Kings Fund Masterclass: Session 1 Opening Plenary
Objectives

• Provide overview of Montefiore Health System (MHS) delivery network
• Develop understanding of key role played by the Care Management Organization (CMO) within MHS structure
• Describe Montefiore’s extensive history and overall approach to Population Health Management (PHM)
• Introduce Montefiore’s PHM model developed over past 20+ years
Overview of Montefiore Health System
Montefiore Einstein Fully Integrated Academic Health System

11 Hospitals, including Burke Rehabilitation Hospital
32,000+ Employees
6,200+ Providers
3,111 Total Beds - Including 166 Rehabilitation Beds
150 Skilled Nursing Beds
200+ Sites Including

Hutchinson Campus – Hospital without Beds
1 Freestanding Emergency Department - First in New York State
65 Primary Care Sites
18 Mental Health/Substance Abuse Treatment Clinics
91 Specialty Care Sites
  • 3 Multi-Specialty Centers
  • 8 Pediatric Specialty Centers
  • 9 Women’s Health Centers
  • 13 Rehabilitation Centers

9 Dental Centers
8 Imaging Centers
Care Management Organization
Home Health Programs
Expanded Regional Presence – Our Partners

Montefiore Hudson Valley Collaborative

- Montefiore is leading the Hudson Valley Performing Provider System, with over 500 partner organizations across 7 counties, including:
  - St. John’s Riverside Hospital, St. Joseph’s Medical Center, HealthQuest, Montefiore Health System hospitals
  - 4 FQHCs with 29 sites, including Hudson River Healthcare
  - 59 Skilled Nursing/Long Term Care/Hospice
- Montefiore is a lead participant in the Bronx Partners for Healthier Communities Performing Provider System, led by St. Barnabas

Clinical Affiliations

- St. Barnabas Hospital, Bronx, NY
- St. John’s Riverside Hospital, Yonkers, NY
- St. Joseph’s Medical Center, Yonkers, NY

Physician Groups

Crystal Run:
- Physician Practice in the Hudson Valley
- Employs over 400 clinicians (MS, NPs, PAs, PTs, etc.)

Scarsdale Medical Group
Our Population Health Journey
Goals of Population Health Management: “Quadruple Aim”

Guiding design and measurement of population health management initiatives

- **Patient Experience**
  - Timely access
  - Patient-centered care

- **Population Health**
  - Better outcomes and functional status
  - Reduced disease burden and risk of incidence

- **Cost**
  - Reduction in total cost of care
  - Decreased utilization of resource-intensive care settings

- **Care Team Experience**
  - Improved employee satisfaction
  - Increased work-life balance
Montefiore’s Journey to Population Health Management

1996
Established the Montefiore IPA and CMO to facilitate risk contracts

2000
Major expansion of risk membership

2009
Montefiore leads creation of Bronx RHIO

2011
Montefiore selected as Pioneer ACO

2012
Creation of Montefiore HMO (MLTC) and expansion of Pioneer ACO

2013
Formation of Montefiore-led Medicaid Health Home Program

2014-2016
DSRIP planning / implementation; development of commercial ACOs; NextGen; Expansion to Health Home serving Children; All-payer ACO approval

2017-2018
Medicaid Innovator; LOI for Health Home expansion for persons with disabilities; NCQA certification

Performance-Based Culture
Affordable Care Act
Managed Care Expansion
Sunset of NYS all-payer hospital reimbursement

Development of care management infrastructure; extension of care management core competencies into network
# Current Value-Based Payment (VBP) Arrangements

<table>
<thead>
<tr>
<th>Source</th>
<th>2018 Population</th>
<th>2018 Est. Revenue</th>
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<tbody>
<tr>
<td>Risk Contracts</td>
<td>218,000</td>
<td>$1,415M</td>
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<tr>
<td>Shared Risk</td>
<td>97,000</td>
<td>$584M</td>
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<tr>
<td>NextGen ACO</td>
<td>47,000</td>
<td>$736M</td>
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<tr>
<td>Medicaid Health Home (Care Coordination)</td>
<td>9,000</td>
<td>$22M</td>
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<tr>
<td>Under Negotiation</td>
<td>64,000</td>
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<tr>
<td><strong>Totals</strong></td>
<td><strong>435,000</strong></td>
<td><strong>$2,757M</strong></td>
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Note: All Value-based payment patients are referred to as “ACO” and inclusive of risk, shared savings and NGACO patients.
Montefiore IPA (MIPA)  
• Formed in 1995  
• MD / Hospital Partnership  
• Contracts with managed care organizations to accept and manage risk  
• Supplies network of par providers committed to cooperation in care improvements  
• Over 4,000 providers

Montefiore ACO IPA

Hudson Valley IPA (HVIPA)  
• Formed in 2015  
• MD/ Hospital Partnership  
• Contracts with managed care organizations to accept and manage risk  
• Supplies network of par providers committed to improving quality of care and improving total cost of care  
• Over 2,000 providers
IPAs and Management Company Relationship

• Established in 1996
• Wholly-owned subsidiary of Montefiore Medical Center
• Performs care management delegated by health plans as well as other administrative functions, (e.g. claims payment, credentialing)

• Includes Behavioral Health management (UBA) to address most severe BH conditions and coordinate care with inpatient psych and specialty provider network
• Over 1,000 staff
Our Core Services

Services integrated into delivery system infrastructure to aggressively manage total cost of care and utilization

- Population identification / stratification
- Whole-person care
- ED triage
- Care transitions
- Disease management
- Utilization management

- Behavioral health program stratification
- Behavioral health co-management with accountable care manager
- Primary care and behavioral health integration

- Outcomes management
- HCC / CRG
- HEDIS stars
- CAHPS, NCQA support
- State, Federal quality measures
- Clinical documentation improvement

- Provider contracting
- Provider services
- Facility/ Provider Support Services
PHM Services Enabled by Organizational Competencies

Core PHM Services

- Care Management
- Behavioral Health
- Quality and Analytics
- Administrative Services

Cross – cutting Organizational Competencies

- Quality and Outcomes Management
- Population Health Analytics
- Process Innovation and Engineering
- Training and Education
- Financial Management
- Project Management Office (PMO)
Typical Care Coordination Environment

• Fragmentation of care
• Poor coordination across continuum
• Disjointed clinical pathways
• Lack of unified care plan and longitudinal record
CMO: Serving as “Air Traffic Control”

- Centralized coordination of care to ensure seamless patient experience
- Proactively targeting populations via ongoing data analytics and surveillance
- Cross-continuum view of specific chronic illness
Our Population Health Model
Population Health Management Foundational Architecture

Developed over twenty years of experience managing highly complex and diverse patient populations

- **Whole Person Care Model**
  - Integrated medical / Behavioral Health
  - Social determinants of health
  - Episodic and longitudinal care management

- **Clinical Programs**
  - Focused clinical care designed to treat advanced needs
  - Cancer, Renal, Cardiac, Respiratory, Transplant, etc.

- **Network Care Setting**
  - Acute care
  - Sub-acute and post-acute care
  - Transitions to home

- **Enabling Technology**
  - Seamlessly connect providers, patients and caregivers
  - Consumer-centric platforms to improve patient experience
Assessment “Big Data” Is Not Enough

Analytics alone will not be able to identify underlying drivers influencing clinical condition

8% Generate 55% of Medical Expense

Unstable Housing
Substance Abuse
Mental Health
Financial Distress
Care Guidance™ Process Lifecycle

Time-limited interventions averaging six months aiming to stabilize individual in a community-based setting

- Identify & Prioritize
  - Identify members requiring care coordination services

- Enroll
  - Enroll highest risk individuals

- Monitor & Update Care Plans until Discharge
  - Link individual to services and organizations to provide care coordination

- Develop Personalized Care Plans
  - Develop personalized care plan based on intensity of services needed
  - Stratify into Programs

- Assess
  - Assess (Baseline and ongoing)
  - Understand member’s medical, behavioral, and social needs

- Patient Primary Care Provider, PCMH
Patient Identification and Prioritization

Attributed Population

Preliminary Screening Logic

Cohort Identification

Care Management Intensity

Well and Worried Well
- Members access information as needed

Functional Chronically ill
- Targeted health education and interventions
- Self-management / empowerment

Frail ill / High Utilizers
- Intensive, complex case management
- Palliative Care

• Data Mining
• Provider Referral
• Sentinel Events (e.g., Post-Discharge)
• Self-Identification

Low

Medium

High

Low

Well and Worried Well
- Members access information as needed

Medium

Functional Chronically ill
- Targeted health education and interventions
- Self-management / empowerment

High

Frail ill / High Utilizers
- Intensive, complex case management
- Palliative Care
Care Guidance™: Core operational foundation

Establishes program foundation for initiating transitioning into PHM environment

**ED Triage**
- Transition potential hospital admissions to appropriate care setting
- Reduce admissions from ER

**Care Transitions**
- Identify population at risk for ED visit, re-admissions
- Ensure patient has PCP and appropriate community supports in place

**Intensive Care Management**
- Monitor progress, identify barriers, goals, interventions to prevent admission
- Keep patient in appropriate level of care and community-based setting
PHM Sustainability Requires Financial Alignment and Accountability

- Provider Alignment
- Reward / Reinvest with Providers
- Accountability
- Total Cost of Care
- Savings Created
- Integrated Care Model
- Quality
- Care Management Programs