COMMENTS ON THE DSRIP INDEPENDENT ASSESSOR MID-POINT ASSESSMENT REPORT

The Coalition for Behavioral Health, Inc. (The Coalition) is the umbrella advocacy and training organization of New York's behavioral health community, representing over 140 non-profit community-based agencies that serve more than 450,000 consumers. Our members serve the entire continuum of behavioral health care in every neighborhood of New York City, and communities in Long Island, Westchester, Rockland, and Orange counties. Coalition members provide access to the range of outpatient mental health and substance use services, supportive housing, crisis intervention, peer support services, employment readiness, Personalized Recovery Oriented Services (PROS), Club Houses, education and nutritional services, as well as many other supports that promote recovery. The Coalition also trains on average 500 human services providers monthly on cutting edge and proven clinical and best business practices through generous support from the New York State Office of Mental Health, New York City Department of Health and Mental Hygiene, the New York City Council, and in conjunction with foundations and leaders from the behavioral health sector.

The Coalition is grateful for the opportunity to provide comments on the recently released "Mid-point Assessment Report" by the DSRIP Independent Assessor. We appreciate the transparency in the process of sharing progress data and commend the State for fostering a learning environment by making data and information available to allow for mid-course corrections and innovation opportunities in this rapidly changing environment. It is an optimistic sign that the findings of the mid-point assessment review of the 25 PPS indicate that they are on track, although importantly noting that a majority of the PPS are lagging in partner engagement. There are many commendable examples of progress and we congratulate the

PPSs for this headway. However, as an organization comprised of "partners" we have deep concerns about the lack of partner engagement which is validated in the October 7, 2016, PPS Progress Report which shows that approximately only 8% of funds have flowed to community based providers. In order to achieve the admirable goals of DSRIP it is imperative that all stakeholders rise to the challenges together and are given equal opportunity to succeed. This includes being provided with the necessary resources to adapt, evolve and innovate.

The Coalition and its members are deeply invested in the success of DSRIP because of the positive impact it can have on the lives of the individuals and communities they serve. Through participation in the initial phase of DSRIP, they had envisioned and strategized a new way forward that is creative, clinically sound and grounded in real experience—they deserve every opportunity to achieve these lofty goals. We are aware that progress is on-going and moving rapidly, and offer our comments to inform, reinforce and strengthen the Recommendations of the Independent Assessor with the perspectives of the behavioral health community.

The Coalition has actively encouraged its membership to report their progress with the implementation of DSRIP to better understand and quantify its impact. As each PPS is required to include at least one measure focused on behavioral health, we believe this input is valuable. Further, behavioral health care promotes the involvement of Home and Community Based Services (HCBS) as an essential tool in recovery. Our members have developed expertise in those services, and we offer that perspective as well. Our comments focus on barriers to Partner Engagement, the ramifications of insufficient Fund Flows and the opportunity for Financial Sustainability and transition to Value Based Payments (VBP).

<u>Partner Engagement</u>

The reports from many of our providers begin with overarching comments regarding the lack of structural congruence between medical and behavioral health care as a barrier to partner engagement. DSRIP proceeds from a medical care paradigm with its inherent perspective, and the institutional bias does not easily comport with or take advantage of the on the ground, immediacy and inventiveness of community based organizations (CBOs), whether they are

providing behavioral health care or the services to address the social determinants of poor health.

For example, members have expressed their frustration with perspectives that revolve on medical solutions and fail to begin with a collaborative, problem solving approach inclusive of multiple perspectives, particularly non-medical solutions. One member describes a “tortuous” process with a PPS regarding childhood asthma mitigation. The PPS looked toward clinical solutions and failed to recognize the value of stress management by CBOs as a preventive opportunity.

Another provider noted “The projects were not designed with the input of community based organizations like ours. As a result, implementation...has been a struggle…had it been designed with the input of our agency, we would have been able to inform the process and ensure that its goals could be achieved.” Even the forms requested information that is “irrelevant to the practice of a community-based behavioral health organization.”

A similar discordancy noted is a “mismatch between community modalities and the projects selected by the PPS. There is a cultural difference in their understanding of viable solutions. It was further noted that being able to offer clinical or clinic-like services facilitated understanding between the medically based PPS and the CBO.

Another barrier to effective partner engagement, one which threatens the stability of the behavioral health infrastructure, is the disadvantage of smaller community based agencies serving fewer, but yet the most vulnerable populations effectively. These organizations, deeply rooted in the neediest communities, are most likely to understand and connect with those communities. Yet they are less able to invest the time, effort and financial resources to engage in the contracting process and are the least likely to be sought out by the PPS lead agencies. Without the PPS leads committing resources to outreach community based organizations,

develop a mutually understandable dialogue and provide the resources to "bring them up to speed," those CBOs best positioned to engage the neediest communities will not be there.

Another factor that stymies effective partnerships is the emphasis on health care as the primary driver of the PPS. As to parity between primary and behavioral health care, our members still believe the PPS "are all essentially focused on primary care." One agency remarked " we chose the only project which could conceivably fall within our agency's mission." Another called it " a bit of a guessing game to determine which projects would be appropriate for our agency." The CBOs questioned the assumption of a "secondary" role, while acknowledging the concerns should medical care be provided in a behavioral health setting. There is a long history of subtle (or not so subtle) discrimination and stigma against individuals living with behavioral health conditions and their providers which several respondents perceive as a barrier to equitable partnership.

Fund Flows

Almost all respondents cited the lack of compensation for the hours and effort that they expend on DSRIP related activities.

CBOs are more likely to be financially challenged yet are being asked to invest deeply in DSRIP readiness. They do not, however, receive any or adequate financial support to engage with PPS, enter into contracts, or participate in various workgroups, panels, committees, program development and management, or developing pilots which, without their expertise and input, are perhaps less likely to be realized and effective. They are being taxed with time and effort that is uncompensated and unrecoverable, and have no guarantee that the programs they help to establish will be actualized, or actualized as the contracted partnership.

Other issues include contracts that were never culminated or contracts that were unclear as to the available compensation or how compensation would be dispensed. "Payment for the work

we have done is extremely slow" and often untimely. Several agencies cited that the compensation is too low to make participation economically sustainable.

Financial Sustainability and VBP

In some instances, organizations are ramping up staff and training them for various community based functions, in order to ensure their place and readiness for when the program goes live. Yet, for a variety of reasons, there is both an uncertainty and insecurity about the sustainability of funding. For example, one program was structured such that only the primary care provider was eligible for payment, with no mechanism for payment to trickle down to the behavioral health co-provider.

One member belongs to six PPS, but receives funds from only three. Another member cites a "main partner" and other partners with who they may cease working. Organizations will continue working with a non-paying PPS if they anticipate substantial and sustainable rewards. While many factors, including compensation, confluence with the project, and equality of partnership enter into the equation, organizations ultimately focus on the PPS they believe are sustainable, even if they have not received any payment.

There is abiding concern about outcome measures for Value Based Payments, and, how that will affect the sustainability of their funding. Respondents noted the lack of existing quality measures for non-medical services and the difference in longer term objectives for clients as opposed to clinical measures which tend to be shorter term and more concrete. The transition to VBP payments will be especially difficult; DSRIP funds were intended to enable transition to payment reform, and should be directed toward providers and organizations to ensure their participation in delivery reform.

Conclusion

While most respondents were cautious, it is clear they believed increasing engagement with behavioral health clinics and other CBOs is necessary to meet the objectives of DSRIP. They believe cultural differences require clear dialogue and meaningful collaboration to ensure the effectiveness and efficiency of the DSRIP objectives. CBO's have stretched their resources for the sake of what they believe will be the finest opportunity to enable healthy individuals and create resilient communities. It is an opportunity that should not be missed. They deserve the confidence of their partners and the security of appropriate financing to successfully transition to delivery system and payment reforms.

Respectfully Submitted,

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