WMCHEALTH PPS DSRIP YEAR 1 REPORT & UPDATE
## Content

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thank You</td>
<td>1</td>
</tr>
<tr>
<td>Building a Sustainable Safety Net</td>
<td>2</td>
</tr>
<tr>
<td>Progress Towards Transformation</td>
<td>4</td>
</tr>
<tr>
<td>Transformation and the Safety Net</td>
<td>6</td>
</tr>
<tr>
<td>MAX Program</td>
<td>7</td>
</tr>
<tr>
<td>Workforce Training and Education</td>
<td>8</td>
</tr>
<tr>
<td>Consolidation, Restructuring, Partnerships</td>
<td>10</td>
</tr>
<tr>
<td>Value-Based Payment Reform</td>
<td>11</td>
</tr>
<tr>
<td>Cross-PPS Collaboration</td>
<td>12</td>
</tr>
<tr>
<td>Integration of Primary Care and Behavioral Health</td>
<td>14</td>
</tr>
<tr>
<td>Voices of the Network</td>
<td>15</td>
</tr>
<tr>
<td>WMCH Health PPS Committees and Workgroups</td>
<td>21</td>
</tr>
<tr>
<td>WMCH Health PPS DSRIP Projects</td>
<td>22</td>
</tr>
<tr>
<td>Implementation Work Streams</td>
<td>23</td>
</tr>
</tbody>
</table>
Thank You

Dear WMCH Health PPS Partner/Supporter,

As we move full-steam ahead into DSRIP Year 2, we wanted to look in our rear-view mirror and reflect on our first year together as a Performing Provider System (PPS). We thank our network partners for all their efforts in establishing the WMCH Health PPS. Because of your diligence and involvement we were able to successfully meet our DSRIP Year 1 goals and milestones.

Your participation and input in our PPS puts us in a good place to establish a robust integrated delivery system for the Hudson Valley supported by sound clinical and organizational governance. We are also grateful for your contributions during our various committee and workgroup meetings, attendance at our DSRIP Summit and Quality Meeting in November and your timely feedback to the network readiness surveys we deployed to gauge the strengths and resource needs across our network.

We are also proud to highlight the successful capital restructuring and finance (CRFP) grant awards to our partners in Kingston and Port Jervis as this will positively impact our participation in the Medical Village project, where we will repurpose existing infrastructure to reflect our transformation into a truly integrated health care delivery system.

There are many more highlights. We invite you to read our DSRIP Year 1 report where we share some of the key developments and accomplishments across our network. As always, we thank you for your continued support and invite you to submit questions or commentary to crhi@wmchealth.org.

Kind regards,

Michael D. Israel
President and CEO
WMCH Health Network
Building a **Sustainable Safety Net** in the Hudson Valley

The healthcare and community provider organizations in the Hudson Valley are a safety net for the entire population of the region, regardless of insurance status. This network provides patient care and social services in local geographies we refer to as Medical Neighborhoods.

The WMCHealth Performing Provider System (PPS), through its investment in DSRIP, will deliver resources that support these Medical Neighborhoods. WMCHealth PPS’ vision is to deliver vital support services in data sharing and analysis, enabling coordinated social services and clinical care, managed by providers connected in each Medical Neighborhood.

Our network of PPS partners will lead a regional care transformation effort that includes more than 240 partner health care organizations and more than 2,500 area physicians. In addition to meeting our DSRIP goals and milestones, the PPS’ project management office will leverage the leadership of the Westchester Medical Center Health Network and the Hudson Valley stakeholder community to identify priority areas for reform and develop new models that work for our communities.

**A sustainable safety net will:**

- Ensure that clients and patients receive timely access to the health care and social services they need.
- Build an integrated delivery system supported by sound IT and data analytics and quality of care protocols that are patient-centered.
- Create a system where clinical and non-clinical providers can positively impact social and economic determinants of health.
- Reduce unnecessary hospitalizations and ED visits.
- Improve overall population health.
- Reduce the overall cost of care by engaging partners in value-based care delivery.

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**Telemedicine Supporting the Safety Net:**

**WMCeHealth Center Opens**

In 2015, Westchester Medical Center opened the WMCeHealth Center, bringing the first telemedicine technology of its kind to the Hudson Valley. The new 5,500-square-foot facility on our Valhalla campus is equipped with the latest innovations to remotely connect healthcare professionals at our network hospitals with patients at other locations. The telemedicine program began with ePsychiatry, connecting patients and staff at WMCHealth’s Poughkeepsie campus with clinical psychiatric specialists throughout the Hudson Valley. The electronic Intensive Care Units (eICUs), a service of the eHealth Center, on both our Valhalla and Poughkeepsie campuses are fully operational. The center is made up of 20 monitoring pods, each staffed 24 hours a day, 7 days a week with healthcare professionals highly trained in using this technology to assist doctors and nurses in delivering the highest quality care.

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Residents of the region can be assured that our PPS’ anchor institution has a long-term plan to sustain the transformation DSRIP hopes to accomplish. Westchester Medical Center’s 2020 Strategic Plan is supported by eight enabling strategies that complement DSRIP goals:

1. Continue to seek new relationships with community hospitals.
2. Strengthen alignment with leading physician groups and evolve our employed physician groups.
3. Expand clinical specialty services.
4. Leverage the DSRIP opportunity to link providers and services across the continuum of care and to build population health management capabilities.
5. Expand outpatient services capabilities.
6. Develop a post-acute services strategy.
7. Institute new academic affiliation agreement with New York Medical College.
8. Develop a new Research Institute.
Medical Neighborhoods

- A - Orange and Rockland
- B - Putnam, Dutchess, and Ulster
- C - Westchester
- D - Sullivan and Delaware

WMCH Health PPS Attributed Patient Density

Data current as of June, 2016
**Progress Towards Transformation**

### DY1 Project Funds Flow

<table>
<thead>
<tr>
<th>Local and Regional Partner Integration Activities</th>
<th>PCMH, MU, and HIE Support</th>
<th>Reporting Patient Engagement*</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.a.i: Create Integrated Delivery System</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>2.a.iii: Health Home At-Risk Intervention Program</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>2.a.iv: Create Medical Village-using existing hospital infrastructure.</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>2.b.iv: Post Hospital Care Transitions-to reduce 30-day readmissions.</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>2.d.i: Patient Activation</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>3.a.i: Behavioral Health-integration of primary care behavioral health services.</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>3.a.ii: Behavioral Health Community-Crisis Stabilization services.</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>3.c.i: Diabetes Management</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>3.d.iii: Asthma Care Management</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>4.b.i: Tobacco Cessation</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>4.b.ii: Cancer Screening</td>
<td>✔</td>
<td></td>
</tr>
</tbody>
</table>

* Funding scheduled to begin in DY2

### Funds Flow Highlights...

- Contracted with Taconic Pro to transform 45 primary care partner sites to meet Level 3 PCMH recognition.
- Created partnerships with community-based providers to assess patient engagement in their care.
- Created workforce training and education platform.
- Pooled resources through cross-PPS collaboration to impact Tobacco Cessation population health improvement. (See page 12)
- Established Medical Neighborhoods and provider engagement infrastructure to begin impacting care transformation.
- Engaged vendors and employed resources to impact network partner connection to the RHIO and improvement of IT infrastructures.

### Milestones & Performance Targets

#### 1. Organizational Work Stream Milestones

- A. Governance
- B. Workforce
- C. Cultural Competency
- D. Financial Sustainability-Value Based Purchasing

#### 2. Quarterly Project Milestones

- A. Project Milestones e.g. Meaningful Use (MU)
- B. Activated Patients
- C. Network / Provider Engagement

#### 3. Population Clinical Performance Measures

- A. Pay for Reporting
- B. Pay for Performance
**DSRIP FUNDING OVER 5 YEARS BASED ON PERFORMANCE**

<table>
<thead>
<tr>
<th>Year</th>
<th>Performance</th>
<th>Reporting</th>
<th>Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y.1</td>
<td>16%</td>
<td>3%</td>
<td>9.6%</td>
</tr>
<tr>
<td>Y.2</td>
<td>17%</td>
<td>3%</td>
<td>4%</td>
</tr>
<tr>
<td>Y.3</td>
<td>27%</td>
<td>4%</td>
<td>12%</td>
</tr>
<tr>
<td>Y.4</td>
<td>25%</td>
<td>4%</td>
<td>16%</td>
</tr>
<tr>
<td>Y.5</td>
<td>15%</td>
<td>4%</td>
<td>13%</td>
</tr>
</tbody>
</table>

* 60% of first year money (~9.6% of total) will be available for “start-up” based on submission of accepted application; all other payments will be based on completing milestones or hitting performance targets.

**PROVIDERS IN OUR NETWORK**

- Primary Care Physicians: 725
- Non-PCP Practitioners: 2,585
- Hospitals: 18
- Clinics: 51
- Health Home / Care Management: 60
- Behavioral Health: 477
- Substance Abuse: 35
- Skilled Nursing Facilities / Nursing Homes: 46
- Pharmacy: 8
- Hospice: 13
- Community-based providers: 333
- All Other: 1,922

**WMCHEALTH PPS MEDICAL NEIGHBORHOODS WITHIN HEALTHY COMMUNITIES**

- **Medical Neighborhood A**
  - Rockland County
  - Orange County

- **Medical Neighborhood B**
  - Putnam County
  - Dutchess County
  - Ulster County

- **Medical Neighborhood C**
  - Westchester County

- **Medical Neighborhood D**
  - Sullivan County
  - Delaware County
OLD APPROACH TO HEALTH CARE
- Fragmented
- Technology-phobic
- Silos
- Uncoordinated
- Volume-based
- Poor Communication

WHERE HEALTH CARE IS GOING
- Comprehensive and coordinated: Provider teams, community accountable
- Better quality and improved safety = better care
- IMPROVED POPULATION HEALTH
- VALUE-BASED PAYMENT ARRANGEMENTS

COMMUNITY
- CBPs—Community-based providers part of integrated continuum of care
- Patient Preference—PCC/Care coordinators collaborate with providers for patient benefit
- Care Coordinators work with patients to close communication loops and find needed services
- Non-Medicaid Providers (e.g., housing, food pantries)

PATIENT CENTERED MEDICAL HOME
Patient Centered—Team approach to care between patient and providers
- PCMH—Coordinated care teams develop care plans
- HIE—EHR—Patient Portal: effective decision making, reduced waste
- Clinically Integrated—Medical neighbors agree on specific roles
- Communicate—Health information exchange

MEDICAL NEIGHBORHOOD & CARE COORDINATION
Compacts of Care + Health Information Exchange
- Accessible—Timely access to services; shorter wait times, care innovations
- Care Transitions—Seamless continuum of care between settings

PROVIDER TYPES:
- Primary Care Providers (PCP)
- Clinics
- Community-Based Providers (CBPs)
- Substance Abuse Providers
- Pharmacies
- Health Homes & Care Management Providers
- Specialty and Developmental Disability Service Providers
- Non-Primary Care Providers (Non-PCP)
- Government Agencies
- Hospitals
- Nursing Homes
- Skilled Nursing Facilities (SNF)
- Behavioral Health (BH) Providers
Rapid Improvement Cycles Significantly Reduce ED Visits and Opioid Use

WMCH Health PPS, Ellenville Regional Hospital and Institute for Family Health Participate in Medicaid Accelerated eXchange (MAX) Series Program

Clinical collaboration and a thorough rethink of the healthcare delivery process between WMCHHealth PPS, Ellenville Regional Hospital and the Institute for Family Health amounted to a significant reduction in ED visits and opioid use among a cohort of 64 patients. The three organizations are participants in the Medicaid Accelerated eXchange (MAX) Program that aims to transform the management of patients with multiple complex health conditions that are high cost through rapid improvement cycles. Other key components of the program includes a redesign and improvement of primary care processes aimed at preventing unnecessary ED use among high-risk patients—with an approach that is truly patient-centered and data driven.

MAX Program Rapid Improvement Cycle Components

- Interdisciplinary and multi-provider teams of front line clinicians came together to redesign the way care is delivered.
- Data was used for problem identification, monitoring and performance measurement.
- In Rapid Improvement Cycles, teams drive results to truly impact the lives of Medicaid members.

WMCHEALTH PPS, ELLENVILLE REGIONAL HOSPITAL & INSTITUTE OF FAMILY HEALTH RESULTS

<table>
<thead>
<tr>
<th></th>
<th>BEFORE</th>
<th>AFTER</th>
<th>CHANGE</th>
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<tbody>
<tr>
<td>ED Visits</td>
<td>70/month</td>
<td>46/month</td>
<td>-34%</td>
</tr>
<tr>
<td>Opioid Orders</td>
<td>98/month</td>
<td>27/month</td>
<td>-73%</td>
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Data reflects rapid cycle improvement period from May 2015 – October 2015
Setting the Foundation

During DSRIP Year 1, members of WMCH Health PPS’ Workforce Committee and Cultural Competency and Health Literacy Workgroups—comprised of leadership from Catskill Hudson Area Health Education Center, 1199SEIU, NYSNA and CSEA labor unions, professional services firm KPMG and our partners at the Training and Education Fund of 1199SEIU collaborated on the deployment of some significant workforce training and education programs.

Approach and Objectives

The approach of workforce training and education development is one of collaboration and inclusion across the WMCH Health PPS network—and covers the entire range of clinicians and providers, care managers and coordinators, ancillary and support staff, community-based providers, state and local agencies, workers representation and education vendors.

Workforce training is delivered using different learning mediums and takes place in traditional classroom settings, online or a combination of both that results in new competencies intended to improve performance in DSRIP project work. These training and education platforms will enable employees to successfully manage the changes in the healthcare system and improve the quality of health and social services delivered to residents in the region.

Online Training, Education and PPS Information Resources Platform Launches

WMCH Health PPS launched its online Learning Institute, accessible to all network partners and stakeholders. While all network partners are encouraged to register to access the site, some training/education resources will be restricted to specific partner staff via enrollment key codes. Once registered, users will be able to self-manage trainings on this platform, be notified of upcoming trainings and complete evaluation surveys of completed trainings. The Learning Institute’s online platform will be the primary source for e-learning courses and access to training materials.

Career Pathways: Developing the Workforce for Healthcare Transformation

The next step in workforce transformation is the launch of the Career Pathways Program in summer 2016. This will be a structured process to introduce members in our communities to health care professions and career paths that support DSRIP activities. Our PPS will collaborate with the Training and Education fund of 1199 SEIU (TEF), the Catskills AHEC, PPS partners and educational partners who provide training, education and/or employment to develop a comprehensive program that includes opportunities to begin or grow a career in the health care field.

The Career Pathways Program in our region will be tailored to the provider gaps and needs identified in our community needs assessment as well as DSRIP-driven changes that will extend patients’ ability to remain in non-institutionalized settings and have a more active role in the management of their health and wellness. Our program will launch in summer 2016 through a training partnership with Mid-Hudson Regional Certified Home Health Services to offer home health aide trainings in Poughkeepsie.
Workforce Training and Education

Patient Activation Measure Training for CBP partners
Focus: Patient Engagement

Medicaid Accelerated eXchange Series-Creating Interdisciplinary Teams
Clinical Care Coordination training

Achieving Equitable Health Care Outcomes: Building a Health Literate and Culturally Competent Organization
Multidisciplinary, Cultural Competency and Health Literacy Training, E-Learning course.

Asthma Educator Training Workshop
Clinical Training. Asthma Certification prep course for PPS partners.

Lung Force Exposition
Clinical Training. Professional development conference. Educational activities addressing asthma management.

Medical Neighborhood for Healthy Communities
Interactive in-person meetings with network partners on local deployment and implementation of DSRIP projects across PPS.

Improving Healthcare for Lesbian, Gay, Bisexual, and Transgender Individuals
Clinical Training. Professional development conference. Improving the quality of healthcare services for LGBT individuals.

Leveraging Opportunities in Healthcare delivery System and Payment Reform Learning Lab Series
In-person and e-Learning program for community-based providers to gain practical skills needed to participate in value-based payment arrangements.

WMHealth PPS DSRIP Summit and Quality Meeting
PPS partners will meet in November 2016 for the third annual meeting to discuss ongoing DSRIP project implementation, participate in education workgroups as well as convene the annual Project Advisory Quality Committee meeting.

Email crhi@wmchealth.org to receive the link to register for our platform.
WMCH ealth PPS Partners Secure Capital Restructuring Grants

In early 2016, New York State awarded approximately $1.2 billion in capital restructuring grants to hospitals and health systems throughout the state. The grant awards were transformational for WMCH ealth and our PPS, with the infusion of $88.8 million for HealthAlliance’s Kingston campus and $24.5 million toward the development of a robust medical village at BonSecours’ Port Jervis campus.

Creating a Medical Village

The $88.8 million will allow HealthAlliance to consolidate its two Kingston hospitals to one campus and repurpose the other into a Medical Village, where the delivery of healthcare will transform from focusing on intervention to prevention. This Medical Village will be a market-driven, “health and wellness” community center providing secondary and primary healthcare to patients in a unique and inspiring environment. At its heart are the community’s existing physicians, but the uniqueness lies in the alignment of a variety of related consumer services, including retail, health education, behavioral health, rehabilitation services, healthy eating, simulation center and other related conveniences.

HealthAlliance Joins WMCH ealth Network

The Westchester Medical Center Health Network welcomed HealthAlliance to the network in Spring.

With a planned renovation and expansion, HealthAlliance’s Mary’s Avenue Campus will become one of the north east’s most advanced community hospitals. It will provide exceptional surgical, diagnostic and therapeutic services through the use of advanced medical technologies while continuing to emphasize patient comfort, safety, efficiency and quality of care.

Westchester Medical Center Health Network and Royal Philips Partner

The Westchester Medical Center Health Network and Royal Philips (NYSE: PHG, AEX:PHIA) announced a multi-year, USD 500 million partnership to transform and improve healthcare in the Hudson Valley. The WMCH ealth – Philips team will work to optimize medical technology deployment and IT integration into a unified platform that will enhance the PPS’ anchor institution’s operations. With early and ongoing access to the latest Philips innovations in health technology, WMCH ealth will be able to maximize the effectiveness of its participation in the DSRIP program. Philips will provide WMCH ealth with a range of clinical and business consulting services, as well as advanced medical technologies such as imaging systems, patient monitoring, telehealth and clinical informatics solutions.

WMCH ealth PPS Teams with Healthify to Impact Social Determinants of Health

The PPS has successfully launched Healthify, an online tool that allows referral tracking for patients, clients and their families in need of community resources, social services, and government benefits. Five network organizations consisting of a hospital, mental health association, and three local governmental units (Departments of Health) in the Hudson Valley region will utilize the tool. Access and training to the online tool will be made available to staff at these organizations and two community based providers in the near future. Network partners will pilot Healthify based on the following criteria: (1) partnership status in the PPS, (2) priority neighborhoods identified in our community needs assessment, (3) volume of clients/patients served annually, (4) service type. Upon completion of the pilot program, the PPS will evaluate Healthify’s effectiveness in addressing local disparities and improving patient health outcomes in the foreseeable future.
Value Based Payment Reform

While DSRIP is expected to transform the way health care services are delivered to residents in communities throughout New York State, there are key elements that will determine long-term success of the investments in the Medicaid waiver. The State has outlined specific regulatory and financial incentives that networks (such as WMCHealth PPS) will be able to reap upon meeting pre-set goals and requirements to establish cost-efficient integrated systems that deliver the highest quality patient-centered healthcare outcomes. In sum, this defines value-based payment reform. The old formula of fee-for-service, volume-based payments, limited community-based involvement in health-related social needs and uncoordinated care-management will soon be in the distant past.

WMCHealth PPS project management office will help network partners address the following challenges:

• How to measure and demonstrate value to other providers and your patients/clients
• How to define or consider appropriate outcome measures for the services you provide
• How to evaluate the ability of internal systems or EHRs to support the transition to VBP

Managed Care Organizations (MCOs) and Value-based Payment Contractors will create VPB payments around:

• Total care for general population
• Integrated primary care
• Selected care bundles around specific chronic conditions
• Special needs sub-populations

To meet requirements of value-based payment reform, WMCHealth PPS’s project management office will work with partners to ensure:

• Electronic Health Records (EHR) and other data sharing resources among partners are compatible with the RHIO and SHI-NY
• Robust governance, financial reporting, ongoing analysis of risk, and assessment of the true costs of care delivery
• Value-based incentive payment arrangements meaningfully address social and economic determinants of health
• Ongoing improvement in the value of services delivered to increase premiums and returns
• Improved quality of care among Medicaid members allowing further reinvestment into the delivery system

GOAL
Improve capacity of community-based providers; identify strengths, costs of services, target populations; strategies to successfully participate in evolving healthcare environment.

CHALLENGE
Connecting medical neighborhoods to communities and care delivery network.

GUIDANCE
CMS Quality Strategy, NYS-DOH Value-Based Payment Roadmap

SOLUTION
100% Collaboration across network
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), originally comprised of the three regional PPS’ (WMCH Health, Montefiore Hudson Valley Collaborative and Refuah Community Health Collaborative) and representatives from more than 20 organizations and advocates, work together on DSRIP Domain 4; population health projects—such as Tobacco Cessation and Cancer Screening.

The council met frequently throughout DSRIP Year 1 and has grown 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 substance abuse prevention and early intervention organization Student Assistance Services Corporation (SASCorp) based in Westchester County, to design campaign resources geared towards the high school population and their parents and guardians.

The campaign focused on anti-vaping, where studies suggest that influencing teens to stay away from vaping reduces the likelihood they will smoke cigarettes later on.
Among school-age users, e-cigs, hookah sticks and vaping are now bigger business than the tobacco industry. 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. The more teens smoke, the more they crave... leading to nicotine addiction. Talk to your teen about not vaping, not smoking e-cigs and not using hookah. For more information, go to www.hrdphc.org

You need help? When your kid tells you...

...don’t worry. It’s safe...

...worry!

Mom, it’s OK because...

...it’s not like a cigarette.

Oh, yes it is.

Mom, it’s OK because...

...it’s not like a cigarette.

Oh, yes it is.

THIS IS THE NICOTINE IN YOUR VAPE.
IT DOESN’T JUST LOOK LIKE HANDCUFFS.

It is handcuffs. Nicotine is an addiction. The more you vape, the more you crave. The more you crave, the more you vape. And while it isn’t tobacco, your lungs aren’t exactly breathing easy. They want you to suck in fresh air.


Learn more at www.hrdphc.org

Phony

You think you’re getting the full smoking experience without the lung cancer. What you’re really getting is a nicotine addiction. The more you smoke, the more you crave. The more you crave, the more you smoke. Why do you think they call it chain smoking?


Blow them all off.

Learn more at www.hrdphc.org

The Council with guidance from SASCorp developed 11 posters with anti-smoking and anti-vaping messages geared towards its target audience and devised a distribution plan to deliver over 2,000 finished posters to schools throughout the region. Visit www.hrdphc.org to learn more.

HRDPHC Starts Laying Groundwork for DSRIP Project 4.b.ii Cancer Screening Advocacy in the Region

The Partner Engagement Sub-Committee of the Hudson Region DSRIP Public Health Council (HRDPHC) has begun a cancer screening initiative with the three Hudson Valley PPSs (WMCH, Montefiore Hudson Valley Collaborative, Refuah Community Health Collaborative). The committee has adopted the New York State Prevention Agenda’s cancer screen rates as its benchmark. To improve on these cancer screening rates the committee will be trained on the Plan-Do-Study-Act (PDSA) process improvement cycle. Partner organizations have self-selected cancer screening rates they would like to improve and the committee will be supporting these organizations in their PDSA process improvement projects.
Bridging the Gap

Our PPS’ implementation of the 3.a.i-Integration of Primary Care and Behavioral Health Services project began in DY1 with the selection of committee members representing a variety of organizations, agencies and practices across our network.

The committee reviewed and recommended processes and protocols for the co-location of behavioral health services within primary care settings — which ensures that clients and patients our PPS serves have access to and receive appropriate services.

Project implementation also includes identifying evidence-based practices and standards, screening tools, gaps in services and resource needs that must be addressed in order to meaningfully integrate behavioral health services across our DSRIP projects.

The chart below illustrates how behavioral health will integrate with each of our DSRIP projects:

<table>
<thead>
<tr>
<th>Project Area</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.a.i: Create Integrated Delivery</td>
<td>Integrated delivery system will build analytical and care management infrastructure for population health management</td>
</tr>
<tr>
<td>2.a.ii: Health Home At-Risk</td>
<td>Integrated care plans will allow behavioral health and primary care to address medical concerns specific to each patient</td>
</tr>
<tr>
<td>2.a.iv: Medical Village</td>
<td>Co-located medical, behavioral and social services will improve access to health and wellness resources</td>
</tr>
<tr>
<td>2.b.iv: Hospital Care Transitions</td>
<td>Evidence-based medication reconciliation and improved communication to reduce re-admissions following BH discharges</td>
</tr>
<tr>
<td>2.d.i: Patient Activation-</td>
<td>Connect patients to regular source of care, options for insurance coverage and links to social services</td>
</tr>
<tr>
<td>3.a.i: BH/PC Integration</td>
<td>BH services at primary care site to include warm handoff of patients who screen positive or need BH services</td>
</tr>
<tr>
<td>3.a.ii: BH Crisis</td>
<td>Improve BH crisis stabilization services throughout the PPS coverage area</td>
</tr>
<tr>
<td>3.c.i: Diabetes.</td>
<td>Employ evidence-based protocols to manage BH medications that can impact diabetes</td>
</tr>
<tr>
<td>3.d.iii: Asthma</td>
<td>Train BH and health home staff on asthma medication management to reduce anxiety related ED visits</td>
</tr>
<tr>
<td>4.b.i: Tobacco Cessation.</td>
<td>Train BH and primary care staff on tactics to promote tobacco cessation among BH population</td>
</tr>
<tr>
<td>4.b.ii: Cancer Screening</td>
<td>Population health management tools will help patients, families, BH and primary care providers to improve preventive care measures</td>
</tr>
</tbody>
</table>

INTEGRATING BEHAVIORAL HEALTH & PHYSICAL HEALTH

70% of physician visits have a behavioral health component.

44% of adults and less than 20% of children and adolescents with diagnosable mental health problems receive needed treatment.

70% of adults with behavioral health issues have 1 or more physical health issues.

Voices of the Network

Partnerships, Accomplishments, Achievements, Care Delivery Improvements, Process Improvements, Collaboration and Participation

We asked network providers to share accomplishments throughout DSRIP Year 1 that will impact the transformation of care in the region.

**A&T Healthcare**

In March 2015, A&T Healthcare, LLC began a partnership with WTBQ AM radio to broadcast a weekly radio show called “Health Matters.” The purpose of this endeavor was to reach out to the local communities to deliver information related to keeping and staying healthy and how to access services for those needing assistance in the community. Some of the topics that have been covered are: Caregiver Support/Resources, Medication Safety, Hospice Care and Healthy Eating.

**Always There Home Care**

Based on our clinicians’ recommendations, we have revised our medication reconciliation printout to now list the patients’ medications, their interactions, and dosages in an easy-to-read format.

We have also supplied all clinicians with an up-to-date clinician’s resource guide specific to our area of coverage, with clinical helps, documentation notes, and hundreds of resources listed for nurses and clinicians alike.

**Boston Children’s Health Physicians**

(formerly Children’s & Women’s Physicians of Westchester)

CWPW has contributed to the overall guidance and leadership of the PPS, through policy and procedure development aimed at ensuring success and through active participation as leaders in the organization. Dr. Gewitz, our Vice President, serves on the Executive Committee of the PPS and Gerard Villucci, our CEO, serves on the Finance Committee of the PPS. Further, our Chief of Pulmonology, Dr. Allen Dozor, serves as the Chairman of the Asthma Project Advisory Quality Committee which has already made great strides towards meeting our shared goal of improving the care of patients with asthma in our region.

**Cabrini of Westchester**

Cabrini of Westchester developed a Pulmonary Rehabilitation Program in Response to Project 2.b.iv (Reducing 30 day hospital readmissions).

As a result of conversations with referring hospitals, Cabrini of Westchester learned that patients with chronic lung disease represented a large portion of hospital readmissions. Seeking to be a good partner to area hospitals and to fill an unmet patient need, Cabrini of Westchester developed a Pulmonary Rehabilitation Program in 2015. The program serves as a step down program to area hospitals after discharge and upon completion of the program there is a warm hand off to Cabrini’s Certified Home Health Agency who follows the same pulmonary protocols in the community setting. To date, both the Pulmonary Short Term Rehabilitation Program and the Pulmonary Home Care Program have been very successful at reducing 30 day re-hospitalizations.

**Cardinal McCloskey Community Services (CMCS)**

**Applied Behavior Analysis (ABA) for Individuals with Developmental Disabilities**

We opened the first integrated adult residential and day programs in NYS that uses an Applied Behavior Analysis (ABA) model and is the only agency in Westchester County that uses ABA for adults as our core clinical intervention on a 24-hour basis. Outcomes achieved by CMCS’s ABA program include decreases in medication regimes, fewer physical restraint interventions, improved socialization skills and higher rates and a broader scope of community integration. In addition, we have had no psychiatric hospitalizations since we launched the ABA program, a significant outcome considering the profound disabilities of many of the individuals in
Cornerstone Family Healthcare (CFH)

Cornerstone Family Healthcare (CFH) had an exciting DSRIP Year 1. For instance, CFH hired an RN Care Transitions Case Manager to work in our local hospital, providing case management to admitted patients at risk for readmission. Cornerstone also hired an RD nutritionist to provide support to our patients in achieving their health goals. Improvements were made in clinical practices such as using scores on the Patient Activation Measure to better engage patients in care, increasing use of asthma action plans, care planning for higher risk patients and dedicating a Care Coordinator to assist and link patients to services. Cornerstone also secured a number of grants to improve care such as for increased substance abuse treatment capacity, enhanced Behavioral Health and Care Management departments, implementation of a PrEP program to combat HIV in our communities, and CRFP resources to expand Urgent Care.

Family Services NY

Family Services Sexual Assault Response Team (SART) mission is to provide a victim-centered, trauma-informed response to sexual violence in our community. With funding from New York State Division of Criminal Justice Service (DCJS), the SART was able to send six individuals across disciplines to a three day conference held by End Violence Against Women International in Washington, D.C., on ending sexual violence. The team heard from experts from diverse fields to educate our local SART on innovative best practices from trauma informed response to sexual violence.
HealthAlliance Hospital

Care Transition
HealthAlliance has diligently worked to streamline and enhance patient care transitions to achieve better patient outcomes. These initiatives include a pilot program utilizing Cipher’s VOICE for post-discharge follow-up phone calls. We are poised to begin conducting robotic PAM surveys and care management/navigation processes via Cipher’s VIEW application and ready to pilot ECHO, allowing recording of salient points relative to discharge instructions so that patients/caregivers can listen when home.

Diabetes Program
In alliance with the Care Transition Program, the HealthAlliance Center for Diabetes provides clear communication to the receiving provider and/or facility to promote continuity of care for the diabetic patient. A discharge diabetes tab in the patient’s EMR has been created to communicate to the receiving provider/facility the patient’s level of diabetes self-management needs, HbA1c for glycemic control, basic diabetes education received during hospitalization and discharge appointments. It is the goal of the Diabetes Center to have an A1C recorded for each patient that travels through the HealthAlliance system, as well as continuing to expand its education and outreach program.

Institute for Family Health

In response to project 3aii Behavioral Health and Community Stabilization, the Institute for Family Health initiated and implemented a Behavioral Health Stabilization Program in Ulster County. The Institute coordinated with local hospitals and the mobile crisis team in order to ensure individuals in need of stabilization had access to services and appropriate levels of care. Care management, substance abuse and case management services were embedded in the program for a comprehensive response and increased ability to address social determinants exacerbating a behavioral health crisis. We expanded the hours at the Institute Center for Counseling at Kingston in order to provide access to behavioral health care 365 days a year for individuals in need of stabilization. The Institute has provided stabilization services to 217 patients who have made 227 visits from August 2015 through March 2016. The stabilization services offer comprehensive services to the residents of Ulster County, avoiding emergency room utilization, decreasing hospitalizations and providing continuity to patients in need of care.

Keon Center CARC

The Keon Center CARC Inc. is pleased to announce that it has received a grant from The Rotary Club of Peekskill for an AED (adult external defibrillator). The unit will be mounted in our main room and will be accessible to all programs in the event of an emergency. This unit will provide us with the ability to respond a sudden cardiac arrest quickly while 911 is called. The center provides a variety of services to developmentally disabled adults.

Marquis Home Care (formerly All Pro Home & Health Care Services)

Marquis Home Care (formerly All Pro Home & Health Care Services) has one main achievement for year 1. We have built and created our own unique EMR system which integrates data and information on all levels across not only our company but numerous MLTC’s, CHHA’s, therapy providers etc. We are now virtually paperless and all clinical documentation, billing/claims submissions etc. are now done electronically through our new state of the art EMR. We are no longer tied down with paper and snail mail and can communicate with agencies, vendors, patients etc. in real time.
MHA of Orange County

The final CC/HL document successfully expressed that health disparities disproportionately affect groups of people that have systemically experienced greater social and economic obstacles. The decision to use HEALTHFY, which addresses social and economic determinants, will hopefully build an evidence base towards having tools

“As an active PPS Partner, it was validating and affirming to be able to articulate the notion that imbalanced distribution of social conditions and their health consequences are not natural or inevitable. They are the consequences of choices that we, as people have made. And we can make those choices differently. It is my hope that I was able to be a voice in the group that heightened our sensitivity to the deeper realities faced by the individuals we are attempting to serve, therefore developing DSRIP projects that are meaningful and relevant.”

“We have experienced increased community engagement and our strategy is clear. In the long run, the success of any health system is more likely if the fundamentals include the best possible foundation of primary care, close integration of medical and social support services, and community-based providers operating in a more unified manner.”

Mount Vernon Neighborhood Health Center

During 2015, the DSRIP funding that was received allowed us to install a new phone system. This resulted in improvement in response time in addressing patients’ needs. In addition the in-house lab interface was initiated and is currently in progress.

Behavioral Health and Primary Care was initiated and as a result of DSRIP participation, we further developed the program to meet the requirements.

In regards to HEDIS compliance for UnitedHealthcare Medicare Advantage members, we exceeded the minimum requirements with a score of 85%.

Open Door Family Medical Center

Open Door Family Medical Center fully embraces the goals of WMC’s DSRIP PPS and is actively engaged in high value primary care as a Level 3 PCMH. Our approach to population health is advancing thanks to robust care management which we perform at the point of care and centrally for patients across our system. This supports patients with chronic diseases including asthma and diabetes and patients in need of preventive screenings. We also utilize an integrated behavioral health care model which expands access to behavioral health care services in the primary care setting. We want to be an important primary care and community resource as the delivery system is transformed and we are happy to partner collaboratively with the many participants in the WMC PPS.

Planned Parenthood Mid-Hudson Valley

As many of you know 2.d.i Patient Activation is one of Westchester Medical Center’s DSRIP projects and in the early fall WMCH made an effort to encouraged participation in offering Medicaid and the uninsured the Patient Activation Measure (PAM). PAM is a tool which allows the provider to assess the patient’s knowledge, skills, and confidence to manage one’s health. Since early December, the PAM which consists of 13 statements has been provided by our Health Center Assistants in our five centers and by educators out in the communities.
In addition, PPMHV has many Community-based provider (CBP) collaborations and is facilitating WMCHealth PPS’ outreach into the four counties where PPMHV has centers – Dutchess, Orange, Sullivan and Ulster. It is clear that knowing a patient’s score can assist the provider or case manager in developing the course of action needed to ensure a medication regime is being followed or healthy decisions are being made. By obtaining knowledge of our patient’s health awareness, we will improve outcomes! Isn’t this what DSRIP is all about?

Putnam Family & Community Services (PFCS)

Putnam Family & Community Services (PFCS) was able to procure a HIT grant to use for access to the RHIO/QE, HealthLinkNY. The initial training with staff has begun to allow us to access other agencies’ clients’ records, and the grant monies will allow us to connect to the RHIO in order to share PFCS’ records. We are also in the process of choosing a new EHR that will help us to better gather outcomes needed for many DSRIP initiatives and managed care. Lastly, PFCS purchased RELIAS Training which has allowed all staff greater access to free training to strengthen our skills and knowledge and prepare us for this evolving new world.

Recco Home Care

In DSRIP Year 1, the agency successfully participated in surveys to provide input regarding our Medicaid clients in Westchester County. The agency has attended meetings to share information and to gain insight into our role in the DSRIP program. We look forward to further participation.

Rockland County Department of Health

During DY1, the Rockland County Department of Health has had a presence at many various DSRIP related meetings and calls. The main achievement thus far would be working towards instituting Patient Activation Surveys (PAMs) at our clinics. A survey training was held at our facility by WMCHealth PPS project management office staff. We have begun the IT process of contributing our patient data to the RHIO through HealthLinkNY, and are expected to have our EMR fully integrated to the system by mid-summer.

Rockland County Department of Mental Health

One of the major DSRIP initiatives is the integration of behavioral health care and physical health care. Rockland County demonstrated this by awarding a contract to Rockland Paramedic Services to provide mobile crisis services. This was a unique endeavor in that the Mobile Crisis Team utilizes staff that have expertise and experience in providing care to individuals with both behavioral health issues and physical health issues who are in crisis.

As a result of the Department’s involvement with the DSRIP PPS, the need for services to become more accessible as well as culturally compatible with the community became apparent. We established two satellite mental health clinics staffed by a Spanish speaking social worker, located in underserved areas, one of which is a middle school, thus providing easier access to culturally competent mental health treatment services.
Rockland Paramedic Services

Rockland Paramedic Services, Inc. implemented a “Behavioral Health Response Team” or mobile mental health team which has operated for a full year as of April, 2016. The team has been widely accepted by the mental health community and the public. The team has far exceeded what was anticipated and has contributed to the reduction of ED visits and unnecessary behavioral health hospitalizations. We are actively involved in DSRIP project 3.a.ii Behavioral Health Crisis Stabilization. This dynamic team consists of mental health professionals and EMS professionals and is working quite well.

Search for Change (Mobile Outreach Team)

Search for Change, Inc. recently developed a Mobile Outreach Team (MOT) with a grant from the Westchester County Department of Community Mental Health. This enabled the agency to enhance and diversify its service capacity by delivering essential outreach and engagement activities to adults with significant behavioral health concerns. During its first year of operation the MOT has achieved successful outcomes that are closely aligned with the overall goals of DSRIP:

- Savings of $114,478 through reduced use of inpatient hospital services
- Savings of $1,265 through reduced use of emergency department services

Somers Manor Rehabilitation and Nursing Center

Somers Manor Rehabilitation and Nursing Center has expanded its Post-Acute beds from 39 to 101. In tandem with this expansion, we have relocated our Rehabilitation Services to be contiguous to that of the short term beds. This allowed us to complete important renovation of the Suite and acquisition of new equipment to serve the physical, occupational, and speech/language services. Therapy needs for our hospital partners. Furthermore, we have implemented a robust electronic health record which allows for enhanced communication within the continuum of care.

VCS Inc.

We were fortunate that as a new provider we could begin our chart and scheduling functions electronically. We collaborate with all of the local providers re: referrals co-management and resource sharing.

In terms of crisis management, we are very lucky to have a mobile crisis unit that came on board just as we were opening our clinic. This has allowed us to manage crisis collaboratively. We utilize them and they refer patients to us.

Patient engagement and retention is quite good for a new clinic. We average 70% for both measures. Our EHR provides a number of reports to track these and others such as productivity, patient groups by insurance, claims paid, rejections etc. The advantage of having our billing function as part of our clinical functions allows us to track fiscal measures and issues.
“Our PPS Governance structure is the backbone of our DSRIP accountability and will have significant, substantive overlap with all DSRIP work streams. Representatives from our PPS partner network will be called on to participate in a wide range of committees and workgroups that will have responsibility for protocols and policy development.”

**PROJECT COMMITTEES + WORKGROUPS**

- Asthma Project Advisory Quality Committee
- Behavioral Health Crisis Project Advisory Quality Sub-Committee
- Behavioral Health Integration Sub Committee
- Behavioral Health Project Advisory Quality Committee
- Care Transitions Project Advisory Quality Committee
- Community Engagement Quality Advisory Committee
- Diabetes Project Advisory Quality Committee
- Extended Care Management Project Advisory Quality Committee
- Financial Sustainability Workgroup
- Interoperability Workgroup
- Medical Village Project Advisory Quality Committee
- Substance Use and Rehabilitation Workgroup
- Value-Based Payment Task Force
- Primary Care Workgroup

**STANDING COMMITTEES**

- Executive Committee
- Finance Committee
- Quality Steering Committee
- Workforce Committee
- Nominating Committee
- PAC Committee
- IT Committee

**CROSS-PPS COMMITTEES + WORKGROUPS**

- Hudson Region DSRIP Public Health Council (HRD-PHC)
- Hudson Region DSRIP Behavioral Health Crisis Leadership Group
- Hudson Valley Health Officers Network
- New York Diabetes Coalition
- Hudson Region DSRIP Clinical Council (HRD-CC)
2.a.i INTEGRATED DELIVERY SYSTEM
Create Integrated Delivery System focused on evidence-based medicine

2.a.i.i.i HEALTH HOME FOR AT-RISK POPULATIONS
Improve access to high quality primary care and support for higher risk patients

2.a.i.v CREATE MEDICAL VILLAGE
Create Medical Village-using existing hospital infrastructure

2.b.i.v POST HOSPITAL CARE TRANSITIONS
Post-hospital care transitions to reduce 30-day readmissions

2.d.i PATIENT ACTIVATION
Integrate uninsured and low or non-utilizing Medicaid populations into community-based care

3.a.i BEHAVIORAL HEALTH PRIMARY CARE INTEGRATION
Integration of primary care and behavioral health services

3.a.i.i.i BEHAVIORAL HEALTH COMMUNITY CRISIS STABILIZATION
Behavioral health community-crisis stabilization services

3.c.i DIABETES MANAGEMENT
Evidence-based disease management for high-risk populations

3.d.iii ASTHMA CARE MANAGEMENT
Implement evidence-based guidelines for asthma management

4.b.i TOBACCO CESSATION
Promote tobacco use cessation, especially among low socioeconomic populations and those with poor mental health

4.b.ii CANCER SCREENING
Increase access to high-quality disease preventive care and management in clinical and community settings
The following work streams will govern implementation during DSRIP Year 1 – 5 and beyond for the WMCH Health PPS network.

**GOVERNANCE**
Encompasses WMCH Health leadership, Executive, Clinical Quality, Workforce, IT Committees — as well a range of DSRIP projects and work stream-specific sub-committees responsible for oversight and accountability of PPS performance.

**FINANCIAL SUSTAINABILITY**
Finance organization and reporting structure, financial health, current assessment of PPS partners, compliance, value-based payment strategy, arrangements and payments across the network are all important components of the financial stability goals of DSRIP transformation as we move towards value-based reimbursement.

**CULTURAL COMPETENCE & HEALTH LITERACY**
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 communities.

**WORKFORCE**
The WMCH Health PPS will plan and support relevant and targeted training and workforce development to equip providers and the workforce with tools to achieve care transformation that is patient focused, supports excellence and fosters a culture of continuous learning and improvement.

**IT & SYSTEMS**
Integral to the success of all projects and long term sustainability of an integrated delivery system, WMCH Health PPS and its partners will rely heavily on information systems to capture, manage, share and analyze data in an efficient, secure manner.

**PERFORMANCE REPORTING**
WMCH Health will create a plan for the development and implementation of platforms to share administrative, milestone and project information with network partners during and beyond the DSRIP period. These platforms will also support the establishment and tracking of data sharing agreements.

**PROVIDER ENGAGEMENT**
WMCH Health PPS will deploy a combination of communication and project management tools to document care provider deliverables, tasks resources, timing, dependencies and active monitoring to meet goals and milestones in accordance with quarterly network reporting to the DOH.

**POPULATION HEALTH MANAGEMENT**
Ongoing assessment of clinical and non-clinical data will inform the WMCH Health PPS network on actionable items aimed at achieving improved population health. We will accomplish this through patient/client and community engagement, provider involvement and partnerships with key stakeholders and community-based providers.

**CLINICAL INTEGRATION**
WMCH Health PPS, working with its network partners will develop a clinical integration strategy encompassing all provider types to achieve coordinated care and achieve DSRIP project goals.

**BUDGET & FUNDS FLOW**
Distribution of funds will be based on contractual understandings and agreements between the WMCH Health PPS and its network partners. Performance of the PPS and its partners and their achievement of DSRIP milestones will align with funds flow.
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