NEW YORK STATE | Department of Health

DSRIP Independent Assessor

Mid-Point Assessment Report

Bronx Partners for Healthy Communities

November 2016

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Prepared by the DSRIP Independent

Bronx Partners for Healthy Communities (St. Barnabas Hospital)

Contents

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I. Introduction

Bronx Partner for Healthy Communities (BPHC) PPS, led by St. Barnabas Hospital, serves Bronx County. The Medicaid population attributed to this PPS for performance totals 356,863. The Medicaid population attributed to this PPS for valuation was 159,201. BPHC was awarded a total valuation of $384,271,362 in available DSRIP Performance Funds over the five year DSRIP project.

BPHC selected the following 10 projects from the DSRIP Toolkit:

Figure 1: BPHC DSRIP Project Selection

Project	Project Description
2.a.i.	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management
2.a.iii.	Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services
2.b.iii.	ED care triage for at-risk populations
2.b.iv.	Care transitions intervention model to reduce 30-day readmission for chronic health conditions
3.a.i.	Integration of primary care and behavioral health services
3.b.i.	Evidence-based strategies for disease management in high risk/affected populations (adults only) (Cardiovascular Health)
3.c.i.	Evidence-based strategies for disease management in high risk/affected populations (adults only) (Diabetes)
3.d.ii.	Expansion of asthma home-based self-management program
4.a.iii.	Strengthen Mental Health and Substance Abuse Infrastructure across Systems
4.c.ii.	Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings (Note: This project targets chronic diseases that are not included in domain 3, such as cancer)

II. 360 Survey Results: Partners' Experience with the PPS

Survey Methodology and Overall PPS Average Results

The Independent Assessor (IA) developed a 360 survey to solicit feedback from the partners of each PPS regarding engagement, communication, and effectiveness. The survey consisted of 12 questions across four PPS organizational areas; Governance, Performance Management, Information Systems, and Contracting/Funds Flow. The Independent Assessor selected a sample of PPS network partners to participate via a sample generator from the PPS Provider Import/Export Tool (PIT)[1] report. A stratified sampling methodology was used to ensure that each category of network partner was included in the surveyed population. This was done to ensure a cross-section of the partner types in the PPS network. The IA used 95% confidence interval and 5% error rate to pull each sample. For the 25 PPS the IA sent out a total of 1,010 surveys, for an average of 40 surveys per PPS partner. The response rate overall was 52%, or 523 total respondents, for an average of approximately 21 responses per PPS.

360 Survey by Partner Category for All PPS

An analysis of the average survey scores by partner category for all PPS identifies some key trends. The two most favorable survey results were from Hospitals and Nursing Homes. The least favorable survey results came from the Mental Health, Hospice, and Primary Care Providers. These results reflect (generally) a high approval rating of PPS' engagement, communication, and effectiveness by institutional providers and a low approval rating of PPS' engagement, communication, and effectiveness by non-institutional/community based providers. A more thorough review of the four PPS organizational areas demonstrated that all partners perceived that Contracting/Funds Flow and Information Systems as the least favorable rankings (compared to Governance and Performance Management).

[1] The Provider Import/Export Tool (PIT) is used to capture the PPS reporting of partner engagement, as well as funds flow for the PPS Quarterly Reports. All PPS network partners are included in the PIT and are categorized based on the same logic used in assigning the partner categorization for the Speed & Scale commitments made during the DSRIP Project Plan Application process.

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Figure 2: All PPS 360 Survey Results by Partner Type and Organizational Area

Partner Type	*Average Score*		Governance	Performance Management	IT Solutions	Funds Flow
Hospital	*3.32*		3.42	3.39	3.04	3.28
Nursing Home	*3.06*		3.15	2.93	2.93	2.79
Community Based Organization	*3.00*		3.17	3.04	2.73	2.97
Case Management / Health Home	*2.93*		2.98	2.87	2.81	2.75
Practitioner - Non-PCP	*2.93*		3.03	2.80	2.64	2.40
Clinic	*2.92*		2.96	3.03	2.75	2.66
Substance Abuse	*2.91*		3.08	2.96	2.78	2.82
Pharmacy	*2.87*		3.00	2.84	2.31	2.25
All Other	*2.84*		2.92	2.83	2.63	2.69
Mental Health	*2.81*		2.94	2.85	2.56	2.75
Hospice	*2.74*		2.93	2.75	2.41	2.41
Practitioner - PCP	*2.66*		2.68	2.66	2.61	2.31
Average by Organizational Area	***2.90***		**3.00**	**2.89**	**2.70**	**2.67**

Data Source: 360 Survey Results

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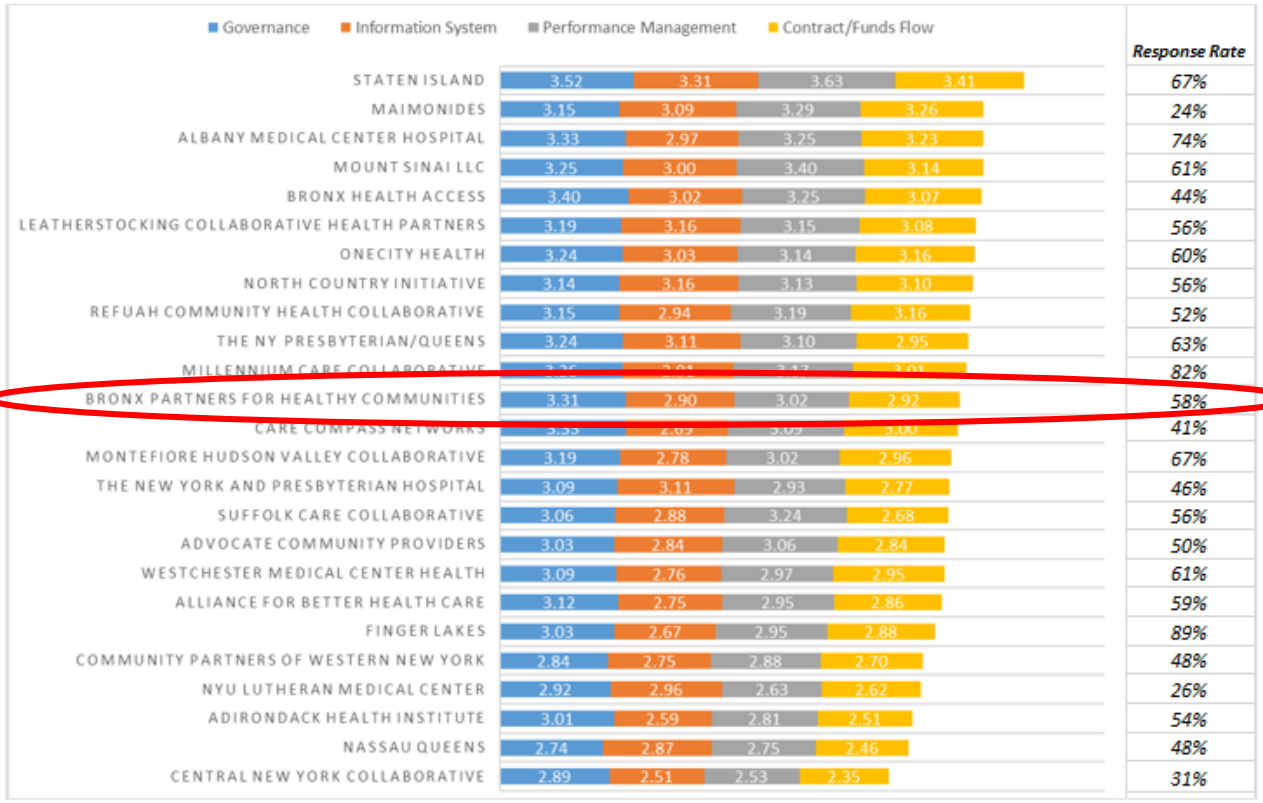
Bronx Partners for Healthy Communities 360 Survey Results[2]

The BPHC 360 survey sample included 24 participating network partner organizations identified in the PIT; 14 of those sampled (58%) returned a completed survey. This response rate was fairly consistent with the average across all PPS (52% completed). The SBH aggregate 360 survey score ranked 12th out of 25 PPS (Figure 3).

Figure 3: PPS 360 Survey Results by Organizational Area



Data Source: 360 Survey Data for all 25 PPS

[2] PPS 360 Survey data and comments can be found in the "Appendix: 360 Survey".

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BPHC PPS 360 Survey Results by Partner Type

The IA analyzed the survey response by partner category to identify any trends by partner type. Figure 4 below identifies and ranks the average survey responses. The Practitioner – Primary Care Provider category survey result was high (6th out of 12) compared to same partner category for all PPS' (12th out 12). Case Management/ Health Home and Hospital survey responses were low for BPHC which was not consistent with the results for the same partner types when compared to the results of other PPS. Most negative answers were for the Contracting / Funds Flow and the IT Solutions questions.

Figure 4: SBH 360 Survey Results by Partner Type[3]

PPS	Partner Type		Respondents over Total Surveyed
Bronx Partners for Healthy Communities	Substance Abuse	3.58	1/1
	Practitioner - Non-Primary Care Provider (PCP)	3.11	5/7
	All Other	3.04	5/7
	Nursing Home	3.00	1/1
	Hospice	2.25	1/1
	Practitioner - Primary Care Provider (PCP)	2.17	1/1
	Case Management / Health Home	0.00	0/2
	Clinic	0.00	0/0
	Community Based Organization	0.00	0/2
	Hospital	0.00	0/0
	Mental Health	0.00	0/0
	Pharmacy	0.00	0/2
Grand Total			14/24

Data Source: SBH 360 Survey Results

While the data from the 360 Survey alone does not substantiate any specific recommendations at this time, it serves as an important data element in the overall assessment of the PPS through the first five quarters of the DSRIP program and may guide the PPS in its efforts to engage its partners.

[3] For the survey results, while the CBO category appears to have returned zero results, the IA found that CBO entities may have also been identified as part of the All Other partner category.

III. Independent Assessor Analysis

The Independent Assessor (IA) has reviewed every Quarterly Report submitted by the PPS covering DY1, Q1 through DY2, Q2[4] and awarded the Achievement Values (AVs) for the successful completion of milestones, as appropriate.

- In DY1, Q2, BPHC **earned all available Organizational AVs and earned one of a possible one Patient Engagement Speed AVs.**
- In DY1, Q4, BPHC **earned all available Organizational AVs and earned four of a possible five Patient Engagement Speed AVs.**

In addition to the PPS Quarterly Reports the PPS were required to submit narratives for each of the projects the PPS is implementing and a narrative to highlight the PPS organizational status. These narratives were required specifically to support the Mid-Point Assessment and were intended to provide a more in depth update on the project implementation efforts of the PPS.

Lastly, the IA conducted site visits to each of the 25 PPS during October 2016. The site visits were intended to serve a dual purpose; as an audit of activities completed during DY1, including specific reviews of Funds Flow and Patient Engagement reporting and as an opportunity to obtain additional information to support the IA's efforts related to the Mid-Point Assessment. The IA focused on common topics across all 25 PPS including Governance, Cultural Competency and Health Literacy, Performance Reporting, Financial Sustainability, and Expanding Access to Primary Care.

The IA leveraged the data sources available to them, inclusive of all PPS Quarterly Reports, AV Scorecards, the PPS Narratives, and the On-Site Visits to conduct an in depth assessment of PPS organizational functions, PPS progress towards implementing their DSRIP projects and the likelihood of the PPS meeting the DSRIP goals. The following sections describe the analyses completed by the IA and the observations of the IA on the specific projects that have been identified as having varying levels of risk.

A. Organizational Assessment

The first component of the IA assessment focused on the overall PPS organizational capacity to support the successful implementation of DSRIP and in meeting the DSRIP goals. As part of the quarterly reports, the PPS are required to submit documentation to substantiate the successful completion of milestones across key organizational areas such as Governance, Cultural Competency and Health Literacy, Workforce, Financial Sustainability, and Funds Flow to PPS partners. Following the completion of the defined milestones in each of the key organizational

[4] At the time of this report, the IA was reviewing the PPS Quarterly Report submissions for DY2, Q2 and had not issued final determinations on PPS progress. However, items not subject to remediation such as engagement numbers and funds flow data were necessary to provide for the most recent and comprehensive IA analysis.

areas, the PPS are expected to provide quarterly updates on any changes to the milestones already completed by the PPS. The following sections highlight the IA's assessment on the PPS efforts in establishing the organizational infrastructure to support the successful implementation of the PPS DSRIP plan.

PPS Governance

BPHC's cross-institutional governance structure is designed to ensure consensus-based decision making on common goals, care models, clinical protocols, interconnectivity, interoperability, budgeting and the value-based payment (VBP) future. The structure consists of an Executive Committee, 4 Sub-committees, multiple work groups and a Central Services Organization that supports the Project Advisory Committee (PAC). Each committee is co-led by BPHC and Montefiore leadership. The 75 member seats for each committee include clinical and non-clinical stakeholders from primary care providers, hospitals, FQHCs, CBOs, MCOs and the Bronx RHIO. Committee and subcommittees were report to have regular meetings bimonthly, monthly, or quarterly, in accordance with committees and sub-committee charters. Ad hoc meetings are held out of necessity to address urgent concerns and meet targets; they also serve as platforms for open discussion, idea exchange and partner support systems.

BPHC has demonstrated vigilance in their communication strategy and consistent partner interactions. This PPS employs an array of biweekly e-Bulletins, electronic newsletters, a BPHC website that includes a member resource directory, live meetings with onsite partner visits, and a variety of workgroups and tools, as means of communication and support to its partners. With a streamlined monitoring process, BPHC also fosters partner collaboration and compliance with policies and guidelines, which encourages effective process implementation.

PPS Administration and Project Management Office (PMO)

The IA also reviewed the PPS spending through the DY2, Q2 PPS Quarterly Reports related to administrative costs and funds distributed to the PPS PMO. It should be noted that PPS administrative spending will vary due to speed of staffing up the PMO, size of the PMO, the type of centralized services provided and the degree of infrastructure investment such as IT that it may find necessary to support the PPS partners to achieve project goals.

In reviewing the PPS spending on administrative costs, the IA found that BPHC had reported spending of $8,383,886.00 on administrative costs compared to an average spend of $3,758,965.56 on administrative costs for all 25 PPS. As each PPS is operating under different budgets due to varying funding resources associated with the DSRIP valuations, the IA also looked at spending on administrative costs per attributed life[5], relying on the PPS Attribution for Performance figures[6]. The IA found that BPHC spends $23.49 per attributed life on administrative

[5] Attribution for Performance was used as a measure of the relative size of each PPS to normalize the administrative spending across all 25 PPS.

[6] The Attribution for Performance figures were based on the data included on the individual PPS pages on the NY DSRIP website.

costs compared to a statewide average spend of $24.23 per attributed life on administrative costs.

Looking further at the PPS fund distributions to the PPS PMO, BPHC distributed $9,196,566.00 to the PPS PMO out of a total of $25,999,563.00 in funds distributed across the PPS network, accounting for 35.37% of all funds distributed through DY2, Q2. Comparatively, the statewide average for PPS PMO distributions equaled $5,966,502.64 or 42.85% of all funds distributed.

The data on the administrative costs and PMO funds flow distributions present a point of comparison across PPS, however do not alone provide enough information from which the IA can assess the organizational capacity of the PPS to support the implementation of DSRIP. It is important for the PPS to invest in the establishment and maintenance of an organizational infrastructure to support the PPS through the implementation of the DSRIP projects to ensure the PPS success in meeting its DSRIP goals.

Community Based Organization Contracting

As part of the DY1, Q4 PPS Quarterly Report, BPHC included a list of all Community Based Organizations (CBOs) in its organization, and whether they had completed contracts. Based on the contract samples reviewed as part of the on-site reviews, the IA found that the PPS has contracted with significantly less CBOs that the number reported in the PIT.

In further assessing the efforts of BPHC in regards to engaging and contracting with CBOs, the IA evaluated the funds flow distributions of BPHC to its CBO network partners relative to that of all PPS. Through DY2, Q2, BPHC has distributed 3.08% of funds to its CBO partners which is slightly greater than the statewide average of 2.30% of funds distributed to CBOs.

Cultural Competency & Health Literacy

The BPHC approach to Cultural Competency and Health Literacy (CCHL) was informed by their Community Needs Assessment (CNA), health survey data, NYC Community Health Profiles 2015, and community forum inputs. BPHC established a CCHL workgroup under its Quality and Care Innovation subcommittee. This workgroup is charged with reviewing the formulation of its strategic plan, reviewing the results of health surveys and community health profiles, and gathering inputs from coordinators of community engagement forums.

BPHC has demonstrated many achievements as it executes its approved Cultural Competency and Health Literacy (CCHL) plan. BPHC has implemented a global sensitivity and educational training program for cultural competency and health literacy with its partners. It has demonstrated research and findings specific to the targeted community and has sought to educate its network partners accordingly. BPHC's CCHL strategy and training continues to evolve as the PPS delves further into the needs of the community.

To date, BPHC has assessed the cultural and linguistic competency of providers in the network and has engaged them in language classes and cultural sensitivity and competency training, according to the PPS' findings on disparities by race, ethnicity, language, geography.

BPHC also presented plans for a state of the art community center that will address many needs identified for the community. Identified areas of deficiency within the community such as exercise, diet, diabetes management, and other self-care skills will be offered through the community center.

Financial Sustainability and Value Based Purchasing (VBP)

The PPS established the Finance and Sustainability subcommittee, a governance group comprised of members representing organizations across BPHC. This group reports to the Executive Committee. During DY1, BPHC conducted its first financial sustainability survey of PPS partners to establish a baseline of the financial status of partner organizations. The PPS has completed the process of assessing and analyzing the data, and making determinations regarding the status of its partners based upon its findings in DY1.

The data reviewed shows that the PPS received responses from 90 network partners, which included all partner categories. The majority of responses (29%) were from CBOs, with Behavioral Health facilities a close second (23%). Of the partners that responded, 3% were identified as being financially fragile. BPHC has outlined a strategy to assist fragile partners and at this time has committed to monitoring fragile partners closely and providing resources for funding.

The PPS has established a VBP planning workgroup that is a subset of the Finance and Sustainability subcommittee. The workgroup met to discuss VBP arrangements with MCOs and included questions assessing VBP readiness in the Financial Health survey. Furthermore, in preparation for the adoption of payment reform, BPHC is in pursuit of Vital Access Provider (VAP) funding to become an early adopter of Level III VBP. As a safety-net institution, becoming an early adopter of VBP would give BPHC and New York State the opportunity to evaluate VBP for a subpopulation whose access to primary care is often further impaired from a combination of socio-economic determinants and immigration status. BPHC is in the process of developing partner education materials to align with its VAP/VBP pursuits.

Funds Flow

Through DY2, Q2 PPS Quarterly Report, BPHC's funds flow reporting indicates they have distributed 96.75% ($25,999,563.00) of the DSRIP funding it has earned ($26,871,551.81) to date. In comparison to other PPS, the distribution of 96.75% of the funds earned ranks the 1st amongst all PPS and places BPHC well above the statewide average of 56.20%.

Figure 5 below indicates the distribution of funds by BPHC across the various Partner Categories in the BPHC network.

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Figure 5: PPS Funds Flow (through DY2, Q2)

Total Funds Available (DY1)	**$26,929,572.26**		
Total Funds Earned (through DY1)	**$26,871,551.81 (99.78% of Available Funds)**		
Total Funds Distributed (through DY2, Q2)	**$25,999,563.00 (96.75% of Earned Funds)**		
Partner Type	**Funds Distributed**	**BPHC (% of Funds Distributed)**	**Statewide (% of Funds Distributed)**
Practitioner - Primary Care Physician (PCP)	$0.00	0.00%	3.89%
Practitioner - Non-Primary Care Physician (PCP)	$0.00	0.00%	0.73%
Hospital	$13,066,322.00	50.26%	30.41%
Clinic	$2,194,252.00	8.44%	7.54%
Case Management/Health Home	$0.00	0.00%	1.31%
Mental Health	$384,536.00	1.48%	2.43%
Substance Abuse	$0.00	0.00%	1.04%
Nursing Home	$0.00	0.00%	1.23%
Pharmacy	$0.00	0.00%	0.04%
Hospice	$0.00	0.00%	0.16%
Community Based Organizations[7]	$801,455.00	3.08%	2.30%
All Other	$0.00	0.00%	5.82%
Uncategorized	$318,932.00	1.23%	0.53%
Non-PIT Partners	$37,500	0.14%	0.58%
PMO	$9,196,566.00	35.37%	41.99%

Data Source: PPS Quarterly Reports DY1, Q2 – DY2, Q2

In further reviewing the BPHC funds flow distributions, it is notable that the distributions are heavily directed towards the Hospital and PMO categories, with over 85% of the funds being directed to those two partner categories. Further analysis indicates 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.

While the PPS has distributed funds to many partner types, the IA notes 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. It will be important for the PPS to distribute funds to these key partners to ensure their continued engagement in the implementation of DSRIP projects.

[7] Within the Partner Categorizations of the PPS Networks, Community Based Organizations are defined as those entities without a Medicaid billing ID. As such, there are a mix of health care and social determinant of health partners included in this category.

B. Project Assessment

In addition to the assessment of the overall organizational capacity of the PPS, the IA assessed the PPS progress towards implementing the DSRIP projects the PPS selected through the DSRIP Project Plan Application process. In assessing the PPS progress towards project implementation, the IA relied upon common data elements across various projects, including PPS progress towards completing the project milestones associated with each project as reported in the PPS Quarterly Reports, PPS efforts in meeting patient engagement targets, and PPS efforts in engaging network partners in the completion of project milestones. Based on these elements, the IA identified potential risks in the successful implementation of DSRIP projects. For each project identified as being at risk by the IA, this section will indicate the various data elements that support the determination of the IA and that will ultimately result in the development of the recommendations of the IA for each project.

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PPS Project Milestone Status

The first element that the IA evaluated was the current status of the PPS project implementation efforts as indicated through the DY2, Q2 PPS Quarterly Reports. For each of the prescribed milestones associated with each Domain 2 and Domain 3 project, the PPS must indicate a status of its efforts in completing the milestone. The status indicators range from 'Completed' to 'In Progress' to 'On Hold'. Figure 6 below illustrates BPHC's current status in completing the project milestones within each project. Figure 6 also indicates where the required completion dates are for the milestones.

Figure 6: BPHC Project Milestone Status (through DY2, Q2)[8]

Data Source: BPHC DY2, Q2 PPS Quarterly Report

The data in Figure 6 above shows that Project 2.b.iii may be at risk due to the current status of project implementation efforts being "On Hold". This status indicates that the PPS has not begun efforts to complete milestones by the required completion date and as such, would be at risk of losing a portion of the Project Implementation Speed AV for this project.

However, further assessment of the PPS project implementation status for project 2.b.iii indicates that the project milestone with a status of 'On Hold' is optional and therefore, not

[8] Note that this graphic does not include Domain 4 projects as these projects do not have prescribed milestones and the PPS did not make Speed & Scale commitments related to the completion of these projects.

required for the PPS to complete. Therefore, there is no risk of project implementation meeting the required completion dates at this time.

Patient Engagement AVs

In addition to the analysis of the current project implementation status, the IA reviewed BPHC's performance in meeting the Patient Engagement targets through the PPS Quarterly Reports. The IA identified one project where the PPS has missed the Patient Engagement target in at least one PPS Quarterly Report. Figure 7 shows the project where BPHC has missed the patient Engagement target for at least one quarter.

Figure 7: 2.a.iii. (Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services) Patient Engagement

Quarter	Committed Amount	Engaged Amount	Percent Engaged
DY1, Q2	0	0	0.00%
DY1, Q4	4,032	2,796	69.35%
DY2, Q2[9]	10,080	1,506	14.94%

Data Source: BPHC PPS Quarterly Reports (DY1, Q2 – DY2, Q2)

For project 2.a.iii, the failure to meet Patient Engagement targets for two quarters, presents a concern, however, this data point alone does not indicate significant risks to the successful implementation of the projects.

Partner Engagement

The widespread engagement of network partners throughout the PPS service area is important to the overall success of DSRIP across New York State. Engagement of partners in isolated portions of the PPS service area will not support the statewide system transformation, improvement in the quality of care, and reduction in costs that are expected as a result of this effort. It is therefore important to the success of the PPS and to the overall DSRIP program that the PPS engage network partners throughout their identified service area.

In continuing to further assess the project implementation efforts of the PPS and to identify the potential risks associated with project implementation the IA also assessed the efforts of the PPS in engaging their network partners for project implementation relative to the Speed & Scale commitments made for partner engagement as part of the DSRIP Project Plan Application.

The IA paid particular attention to the PPS engagement of Practitioner – Primary Care Provider (PCP) and of behavioral health (Mental Health and Substance Abuse) partners given the important role these partners will play in helping the PPS to meet the quality improvement goals tied to the Pay for Performance (P4P) funding. The engagement of PCPs and behavioral health

[9] The DY2, Q2 Patient Engagement figures reflect 'As Submitted' data by the PPS and have not been validated by the IA at the time of this report.

partners is especially important across Domain 3a projects where six out of ten High Performance Funding eligible measures fall.

As part of this effort, the IA reviewed all projects with a specific focus on those projects that were identified as potential risks due to Project Milestone Status and/or Patient Engagement performance. Figures 9 through 10 illustrate the level of partner engagement against the Speed & Scale commitments for all projects based on the PPS reported partner engagement efforts in the DY2, Q2 PPS Quarterly Report. The data included in the tables is specifically focused on those partner categorizations where PPS engagement is significantly behind relative the commitments made by the PPS.

The data presented in the partner engagement tables in the following pages includes the partner engagement across all defined partner types for all projects where the PPS is lagging in partner engagement. The PPS reporting of partner engagement, as well as funds flow, is done through the Provider Import Tool (PIT) of the PPS Quarterly Reports. All PPS network partners are included in the PIT and are categorized based on the same logic used in assigning the partner categorization for the Speed & Scale commitments made during the DSRIP Project Plan Application process.

In many cases, PPS did not have to make commitments to all partner types for specific projects, as indicated by the '0' in the commitment columns in the tables, however PPS may have chosen to include partners from those partner categories to better support project implementation efforts. It is therefore possible for the PPS to show a figure for an engaged number of partners within a partner category but have a commitment of '0' for that same category.

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Figure 8: Project 2.a.i (Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management) Partner Engagement

Partner Type		Committed Amount	Engaged Amount
All Other	Total	1,773	0
	Safety Net	677	0
Case Management / Health Home	Total	16	0
	Safety Net	7	0
Clinic	Total	24	4
	Safety Net	25	4
Community Based Organizations	Total	46	0
	Safety Net	0	0
Hospice	Total	6	0
	Safety Net	1	0
Hospital	Total	3	2
	Safety Net	4	2
Mental Health	Total	308	0
	Safety Net	83	0
Nursing Home	Total	35	0
	Safety Net	34	0
Pharmacy	Total	7	0
	Safety Net	5	0
Practitioner - Non-Primary Care Provider (PCP)	Total	3,130	2,006
	Safety Net	726	410
Practitioner - Primary Care Provider (PCP)	Total	889	577
	Safety Net	301	279
Substance Abuse	Total	30	0
	Safety Net	30	0
Uncategorized	Total	0	1
	Safety Net	0	0

Data Source: BPHC DY2, Q2 PPS Quarterly Report

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Figure 9: 2.a.iii (Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services) Partner Engagement

Partner Type		Committed Amount	Engaged Amount
All Other	Total	203	0
	Safety Net	203	0
Case Management / Health Home	Total	16	0
	Safety Net	7	0
Clinic	Total	24	4
	Safety Net	25	4
Community Based Organizations	Total	46	0
	Safety Net	0	0
Hospital	Total	0	1
	Safety Net	0	1
Mental Health	Total	231	0
	Safety Net	83	0
Pharmacy	Total	7	0
	Safety Net	5	0
Practitioner - Non-Primary Care Provider (PCP)	Total	1,878	1,593
	Safety Net	617	336
Practitioner - Primary Care Provider (PCP)	Total	711	528
	Safety Net	256	260
Substance Abuse	Total	30	0
	Safety Net	30	0
Uncategorized	Total	0	1
	Safety Net	0	0

Data Source: BPHC DY2, Q2 PPS Quarterly Report

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Figure 10: Project 2.b.iv (Care transitions intervention model to reduce 30-day readmission for chronic health conditions) Partner Engagement

Partner Type		Committed Amount	Engaged Amount
All Other	Total	532	0
	Safety Net	203	0
Case Management / Health Home	Total	16	0
	Safety Net	7	0
Clinic	Total	0	4
	Safety Net	0	4
Community Based Organizations	Total	46	0
	Safety Net	0	0
Hospital	Total	3	2
	Safety Net	4	2
Practitioner - Non-Primary Care Provider (PCP)	Total	2,504	1,946
	Safety Net	617	403
Practitioner - Primary Care Provider (PCP)	Total	711	574
	Safety Net	256	279
Uncategorized	Total	0	1
	Safety Net	0	0

Data Source: BPHC DY2, Q2 PPS Quarterly Report

As the data in Figures 8 through 10 above indicate, the PPS has engaged network partners on a limited basis for the projects highlighted. With exception to 2.a.iii, these projects were not highlighted for the PPS failure to meet Patient Engagement targets in any of the PPS Quarterly Reports. The combination of the PPS failure to meet Patient Engagement targets and limited Partner Engagement on the same project indicates an elevated level of risk for the successful implementation of project 2.a.iii.

While the data in Figures 8 through 10 indicate limited partner engagement across most partner categories, it should be noted that the PPS has demonstrated a commitment to engaging PCP and non-PCP practitioners across all projects. For example, on project 3.a.i, BPHC indicates it has engaged 1,593 non-PCP practitioners against a commitment of 782 non-PCP practitioners and engagement of 523 PCP partners out of a commitment of 756 PCP partners. Conversely, for that same project, BPHC committed to engaging 185 Mental Health partners and has engaged zero Mental health partners through the DY2, Q2 PPS Quarterly Report; an area of concern that the PPS must address.

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PPS Narratives for Projects at Risk

For those projects that have been identified through the analysis of Project Milestone Status, Patient Engagement AVs and Partner Engagement, the IA also reviewed the PPS narratives to determine if the PPS provided any additional details provided by the PPS that would indicate efforts by the PPS to address challenges related to project implementation efforts.

2.a.iii. (Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services): The PPS identified challenges with regard to integrating various provider systems into a centralized care management platform. The PPS has struggled with identifying the right vendor to meet the needs of the PPS, resulting in delayed development of BPHC's desired IT solution. In addition, also IT-related, affiliated entities have expressed challenges around the pre-identification of the Health Home At-Risk population among their patient panels. The PPS identified further challenges with the recruitment and training of sufficient numbers of qualified, bilingual care coordination staff to serve the needs of the Bronx population. This impacts the ability to provide proper care coordination, which in itself is a barrier to referrals.

IV. Overall Project Assessment

Figure 11 below summarizes the IA's overall assessment of the project implementation efforts of BPHC based on the analyses described in the previous sections. The 'X' in a column indicates an area where the IA identified a potential risk to the PPS' successful implementation of a project.

Figure 11: Overall Project Assessment

Project	Project Description	Patient Engagement	Project Milestone Status	Partner Engagement
2.a.i.	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management			X
2.a.iii.	Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services	X		X
2.b.iii.	ED care triage for at-risk populations			
2.b.iv.	Care transitions intervention model to reduce 30-day readmission for chronic health conditions			X
3.a.i.	Integration of primary care and behavioral health services			
3.b.i.	Evidence-based strategies for disease management in high risk/affected populations (adult only)			
3.c.i.	Evidence-based strategies for disease management in high risk/affected populations (adults only) (Diabetes)			

3.d.ii.	Expansion of asthma home-based self-management program			

V. Project Risk Scores

Based on the analyses presented in the previous pages the IA has assigned risk scores to each of the projects chosen for implementation by the PPS. The risk scores range from a score of 1, indicating the Project is on Track to a score of 5, indicating the Project is Off Track.

Figure 12: Project Risk Scores

Project	Project Description	Risk Score	Reasoning
2.a.i.	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management	2	This is a low risk score indicating the project is more than likely to meet intended goals but has minor challenges to be overcome.
2.a.iii.	Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services	3	This is a moderate risk score indicating the project could meet intended goals but requires some performance improvements and overcoming challenges.
2.b.iii.	ED care triage for at-risk populations	1	This is the lowest risk score indicating the project is on track and more than likely to meet intended goals.
2.b.iv.	Care transitions intervention model to reduce 30-day readmission for chronic health conditions	2	This is a low risk score indicating the project is more than likely to meet intended goals but has minor challenges to be overcome.
3.a.i.	Integration of primary care and behavioral health services	1	This is the lowest risk score indicating the project is on track and more than likely to meet intended goals.
3.b.i.	Evidence-based strategies for disease management in high risk/affected populations (adults only) (Cardiovascular Health)	1	This is the lowest risk score indicating the project is on track and more than likely to meet intended goals.
3.c.i.	Evidence-based strategies for disease management in high risk/affected populations (adults only) (Diabetes)	1	This is the lowest risk score indicating the project is on track and more than likely to meet intended goals.

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3.d.ii.	Expansion of asthma home-based self-management program	1	This is the lowest risk score indicating the project is on track and more than likely to meet intended goals.

****Projects with a risk score of 3 or above will receive a recommendation.***

VI. IA Recommendations

The IA's review of the BPHC PPS covered the PPS' organizational capacity to support the successful implementation of DSRIP and the ability of the PPS to successfully implement the projects the PPS selected through the DSRIP Project Plan Application process. Bronx Partners for Healthy Communities has achieved many of the organizational and project milestones to date in DSRIP. The PPS has made positive strides to develop the infrastructure to run a successful PPS in their region. It appears that BPHC is engaging patients and implementing projects successfully.

The IA did, however, identify partner engagement as one area where the PPS must focus its efforts. The IA identified three projects where the PPS has had limited engagement with network partners. While project 3.a.i. was not specifically highlighted as being at risk for successful implementation, the IA notes that the PPS must increase its engagement of Mental Health partners to ensure the successful implementation of this project.

One other area of focus is project 2.a.iii. The PPS identified some issues implementing the project in the PPS narrative submitted. Of note is the difficulty recruiting and engaging the bilingual Care Coordinators in the Bronx and the difficulty finding a Care Management System that would meet the diverse needs of the PPS.

The following recommendations have been developed based on the IA's assessment of the PPS progress and performance towards meeting the DSRIP goals. For each recommendation, it is expected that the PPS will develop a Mid-Point Assessment Action Plan (Action Plan) by no later than March 2, 2017. The Action Plan will be subject to IA review and approval and will be part of the ongoing PPS Quarterly Reports until the Action Plan has been successfully completed.

A. Organizational Recommendations

Partner Engagement

Recommendation: The IA recommends that the PPS develop a strategy to increase partner engagement across all projects, with a specific emphasis on Mental Health partners for Domain 3a projects.

B. Project Recommendations

Project 2.a.iii: Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services

Recommendation 1: The IA recommends the PPS 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.

Recommendation 2: The IA recommends 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.