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BPHC Comments on the Mid-Point Assessment Independent Assessor Report

I. BPHC would like to rectify the following incorrect information presented in the IA report.

1. **PPS Governance**. The IA report states that each of the committees in the BPHC governance structure is *co-led by BPHC and Montefiore leadership*. This is inaccurate, as Montefiore leadership does not act as co-lead on all committees. The members and leadership within the governance structure represent all provider sectors and a broad range of BPHC partners critical to transforming health care in the Bronx, *including* Montefiore. (Co-)chairs of the committees are as follows:

Executive Committee	Leonard Walsh	SBH Health System
Nominating Committee	Patricia Belair	SBH Health System
Finance and Sustainability Subcommittee	Todd Gorlewski David Menashy	SBH Health System Montefiore Medical Center
Information Technology Subcommittee	Jitendra Barmecha Mike Matteo	SBH Health System Centerlight Health System
Workforce Subcommittee	Rosa Mejias Mary Morris	1199 TEF BPHC
Quality and Care Innovation Subcommittee	David Collymore Debbie Pantin	Acacia Network VIP Community Services

2. **Funds Flow.**

   a. The IA states that the primary recipients of funding in the hospital category are SBH and Montefiore, a "*collaborating hospital PPS*," receiving the second highest funds flow dollars under this PPS. This is an incorrect statement, as Montefiore Medical Center Bronx-based hospitals are part of the BPHC PPS. BPHC has not distributed funds to any other PPS.

   b. The IA also states that the PPS has *distributed no funding* to the PCP partners. This is entirely incorrect, as **BPHC distributed waiver level-one funds** to the seven (7) organizations—who together provide 97% of the primary care services to the PPS's attributed patients—based on number of PCPs and the complexity with which the organization was categorized. Since these were level-one funds, they were distributed to the organizations' primary category, despite much of the funding being geared towards primary care-focused staff and activities. The following table demonstrates the partner organizations with PCPs that got funded by BPHC: **we have funded 963 PCPs** through these partners.

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Partner Org	No. of PCPs	Categories given by SDOH	Funding Category
Montefiore Medical Center	703	Hospital, All Other, Case Management/Health Home, Clinic, Community-Based Organization (CBO), Mental Health, Nursing Home, Pharmacy, Substance Abuse, Uncategorized	Hospital
SBH Health System	65	Hospital, All Other, Clinic, Mental Health, Nursing Home, Pharmacy, Substance Abuse, Uncategorized	Hospital
Acacia Network	18	Clinic, All Other, CBO, Mental Health, Substance Abuse, Uncategorized	Clinic (the primary category)
Institute for Family Health	80	Clinic, All Other, Case Management/Health Home, Mental Health	Clinic (the primary category)
Morris Heights Health Center	42	Clinic, All Other Mental Health	Clinic (the primary category)
Union Community Health Center	13	Clinic, All Other, CBO Uncategorized	Clinic (the primary category)
Bronx United IPA	42	Uncategorized	Non-safety net
Total PCPs:	**963**		

3. **Partner Engagement.**

   a. Partner engagement tables show a lack of engagement with Health Homes, BH providers, Pharmacies, and others. However, we feel that this is a false assessment of what level of effort and work have actually been done. First of all, this statement seems to reflect *engagement through funds flow only and does not at all reflect operational and strategic engagement and the process thereof*. Though funds have not flowed directly to Health Homes, BH providers or pharmacies as of the end of DY2Q1, BPHC has built and maintained workgroups dedicated to these provider categories where strategic involvement is discussed and workflows are developed to leverage the services and expertise of these providers. Second, some of the partners in these categories have absolutely been funded through various community programs that we have been working on – community health literacy, community behavioral health work groups, critical time intervention (CTI), to name a few – immediately after the end of DY2Q1 (i.e., DYQ2-Q3) and continue to be funded. Even though the formal Mid-Point Assessment covered the period of DY1Q1 through DY2Q1, we consider ourselves in the midst of the true "mid-point" of the DSRIP work right now, where the timing and infrastructure for funding such organizations is optimal. Third, The State has not yet provided clear guidance on various definitions of provider engagement, and BPHC has in fact recently submitted a set of questions to the Account Support Team and IAs in an effort to obtain improved such

guidance.

b. The IA states that BPHC committed to engaging 185 mental health partners and has engaged zero mental health partners through the DY2Q2 PPS Quarterly Report. This is not accurate. BPHC's Wave 3 funding to partners (to cover all of DY2) focused on PCMH and project support for large primary care *and* behavioral health providers. More detail provided in Section II.1 below.

4. **Project Selection.** The IA report does not specify that for project 4.c.ii, BPHC is implementing ***Increase early access to, and retention in, HIV care*** (Focus Area 1; Goal #2).

II. BPHC responses to the IA's recommendations

1. The IA noted that **Project 3.a.i**. was not specifically highlighted as being at risk for successful implementation, but that the PPS must increase its engagement of Mental Health partners to ensure the successful implementation of this project. This appears to relate to the PIT project participation section and funds flow observations, as we have already addressed in the Section I above. BPHC disagrees with the IA's statement that "*The PPS has distributed no funding to the PCP partners and its funding distributions to Behavioral Health (Mental Health and Substance Abuse) partners has been limited*," as the PIT project participation section makes it difficult to represent the full and actual picture of provider participation, due to multiple listings of the same provider in different categories. We have 388 Mental Health entities (with Entity ID) submitted by the following eight (8) organizations: Acacia Network, Institute for Family Health, Montefiore Medical Center, Montefiore Medical Center Employed, Montefiore Medical Center SBHC, Morris Heights Health Center, SBH Health System, Union Community Health Center. All but two (2) are also listed in other categories (with NPI). In most cases these providers' project participation was marked "Yes" when connected to their NPI, but was left blank with the duplicative listing associated with their entity ID. This resulted in the IA's misreading that Mental Health providers have not been engaged. The necessity of flowing funds at the Tier 1 level makes it difficult to represent the full range of providers that the distributed funds support. SDOH has provided the option of reporting Tier 2 funding; however, this does not provide a satisfactory solution, as we cannot accurately report how our large organizations, with multiple provider types and service categories, have distributed every DSRIP dollar they have received.

2. IA's recommendation that the "*PPS develop a strategy to increase partner engagement across all projects, with a specific emphasis on Mental Health partners"* also seems to have missed our reporting and the site visit presentation in this area. BPHC reached out to **100%** of the mental health partners in the PPS to gauge their interest and capacity to participate in project 3.a.i. In the manner described above, Tier 1 funds have been distributed by way of the PPS's seven largest organizations to *13 unique mental health sites*, which ultimately have participated in Model 2 of project 3.a.i. Many behavioral health organizations did not have the physical space or funds to co-locate primary care in their facilities. Moreover, we have abided by our Project Implementation Plan to get the collaborative care model

(Model 3) established and moving first, and we are well aware that our milestones to implement the Models 1 and 2 (co-locations) are not due until DY3. We have also recognized the need to better support behavioral health organizations early on, and so the CSO had launched the **Community Behavioral Health Workgroup** at the end of DY2Q1, which focuses on engaging the behavioral health organizations in our PPS around three high needs areas, including ADHD in Children, Mental Health and Substance Abuse Screening and Referrals, and Schizophrenia and Diabetes. Behavioral health organizations were funded to develop actionable work plans to address these topics, which include elements of improving access to primary care, through the wave 5 funding cycle.

3. We are aligned with the IAs' recommendation related to **Project 2.a.iii**, to "*create a plan to address the shortage of qualified and trained staff to engage in this project, thus improving the availability of proper care management and creating a foundation for appropriate referrals*," and we have already taken steps to address the issues. In addressing the shortage of qualified staff through labor pool initiatives to develop the local workforce, we have been struggling with this endemic Bronx-wide issue from the very beginning of DSRIP, and have produced quite a bit of results to fruition starting the beginning of DY2. BPHC's extensive Care Coordination Training Series that we have development in conjunction with Primary Care Development Corporation (PCDC), has been active since spring of 2016, and includes Medical Office Assistant Refresher and Certification, Care Coordinator Training Program, Nurse Care Management Supervisor, and Essentials of Care Coordination. We have a total of **105** staff trained to date. By expanding care coordination as part of a team-based primary care model, BPHC seeks to transform the delivery of care and the patient experience, particularly for high risk and high needs patients, and to ensure patients gain access to community-based services that address the social determinants of health. Beyond new employment and training, we also focus on the redeployment and retraining of existing staff, specifically for the roles of medical assistants and navigators – a critical aspect of retaining and workforce.

   Additionally, BPHC has undertaken various labor pool development initiatives to address the shortage of qualified staff in the local workforce. The PPS is working closely with the Phipps Neighborhoods Career Network on Healthcare, which is a career development program helping to connect young adults in the Bronx to healthcare-related employment and education credentials. BPHC has also launched training and advancement programs with the New York Alliance for Careers in Healthcare (providing Bronx residents with paid internships within BPHC partner organizations), WF1 Healthcare Career Center (working with job seekers across NYC to help match qualified talent for both clinical and administrative positions) and CUNY (through the development of frontline worker training programs, including peer workers, community health workers, and other in-demand titles). Finally, the TEF Employment Center Services are being made available to PPS partners to assist with recruitment and sourcing of candidates.

   Lastly, as of DY2Q3, we initiated the PPS-wide referral management system implementation. We have created a BPHC Directory in Q1-Q2, of the PPS members and services they offer. We have also

established on-line processes for regularly collecting and refreshing organizational profiles and contact information, as well as profile management via Salesforce, and continue to assess needs, requirements and expectations for referral processes from partners including Health Homes. We have also incorporated requirements for referral processes as deliverables in our contracts with CBOs and Behavioral Health agencies. By establishing a partnership with NYCDOHMH (PCIP) to provide hands-on technical support (TCPI) to member organizations, we have initiated our work to establish effective closed-loop referrals workflows.

4. The IA also recommends for **Project 2.a.iii** that "*the PPS work with its partners in deciding on a vendor to provide IT solutions. The PPS will need to work with the vendor and network partners to address interoperability requirements that will enable the necessary data exchange for proper care management planning and documentation, as well as accurate patient engagement counts*." Again, we are aligned with this recommendation and in fact signed a contract in November 2016 with GSI Health, a third-party population health management system vendor. GSI Health will host the BPHC comprehensive care management system (CCMS), which will be leveraged to conduct assessments, care planning, care plan management, reporting and analytics in primary care-based, hospital-based and community-based care planning across the PPS.

III. Other Responses and Feedback to the IA

360 Survey. The 360 Survey component of the Mid-Point Assessment was a welcome opportunity for BPHC to learn how effective we are in provider engagement and funds flow, and to discover opportunities for growth and improvement. While we had a highly constructive approach and did look forward to learning, we are disappointed with the inherent flaws in the 360 Survey's design and process, which resulted in incomplete outcome at best, and inaccurate and skewed outcome at worst. The ranking of PPSs on the basis of this flawed process misrepresents their relative progress and successes. We would like a similar opportunity to get the feedback we need in the future; however, we request that the process be more thoughtfully and scientifically designed and executed.

Below we detail out where in the design and process the survey is flawed.

1) Originally, IAs has announced that partner *organizations* will be randomly selected. Instead, *individual providers* from organizations were selected. This is tricky because even individual providers at a certain partner organization may not necessarily know whether/how much funding the organization received from BPHC, nor all the details of the effort of organization-wide DSRIP engagement.

2) Moreover, we were sent a list of 56 randomly selected providers from 23 unique organizations, 4 of whom were no longer part of our PPS (all from Montefiore Medical Center), decreasing our sample size to 52 individuals from 23 organizations. However, because the survey was sent out only to the "main contact persons" of the randomly sampled providers whose contact info we did not have (the organizations

themselves did not know), only 23 organizational contacts ended up filling out the survey. Although this process eliminated our concern described in 1), i.e., individuals who may not be familiar with funds flow did not even get to see the survey, we still feel that this process has highly likely skewed the results.

3) Because of such small sample size (actual n=23, out of 8,000+ entries), and even lower response rate (14 of them, or 58%) returned a completed survey. While this response rate is even somewhat higher than the average across all PPSs (52% completed), this result cannot be considered to broadly represented in a statistically significantly manner, the true opinions of the PPS partners and status of our partner engagement efforts and funds flow. Additionally, because partners like Montefiore and SBH were oversampled (i.e., more individuals selected from those orgs compared to others, to make up the total N=52) but then only 1 contact person got to represent the entire organization, the results ended up becoming disproportionately weighted and Montefiore and SBH undersampled. Equally critical, the organizational sample pool includes such organizational types as hospice, home care and LTC. Because of the 1) project implementation requirements and process flow, some of the provider/organizational types we have not yet closely engaged, and 2) lack of clarification from the State on provider engagement as it relates to milestone requirements, the survey results were adversely affected by poor/no response which was weighted equally (1/14) as other/larger responses.