NewYork-Presbyterian
The University Hospital of Columbia and Cornell

David Alge
Senior Vice President
Community and Population Health

NewYork-Presbyterian/Weill Cornell
525 East 68th Street, Mailbox 259
New York, NY 10065

TEL 212-746-4222
FAX 212-746-4899
daa9020@nyp.org

December 1, 2016

Independent Assessor
Public Consulting Group
Boston, MA

To Whom It May Concern:

Thank you for the opportunity to comment on the "DSRIP Independent Assessor Mid-Point Assessment Report" that was released on November 22nd, 2016. We appreciate the opportunity to contribute to the discussion.

There are a number of areas in The New York and Presbyterian Hospital Performing Provider System (NYP PPS) specific report we would like to respond to with additional clarifying details. These include:

1. **PPS Governance** (page 7) – There are a number of clarifications we request be made to this section to reflect the details that were highlighted during our IA site visit. The attached document (ATTACHMENT I) provides suggested, red-lined edits.

2. **Community Based Organization Contracting** (page 8) – This is an area of significant priority for the NYP PPS. The report does not currently reflect the 16 contracts (for approximately $1.4 million/year) that have been executed with CBOs to support field-based staff (CHWs, Peers, etc.), the indirect support provided to independent community providers, or the costs related to rolling out IS tools related to RHIO connectivity and care management across the PPS. Since the current NYS reporting tool does not allow the PPS to report on the indirect flow of funds to collaborators, these investments are only recognized in the Hospital funds flow (as the PPS lead). **The PPS recommends the Independent Assessor amend or addend the Assessment to note (1) CBO contracts exist and funds flow will continue to grow; (2) indirect investments in the PPS network are not shown in the current reporting tools, and (3) the 95/5% safety net requirement limits the ability to directly flow funds to non-Medicaid billing community-based organizations and therefore those expenditures must initially flow through the PPS's lead (a designated safety net organization).**

3. **Cultural Competency and Health Literacy** (pages 8-9) – The PPS appreciates the Independent Assessor's feedback on its Cultural Competency and Health Literacy efforts as this is a priority for us. There are concrete plans to move forward with the CC/HL strategy that has been submitted to the State, including (1) training, (2) distribution of "tip sheets," and (3) distribution of a web-based tool to support cultural competency (Quality Interactions). The PPS is also investigating the best use of Medicaid claims data to support health disparity measurement. **No PPS recommendations at this point.**

   There are a number of simple clarifications that should be considered, similar to the PPS Governance section above. Please see ATTACHMENT I for a red-lined version.

4. **Figure 5: PPS Funds Flow through DY2, Q2** (page 10) – The NYP PPS acknowledges the current reporting gives the appearance that the majority of the funds are flowing to the Hospital, although this is an inaccurate characterization of what is actually occurring. The current reporting mechanism does not allow a PPS to accurately document the distribution of funds to primary care or mental health providers who are employees

or affiliates of a larger organization. In the NYP PPS case, the "Hospital" category, which includes distributions to the NewYork-Presbyterian Hospital, represents funds that are distributed to NYP's Ambulatory Care Network, a network of 14 primary care practices and 50 specialty practices, that includes nearly 1,000 providers and residents and over 1,000 allied health staff. The NYP Ambulatory Care Network provides nearly ~650,000 visits per year to over 175,000 distinct individuals.

This display of the funds flow does not accurately demonstrate investments in the PPS provider network that are managed through direct sub-contracts with NewYork-Presbyterian Hospital, including consultant time to assist independent community physicians in achieving medical home status or time dedicated to rolling out shared health information exchange platforms.

The PPS recommends the Independent Assessor amend or addend the Assessment to note (1) funds flowed to the Hospital are going directly to hospital-based primary care and behavioral health practices in many instances; (2) indirect investments in the PPS network are not depicted in the current tools, and (3) the 95/5% safety net requirement limits the ability of the PPS to directly flow funds to non-Medicaid billing community-based organizations and therefore those expenditures must initially flow through the PPS's lead (a designated safety net organization).

5. **PPS Project Milestone Status – 2.b.iii ED Care Triage** (page 11) – The Independent Assessor notes Project 2.b.iii ED Care Triage was currently at-risk because of one milestone marked "On Hold." This is a misrepresentation of the project's progress; the milestone marked "On Hold" (#4) is not a requirement, and is considered optional by NYS and the IA. **The PPS recommends the PPS remove the statement, "Furthermore, Project 2.b.iii may be at risk due to the current status of milestones which are due in DY2, Q4 as "On Hold". This status indicates that the PPS has not begun efforts to complete these milestones by the required completion date and as such are at risk of losing a portion of the Project Implementation Speed AV for each project."**

6. **Partner Engagement** (pages 13-19) – The Independent Assessor notes on page 19, "the PPS has engaged network partners on a limited basis across all projects." This statement does not accurately reflect the PPS's partner engagement efforts over the past 18+ months. Partners have been thoroughly engaged in the PPS governance structure, project-specific committees, project-specific workflow development, and the rollout of Healthix (RHIO connectivity) and other IT tools. Furthermore, the Independent Assessor notes (page 5) that the 360 Survey data "indicates that NYP has an engaged network of partners in DSRIP."

   The tables on pages 13-19 represent a specific extract from the Provider Import Tool (PIT) showing which providers are currently meeting the specific Domain 1 Requirements of each project; it does not represent the total efforts of the PPS. To-date, the PPS has not submitted specific providers for each project, since there are significant inconsistencies in the data. The PPS plans to address this in early 2017. **The PPS recommends the Independent Assessor note each of these tables represents the providers/organizations that a PPS has identified for meeting the Domain 1 project requirements, and does not speak to the overall level of partner engagement in the projects.**

7. **PPS Narratives for At-Risk Projects** (page 19) – The Independent Assessor documented project 3.e.i as "Integration of Palliative Care into the PCMH model," when this project is the "HIV Center of Excellence." This edit is also noted in ATTACHMENT I.

8. **Overall Project Assessment** (page 21) – Given the limitations of the PIT-based reporting we stated in comment #6, we do not believe it is accurate to describe partner engagement as a "potential risk" for each project. This is also inconsistent with the IA's statement on page 8 that "the PPS has contracted with the CBOs necessary to meet project requirements."

   As was discussed earlier, the PPS is not currently at-risk for missing the Project Milestones associated with project 2.b.iii. This is an inaccurate representation of an optional milestone.

   The designation of "at-risk" for project 3.e.i for patient engagement is also inaccurate. There was limited guidance at the time of submission of the patient engagement commitments to NYS and the IA. In this project's case, the NYP PPS included patients who are NYS AIDS Drug Assistance Program (ADAP) beneficiaries in their commitment. These beneficiaries were later excluded from the patient engagement definition by NYS; however, the PPS was not allowed to make the commensurate adjustments in the patient engagement numbers. This is a known challenge that has been communicated with the DOH and IA.

   The PPS recommends the "potential risk" designation be removed for:
   1. **Project Milestone Status for 2.b.iii (ED Care Triage)**
   2. **Each project under Partner Engagement**

9. **Figure 17 Project Risk Scores** (page 22) – **The PPS recommends the risk score for project 3.e.i be reduced from 3 to 2, given the partner engagement and patient engagement efforts detailed under comment 8 above.**

10. **IA Recommendations** (page 23) – The IA notes, "PPS has not distributed funds across many of its partners and that Partner Engagement has been limited across multiple projects." This is an inaccurate representation of the PPS's funds flow and partner engagement efforts, as detailed in comments 2, 4, and 6 above. **The PPS recommends the comments, "The IA noted that the PPS has not distributed funds across many of its partners and that Partner Engagement has been limited across multiple projects. The PPS must identify opportunities to better engage its partners and to distribute funds to ensure the continued engagement of key partners in the implementation of the DSRIP projects" be removed from the current report.**

Again, thank you for the opportunity to respond to the Independent Assessor's Mid-Point Assessment of the NewYork-Presbyterian Performing Provider System. We hope the previous comments will be considered in light of the next review/revision of the Midpoint Assessment.

Please do not hesitate to contact me or our DSRIP Director, Isaac Kastenbaum (ink9012@nyp.org) with any questions about our Mid-Point Assessment response.

Sincerely,

David Alge
Co-Chair, Executive Committee
NewYork-Presbyterian Hospital Performing Provider System

Senior Vice President, Community and Population Health
NewYork-Presbyterian Hospital

NewYork-Presbyterian Performing Provider System (NYP PPS)
Proposed Midpoint Assessment Edits
Attachment I

PPS Governance (page 7)

The PPS Governance structure includes five oversight committees and several ~~sub-committees~~workgroups responsible for monitoring ongoing DSRIP activities and the effectiveness of its governance. The primary committees: Executive, Finance, Clinical Operations, IT/Data Governance, and Project Advisory (PAC). The Executive, Finance, Clinical Operations and IT/Data Governance , ~~are~~Committees are each co-led by representatives of NYP and a representative "collaborator", a term that this PPS uses in reference to its contracted partners that are active with DSRIP projects. The PAC is chaired by the Vice President, Government & Community Relations at NYP.

The PAC is comprised of 57 members, almost half of which are invited non-PPS community representatives. Other members of the PAC are representatives from the PPS' partner network. The Finance, IT/Data Governance and Clinical Operations Committee are each comprised of 10-11 network partner members, including two chairpersons. The Executive Committee is comprised of~~by~~ NYP staff who serve as the Co-Chairs of the other NYP PPS Governance Committees as well as representatives from collaborator organizations. The workgroups are less rigid with regards to membership and are populated based on interest/expertise from collaborator organizations and NYP PPS staff who work in the associated programmatic area. ~~NYP's committees and sub-committees, such as the Executive Committee, Finance, IT/Data Governance, Project Advisory and the Clinical Quality Committee, which has oversight for quality monitoring, all have 10 to 11 network partner members and two to three chairpersons. All committees~~ The Executive, Clinical Operations, IT/Data Governance and Finance Committees follow a random-selection process with 12 ~~to 18 -~~month term limits (with the exception of the initial term which was extended to 18 months). Regular committee meetings are held bimonthly, monthly, or quarterly, in accordance with the committees' charters. ~~These committees serve as platforms for theme based meetings~~ Committee meetings to date have focused on providing project updates with an opportunity for feedback and guidance from Committee members as well as completion of organizational milestones and strategies.~~as well as open discussion for questions, concerns, and idea exchange.~~

Cultural Competency and Health Literacy (page 8)

NYP PPS has adopted a patient-centered approach to cultural competency, known as the "Culture of One.~~,~~" It uses evidence-based standards and best practices, as articulated in the federal Culturally and Linguistically Appropriate Standards (CLAS) and the National Quality Forum's (NQF) Comprehensive Framework for Cultural Competence, to guide its cultural competency work. ~~which is aligned with the National Quality Forum's (NQF) Cultural Competency framework.~~ NYP submitted its CCHL Training Strategy with its DY2, Q1 Quarterly Report. The PPS aims to provide training specific to cultural competency and health literacy for the PPS partners and staff. The training aims to educate the workforce on what cultural competency and health literacy are and why they are important concepts for all patient interactions, not just for clinical providers. The trainings will help work towards the goal of having cultural competency and health literacy embedded into the foundation of the care provided at each of the PPS partner sites.

NYP PPS has endorsed the use of Community Health Workers (CHWs) from the community to provide outreach within various facilities. The PPS also has in use, general health education materials that meet CLAS standards. NYP PPS continues efforts to develop further materials geared towards cultural competency and health literacy to meet the needs of patients under its DSRIP projects.

During the IA on-site review it was revealed that many aspects of the CCHL plan have not yet been implemented. NYP PPS has an eLearning and resource portal for cultural competency training. This portal, *Quality Interactions* ~~anticipated to go live in November 2016~~, is an online tool for healthcare providers that serves as a convenient guide to quickly access the information needed to navigate cross-cultural interactions. It contains a wealth of resources that can be used at the point of care to enrich the relationship between healthcare professionals and patients.

The PPS is also establishing a Learning Management System which will serve as a platform to provide PPS-wide trainings, including but not limited to a variety of online cultural competency and health literacy trainings. The platform will enable participants to register and track participation in learning modules, as well as track their progress by use of surveys and assessment tools. At the time of review, ~~it was unclear whether NYP PPS will use information obtained from the portal in establishing best practices, and how the PPS will monitor outcomes and determine specific cultural competency needs of its partners.~~the PPS stated processes to identify, measure and evaluate the impact of its efforts on health disparities are under development.

PPS Narratives for At-Risk Projects (page 19)
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 for additional details provided by the PPS that would indicate efforts to address challenges related to project implementation.

- 3.e.i. (~~Integration of palliative care into the PCMH Model~~HIV Center of Excellence):