Westchester Medical Center PPS

Hudson Valley Health Regional Officers Network Meeting
March 6, 2015
<table>
<thead>
<tr>
<th>Discussion Topic</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome &amp; Status Update</td>
<td>12:00 – 12:10 pm</td>
</tr>
<tr>
<td>Implementation Plan Overview</td>
<td>12:10 – 12:35 pm</td>
</tr>
<tr>
<td>• Four Key Elements</td>
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<tr>
<td>• Behavioral Health Project plans</td>
<td></td>
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<tr>
<td>• Building and Facilitating Relationships Through IT</td>
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<tr>
<td>One Region, One CNA: Survey Results</td>
<td>12:35 – 12:45 pm</td>
</tr>
<tr>
<td>Opportunities to Participate</td>
<td>12:45 – 1:00 pm</td>
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<tr>
<td>• Project 11</td>
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<tr>
<td>• Tobacco Cessation</td>
<td></td>
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<tr>
<td>Questions</td>
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</tbody>
</table>
WHERE WE ARE
OUR DSRIP ACTIVITIES TO-DATE

PREFACE

The Westchester Medical Center-led PPS network has identified six goals that align with New York State’s DSRIP program:

1. Create an integrated delivery system
2. Decrease hospitalizations and ED visits
3. Transform behavioral and physical care delivery services
4. Establish robust information exchange between providers
5. Improve health of Medicaid and uninsured populations
6. Move to a value-based contracting model.

OUR PPS

Partners in our network will collaborate on DSRIP projects to transform healthcare delivery services in the Hudson Valley region.

COMMUNITY NEEDS ASSESSMENT (CNA)

Identified several specific conditions and community needs that informed our DSRIP project selection. Nine zip codes in the region have been designated Medically Underserved Areas (MUAs).

DSRIP PROJECTS

Our PPS has identified the eleven DSRIP projects we will engage in.

PAC + WORKGROUPS

Project Advisory Committee (PAC) and Workgroups provides guidance, governance, counsel, leadership on DSRIP Projects and CNA.

PROJECT HUBS

Hubs will allow us to centralize services geographically; allows for efficient assessment of performance.

PROJECT APPLICATION

We submitted our application to NYS in December 2014.

IMPLEMENTATION PLAN

We will submit our DSRIP Project Implementation plan in April 2015.

DSRIP YEAR 1

April 2015: DSRIP Year 1 begins.

Westchester Medical Center Performing Provider System (PPS) | www.crhi-ny.org
Status: Where We Are

November 14
- Updated Project Plan Application released
- Project Plan Application Prototype released
- Capital Restructuring Financing application released (delayed)
- 3rd round of initial attribution results published

December 22
- Project Plan Application due
- Capital Restructuring Financing Program Application due

February 20

November 20
- Financial Stability Test results made available

November 24
- Scope and Speed of Application template released
- Leads to submit final partner lists in Network Tool

March 1
- Draft Implementation Plan Due

March 2015

April 2015
- Implementation Plan Due

April 1
- DSRIP Year 1 begins

DSRIP Year 1 begins

DSRIP Year 1 begins

DSRIP Year 1 begins
Four Key Elements
Four Key Elements

- Governance
- Financial Sustainability
- Workforce
- Cultural Competency
Four Key Elements

Governance

How our PPS will advance from a group of affiliated providers to a high performing IDS will be influenced by our governance process. We recognize the need for both central governance, clinical and administrative, to insure standards and efficiency and also the need for regional (Hub) governance to ensure local stakeholder input and decision-making.
Four Key Elements

Financial Stability

Success for our PPS beyond service delivery integration requires the ability to implement financial practices that will ensure financial sustainability of the PPS.
Four Key Elements

Workforce

The primary DSRIP goal is a 25% reduction in avoidable hospital use, involving over 40,000 of us and our employees. Our success at transformation includes appropriately preparing our PPS workforce.
Four Key Elements

Cultural Competency

Our ability to develop solutions to overcome cultural and health literacy challenges is key to addressing healthcare disparities within our region. We will use our CNA to identify known challenges and priority groups and *continue to engage community members* as part of our process.
Project Plans
## WMC PPS Projects

<table>
<thead>
<tr>
<th>Project</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domain 2: Systems Transformation Projects</strong></td>
<td></td>
</tr>
<tr>
<td>2.a.i</td>
<td>Create an Integrated Delivery System Focused on Evidence-Based Medicine and Population Health Management</td>
</tr>
<tr>
<td>2.a.iii</td>
<td>Health Home At-Risk Intervention Program</td>
</tr>
<tr>
<td>2.a.iv</td>
<td>Create a Medical Village Using Existing Hospital Infrastructure</td>
</tr>
<tr>
<td>2.b.iv</td>
<td>Care Transitions Intervention Model to Reduce 30-day Readmissions for Chronic Health Conditions</td>
</tr>
<tr>
<td>2.d.i</td>
<td>Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care (Project 11)</td>
</tr>
<tr>
<td><strong>Domain 3: Clinical Improvement Projects</strong></td>
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</tr>
<tr>
<td>3.a.i</td>
<td>Integration of Primary Care and Behavioral Health Services</td>
</tr>
<tr>
<td>3.a.ii</td>
<td>Behavioral Health Community Crisis Stabilization Services</td>
</tr>
<tr>
<td>3.c.i</td>
<td>Implementation of Evidence-Based Strategies in the Community to Address Chronic Disease – Diabetes</td>
</tr>
<tr>
<td>3.d.iii</td>
<td>Implementation of Evidence-Based Guidelines for Asthma Management</td>
</tr>
<tr>
<td><strong>Domain 4: Population-Wide Prevention Projects</strong></td>
<td></td>
</tr>
<tr>
<td>4.b.i</td>
<td>Promote Tobacco Use Cessation, Especially Among Low SES Populations and Those with Poor Mental Health</td>
</tr>
<tr>
<td>4.b.ii</td>
<td>Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings - Cancer</td>
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</table>
### 3.a.i
Integration of Primary Care and Behavioral Health Services

<table>
<thead>
<tr>
<th>Total # providers committed</th>
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</thead>
<tbody>
<tr>
<td><strong>Primary Care Physicians</strong> 100</td>
</tr>
<tr>
<td><strong>Non-PCP Practitioners</strong> 100</td>
</tr>
<tr>
<td><strong>Clinics</strong> 25</td>
</tr>
<tr>
<td><strong>Behavioral Health</strong> 115</td>
</tr>
<tr>
<td><strong>Substance Abuse</strong> 11</td>
</tr>
<tr>
<td><strong>Community Based Organizations</strong> 20</td>
</tr>
<tr>
<td><strong>All Other</strong> 200</td>
</tr>
<tr>
<td><strong>All Committed Providers</strong> 571</td>
</tr>
</tbody>
</table>

**Domain 1 Requirements Completion Date:**
December 2017

**Project Requirements:**
(Model 1, BH services at primary care site)
- All practices meet NCQA Level 3 PCMH and/or APCM standards by the end of DY#3.
- Conduct preventive care screenings, including behavioral health screenings (PHQ-9, SBIRT) implemented for all patients to identify unmet needs.

**ACTIVATED PATIENTS:** Number of patients (age 12 and older) screened for mental health and substance use: (PHQ-9 / SBIRT)

**EXPECTED ACTIVELY ENGAGED PATIENTS:** 31,000/year

**Activated Patients by June 2015:** 2000
### Behavioral Health Community Crisis Stabilization Services

**Domain 1 Requirements Completion Date:**
December 2017

**Project Requirements (3 of 11):**
- Deploy mobile crisis team(s) to provide crisis stabilization services using evidence-based protocols developed by medical staff.
- Establish central triage service with agreements among participating psychiatrists, mental health, behavioral health, and substance abuse providers.
- Expand access to observation unit within hospital outpatient or at an off-campus crisis residence for stabilization monitoring services.

<table>
<thead>
<tr>
<th>Number of Crisis Intervention Programs meeting all project requirements</th>
<th>Total # providers committed</th>
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</thead>
<tbody>
<tr>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of Committed That Are Safety Net Providers*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Physicians</td>
</tr>
<tr>
<td>Non-PCP Practitioners</td>
</tr>
<tr>
<td>Hospitals</td>
</tr>
<tr>
<td>Clinics</td>
</tr>
<tr>
<td>Health Home / Care Management</td>
</tr>
<tr>
<td>Behavioral Health</td>
</tr>
<tr>
<td>Substance Abuse</td>
</tr>
<tr>
<td>All Other</td>
</tr>
</tbody>
</table>

**ACTIVATED PATIENTS:** Participating patients receiving crisis stabilization services from participating sites, as determined in the project requirements.

**EXPECTED ACTIVELY ENGAGED PATIENTS:** 3,150/year

**Activated Patients by June 2015:** 150
BH Regional PPS Collaboration

Meeting:
Integration of Primary Care and Behavioral Health
March 12, 2015
Useful NYSDOH website that includes links to Project Plan Applications and Independent Assessor PPS Project Scores as well as information on the Implementation Plan, Workforce and related webinars:

https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/providers_professionals.htm
Building and Facilitating Relationships Through IT
### Empire County Department of Health

<table>
<thead>
<tr>
<th>Account Name</th>
<th>Empire County Department of Health [View Hierarchy]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Account Owner</td>
<td>Helene Kosal [Change]</td>
</tr>
<tr>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>Alternate Org Name (aka)</td>
<td></td>
</tr>
<tr>
<td>Phone</td>
<td>(914) 555-1212</td>
</tr>
<tr>
<td>Parent Account</td>
<td></td>
</tr>
<tr>
<td>County</td>
<td>Duchess</td>
</tr>
<tr>
<td>Healthcare Provider</td>
<td>Yes</td>
</tr>
<tr>
<td>Service Type</td>
<td>Local Health Dept</td>
</tr>
<tr>
<td>Health Home Provider</td>
<td></td>
</tr>
</tbody>
</table>

**PCMH Recognition**

- PCMH Recog Year: [Not Eligible]
- EMR in Use: GCW
- RHIO Access Type: Bi Directional
- Safety Net: Yes
- WMC

**Website**

- http://www.empiredoh.gov

**Community Resource Type**

- Community Resource
Survey Results
ONE REGION, ONE CNA

AN EIGHT COUNTY COMMUNITY NEEDS ASSESSMENT (CNA) UNDERTAKEN IN COLLABORATION WITH: WESTCHESTER MEDICAL CENTER, MONTEFIORE MEDICAL CENTER, REFUAH HEALTH CENTER AND HEALTH ALLIANCE OF THE HUDSON VALLEY
CNA PROCESS and TIMELINE

Prior to Mid September 2014
* Prepared, translated, & finalized survey instruments; created public facing websites as platforms for data collection and communication
* Distributed survey through email and postal mail to DOH and PPS partners; carried out public awareness campaign
* Commenced data collection

Mid-September – December 2014
* Continued with data collection and entry
* Conducted quality assurances and data cleaning
* Performed preliminary data analyses for PPSs’ DSRIP applications

January 2015 – Present
* Completed data collection and entry
* Completed data cleaning and quality assurances
* Continue with data analyses and research findings dissemination activities
CNA – Demographics – Respondents Maps (N=4,952)
CNA - Demographics

Survey Respondents (Total N=4,952)
CNA Demographics (cont.)

Regional View - Race

- White, 68%
- Black, 18%
- Other, 11%
- Asian, 2%
- Native, 1%

Regional View - Demographics

- Hispanic: 79%
- Not Hispanic: 21%
- Male: 32%
- Female: 69%
- Medicaid*: 31%
- Medicare*: 16%
- Private: 40%
- Uninsured: 10%
- Other: 12%
- Unemployed: 50%
- Yes, FT: 33%
- Yes, PT: 17%
CNA Demographics (cont.)

Regional View - Age Groups:
- 18-24: 7%
- 25-34: 17%
- 35-44: 17%
- 45-54: 24%
- 55-64: 24%
- 65-74: 8%
- 75 and older: 3%

Regional View - Annual Household Income:
- Less than $10K: 22%
- $10K - $19K: 14%
- $20K - $29K: 9%
- $30K - $39K: 9%
- $40K - $49K: 6%
- $50K - $79K: 11%
- $75K and over: 29%
CNA – Overall Health/Mental Health

Regional View

<table>
<thead>
<tr>
<th>Category</th>
<th>Overall Health</th>
<th>Overall MH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>20%</td>
<td>32%</td>
</tr>
<tr>
<td>Very Good</td>
<td>32%</td>
<td>31%</td>
</tr>
<tr>
<td>Good</td>
<td>34%</td>
<td>26%</td>
</tr>
<tr>
<td>Fair</td>
<td>12%</td>
<td>9%</td>
</tr>
<tr>
<td>Poor</td>
<td>2%</td>
<td>2%</td>
</tr>
</tbody>
</table>
Top health issues in the community (out of 17):

- Cancers*
- Diabetes*¥
- Heart Diseases*
- Obesity
- Mental Health

The same issues appeared for each county

- *Top 3 leading causes of death in NYS, according to the NYS DOH Vital Statistics
- ¥One of the leading causes of death among minority populations
CNA – Health Services Access & Utilization

Access to Provider/Aware of ways to pay for healthcare (UI)

- Have a provider when sick
- UI, know how to get health care paid for

- Dutchess: 89%, 41%
- Orange: 91%, 54%
- Putnam: 88%, 15%
- Rockland: 88%, 29%
- Sullivan: 78%, 29%
- Ulster: 94%, 43%
- Westchester: 85%, 26%
- Regional: 87%, 32%
Regional View - Last Routine Health/Dental Check-up

- **Past year**: 76%
- **Past 2 years**: 14%
- **Past 5 years**: 4%
- **5 or more years**: 3%
- **Never**: 1%

DENTAL, 68%
~ 8% of respondents (n=361) never had or had not had a routine checkup in > 2 yrs. The same reasons were cited by those without a dental check-up (n=1,473)

Healthy (81%)

- High Cost (73%)
- Lack of Time (63%)
- Fear (29%)
Regional View - Went to the ED – Past Year

About 27% (n=1,221) of respondents went to the Emergency Department last year for care
CNA – Health Services Access & Utilization (cont.)

Self/Family Traveled Out of County for Health Services - Past Year, Regional - n=713

- Dutchess: 18%
- Orange: 18%
- Putnam: 21%
- Rockland: 18%
- Sullivan: 28%
- Ulster: 31%
- Westchester: 7%
- Regional: 16%
CNA – Health Services Access & Utilization (cont.)

Top Health Services to Leave County for Care (out of 9)

1. Specialty Care (41%)
2. Primary Care (22%)
3. Ob/Gyn. (21%)
4. Dental Care
5. Hospital Care
6. MH Care
CNA – Health Services Access & Utilization (cont.)

Regional View - Reasons to leave County for Care

- No provider in County, 21%
- Closer to work/home, 15%
- For better care, 64%
CNA Health Services Access & Utilization – Take Away Points

Even though the %s of those having access to a provider when needed were high, there were still challenges, especially among the UI.

Costs, time, fear, and the quality of care were some of the barriers for participants to access good primary and preventive care.

Some of these barriers were unique at the county level.

Cancers, diabetes, heart diseases, obesity, etc. were identified among the top community health issues, yet many respondents did not know where to get the basic preventive care for these conditions and fewer utilized these services in the past year.
CNA - Conclusions

This CNA was a successful endeavor made possible only by the contribution of all involved partners: government agencies, NGOs, CBOs, health care providers and consumers, and the general public living in 8 counties in the Hudson Valley region.

While there were a lot of positive health outcomes reported, there are also gaps and challenges to overcome in healthcare services access and utilization, especially among minority groups and the uninsured.

These challenges helped identify and support our project selections.

This CNA has been informative as a baseline snapshot. A follow-up region-wide CNA is recommended after the implementation of DSRIP to examine the changes and effectiveness over time. We will coordinate this with local CHNA and plans.

THANK YOU!!!
Opportunities to Participate

(We need your help!)
Participation Opportunities

• **WHAT’S YOUR PASSION?**
  • We are committed to being *a learning organization*!
  • We will be forming groups within our PPS and with the other PPSs in our region to discuss and share information about our projects. Look for announcements in our newsletter and on our website: [www.crhi-ny.org](http://www.crhi-ny.org)
  • We will be mixing it up on the MIX to share information within our groups.

JOIN THE MRT Innovation eXchange - MIX
[https://www.ny-mix.org/login](https://www.ny-mix.org/login)
The *Patient Activation Measure™ (PAM™)* survey assesses the knowledge, skills and confidence integral to managing one's own health and healthcare. With the ability to measure activation and uncover related insights into consumer self-management abilities, care support and education can be more effectively tailored to help individuals become better self managers.

SMOKING CESSATION UPDATE

- Recap of project design methodology
- Final project selections
- Next steps
- MIX tool
OVERVIEW OF PROJECT 4.B.I: SMOKING CESSATION DISCUSSIONS

Data considerations for project design

• Wide dispersion of smoking rates amongst counties, with Dutchess, Ulster, Orange and Sullivan having the highest rates
• Overall drivers include behavioral health needs and socioeconomic status, but relative importance varies across the region
• Only 17% of smokers using smoking cessation benefit (State target of 40%)

Model options

• **Media campaigns** with demonstrated effectiveness in driving outcomes
• **Increased provider use** of cessation tools
  – Automated reminders and quitline referrals
  – Dedicated staff for NRT monitoring
  – Directory of community-based resources
• **Advocacy** with local authorities
  – Promote more effective outdoor policies
  – Tobacco retail policies
WE LOOKED AT GEOGRAPHIC VARIABILITY

<table>
<thead>
<tr>
<th>Region</th>
<th>Smoking rate % of population</th>
<th>Relative burden of poverty and SMI % of highest rate in region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dutchess</td>
<td>18</td>
<td>Poverty 55, SMI burden 100, Relatively stronger focus on SMI population</td>
</tr>
<tr>
<td>Orange</td>
<td>20</td>
<td>Poverty 62, SMI burden 68</td>
</tr>
<tr>
<td>Putnam</td>
<td>13</td>
<td>Poverty 32, SMI burden 12</td>
</tr>
<tr>
<td>Rockland</td>
<td>10</td>
<td>Poverty 69, SMI burden 71</td>
</tr>
<tr>
<td>Sullivan</td>
<td>29</td>
<td>Poverty 71, SMI burden 100</td>
</tr>
<tr>
<td>Ulster</td>
<td>23</td>
<td>Poverty 62, SMI burden 72</td>
</tr>
<tr>
<td>Westchester</td>
<td>12</td>
<td>Poverty 53, SMI burden 74</td>
</tr>
</tbody>
</table>

Relative burden of poverty and SMI (% of highest rate in region):
- Poverty
- SMI burden

WE CONSIDERED THE USE OF HARD HITTING MEDIA

Hard hitting media campaigns generate sustained awareness

..and show results but not in all populations

Significantly higher recall for graphic and emotional advertisements

Questions for consideration
- How do we optimally target the campaign?
- What is the resource requirement and how do we leverage DOH?
- How should we manage adverse reactions to graphic advertisements?

Quit attempts
Percent of respondents

<table>
<thead>
<tr>
<th>Advertising dose</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>51</td>
<td>52</td>
<td>61</td>
</tr>
</tbody>
</table>

However, effect not seen in individuals with behavioral health needs

Source: NYS DOH; Nonnemaker, et al., PLOSONE (2014)
WE LANDED ON 8 CORE WORK STREAMS

• Adopt tobacco free outdoor policies
• Implement the **US Public Health Services Guidelines** for treating tobacco use
• Use **electronic medical records** to prompt providers to complete the 5As (Ask, Assess, Advise, Assist, and Arrange)
• Facilitate referrals to the NYS Smokers’ Quit line
• Increase Medicaid and other health plan **coverage of tobacco dependence treatment counseling and medications**
• Promote smoking cessation benefits among Medicaid providers
• Create **universal, consistent health insurance benefits for prescription and over the counter cessation medications**
• Promote **cessation counseling among all smokers**, including people with disabilities
EXAMPLE OF VARIABILITY IN SMOKING CESSATION COVERAGE ACROSS MEDICAID PLANS

<table>
<thead>
<tr>
<th>Plan</th>
<th>Bupropion SR</th>
<th>Varenicline</th>
<th>NRT Gum</th>
<th>NRT Patch</th>
<th>NRT Nasal Spray</th>
<th>NRT Inhaler</th>
<th>NRT Lozenge</th>
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<td>1 MetroPlus</td>
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<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
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<td>12 Neighborhood Health Providers</td>
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<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<td>13 Capital District Physicians Health p</td>
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<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>Y</td>
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<tr>
<td>14 Excellus BCBS Health/Premier Health</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>15 BCBS of WNY (includes HealthNow)</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>16 HudsonHealthPlan</td>
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<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<td>17 Independent Health</td>
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</tr>
<tr>
<td>18 MVP</td>
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<tr>
<td>19 Total Care</td>
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</tr>
</tbody>
</table>

Source: NY DoH DSRIP website, as of 9/29/2014
PARTICIPATION OPPORTUNITIES

• How can we best engage with you all on these efforts?

• Who else should we be dealing with?

• We will be mixing it up on the MIX to share information within our groups.

JOIN THE MRT Innovation eXchange - MIX
https://www.ny-mix.org/login
HRD - PHC Discussion Group

News

Medicine Given Even Before Smokers are Ready to Quit....

A study published in JAMA and reported on in the NYT found that anti-smoking pills were effective in helping people quit smoking even if they didn’t want to stop right away.

Recent contributions

Newburgh Council approves tobacco law - News - recordonline...

http://www.recordonline.com/article/20150112/News/150119785

CITY OF NEWBURGH – Newburgh’s City Council approved what may be the state’s toughest local licensing requirement for stores selling cigarettes, cigars, e-cigarettes and other tobacco and tobacco-related products on Monday. Beginning March 1,....

Link by Deborah Viola 1 day ago

Medicine Given Even Before Smokers are Ready to Quit....


News item, posted 1 day ago in this group

Tobacco Policy Center -New England Law School in Boston

http://tobaccopolicycenter.org

Link by Deborah Viola 1 day ago
Please send your questions or thoughts!

• Questions, comments, thoughts may be shared with us anytime by email: crhi@wcmc.com

• Please check our website for meeting updates and registration information: http://www.crhi-ny.org/
THANK YOU!


March 1
Draft Implementation Plan Due

April 1
Implementation Plan Due

April 1
DSRIP Year 1 begins
Spring AHEAD!

Set clocks ahead one hour before bed Saturday night

Source: fox6now.com
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