

# MHVC: Creating a Culture of Sustainability

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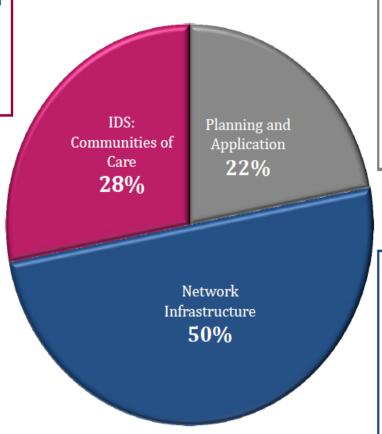




### **PMO Expense Types as of DY2Q2**

Waiver + Non-waiver

- 18% Project
   Implementation Personnel
- 7% Medical Village Strategic Plans
- 3% Care Management



- 12% Project Planning and Program
   Development
- 5% Stakeholder Engagement
- 3% Application Development
- 2% Community Needs
   Assessment

- 14% Partner Contracting, Sustainability, VBP
- 12% Workforce
- 10% Administrative Personnel
- 9% Technology Services
- 5% Office Expense

### Creating the MHVC Network Infrastructure

### Strengthening Primary Care Teams

- 45 partner sites have achieved PCMH 2014
- 82 are in progress (40 MHVC, 21 BPHC, 21 WMC). 6 small practices considering APC
- Behavioral Health / Primary Care Learning Collaborative 18 month program for 28 partners. The goal is to improve regional linkages that promote wholistic patient care

### Building Network Interoperability

- 85% of contracted entities are connected to the RHIO
- A multi-stakeholder process created our Population Health Roadmap

#### Using Data to Drive Decisions & Actions

- Piloted 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 \$12M in contracts to date, an additional \$8.7M projected in early 2017
- 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

### Supporting a More Integrated Workforce

### Trainings Utilize a Train-The-Trainer (TTT) Model

Once trained, participants commit to providing a minimum of 2 trainings/year

- 24 trainers have completed Brief Action Planning
- By March, 12 trainers will complete Motivational Interviewing
- Through 2017, an additional 50 trainers for Care Management and 3 trainers enrolled in the MAX TTT program

### Increasing Primary Care Capacity for the Region

- Launching a Nurse Practitioner residency program in Sept 2017
- 18 24 Nurse Practitioners over 4 years
- Placements in FQHC's, Behavioral Health and Primary Care sites
- MHVC covers tuition costs and preceptor costs

### Partnering w/ Regional Colleges to Design Future Workforce

6 Meetings w/ local colleges to define future curriculum needs

### Promoting Health Equity

- All trainings include a module that relates to cultural competency
- Supporter of the Blueprint for Health Equity, 3 events held in 2016, 7 planned for 2017
- Cultural Competency TTT program in 2017 for up to 60 trainers



### Impacting Care for our Community

#### Understanding the role of the Emergency Room

- Two MAX teams drawn from our network hotspots of Yonkers and Newburgh
- Patients experienced a 22 33% 

  in ER utilization and up to 88% 

  in admissions
- Newburgh: Patients food insecurity drove creation of a Food Bank on site
- Yonkers: Improved workflows with local dialysis center
- Dutchess/Putnam: 3<sup>rd</sup> team to kick off in 2017
- Bring in the patient's voice through focus groups to further drive system transformation

#### Standardizing Behavioral Health Crisis Services

- Designing a model for the future, including the role of "Community Gatekeepers"
- Rockland/Nyack: 150%+ ♣ in 911 calls and ED transfers from group homes
- Orange/St Luke's: Workgroup kickoff first responders request "alternatives to 939 transfers"
- Westchester process mapping this week! (Thursday pediatrics, Friday adult)

#### Building Communities of Care

- Developing comprehensive Strategic Plans for MHVC's 7 Medical Villages
- Leveraging all network innovation into regional care continuum
- Seeking regulatory relief to enable shared space
- Improving CBO Tier 1 Linkages
- Incorporating the work of our Hudson Valley Public Health council



### CBOs Strengthen Our Communities of Care

#### Phase I

Outreach and Empowerment DY1 –DY2

- Outreach inclusion of CBOs in MHVC Subcommittees / Workgroups and Regional Public Health Council
- Promote Outcomes Provide PDSA training to CBOs
- 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:

- CBOs provide patient education / patient engagement initiatives
- CBOs participate in bi-directional referral tracking systems within their community

#### Phase III

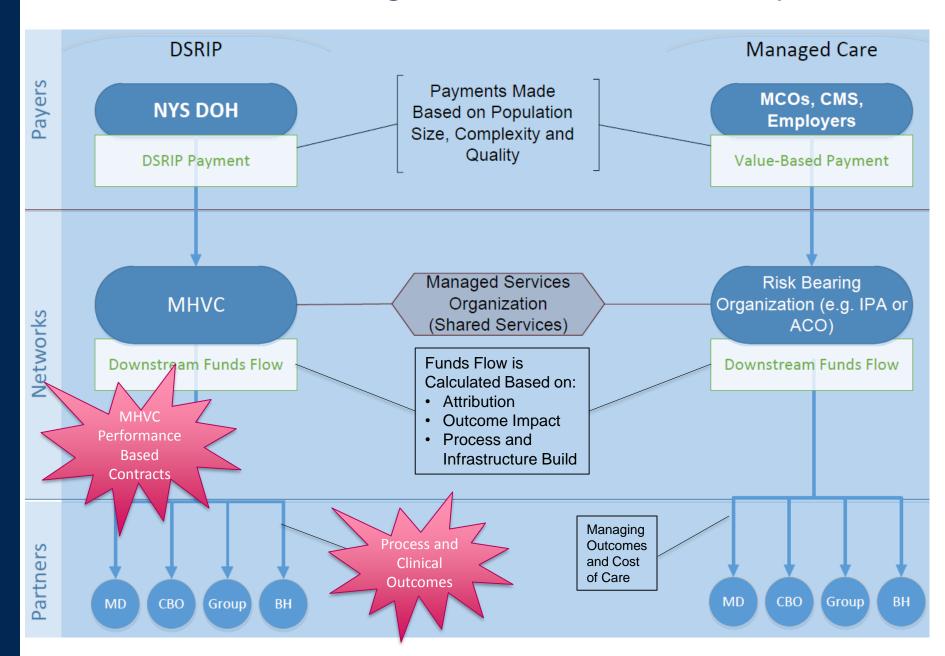
Supporting Sustainability DY3 – DY5 outcomes / research effortsAdvocate for VBP models th

Document Success – MHVC

Advocate for VBP models that recognize CBO impact



### MHVC Contracting Builds Sustainability





### Thank You!

