MHVC: Creating a Culture of Sustainability

Allison McGuire, MPH – Executive Director
Damara Gutnick, MD – Medical Director
June 2017
Housekeeping
DSRIP is . . . Alphabet Soup

We will do our best to define terminology.
Please call us on it if we forget!!!
Who is in the audience?

Show of hands

- Clinicians
- Administrative leadership
- Front Line Staff
- IT or Analytics
- Peers
- Community Based Organizations
- Patients/Clients/ Members etc.
- Other?
What kind of “care” do you provide?
What are your goals for today?
# Our Agenda

1. *Creating a Culture of Sustainability*  
   Allison McGuire  

2. *Being Patient Centered About Things that Matter*  
   Damara Gutnick, MD FACP  

3. *Moving to Retail: VBP Training Breakout Groups*  
   - Primary Care  
   - Behavioral Health  
   - Community Based Organizations  
   Kristin Woodlock, RN & MHVC Team Facilitators  

4. *Engaging our Communities: The Innovation Fund*  
   Marlene Ripa  

5. *Making Connections: Group Activity*  
   - Networking & Innovation Fund Brainstorming  
   MHVC Team  

   MHVC Team
MHVC: Creating a Culture of Sustainability

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June 2017
Montefiore Hudson Valley Collaborative (MHVC): An Expansive Scope

• Spans lower Westchester, Rockland, Orange, Sullivan, Dutchess, Ulster and Putnam Counties.

• ~600 entities from ~200 unique organizations, including a broad array of provider types and community-based organizations.

• Substantial attributed Medicaid lives, estimated at >200,000.
Why is an Integrated Delivery System Important?

- Historically, coordinating care has been challenging
  - Many silos of care (PCP, hospitals, SNF, BH)
A Community of Care

- FQHC’s
- Hospitals
- Small Practices
- Specialists
- DD
- CMA’s
- CBO’s
- Health Homes
- Skilled Nursing Facilities
- Pharmacy
- MH & SUD

Patient

Community

Hospitals

Small Practices

Specialists

Skilled Nursing Facilities

Pharmacy

MH & SUD

Health Homes

CBO’s

CMA’s

DD

FQHC’s

Patient
**Right-Sizing the Use of the Emergency Room**

- **Goal:** reduce inappropriate utilization, define cohorts of patients best served in ambulatory care locations, address gaps in care

- **Go-Live of ED Care Triage Program** September 2017
  - Standard policies, procedures, job descriptions, performance reporting
  - Integration of Health Home referral procedures

- **State funded MAX teams** deployed in regional hotspots (Yonkers and Newburgh) and Dutchess County to address cohorts of high utilizers
  - 22 – 33% decline in ER utilization & up to 88% decline in admissions
  - MHVC and partners trained as MAX trainers to spread this innovation
Standardizing Behavioral Health Crisis Services

• **Developed regional best practices model with area PPS’s**

• **Regional program planning collaboratives** in Rockland, Orange and Westchester to address identified gaps in services.
  – Review of ED utilization data, process mapping with key stakeholders and convening regional discussions.

• **Development of program models and interventions in collaboration with state and local government, police, paramedics, jails, and MHVC partners.**
Strengthening Primary Care Teams

• Promoting Patient Centered Medical Homes
  – 45 partner sites have achieved PCMH 2014
  – 82 are in process
  – 6 community practices exploring Advanced Primary Care (APC)

• Integrating Behavioral Health and Primary Care
  – Learning Collaborative – 18 month program for 28 partners. The goal is to improve regional linkages that promote holistic patient care

• Promoting Self-Management for Cardiovascular Disease
  – Ongoing provider trainings: Brief Action Planning, Motivational Interviewing and Care Management.
  – Provider toolkits for Care Management teams

• Reducing ED Utilization by Members with High Risk Asthma
  – 20 MHVC Partners (pediatrics and specialists)
  – ASTHMA Educator App as a technology tool for partners.
Defining Roles Across the Care Continuum

- **Deploy Evidence Based Guidelines**
  - Asthma Management, CVD, BH

- **Adopt Screening Tools**
  - PHQ-9, SBIRT, Social Determinants of Health - SDH
  - Tools & training to support assessment delivery & patient empowerment
  - Motivational Interviewing; Brief Action Planning; Self Management Support

- **Referral Protocols to Ensure Resource Linkages**
  - Standard Health Home Referral Policy
  - Tools & training to support warm hand offs for care transitions

- **Protocols around Care Transitions**
  - Clearly defined roles & responsibilities

- **Health IT requirements (inter-operability)**
  - Linkage to RHIO / QE
Developing the Workforce of the Future

**Increasing Primary Care Capacity for the Region**
- Launching Nurse Practitioner (NP) residency program September 2017
- 18-24 NP placements over four years, in FQHCs, BH, and primary care sites

**Training on Patient Centered Models of Care**
- What Matters to You Campaign – June 2017
- Brief Action Planning (24 trainers), Motivational Interviewing (16 trainers), Care Management (80 trainers)

**Promoting Health Equity**
- All trainings include Cultural Competency & Health Literacy components
- Partner in Blueprint for Health Equity. Recent event for 20 Colleges/Universities

**Tools for Partners**
- Launched Regional Job Board
- Deployed Workforce Communication & Engagement Toolkit re: Population Health
Outcomes, Outcomes, Outcomes

• **Using Data to Drive Decisions & Actions**
  – Gaps in Care Reports, using MAPP Snapshot data to generate Chase Lists
  – Releasing Provider Dashboards detailing project outcome metrics (site/org level)

• **Building Accountability to Network Outcomes**
  – All partner contracts are performance based and support the build of our integrated network. Approved $21M in contracts to date.
  – Building accountability by using our governance subcommittees and workgroups to define the project deliverables embedded in MHVC contracts.
  – 25% of partner payments are contingent on achievement of network outcomes

• **VBP Readiness**
  – MHVC routinely surveys partners on % of revenue in VBP.
  – NYAPRS training for CBO’s
  – PDSA Trainings

• **Cost Model Strawmen**
  – Utilizing claims data to define opportunities for shared savings across provider network
Hudson Region DSRIP Public Health Council Capacity Building Roadmap

**Completed**

- Plan Do Study Act Training and Materials
- Standard Cancer Screening Guidelines
- Connecting to NYS Smokers Quitline
- Tobacco Cessation and Cancer Screening Initiatives
- Anti Vaping Materials for Teens Provided to Schools and Partners

**Upcoming Initiatives**

- Motivational Interviewing Training
- Plan Do Study Act Tool Kit
- Tobacco Cessation and Cancer Screening Measurement
- Targeted BH Tobacco Cessation Campaign Initiatives
- Education on Embedded Cancer Screening Alerts
CBO’s Strengthen Our Communities of Care

**Phase I**
Outreach and Empowerment
DY1 – DY2

- **Outreach** - inclusion of CBO’s in MHVC Subcommittees / Workgroups and Regional Public Health Council
- **Promote Outcomes** – Provide PDSA training to CBO’s
- **Plan for Value Based Payment Models** – Assess/educate network - NYAPRs, Map CBO footprint

**Phase II**
Targeted Interventions
DY3 – DY5

- **Engage MHVC members through their relationship with regional CBO’s:**
  - CBO’s provide patient education / patient engagement initiatives
  - CBO’s participate in bi-directional referral tracking systems within their community

**Phase III**
Supporting Sustainability
DY3 – DY5

- **Document Success** – MHVC outcomes / research efforts
- **Advocate for VBP models that recognize CBO impact**
MHVC Contracting Builds Sustainability

Payments Made Based on Population Size, Complexity and Quality

Funds Flow is Calculated Based on:
- Attribution
- Outcome Impact
- Process and Infrastructure Build

59 Org’s w/ Performance Based Contracts

>$20M in Partner Contracts

Managing Outcomes and Cost of Care
Being Patient Centered About Things That Matter

• Damara Gutnick, MD FACP
Person Centered Lens
WHAT MATTERS TO YOU?

https://www.youtube.com/watch?v=bAT6Q9fBYe8
Once you have had the conversation. . .

We’d love to hear about how it went.

- Who did you talk to?
- How did it feel?
- What happened?
- What will you do differently in the future?
- How will you measure the impact?
What do you think?
Value Based Payment Training Breakouts
DSRIP is. . . An Opportunity!
A Community of Care

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Patient

Network

Pharmacy

Skilled Nursing Facilities

Health Homes

CBO’s

CMA’s

DD

FQHC’s

Hospitals

Small Practices

Specialists
DSRIP Funding Tied to Reaching Outcome Metrics

- Projects: 1.5 million
- Outcomes: 77+ million
Innovation

in·no·va·tionˌinəˈvāSH(ə)n/
*Noun* - the action or process of innovating.
DY3 Innovation Fund

**Category A**
Contracted partners
$1.2 million

**Category B**
Tier 1 CBOs
$650K
## Eligibility & Funding

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<thead>
<tr>
<th>Category</th>
<th>Eligibility (Lead Applicant)</th>
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| **Category A** | MHVC Contracted Partners only  
• A contracted MHVC partner in good standing must be the lead applicant for Category A funding. Collaboration between partnering organizations with downstream funds flow to Tier 1* and 2** CBOs is encouraged. |
| **Category B** | Tier 1* Community Based Organizations (CBO) only  
• A Tier 1 CBO must be lead applicant for Category B funding. Collaboration between partnering organizations including Tier 2 & 3 CBOs (including FQHCs) is encouraged  
• A provider of social, human and other support services to Hudson Valley service area residents  
• Able to provide proof of NYS non-profit status if selected to submit a full proposal  
• Capable of providing quality services to clients in a financially responsible manner  
• Capable of tracking and documenting client services delivered  
• Capable of demonstrating budget accountability  
* Please note MHVC will offer Technical Assistance to Tier 1 CBO applicants |
## What Tier Are You?

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<thead>
<tr>
<th>CBO Tier</th>
<th>NYS DOH Definition</th>
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<tbody>
<tr>
<td><strong>Tier 1</strong>*</td>
<td>Non-profit, non-Medicaid billing, community based social and human services organization (e.g. housing, social services, religious organizations, food banks).</td>
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<tr>
<td><strong>Tier 2</strong></td>
<td>Non-profit, Medicaid billing, non-clinical service providers (e.g. transportation, care coordination).</td>
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<tr>
<td><strong>Tier 3</strong></td>
<td>Non-profit, Medicaid billing, clinical and clinical support service providers licensed by the NYS Department of Health, NYS Office of Mental Health, and NYS Office with Persons with Developmental Disabilities, or NYS Office of Alcoholism and Substance Abuse Services.</td>
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How can my organization get involved?

Are you currently contracted with MHVC?

- Yes → Category A
- No
  - Are you a CBO?
    - Yes → Which tier are you?*
      - Yes → Tier 1
        - Tier 2
          - Tier 3
            - Not eligible to apply as the lead applicant. We encourage partnership with a Tier 1 CBO.
  - No → Or contracted partner
Innovation Fund Priorities

Priority will be given to projects that:

- Are responsive to Regional needs
- Are designed to impact one or more high priority clinical outcome metrics – data driven evaluation strategy
- Address social determinants of health
- Allow for the provision of services not currently billable to Medicaid, or expansion of services to meet needs of the community
- Demonstrate multi-stakeholder collaboration
- Demonstrate sustainability
GOAL: Design Innovative Projects that have capacity to impact these metrics.
Innovation Fund Key Dates

- **Regional Meetings**
  - 6/19-2/21

- **CBO Early Submission for Technical Assistance**
  - 6/26

- **Letters of Intent Due**
  - 7/5

- **Notification of Invitation to submit Full Proposal**
  - 7/17

- **Invited Proposals Due**
  - 8/14

- **Selected Proposals Notified & Contracts executed**
  - 9/30
Making Connections

DSRIP

BINGO!
DSRIP is... An Opportunity!