Organizations

BRONX PARTNERS FOR HEALTHY COMMUNITIES

SBH is leading the BPHC PPS

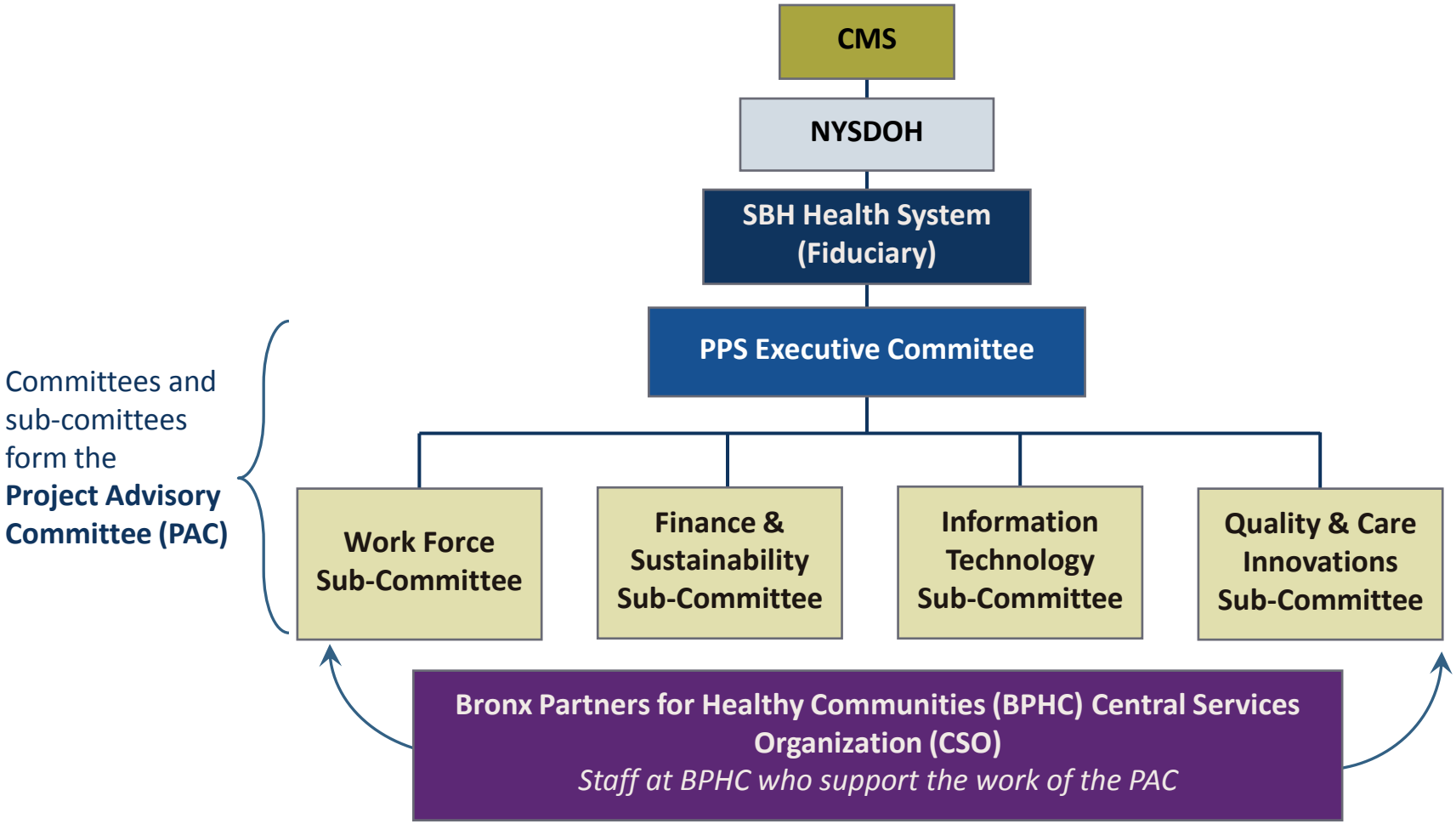
BPHC represents a network of more than 205 member organizations, including:

205 Unique Organizations

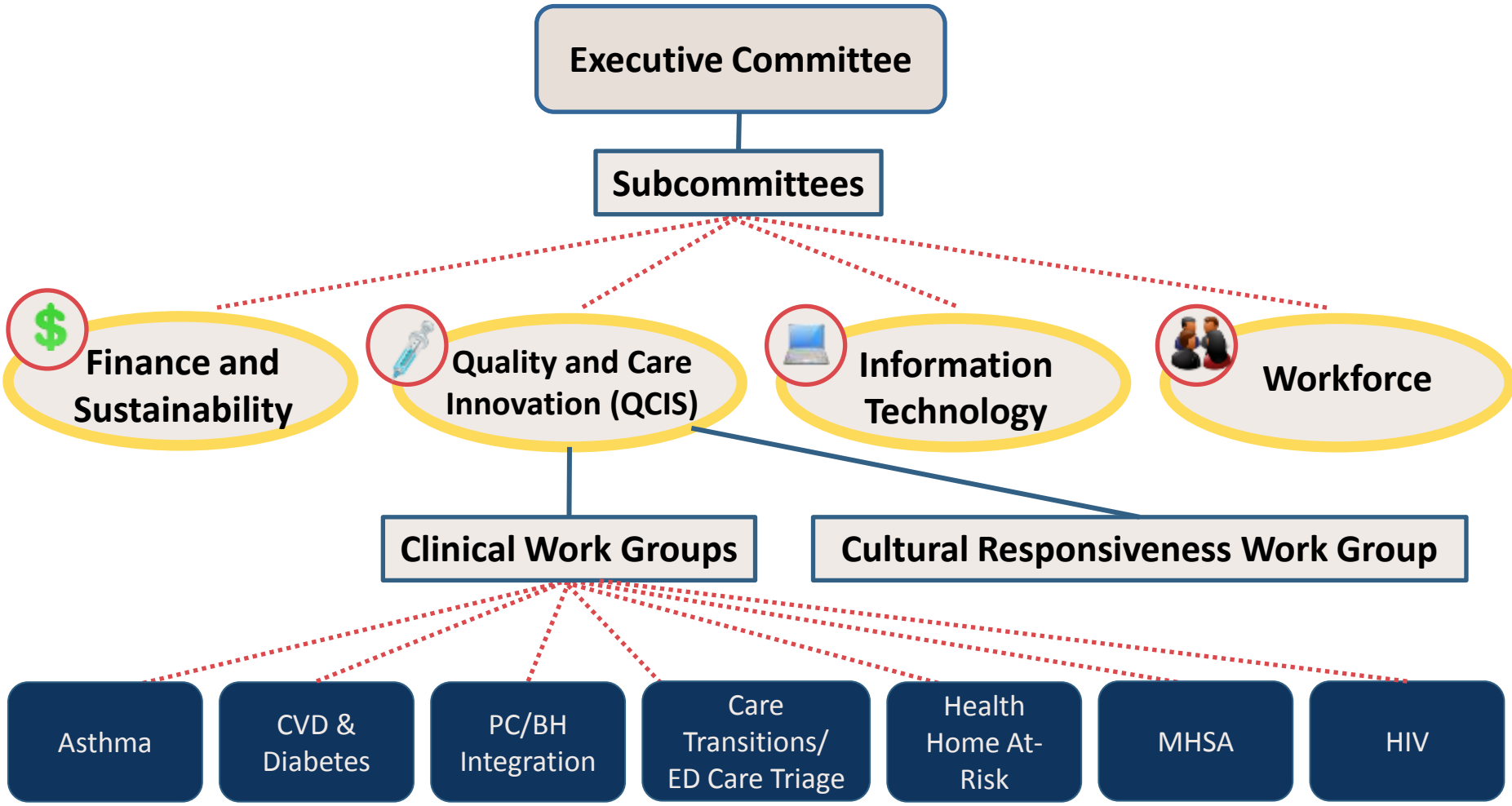
1,200 Total Locations/Sites

- 5 Assisted Living Facility Locations
- 30 Diagnostic & Treatment Center Locations
- 2 Long Term Home Health Care Provider Locations
- 19 OASAS (Article 32) Provider Locations
- 6 OPWDD (Article 16) Provider Locations
- 9 Sole Community Provider Locations
- 146 Other (i.e. Housing, Hospice, Community Based Organizations, LHCSA, etc.)
- 18 Certified Home Health Agency Locations
- 32 Federally Qualified Healthcare Center Locations
- 13 Nursing Home Locations
- 39 OMH (Article 31) Provider Locations
- 19 Skilled Nursing Facility Locations
- 2 Voluntary Hospitals (33 Locations)

BPHC Operational Governance Structure



BPHC Committee Structure



BPHC Executive Committee

Roles and Responsibilities

- 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

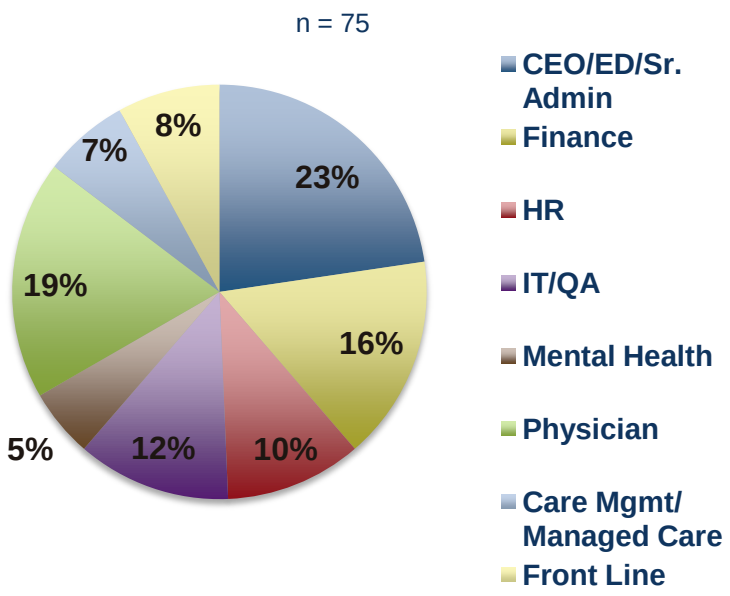
Members

- **Eric Appelbaum**, SBH Health System
- **Maxine Golub**, Institute for Family Health
- **Marianne Kennedy**, Visiting Nurse Service of NY
- **Pamela Mattel**, Acacia Network
- **Fernando Oliver**, Bronx United IPA
- **Tosan Oruwariye**, Morris Heights Health Center
- **Amanda Parsons**, Montefiore Medical Center
- **Paul Rosenfeld**, CenterLight Health System
- **Stephen Rosenthal**, Montefiore Medical Center
- **Charles Scaglione**, Bronx RHIO
- **Eileen Torres**, BronxWorks
- **Len Walsh**, SBH Health System - Chair
- **Pat Wang**, Healthfirst
- **Gladys Wrenick,** 1199 SEIU
- **Douglas York**, Union Community Health Center

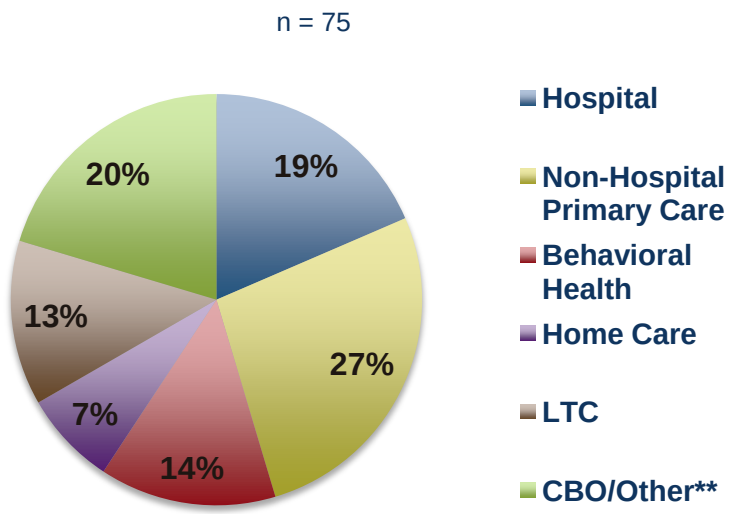
BPHC Governance

Make-Up of Governance Committees*

Participating Disciplines



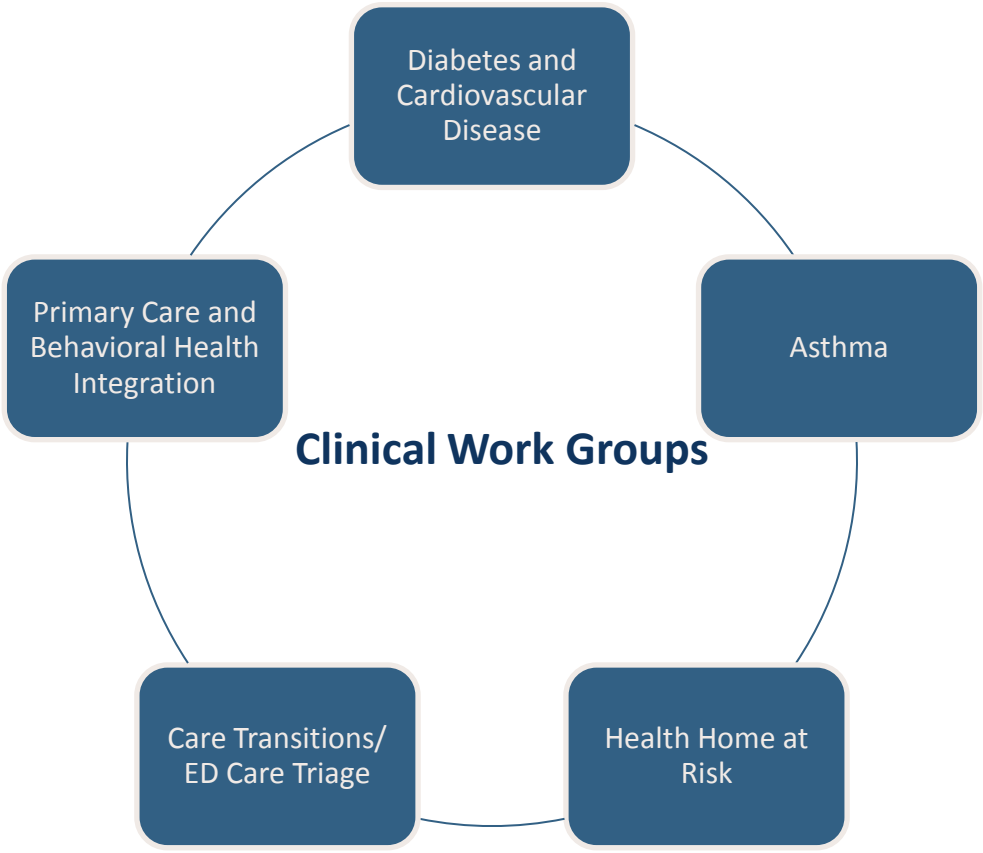
Committee Organization Types



**Other: BPHC CSO, Education, Housing, DD, MCOs, RHIO, Unions

* Includes Executive Committee & four Sub-committees: Finance & Sustainability, Work Force, IT and Quality & Care Innovation

Clinical Work Groups Support QCIS



***Transitional* Work Groups (TWGs)** convened to contribute clinical and community expertise to BPHC's Clinical Operations Plans (COPs) during the planning phase. are Composed of experts in the field, the TWGs helped outline timelines and milestones, workflow, operations, and other elements specific to each BPHC Project to support implementation.

Once the projects launch, the TWGs transition into ***Implementation* Work Groups (IWGs) that** meet to provide clinical expertise and support implementation.

The BPHC Ecosystem

Healthcare Providers

- Receive funds to support DSRIP activities
- Coordinate care within and across services
- Implement evidence-based care protocols
- Promote patient self-management
- Transition to value-based payments

Community-Based Organizations

- Provide services to:
  - Support healthy lifestyle
  - Improve access to care
- Refer patients to PPS providers

BPHC Central Services Organization (CSO)

- Provide centralized support to the PPS :
  - Project planning & management
  - Communications hub
  - Training and workforce development
  - Information Technology
  - Performance analysis, monitoring & improvement
  - Financial management, including distribution of DSRIP funds to PPS members
  - Support governance function & activities

Roles: Partners, Members and Vendors

Partner

Organizations that will participate in BPHC and are expected to receive DSRIP funds.

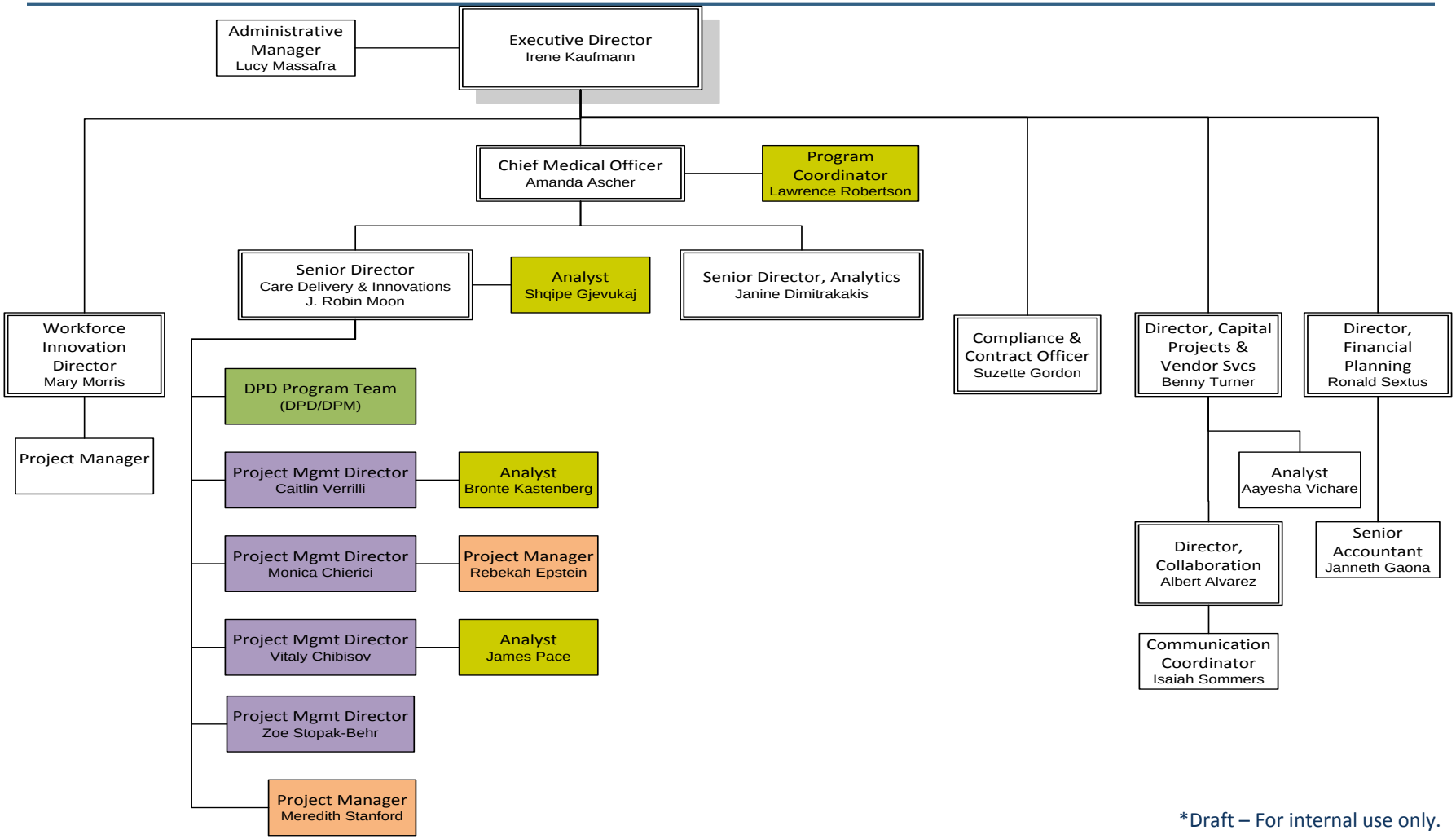
Member

Organizations that will participate in BPHC but are not expected to receive DSRIP funds.

Vendor

Organizations that will not participate in BPHC but will provide services and receive payment for rendering services (e.g., IT vendor, PCMH technical assistance provider).

Organizational Chart



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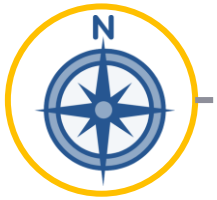
CSO Operational Functions



Patient & Provider Engagement
- Care management support
- Patient registries support
- Provider engagement

Data & Analytics
- Population health management
- Data / trend reporting
- Partner performance feedback

Clinical Support
- Clinical operation plans
- Target population identification
- Protocol compliance
- Performance monitoring

Information Technology
- IT infrastructure strategy
- HIT, HIE, and telehealth
- Central data management

Workforce, Staffing & Training
- Workforce development
- Recruiting / deployment
- Training

Financial / Program Management
- Fiscal agent / funds distribution
- Contracting
- Compliance
- Sustainability and VBP planning

PPS Partners and Central Services Organization (1/2)

	Partner responsibilities:	CSO support may include the following functions/services:
Information Technology	❑ Report information on IT systems and capabilities to the CSO, as needed (e.g., partner assessment surveys) ❑ Ensure IT systems meet DSRIP requirements (e.g., EHR that meets Meaningful Use stage 2, EHR that connects to RHIO/SHIN-NY)	❑ Aggregate and track information on overall IT landscape and partner IT systems and capabilities ❑ Develop IT strategy for the PPS, including protocols for adoption and use of IT across the PPS ❑ Build and staff 24/7 call center to enhance scheduling capabilities and provide telephone triage for the PPS
Performance data tracking and analysis	❑ Submit data and documentation to the CSO in a timely manner and according to specified data submission process ❑ Leverage data analytics provided by CSO to inform operations and population health management	❑ Coordinate quarterly reporting to NY • Develop quarterly reporting strategy for the PPS, process and data sources • For data and documentation needed from partners: identify contents, outline process, and support submission (e.g., develop submission tools, host webinars) • Compile and submit quarterly report to NYS ❑ Gather and provide data analytics necessary to support operations and performance improvement of the PPS
Partnership management	❑ Formalize relationships with PPS through contracting and other means ❑ Provide information on entity, organization, and site (e.g., location, clinical services, staff and capacity) as requested by the CSO ❑ Engage with CSO and other partners by attending meetings and reading communications	❑ Formalize relationships with network of partners through contracting and other means ❑ Maintain database of partner information (e.g., location, clinical services, staff and capacity) ❑ Engage partners through a variety of channels (e.g., Hub- and PPS-level planning meetings and PACs, webinars, written communications)

PPS Partners and Central Services Organization (2/2)

	Partner responsibilities:	CSO support may include the following functions/services:
Project protocol design and evaluation	❑ Provide subject matter expertise to develop and refine clinical protocols and operational guidelines, care management strategy, and approach to community and patient engagement ❑ Implement clinical protocols and operational guidelines	❑ Guide and coordinate development and modification of clinical protocols and operational guidelines, including guidance on how to incorporate into workflow ❑ Develop PPS approach to care management in coordination with partners ❑ Develop processes related to community and patient engagement
Finance	❑ Track and report DSRIP-related expenses as specified by PPS Governance bodies and CSO	❑ Create project budgets ❑ Design processes for funds flow to partners ❑ Track expenses of project implementation and distribution of funds to partners
Workforce development	❑ Submit data on workforce to PPS for the purpose of workforce baseline and ongoing monitoring ❑ Partner with CSO in development of training content and schedule ❑ Train staff	❑ Document workforce baseline, outline target state, and conduct gap analysis ❑ Develop training content ❑ Develop training schedule and track training conducted across the PPS ❑ Lay out approach to enhancing access, including recruitment efforts
Healthcare management consulting services	❑ Identify roadblocks to implementation and optimal performance; escalate to CSO and PPS leadership	❑ Develop roll-out plan across PPS (where and when to implement each project) to include in contracting ❑ Monitor implementation progress and performance across the PPS ❑ Work with partners (in groups, 1-on-1) to improve performance

PERFORMANCE EVALUATION AND FUNDING

Budgeting Approach

Top Down

- Use approved budget assumptions to allocate NPV, SNE Performance and SNE Guarantee funds across DSRIP projects, using NYSDOH-assigned project valuations
- Disregard High Performance funds

- Use approved budget assumptions to calculate funds available for implementation during each of the DSRIP years

- Set aside funds for centralized cost (CSO, IT, Workforce, consulting contracts, etc.)

- Group DSRIP projects into categories (“buckets”) combining/consolidating implementation funds available

Initial Funds Distribution

- Develop bottom-up central infrastructure, global care model and project-specific buckets
- Develop RFI to inform bottom-up budgeting

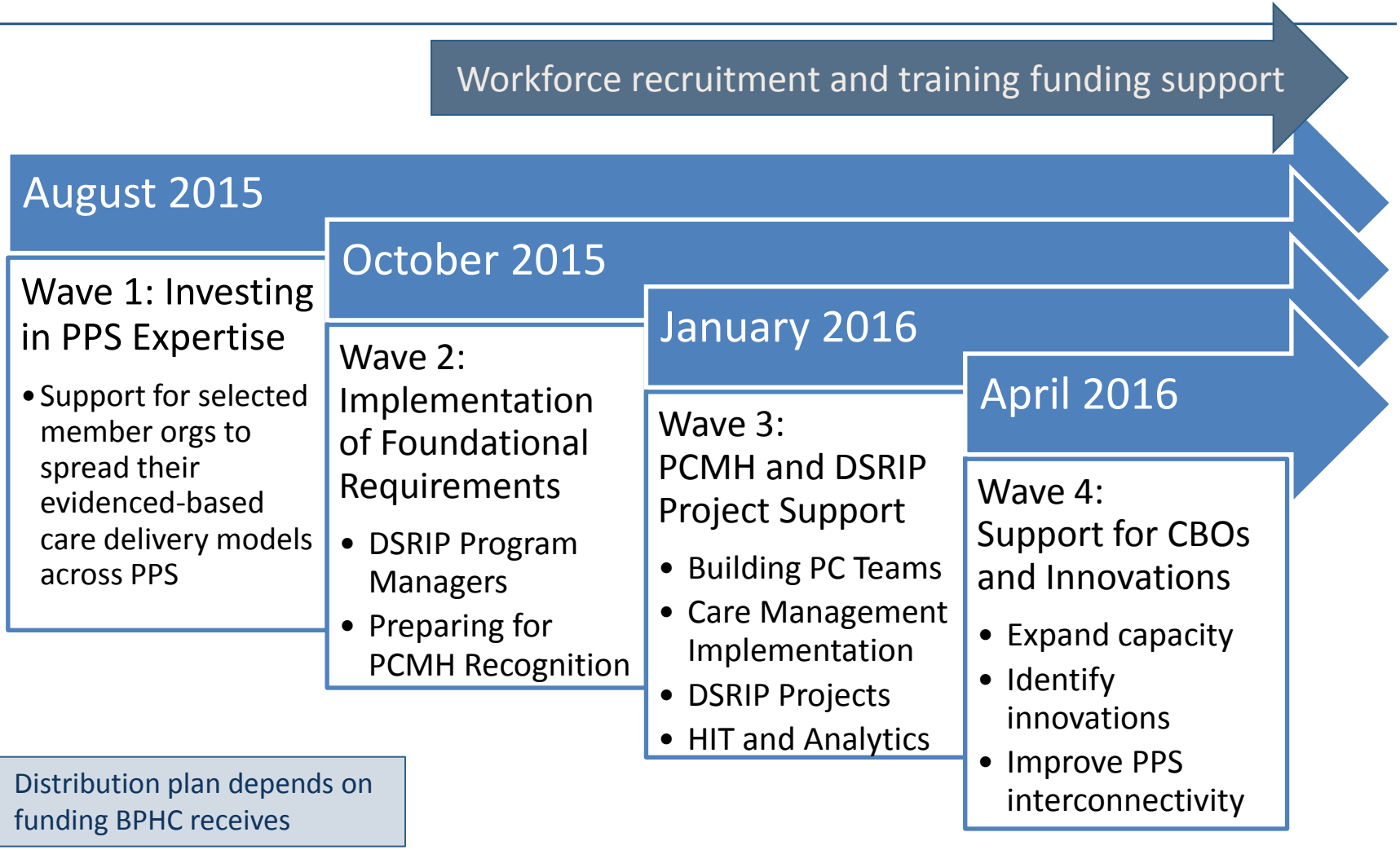
Bottom Up

DSRIP Fund Distribution

- Underlying principles driving distribution of DSRIP Funds:
  - **Facilitating**: project implementation
  - **Unifying**: adoption and spread of standardized protocols, clinical guidelines, interventions, care models, and systems
  - **Achieving**: DSRIP targets by supporting work, processes and resource needs of member organizations
  - **Inclusive:** extend funding opportunity broadly to PPS members

- **Three** categories of Implementation Funds:
  - **Centralized** systems, services, and personnel foundational to DSRIP success
  - **Core resourcing** for implementing standardized care team and care management model
  - **Project-specific Resources** (Domains 2-4)
  - **Community services and innovations support**

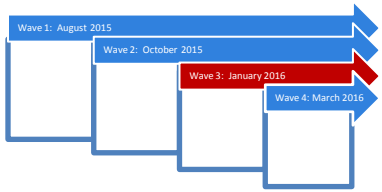
Plan for Distribution of Funds



Distribution plan depends on funding BPHC receives

Wave 3: Funds to Build Robust Primary Care and DSRIP Projects

- Provide opportunity for member organizations to identify resource gaps that could impact their capacity to meet PCMH and DSRIP Projects implementation targets, including:
  - Access to centralized systems and services foundational to overall DSRIP success
    - Support for interconnectivity, IT infrastructure
    - Access to care management systems and registries
  - Access to resources to establish
    - Care management services
    - Personnel to right-size primary care teams
    - Training for team-based care competencies
  - Resources specific to individual projects
- BPHC will guide the resource gap analysis through an RFI process offering a unified vision for BPHC's projects and PCMH medical home using references developed through the DSRIP planning and implementation process, including:
  - Summary of key elements of Clinical Operation Plans (COPs)
  - PCMH:DSRIP project crosswalks
  - Care models
  - PCMH gap analysis and baseline staff



Priorities for Waves 3 and 4 Funding

Scope of RFI

Resource/Capacity Priority	Roles/Infrastructure
Wave 3a: PCMH Support for Large Primary Care Partners and DSRIP Project Support for Large Primary Care Partners, Selected Behavioral Health Partners, and Hospitals	
PCMH support	In process
Primary care team right sizing	Medical assistants
Care management for at-risk and disease management populations	Care coordinators and nurse care management supervisors
Primary care/behavioral health integration	LCSWs (IMPACT model) and telepsychiatry (IMPACT model and co-location)
ED triage (hospitals only)	ED care navigators
Care transitions (hospitals only)	Transitional care coordinators
IT needs	TBD
Wave 3b: PCMH Support for Small Primary Care Partners and DSRIP Project Support for All Partners	
PCMH support	Not yet started
Care management for at-risk and disease management populations	Care coordinators and nurse care management supervisors
Centralized services	TBD
Wave 4: Support for CBOs and Innovations (Priorities TBD)	

CSO Responsibilities Leading to Funds Flow

- **PCMH Technical Assistance**
  - Procure and manage consultant to produce individual partner work plans for achieving PCMH 2014 Level 3 recognition
- **Partner Request for Information**
  - Solicit partner response to inform resource planning and funds distribution
- **Budgeting**
  - Pro forma budget for partner funding (not individual partner) through March 2017 (18 mos.)
  - Individual partner funding allocations through March 2017
  - PPS budget through March 2017
- **Contracting**
  - Wave 3 partner startup contract schedules for staffing and other resource requirements through March 2017
    - 3a large primary care partners, selected behavioral health partners, and hospitals
    - 3b small primary care partners and other types of partners

Wave 3 Partners: PCMH Implementation

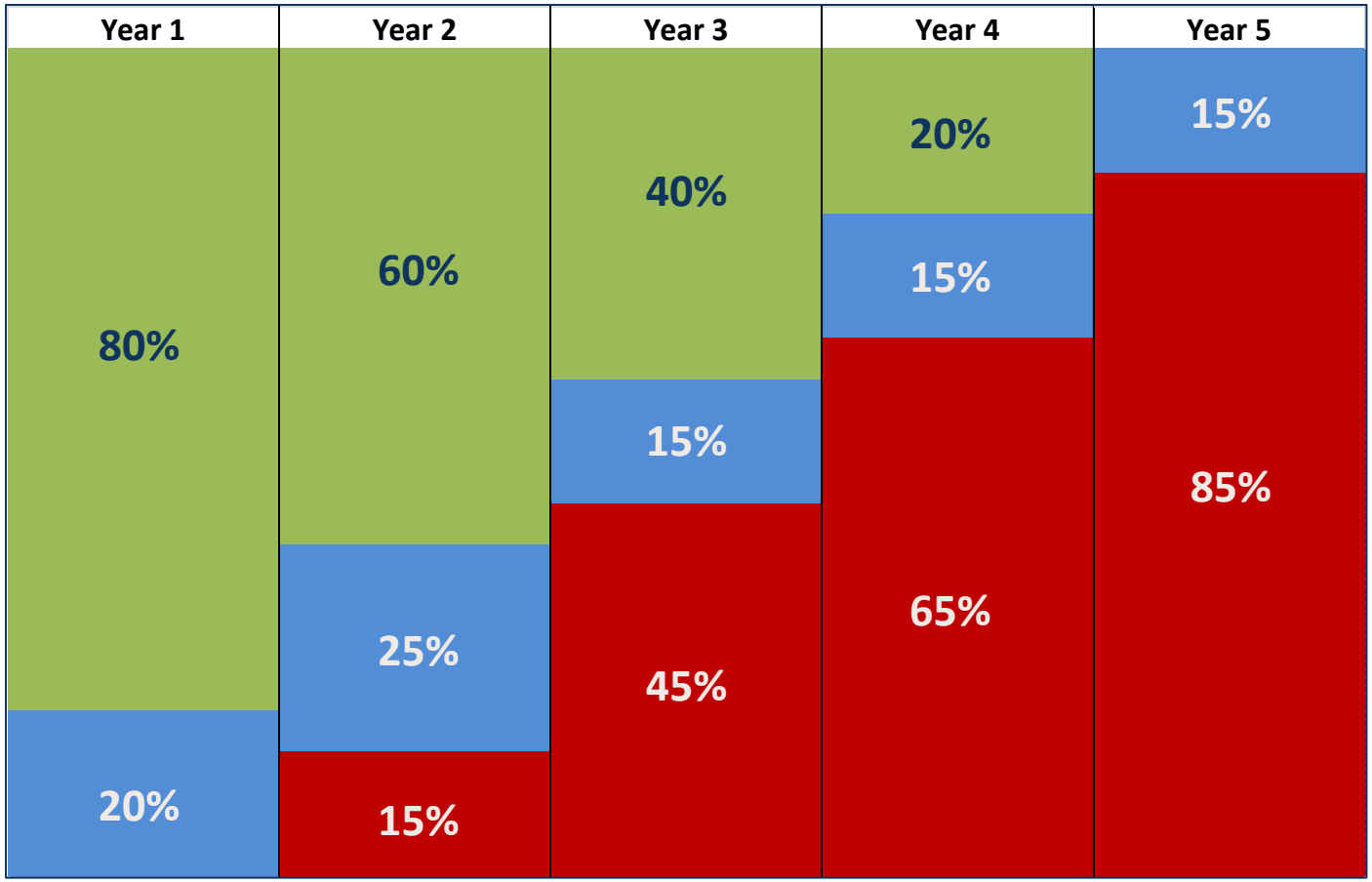
Member Entity	Type	Location Count	PCP Count
Acacia Network	Multi-type*	7	16
Bronx United IPA	Physicians Group	29	39
Institute for Family Health	Article 28 & 31	4	21
Montefiore Medical Center - Faculty	Multi-type	46	218
Montefiore Medical Center - MMG	Multi-type	20	243
Montefiore Medical Center - SBHC	Multi-type	9	10
Montefiore Medical Center - Voluntary	Multi-type	156	182
Morris Heights Health Center	Article 28	13	35
SBH Health System	Multi-type	9	63
Union Community Health Center	FQHC	3	31
Independent Clinics in Non-Traditional Settings	Multi-type	64	90

*Provides primary care, long term care, mental health, substance abuse, and housing services
Shaded providers are the first to receive the RFI ("Wave 3a")

Project Progress Milestones (Domain 1)

	Project Requirements Domain I	Project Measures Domains 2-4
What do they track?	Process establishment and project implementation	Outcomes of DSRIP work – some are linked to reporting only (P4R), some are linked to meeting performance goals (P4P)
Who reports?	Primarily CSO/Sites	Primarily NYSDOH
When are they emphasized?	Most important in years 1-2	Most important in years 3-5
What time period do they measure?	Previous quarter	About 1 year lag

DSRIP Funding Mix Evolution Over Time



Domain 1

Domain 2-4 (P4R)

Domain 2-4 (P4P)

Total potential in base award = $170M

Source: Attachment I – Program Funding and Mechanics

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

PREPARING FOR IMPLEMENTATION

Partner Contracting: The MSA

Partners must sign an MSA (Master Services Agreement) to receive funds from BPHC. The MSA, along with its exhibits and schedules, establishes roles and responsibilities.

What the Agreements Do:

- Establish general roles and responsibilities of the parties.
- Outline general framework for the PPS's process for distributing DSRIP payments.
- Outline governance process.
- Describe process for establishing Partner's responsibilities related to implementing specific projects.
- Provide basic legal terms governing relationships among the parties.

What the Agreements Do Not Do:

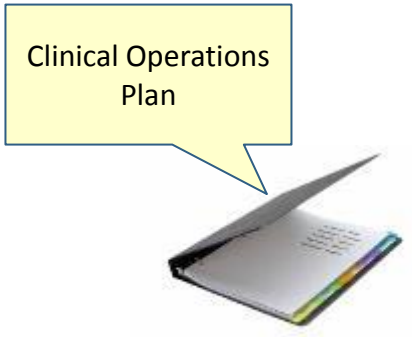
- Describe the projects in which each Partner will participate.
- Establish Partner's specific obligations related to implementing a particular project.
- Identify amount of DSRIP funds Partners will receive for implementing a particular project.

Clinical Project Planning

NYS defined basic project requirements and timelines, as well as project measures, for all clinical projects

For CVD, Diabetes, Asthma, and Health Home At-Risk transitional work groups (TWGs) have been identifying resources and guidelines to implement the project requirements and collect data for measures; this, along with CSO-wide strategies, will form the basis of the Clinical Operations Plan (COP) for each project

PPS members with project-specific expertise have been identified and engaged to assist in COP development in 3 additional projects: ED Care Triage, 30-Day Care Transitions and Primary Care / Behavioral Health Integration



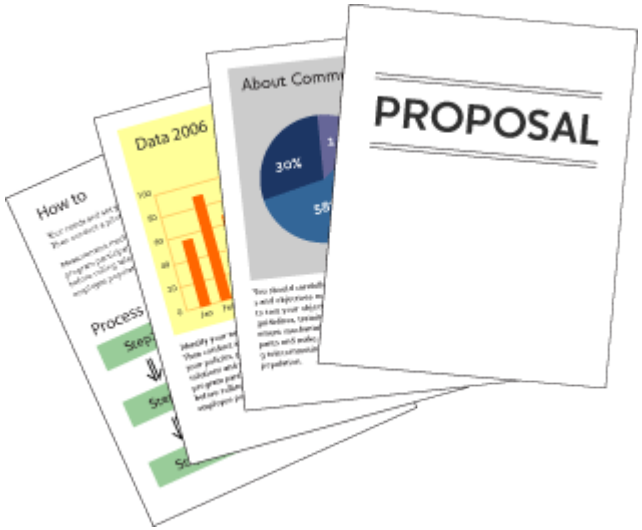
Clinical operations plans (COPs) will provide guidance for project implementation as well as basis for determining resource needs for participating providers

Quality and Care Innovation Subcommittee (QCIS) and Executive Committee (EC) approve elements of the COPs

PCMH Planning

2014 PCMH Level-3 Recognition is a DSRIP requirement for primary care providers in a PPS

- 952 BPHC PCPs across >150 locations will need to achieve NCQA Level-3 Recognition by March 2018
- Implementation and submission of application takes 12-18 months



CSO recruited experienced consultants to assist with this significant effort

- > 20 Consulting firms were identified
- 18 submitted letters of intent
- Organizations interviewed and selected a consultant

Consultants are carrying out pre-contract deliverables using universal tools:

- Gap analysis
- Project plan and timeline, including projected hours and cost/site
- Staffing baseline
- PCMH milestones
- MOU between consultant and practice leadership

Implementation Planning

Workforce

- The Workforce Subcommittee is developing BPHC's comprehensive workforce strategy. Workgroups have been formed for Planning and Communications to aid in the creation and rollout of BPHC's recruitment, redeployment, training, and retention strategies. This includes defining the workforce future state and conducting a gap analysis.

IT

- The IT Subcommittee is developing protocols to help PPS members communicate and collaborate, both within care teams and between partner organizations. The Subcommittee is working to select information sharing software and developing plans for common IT infrastructure, with a focus on clinical data sharing, referral tracking, security, and compliance.

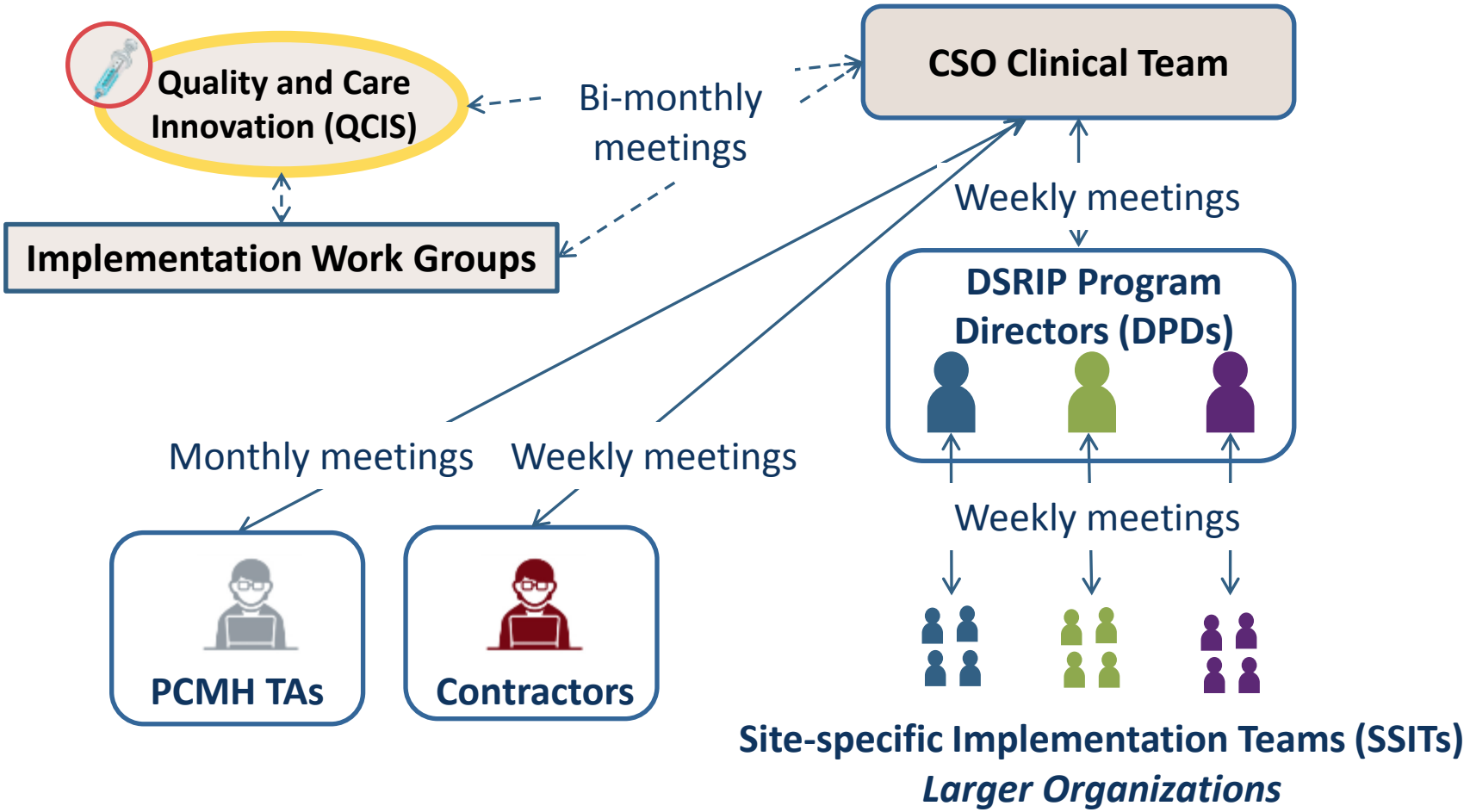
CBOs

- CBOs from nearly 40 PPS member organizations have convened to explore the role of community-based services in our DSRIP projects. Workgroups that emerged from these discussion sessions are actively developing BPHC strategies for community engagement, service coordination and integration, and interconnectivity.

Current Implementation **Support Partners**

- a.i.r. nyc
  - 3.d.ii Asthma Home-Based Self-Management Program
- Montefiore Medical Center CMO
  - 2.b.iii Emergency Department (ED) Care Triage for At-Risk Populations
  - 2.b.iv Care Transitions to Reduce 30-Day Readmissions
- Institute for Family Health
  - 3.a.i Integration of Primary Care & Behavioral Health Services (Co-location Models)
  - 3.a.i Integration of Primary Care & Behavioral Health Services (IMPACT Model)
- More are being identified…

Implementation Support Process Flow



ROLES & RESPONSIBILITIES FOR DSRIP PROGRAM DIRECTORS / MANAGERS

Management Structure

- The **Central Services Organization** (CSO) of BPHC is made up of staff members working to support the entire PPS, helping create an integrated delivery system where patients are followed and supported through transitions of care. The CSO has teams working on Collaboration, Finance, Workforce, Analytics and the Clinical Projects. Clinical project management lies with the CSO Clinical Team.
- **CSO Clinical Team** is responsible for **managing** all of the 10 DSRIP projects and managing or coordinating the 10 work streams; **reporting** quarterly to the State; **representing** the PPS to the State; and **working** with the partner organizations to ensure on-target project progress.
- **CSO Clinical Team** manages the Implementation Work Groups (IWGs), manages/interacts with the PCMH consultants and other contractors, and DSRIP Program Directors/Managers (DPD/DPM) and the site specific implementation teams (SSIT).

Management Structure, cont'd

- **Implementation Work Groups** (IWG, aka rapid deployment collaborative, or "rdc"): IWGs work with key PPS organizations and CBOs to select thought leaders from among the major practitioner groups and community-based organizations (CBOs), including primary care physicians, sub-specialists, nurses, mental health professionals, social workers, and peers, who will develop engagement strategies specific to the PPS quality improvement agenda and DSRIP projects.
- IWGs will meet approximately every other month, and be led and staffed by the CSO PMDs/PMs in charge of the respective projects. These IWGs will also serve as project clinical quality councils, and will report up to the Quality and Care Innovation Subcommittee (QCIS) for major decision-making items.
- Current IWGs: **ED/Care Transition, Health Home @ Risk, PC/BH Integration, CVD/DM2, Asthma, HIV, MHSA**

Management Structure, cont'd

- **Site-Specific Implementation Teams (SSIT):** All partners directly engaged in project implementation will have SSITs, either stand-alone or collaborative. Practices/Sites will choose their SSIT members, but for larger practices we recommend including leadership, operations staff, a PCP, nursing staff (RN/LPN/MA) and clerical staff. If Care Management staff are in place, they should be included as well. The largest primary care organizations will hire DPDs/DPMs, who will play the management, coordination and liaison role between the SSIT and the CSO.
- Project-specific launches will follow the Launch Event (Dec 3), in a phased manner (please see Implementation Timeline). These launches will include the SSITs.
- There will be meetings between the SSIT and CSO Clinical team staff, remotely and in-person, at the sites or at the CSO, to facilitate the project progress reporting, troubleshooting, and relationship building. This will be facilitated and managed by the DPD/DPM who will have close working relationship with the CSO while working full-time at the partner sites.

DPD/DPM Roles

- The DPD/DPM will coordinate and monitor the progress of the clinical projects at our larger clinical partner organizations and serve as the liaison between the partner organization and the CSO.

- Working closely with the site-specific implementation teams and site leadership, the DPD/DPM will ensure the success of project implementation, monitoring, reporting (including Rapid Cycle Evaluation Metrics) , communication and coordination.

- The DPD/DPM will report to clinical and/or administrative leadership (CMO and/or COO) of the member organization.

- DPD/DPM will meet regularly with BPHC CSO staff for individual and group-based training, coaching and to report progress of project implementation.

DPD/DPM Responsibilities

- They will be the points of contact for CSO's reporting submission, on behalf of the partner organizations they represent, among other responsibilities.

- Reporting includes, but not limited to:
  - State quarterly reports
    - Major Risks to Implementation and Mitigation Strategies
    - Project Implementation Speed
    - Patient Engagement Speed
    - Project Implementation Requirements
  - Rapid Cycle Evaluation Metrics

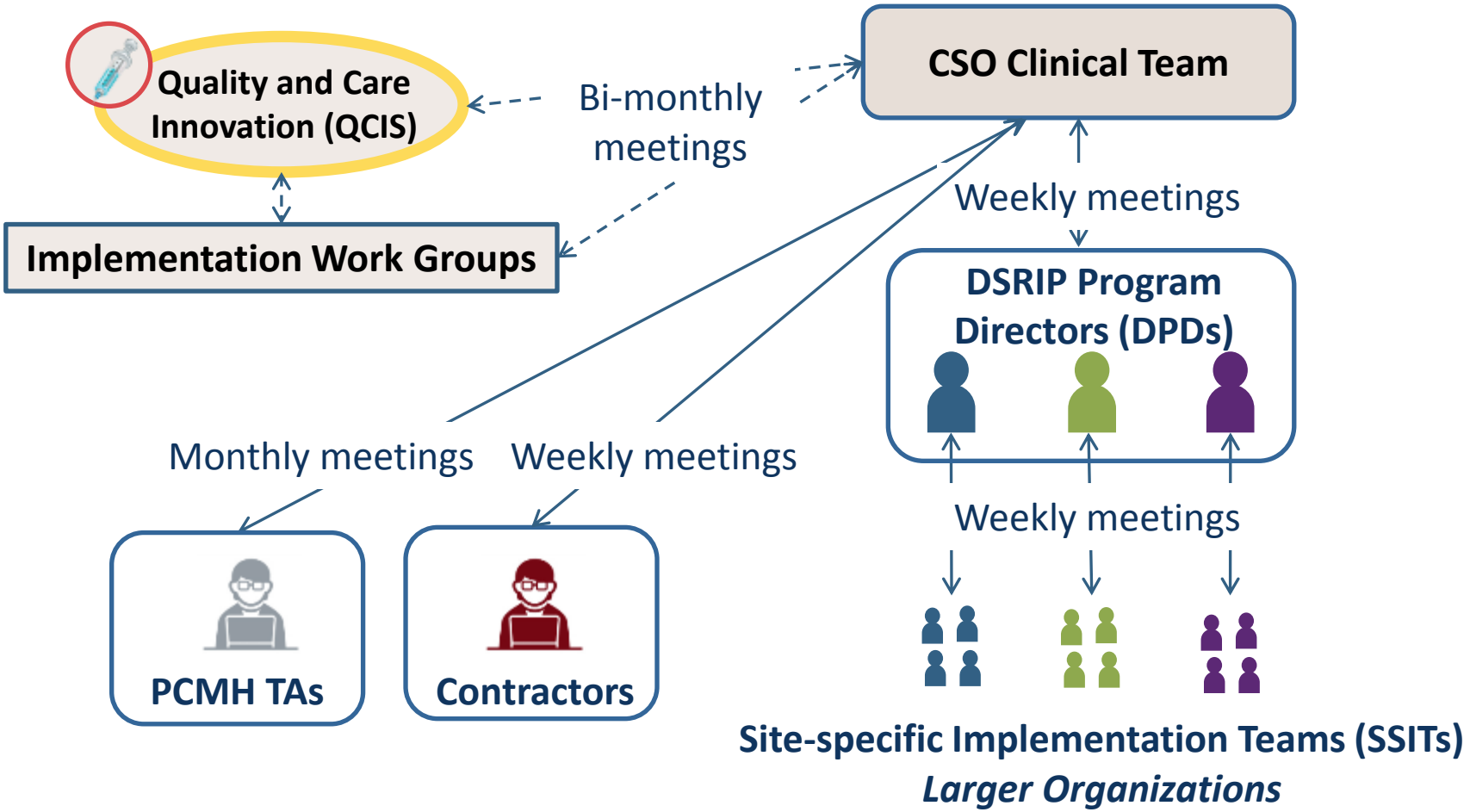
CSO & DPDs Relations

- CSO represents our PPS to the State; our PPS consists of our partners
- CSO's job is to support and advocate for the partner organizations in *every possible way* to enable them to accomplish their DSRIP goals and objectives
- CSO-Partner relation for the large primary care org partners is vis-à-vis DPDs/DPM
- DPDs/DPM are employees of and represent the respective partner organizations
- DPDs/DPM also have reporting responsibility to the CSO
  - CSO needs DPDs/DPM to be the CSO's voice back at their orgs
  - DPDs/DPM help CSO accomplish BPHC's DSRIP requirements
- DPDs/DPM build relations and accountability among themselves

Management Structure, cont'd

- **PCMH Consultants / TA Providers**: CSO has hired independent PCMH consultants to engage with many of our partner organizations and their PCPs to ensure the achievement of PCMH 2014 Level 3 recognition by DY3Q4. These consultants report to the CSO Executive Director and the PMDs will start working closely with them. The consultants gap analysis will determine the level of effort necessary for the transformation process. CSO will work with the consultants on a regularly basis to align the project requirements and expectations as closely as possible with the PCMH transformation process.
- **Contractors**: CSO has also hired contractors to assist with project implementation. The PMDs responsible for these projects work closely with the respective contractors, from the kickoff the project through post-implementation support Current contractors include:
  - Institute for Family Health (IFH), for 3.a.i.
  - Montefiore Care Management Organization (CMO), for 2.b.iii + 2.b.iv
  - a.i.r. nyc/ a.i.r. Bronx, for 3.d.ii

Implementation Support Process Flow



Accountability & Logistics

- Orientation; DPD/PMD 1:1 Project Overviews
- Weekly Status Updates to CSO SD
- Regular Meeting Schedule (subject to change):
  - CSO Clinical Team + DPD/DPMs: Twice-monthly status meetings
    - Tagging onto the weekly CSO Clinical Team meetings (generally Weds 9-11am)
  - CSO Clinical Team + DPD/DPMs: Start-, Mid-, End-Quarterly meetings
  - CSO Clinical Team Leads (CMO, SD) + PMD/DPM: weekly standing meetings
- As-Needed Project-Specific Meetings
- As-Needed not-Project-Specific Meetings (work stream, over-arching)
- Other/Admin Meetings
- Meetings amongst DPDs
- Use of DSRIP Tracker (“Performance Logic”) for Project Management
- Timely Communication with the CSO leads

PROJECT- SPECIFIC &PCMH STRATEGY

Foundational Components of BPHC's Program

By DY2 | By DY5

Technology

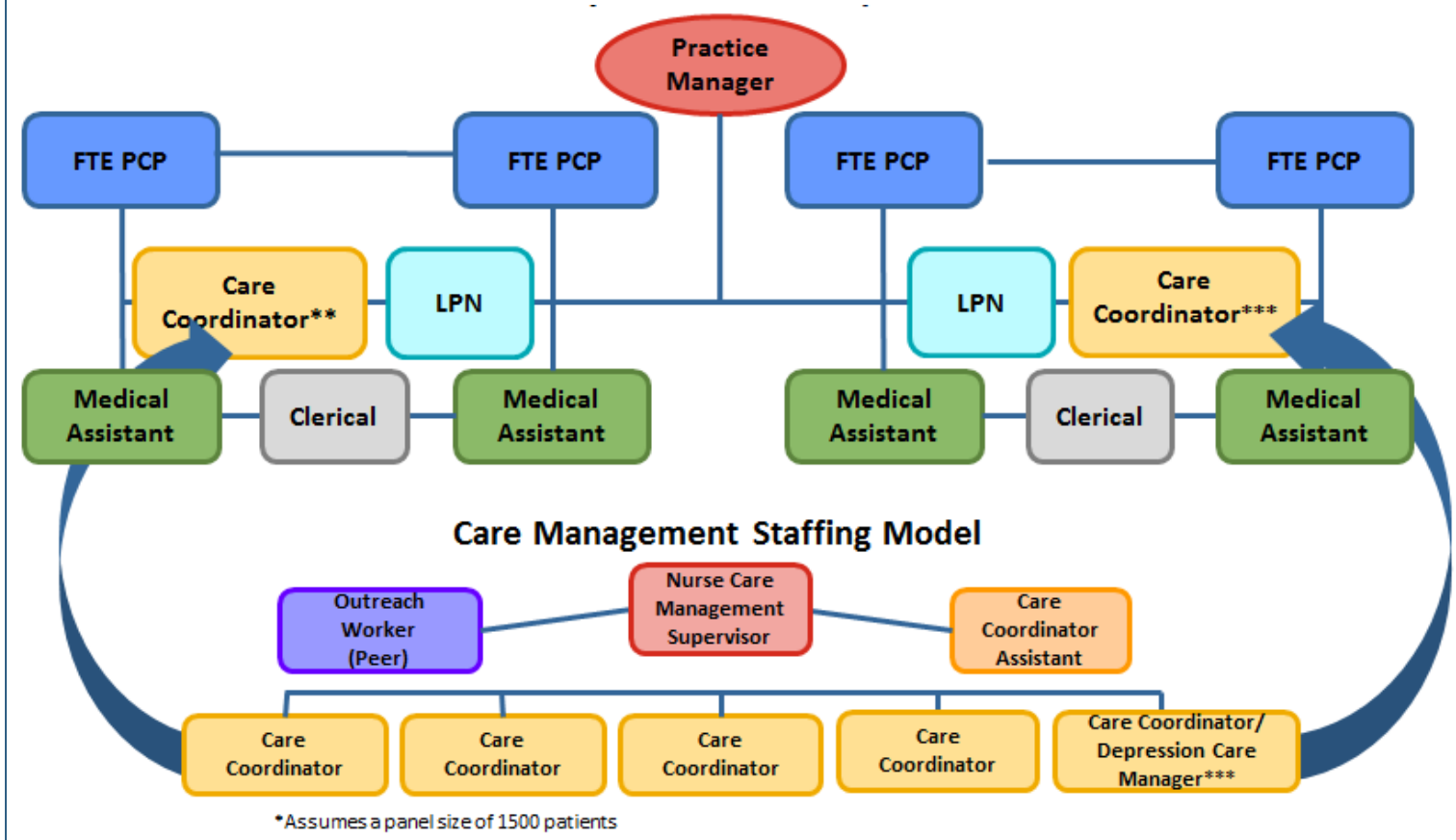
- Community Resources Database
- CCMS
- MU2 Stage 2
- Referral Mgt System
- RHIO Consent and Connectivity
- PCMH Level 3

Programmatic

- Adopt PPS Evidence-based Guidelines
- Implement team-based care model
- Care Coordination/ Care Transitions
- Utilize Population Health Mgt
- Complete Required Trainings
- Use/Distribute Patient Education

Care Team and Care Management Structure

Large Practice

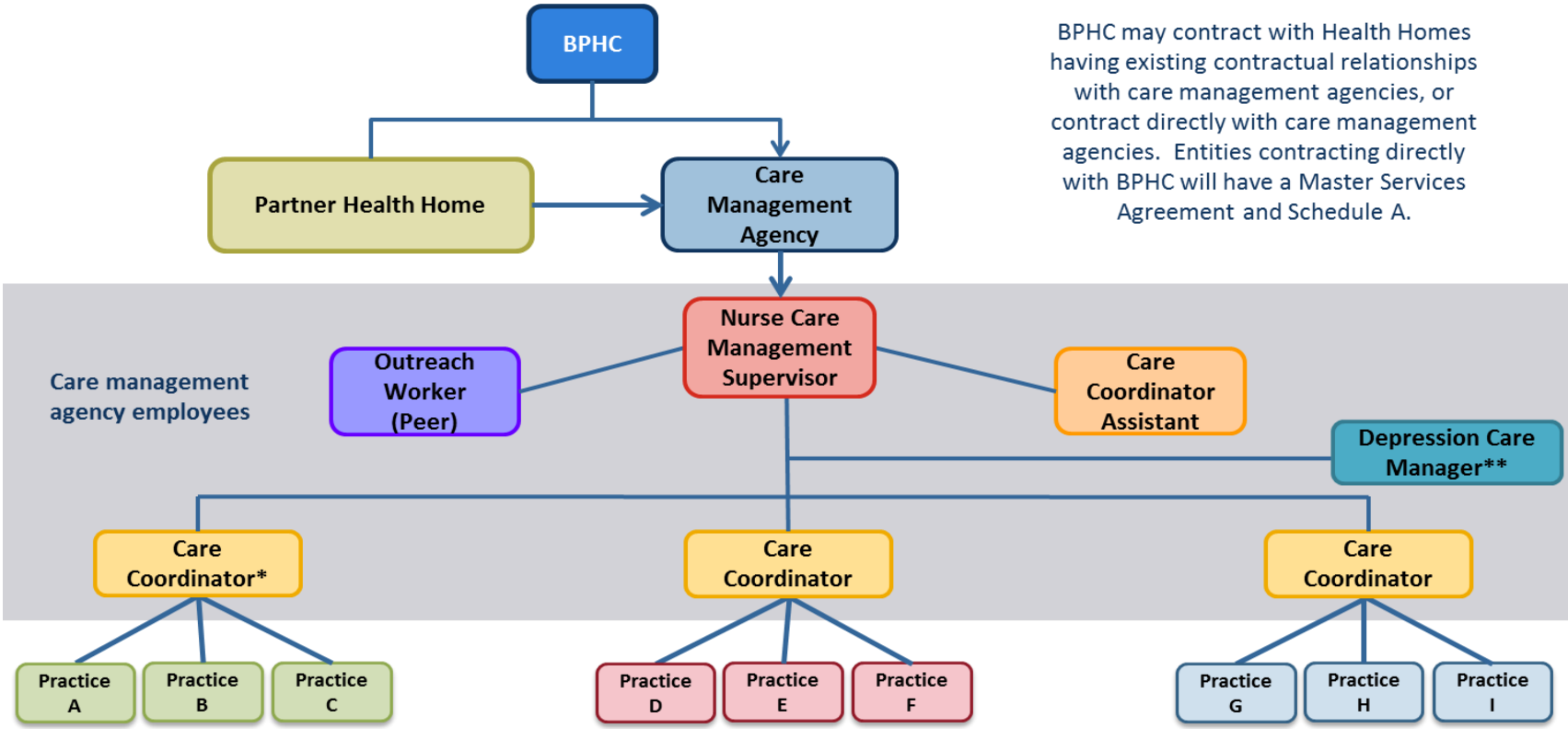


Possible Existing Supporting Team Members (Project Alignment)

- Social Worker *(All projects)*
- RN *(3.b.i, 3.c.i)*
- Psychiatrist *(3.a.i)*
- Dietician *(2.a.iii, 3.b.i, 3.c.i)*
- Clinical Pharmacist *(All projects)*

Care Team and Care Management Structure

Smaller/Independent Practice



* Care coordinators will be assigned to practices on the basis of geographic proximity. A care coordinator may be assigned to greater or less than three practices depending on the size of the Health Home at-risk caseload at each site.

** Depression care managers will be used for the IMPACT model

COP Example: Diabetes

Cross-Cutting Chapters
Evidence-Based Guidelines
Patient Education
PHM and Registry Use
Practitioner Engagement
Quality Management
Referral Management
Care Plan
Workforce & Training
IT

Cross-Cutting Chapters
Evidence-Based Guidelines • 2015 ADA Clinical Practice Recommendations
Clinical initiatives • Influenza vaccine • Self-management goals
PHM • Hot-spotting Strategy
Referral Protocols • Stanford Model Classes & LEAP Program
DSRIP Measures

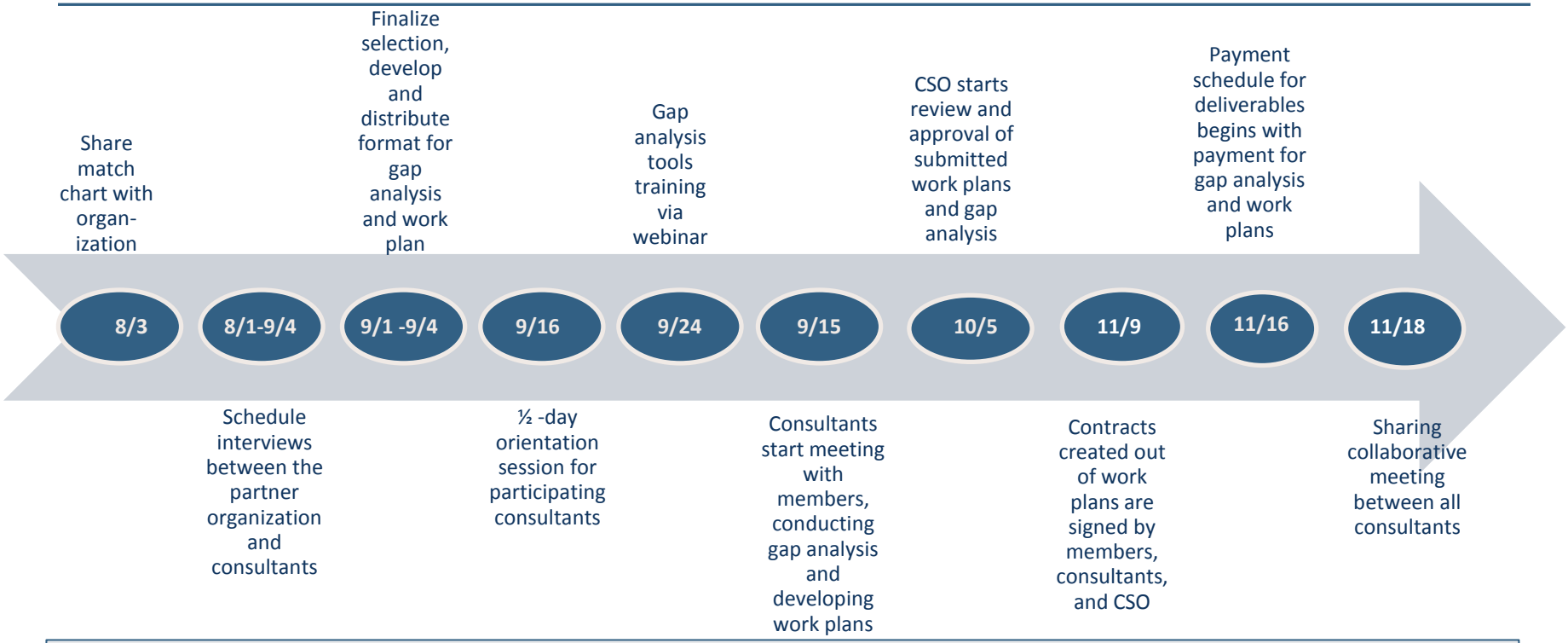
Project-Specific Launches

Domain	Project	Date
3	Primary Care/Behavioral Health Integration	September 30
2	30 Day Care Transitions	November 11
2	ED Care Triage	November 23
2	Health Home At-Risk Intervention	January 11, 2016
3	CVD/Diabetes Disease Management	Feb 11, 2016
3	Asthma Home-Based Self-Management	March 10, 2016
4	Mental Health and Substance Abuse	Spring 2016
4	Early Access / Retention in HIV Care	Spring 2016

Already Launched

To Launch in 2016

PCMH Project Timeline (2015)



Consultants have completed a number of gap analyses and are formulating work plans

Practices submit NCQA PCMH Application no later than August 2017