Project Advisory and Oversight Panel Report Out

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Our Collective Vision for MHVC

• A more *integrated* delivery system, *better able to take on risk and deliver value*

• A more *sustainable* delivery system, care delivered *locally* and in the *right care setting*

• A more *patient-centered* delivery system, with *expanded access* to *services tailored to the unique needs* of our patients and communities
Montefiore Hudson Valley Collaborative (HVC) has an expansive scope and leverages Montefiore’s expertise

• **7 Counties:** Westchester, Rockland, Orange, Sullivan, Dutchess, Ulster, and Putnam

• **>250 Organizations:** >1000 entities representing full care continuum (including most of region’s hospitals), community-based organizations, and LGU and SME experts

• **229,000 Attributed Lives**

• **Leverages Montefiore’s experience:** >20 years in VBAs, manages >400,000 lives; fluent in care transformation, including experience as Health Home lead and nation’s top performing Pioneer ACO
Where do our members live?

Key Takeaways:
- Network Membership – 229,000
- Yonkers and Newburgh – highest membership, 19% and 6%
- Majority of MHVC membership are either White or Hispanic
- 31% of MHVC’s Hispanic population lives in Yonkers

**Note: This map only includes zip codes with more than 800 members.**
MHVC Governance

Montefiore

MHVC Steering Committee

- Finance and Sustainability
- Information Technology
- Workforce Transformation
- Clinical Quality
- Legal and Compliance

Workgroups report up to their respective Governance Subcommittee
Clinical Subcommittee Workgroups

... the power of planning from multiple perspectives

Project Specific
- ED Care Triage
- HH at Risk
- BH Integration
- Cardiovascular
- Asthma

Cross Cutting Themes
- Integrated Delivery System
- PCMH
- Care Management
- Provider Engagement
- Patient Engagement

Cross PPS
- 3aii Crisis Stabilization
- 4bi Smoking Cessation
- 4bii Cancer Prevention
Leveraging Collaboration

Regional

Hudson Region DSRIP Public Health Council
- Representation from MHVC, WMC, Refuah
- Tobacco Cessation
  - Schools
  - Smoke Free campus
  - Quit Line
  - Website
- Cancer Prevention
  - Community Screening
  - Adapt DH 2018 Prevention Goals
- Evidence Based Protocols
- Regional LGU and Provider Engagement
- Alignment of “Engagement” Definitions & Reporting Requirements

BH Crisis Leadership Group
- Local IMPACT initiative
  - West/Rock LGU’s
  - Walking & Bodega initiatives
- PHIP - Poverty Simulation
- Community Forums CCHL/BH CBO Engagement

County & Community Engagement

State

HHC, Albany, BPHC, FLPPS
- Co-Development and Sharing of Materials
- Project Alignment

Cross PPS Collaboration
- Cultural Competency
- Medical Directors (GNYHA)
- Project 3bi Cardio (MIX)
- Advocacy (GNYHA, HANYS)
- Regulatory Relief

Cross PPS
Using Cultural Competency & Health Literacy *in context*

Our community partners think about cultural competency in a broad way that includes more than race, ethnicity and language. They consider “what matters to you [the patient]?”

“The best place we can stand is from that place of not knowing.” Balancing expertise – our own, as providers, with our clients - as experts in their own lives.

*Foundation for our strategy:*
- **We ask ourselves:** Needs & resource assessments
- **We ask each other:** County-level coalitions
- **We ask individuals:** Surveys/community forums
Workforce Transformation Subcommittee

Workgroups:
- Cultural Competency / Health Literacy
- Communication & Engagement
- Training Strategy
- Compensation & Benefits

Multi-Stakeholder Membership:
- Community Partners
- Labor Unions
- Special Needs Populations
- Subject Matter Experts
- Peers
- Patients

Subcommittee/Workgroup Responsibilities:
- Co-chaired by Partners Staffed by MHVC
- Workforce Survey
- Cultural Competency Strategy & Training
- Webinars and Partner Education
- Communication & Engagement
- Workgroup Membership
- Metrics
- Emerging Roles & Career Ladders
Empowering Our Workforce

• Understanding Emerging Titles
  – Care Management / Care Coordinators
  – Visiting Nurses / Home Health Aides
  – Patient Educators / Community Health Workers
  – Peer Coaches / Peer Support Staff
  – Crisis Intervention Professionals

• Building career ladders to create a strong system with an engaged workforce
  – Collaborate with community colleges so that training translates to credits for career advancement and/or degree attainment

• Creating “bottom-up approach”, to workforce communication and engagement, focused on healthcare workers leading the change

• Partnering with 1199SEIU in training strategy and curriculum
Aligning on PCMH Capacity Building

Integrated Delivery System (2ai)

Health Home At Risk (2aiii)

Medical Village (2aiv)

Behavioral Health Integration (3ai)

Cardiovascular Evidence Based Guidelines (3bi)

Asthma Evidence Based guidelines (3diii)
Empowering Primary Care Practices

- MHVC project selection based on regional community need assessment – large unmet need for primary care projects

- PCMH Approach
  - Understand provider overlap within PPSs (align on resource commitments to “lift” practices)
  - Baseline survey, followed by site readiness assessments
  - Consulting services to assist MHVC-wide PCMH efforts
Every Project Crosswalks to Behavioral Health

**Care Transitions**
- ED Care Triage
- Crisis
- Medical Village

**Chronic Disease**
- BH Integration
- HH At Risk
- CVD
- Asthma

**Clinical Response:**
- Treat the whole person
- Care plans / Referrals
- BH assessment & screening
- Support for Self-Management

**Social Determinants of Health Response:**
- Linkages to CBOs
- Community Partners
- Access to training & resources
Supporting Innovation in the Delivery of Behavioral Health

Four (4) MHVC partners have achieved recognition under two new state programs for their vision of behavioral health/primary care integration

- **OMH IMPACT** – recent OMH pilot project, 5 MHVC practice sites named via a competitive process, eligible to receive $150 PM/PM to support care coordination.
  - Hudson River HealthCare – 3 FQHC sites
  - Middletown Community Health Center – 1 FQHC site
  - Greater Hudson Valley Family Health Center – 1 FQHC site

- **DOH MAX** series to support Model 2 – the integration of primary care into an Article 31 licensed setting – selected partner:
  - Access Supports for Community Living
Additional Behavioral Health Program Opportunities

- **Practice Transformation Network (PTN) Grant** – Montefiore is a regional lead for the National Council for Behavioral Health’s PTN grant award. Providers can receive incentive payments of $1,500 for participation in collaborative care planning for psychiatric discharges.

- **UHF Grant – Behavioral Health Integration Framework** – Dr. Henry Chung, Montefiore is leading an initiative to develop a framework to support small primary care practices across the continuum of behavioral health integration.

- **Telemedicine** – MHVC is exploring the use for subspecialty and psychiatric care.
MHVC’s Prevention Agenda Campaign

- Developed by Cross PPS Regional Public Health Council
- Alignment with DOH Prevention Agenda
  - Smoking Cessation
  - Cancer Prevention
- Engagement Plan
  - 1 CBO per region contracted to disseminate campaign to local schools
  - Regional Public Health Council links to local CBO resources
DY1 - Linking Planning to Partner Payments

- Cooperating Provider Agreement reviewed and vetted with Steering Committee, Sept-Nov’15

- Phase 1 Partner Engagement – launched November 2015
  - Defined “envelope” of funds - $5M
  - Utilized state Attribution for Performance data (A4P) to target partners that are designated as the primary point of contact for our members
    - Eligible Partners – top 50 partners that represent >95% of attribution
    - Designed partner activities/metrics that reward meaningful engagement in project planning
    - Incentivized the completion of all activities/metrics
      - 30% at contract signing – **over $1.2M distributed to date**
      - 70% at completion of all activities/metrics
DY2 – Expand the Reach of Partner Contracting

- Identify partner’s role in impacting performance measures and align payments with outcomes
  - Assures alignment with construct of VBP payment models

- Expand contracting efforts to include CBO’s.
  Options under consideration:
  - Direct contract with MHVC
  - Via subcontract from partners with attribution
  - Track CBO’s who become eligible for safety net designation as they enter into Medicaid billing relationships for services like 1915i/HARP
The Way Forward!

Critical Success Factors:

• Consistent access to accurate and timely member data to drive decision making and resource allocations.

• Ensure alignment and proper incentives for MCO’s to engage with MHVC and our partners in the transition to VBP.

• Simplify the EIP/EPP program so that it does not adversely impact PPS cash-flow or create additional onerous reporting requirements

• Announce CRFP funding awards
Thank You