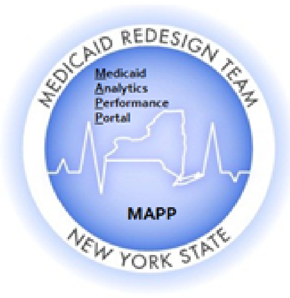


SECTION 1 – EXECUTIVE SUMMARY:

Section 1.0 - Executive Summary - Description:

Description:

The DSRIP PPS Organizational Application must include an executive summary clearly articulating how the PPS will evolve into a highly effective integrated delivery system. This section will also include questions about any application(s) for regulatory relief the PPS is pursuing.

Scoring Process:

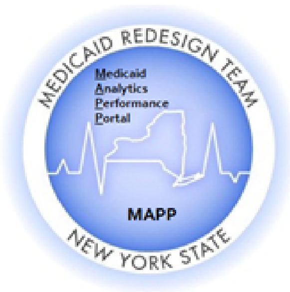
This section is not factored into the scoring of the PPS application. This response will be reviewed for completeness and a pass/fail determination will be made.

Section 1.1 - Executive Summary:

***Goals:**

Succinctly explain the identified goals and objectives of the PPS. Goals and objectives should match the overall goals of the NY DSRIP waiver and should be measurable.

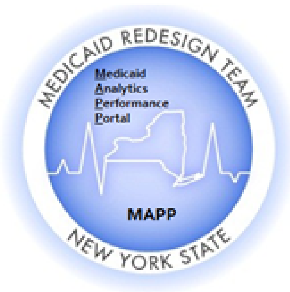
#	Goal	Reason For Goal
1	Transform to an integrated delivery system (IDS) spanning the care continuum by DSRIP Year (DY) 5	The CNA confirms that the Bronx is the least healthy county in New York State. Poverty; cultural, immigration and language barriers; and the transient nature of the population have confounded the borough's best efforts for sustained population health improvement. While BPHC cannot eliminate these factors, it can fight their effects on health through an IDS with: a) Greater clinical integration among Bronx-based providers and expanded use of community-based and non-clinical care coordination resources to expand access to health services b) Eventual financial integration, beginning with expanded provider incentives for treating the whole person, moving to value-based payment arrangements c) Information-sharing infrastructure and environment giving providers more visibility into and control over performance and outcomes d) Governance that integrates services for addressing social determinants of health and enables neighborhood and Bronx-wide capacity planning to address shortages
2	Integrate social service programs and organizations into the network of IDS partners by DY5	While the Bronx is fortunate to have a deep base of community resources, more than one-third of CNA respondents do not find social services to be readily available. The concern in the Bronx is not so much the composition of resources as it is that the level of need exceeds the available community resources. DSRIP provides an opportunity to increase the reach and impact of existing resources. We will seek to mobilize key resources to help address: a) Housing issues: Over 50% of Bronx CNA respondents noted a lack of affordable housing in their community b) Food insecurity and nutrition: Over 40% of CNA respondents felt that there is a lack of access to healthy foods in their community c) Employment: Almost two-thirds of CNA respondents felt that job training was somewhat unavailable in the community d) Recidivism prevention: The Bronx's rate of jail admissions is 15% higher than NYC overall. A large percentage of state prison releasees move to the Bronx after their sentence is complete
3	Reduce avoidable hospital admissions and readmissions by 25% by DY5	The Bronx has the highest rate of potentially avoidable inpatient hospitalizations of any New York City borough. Chronic conditions, including asthma/COPD, cardiovascular conditions, and diabetes, account for the highest proportion of potentially preventable admissions. The



#	Goal	Reason For Goal
		Bronx's rate of potentially preventable readmissions (PPRs) is 5% higher than NYC and 13% higher than NYS as a whole, and Bronx hospitals have 13% more PPRs than expected.
4	Reduce avoidable emergency department use by 25% by DY5	There are significant opportunities to reduce avoidable emergency department (ED) use in the Bronx. Almost one-quarter of beneficiaries attributed to our PPS had one or more ED visit of emergency severity level 3 (low or moderate severity), suggesting inappropriate use of the ED or lack of primary care availability. The neighborhoods identified by the Community Health Care Association of New York State as most needing community health expansion also have the highest rate of PPVs in the Bronx, reaching up to 49 PPVs/100 beneficiaries. By comparison, Bronx-wide, NYS, and NYC rates are 42/100, 36/100, and 34/100 beneficiaries, respectively.
5	Reduce excess acute care beds in the Bronx by DY5	The Bronx has 3,794 hospital beds (2.74/1,000 population, a decline from 3.14/1,000 in 2004). Since 2009, SBH has closed 81 medical and surgical beds and repurposed space for clinical programs such as hospice, sleep labs and wound care. In addition, in 2013, SBH closed a 24-bed detox unit to create an ambulatory center focused on asthma, diabetes and geriatric services and Montefiore repurposed Westchester Square Medical Center acute care units as an ED/ambulatory surgery center. In light of these reductions, BPHC does not believe there is material excess hospital bed capacity in our PPS. A 25% reduction in preventable hospitalizations will result in only a 1-1.5% reduction in demand. The Bronx has 46 nursing homes with 11,732 beds, much higher capacity than NYC and NYS rates, indicating a potential excess of nursing home beds. Beds are filled almost to capacity, suggesting that social factors prevalent in the Bronx are generating strong demand and, if addressed, may allow reductions.
6	Transition care from inpatient to community settings and improve population health management by DY5	The clinical transformation required under DSRIP, including reductions in avoidable admissions, readmissions, and ED visits, will result in major shifts in care delivery. Care will be more focused on prevention, integrated care, self-management, and population health management, increasing the demand for community-based care. DSRIP has encouraged and enabled BPHC to conceptualize integration for population health management on a large scale, as it will be managing the health and social supports of an anticipated 250,000-350,000 patients holistically.
7	Engage a robust and well-trained workforce in transformation efforts under DSRIP beginning in DY1	A robust and well-trained workforce, rooted in the diverse communities of the Bronx, and engaged in the transformative change required under DSRIP will be central to the success of BPHC. As BPHC seeks to shift care from institutional to ambulatory care settings supported by tightly coordinated care management teams, the most significant workforce impacts – and challenges – will be the need to both retrain a significant number of workers in the existing workforce and hire more healthcare professionals and care management staff to meet expanding demand. This challenge translates into an opportunity for workers – as increased demand for workers rooted in the community; new education, training and retraining opportunities; expanded and more clearly defined care roles and career ladders; and coordinated recruiting and retention supports to empower workers to transform careers and positively impact the Bronx community.
8	Achieve PCMH Level 3 (2014) recognition for all Primary Care Provider partners by the end of DY3	Working with primary care providers to achieve 2014 Level 3 PCMH recognition is a key strategy for BPHC. Within primary care sites, there is currently a lack of care management staffing to fully implement PCMH care teams, preventing PCMHs from reaching their potential. Having robust PCMH infrastructure within our PPS is critical to the success of our Health-Home At-Risk (2.a.iii), Integration of Primary Care and Behavioral Health Services (3.a.i), and Evidence-Based Strategies for Disease Management in High Risk/Affected Populations for Cardiovascular Disease and Diabetes (3.b.i and 3.c.i) projects.
9	Expand primary care capacity and access by DY5	The Bronx has a need for increased primary care capacity in targeted neighborhoods. While the Bronx's rate of primary care physicians per population (115.6/100,000) is lower than the NYC (134/100,000) and NYS

St. Barnabas Hospital (dba SBH Health System) (PPS ID:36)

#	Goal	Reason For Goal
		(120/100,000) rates, and access to physicians is even more limited for Medicaid and uninsured patients, especially for those living in several densely populated Bronx neighborhoods with acute primary care shortages.
10	Expand access to behavioral health services by integrating them into primary care settings by DY3	The Bronx has a need for integrated primary care and behavioral health services and improved care coordination services. Bronx residents report higher rates of serious psychological distress (7.1%) than New York City as a whole (5.5%). Community members have indicated that behavioral health issues, including anxiety, depression and substance abuse, are among the most pressing health issues facing residents. Key stakeholders point to the 'silos' among mental health and substance abuse providers as barriers to access. In addition, over half (54.4%) of Bronx adults with behavioral health issues served by NYS Office of Mental Health programs had one or more chronic medical condition. This high degree of overlap indicates that more coordination is needed between behavioral health and physical health services.
11	Increase availability of care management services beginning in DY1	The Bronx has a need to expand care management services and increase provider knowledge of existing care management resources. Care management services present a well-documented strategy for addressing chronic health issues and improving patient outcomes for high-need populations. PPS members and CNA informants identified gaps to accessing care management services at critical junctures in care. According to providers, the system is highly fragmented; there is lack of provider knowledge of and engagement in care coordination services, inadequate/inconsistent IT to conduct care management, inadequate risk stratification to identify "at-risk" populations, and limited discharge planning/referrals after hospital stays.
12	Implement new evidence-based disease management approaches for chronic conditions in DY1	Overall, the Bronx has higher prevalence of chronic disease than New York City or State as a whole; as a result, there is a need for BPHC to implement new evidence-based disease management approaches, including self-management, for chronic conditions. In its clinical projects, BPHC is specifically targeting management of cardiovascular disease, diabetes, asthma, and HIV.
13	Achieve Level 2 meaningful use (MU) and RHIO/SHIN-NY connectivity for eligible partners by DY3	Access to a complete medical record – using electronic health records, health information exchange and other health information technology – makes care coordination and population health management (PHM) feasible, scalable and sustainable. The Meaningful Use standards and incentives – along with prior investments in RHIOs and the SHIN-NY for health information exchange – represent today's de facto infrastructure for care coordination and PHM. BPHC will build PPS-wide capabilities using these tools to collect data, populate repositories and registries, and for managing performance. Features such as direct exchange, secure messaging, encounter notifications, alerts, patient record look up, referral tracking and direct messaging will help prepare patients better and enable providers to coordinate care without overburdening financial and human resources, allowing care teams to spend less time performing routine tasks and more time interacting with patients who need their assistance.
14	Transition to a transparent, inclusive Collaborative Contracting governance model in DY1	BPHC recognizes the importance of a transparent, inclusive governance process to the success of our PPS. The Collaborative Contracting Model will facilitate Partner buy-in during early DSRIP phases while creating accountability as the PPS establishes the systems and relationships necessary to transition to risk-based contracting. The contractual relationships will: (i) provide accountability for DSRIP program milestones; (ii) enforce Partner obligations; and (iii) provide a basis for evaluating/tracking BPHC and Partner performance against established metrics.
15	Create a Central Services Organization (CSO) in DY1 to support the evolving IDS	BPHC's CSO will provide the backbone for supporting and overseeing our PPS's operations. The CSO will provide and/or arrange for a range of services to the PPS, including:



#	Goal	Reason For Goal
		a) Clinical supervision services; b) Information technology services; c) Financial services, including evaluation, development of funds distribution methodologies, and sustainability and value-based payment planning; d) Training; e) Analytics; f) Back office/administrative services; and g) Care management/coordination.

*Formulation:

Explain how the PPS has been formulated to meet the needs of the community and address identified healthcare disparities.

Under SBH's leadership, BPHC has been formulated to meet community needs and address health disparities through three phases of change.

1) Phase 1, BPHC's planning process, represents an unprecedented level of community-based collaboration, supported by inclusive, transparent governance and robust stakeholder engagement to build trust, mobilize Bronx leaders to select DSRIP projects needed by the community and begin business planning. BPHC members offer a diverse network of over 160 providers, social services entities and other critical partners.

2) Phase 2 begins April 1 when BPHC will launch a new implementation governance structure. BPHC will create a Central Services Organization (CSO) to support Rapid Deployment Collaboratives charged with rolling out clinical projects; launch large-scale vendor-supported training, recruitment and redeployment; deploy new IT and care management systems; and finalize financing and incentive mechanisms.

3) New relationships will be forged with Managed Care Organizations (MCOs) to bridge BPHC to its final phase, which will increase reliance on real-time data and create clear lines of accountability between BPHC partners, vendors and the CSO.

*Steps:

Provide the vision of what the delivery system will look like after 5 years and how the full PPS system will be sustainable into future.

To ensure BPHC's transformed delivery system is sustainable as we reach Phase 3 in 5 years, BPHC will have mature partnerships with MCOs that fund infrastructure and capabilities. Montefiore Medical Center (MMC) provides a critical foundation for this effort: an estimated 45-55% of BPHC's attributed population is already under MCO contract with MMC's Care Management Organization (CMO), and MMC's IPA is the county's largest clinically integrated enterprise. BPHC will build upon these capabilities in care coordination, patient stratification and patient engagement, to provide a next generation approach for BPHC partners. Through deploying evidence-based clinical standards consistently across a diverse and accountable network of providers, undergirded by IT and analytic capabilities that support rapid cycle evaluation and program improvement, and incentivized through value-based reimbursement, DSRIP will fundamentally change care to empower patients, build care coordination teams communicating in real time, and integrate physical, behavioral and social services in a manner that addresses the full range of issues that may cause overuse of our expensive inpatient healthcare system.

*Regulatory Relief:

Is the PPS applying for regulatory relief as part of this application? Yes

For each regulation for which a waiver is sought, identify in the response below the following information regarding regulatory relief:

- Identify the regulation that the PPS would like waived (please include specific citation);
- Identify the project or projects in the Project Plan for which a regulatory waiver is being requested and outline the components of the various project(s) that are impacted;
- Set forth the reasons for the waiver request, including a description of how the waiver would facilitate implementation of the identified project and why the regulation might otherwise impede the ability of the PPS to implement such project;
- Identify what, if any, alternatives the PPS considered prior to requesting regulatory relief; and
- Provide information to support why the cited regulatory provision does not pertain to patient safety and why a waiver of the regulation(s)