PRIMARY CARE PLAN: WMCHEALTH PPS

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About this document:

This document was developed in response to New York State Department of Health (NYS DOH) requirement for each PPS to submit a Primary Care Plan (PC Plan). Submitted in August 2016, it outlines WMCHealth PPS' plan to integrate and strengthen the Primary Care sector such that we ensure quality care for all our patients.

WMC Health | Performing Provider System (PPS)
Westchester Medical Center Health Network

INTRODUCTION

WMCHealth Performing Provider System (PPS) spans nearly 6,200 square miles across eight counties in the Hudson Valley region, including the counties of Westchester, Rockland, Putnam, Dutchess, Orange, Ulster, Delaware, and Sullivan. The PPS is anchored by WMCHealth network, and encompasses ten hospitals across the Hudson Valley region. The network of PPS partners includes more than 240 partner health care organizations and more than 2,500 area physicians; together they are engaged in system-wide transformation efforts to provide safety net healthcare for the entire population of the region, regardless of insurance status. As outlined in the WMCHealth PPS DSRIP Year 1 Report & Update, a sustainable safety net will:

- Ensure that clients and patients receive timely access to the health care and social services they need.
- Create a community based, functionally integrated delivery system supported by sound informational technology (IT), 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.

Given the population health needs across the Hudson Valley region, and the imperative set by New York State Department of Health (NYSDOH) to advance primary care, WMCHealth PPS outlines three separate but interrelated objectives in its Primary Care Plan:

(i) Expand access to primary care in high need communities through Medical Villages;

(ii) Enhance capacity of current primary care providers to deliver high quality, patient-centered care and prepare for Value Based Payments (VBP) through Patient Centered Medical Home (PCMH) transformation;

(iii) Link primary care to other providers and community resources through Medical Neighborhoods.

CURRENT PRIMARY CARE CAPACITY

Demographics & Community Need: Across the eight counties (Westchester, Rockland, Putnam, Dutchess, Orange, Ulster, Delaware, Sullivan), WMCHealth PPS spans densely populated urban areas, sparsely populated rural communities, and mid-size suburban commuter communities encompassing simultaneous pockets of great wealth and of poverty. While the majority of the population is White, the region has also seen marked increases in minority populations: Hispanic and Asian populations are the fastest growing minority populations, with 74% and 64% growth respectively, across the region since 2000. The city of Mount Vernon in Westchester County has the highest urban concentration of African American residents (60%) in New York. The median age for the region is roughly 42 years; however, the aging population (≥65 years of age) in the region is expected to increase by 28.5% by 2020, outpacing NYS's projected growth of 22.4%. Health literacy challenges are most prominent in communities where English is not the main language and is compounded when an individual is not literate in their native language. Providers in the area have noted typical challenges with cultural competency elements that present when the providers and staff do not demographically represent the target population, and/or when providers lack awareness of particular competencies needed for special needs populations that they serve.

Issues of access to quality primary care are demonstrated in the DSRIP Community Needs Assessment (CNA)[1] [1]conducted in December 2014, for the Hudson Valley region. Based on Medicaid claims data, we identified 9 "high priority" zip codes with higher emergency room visit rates, increased utilization of behavior-related services (alcohol use, substance use), and less preventive care (cholesterol testing). These zip codes are in areas of Dutchess County (Poughkeepsie), Orange County (Newburgh and Middletown), Rockland County (Spring Valley), Ulster County (Kingston), Westchester County (Mount Vernon, Yonkers, and New Rochelle, respectively).

Port Jervis in Orange County is geographically isolated and also demonstrates specific needs for expanded primary care services. According to 2009-2013 American Community Survey 5-Year Estimates, 12.4% of residents of the City of Port Jervis are uninsured, which exceeded the rates for New York State (11.1%) and Orange County (9.9%). Furthermore, 17.7% of Port Jervis residents live below the Federal Poverty Level, which also exceeds state and county averages (15.3% and 12.4% respectively).

The County Health Outcomes rankings (see Figure 1) highlight poorer health outcomes and/or fewer primary care physicians for the populations served in Delaware and Sullivan counties. In these areas Federally Qualified Health centers (FQHCs) across the eight counties have been designated by Health Resources Services Administration to fill a significant portion of the primary care needs. WMCHealth PPS collaborates with the following FQHC/HRSA providers to build primary care capacity. They include Community Medical and Dental, Cornerstone-formerly

[1] Westchester Medical Center DSRIP Community Needs Assessment. December 2014

Greater Hudson Valley Family Health Center, Institute for Family Health, Open Door Family Health Center, Middletown Community Health Center and Mount Vernon Neighborhood Health Center.

Figure 1. *County Rankings and other key factors within WMCHealth PPS (County Health Rankings for 2016)*

COUNTY	HEALTH OUTCOMES RANKINGS	POPULATION: PCPs	POPULATION: BH PROVIDERS	PREVENTABLE HOSPTIAL STAYS
WESTCHESTER	5th	710:1	300:1	49
ROCKLAND	3rd	1,060:1	420:1	48
PUTNAM	4TH	1,990:1	370:1	51
DUTCHESS	10TH	1,310:1	410:1	50
ULSTER	16TH	1,560:1	320:1	61
ORANGE	23RD	1,340:1	510:1	54
DELAWARE	42ND	2,460:1	950:1	72
SULLIVAN	61ST	2,320:1	700:1	55

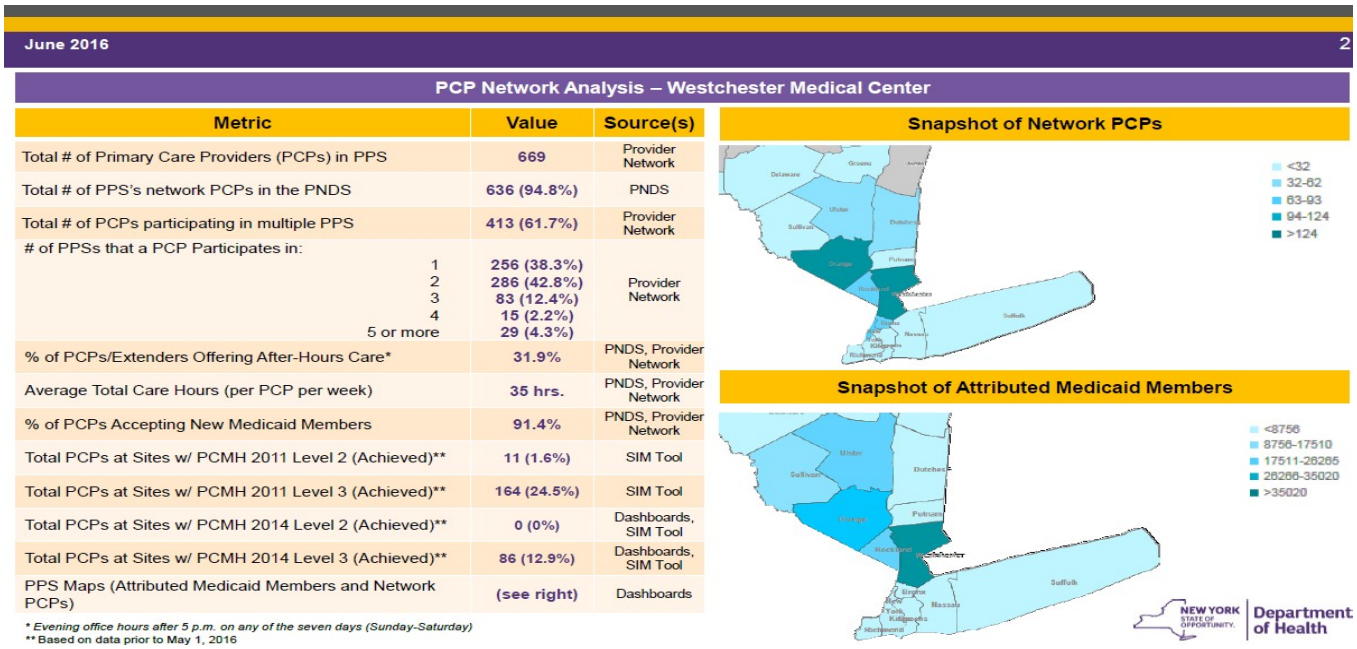
WMCHealthPPS is also building strong ties with both hospital affiliated and independent medical groups and practices both small and large, and is actively providing support for these independent practices to succeed in primary care transformation.

Primary Care Capacity and Performance: WMCHealth PPS engaged Healthcare Association of New York State (HANYS) to conduct a Current State Assessment (CSA) to understand the capacity, readiness and overall preparedness for transformation of affiliated Primary Care Providers (PCPs). The assessment identified opportunities for WMCHealth PPS to support Patient Centered Medical Home (PCMH) transformation for 45 primary care practices including many in high need areas.

WMCHealth PPS DSRIP project implementation for primary care includes working with the PPS supported transformation practices sites, along with 39% of the total 669 PCPs who have already achieved some level of National Committee for Quality Assurance's (NCQA) PCMH recognition (See Figure 2). As per the New York State Department of Health (NYS DOH) Network analysis, it is important to invest in assisting the remaining PCPs to achieve this recognition, towards meeting NYS end goal of advancing primary care in preparation for value-based

contracting.

Figure 2. *PCP Network Analysis: Westchester Medical Center (New York State Department of Health, June 2016)*



June 2016 2

PCP Network Analysis – Westchester Medical Center

Metric	Value	Source(s)
Total # of Primary Care Providers (PCPs) in PPS	669	Provider Network
Total # of PPS's network PCPs in the PNDS	636 (94.8%)	PNDS
Total # of PCPs participating in multiple PPS	413 (61.7%)	Provider Network
# of PPSs that a PCP Participates in:		
1	256 (38.3%)	Provider Network
2	286 (42.8%)	
3	83 (12.4%)	
4	15 (2.2%)	
5 or more	29 (4.3%)	
% of PCPs/Extenders Offering After-Hours Care*	31.9%	PNDS, Provider Network
Average Total Care Hours (per PCP per week)	35 hrs.	PNDS, Provider Network
% of PCPs Accepting New Medicaid Members	91.4%	PNDS, Provider Network
Total PCPs at Sites w/ PCMH 2011 Level 2 (Achieved)**	11 (1.6%)	SIM Tool
Total PCPs at Sites w/ PCMH 2011 Level 3 (Achieved)**	164 (24.5%)	SIM Tool
Total PCPs at Sites w/ PCMH 2014 Level 2 (Achieved)**	0 (0%)	Dashboards, SIM Tool
Total PCPs at Sites w/ PCMH 2014 Level 3 (Achieved)**	86 (12.9%)	Dashboards, SIM Tool
PPS Maps (Attributed Medicaid Members and Network PCPs)	(see right)	Dashboards

** Evening office hours after 5 p.m. on any of the seven days (Sunday-Saturday)*
*** Based on data prior to May 1, 2016*

The next step in addressing the primary care capacity within the PPS network was to engage a transformation agent to assist these 45 primary care practices in their PCMH transformation process. WMCHealth PPS identified an experienced consulting firm, Taconic Professional Resources (Taconic Pro), with a proven record of success in large scale primary care transformation projects in the Hudson Valley. The practice sites are a mix of large FQHCs, hospital based medical groups, and large, medium and small size privately held practices-all of whom serve the Medicaid population. The patients that these practices serve are a mix of adult and pediatric population, with some practices serving Orthodox Jewish population, and some with substance use and behavioral health needs in the communities.

The WMC Health PPS implementation efforts align PCMH standards and the DSRIP project requirements to minimize burden on primary care practices to participate in projects (See Figure3).

Figure 3. *Aligning PCMH Standards Requirements to DSRIP projects*

Primary Care Plan: WMCHealth PPS Primary Care Plan includes:

1. Expand primary care in high need communities:

(i) In Kingston (Ulster County) and Port Jervis (Orange County), WMCHealth PPS collaborates with local FQHCs to convert underutilized hospital facilities into expanded primary care and other outpatient services. These Medical Villages create an integrated primary care and outpatient destination in a convenient, 'one-stop' location using DSRIP resources.

(ii) The Team based care approach that is part of the practices' PCMH transformation process in the high need areas, also increases patient access to primary care related services.

2. Build up the capacity of the current primary care providers to deliver high quality, patient centered care and to be prepared for value based payments through Patient Centered Medical Home (PCMH) transformation:

   (i) Along with the 12.9% of the total PCPs who have already achieved PCMH 2014 Level 3 recognition, WMCHealth PPS is working with 45 primary care practice sites to achieved PCMH recognition, thus increasing the capacity of our PCPs.

3. Link primary care to other providers and community resources:

   (i) Medical Neighborhoods are the ideal venues to help link PCPs with other clinical services, secondary and tertiary specialty care and with community resources.

   (ii) Primary care integration with Behavioral Health (BH) helps establish and cement linkages with the BH providers in the community.

PRIMARY CARE PRACTICE AND WORKFORCE TRANSFORMATION SUPPORT

Practice Transformation Support: As reflected in NYS advancing primary care goals, the WMCHealth PPS is working on provider education & training, and providing centralized resources to sustain practice transformation efforts. For primary care, this means workforce trainings are delivered using different learning mediums and take place in traditional classroom settings, online or a combination of both. Training topics include competencies intended to improve performance across DSRIP projects. These trainings and education platforms will enable primary care providers to successfully manage the changes in the healthcare system and improve the quality of health and social services delivered to the residents in the region.

Taconic Pro's extensive assessments, gap analyses and project plans of practice organizations-both at the corporate level and at any associated sites level, provide a structural framework for transformation efforts. This is especially helpful for those medium to small practices that recognize the imperative to transform into a PCMH practice, but may not necessarily have the skills or resources to undertake such an overwhelming task within the allotted DSRIP timeframe. For those medical groups affiliated with any of our network hospitals, the transformation needs may be primarily sourced around staffing needs, or even helping to strategize staffing roles and expectations within the larger hospital-medical group community.

Provider Education & Training Support: The larger goal for WMCHealth PPS' Workforce Education and Training strategy is to improve and sustain the workforce competencies needed in a post-DSRIP future. Thus the approach of our Workforce Training and Education for primary care is one of innovative collaborations and inclusionary approaches across the WMCHealth PPS network. It covers the entire range of clinicians and providers, care managers, care coordinators, ancillary and support staff, community-based organizations, state and local agencies, workers representation and educational vendors. WMCHealth PPS invested in a web-based learning platform (Moodle) for primary care staff to access training materials related to VBP, Cultural Competency, Health Literacy and other DSRIP project related trainings. The education and training support also includes utilizing innovative collaborations and partnerships within the community, taking full advantage of other existing statewide resources for technical assistance and training while being mindful not to duplicate any support already given to the practice from other public sources.

Primary Care representation in PPS governance: WMCHealth PPS recognizes the role of Primary Care as pivotal in not only practice transformation to PCMH but also across all PPS committees and workgroups. The membership in the governance structure come from PPS' network partners that provide primary care services: the Quality Steering Committee has 7 out of 14 members who represent Primary Care

organizations and the Executive Committee has 7 out of 24 total members representing Primary Care. In addition, WMC Health Clinical Governance and DSRIP project advisory committee structure provides ample opportunities to train PCPs. Each DSRIP project has a Project Advisory Quality Committee (PAQC) that serves as an advisory body to the Quality Steering Committee. WMCHealth PPS has actively recruited participation to ensure the primary care perspective is represented within each PAQC and that primary care providers have input in project development and oversight. For instance, the Extended Care Management PAQC, (Health Home At-Risk-Project 2.a.iii), has agreed upon components of a Comprehensive Care Plan with input from both Primary Care, Behavioral Health and Health Home providers. Trainings were provided on the components of the required care plan earlier in the year, and we anticipate providing similar trainings as we move towards finalizing our model for Care Coordination. In addition to training on components of the Comprehensive Care Plan, we have a need for training staff on roles and responsibilities of care managers and care coordinators, around care coordination protocols, and specifically on how they align with PCMH standards requirements.

A similar approach was followed to agree on components of an Asthma Action Plan as part of Asthma Care management project (Project 3.d.iii) and a plan to adapt and incorporate nationally recognized Asthma best practices and guidelines to local primary care considerations. The PAQC committee brought together primary care, asthma specialists (Pulmonology and Allergy) with representatives of the Regional Asthma Coalition.

PAQC meetings also prove to be ideal venues to inform & recruit primary care for project-specific trainings, and some have served as ideal pilot sites for new and innovative trainings & educational opportunities. Based on the identified needs, WMCHealth PPS has partnered with Inquisithealth to pilot an evidence-based, peer mentor intervention program targeted towards patients with uncontrolled diabetes. Workforce development opportunities, such as Asthma Educator certification exam Prep workshops, help build the capacity of primary care providers and pediatricians in addressing the needs of their patient population with an Asthma diagnosis. This resource helps to meet the DSRIP Asthma Project deliverable, but also helps practices demonstrate meeting the standards requirements for PCMH around Team Based Care, Population Health Management, Care Management and support and Performance Measurement and Quality Improvement. As the DSRIP projects are implemented and the primary care sector continues transformation work towards PCMH recognition, we anticipate additional trainings that will address both DSRIP project goals and PCMH standards.

Primary Care at the center of a community based functionally integrated delivery network: Given the geographical breadth and diversity of WMCHealth PPS Network, it is recognized that the local and regional referral relationships using a medical home model need to be supported in order to transform patient care. PCMH practices function more effectively when supported within the context of a Medical Neighborhood. Utilizing the Agency for Healthcare Research on Quality (AHRQ) 2008 White Paper concepts, WMCHealth PPS uses the concept of Medical Neighborhoods as the organizing principle through which we integrate our delivery system, deploy DSRIP projects and resources, and inform our Primary Care Plan.

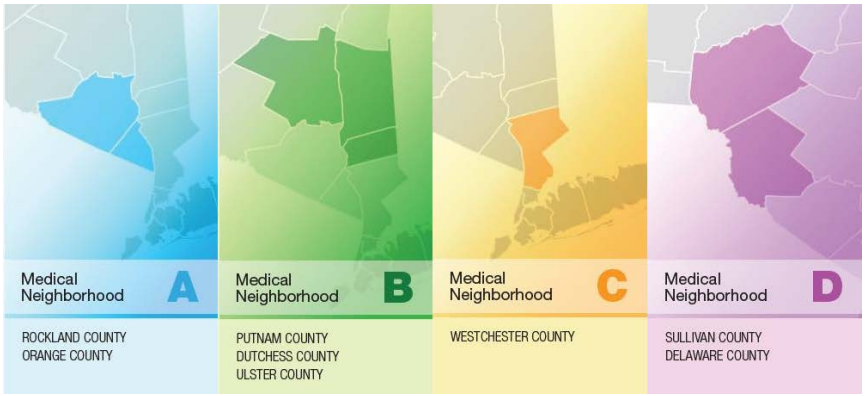
A Medical Neighborhood is a large scale non-physical construct that highlights the connections between primary care, and the constellation of other clinicians providing healthcare services to patients within it, along with area
hospitals, community and social service organizations, State and local public health agencies[2][2]. These hubs of patient-centered delivery of care utilize the organizational relationships thatrevolve around the care of a patient,

and form the figurative brick and mortar of the Medical Neighborhood. Helping affiliated primary care practices to achieve recognition per NCQA's 2014 Level 3 standards is a major component of building effective medical neighborhoods across our PPS.

The PPS developed a model of medical neighborhoods across the geographic coverage area -with an eye to the future of IT infrastructure building, population health, and practitioner performance measurement. There are four Medical Neighborhoods clustered in the geographies illustrated below (see Figure 4). Many of the primary care practices in the high need areas within these four Medical Neighborhoods are undergoing WMCHealth PPS supported PCMH transformation.

Figure 4. *Medical Neighborhoods across WMCHealth PPS*

[2] Agency on Healthcare Quality *Research Coordinating Care in the Medical Neighborhood: Critical components and Available Mechanisms* AHRQ Publication No. 11-0064 June 2011



PRIMARY CARE PREPARES FOR VALUE BASED PURCHASING

Value Based Payment Preparation: WMCHealth PPS invests its energy and resources in assisting its network partners to be prepared for Value Based purchasing (VBP). One such example is the VBP Learning Lab series developed and delivered to Community based providers (CBPs) within its network. This learning lab is an opportunity for CBPs to gain the knowledge and practical skills needed to participate strategically in the evolving healthcare environment and prepare for the transition to VBP. As CBPs are key partners with primary care in meeting the social determinants of health and identified in NYS VBP Roadmap, it is important to support these relationships. WMCHealth PPS will continue to educate CBPs and primary care in the role of care coordination and care management as further preparation for value based care.

Building Skills for VBP: Through the implementation of the DSRIP projects, WMCHealth PPS supports its primary care providers' readiness for VBP by providing centralized services in:

(i) Care management platforms to share data on care plans
(ii) Workflows for care transitions including discharge notification and summaries
(iii) Training of primary care on integrating behavioral health
(iv) Cultural competency trainings (in person and via WMCHealth PPS Learning platform)
(v) Process improvement via Plan-Do-Study-Act (PDSA) trainings

WMCHEALTH PPS FUNDS FLOW TO SUPPORT PRIMARY CARE STRATEGIES

WMCHealth PPS developed a model of funds distribution that aligns our strategy to support Primary Care providers. Figure 5 is a pyramid reflecting provider contracts; the distribution of funds differs upon the type of contracts: Actively Engaged Patients (AEP)/Pay for Reporting (P4R) as well as Threshold contracts,

Implementation contracts and for select providers-Patient Activation Measure (PAM) contracts.

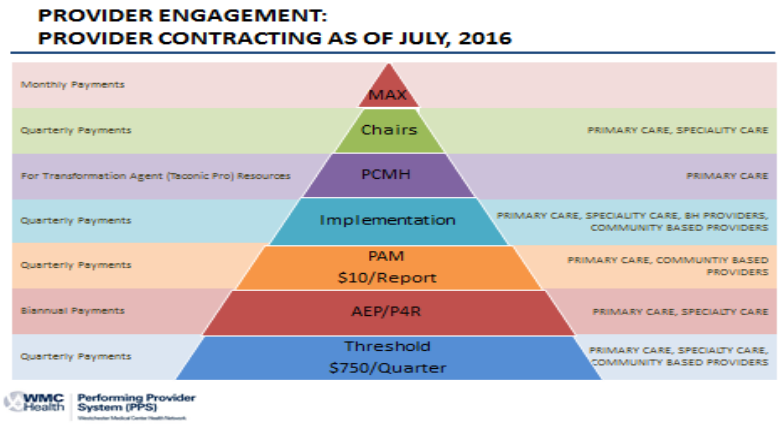


Figure 5. *Provider Contracting model*

PPS has allocated in-kind service agreements for technical assistance with Patient Centered Medical Home transformation. The chosen vendor, Taconic Pro, has worked with more than 350 Primary Care providers facilitating the adoption of PCMH model of practice transformation and their staff are recognized as PCMH Certified Content Experts. The Implementation contracts call out the partner expectations for creating an integrated Health Information Exchange via connections to Qualifying Entity. In addition, the Quarterly Participant Performance Requirement (QPPR) template for contracted partners serves dual roles: a) as an additional DSRIP projects' training & guideline tool for providers to understand the parameters of their DSRIP participation requirements, and b) as a tool to collect documentation of our partners' performance over the course of a quarter to and to determine eligibility for ongoing DSRIP project funding. A summary of the different types of contracts are shown in Figure 5.

Figure 5. *Types of contracts used to support funds flow to primary care organizations*

TYPE OF CONTRACTS	DESCRIPTION	SUMMARY
Threshold	Threshold WMC PPS Participation	DSRIP support for completion of DSRIP readiness assessment, support and guidance.
PAM	Patient Activation Measure Survey	DSRIP support for completion of Patient Activation Measure Survey for DSRIP Project 2.d.i.
AEP/P4R	Actively Engaged Patient/Pay for Reporting	DSRIP support for data submissions on actively engaged patients.
Implementation	Implementation Project Activities	DSRIP resource support to assist in the successful completion of DSRIP project implementation activities, milestones and deliverables.
Committee Leadership	Committee Chairs, Co-Chairs, Co-Vice Chairs	DSRIP support for engagement in committee leadership activities critical to WMCHealth PPS's success.
IDS/PCMH	Integrated Delivery System – Patient Centered Medical Home (PCMH)/ Meaningful Use/ Qualifying Entity Connection	Technical Assistance Consulting to help practices meet 2014 NCQA Level 3 PCMH and/or APCM standards, as well as Stage 2 Meaningful Use Stage 2 CMS requirements and connection to

INTEGRATING PRIMARY CARE AND BEHAVIORAL HEALTH

From the beginning, WMCHealth PPS has embraced that the integration of Behavioral Health (BH) must be a consideration in every DSRIP project (See Figure 6). Our understanding of how to do that is evolving as the DSRIP project work unfolds. We are now approaching BH integration from three perspectives: from primary care, from behavioral health, and from the community.

Figure 6. *From presentation to the DSRIP Oversight Panel, November 10, 2015*

Integrating Behavioral Health into Eleven Projects	
2ai Integrated Delivery System*	An integrated delivery system will build the analytical and care management infrastructure for Population Health Management.
2.a.iii Health Home At Risk*	An integrated Care Plan alerts BH providers to medical concerns; helps primary care to incorporate patient centered goals.
2.a.iv Medical Village*	Co-located Medical, behavioral and social services will create opportunities for training workforce in integrated care delivery.
2.b.iv Hosp Transitions*	Adapt evidence based practices like Medication Reconciliation to address medical re-admissions following BH discharges.
2.d.i Patient Activation*	Connect patients to regular source of care and to options for insurance coverage; provide links to social services.
3.a.i BH/PC Integration*	BH professional services at PC site, "warm transfer" of patients who screen positive or need BH services, BH notes in PC record.
3.a.ii BH Crisis Stabilization*	Improve BH crisis stabilization services throughout seven counties in the PPS service area.
3.c.i Diabetes*	BH medications exacerbate diabetes; protocols adapted to different practice settings support disease management for all.
3.d.iii Asthma*	Asthma medications can precipatate anxiety attacks; training BH & HH on asthma treatment to reduce anxiety related ED visits.
4bi Tobacco Cessation*	A focus of the tobacco cessation work is the BH population including development of training for BH staff.
4bii Cancer Screening*	BH patients often fail to get routine medical preventive care. Population Health Management tools will help patients, families and BH and primary care to be aware of gaps in care.

*includes TRAINING for partner staff and/or development of new positions

Integration from the Primary Care Side: The primary care approach to BH integration has three components:

*Project 3.a.i (Integration of Primary Care and BH, embedded BH at primary care sites);

*Identifying and addressing needs for training and support around management of BH conditions;

*Improving "warm" hand-offs from primary care to BH for specialty care.

The PAQC for Project 3.a.i includes both primary care and BH participants. Early reporting of Actively Engaged Patients was limited to depression screening and the numbers reported have been higher than anticipated, indicating that participating practices are already implementing depression screening

guidelines. The committee then reached consensus on the importance of encouraging primary care practices to screen for Substance Use Disorder (SUD) in addition to universal screening of adults and adolescents for depression. The Committee reviewed SUD screening tools and approved several. The next step is to get a more in depth understanding of the perspectives of primary care practices on integrating more behavioral health care. Some of the needs have been articulated as questions around:

1. What training needs do primary care physicians and nurse practitioners have for themselves and for their staff?
2. What kind of BH support would increase PCPs' comfort level in providing basic BH services?
3. What are the obstacles, barriers and best practices in embedding BH practitioners at primary care sites?
4. What needs to happen to facilitate "warm" hand-offs from primary care to BH providers, when more specialized BH services are required?

To understand this better, WMCHealth PPS has contracted with a Senior Psychiatrist with many years of experience in ambulatory BH practice and also experience in developing training materials. Accompanied by the project management office program manager for Project 3.a.i, Dr. Levin is conducting onsite interviews with key primary care partners in different practice settings. The learnings from his interviews will be reviewed by the PAQC and will be used to inform the development of training materials and next steps for the project.

Integration of primary care and BH from the behavioral health side:

(a) Collaborating on developing and implementing protocols in BH outpatient clinics and other venues to identify patients at increased risk for diabetes and/or cardiovascular disease as a consequence of exposure to certain anti-psychotic medications.
(b) Identifying and addressing BH needs for training and support around screening for and co- management of medical conditions commonly seen in a population of BH patients including the condition of neglect of routine medical care or dental care;
(c) Improving hand-offs from BH to primary care for medical management.

On May 24th the Hudson Region DSRIP Clinical Council (HRDCC) comprised of representatives of the three PPS in the Hudson Valley convened a meeting attended by Behavioral Health Providers from both ambulatory and inpatient settings, PCPs including FQHCs, Health Home agencies, Medicaid Managed Care and Managed Behavioral Health Care. The purpose of the meeting was to review a subset of the DSRIP performance measures that focus on patients

being treated for BH conditions. Following a review of the measure specifications and the data sources and data collection process, the group discussed existing barriers, best practice, and strategies for improvement. Subsequently the group met by Webinar to draft a general workflow that could improve measure results in an outpatient BH setting. An onsite process mapping session to implement the workflow is planned for mid- September. The learnings from this session will be reviewed by the HRDCC and will be used to inform the development of training materials and next steps for the project including how to best manage "warm" hand-offs to primary care. The group chose to begin this work with the narrow focus of 5 Healthcare Effectiveness Data and Information Set (HEDIS) measures but understands that other medical conditions, including lack of medical care, warrant similar approaches.

Integration of primary care and BH from the community:

1. Collaborating on Crisis protocols with other PPS and with county agency on training primary care providers in identifying patients at risk and how to effectively use BH Crisis services.
2. Examples of work integrating primary care and behavioral health from the community with specific network partners include the Dutchess County Crisis Stabilization Center, and the MAX pilot project with Ellenville Hospital and the Institute for Family Health.
    a. The Dutchess County Crisis Stabilization Center is a multi-agency, single care team collaborative, providing medical, behavioral and substance use services.
    b. At Ellenville Hospital, as part of the MAX pilot project, opioid users are screened, triaged and connected with primary care, substance use, and recovery services.

Other communities have shown interest in replicating these innovative and comprehensive models of care pathways in addressing needs of the population.

SUMMARY

WMCHealth incorporates advancing primary care support into all of its DSRIP project work. Below is a summary table highlighting key areas of primary care needs identified within our PPS network and elements in place to address them (See Figure 7). The PPS appreciates the central role of primary care in the transformation of the delivery system.

Figure 7. *Fundamental Elements of Primary Care Plan*

NYS FUNDAMENTAL ELEMENTS OF A PRIMARY CARE PLAN	WMCHEALTH PPS PRIMARY CARE NEEDS	PRIMARY CARE PLAN ELEMENTS
Assessment of primary care capacity, performance, needs	Expand primary care in high need areas Enhance capacity of primary care Link primary care to other providers	Medical villages PCMH transformation -Team Based Care Medical Neighborhoods
Primary care expansion, practice and workforce transformation support	Practitioner engagement and training Primary Care Workgroup PPS Workforce training sessions Vendors to support key activities	Education via WMCHealth PPS Learning Platform: -Cultural Competency -Health Literacy -Process Improvement via PDSA Trainings Team Based Care PCMH Technical assistance
Primary Care role within Integrated Delivery System	Place primary care at the center of an integrated delivery network	Medical Neighborhood
Primary Care participates effectively in a Value Based Payment system	Provider Education Skills needed to succeed in a VBP environment	VBP Learning Lab series Care coordination/Care Management
Funds flow to support primary care	DSRIP resources for primary care providers	Contracts for DSRIP funds and resources
Integrating Primary Care with Behavioral Health	Enhanced access to Behavioral Health	Handoffs from Primary Care to Behavioral Health