Thank You

Dear WMCH Health PPS Partner/Supporter,

In this edition of the WMCH Health PPS Annual Report, we look back on the entire DSRIP program to date; at our joint accomplishments, innovative programs, and the individuals and organizations that have participated and led these significant improvements in the way care is delivered to the people of our region.

Over the past several years, your committee membership participation and the commitment of hundreds of medical neighborhood contributors collectively disclosed the specific needs and gaps in service that existed in our communities. Together, in pursuit of common goals, we have achieved positive outcomes and results and reshaped care in the community, creating unique and impactful programs and innovative pilots. Most importantly, many lives have been improved as a result of our collaborative efforts.

I also commend your remarkable participation in the PPS workforce development series, demonstrating your ongoing transformative journey to addressing broader issues beyond our individual scopes. Your eager shift to new responsibilities and roles to meet current and evolving and complex healthcare challenges is admirable.

Finally, Hudson Valley transformation of patient-centered care continues to definitively evolve thanks to the efforts of the WMCH Health PPS participants.

As DSRIP begins to wind down, WMCH Health remains committed to our partners and to innovative collaborations that improve the lives of our neighbors and our communities. We look forward to continuing to work closely with your organizations to improve access to care, to deliver integrated medical and behavioral health care services, to work with our newly recognized Patient Centered Medical Home partners, to reduce unnecessary emergency room usage and admissions through improved care coordination, and to meet the final DSRIP goals.

I thank each and every one of you for your vision, hard work and commitment and for the many newly developed relationships that you have fostered, and I look toward to the future as our journey takes us from participants to partners.

Sincerely,

Michael D. Israel
President and CEO
WMCH Health

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Michael D. Israel,
President and CEO,
WMCH Health Network
Rewind… In the Beginning

In early 2015 WMCH was selected by the New York State Department of Health to develop, operationalize and evaluate 11 projects as one of 25 Performing Provider Systems (PPS). Required milestones over the lifespan of each project continue to be met. Innovative pilots have evolved as a result of PPS learnings about additional community needs and resources.

Infrastructure to Support the PPS

Providing Workforce Training and Education

Our goal is to support learning opportunities for our PPS organizations’ front line team members, clinicians and other segments of their workforce by providing & leveraging partnerships for skills enhancement training, stackable certificates and ongoing learning opportunities to support their roles and delivery of service to the members of their organizations and our communities.

WMCH PPS has offered over 545 educational and training opportunities, to date, across all 8 counties in the PPS Network in an effort to equip the healthcare workforce with the necessary skills to meet the needs of patients, providers, and staff in a period of healthcare delivery transformation. The PPS engaged participants in training opportunities such as: cultural competency, health literacy, performance measures, performance reporting, professional development, care coordination, chronic disease management, population health, patient engagement, organizational development and more.

These trainings are provided for diverse audiences which include: students, volunteers, community advocates and staff of various facility types. Customized in-person staff training was also offered that included such topics as: motivational interviewing, trauma informed care, and community & member/patient engagement best practices. The PPS continues to support partners through innovation pilot projects, overall transformation and value-based payment readiness by facilitating training for front line staff, clinical skills enhancement, as well as physician leadership workgroups, in-person trainings, and web-based educational resources. Access to approximately 53 training modules is provided through our open access learning management system (LMS) https://www.crhi.training.wmchealth.org

2.a.i Create an integrated Delivery System focused on evidence based medicine and population health management
2.a.iii Provide proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services
2.a.iv Create a Medical Village using existing hospital infrastructure
2.b.iv Care transitions intervention model to reduce 30 day readmissions for chronic illness
2.d.i Implementation of patient activation activities to engage, educate, and integrate the uninsured and low/non-utilizing Medicaid populations into community based care
3.a.i Integration of mental health and substance use with primary care services to ensure coordination of care for both services
3.a.ii Behavioral health community crisis stabilization services
3.c.i Implementation of evidence-based strategies in the community to address chronic disease in the high risk/affected populations
3.d.iii Implementation of evidence-based medicine guidelines for asthma management
4.b.i Promote tobacco use cessation especially among low socioeconomic status populations and those with poor mental health
4.b.ii Increase access to high quality chronic disease preventative care and management in both clinical and community settings
IT Summary

To date, 120 out of 200 WMCHealth PPS partners have signed a Participation Agreement with the Qualified Entity (QE), or regional health information organization.

In February 2018, WMCHealth PPS conducted a brief survey used to garner feedback from our partners on their experiences with connecting to and using the QE (HealthLinkNY). This survey was sent out to 173 partners across various organization types, of which 79 responses were received. The survey was separated into 4 categories - Understanding the role of the QE, Ease of Contracting with the QE, Training (by the QE to the partners), and Usefulness of QE Functions, with an emphasis on alerts and access to Usable Information. Three common themes derived from the results include:

Barriers to Implementation
• QE functionality does not often integrate well with the EHR
• Follow through after signing the participation agreement could be improved
• Better guidance for continuing maintenance, especially for receiving alerts
• Implementation can be cost prohibitive
• Partner resources are limited

User Issues
• Information not useful for all provider types
• End user doesn’t always know what to do with the data
• Often difficult to obtain Patient Consent

Training
• Some organizations reported limited follow up and training by the QE
• Staff at the organization have limited expertise to work with the portal

WMCHealth PPS will continue to facilitate webinars between HealthlinkNY and WMCHealth PPS Partners to discuss issues and challenges experienced by the partners, with a working title of Benefits of Using the QE & Where You Fall on the Connection Spectrum. Emphasis on HealthLinkNY conducting more user group meetings and improved customer support will also be discussed.

On September 27th, 2018 HealthLinkNY announced a strategic partnership with HealtheConnections to accelerate HIE use by providers, with a goal of connecting providers across much of New York State, from the northern border of New York City, through the Hudson Valley, and throughout the Southern Tier and Central New York to the Canadian border. We look forward to working together in the future.

Impact: Key Workforce Training Metrics

• 545 diverse training and educational opportunities offered for retraining and training to upgrade staff skills, new staff training for the new roles or functions of healthcare transformation.

• 8 Counties supported through offerings

• 5,769 participants enrolled in in-person trainings and 794 participants enrolled through the PPS online learning management system.

• All Trainings are posted on CRHI website www.crhi-ny.org and LMS.

For any questions or requests for trainings, please reach out to PPS Workforce contacts: Bonnie Reyna at Bonnie.Reyna@wmchealth.org or Ed McGill at Edward.McGill@wmchealth.org.

Care Coordination for Front Line Workers
“I found the Care Coordination For Front Line Workers training to be informative and helpful. I felt that it was valuable to my role as an Adult Health Home Care Manager.”

Nazera Reid, M.A., Health Home Care Manager

2 Day Asthma Educator Training
“The 2 Day Asthma Educator Training has prepared me to sit for the AEE. This training gave real world experience; all speakers were doctors or other professionals in the field who work with Asthma every day. I was very pleased with the training. I feel confident that the training has prepared me for the exam, which in turn will enhance my job skills.”

Shannon Carver, Quality Management

Patient Centered Medical Home Care Coordinator
“I felt that the care coordinator training experience was an exceptional opportunity to enhance my job skills. It has helped me build stronger relationships with my patients, engage them in their care, and coordinate their services; with keeping in mind that compassion is a VITAL tool to keeping patients moving forward towards a healthier future.”

Michael Francescone
## WMCHealth PPS Quality Steering Committee

The Quality Steering Committee (QSC) is responsible for adopting clinical processes and protocols that will be applicable to participants in the provider system... needed to meet DSRIP project requirements and goals... committee membership will include leaders and others from Participant organizations... extracted from WMCHealth PPS QSC Charter

### QSC Membership

<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Position</th>
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<tbody>
<tr>
<td>Ashley Brody, MPA, CPRP</td>
<td>CEO, Search for Change</td>
</tr>
<tr>
<td>Joseph DeMarzo</td>
<td>Deputy Commissioner, Putnam County Dept. Mental Health, Social Services and Youth Bureau</td>
</tr>
<tr>
<td>Allen Dozor, MD</td>
<td>Professor of Pediatrics and Clinical Public Health Chief, Pediatric Pulmonology, Allergy, Immunology, and Sleep Medicine NYMC, Boston Children’s Health Physicians</td>
</tr>
<tr>
<td>Stephen Ferrando, MD</td>
<td>Chairman of Psychiatry at New York Medical College and Director of Psychiatry at Westchester Medical Center</td>
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<tr>
<td>Renee Garrick, MD</td>
<td>Executive Medical Director WMCHealth Network, Vice Dean for WMC, Professor of Clinical Medicine, NY Medical College, Boston Children’s Health Physicians</td>
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<tr>
<td>Scott Hines, MD</td>
<td>Chief Quality Officer, Crystal Run Healthcare</td>
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<tr>
<td>Cheryl Hunter-Grant, LMSW</td>
<td>Exec. Director, LHVPN / VP, Perinatal Programs-Children's Health and Research Foundation, Inc.</td>
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<tr>
<td>Suzanne Kaseta, MD</td>
<td>Chief Quality Office for Ambulatory Care, Boston Children’s Health Physicians</td>
</tr>
<tr>
<td>Mary Leahy, MD</td>
<td>CEO, Bon Secours Charity Health System</td>
</tr>
<tr>
<td>Cecile Liotard, RN, LNC, SAFE</td>
<td>Mid-Hudson Regional Director of Nursing, Institute For Family Health</td>
</tr>
<tr>
<td>Paul Llobet, MD</td>
<td>Chief Medical Officer, Health Alliance; President, Llobet Medical Group</td>
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<tr>
<td>Nasir Mahmood Syed, RPhl, MBA, CCP</td>
<td>President, Pine Plains Pharmacy</td>
</tr>
<tr>
<td>Gary Todd Midelton, MD</td>
<td>CMO, Forme Medical and Urgent Care</td>
</tr>
<tr>
<td>Susan Miller, LCSW, ACSW</td>
<td>Managing Director, Orange/Sullivan Division, Rehabilitation Support Services, Inc.</td>
</tr>
<tr>
<td>Jonathan Nasser, MD, CHAIR</td>
<td>Chief Clinical Transformation Officer, Crystal Run Healthcare</td>
</tr>
<tr>
<td>Andrew Grady</td>
<td>CEO, MHA Dutchess County</td>
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<tr>
<td>Patrick Roohan</td>
<td>VP Data Management and Analytics Solutions, MVP Health Care</td>
</tr>
<tr>
<td>Avi Silber, MD</td>
<td>Medical Director, Cornerstone Family Healthcare</td>
</tr>
<tr>
<td>Jane Ulrich, MBA, BSN, RN, CNOR</td>
<td>Sr. Director of Nursing, Health Alliance Hospital/ WMCHealth Network</td>
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<tr>
<td>Daren Wu, MD</td>
<td>Chief Medical Officer, Open Door Family Medical Centers</td>
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<tr>
<td>Andrew Levin, MD</td>
<td>CRHI Consultant to the QSC</td>
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<tr>
<td>Ana Mercado, RN</td>
<td>CRHI Staff to the QSC</td>
</tr>
<tr>
<td>Harman Sidhu, MS</td>
<td>CRHI Staff to the QSC</td>
</tr>
<tr>
<td>Janet (Jessie) Sullivan, MD</td>
<td>CRHI Staff to the QSC</td>
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</table>
Process Design

At the WMCH eHealth PPS, we are a community of providers who serve a population of patients. Together, we work to improve healthcare and health outcomes for our communities.

By collaborating to improve the clinical performance measures selected by New York State for DSRIP we engaged the use of various tools and resources for our PPS partners’ use. Together we built skills, relationships, data flow, and protocols that will serve our patients and our organizations beyond the scope and term of DSRIP.

The WMCH eHealth “Tips and Tools” along with organizational learning sessions ensured we agreed upon interventions and activities to improve health outcomes. As we collectively moved from ideation to implementation and learned about evaluation, the tools developed for each participating member will have application for future sustainable programming.
Medical Neighborhoods
Share Common Patients
Building Quality Care for the Future
The WMCHealth Medical Neighborhoods

In a study conducted by Partnership for Solutions (a Robert Wood Johnson Foundation program based at Johns Hopkins University), data showed that in the general population, people with five or more chronic conditions have an average of almost 15 physician visits and fill over 50 prescriptions a year (Chronic Conditions: Making the case for Ongoing Care, September 2004 Update, Partnership for Solutions).

The data highlights the need for coordinated & informed care across providers and service settings; yet, the reality that this has yet to be a universal imperative has forced providers and healthcare settings to seek realistic alternatives. One such alternative, the creation of Medical Neighborhoods as clinical-community partnerships of medical, social and behavioral health supports required for optimal patient care, presupposes the medical practices functioning as Patient Centered Medical Homes (PCMH) in the “neighborhood”.

The ideal primary care ‘neighbors’ share these following principles that result in excellent outcomes for individuals and families, and more satisfying and sustainable careers for clinicians and staff. It is a vision that is aspirational yet achievable when stakeholders work together. (PCPCC, 2018)

WMCHealth PPS formulated the concept of Medical Neighborhoods as the structural framework to address healthcare coordination from the local to the regional level. Since 2016 there have been thirty-three discreet meetings consisting of primary care, community-based agencies, healthcare service organizations, and the WMCHealth PPS Network hospitals. We came together to address the pain points of healthcare delivery as active participants with goals of improving our communities. When identified, effectively addressing those specific gaps in care could potentially change the trajectory of positive health outcomes in our communities.

Through focused, guided work sessions, each individual contributed their perspective, challenges and possible solutions. Workflows were created which gave clear visible illustration of gaps in service, overlaps and communications breaks.

New and exciting programs and pilots evolved as a result of each of the medical neighborhoods’ newly minted relationships and deepening partnerships.

The following pages celebrate the unique collaboration amongst the WMCHealth PPS partners.
Youth Career Pathways Scrubs Clubs, Sponsored by Catskills Hudson Area Health Care Education

Scrubs Club helps to prepare students to meet the challenges of the health workforce, and helps build students’ self-esteem and confidence. Engage your High School students with hands-on activities in the exploration of healthcare career choices!

- Pathways to the health industry are being offered in various community schools and a larger multi-pronged pilot in Sullivan County
- Because of challenging gaps in the healthcare workforce facing Sullivan County, an inter-agency planning coalition was formed to assist Sullivan County BOCES in establishing a comprehensive effort to form health careers exploration afterschool programs.

- Working with the Foundation for Community Health, “Scrubs Club: Pathways to Health Careers” was created
- As a result, “Scrubs Clubs” will now launch this fall 2018 in Sullivan County’s public school districts
Cancer Screening + Follow-up

**BRIEF:** Our project aims to increase access to cancer prevention care in clinical and community settings.

**GOAL:** Cancer screening is one of the “gaps in care” for which many providers currently assess patients to ensure they are getting timely access to high quality care. However, new resources need to be developed to support more providers to reach a higher proportion of patients, especially in those communities with particularly low screening rates.

**INTERVENTION:** WMCHealth PPS adopted a comprehensive care plan template that included routine cancer screening for all patients. The Council sponsored training sessions to promote best practices.

**METRICS**
- Developed a comprehensive implementation plan
- Assisted with a community needs assessment
- PDSA implementation

![Image](226x234 to 423x390)

**FIGURE 1:** Implementation of Routine Cancer Screening Alerts in EHR. N = 87

**Supporting and Facilitating the Transition of Care: A WMCHealth PPS Partner Story**

**BRIEF:** Independent Living Inc. Peer Specialists and PEOPLe Inc. engage and support recipients from inpatient hospitalization through successful reintegration in their community. Peer Specialists offer lived experience, empathy, validation and flexibility, recognizing personal recovery as a dynamic and continuing process and facilitating positive outcomes.

**GOAL:** Peer Specialists’ efforts are aimed at reducing avoidable hospitalization and the cyclical use of crisis services, improving internal and external factors that contribute to symptom recurrence, expanding social support networks, and facilitating continuing wellness and elevated quality of life.

![Image](425x426 to 620x619)

**Create Medical Village Using Existing Hospital Infrastructure**

The foundation of the Medical Village is the Medical Neighborhood for Healthy Communities. Medical Neighborhood discussions in Kingston and Port Jervis convened WMCHealth PPS clinical and community partners. Together, participants imagined the experience of patients in their communities transitioning from inpatient to community care. In the process providers identified where patients might “fall through the cracks”, and strategized about how partners could work together to close the identified gaps in care.

**WMCHEALTH PPS KINGSTON MEDICAL VILLAGE**
- Emergency Department Care Navigator
- Embedded Care Manager Llobet Medical Group & Always There Home Care
- MAX High Utilizer Project for Inpatient and ED w. Institute for Family Health & Health Alliance Hudson Valley Hospital
- Medical Neighborhood in Kingston

![Image](425x234 to 623x390)

2018 WMCHEALTH PPS DSRIP REPORT & UPDATE / P. 9
Six pediatrics residents were selected to participate in the continuity clinic in Ossining for the 2018-2019 academic year. At MVNHC - Yonkers, the six WMC residents see pediatrics patients, obtain histories, perform exams, present findings, and complete case study discussions.
Management of Frequent Visitors to the Emergency Room

**BRIEF:** Create a care management intervention to work with “Frequent Visitors” to the Emergency Room to help them avoid unnecessary visits by helping address social determinants of health that may be contributing to their frequent use of the Emergency Department.

**GOAL:** To assist patients with frequent visits to the Emergency Department manage their social and non-life threatening clinical needs to help reduce potentially avoidable ED use through the establishment of a Frequent Visitors Program.

**THE PROGRAM’S OBJECTIVES ARE:**
- To reduce frequent unnecessary use of the ED
- To address the social determinants of health in ED visits
- To improve the throughput in the ED in low and peak times by managing volume, resources and time

**STRATEGIES FOR SUSTAINABILITY:** While this program focuses on an individual ED, through integrated medical records and care plan sharing, individuals whose visit frequency pattern may have moved from our location to another ED could be tracked and the action plan of care shared and initiated with consistency across EDs to improve the patients’ outcomes regardless of which ED is frequented. This would be facilitated at first by a singular integrated EMR within the WMCHealth network followed by information exchange capabilities between non-network EDs as well.

**FREQUENT VISITOR TRENDS BY GROUPS AND NUMBER OF VISITS**

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Innovation Project My C.H.O.I.C.E. Choosing Healthy Options in the Childhood Experience, a Resident-Led School Based Health Education Program

**BRIEF:** Develop a creative and sustainable 6-week health education program for 6th graders at the Alice E. Grady Elementary School in Elmsford, NY

**GOAL:** To create and implement six 1-hour weekly sessions to be led by pediatric residents from Maria Fareri Children’s Hospital with the aim of affecting the behaviors and attitudes of the students, empowering them to make life choices that will prevent obesity and related complications.

**INTERVENTION**
- A 6-week health education program was designed and administered to all 6th graders at Alice E. Grady Elementary School during the 2016-2017 school year.
- The curriculum tackled different topics such as “my plate,” “label reading,” “advertisements,” “physical activity,” and “screen time.” The topics were introduced through fun and interactive activities.
- Data were collected at baseline and post intervention to assess program impact on self-reported food intake and physical activity, measures for previous day dietary intake, nutrition knowledge, TV viewing, physical activity participation and body mass index (BMI) in a self-selected cohort of 41 students.

**NEXT STEPS:**
1. Extend the project to a second group of 6th graders to increase study’s sample size as well as follow-up with the first group.
2. Submit for additional funding to expand and sustain the program.

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The Living Room Day Crisis Respite

**BRIEF:** The Living Room is a non-hospital crisis day Respite Service, designed to provide a comfortable, calm and relaxed environment for individuals in escalating behavioral health crisis who need a safe place to support their mental health. As an alternative to an emergency room, Guests will be offered both peer and professional support to develop short and long-term planning strategies and receive Best Practice services to address their immediate situation. Guests of Living Room programs report feeling supported and heard.

The Living Room is staffed by Certified Peer Specialists, LMHC/CASAC, Social Workers and a Registered Nurse. There is a Psychiatrist on-call for consultation. A Licensed Clinical Social Worker provides oversight of the program.

**COMMUNITY LINKAGE / PREVENTION**
- Transportation Info
- Care Management
- Clinical/Medical
- Planned Respite
- Crisis Hot line Info
- Quit Line Referral
- Assurance Phone
- Housing Referral
- SUD Referral (AA/NA etc.)
- Peer Support (NAMI etc.)
- Immigration Resources
- Voter Registration
- HARP/HCBS Consultation

**CRISIS STABILIZATION SYSTEM**
- Vocational Supports
- Educational Supports
- Care Management (HH)
- Continued outreach/education of providers and consumers
- Continued daily respite 12 hours per day/ 7 days/ 365 (Expansion if possible)
- Continue referrals to planned overnight crisis respite
- Increase access to transportation for those traveling distance
Demonstrating Impact: Behavioral Health Community Crisis Stabilization Services

OBJECTIVES
- Develop and expand community-based crisis stabilization services to reduce potentially unnecessary ED and Hospitalizations.
- Coordinate ongoing care and patient centered services to keep people safe and well within the community.
- Connect BH patients who frequently utilize emergency room services to comprehensive, coordinated and ongoing services within the community.

KEY WORKFORCE FUNCTIONS NEEDED TO MEET PROJECT OBJECTIVE
- Clinical and non-clinical staff
- Staff may function as multidisciplinary teams to intervene during a crisis and provide care coordination to prevent unnecessary emergency room services
- Crisis Intervention skills & Intensive case management skills
- De-escalation Skills & Motivational Interviewing
- Medication Reconciliation

TRAININGS
- Motivational Interviewing
- Trauma Informed Care Training
- County DOH (Behavioral and Community Health)
- Healthify Training
- Prevention Conference Law Enforcement & Public Health
- Dutchess County DLA20 Training and Train the Trainer
- Orange County CIT (Crisis Intervention Training)

“The City of Newburgh Police CIT-Crisis Intervention Training program has experienced great success and positive outcomes due to the many partnerships in place that form the foundation of our program. Our Orange County Department of Mental Health, Mobile Mental Health Team, Peer Support services and Community Support and education groups have not only helped train our first responding officers but have also educated us on the behavioral health system and how law enforcement plays an important role in the entire collaborative effort to assist individuals in our community suffering from mental health issues.”

Lt. Richard Carrion – CIT Coordinator, City of Newburgh Police Department.
**Asthma Care Management**

**BRIEF:** Build capacity for team based implementation of Evidence-Based Guidelines for Asthma Care. The goal of this project is to implement asthma management practice guidelines, develop asthma action plans, and increase access to pulmonary and allergy specialists in areas of New York State.

**INTERVENTION & IMPACT**

Our PPS pursued several strategies toward achieving better asthma management.

- The Asthma Project Advisory Quality Committee (PAQC) reviewed evidence-based guidelines for the management of asthma and particularly the role of Asthma Action Plans (AAPs)
- Creating and tracking Asthma Action Plans often requires new workflows and potential modifications of Electronic Health Records. The number of practices successfully creating and tracking and reporting Asthma Action Plans to the PPS central registry for actively engaged patients has increased every quarter.
- The PPS sponsored on-site training for 31 Physicians; 24 care managers were trained. 154 persons have taken the e-course on the PPS learning system platform.

**CRHI Project ECHO® (Extension of Community Healthcare Outcomes): Behavioral Health in Primary & Family Practice**

**BRIEF:** Increase access to specialty treatment via a hub-and-spoke model of continuous learning. Specialists share knowledge with Primary Care practitioners in order to expand access to best-practice BH care across the Mid-Hudson region.

**GOAL:** Develop the capacity to safely and effectively treat chronic, common, and complex BH conditions in rural and underserved areas and monitor the outcomes of these treatments for adults and children.

**SPECIALISTS’ EXPERTISE**

- Adult Psychiatry
- Child/Adolescent Psychiatry
- Addiction Medicine
- Psychotherapy
- Social Work
- Pharmacy (TBD)
- Pediatrics/Neonatology

**PPS ADDRESSES:** Increase local professional capacity to provide quality behavioral health care and treatment for adults and children.

**DISCLAIMER:** In addition to the WMCHealth PPS’ support, Project ECHO® at CRHI is being supported by funding opportunity number CMS 1G1CMS331402 from the U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services.

**Embedded Care Managers in Primary Care Practices: Expanding the Role of Community-Based Care Manager**

**BRIEF:** Care Management for Primary Care in Medical Neighborhoods.

**OBJECTIVES:** To support practice transformation and identification of clinical and social needs for their Primary Care patients; to facilitate ongoing relationships between primary care practices and Health Homes.

**INTERVENTION**

- Embed care managers from Care Management and Home Care Agencies into Primary Care Practices (PCPs) to develop comprehensive care plans, and connect patients to necessary referrals and resources.
- Develop and implement new communication protocols and procedures, data collection, and reporting capabilities.
- Provide ongoing coaching and evaluation to assess contract vulnerabilities, and disseminate best practices between partners

**ACTION PLAN**

Indicate how prioritized gaps or needs can be addressed by patient or caregivers, health system or community supports

**COACHING AND REPORTING**

- The PPS supported these practices and the community based agencies through their transitions with regularly scheduled coaching sessions
- As each group progressed through the required learning sessions, each practice and community based agency would provide written documentation about their journey as embedded care managers and PCMH practices.
- Each quarter’s reporting required adding new skills and practical approaches to care management
Patient Centered Medical Home

Concurrent with the development of Medical Neighborhoods across the Hudson Valley region, was WMCH Health PPS’ focus on transforming Primary Care to deliver the most effective healthcare that was wholly patient-centered.

Thus began the 18-20 month journey for the PPS sponsored practices that had transformation consultants on-site to help providers achieve NCQA’s PCMH 2014 Level 3 recognition. The practices were given in depth assessments, gaps analyses along with detailed project plans that addressed each element of the 6 standards that they had to demonstrate meeting:

i. Patient centered access
ii. Team based care
iii. Population health management
iv. Care management and support
v. Care coordination and Care Transitions
vi. Performance Measurement and Quality Improvement

WMCH Health PPS ensured that each Medical Neighborhood had a representation of primary care practices that were undergoing the PCMH transformation so that the expectations for the ideal medical “neighbor” was not only communicated to them, but the practices also had the opportunity to put these newly formulated policies into action. Some examples of the functionalities of a PCMH practice being an effective neighbor in the Medical Neighborhoods are:

Clear agreements on and delineation of the respective roles of neighbors in the system (e.g., care coordination agreements: between PCPs and specialty care, agreements on care transitions, pre-referral arrangements, referral and follow up guidelines from professional societies or others).

Sharing of the clinical information needed for effective decision making and reducing duplication and waste in the system, supported by appropriate health IT systems developed in a region-specific way. As part of the DSRIP work, the PPS ensured that information on how to participate with the local Qualifying Entity that connects to the larger Statewide Health Information Network for New York (SHIN-NY) was made available at every Medical Neighborhood meeting.

Care teams, typically anchored by the PCMH, to develop individualized care plans for complex patients (such as those with multiple chronic conditions) that describe a proactive sequence of health care interventions and interactions — followed by tracking and assisting to ensure that this takes place (including care transitions).

Continuity of needed medical care when patients transition between settings (e.g., when transferred from a hospital to a skilled nursing facility, and then to an assisted living facility), with active communication, coordination, and collaboration among everyone involved in the patient’s care, including clinicians, patient, and family. This requires the hospitals and PCPs to recognize each other electronically as important patient caregivers, such that the necessary transitions of care documents including discharge summaries and medication lists are exchanged in a timely manner.

The required focus on the patient’s preferences, perhaps with the PCC or dedicated care coordinator within the PCMH playing a key role in interfacing with other clinicians to ensure that patient preferences are incorporated into decision making, was incorporated into the WMCH Health PPS region-wide PCP-CMA initiative that began in late 2016. (PCPCC, 2018)
**Level III Recognized Providers: WMCH Health PPS**

WMCH Health PPS congratulates all providers who have achieved NCQA’s PCMH Level 3; we especially would like to recognize the hard work of the following practices:

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<thead>
<tr>
<th>PRACTICE / ORGANIZATION</th>
<th>LOCATION</th>
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<tbody>
<tr>
<td>Bambini Pediatrics</td>
<td>Poughkeepsie</td>
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</table>
| Boston Children’s Health Physicians  | Washingtonville • Newburgh • Bardonia
Sleepy Hollow • Hopewell Junction
White Plains • Eastchester • Tarrytown
Orangeburg • Middletown               |
| Community and Dental                 | Monsey                            |
| Fallsburg Pediatrics                 | Fallsburg                         |
| Forme Medical and Urgent care        | White Plains                      |
| Greater Hudson Valley Health System  | Monroe • Monticello • Callicoon
Livingston Manor • Middletown         |
| Llobet Medical Group                 | Kingston • Margaretville          |
| Middletown Community Health Center   | Middletown • Pine Bush • Port Jervis
Washingtonville                       |
| Mount Vernon Neighborhood Health Center | Mount Vernon • Yonkers • Greenburgh |
| The Center for Discovery             | Monticello                        |
| Westchester Institute for Human Development | Valhalla                      |

**OTHER PPS SUPPORTED PCMH ORGANIZATIONS & SITES**

<table>
<thead>
<tr>
<th>Organization</th>
<th>Location</th>
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</thead>
</table>
| Bon Secours Charity Health System   | Suffern • Montebello • Goshen • Pomona
West Nyack • Port Jervis • West Haverstraw
New City                             |
| Bridge Street Family Medicine       | Saugerties                                    |
| Cornerstone Family Healthcare       | Newburgh • New Windsor • Highland Falls      |
| Crystal Run Healthcare              | Stony Point • Milton • West Nyack • Goshen
Middletown • Warwick • Liberty • Rock Hill
Newburgh • Haverstraw                |
| Institute for Family Health         | Ellenville • Hyde Park • Port Ewen • New Paltz
Kingston                             |
| Liberty Pediatrics                  | Ferndale                                      |
| Middletown Medical                  | Middletown                                    |
| Open Door Family Medical Center     | Port Chester • Brewster • Ossining
Sleepy Hollow • Mount Kisco          |
| Poughkeepsie Medical Group          | Poughkeepsie                                  |

**PROVIDERS BEFORE AND AFTER DSRIP**

| Providers with PCMH recognition in 2014 (pre DSRIP Implementation): | 86 |
| Providers with PCMH recognition in 2018: | 431 |
| TOTAL: | 517 |

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**Social Determinants of Health**

Social determinants account for 80% of health outcomes, which means that the majority of our health care costs can be attributed to non-clinical factors.

Addressing social determinants of health can have a significant impact on the outcomes of health. Social factors and physical conditions in the environment impact the health of communities. Factors of social determinants of health include areas in which people are born, live, learn, work, and play.

**Economic Stability**
- Poverty
- Housing security and stability
- Employment
- Food security
- Transportation

**Social and Community Context**
- Social cohesion
- Civic participation
- Perceptions of discrimination & equity
- Incarceration/ Institutionalization

**Education**
- Early childhood education and development
- High school education
- Enrollment in higher education
- Language and literacy

**Health and Health Care**
- Access to health care-gaining entry into health system
- Access to primary care- trusted provider
- Health literacy

**Neighborhood and Environment**
- Affordable/ quality housing
- Environmental conditions
- Access to healthy foods
- Crime and violence
To many who have been involved in the DSRIP Program the phrase: “Transformation happens at the speed of trust” rings true. Furthermore, this statement accurately describes the efforts taken to develop the connections between the WMCH Health Performing Provider System (PPS) and more than 200 partners throughout the 8 county lower Hudson Valley Region. It is through being there time and again that trust is earned and ongoing relationships are created. The PPS has established a framework for sustainability by creating and convening Medical Neighborhoods, educating the healthcare workforce of the future, breaking down the silos between primary care and behavioral health, and connecting people to community-based social determinants of health services.

The PPS has worked to connect organizations that may have never worked together before, but have oftentimes treated the same person. From educational institutions to addiction centers, hospitals to health homes, primary care practices to behavioral health providers, community-based organizations to federally qualified health centers, and more... the WMCH Health PPS has leveraged the DSRIP opportunity offered by New York State, and worked to forge connections between and amongst a myriad of disparate entities. By bringing these entities together, the PPS has created a regional approach toward taking care of all of us; not just for our healthcare needs, but for the social and economic determinants that effect health outcomes in our communities. The activities and relationships that have resulted from engagement with the WMCH Health PPS will continue and evolve long after the formal DSRIP program is over.

Edward McGill
Executive Director, WMCH Health PPS Project Management Office

As we enter into the next phase of health care transformation, financing becomes a key facet of the future. Hence, value-based payment comprehension becomes a critical skill for providers. Primary care, community-based organizations, behavioral health providers and other health care service providers all will need to develop their plan.

The WMCH Health PPS provided VBP training in medical neighborhood meetings over the past year.

“By DSRIP Year 5 (2020), all MCOs must employ VBP systems that reward value over volume for at least 80% of their provider payments.”
Dept of Health February 2018

The Plan:

- Address your current state
- Define stakeholders to create deeper and more financially driven relationships
- Create a governance and business strategy
- Identify data sources
- Address your organizations capability to take risk or define a phased approach to risk arrangements

Edwards McGill, Executive Director, WMCH Health PPS Project Management Office

Edward McGill
Executive Director, WMCH Health PPS Project Management Office
This report celebrates five years of collaboration and partnership that DSRIP has helped to convene, foster and support. We should all give ourselves credit for so thoroughly embracing transformation efforts designed to enhance the experience of healthcare and create healthier communities. All of our PPS partners have given of their time, energy and resources to establish the basis for collaboration and coordination required as the underpinnings of a changed-for-the-better system of care, a system that recognizes the crucial role played by organizations dedicated to the social and economic aspects of community health.

I am grateful to all of the organizations and people who have contributed to our DSRIP efforts including organizations, individuals and the superb staff from the DSRIP Project Management Office (PMO). Your efforts in convening, facilitating and staffing the myriad of DSRIP committees and workgroups have enabled our PPS to accomplish the successful creation of a region-wide movement to enhance life and health for all of the residents of the Hudson Valley.

We celebrate all of the work and successes and urge your continuation of these ventures post-DSRIP. Thanks to each and every person who has participated in this journey.

June Keenan, MS, MPH
SVP, Delivery System Transformation; Executive Director, CRHI
WMCHHealth Network & PPS Staff

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The Westchester Medical Center Health Network (WMCHealth) is a 1,700-bed healthcare system headquartered in Valhalla, New York, with 10 hospitals on eight campuses spanning 6,200 square miles of the Hudson Valley. WMCHealth employs more than 12,000 and has nearly 3,000 attending physicians. With Level 1, Level 2 and pediatric trauma centers, the region’s only acute-care children’s hospital, an academic medical center, several community hospitals, dozens of specialized institutes and centers, skilled nursing, assisted-living facilities, homecare services and one of the largest mental-health systems in New York State, WMCHealth is the pre-eminent provider of integrated healthcare in the Hudson Valley. Visit WMCHealth.org.

WMCHealth includes flagship Westchester Medical Center, Maria Fareri Children’s Hospital and the Behavioral Health Center, all in Valhalla; MidHudson Regional Hospital in Poughkeepsie; Good Samaritan Hospital in Suffern; St. Anthony Community Hospital in Warwick; Bon Secours Community Hospital in Port Jervis; HealthAlliance Hospital: Broadway Campus and HealthAlliance Hospital: Mary’s Avenue Campus, both in Kingston, and Margaretville Hospital in Margaretville.
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Westchester Medical Center Health Network includes

Westchester Medical Center  I  Maria Fareri Children’s Hospital  I  Behavioral Health Center  I  MidHudson Regional Hospital
Good Samaritan Hospital  I  Bon Secours Community Hospital  I  St. Anthony Community Hospital  I  HealthAlliance Hospital: Broadway Campus
HealthAlliance Hospital: Mary’s Avenue Campus  I  Margaretville Hospital

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