The PPS supported the growth of PCMH in the Hudson Valley to improve care and coordination across providers in the region. PCMH is a model designed to improve patient outcomes by addressing aspects of primary care practice to deliver better care. The five key functions of a medical home revolve around:

- Provide patient education & care (includes referrals to specialists)
- Coordinate care across settings & sources
- Support patient self-management activities & behaviors
- Provide patient-focused primary care
- Support patient-directed care decisions & shared decision making

PCMH Standards & DSRIP Projects
1. Patient Centered Access
2. Team Based Care
3. Population Health Management
4. Care Management & Support
5. Care Coordination & Care Transitions
6. Performance Measurement & Quality Improvement

**GOAL**

**INTERRUPTION**

The Medical Neighborhood, a concept defined & promulgated by the Agency for Healthcare Research and Quality in 2011, conceptualizes optimal care for the patients delivered by a Patient Centered Medical Home (PCMH) in close communication with other providers such as specialty providers, behavioral health providers, hospitals and in concert with local/state governmental agencies. The PCMH project was the surrounding medical neighborhoods focus on meeting the needs of the individual patient but also include aspects of overall population health and community health needs, all the while keeping the patient at the center of care.

A joint PPS collaboration around Community Needs Assessment for the Hudson Valley region in 2014 highlighted issues of access to quality primary care. The County Health Outcomes rankings for the region in 2014 also shows poorer health outcomes along with fewer physicians for the populations served in some of the northern areas of the PPS. WMCHealth PPS worked closely with the primary care practices in the PPS to re-imagine, redesign and operationalize primary care transformation for practices located in high need areas serving vulnerable populations.

Why Should Primary Care Practices Develop Care Compacts In Their Medical Neighborhood?

- Patient experience
- Patient safety
- Quality outcomes
- Care coordination
- Appropriate referrals
- Increased communication
- Support PCP & Specialist care plan
- Lower costs
- Decrease duplication of testing

**PRACTICE CONTACT SAMPLE**

**Performance Measurement & Quality Improvement**

- Patient experience
- Patient safety
- Quality outcomes
- Care coordination
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- Support PCP & Specialist care plan
- Lower costs
- Decrease duplication of testing
DOCTORS ACROSS NEW YORK (DANY)
AMBULATORY CARE TRAINING PROGRAM

BRIEF
Expand primary care medical service capacity in the Hudson Valley region.

GOAL
Increase the number of primary care physicians in rural and underserved communities.

INTERVENTION
Doctors Across New York (DANY) is a 3-year state funded initiative which trains and places physicians in underserved communities in ambulatory, outpatient settings to care for New York’s diverse population. By training new medical students and residents, the DANY program aims to increase the number of physicians who will remain in underserved communities after residency.

METRICS
• Train 20 WMC internal medicine residents at Open Door Family Medical Center - Ossining, 100 Woods Rd., Valhalla, NY 10595.
• Train 83 WMC pediatrics residents at Mount Vernon Community Health Center (MVNHC) - Yonkers, 165 Main St., Ossining, NY 10562.
• Train 4 NYMC medical students, undergraduate, at New York Medical College (NYMC) - Yonkers, 30 S Broadway, Yonkers, NY 10701.
• Train 7 NYMC medical students, undergraduate, at Mount Vernon Community Health Center (MVNHC) - Yonkers, 165 Main St., Ossining, NY 10562.
• Train 7 NYMC medical students, undergraduate, at Westchester Medical Center.

WMC PEDIATRICS

Caring for Unaccompanied Immigrant Children
Component (PUIC)

WMC pediatrics residents are also trained to work with unaccompanied children, specifically unaccompanied immigrant children (PUIC), focusing on immigrant health with an emphasis on the challenges encountered by unaccompanied immigrant children (PUIC).

PRJCT2.ai

AMBULATORY CARE TRAINING PROGRAM

NEW YORK (DANY)

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WMC INTERNAL MEDICINE

Caring for Unaccompanied Immigrant Children Component (PUIC)

WMC internal medicine residents are also trained to care for the most vulnerable children, specifically unaccompanied children who have fled conflict, poverty, and lack of safe protection in their country of origin to the US.

PRJCT2.ai

AMBULATORY CARE TRAINING PROGRAM

NEW YORK (DANY)

DOCTORS ACROSS NEW YORK (DANY)
AMBULATORY CARE TRAINING PROGRAM
WORKFORCE DEVELOPMENT AT WMCHALTH PPS

What is Workforce Development in DSRIP?

- NYSDOH has aligned Workforce development and support with DSRIP project goals in order to support DSRIP transformation.
- Emphasis on Cultural Competency and Health Literacy are aligned with Workforce Development.
- Training Strategy & Plan:
  - Enhance and expand access to education and training opportunities for all segments of the current healthcare workforce and the future workforce, from front line to clinical, as envisioned by healthcare transformation.
  - Workforce reporting: PPS in collaboration with PPS partners: PPS partners surveyed to document the impact of DSRIP on workforce.
  - Workforce impact assessed based on DSRIP project participation and on job families (job titles), facility types, and persons newly hired, redeployed or retrained.
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WMCHALTH PPS Educational Resources for patient engagement available

- Culturally competent & Health literate materials for chronic conditions:
  - Materials can be found on our LMS platform.
  - asthma Flip Chart as requested by PPS network organizations.
  - Diabetes material as requested by PPS network organizations.

Youth Career Pathways Scrubs Clubs Catskills Hudson Area Health Care Education

Pathways to the healthcare industry are being offered in various community schools and a larger multi-pronged pilot project in Sullivan County. Because of challenges seen in the healthcare workforce that are facing Sullivan County, an inter-agency planning coalition has formed this year to assist Sullivan County BOCES in establishing a comprehensive effort to train health careers exploration afterschool programs in the schools of the county to engage students, using a curriculum that our organization developed in another rural part of the Hudson Valley, working with the Foundation for Community Health, called “Scrubs Club: Pathways to Health Careers.”

As a result, “Scrubs Clubs” will now launch in the fall of 2018 in most, if not all, of Sullivan County’s public school districts supported by WMCHALTH PPS and in partnership with the Sullivan County BOCES and School Districts, Catskill Area Healthcare Educational Center, Greater Hudson Valley Health System, the Sullivan County Long-Term Care Council/ NYS Connects, Hospitals of Orange and Sullivan, and the Sullivan County Rural Health Network, via Sullivan County Public Health Services.

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PPS Learning Management System (LMS) and in person trainings (www.crhi.training.wmchealth.org)

- PPS LMS Platform is open to all network partners and stakeholders and offers access to e-courses, meeting materials and presentations.
- To request additional DSRIP related trainings the PPS could support, please fill out the PPS Partner Training Survey https://www.surveymonkey.com/r/VXRG2D0.

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HEALTH HOME AT-RISK INTERVENTION PROGRAM

INTRODUCTION

• Create a care management structure within the WMCHealth PPS to build capacity among the partners to provide care management to Medicaid patients at risk for declining health issues.
• Assess capacity of Primary Care Practices for participation in a care management program, including their engagement with the WMCHealth PPS to support care coordination services, staffing and training needs, and technology capacity (e.g. EMR).
• Identify Care Management Agencies interested in participating and assess capacity.
• Identify gaps among partners and create relevant training curricula.
• Provide exercises of GSRP Projects and Deliverables, and educate PCPs and CMAs on the PPS-created care plan protocols and elements.

METRICS

• Patient Workflows, Care Plans, Referral process for health home
• Patient Workflows, Care Plans, Care Management Agencies interested in participating and assess capacity.
• Identify gaps among partners and create relevant training curricula.
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NEXT STEPS

• End-of-life care managers from Care Management and Home Care Agencies into Primary Care Practices which work with Medicaid partners to develop care plans for eligible patients, and connect patients to necessary referrals and resources.
• Develop supportive workflows to enable practices to assess at-risk patients with accurate data for short-term Health Home care management services.
• Work closely with our region’s Health Homes to increase their capacity to accept and manage the additional population.

WMCHealth PPS Medical Neighborhoods Within Healthy Communities

• Health home partners with provider organizations to care for Medicaid beneficiaries who meet Health Home criteria and expand their reach to eligible for Health Homes through access to high quality primary care and support services.

How will the Medical Neighborhood Meet the Needs of the Eligible Population?

• Key areas of concentration:
  - Care connections, when not present, to PCP based services
  - Ensure connectivity to Health Homes and BH providers
  - Identify barriers to including housing and other social/ environmental supports
  - Reduce avoidable services
  - Reduce unnecessary emergency department services
  - Utilize skilled nursing facilities appropriately through follow up by care managers

• Improve community based services connectivity
  - Health homes
  - BH/Substance use providers
  - Home health care
  - Skilled sub-acute services
  - Group homes

• Comprehensive assessments
  - Initial; Ongoing; Change-in-Condition; Admissions

• Assist individuals with navigation through a complex system
• Interdisciplinary approach through MN participation

BRIEF

• Improve access to high quality primary care and support for higher risk patients

GOAL

• Provide proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services.

METRICS

• Evaluate workflows, Care Plans, and referrals process for Health Home
• Evaluate workflows, Care Plans, Care Management Agencies interested in participating and assess capacity.
• Identify gaps among partners and create relevant training curricula.
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CONTACT: Janet (Jessie) Sullivan, MD
7 Skyline Drive / Suite 385 / Hawthorne, NY 10532
Janet.Sullivan@wmchealth.org // 914.326.4202
**BRIEF**

**Care Management for Primary Care in Medical Neighborhoods**

**GOAL**

To Support Practice Transformation and Identification of Clinical and Social needs for their Primary Care Patients; to establish best practices between primary care practices and Health Homes.

**INTERVENTION**

- Embed care managers from Care Management and Home Care Agencies into Primary Care Practices (PCPs) who will work with providers to identify and address care gaps (primary care, mental health, long term care, home health, etc.)
- Develop and implement new care coordination protocols and procedures, data collection, and reporting capabilities.

**METRICS**

- Number of eligible Medicaid patients referred to and enrolled in Health Homes
- Number of care plans created
- Number of referrals to community resources
- Timeliness of PCP follow-up visit for patients on ToC list
- Number of Medicaid patients evaluated for Medicaid eligibility and coordination

**Impact of CMA-PCP Innovation Pilot** - In their own words, comments from Innovation Pilot participants

Susan Miller, Managing Director, Rehab Brain

Maria Trusa, CEO, Forme Medical Center

Amy Anderson-Wickidi, CEO, Access Supports for Living – Care Management Agency

**EXPANDING THE ROLE OF COMMUNITY-BASED CARE MANAGER**

**IN PRIMARY CARE PRACTICES**

**EMBEDDED CARE MANAGERS**

- Required: all below as applicable
  - Condition List
  - Gaps in Care
  - Personal goals
  - Race, ethnicity, and language
  - Patient Centered Health Care Team Members
  - Social Determinants of Health
  - Patient-Centered Care
  - Goals in Care

**Components of a Comprehensive Care Plan**

- Required: all below as applicable
  - Physical health
  - Mental health
  - Social determinants (including support system)

**Action Plan**

- Required: at least one of the following
  - Medical management gaps
  - Social determinants
  - Care coordination gaps

**WMC PPS CM Pilots**

**The PPS supported these practices and the community-based agencies through regular scheduled coaching sessions.**

**Each quarter’s reporting required adding new skills and practical approaches to care management.**

**Notes:**

- The PPS supported these practices and the community-based agencies through their transitions with regularly scheduled coaching sessions.
- 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.
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**IMPACT OF CMA-PCP INNOVATION PILOT - in their own words, comments from Innovation Pilot participants**

PRJCT 2.a.iii

**System (PPS)**

**Performing Provider System (PPS)**

Westchester Medical Center Health Network

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**EMBEDDED CARE MANAGERS IN PRIMARY CARE PRACTICES**

**EXPANDING THE ROLE OF COMMUNITY-BASED CARE MANAGER**

**IMPROVEMENT OF CMA-PCP INNOVATION PILOT - in their own words, comments from Innovation Pilot participants**

**Susan Miller, Managing Director, Rehab Brain**

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**Maria Trusa, CEO, Forme Medical Center**

**PCMH Level 3 Provider**

**Care Management**

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  - Patient Centered Health Care Team Members
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**Action Plan**

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MISSION
Our mission at WMCHealth PPS is to enhance culturally and linguistically appropriate awareness, education and inter-professional collaboration of all providers in our network; in an effort to foster an organizational culture that promotes the provision of equitable, person-centered health care and services for all members of our community.

GOAL
Participants will demonstrate learning and application in partnerships through the following: create connections and collaborate with key stakeholders to promote learning and improve care coordination; incorporation of multi-stakeholder workforce committee between primary care practices and WMC Health PPS to ensure that the training materials were taken to incorporate tools and materials from the health network to ensure that the training focused on areas that were important.

TRAINING HIGHLIGHT
Supporting Front Line Workers through Healthcare Transformation; Training the Health Care Workforce by Building Effective Partnerships

Part 1: In-Person Training
In an ever-changing Health Care environment, it is important to know that there are partners you can count on to develop and deliver the best workforce training experience. And how do you do this when, as we often say, “we are building the plane while flying?”

Through the collaboration between WMCHealth PPS and the 1199SEIU Training and Upgrading Fund, we developed a hybrid training intervention around the core competencies of Care Coordination designed to upgrade the skills of frontline workers. To address the unique needs of frontline workers, a customized Care Coordination training was created for WMCHealth PPS.

Trainings were held across the PPS Region and enabled the PPS to successfully reach a broad spectrum of frontline workers. Special attention was taken to incorporate tools and materials from the health network to ensure that the training focused on areas that were important.

Part 2: Online Learning Management System
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HealthAlliance Medical Village in Kingston plans to:

- The Broadway campus will be the site for the Kingston Medical Village that will offer primary and ambulatory care, complementary and alternative medicine services, senior services; housing; support; transportation coordination and other health and human services, along with a retail pharmacy and shopping opportunities; and
- Become home to a technology-enhanced active learning classroom and conference center at its Broadway campus, focused on educational and workforce redevelopment. The learning classroom will provide invaluable training and experience, using "virtual" technology to help participants learn new tasks and refine techniques focused on patient safety standards held by HealthAlliance and WMCHealth.

BRIEF

Integrated outpatient service centers providing emergency / urgent care as well as access to the range of outpatient services needed within the community. A "one stop" site, the Medical Village will be a neighborhood focal point where WMCHealth and community partners will offer primary care, behavioral health and other support services.

GOAL

HealthAlliance Medical Village at 2 PPS Hospital sites (Bon Secours Community Hospital and HealthAlliance of the Hudson Valley) to receive data from Medical Village partners to track patients and share health information on the State Health Information Network of New York (SHIN-NY). The SHIN-NY will engage continuously of admissions discharge and transfer alert functionality. The PPS will develop a platform to digitize data to help Medical Village partners to track patients and support program measurement evaluation.

INTERVENTION

Based on a comprehensive planning process at both Bon Secours Community Hospital (Port Jervis) and HealthAlliance of the Hudson Valley (Kingston), each site in WMCHealth/Hudson will become the center of a "Medical Village" — a partnership between the hospitals and other healthcare providers in the community with a focus on health information technology implementation.

Bon Secours Community Hospital (BSC) in Port Jervis plans to:

- Update and expand its Emergency Department and add the certified bed capacity to reflect anticipated reductions in unnecessary admissions due to enhanced access to use of primary care services;
- Develop an evidence-based care coordination/transitional care program that links patients with community-based primary care providers, improved patient health literacy and confidence in self-management of their health conditions, enhances provider-to-provider communication, increased provider support and transition individuals to the least restrictive environment for care;
- Add an expanded Imaging Center with advanced diagnostic equipment, along with a newly designed Emergency Department and onsite pharmacy;
- Collaborate with Cornerstone Family Healthcare and the Orange County (Department of Mental Health and a Federally Qualified Health Center (FQHC) to offer outpatient behavioral health and advanced primary care services; and
- Use the conference center at its Broadway campus, focused on educational and workforce redevelopment.

Kingston:

- Prior to construction of new facilities at Mary’s Avenue, WMCHealth designed a “Virtual Medical Village” that provides an infrastructure for community partners to communicate and participate in shared care management/care transition processes to accelerate the development of systems and protocols that define the completed Medical Village. The Virtual Medical Village will be implemented and build upon decades of collaboration through a central location with a large array of providers and services. WMCHealth PPS uses resources available for care coordination, technology and training to support this shared infrastructure for healthcare in alignment with DSRIP initiatives. The Virtual Medical Village focuses on quality, access and convenience of care for the community. By connecting the community to new interfaces and advanced primary care services, and
- HealthAlliance Medical Village in Kingston plans to:

- Move clinical care from its Broadway campus to the Mary’s Avenue campus, continuing to provide all behavioral health and other essential services to the community. The Mary’s Avenue campus will include the construction of 11,000 sq. ft. of new space that will house a new Behavioral Health note and Outpatient Fung and Day Surgery units and new connected private patient rooms.

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The foundation of the Medical Village is the Medical Neighborhood for Healthy Communities...

Medical Neighborhoods Share Common Patients

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WMCHealth PPS Initiatives in Medical Village Communities
Port Jervis w/Bon Secours Community Hospital / Kingston w/Health Alliance of Hudson Valley (HAVH)

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Performing Provider   
System (PPS)
Westchester Medical Center Health Network
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IN FOCUS: HOSPITAL TRANSITION MODEL

Care transitions intervention needed to reduce 30 day readmissions for chronic health conditions

BRIEF

Provide 30-day transitional support for patients at high-risk of readmission, particularly those with cardiac, renal, diabetes, respiratory and/or behavioral health disorders.

GOAL

Provide 30-day transitional support for patients at high-risk of readmission, particularly those with cardiac, renal, diabetes, respiratory and/or behavioral health disorders.

METRICS

Hospital Patient Satisfaction Survey; Care Transition Metrics; Health Plan Member Satisfaction Survey; Care Coordination with providers to update data about care received from other providers.

INTERVENTION

1. Early notification of planned discharges will facilitate pre-discharge transition planning with patient and families.
2. PPS will use EHRs and other technical platforms to track all patients engaged in the project.
3. Early notification of planned discharges will facilitate pre-discharge transition planning with patient and families.
4. PPS will use EHRs and other technical platforms to track all patients engaged in the project.

1. Maintain inventory of hospital/home discharge protocols at PPS hospitals.
2. Analyze the root causes of Medicaid readmissions.
3. Modify current efforts to reduce readmissions to better meet Medicaid patient needs.

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2. Establish region-wide hospital-to-home discharge processes and expectations.
3. Assess re-admission risk, especially for behavioral health disorders, diabetes, heart, renal or respiratory disease.
4. Engage the patient, family/caregivers & care managers in developing a plan of care.
5. Follow-up;
6. PPS will use EHRs and other technical platforms to track all patients engaged in the project.

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5. Follow-up;
6. PPS will use EHRs and other technical platforms to track all patients engaged in the project.

2. Establish region-wide hospital-to-home discharge processes and expectations.
3. Assess re-admission risk, especially for behavioral health disorders, diabetes, heart, renal or respiratory disease.
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**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 Visitor 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.

**METRICS:**
Measuring success will be based on reducing the “revisit rate” of the cohort with a goal of not having any individual on average return more than twice (2 times) per month for ED visits deemed unnecessary. Below are successes and metrics used to date:

**Frequent Visitor Trends by Groups and Number of Visits**

**INTERVENTION**
In order to achieve these objectives, on a monthly basis, a cohort of 6 patients who meet the “Frequent Visitor” criteria of greater than 10 visits in a 3 month period will be reviewed and addressed by an interdisciplinary team with representation from: ED (Physician and Nursing), Case Management, Social Work, Psychiatry and other identified areas as needed for input to the cohort. At the monthly meetings each patient in the cohort will be reviewed and an action plan of care developed and shared on the ED. Each of the patients in the cohort is flagged in the ED system indicating they are in this program. Once the individual comes to the ED the plan of care will be initiated and when patient is receptive, engage the patient fully in the plan of care.

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**Frequent Visitor Trends by Groups and Number of Visits**
Peers for transition support.

For the period December 2017-July 2018, 99 patients have been referred to ILI Behavioral Health team, working as equally contributing partners across the Behavioral Health team, working as equally contributing partners across the Essential to successfully diverting preventable hospitalizations and maintaining personal recovery as a dynamic and continuing process and facilitating positive outcomes by implementing services that value and build upon the depth and quality of interpersonal connections.

GOAL
Peer Specialists’ efforts are aimed at reducing skeptical hospitalizations 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 an elevated quality of life.

INTERVENTION
ILI Peer Specialists provide awareness and flexible, intensive peer intervention during transitional periods where individuals are experiencing increased vulnerability and are at greatest risk. Peer services maximize existing resources by providing complementary, non-duplication support well-integrated into the delivery system, dedicated to avoiding crises during and following periods of hospitalization, with an concurrent focus on building and sustaining community connections.

In summary, ILI Peer Specialists meet with consumers while still on the ward and resume in contact for 30 days following discharge. Peer support encompasses:
- Providing assistance to ensure prescription for antipsychotic and anti-depressant medications are filled as reviewed, which has enjoyed a 89% success rate.
- Making contact including home visits within 48 hours of discharge and providing transportation and peer support as required to facilitate adherence at 7 and 30-day behavioral health and other healthcare appointments.
- Avoiding behavioral health and substance abuse treatment appointments at the consumers’ request. With peer support, 95% of consumers attend at least 1 treatment session within the first 30 days.
- Building connections to recognize their progress using the DLA-20 – completed within the BHU and 30 days following discharge.
- Providing a service benefit to other services and resources aimed at facilitating continuing recovery.
- Assisted with application for housing, employment, and Social Security benefits and with receiving food from local food pantry.
- Helping with entitlements and finances.
- Providing support with housing, child care, medical, and employment-related concerns.
- Building sustainable circles of community support.
- WRAP planning.
- Facilitating connections with mental support groups, peer organizations and provider agencies (including applicable medical resources), linking eligible individuals with a Health Home if not already enrolled.

Process & Implementation

**SUMMARY**

ILI Peer Specialists meet with consumers while still on the ward and resume in contact for 30 days following discharge. Peer support encompasses:

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BRIEF
Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured (UI) and low/non-utilizing (LU/NU) Medicaid populations into Community Based Care

GOAL
Our PPS will focus on the UI, LU and NU Medicaid populations and work to engage and activate individuals to utilize primary and preventive care services.

METRICS
Evaluation of patient engagement using the Patient Activation Measure (PAM®)

INTERVENTION
To improve patient activation, we will pursue a two-pronged strategy: (1) leverage the resources of organizations that work with LU and NU Medicaid members and the UI, and (2) develop a core capability to coordinate, train, and conduct patient activation activities across the region. Administering patient activation surveys represents a new and significant responsibility for our PPS partners. We will use Plan-Do-Study-Act cycles to help incorporate PAM® screening into our partners’ workflows.

PATIENT ACTIVATION PROJECT

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COMMUNITY ENGAGEMENT, CULTURAL COMPETENCY & HEALTH LITERACY

INTERVENTION
Provided innovative Cultural Competency and Health Literacy training through online, on-site, tailored trainings, as well as an online platform:
- Achieve Equitable Health Care Outcomes
- HVR, working with a platform of artists to teach cultural competency; structural competency, and Narrative Humility (collaboration with City Lore, NY)
- Health Literacy Train the Trainer sessions that provided post training teaching materials, and launched 3 innovative e-courses that meet front line worker training and organizational team needs around understanding CLAS (Culturally and Linguistically Appropriate Services) standards and how to implement them, with Dr. Terri Anne Parrell, Health Literacy Partners, LLC
- Social Determinants of Health and Structural Racism trainings for Medical Neighborhood meetings, community coalitions, frontline workers, and Primary Care Physicians, with Dr. Martine Hackett, Hofstra University
- Narrative Humility presentation and course development with Dr. Sayantani Dasgupta

Conducted “Listening” sessions with “vulnerable” communities, in conjunction with local organizations, including:
- SNOL, an anti-violence organization
- AND Head Start, working with undocumented parents
- Latino/Latina communities, and
- LGBT community members from Port Jervis and surrounding areas.

Community Engagement programs conducted, included:
- Snap,” developed Action Plans with networks of community-based organizations, governmental agencies and health providers, including: Spring Valley Collaborative, Poughkeepsie Black and Latino Healthy Coalition, Western Rempex Collaborative, and the Newburgh Black and Latino Healthy Coalition.
- “Blueprint for Equity Poverty” simulations throughout the Hudson Valley in collaboration with Montefiore PPS, Rockland PPS, Health@NC, and several community-based organizations, local governmental agencies and healthcare providers
- “Counting the Homeless/A Point in Time” in Suffern, NY Community ID” event in Haverstraw, NY, in conjunction with the Rockland Immigration Coalition.
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BRIEF
Integration of mental health and substance abuse with primary care services to ensure coordination of care for both services.

GOAL
Care for all conditions delivered under one roof by known healthcare providers.

IN FOCUS: KEY ELEMENTS OF INTEGRATED CARE MODEL
- Uniform, evidence-based BH screenings delivered at primary care sites.
- BH assessment & time-limited evidence-based or promising treatment interventions (EBPI) by on-site BH professionals.
- Referral to collaborating locally-based specialty mental health and substance abuse treatment providers.
- Integrated treatment team utilizes a single coordinated treatment plan and process.

INTEGRATED CARE “KIT OF PARTS”

Referral for Specialty BH Care

1. Agreements with specialty BH providers to participate in integrated model (e.g., Behavioral Health Interventions, share information, routine collaborative treatment planning).
2. Protocols for “warm hand-off,” ensure appointment is kept, questions answered.
3. Arrangements with Managed Care Organizations to facilitate care by collaborating providers.

Hudson Valley DSRIP PPS WILL:

- Common Regional Advisory Group to adopt protocols
- Provide training on evidence-based and promising assessments and interventions
- Provide Technical Assistance & implementation support
- Track process and performance metrics over 5 years
- Address regulatory, HIT and financial barriers

METRICS
1. Potentially Preventable ED Visits (for persons with BH diagnosis)
2. Antidepressant medication management
3. Diabetes monitoring for people with Diabetes and Schizophrenia
4. Diabetes Screening for people with Schizophrenia
5. Cardiovascular monitoring for people with Cardiovascular Disease and Schizophrenia
6. Follow-up care for children prescribed ADHD medications
7. Follow-up after hospitalization for Mental Illness
8. Screening for Clinical Depression and follow-up
9. Adherence to Antipsychotic medications for people with Schizophrenia
10. Initiation and Engagement of Alcohol and other Drug Dependence treatment (EDT)

INTERVENTION
1. Co-locate behavioral health services at primary care center(s). Primary care providers must meet 2014 NCQA level 3 PCMH or Advanced Care Practice standards by 2017.
2. Develop collaborative evidence-based standards of care including medication management and treatment.
3. Conduct preventive care screenings, including behavioral health screenings (PHQ-9, SBIRT) implemented for all patients to identify unmet needs.
4. Use EBPI or other technical platform to track all patients engaged in this project.

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**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.

**METRICS**

- Conduct 60 ECHO sessions for the duration of the project.
- Assess spokes’ participation under the following domains:
  - Attendance
  - Self-efficacy
  - Knowledge
  - Workforce
  - Practice/behavior
  - Spokes/Chairs

**INTERVENTION**

Transform the way knowledge and education are transferred to reaching remote patients and clients through telementoring, Project ECHO® at Westchester Medical Center-CRHI uses a peer-to-peer hub and spoke model of continuous learning developed by the University of New Mexico, partnering community providers in outlying areas with behavioral health specialists at our hub. Interested organizations sign the Statement of Collaboration and receive the necessary equipment, as needed, to participate. Spokes will join bi-weekly ECHO sessions, each having a unique didactic presentation during the first 15-20 minutes. The remainder of the session will be dedicated to the analysis of two case presentations submitted by spoke participants. Specialists and spokes participants then discuss the cases, and conclude with specialists offering best practice recommendations to the presenting spoke participant. CRE credits are offered free of charge to all participants: 1 CRE credit per 1 hour of participation.

**TARGET AUDIENCE**

- Physicians
- Nurse Practitioners
- Meditation Nurses
- Physician Assistants
- Care Coaches
- Clinical Assistants
- Behavioral Specialists
- Social Workers
- Community Health Workers
- Other Healthcare Professionals

**SPECIALISTS’ EXPERTISE**

- Adult Psychiatry
- DBH Addle/Behavioral Psychiatry
- Addictions Medicine
- Psychotherapy
- Social Work
- Pharmacy (TBD)
- Pediatric/Neonatology

**EXAMPLE DIDACTIC TOPICS**

- Depression
- Anxiety
- Substance Use
- ADHD
- Autism
- Developmental Delirious Disorder
- Neurodevelopmental syndromes
- Psychopharmacology of substances
- Transgender and BH

**TACTICS**

- Increase local professional capacity to provide quality behavioral health care and treatment for adults and children.
- Increase access to specialty treatment via a hub-and-spoke model of continuous learning.
- 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.
- Transform the way knowledge and education are transferred to reaching remote patients and clients through telementoring.
- Increase access to specialty treatment via a hub-and-spoke model of continuous learning.
- 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.
- Transform the way knowledge and education are transferred to reaching remote patients and clients through telementoring.
- Increase access to specialty treatment via a hub-and-spoke model of continuous learning.

**Next steps**

- Recruit additional spoke sites (15)
- Continue through Jan, 2020
BEHAVIORAL HEALTH COMMUNITY CRISIS STABILIZATION

BRIEF
Develop behavioral health community crisis stabilization services.

GOAL
To provide easily accessible behavioral health crisis stabilization services, expanding opportunities of service and providers, supporting a rapid de-escalation of the crisis.

METRICS
1. PPS will address:*1. Access to the right care at the right time; 2. Follow-through to ensure people are connected with services; 3. Service gaps that lead to crises; 4. Integration of current programs within a systems approach; 5. Prioritization of resources; 6. Achievement of outcome metrics.

INTERVENTION
1. Establish regional advisory council involving all stakeholders; 2. Explore ways to improve triage/assessment/deployment of crisis services while integrating current resources.

PROPOSED MODEL WITH COORDINATED BEHAVIORAL HEALTH SERVICES ENHANCEMENTS

REFFERAL SOURCES
ED & Hospitals
Primary Care Settings
BH Providers
Schools
LGCAs
RP & RTC
Adult Homes
Self & Family
Prisons & Jails
Shelters
Police
Health Homes

REGIONAL CALL & ASSESSMENT CENTER

REGIONAL OUTREACH/EDUCATION

CRISIS INTERVENTION SERVICES
Mobile Mental Health Team with ED Peer Specialists
Crisis Respite Services
 Urgent Care After Hours
Short Term Residential
Crisis Co-occurring Living Rooms

CRISIS PREVENTION SERVICES
Health Home Care Management
Mobile Peer Recovery Network
Telepsychiatry

NEXT STEPS:
1. Work with LGUs to map local county MH and SA crisis services; 2. Establish regional advisory council involving all stakeholders; 3. Explore ways to improve triage/assessment/deployment of crisis services while integrating current resources.

CRISIS STABILIZATION SYSTEM
- Ongoing education of providers/consumers
- A 24/7 Regional Triage/Assessment Center
- Urgent Care After Hours Service
- Mobile-Multiphasic BH Teams
- Crisis Respite Services
- Monitor intake up to 48 hour crisis beds.

PPS WILL ADDRESS:
- Access to the right care at the right time; - Follow-through to ensure people are connected with services; - Service gaps that lead to crises; - Integration of current programs within a systems approach; - Prioritization of resources; - Achievement of outcome metrics.

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DEMONSTRATING IMPACT
BEHAVIORAL HEALTH COMMUNITY
CRISIS STABILIZATION SERVICES

PROJECT OBJECTIVES
• Develop and sustain community-based crisis stabilization services to reduce potentially unnecessary ER and Hospitalization visits.
• Coordinate ongoing care and patient centered services to keep people safe and well within the community.
• Connect BI patients who frequently utilize emergency room services to comprehensive, coordinated and ongoing services within the community.

KEY WORKFORCE FUNCTIONS NEEDED TO NEXT PROJECT OBJECTIVE
• Clinical and non-clinical staff
• Staff may function as multidisciplinary teams to intervene during a crisis
• Staff may function as multidisciplinary teams to prevent an unnecessary emergency room visit

SKILLS, KNOWLEDGE AND COMPETENCIES NEEDED
• Crisis Intervention skills & Intervene in case management skills
• Pre-admission Skills & Interdisciplinary Interventions
• Use of registries
• Medication Recordation
• Psychopharmacology
• Trauma informed care

TRAININGS
• Multidisciplinary interview
• County Trauma Informed Care Training
• County DMR (Behavioral and Community Health)
• Healthify Training
• Prevention Conference Law Enforcement & Public Health
• Dutchess County (SLAD) Training and Train the Trainer
• Orange County CIT Crisis Intervention Training.

WORKFORCE TRAINING HIGHLIGHT
GOAL of Orange County Crisis Intervention Training Model
1. Participants will realize the value of a strategic partnership between behavioral health and other stakeholder systems in supporting/reaching at-risk community members.
2. Participants will learn the model of Crisis Intervention Team (CIT) Training and Lessons Learned.
3. Key steps will be shared on how to replicate the Orange County model.

Intervention:
Orange County Department of Mental Health model of Crisis Intervention Team (CIT) Training (Health and Social Services for Orange County, the Director of Chemical Dependency, Adult Mental Health Services for Orange County, and Samuel L. Exley Center -Albany County Police Department). New York State’s CIT model was introduced to Orange County in the mid-2000’s when Orange County received a federal responsive program that has been nationally known as the “Martha’s Model” for pre-arrest jail diversion for those in a mental illness crisis and co-existing substance abuse disorders. Orange County CIT Model provides law enforcement team members crisis intervention training for helping vulnerable community members. In addition, the Orange County CIT model works in partnership with those in mental health and substance abuse care to provide a system of services that is friendly to the individual with mental illness, substance abuse needs, family members, and the police officers. The Local Government and AIDS strategic partners make positive impact of such diversion efforts such as hospital diversion, and criminal and/or judicial diversion efforts.

Through the initiative VHAHealthMatters is supporting the training of police officers from various municipalities in Orange County.

Metrics:
• National Patient Satisfaction Survey, Care Transition Metrics, Health Plan Member Satisfaction Survey, Care Coordination with provider up-to-date about care received from other providers.

NEXT STEPS
Workforce transformation training initiatives will continue into 2019 and opportunities of sustainable path will be leveraged.

“...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 responders officers but 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

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BEHAVIORAL HEALTH COMMUNITY
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• Psychopharmacology
• Trauma informed care

TRAININGS
• Multidisciplinary interview
• County Trauma Informed Care Training
• County DMR (Behavioral and Community Health)
• Healthify Training
• Prevention Conference Law Enforcement & Public Health
• Dutchess County (SLAD) Training and Train the Trainer
• Orange County CIT Crisis Intervention Training.

WORKFORCE TRAINING HIGHLIGHT
GOAL of Orange County Crisis Intervention Training Model
1. Participants will realize the value of a strategic partnership between behavioral health and other stakeholder systems in supporting/reaching at-risk community members.
2. Participants will learn the model of Crisis Intervention Team (CIT) Training and Lessons Learned.
3. Key steps will be shared on how to replicate the Orange County model.

Intervention:
Orange County Department of Mental Health model of Crisis Intervention Team (CIT) Training (Health and Social Services for Orange County, the Director of Chemical Dependency, Adult Mental Health Services for Orange County, and Samuel L. Exley Center -Albany County Police Department). New York State’s CIT model was introduced to Orange County in the mid-2000’s when Orange County received a federal responsive program that has been nationally known as the “Martha’s Model” for pre-arrest jail diversion for those in a mental illness crisis and co-existing substance abuse disorders. Orange County CIT Model provides law enforcement team members crisis intervention training for helping vulnerable community members. In addition, the Orange County CIT model works in partnership with those in mental health and substance abuse care to provide a system of services that is friendly to the individual with mental illness, substance abuse needs, family members, and the police officers. The Local Government and AIDS strategic partners make positive impact of such diversion efforts such as hospital diversion, and criminal and/or judicial diversion efforts.

Through this initiative VHAHealthMatters is supporting the training of police officers from various municipalities in Orange County.

Metrics:
• National Patient Satisfaction Survey, Care Transition Metrics, Health Plan Member Satisfaction Survey, Care Coordination with provider up-to-date about care received from other providers.

NEXT STEPS
Workforce transformation training initiatives will continue into 2019 and opportunities of sustainable path will be leveraged.

“...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 responders officers but 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
THE LIVING ROOM DAY CRISIS RESPITE

WHAT TO EXPECT WHEN A GUEST ARRIVES AT THE LIVING ROOM

A Guest will be welcomed into the Living Room Library to speak with staff to ensure that the Living Room has the services available to support the individual. After a brief meeting the Guest will be introduced to a Peer Care Manager who then will provide coordination of the living environments. The Guest will be introduced to a Peer Care Manager who has their own personal experience in receiving behavioral health services and who is trained to talk with the Guest about their concerns. Together the Guest and the Peer Care Manager will develop a plan for the day to address their needs and future goals.

GOAL

To provide a non-clinical setting for individuals in escalating behavioral health crisis to develop short- and long-term goals to prevent unnecessary ED or Inpatient stays. To provide a non-clinical setting for individuals in escalating behavioral health crisis to develop and implement referrals for Integrated Services.

COMMUNITY LINKAGE / PREVENTION

- Peer Support/Comprehensive Community Services (CCS)
- Health Homes, Community Based Providers
- Connections to services for consumers during community meetings and support

TO THE LIVING ROOM?

- Clinical Providers
- Peer Care Managers
- Providers
- Medical Providers
- Partial Hospitalization
- Web-based Services
- Day Support Services
- Peer Care Manager Center
- Peer Support Services/Mobile Support Services
- Self-Rescue
- Skills Training
- Law Enforcement

SERVICES/INTERVENTIONS

- Symptom Management
- Psychiatric medication
- Individual and Group counseling
- Family therapy
- Crisis Assessment
- Emergency Services
- Non-clinical Setting
- Non-hospital Setting
- Peer Support Services
- Partial Hospitalization

LIVING ROOM METRICS:

- Total # of Visits: 1010
- Total Guests Served: 1223
- Total # of Visits: 7/19/2017 – 12/31/2017
- Total Guests Served: 2017 Year to Date
- Total Hours of Face to Face Services: 3598
- Total Guests Served: 2018

INTERVENTION

- Develop or support existing WRAP (Recovery Action Plan) Activities for Voracity
- Peer Support Services
- Partial Hospitalization
- Comprehensive Community Services (CCS)
- Community Based Providers
- Connections to services for consumers during community meetings and support

COMMUNITY LINKAGE / PREVENTION

- Peer Support/Comprehensive Community Services (CCS)
- Health Homes, Community Based Providers
- Connections to services for consumers during community meetings and support
- Present Living Room services to consumers during community meetings and support

CRISIS STABILIZATION SYSTEM

- Crisis Assessment
- Medical Evaluation/Needs
- Emergency Services
- Non-clinical Setting
- Non-hospital Setting

WHEN A GUEST ARRIVES AT THE LIVING ROOM

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GOAL

To provide a non-clinical setting for individuals in escalating behavioral health crisis to develop short- and long-term goals to prevent unnecessary ED or Inpatient stays. To provide a non-clinical setting for individuals in escalating behavioral health crisis to develop and implement referrals for Integrated Services.
**BRIEF**  
Support implementation of evidence-based best practices for disease management, specific to diabetes, in medical practices related to diabetes.

**GOAL**  
Ensure clinical practices in the community and ambulatory care settings use evidence-based best practices to improve disease management, self-management, and expand the availability of evidence-based self-management training for patients in the community setting.

**METRICS**  
- Implement evidence-based best practices for disease management, specific to diabetes, in community and ambulatory care settings; engage at least 80% of PPS primary care providers.
- Develop care coordination teams (including diabetes educators, nursing staff, behavioral health providers, pharmacy, community health workers, and Health Home care managers) to improve health literacy, patient self-efficacy, and patient self-management.
- Develop "hot spotting" strategies, in concert with Health Home, to implement programs such as the Stanford Model for chronic diseases in high-risk neighborhoods.
- Coordinate with the Medicaid Managed Care Health Homes, to implement programs such as Health Home resources and community-based self-management training.

**INTERVENTION**  
- Our PPS will work with the three regional Health Homes to identify "hot spots" where diabetes self-management programs are needed and under-resourced. We will provide training to Health Home care coordinators on closing "gaps in care" for management of diabetes and other medical conditions and will provide training to affiliated PCPs on how better to link patients with Health Home resources and community-based self-management training.

Specifically, this includes improving practitioners' population management, increasing patient self-efficacy and confidence in self-management, and implementing diabetes management evidence-based guidelines.

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Specifically, this includes improving practitioners' population management, increasing patient self-efficacy and confidence in self-management, and implementing diabetes management evidence-based guidelines.
BRIEF
Employed both established evidence-based approaches using Certified Diabetes Educators, as well as new innovative pilot programs testing peer-to-peer coaching.

GOAL
To develop care coordination teams to improve health literacy, patient self-efficacy, and patient self-management.

INTERVENTIONS
WMCHealth PPS pursued multiple strategies to meet this goal: training Health Home and Behavioral Health care managers on the basics of diabetes care; promoting use of Certified Diabetes Educators; piloting a telehealth model to provide peer-to-peer coaching on diabetes self-management.

METRICS AND IMPACT
A total of 255 staff from partner organizations have been trained in workshops, practice were reported at our Summit in 2017. To date, a total of 255 practice is still implementing the peer program; the results from the practice were reported at our Summit in 2017. To date, a total of 255.

The PPS engaged 2 medical practices to test the peer-coaching model, 2 medical practices to test the peer-coaching model, the results from the practice were reported at our Summit in 2017. To date, a total of 255.

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To develop care coordination teams to improve health literacy, patient self-efficacy, and patient self-management.

INTERVENTION
Building on the DSMP success of a Bronx Community Based Organization, Health People, WMCHealth PPS engaged with multiple community-based organizations to adapt the Health People approach in the Hudson Valley.

METRICS AND IMPACT
WMCHealth PPS has contracted with 4 Community Based Organizations, 1 Mental Health Services Provider and 1 Federally Qualified Health Center to deliver DSMP training. By working with organizations with deep roots in the communities they serve, our partners tailor the DSMP presentations to meet the specific linguistic, cultural and special needs of high priority populations.

The PPS has sponsored training for DSMP leaders in both English and Spanish, and over 100 Medicaid beneficiaries with type 2 diabetes have successfully completed the DSMP program. Successful completers include patients with mental illness who are at high risk for diabetes because of side effects of medications they must take.

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BRIEF

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," "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, hours spent watching TV per weekend, hours spent playing video games on weekends.

The 6-week curriculum showed a general trend of improvement in the students' health attitudes and lifestyle choices. The positive direction shown by our data is a clear example of how just 6 hours in the life of a 6th grader can make a difference that could potentially benefit them for a lifetime.

Collaboration across different sectors to address a community health issue.

GOAL

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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.

NEXTE STEPS

Submit for additional funding to expand and sustain the program.

THE PPS ADDRESSES

- Obesity prevention and health promotion in youth
- Collaboration across different sectors to address a community health issue
- Submit for additional funding to expand and sustain the program.

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Janet.Sullivan@wmchealth.org  //  914.326.4202

Vice President, Medical Director, WMCHealth PPS

RESULTS

- Change in health attitudes
- Change in dietary intake
- Change in physical activity participation
- Change in body mass index (BMI)

The 6-week curriculum showed a general trend of improvement in the students' health attitudes and lifestyle choices. The positive direction shown by our data is a clear example of how just 6 hours in the life of a 6th grader can make a difference that could potentially benefit them for a lifetime.
**BRIEF**

Implementation of Evidence-based Medicine Guidelines for Asthma Management

**GOAL**

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.

**METRICS**

1. Implement evidence-based asthma management guidelines between primary care practitioners, specialists, and community-based asthma programs (e.g., NYS Regional Asthma Coalitions) to ensure a regional population-based approach to asthma management.
2. Establish agreements to adhere to national guidelines for asthma management and protocols for access to asthma specialists, including EHR-HIE connectivity and telemedicine.
3. Deliver educational activities addressing asthma management to participating primary care providers.
4. Ensure coordination with the Medicaid Managed Care organizations and Health Homes serving the affected population.
5. Use EHRs or other technical platforms to track all patients engaged in this project.

**INTERVENTION**

Our PPS will utilize four strategies to engage and address attributed Medicaid patients with asthma:

1. Specialists in our PPS will review and adopt national and state evidence-based guidelines for asthma management, including protocols for appropriate spirometry, a common office tool used to assess how a patient’s lungs work, specialty referrals, and an Asthma Action Plan.
2. We will establish a PPS-wide registry to track asthma patients enrolled in our program. We will use this registry to evaluate analytics and population health management platforms (during DY 1 we will implement a system to identify and track patients with chronic disease, including asthma, and monitor patient and provider adherence to treatment guidelines).
3. We will implement health information exchange (HIE) protocols for creating, updating, and sharing patient-centered asthma action plans among treating providers, Health Homes, patients, and their families (to do so, a region-wide, all-PPS asthma workgroup will engage with HealthlinkNY, the local RHIO, to facilitate HIE); and
4. We will expand training for primary care providers (PCPs) on asthma management and use of spirometry and expand the availability of evidence-based asthma education for patients and parents of patients who are minors.

**RESULTS**

We will implement health information exchange (HIE) protocols for creating, updating, and sharing patient-centered asthma action plans among treating providers, Health Homes, patients, and their families; and

**CONCLUSIONS**

We will establish a PPS-wide registry to track asthma patients enrolled in our program. We will use this registry to evaluate analytics and population health management platforms (during DY 1 we will implement a system to identify and track patients with chronic disease, including asthma, and monitor patient and provider adherence to treatment guidelines).
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.

Our PPS pursued four strategies toward achieving better asthma management:

1. The Asthma Project Advisory Quality Committee (PRJCT3.d.iii) created an Asthma Action Plan template that could be shared across practices within the WMCHealth Network to facilitate the exchange of best practices. This network is composed of organizations that have completed the training. Certified Asthma Educators; 42 persons from nine sites of the Mt. Vernon Neighborhood Health Center on asthma management and use of spirometry; 24 care managers were trained on the basics of Asthma and diabetes during the 2016 WMCHealth PPS summit, and subsequently, 154 persons have taken the e-course on the PPS training platform. The PPS sponsored on-site training for 31 Physicians from three sites of the Mt. Vernon Neighborhood Health Center on asthma management and use of spirometry; 24 care managers were trained on the basics of Asthma and diabetes during the 2016 WMCHealth PPS summit, and subsequently, 154 persons have taken the e-course on the PPS training platform.

2. Because creating and tracking Asthma Action Plans often requires information and modifications of Electronic Health Records, the group reviewed barriers and trained partners on the most recent New York State guidelines. The Asthma Project Advisory Quality Committee (PRJCT3.d.iii) created an Asthma Action Plan template that could be shared across practices within the WMCHealth Network to facilitate the exchange of best practices. The number of practices successfully creating and tracking and reporting Asthma Action Plans has increased every quarter.

3. The PPS worked collaboratively to increase the use of technology to improve Asthma care. With other PPSs and entities of the State Health Information Network—New York (SHIN-NY) the PPS worked toward developing an Asthma Action Plan template that could be shared across practices within the WMCHealth Network to facilitate the exchange of best practices. The PPS commissioned a regional study and surveyed partner regions on the feasibility of telemedicine to make specialty care for Asthma more readily available. WMCHealth implemented a state-of-the-art Health Information Network (SHIN-NY) program using the latest technology to monitor critical patients, including patients with acute asthma exacerbations, in ambulances and intensive care facilities affiliated with the WMCHealth Network.

4. The PPS continues to support training at multiple levels to increase capacity for team-based care for Asthma. The PPS sponsored on-site training for 31 Physicians from three sites of the Mt. Vernon Neighborhood Health Center on asthma management and use of spirometry; 24 care managers were trained on the basics of Asthma and diabetes during the 2016 WMCHealth PPS summit, and subsequently, 154 persons have taken the e-course on the PPS training platform. The PPS sponsored on-site training for 31 Physicians from three sites of the Mt. Vernon Neighborhood Health Center on asthma management and use of spirometry; 24 care managers were trained on the basics of Asthma and diabetes during the 2016 WMCHealth PPS summit, and subsequently, 154 persons have taken the e-course on the PPS training platform. The PPS sponsored on-site training for 31 Physicians from three sites of the Mt. Vernon Neighborhood Health Center on asthma management and use of spirometry; 24 care managers were trained on the basics of Asthma and diabetes during the 2016 WMCHealth PPS summit, and subsequently, 154 persons have taken the e-course on the PPS training platform.

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TOBACCO CESSATION

GOAL
- Decrease the prevalence of cigarette smoking by adults 18 and older by increasing the use of tobacco cessation services, including NYS Smokers’ Quitline and over-the-counter medications.

METRICS
- New York State Preventive Agenda related measures.

INTERVENTION
- The convened Region-wide Quality Council will review and develop a proposal for uniform coverage among the health plans.
- Complete the 9 A’s (Ask, Assess, Advise, Assist, and Arrange).
- Implement the US Public Health Services guidelines for Treating Tobacco Use.
- Facilitate referrals to the NYS Smokers’ Quitline.
- Implement tobacco-free outdoor policies.
- Promote smoking cessation benefits among Medicaid recipients.
- Create a uniform, consistent health insurance benefit for prescription and over-the-counter medications.

TOBACCO CESSATION INTERVENTIONS

Tobacco Free Outdoors

- Provide PPS with English and Spanish smoking cessation materials for their waiting rooms.
- Provide smoking cessation Medicaid billing information.
- Promote smoking cessation counseling among all smokers, including people with disabilities.

Tobacco Free Action Coalition, Smoke Free Outdoors

- Implement the US Public Health Services guidelines for Treating Tobacco Use.
- Promote smoking cessation benefits among Medicaid recipients.
- Create a uniform, consistent health insurance benefit for prescription and over-the-counter medications.

TOBACCO CESSATION PROVIDER WORKFLOW

1. Ask every patient about tobacco use.
2. Advise to quit.
3. Refer to NYS Smokers’ Quitline through EHR.
4. Facilitate referrals to the NYS Smokers’ Quitline.
5. Implement the US Public Health Services guidelines for Treating Tobacco Use.

TOBACCO CESSATION WAITING ROOM SMOKING CESSATION INFORMATION

1. Provide PPS with English and Spanish smoking cessation materials for their waiting rooms.
2. For patients, the flyers will include:
   - Tips for how to quit smoking.
   - New York State Smokers’ Quitline information.
3. For providers, the flyers will include:
   - Smoking cessation Medicaid billing information.
   - ICD-9CM Diagnosis code 305.1 tobacco use disorder.
   - CPT 99406, intermediate smoking cessation counseling, 3-10 minutes (not billable for group visits or CPT 99407; smoking cessation counseling greater than 10 minutes).

TOBACCO CESSATION SAMPLE POSTER

- SAMPLE POSTER
- SAMPLE POSTER

TOBACCO CESSATION BRIEF

This project will educate patients about smoking.

Guidelines for Treating Tobacco Use

- Promote smoking cessation benefits among Medicaid recipients.
- Create a uniform, consistent health insurance benefit for prescription and over-the-counter medications.

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TOBACCO CESSATION

CROSS-PPS COLLABORATION YIELDS RESULTS
Hudson River DSRIP Public Health Council (HRD PHC) Launches Anti-vaping Campaign

The Hudson River DSRIP Public Health Council (HRD PHC), comprised of the three regional PPS (Westchester Medical Center, Montefiore Hudson Valley Collaborative, and Rockland Community Health Collaborative) and representatives from more than 30 organizations and advocates, work together on DSRIP Domain 4, population health projects — such as Tobacco Cessation and Cancer Screening.

The council frequently throughout DSRIP Year 1–3 grew from a group of approximately 20 to over 45 agencies and organizations representing local/state entities, behavioral/mental health providers, public health advocates, care providers and community-based providers.

LAUNCHED: Anti-vaping Campaign Geared Towards High School Students in Hudson Valley

Following quarterly meetings and the development of a plan to tackle the DSRIP 4.b.i Tobacco Cessation population health project, the Council partnered with behavioral health and community health organizations to design campaign resources geared towards the high school population and their parents and guardians.

The campaign focuses on anti-vaping, where studies suggest that influencing teens to stay away from vaping reduces the likelihood they will smoke cigarettes later on.

The bad news.

Vaping, e-cigs and hookah smoking is on the rise, leading to nicotine addiction.

The good news.

Cigarettes smoking is down among high-school age teens.

For more information, go to www.hrdphc.org

Visit Us Online... more information about the Public Health Council or local services go to www.hrdphc.org

TOBACCO CESSATION

PRJCT4.b.i

A program of the Hudson Region Delivery System Reform Incentive Payment Public Health Council.

For more information, go to www.hrdphc.org

Learn more at www.hrdphc.org

Hypocrite
Phony


When your kid tells you... don’t worry. It’s safe...

...don’t worry. It’s safe...

When hookahs are shared.

You think you’re getting the full smoking experience without the mouthpiece. Fact. Strictly bad news.

Nicotine too. You also expose yourself to infectious disease when you share the mouthpiece. This is not “safe” smoking. No, the water doesn’t filter out toxic chemicals. If you use it as a tobacco pipe, you can suck in more toxins than by smoking a cigarette.

You think you’re getting the full smoking experience without the mouthpiece. Fact. Strictly bad news.

The more you smoke, the more you crave.

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The more you smoke, the more you crave.

You don’t know what you’re breathing in. Nobody knows. It’s a totally unregulated industry, and you’re paying to be their guinea pig.

CANCER SCREENING + FOLLOW-UP

GOAL: IMPROVE SCREENING & FOLLOW-UP FOR BREAST, CERVICAL, COLON AND LUNG CANCER

1. Develop & implement evidence-based protocols for cancer screening, follow-up & management
   - Convene Regional Quality Council to adopt evidence-based protocols.
   - Develop and deploy regional training for primary care clinical staff.
   - Incorporate protocols in EHRs & other technology to generate reminders.
   - Monitor compliance with screening & follow-up.
   - Review protocols to reflect learnings and guideline changes.

2. Identify Patients in need of screening; Ensure needed follow-up
   - Identify populations who have not had recommended screening for breast, cervical, colorectal, and lung cancers.
   - Identify and address barriers to screening.
   - Conduct outreach to patients and facilitate screenings.
   - Leverage the Regional Quality Council to align public service messages to maximize impact of public health campaigns.
   - Develop protocols to track results and ensure follow-up of positive screenings.
   - Identify and address barriers to evidence-based diagnostic work-up.
   - Identify and address barriers to evidence-based treatment.

3. Connect patients to community-based preventive care & management
   - Inventory community resources for cancer screening and treatment, maintain accessible directory.
   - Develop and deploy a regional platform to facilitate referral tracking, including community-based resources.
   - Train clinical staff and community resources on use of directory and referral system.

4. Address reimbursement and/or incentives for cancer screening & management
   - Identify effective payment models regionally and beyond that may be leveraged or replicated.
   - Test interventions & incentives for efficacy in improving cancer screening and follow-up.
   - Share results transparently within the PPS and more broadly to create a learning community.
   - Deploy best practices broadly.

INTERVENTION

• Decrease inaccessibility to high-quality chronic disease prevention care and management in both clinical and community settings.

METRICS

New York State Prevention Agenda-related measures.

IMPACTS

Test interventions & incentives for efficacy in improving cancer screening and follow-up.

• Develop evidence-based screening, follow-up & management protocols for cancer screening & management.

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   - Leverage the Regional Quality Council to align public service messages to maximize impact of public health campaigns.
   - Develop protocols to track results and ensure follow-up of positive screenings.
   - Identify and address barriers to evidence-based diagnostic work-up.
   - Identify and address barriers to evidence-based treatment.
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**
Our PPS, under the umbrella of the Hudson Regional DSRIP Public Health Council, a cross PPS committee (WMCHealth, Montefiore, and Refuah), coordinated region-wide project implementation with local health departments and other community partners and shared best practices and lessons learned. The Council also worked with hospitals across the region to incorporate Prevention Agenda goals and objectives into hospital community service plans and with Medicaid MCOs and health plans to seek enhanced reimbursement for cancer screening and prevention services.

WMCHealth PPS adopted a comprehensive care plan template and prevention services. Health Council, a cross PPS committee (WMCHealth, Montefiore, and Refuah), coordinated region-wide project implementation with local health departments and other community partners and shared best practices and lessons learned. The Council also worked with hospitals across the region to incorporate Prevention Agenda goals and objectives into hospital community service plans and with Medicaid MCOs and health plans to seek enhanced reimbursement for cancer screening and prevention services.

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Participated WMCHealth PPS Partners in Project 4.b.ii – Cancer Screening

- BarnABird Pediatrics PC
- Center for Tobacco Free Hudson Valley
- CMADC
- Cornerstone Family Healthcare
- Crystal Run Healthcare
- FORMÉ
- GHVHS
- Liberty Pediatrics, PC
- Lower Hudson Valley Perinatal Network
- Open Door Family Health Centers
- Poughkeepsie Medical Group, LLP
- Planned Parenthood Mid-Hudson Valley, Inc.
- Westchester Institute for Human Development

**METRICS**
- Developed a comprehensive implementation plan
- Assisted with a community needs assessment
- PCMH implementation
- Partner presentations of best practices and lessons learned (Open Door Family Medical Center, Westchester Medical Center Adult Outpatient Primary Care Department, and MidHudson Community Health Care)
- Developed a technology enablement plan to embed cancer screening guidelines, alerts, and reminders in EHR (see Figure 1)
- Ensured providers have developed or adopted POEIR or team-based care models (see Participated WMCHealth PPS Partners list)
- Partner responses to PPS Survey
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FIGURE 1: Implementation of Routine Cancer Screening Alerts in EHR. N=87

The PPS will continue to share best practices among partners so those who have not yet implemented screening alerts can learn from those who have done so.

**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.

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