

College Bowl 2018



Montefiore

HUDSON VALLEY
COLLABORATIVE

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Case Study Overview

The Montefiore Hudson Valley Collaborative (MHVC) is a subsidiary of the Montefiore Health System.

- ❑ Role
- ❑ Performing Provider System (PPS)
- ❑ Delivery System Reform incentive Payment Program (DSRIP)

What is Performer Provider Systems (PPS)?

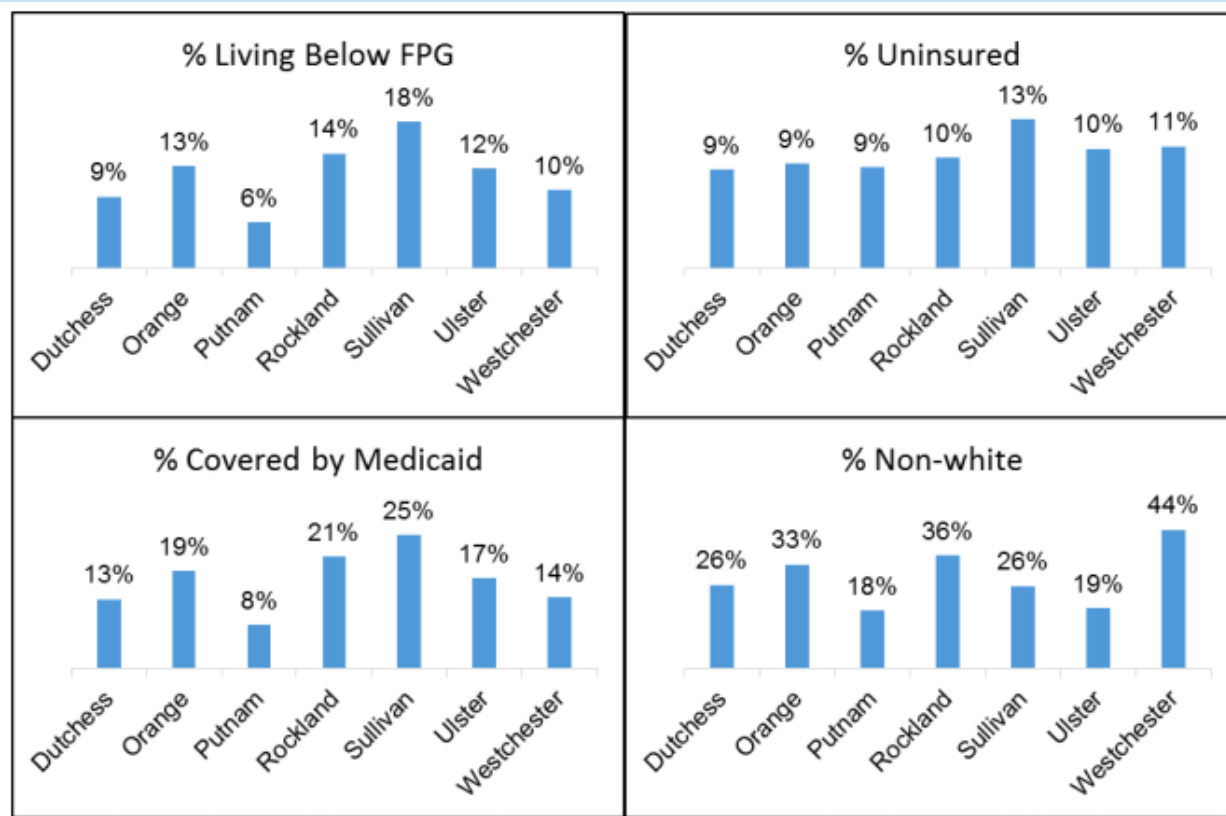
Pay for Performance

- This is a five-year **incentive program**
- If community health does not improve during years 1-5, Performing Provider Systems may receive ***less than their maximum award***
- Statewide Accountability: all Performing Provider Systems in NYS will need to meet their goals in order to receive maximum funding
- Year 1 begins April 2015

Delivery System Reform Incentive Payment Program (DSRIP) Goals

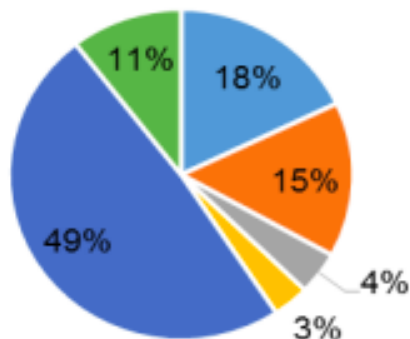
1. Safety Net Transformation at the system and state level
2. Accountability for reducing avoidable hospital use and improvements in population health measures
3. Sustainability of delivery system transformation through managed care programs

Community Statistics



Community Statistics

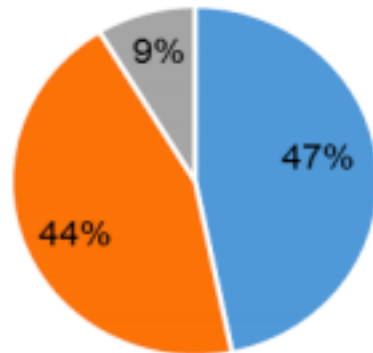
2014 Drug / Alcohol-Related Hospitalization Costs Total of \$271,729,903 and 14492 patients



- Alcohol = \$48,681,429
- Opioids = \$41,186,646
- Cocaine = \$11,387,024
- Other Drugs = \$9,279,394
- Drugs/Alcohol with Rehab Stay = \$132,669,642
- Drugs/Alcohol, Left Against Medical Advice = \$28,525,767

Community Statistics

2014 Mental Health-Related Hospitalization Costs
Total of \$715,111,740 and 16709 patients



- Mood Disorders = \$334,519,542
- Schizophrenia and other psychotic disorders = \$318,340,530
- Other Mental Health = \$62,251,668

How can we help?

- ❑ Meet non-medical needs of the population
 - ❑ Housing
 - ❑ Transportation
 - ❑ Food
- ❑ Integrate CBO for behavioral health, primary care, and health clinics
- ❑ Make these non-medical needs cost effective and ensure financial sustainability

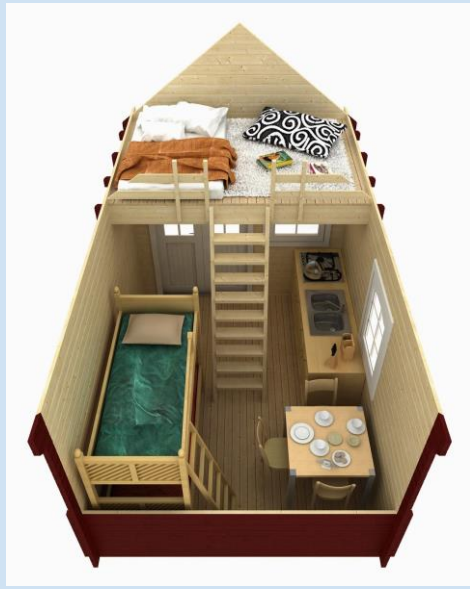
DSRIP Project Plan

All Other	2514
Behavioral Health	482
Clinics	57
Community Based Organizations	105
Health Home / Care Management	30
Hospice	10
Hospitals	30
Non-PCP Practitioners	4970
Pharmacy	12
Primary Care Physicians	1242
Skilled Nursing Facilities / Nursing Homes	79
Substance Abuse	33

50 Square Feet	Behavioral Health Clinic
Larger sizes for families	Education Center
50 Square Feet	Primary Care Center/ Urgent Care
50 Square Feet	Showers
	Cleaning Services
Other Services	Cafeteria

Outreach and Rehabilitation Village

- Behavioral Health clinic
- Education Center/Career Builder Center
- Primary Care Center
- Urgent Care services
- Transportation
- EVS services
- Dietary Services



Outreach and Rehabilitation Village

- Microwave
- Stove top
- Bed
- Running water
- Laundry units
- Heat/ Air Conditioning
- Accessible Food
- Toiletries

Project Justification

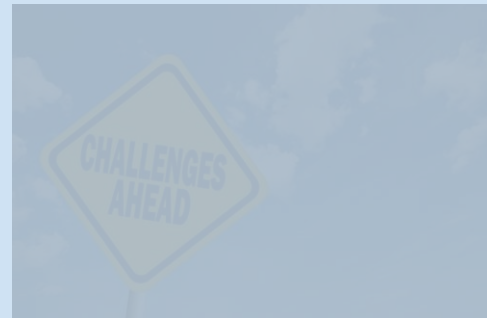
- ❑ Community Needs Assessment
- ❑ MVHC member's health and well-being go beyond traditional healthcare it includes:
 - ❑ Transportation
 - ❑ Vocational coaching
 - ❑ Family support
- ❑ MHVC has over 750 partners and uses both traditional and nontraditional providers who can improve care for our over 200,000 attributed lives

Assets

- ❑ Implement matching IT operations
- ❑ Education
- ❑ Accessible Resources
- ❑ Housing
- ❑ Transportation
- ❑ Food
- ❑ Medication Access

Anticipated Project Challenges

- ❑ All Community Based Organizations working as one.
- ❑ IT challenges
- ❑ Engaging members in the new delivery system
- ❑ Helping partners with the transition from traditional payment models to value-based payments



DSRIP Project Requirements Milestones & Metrics

Metrics:

Avoidable ED Visits (All Population)	Diabetes Monitoring for People with Diabetes and Schizophrenia
Avoidable Re-hospitalizations (All Population)	Cardiovascular Monitoring for People with CVD and Schizophrenia
Avoidable ED Visits (BH Population)	
Avoidable Re-hospitalizations (BH Population)	Controlling Hypertension (NQF 0018)
Follow-up for Hospitalization for Mental Illness	Tobacco Cessation (NQF 0027) (component on discussing smoking and tobacco use cessation strategies)
Antidepressant Medication Management	

Measure Effectiveness

- ❑ ED Visit rates decreased by 20%
- ❑ Child primary care visits have gone up by 15%
- ❑ Behavioral health readmissions decreased by 15%
- ❑ Mental Health Readmissions decreased by 20%



Critical Success Factor

- ❑ Having all Community Based Organization work as one unit rather than the being siloed.



Conclusion

1. For patients, care will feel different: more coordinated, easier to access, and prevention-focused. The initial emphasis will be on the chronically ill, but all patients will benefit.
2. For providers, there will be greater accountability.
3. Care will be more collaborative, with shared IT and care plans, and fewer regulatory barriers.
4. For communities, there will be a more responsive system and better integration between providers and social services.